

**Study of Undiagnosed Brain Injuries
In Wyoming's
Prison Population**

Prepared for

**The Wyoming Department of Health
Division Developmental Disabilities**

By

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Executive Summary

According to jail and prison studies, 25-87% of inmates report having experienced a head injury also known as a Traumatic Brain Injury (TBI) as compared to 8.5% in a general population reporting a history of TBI. See the attached Centers for Disease Control and Injury Prevention (CDC) publication entitled *Traumatic Brain Injury in Prisons and Jails: An Unrecognized Problem*.

In Wyoming, prison populations had never before been screened for brain injuries. When the Department of Corrections (DOC) was approached about the project, they were very willing to consider that this population was likely to have brain injuries, but DOC had no screening tools to attempt to identify those inmates with such a history.

The CDC Prevention state-by-state comparison data from 1999 stated that Wyoming had the highest per capita incidence of brain injury in the nation at 3%, compared with the national average of 2%. It might suggest that Wyoming had a potentially larger prison population living with brain injury as well.

Although the sample population was screened using a self-reporting tool, the Brain Injury Screening Questionnaire (BISQ), that identifies potential brain injury based on history and reported symptoms, it is not a definitive test for brain injury and will result in a report only of the LIKELIHOOD of inmates to have a brain injury. Therefore, it is important for DOC to recognize that those whose results indicate a moderate to high likelihood will require additional testing, such as a neuropsychological evaluation, to confirm a diagnosis of brain injury.

It was interesting to note that the scores returned from the screening indicated that just 18% were negative, meaning they reported no symptoms or history indicating potential for brain injury. This figure is right in line with the CDC figure of 25-87% of the population being positive for the condition. Although Wyoming's general population has a higher per capita incidence of brain injury, it appears that incarcerated persons across the country have a similar rate of brain injury as those within the state of Wyoming. It is interesting to note, however, that Wyoming's rate does fall toward the high end of the statistics.

Recognizing brain injury and identifying its survivors are good first steps in addressing the needs of those inmates. This report provides some recommendations to address the needs of those survivors, particularly in preparation for their return to society. It is our hope that with supports and services in place, those brain injury survivors would be less likely to return to prisons in the future.

Introduction

In 2004, the Wyoming Department of Health, Developmental Disabilities Division was approved for its first Health Resources Services Administration (HRSA) Planning Grant, to assess the state of services for Traumatic Brain Injury (TBI) in Wyoming. Named the Wyoming Gaps and Needs Survey, this first collection of data was presented to the Wyoming Acquired Brain Injury Task Force (the Task Force) by the surveyor, Earl DeGroot, of Western Management Services, Inc. The Gaps and Needs survey looked at state programs, non-profit organizations, federal programs, and community services. A brain injury survivor forum was needed in order to survey brain injury survivors. The surveyors utilized the Brain Injury Association of Wyoming's support groups and mailing list to contact survivors and their families, and surveyed 500 brain injury survivors across Wyoming. Once the data was analyzed, the Task Force realized that children were under-represented in the data, and inmate populations were not included in any way. The ABI Task Force decided to complete assessments of both population groups, to see what additional information could be gathered. They also wanted to know how we could help these populations, once we knew more about them. The children's study is available upon request.

The HRSA grant provided a limited amount of money for the assessment, and a random sampling number of participants were needed. The Task Force settled on a sampling of 200 people from the inmate population. The State of Wyoming has a population of just over 500,000 people. The Centers for Disease Control and Injury Prevention say that approximately three percent of Wyoming residents live with the effects of traumatic brain injury. Three percent of Wyoming's population would be 15,000 people. Of those 15,000 brain injury survivors, 500 were surveyed during the gaps and needs survey. If the three percent statistic holds true, we would expect to see just six people with high probability of brain injuries being identified by the BISQ as a result of the prison survey. This would mean then that 506 Wyoming brain injury survivors' needs had been identified as a result of the HRSA funding. That number represents approximately 3% of the brain injury survivors in the state. Due to the small general population in the state, it might not be possible to survey a statistically valid number of brain injury survivors. Therefore, a random sampling was considered the best approach.

The tool selected for this assessment was the Brain Injury Survey Questionnaire (BISQ), developed by Dr. Wayne Gordon of Mt. Sinai School of Medicine. Because this tool was specifically designed to provide outcomes that stated the likelihood of a previously undiagnosed brain injury and accommodations for reported symptoms, it was felt that this tool most closely fit the purpose of the study. Dr. Gordon's BISQ assessment forms and accompanying set of manuals, instructions sheets, and analysis of validity are available at the Brain Injury Association of Wyoming (BIAW) upon request.

Dr. Gordon was contacted and provided consultation in the manner of completion of the questionnaire, as well as technical assistance throughout the survey process. Once all forms were filled out by participants, the forms' administrative sections were then completed per Dr. Gordon's instructions. The bubbles matching the participant data were filled in by the surveyors, the completed forms were stripped of identifying information, and the BISQ forms were then shipped to Dr. Gordon for data processing.

Each form was coded with a number that would allow the surveyors to get individual report outcomes back to participants, without identifying those individuals to Dr. Gordon, while still protecting privileged medical data. Once the data was entered into his system, Dr. Gordon completed a profile for each person surveyed, provided a printed report (based on the participant code numbers), and shipped them back to BIAW. While the forms were being shipped, Dr. Gordon e-mailed the coded data files to BIAW for statistical analysis.

Purpose and Approach

In general, the approach was to administer an accepted and validated screening tool to both males and females in the prison population. The survey tool selected was the Brain Injury Screening Questionnaire (BISQ) created by Dr. Wayne Gordon of the Department of Rehabilitation Medicine, Mount Sinai School of Medicine. This survey instrument is a fill-in-the-dot format that is machine score-able. The results indicate the likelihood the subject has a brain injury and suggests accommodations based on the symptoms reported by the subject. This is not a diagnostic tool and results indicating a likelihood of brain injury should be followed up with a neuropsychological examination to secure an accurate diagnosis.

The purpose of the study is to identify previously undiagnosed brain injuries in Wyoming prison inmates. Specifically the goals were to 1) assess the likely percentage of Acquired Brain Injury (ABI) survivors in the Wyoming prison populations, 2) assess the existing supports being used to address the needs of this brain injury population, 3) determine whether brain injury survivors are receiving appropriate services and supports prior to having their brain injuries identified, and 4) assess the need for development of brain injury services and supports within Wyoming correctional facilities.

By researching the numbers of inmates with previously undiagnosed brain injuries, a determination could be made whether this type of assessment should be completed for each new inmate upon admission as part of the usual screening process. Identifying survivors of brain injury would assist correctional facility staff in resolving conflicts, providing appropriate supports, reducing the numbers of inmate/staff and inmate/inmate miscommunications. Potential could exist to develop correctional facility staff training specific to brain injury, support groups, cognitive re-training curricula, accommodations for cognitive deficits, and a community re-entry plan for those brain injury survivors experiencing significant symptoms. These services and supports could potentially help reduce recidivism in Wyoming inmates living with deficits as the result of a brain injury.

Samples in the incarcerated population were to include men and women in numbers proportional to the number of men and women in the prison population. At the outset of the survey, a selection of 200 prisoners were felt to be representative, and in fact, turned out to be 26% of the in-state prison populations housed at the Wyoming State Penitentiary (WSP) in Rawlins, and the Women's Correctional Facility (WCF) in Lusk. (Actual counts of prisoners on the dates of testing were 626 men at WSP and 132 women at WCF.)

Male participant ages ranged from 17 years to 82 years, with the average at just under 37 years. Seventy-eight percent of males taking part in the study were Caucasian while twelve individuals were Hispanic, nine were Native American, five were African American, four of other ethnic backgrounds, and one was Asian. One did not specify ethnic origin.

Female participant ages ranged from 20 years to 58 years, with the average at just under 36 years. Ninety-one percent of the female participants were Caucasian; the remainder made up of three Native Americans, one African American, and one Hispanic.

Thirty percent of male and fifty-nine percent of female participants denied permission to share their individual results with the Department of Corrections.

The Process

The BISQ survey tool was selected by the surveyors. The Department of Corrections (DOC) was contacted to request their assistance and gain access to the subjects. A meeting with DOC staff was held during which numerous questions were asked about the process, purpose, and possible outcomes of the study. Suggestions were made about the proposed process and the surveyors were referred to have the study approved by an institutional review board.

Sam Borbely, a lead DOC staff, was selected to be the point of contact. Mr. Borbely made all of the staff arrangements and scheduled the dates/times for the surveys to be presented to the subjects. He arranged for assessment rooms, pod schedules, chairs etc. and took the surveyors personally to the various pods where the subjects were located.

Department of Corrections staff members were asked to randomly select 200 participants for the survey. However, they did not do so. Instead they asked all inmates who were interested in taking a health survey to complete an informed consent form. Those inmates, whose forms were returned, were called out in pre-determined groups to complete the questionnaire. One hundred ninety-five of the two hundred desired subjects participated. Each inmate was offered and received a five dollar credit to their prison account, as an incentive to complete the questionnaire.

Once they entered the assessment area, each group of subjects was given two new informed consent forms to complete. One required a full signature and inmate number while the other asked for only their inmate number as a signature. This would ensure that surveyors did not have access to inmate names and could not identify them. The forms with the inmate names and signatures were returned to DOC while those with only inmate numbers were retained by the Brain Injury Association of Wyoming (BIAW) and shared with Dr. Gordon so that he had a statement that the subjects understood he would be compiling the data for the study.

The surveyors provided instructions on completion of the forms, and remained in the room while the subjects did so. Subjects were encouraged to ask questions if they did not understand questions, and the surveyors assisted any subjects who were unable to read the forms. In one case there were two participants at the same time that needed help. One only spoke Spanish, and the other did not read. Another inmate read the questions out loud in English and Spanish and explained them to the men on either side of him. When the questionnaires were completed, the surveyors checked to see if any questions had been skipped and whether the forms were filled out correctly. Errors were identified and the surveyors helped the subjects correct them before they left the assessment area.

Completed forms were transported back to BIAW where they were kept in a locked closet until the administrative sections were completed and they were shipped to Dr. Gordon. Upon return from Dr. Gordon, the BISQ's and related release forms were kept locked until the data could be analyzed.

Once the data was analyzed, the forms were sorted according to whether the participants wanted their information shared with the Department of Corrections (DOC). Those whose data could not be shared will be provided a copy of the outcome of the BISQ and any recommended accommodations. These will be hand-delivered in sealed manila envelopes. Because subjects are not known to the surveyors, all results and materials are subject to high security safety rules. No staples, paperclips or other metal will be included in or on any envelope. Those results which can be shared with DOC will be photocopied and a copy of the results and any recommended accommodations will be provided to DOC

Upon acceptance of the final report, all surveys and accompanying release forms will be shredded by the Brain Injury Association of Wyoming.

Difficulties

There are challenges whenever one undertakes a study involving human subjects. A standard and necessary part of developing a human study is to include review by an Institutional Review Board (IRB). The purpose of the IRB is to review the proposed study to ensure that subjects are treated humanely, and that their rights and privacy are preserved. These needs are particularly acute when the subjects belong to a vulnerable population such as the prison population. The IRB brings expertise from fields like health, ethics, and subject population specialists etc., to look carefully at the architecture of the study and recommend changes that will ensure the subjects are protected and that the study is successful in terms of obtaining un-coerced data.

The Wyoming Department of Health has a standing IRB used to review research performed within State agencies. This group meets monthly and was a good fit for our project as it is funded through a federal grant administered by the Department of Health, Division of Developmental Disabilities.

The IRB has a collection of documentation it requires in advance of the review board meeting. Those items were provided via e-mail for review by the IRB members. Our meeting with the IRB was conducted by phone and involved difficult, direct questions about what we sought to learn, how we proposed to gather the information, and how the data would be treated during and after the study. The board was professional and direct in questioning and expressing concerns. They also suggested alternative approaches where the initial plan had perceived weaknesses. The result of the meeting was a letter of conditional acceptance of the plan. This was accompanied by a list of changes we had agreed on during the meeting. Upon resubmitting the plan with the updates, the final letter of acceptance was issued.

Some of the specific concerns for the prison study included:

- While being offered the opportunity to participate in the study, inmates were given no indication that the study was to look for brain injuries. The surveyors did not wish subjects to self-select for brain injury, or to opt out because of the subject matter. The IRB wanted the surveyors to be sure the subjects were aware of specifically what the project was about before they agreed to participate. This resulted in a “blind study” informed consent form that subjects completed in order to opt into the study. At the time of the survey, subjects were given a second informed consent form that told them the true purpose of the study.
- The informed consent forms needed to be revised to make it clear to subjects that they could opt out of the study at any point in the process and that the only consequence for doing so was the loss of the five dollar study completion incentive.
- The informed consent form had to tell the subjects that data would be kept private and that they had the option to either share or not share their data with the Department of Correction staff.

The prison staffs were very supportive and helpful. This was critical as there are complexities to performing research in a prison setting. A great deal of effort was made to gather enough participants for the study, and to balance the number of male and female subjects. Schedules for staff and inmates were disrupted by the process, and staff were extremely accommodating to the needs of the surveyors.

When it appeared we would not have enough participants due to people opting out, staff went among the other inmates asking for additional volunteers. There were many more people interested in taking the survey, and at some point some stated that their blind study informed consent forms had apparently been lost. The inmates were eager to earn the \$5 participation incentive, which represented a week's pay, and completed the forms for our records before joining in the study.

In the Women's Correctional Facility, groups of as many as 25 women were asked to complete the BISQ form. All together, 51 women were surveyed. All surveys were completed in the dining room of the facility, with DOC staff attending the groups. The women were quiet and cooperative, only speaking when they had questions or were finished with the questionnaire.

In the State Penitentiary the BISQ was administered to the inmates according to their housing pod. Group size varied from eight to twenty-two men at a time. The men used the time to jokingly poke fun at each other when they got to questions they found interesting. It appeared that the testing became a social activity for them, and they used the time to speak with people they did not usually interact with. In some pods the men were medically or behaviorally restricted. Surveyors were required to administer the BISQ through heavy steel doors, speaking through small food-tray openings. Working in this manner slowed the process, and so it took two full days to assess 144 men. At times, the schedule of the facility required counting the inmates, and the surveyors were locked in with a group of subjects for as much as an hour longer than the group needed to complete the forms. When this happened, the surveyors visited with the men, and some shared their stories about the reason for their incarceration or the illegal activities they had been involved in at this and previous criminal institutions. However, at no time did the surveyors ever feel threatened or uncomfortable with the interactions. In fact, other inmates prompted those using strong language to revise it because the two surveyors were women and "...that's just not right in front of the ladies."

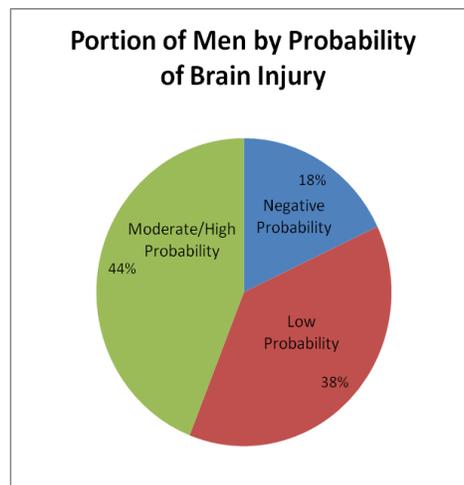
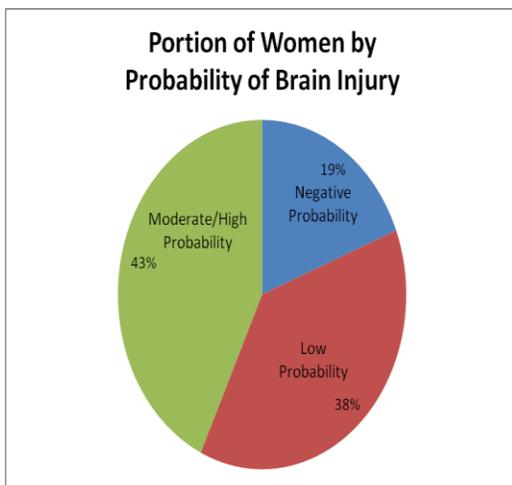
The men's facility is a maximum security prison. Because of this, there were numerous security measures being used. One of those included a locator box assigned to each non-inmate. This box was shaped and sized similarly to a cell phone and was attached to each person's waistband or pocket. These boxes were positionally sensitive, so if you were wearing one and bent over, fell, were knocked down etc., the box would begin to beep increasingly faster and security staff would be alerted. After a few hours, the surveyors were no longer so consciously aware of the devices. At one point, while leaning forward to speak through one of the heavy steel doors, an inmate told one surveyor "Uh, ma'am, you're beeping." She immediately straightened up and returned the locator box to upright. Within a couple of minutes she was tapped on the shoulder by a large, armed man, in a black correctional officer's uniform. He asked her name and spoke very sternly and crisply into a walkie-talkie indicating that he had located

the surveyor in question and that she was all right. After this, the surveyors were more careful about position, and there were no safety issues for the remainder of the study.

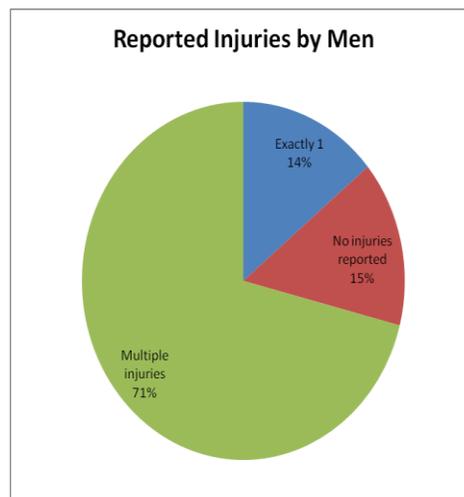
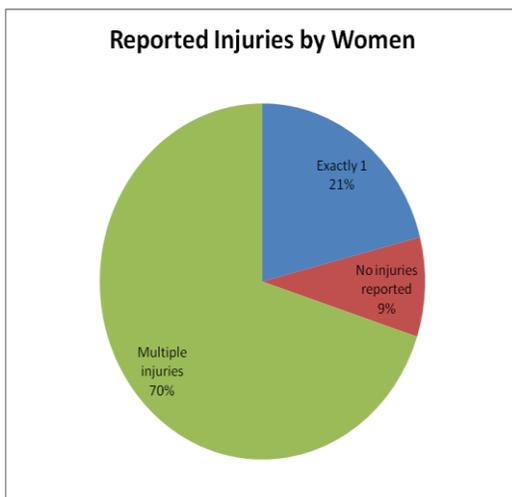
The Results

This section summarizes the results of the project and in particular highlights trends seen through the data. This is not raw data, but rather interpreted data that is included to demonstrate brain injury prevalence and possible causes as they apply to these specific populations. It must be recognized also that relationships between life experiences and the likelihood of a brain injury are not necessarily causal in nature, but simply relationships between different data elements.

One hundred forty-four males and fifty-one females were surveyed with results described in terms of the probability of a brain injury. Individual results may be: negative (indicating it is highly unlikely the subject has received a brain injury), low probability, or moderate/high probability of a brain injury. The graphs below show the distribution of the results for male versus female populations:



Clearly the likelihood of brain injury appears to be about the same regardless of gender within the prison system.

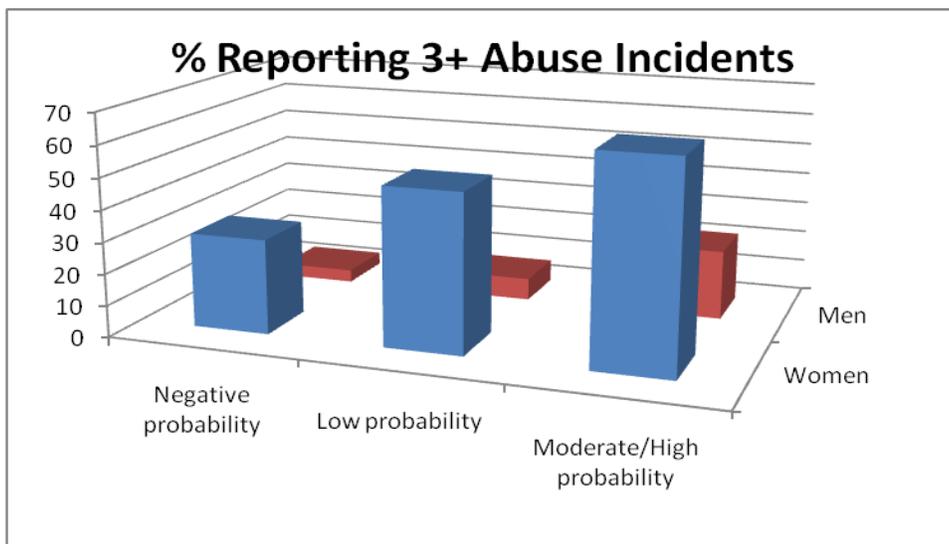


The charts above reflect how the male and female populations reported the number of injuries they received.

The average age of men reporting multiple injuries was 36.3 years with the average age of first and last injury reported as 12.4 years and 28 years, respectively. When a single injury was reported the average age was 39.3 years with average first and last injury ages reported as 22 years and 61 years. For men, the average number of years between first and last injury was 15.5 years with the average time since the last injury reported as 8.3 years.

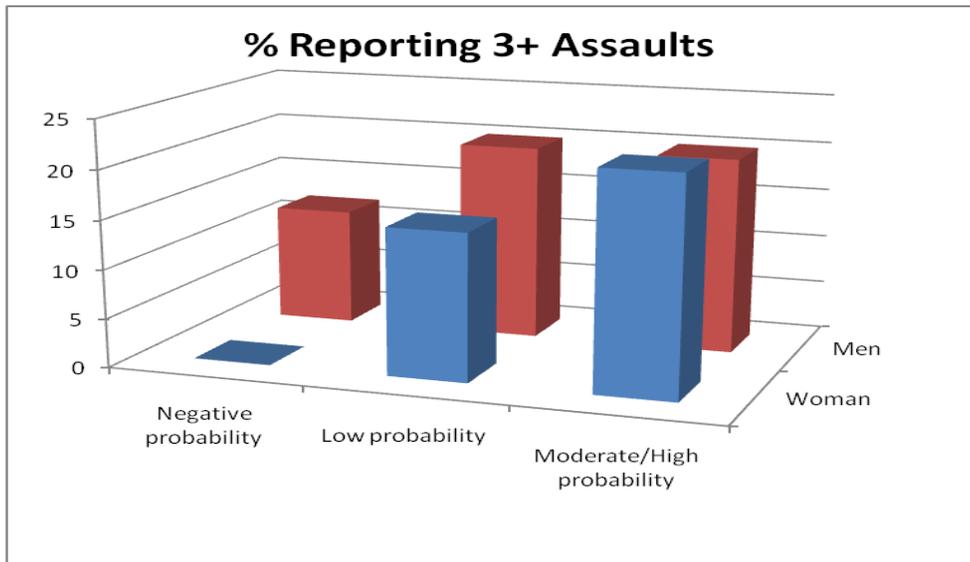
For women reporting multiple injuries, the average age was 37.4 years with the age of the first and last injuries occurring at ages 14.7 years and 32.3 years, respectively. Average single injury age was 32.9 years with first and last injury ages being 10 and 33 respectively. For multiple injuries, the time span from first to last was 17.6 years on average with 5.1 years having elapsed on average since the last injury.

Participants were asked about head injuries resulting from abuse. For males and females whose results indicate a negative, low or moderate/high probability of brain injury, the charts below show what portion of the population report one or more incidents of abuse. The chart shows that as the probability of a brain injury goes up the likelihood of incidents of abuse also goes up. The percentage of women reporting incidents of abuse is significantly higher than for men.

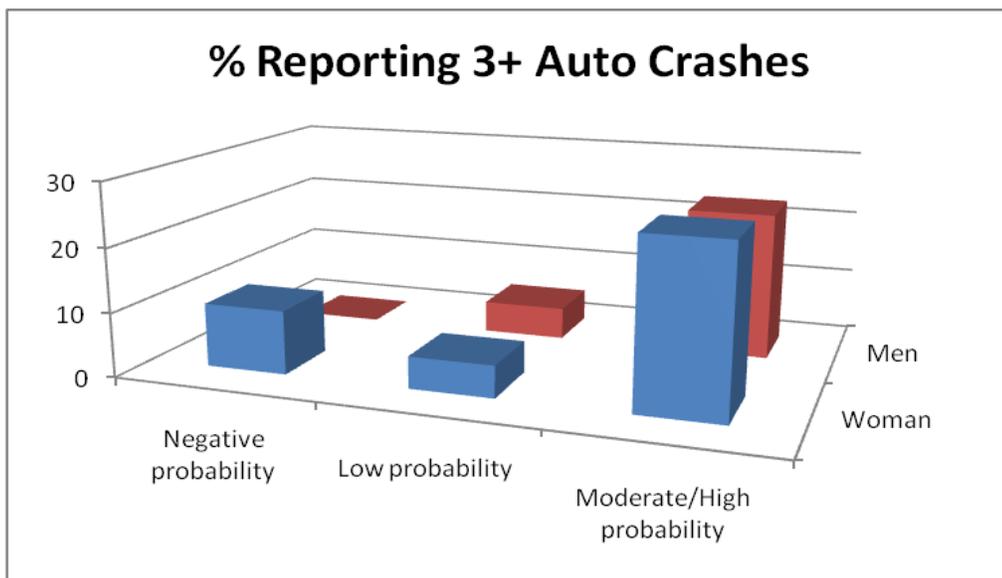


Reports of assault among the male population were much higher than reported incidents of abuse. It is not clear whether this is a result of men having reservations about reporting abuse whereas they have no such reservations about reporting assaults. The graphs below examine reports of three or more incidents of assaults for men and women with data separated by their probability of brain injuries. Data indicates higher reported incidents of assault for both men and women among those with higher probability of

brain injury. Women especially display the trend of increasing likelihood of brain injury with high incidents of assault.



Car/van/truck/bus crashes are a major cause of brain injuries both in Wyoming and the nation. In the prison population almost 26% of women and 58% of men reported being involved in one or more vehicle crashes. When examined based on probability of brain injury, the trend indicates significantly larger portions of the population reporting three or more automobile crashes when the probability of brain injury is moderate or high. The following chart shows the study data:



The injuries most commonly cited by women with a moderate or high probability of brain injury are summarized in the table below along with the percent of those subjects reporting the injury.

(Many respondents reported numerous incidents of blows/injuries, therefore, the total percentage of those reporting will equal more than 100% of the respondents.)

Injuries Most Reported by WOMEN with Moderate/High Probability of Brain Injury

Cause of blow	Percent Reporting
Car/van/truck/bus crash	91.30%
Being physically abused	82.60%
Falling during a drug or alcohol blackout	Each category was reported 60.87%
Being assaulted or mugged	
Falling down stairs	52.17%
While playing on playground	47.80%

Similar information for men is shown in the following table:

Injuries Most Reported by MEN with Moderate/High Probability of Brain Injury

Cause of blow	Percent Reporting
Car/van/truck/bus crash	70%
Being assaulted or mugged	52%
Falling during a drug or alcohol blackout	42%
Being physically abused	Each category was reported 39%
While biking	
In sports (football, baseball, basketball)	Each category was reported 38%
While on the playground	
Being hit by a falling object	
Falling from a high place	

It is worth noting that a significantly higher percentages of women reported injuries than did men.

The five most common symptoms reported by men and women along with the percent reporting the symptom is shown in the following two tables:

Symptoms Most Reported by WOMEN with Moderate/High Probability of Brain Injury

Symptom Reported	Percent Reporting
Feeling frustrated	Each category was reported 96%
Feeling tired	
Losing your train of thought	
Feeling moody	
Being easily distracted	Each category was reported 91%
Forgetting what you just said	
Losing track of time	
Feeling impatient or irritable	
Feeling cold	Each category was reported 87%
Having headaches	
Difficulty concentrating, having a poor span of attention	
Forgetting if you have done things	
Forgetting, missing or being late for appointments	
Experiencing rapid changes in mood	
Feeling angry	
Having repeated thoughts	
Feeling lonely	
Feeling jumpy, restless or unable to stay still	
Feeling sad or blue	
Not feeling confident	
Feeling misunderstood	Each category was reported 87%
Being clumsy, dropping or tripping over things	Each category was reported 83%
Forgetting what happened yesterday or other recent events	
Forgetting well-known phone numbers or addresses	
Misplacing things, forgetting where things are	
Forgetting where you just read	
Having difficulty getting started on things	
Feeling uncomfortable around others	

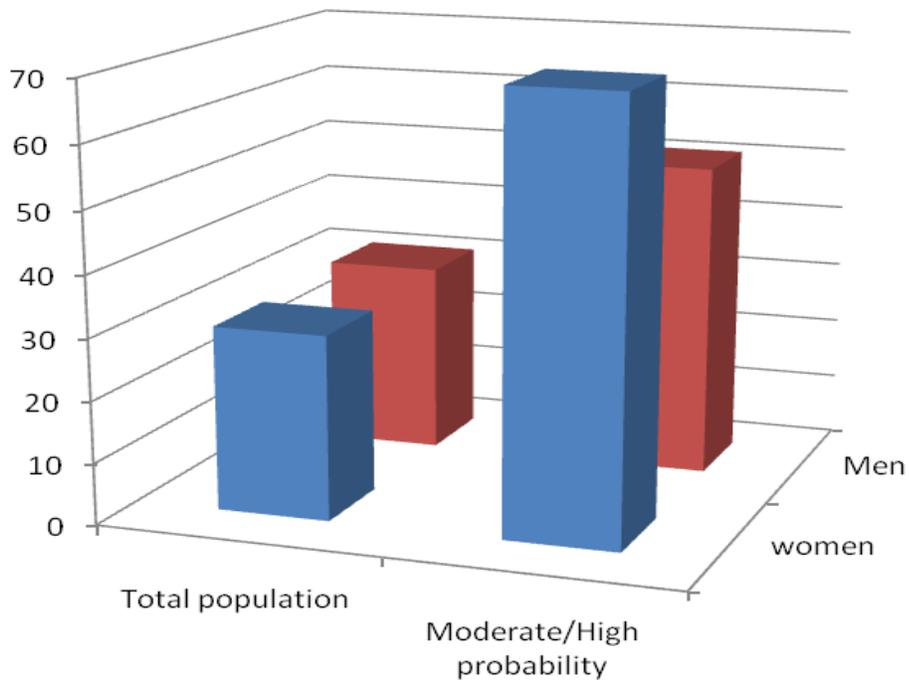
Similar information for men is shown in the following table:

Symptoms Most Reported by MEN with Moderate/High Probability of Brain Injury

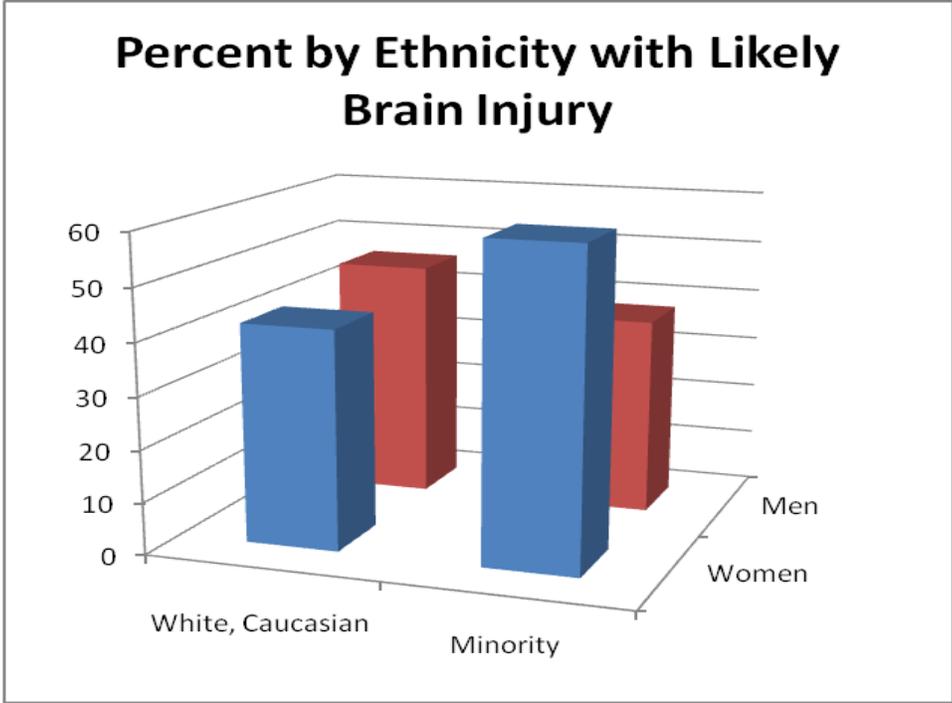
Symptom Reported	Percent Reporting
Feeling impatient or irritable	92%
Losing your train of thought	91%
Feeling moody	Each category was reported 89%
Feeling lonely	
Feeling sad or blue	
Being easily distracted	Each category was reported 88%
Difficulty concentrating, having a poor span of attention	
Having trouble falling asleep or staying asleep	
Having headaches	86%
Feeling angry	Each category was reported 86%
Experiencing rapid changes in mood	

Looking at the relationship between having a moderate or high probability of having a brain injury and the likelihood of being involved in alcohol or substance abuse treatment or a support group is shown in the following chart. The percent of the general population involved in treatment or a support group is also displayed. Women with a high likelihood of brain injury are involved in treatment or support in significantly higher percentages than men. Both men and women with high likelihood of brain injury are more apt than the general population to be involved in treatment or support groups for alcohol or substance abuse.

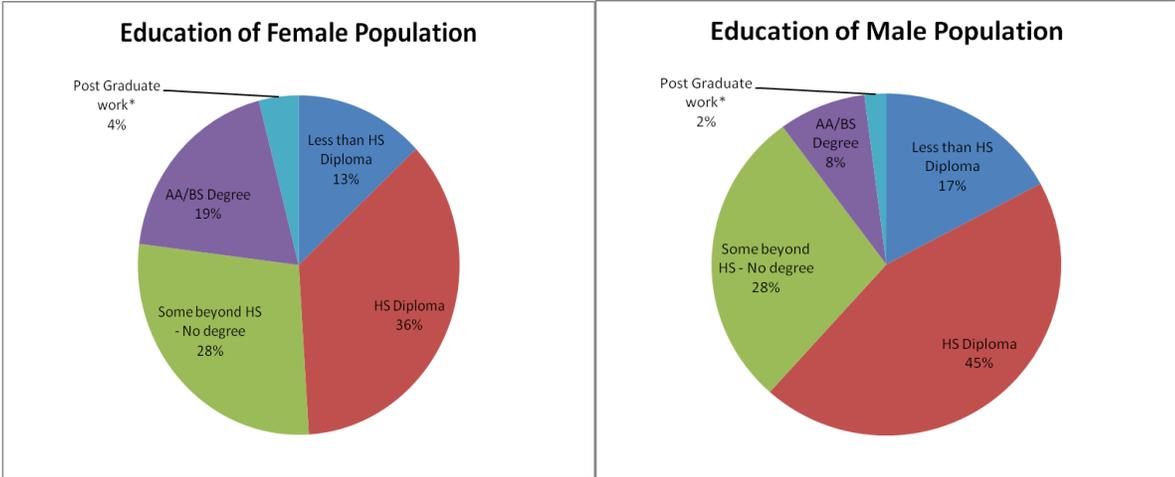
Percent in Alcohol or Substance Abuse Support/Treatment



This chart looks at ethnicity as it relates to the likelihood of having a brain injury, the following chart suggests that while minority males experience brain injury at lower rates than their Caucasian counterparts, minority females experience a higher likelihood of having brain injury.



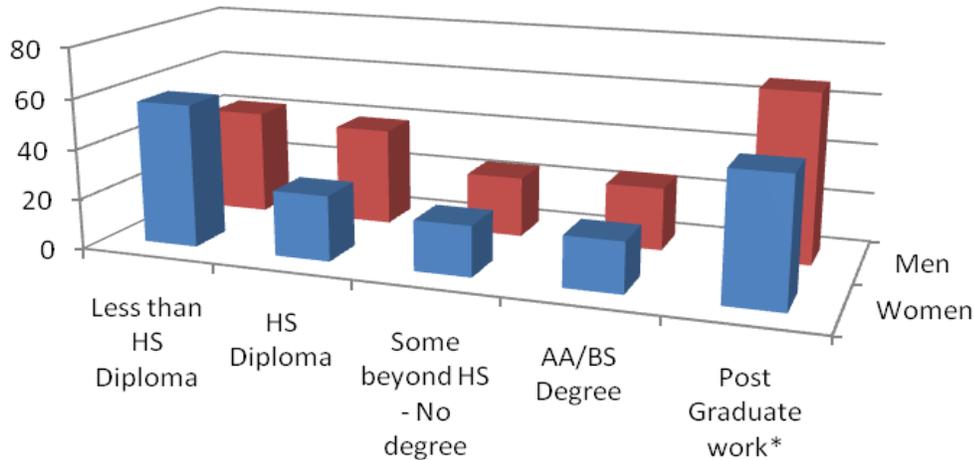
The education level of the general prison population is shown in the following two charts:



There is a higher percentage of women with college degrees.

The following charts reflect the percentage of likely brain injuries by education level. The number of participants having post graduate education was small for both men and women hence the results for this group are not likely to be statistically relevant. In general, the trend suggests a higher likelihood of brain injuries among those with less education.

Percent with Likely Brain Injury by Education



Sixty-seven percent of the male population had sustained injuries resulting in loss of consciousness (LOC) with 72% of those individuals having experienced three or more incidents of LOC. Among those with a moderate or high probability of having a brain injury, 94% had injuries resulting in LOC with 67% of those persons experiencing three or more LOC incidents.

For women, 79% of the sample experienced LOC from injuries with 83% of those experiencing three or more LOC incidents. Ninety-six percent of the women in the sample with a moderate or high probability of having a brain injury had at least one LOC experience, and of those 82% experienced three or more LOC incidents.

Recommendations

Based on the results of the BISQ the following recommendations are suggested as opportunities to have a positive impact on the populations studied. Specifics of how to implement the recommendations are not provided. Outcomes that are viewed as benefiting likely brain injury survivors or that would help prevent future brain injuries for these or other populations are listed below.

1. A brief brain injury screening tool should be incorporated into the correctional facility intake process. One such tool was provided to the Department of Corrections (DOC) at the time of the surveys.
2. If the brief screening tool should indicate a possible brain injury, the longer BISQ screening tool should be completed.
3. If the BISQ should indicate a high likelihood of a brain injury, a referral should be made to a neuropsychologist for a neuropsychological evaluation. Specifically this evaluation should be completed to the standards of the Wyoming Acquired Brain Injury Waiver (ABI Waiver) application for services, and should address cognitive deficits and possible accommodations to address those deficits. The purpose of completing an assessment to ABI Waiver standards is that the inmate will likely need supports and services upon release from the correctional facility, and the ABI Waiver can pay for many of those services for those who are medically and financially eligible.
4. If the neuropsychological evaluation should indicate additional mental health or medication needs, appropriate referrals should be made.
5. DOC staff, particularly case managers and security staff, should participate in brain injury awareness training. Medical staff treating those inmates should receive a more advanced level of training to help them understand the medical needs of brain injury survivors. For example: training should include headache management, and differing effects of medication on the damaged brain. The ABI Task Force and Brain Injury Association of Wyoming are available to provide free training in these areas.
6. A support group for brain injury survivors should be made available in both the men's and women's correctional facilities. Training in management of a brain injury support group can be provided by the Brain Injury Association of Wyoming, who can also provide a manual, contact names and information about others in the state providing such support groups, a potential list of speakers to present to the group, a variety of support group formats/focuses, and annual training/peer interaction for support group leaders.
7. For those inmates who test positive for brain injury on the BISQ and whose brain injury is verified through a neuropsychological evaluation, a transition plan should be developed six

months prior to their release date. This transition plan should include: a life skills assessment including home safety skills, medication management, and community safety skills; referral to the Wyoming ABI Waiver; selection of an ABI Waiver case manager; identification of services and supports for brain injury survivors in the city in which the inmate will reside; provision of a brain injury recovery kit and training in its use; development of a plan for financial stability whether that includes work or return to or application for social security disability; referral to a support group nearest the inmate's home ; and referral to the Brain Injury Association of Wyoming to assist with needs after the release date.