

TRAUMATIC BRAIN INJURY IN CRIMINAL LITIGATION

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Traumatic brain injury (TBI) is a highly prevalent cause of neurocognitive disorders resulting in approximately 2.5 million emergency department visits per year.¹ As a result, the prevalence rate of traumatic brain injury is remarkably high among criminal defendants as derived from studies of individuals in prisons and jails. The Center for Disease Control (CDC) estimated that twenty-five to eighty-seven percent of individuals in jail and prison report having experienced a TBI. In this review we discuss common referral questions involving individuals with a history of TBI in criminal litigation. We cover competency to proceed, mental state defenses, and mitigation in capital and non-capital cases.

I. OVERVIEW

Traumatic brain injury (TBI) is a highly prevalent cause of neurocognitive disorders resulting in approximately 2.5 million emergency department visits per year.² Every day approximately 138 people die as a result of TBI related causes in the U.S.³ However, most individuals survive traumatic brain injury, which can result in temporary or permanent impairments in emotional and cognitive functioning.⁴ The purpose of this article is to discuss the implications of brain-injury for criminal litigation. We will begin with an overview of the prevalence and general impact of traumatic brain injury and then discuss traumatic brain injury in relationship to specific legal questions that commonly arise in criminal litigation.

II. PREVALENCE AND IMPLICATIONS

In general, according to the Center for Disease Control, total combined rates for traumatic brain injury (TBI)-related emergency department (ED) visits, hospitalizations, and deaths have increased over the past decade despite progress

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¹ *Basic Information about Traumatic Brain Injury and Concussion*, CTRS. FOR DISEASE CONTROL AND PREVENTION, <http://www.cdc.gov/traumaticbraininjury/basics.html> (last visited Sept. 17, 2015).

² *Id.*

³ *Traumatic Brain Injury in the United States: Fact Sheet*, CTRS. FOR DISEASE CONTROL AND PREVENTION, http://www.cdc.gov/traumaticbraininjury/get_the_facts.html (last visited Sept. 17, 2015).

⁴ *Id.*

in safety equipment.⁵ Total combined rates of TBI-related hospitalizations, ED visits, and deaths also climbed but more slowly “from a rate of 521.0 per 100,000 in 2001 to [a rate of] 823.7 per 100,000 in 2010.”⁶ According to the CDC,

Total combined rates of TBI-related hospitalizations, ED visits, and deaths are driven in large part by the relatively high number of TBI-related ED visits. In comparison to ED visits, the overall rates of TBI-related hospitalizations remained relatively stable changing from 82.7 per 100,000 in 2001 to 91.7 per 100,000 in 2010. TBI-related deaths also decreased slightly over time from 18.5 per 100,000 in 2001 to 17.1 per 100,000 in 2010.⁷

Taken together, this suggests that there has been an increase in emergency department visits overall, and this increase appears to be driven among cases of mild traumatic brain injury and concussion. Across age groups, men remain more likely to suffer from TBIs although the increase in ED visits has occurred in both men and women.⁸

The injury mechanisms (external causes of injury) associated with TBI-related ED visits also vary by age group. For example, falls are the primary mechanisms of TBI-related ED visits in the youngest (zero to four years) and oldest (sixty-five years and older) age groups, accounting for 72.8% and 81.8% of TBI-related ED visits, respectively.⁹ Injuries caused by being struck by/against an object (34.9%) and falls (35.1%) account for the majority of injury in youth five to fourteen years of age with respect to TBI-related ED visits.¹⁰ For persons in age groups fifteen to twenty-four years and twenty-five to forty-four years, the proportions of TBI-related ED visits due to assaults, falls, and motor vehicle traffic events are nearly equal within and across both age groups.¹¹ In this group of individuals, traumatic brain injury is most likely to result from motor vehicle effects, assaults, and falls.¹² Of course, criminal defendants may also have a history of TBI from childhood that predates the instant offense.

The prevalence rate of traumatic brain injury is remarkably high among criminal defendants as derived from studies of individuals in prisons and jails. The CDC estimated that twenty-five to eighty-seven percent of individuals in jail

⁵ See *id.*

⁶ *Rates of TBI-related Emergency Department Visits, Hospitalizations, and Deaths – United States, 2001-2010*, CTRS. FOR DISEASE CONTROL, <http://www.cdc.gov/traumaticbraininjury/data/rates.html> (last visited Oct. 12, 2015).

⁷ *Id.*

⁸ See *Traumatic Brain Injury in the United States: Fact Sheet*, *supra* note 3.

⁹ See *Percent Distributions of TBI-related Hospitalizations by Age Group and Injury Mechanism – United States, 2006-2010*, CTRS. FOR DISEASE CONTROL, http://www.cdc.gov/traumaticbraininjury/data/dist_hosp.html (last visited Sept. 17, 2015).

¹⁰ See *id.*

¹¹ See *id.*

¹² See *Traumatic Brain Injury in the United States: Fact Sheet*, *supra* note 3; see also *Percent Distributions of TBI-related Hospitalizations by Age Group and Injury Mechanism*, *supra* note 9.

and prison state they have experienced a TBI.¹³ Prisoners who have sustained a TBI are more likely to have abused substances in the past year and to self-report mental health symptoms in higher rates than individuals without a TBI history.¹⁴ Prisoners who have a history of TBI are also more likely to have been homeless in the past year.¹⁵ Once in jail or following release, prisoners with a history of traumatic brain injury are at greater risk to reoffend.¹⁶ As a result of this research, a report was drafted by the Commission on Safety and Abuse in America's prisons that strongly recommended increased screening, evaluations, and treatment for TBI in the offender population.¹⁷

In summary, the research indicates that criminal defendants are at a very high risk for traumatic brain injuries that pre-date the instant offense and more likely than the general population to sustain traumatic brain injuries.¹⁸ These injuries result in increased co-morbidity of cognitive symptoms and mental health symptoms that result in increased risks of homelessness and substance abuse.¹⁹ Once in prison, these prisoners may display behaviors that are interpreted as defiance or disciplinary problems but are a direct result of the cognitive and emotional impairments secondary to traumatic brain injury.²⁰ For example, deficits in attention may make it difficult for prisoners to focus or directly respond to a correctional officer. Deficits in memory can make it difficult to understand or remember rules, especially if there are changes. Deficits in impulse control, sexual disinhibition, and irritability may lead to increased incidents with other inmates.²¹ Once released from prison, these individuals are at higher risk for additional head injuries and to reoffend.²²

III. COGNITIVE AND BEHAVIORAL IMPACT OF TRAUMATIC BRAIN-INJURY

TBI ranges in severity from mild, moderate, or to severe. Associated symptoms also vary dramatically depending upon the severity of the injury, the

¹³ *Traumatic Brain Injury in Prisons and Jails: An Unrecognized Problem*, CTRS. FOR DISEASE CONTROL 1, available at http://www.cdc.gov/traumaticbraininjury/pdf/Prisoner_TBI_Prof-a.pdf (last visited Sept. 17, 2015). See also Peter W. Schofield et al., *Traumatic Brain Injury Among Australian Prisoners: Rates, Recurrences, and Sequelae*, 5 BRAIN INJURY 20, 499-506 (2006); Robert F. Morell et al., *Traumatic Brain Injury in Prisoners*, 27 JOURNAL OF OFFENDER REHABILITATION 3-4, 1-8 (1998).

¹⁴ See *Traumatic Brain Injury in Prisons and Jails: An Unrecognized Problem*, *supra* note 13, at 2.

¹⁵ *Id.*

¹⁶ *Id.*

¹⁷ See generally John J. Gibbons and Nicholas de B. Katzenbach, *Confronting Confinement* COMM'N ON SAFETY AND ABUSE IN AMERICA'S PRISONS 14, available at http://www.vera.org/sites/default/files/resources/downloads/Confronting_Confinement.pdf (recommending proper screening for prisoners suffering from a mental illness).

¹⁸ *Traumatic Brain Injuries in Prison and Jails: An Unrecognized Problem*, *supra* note 13, at 1.

¹⁹ *Id.* at 1-2.

²⁰ *Id.* at 2.

²¹ *Id.*

²² *Id.*

etiology, and the time since the injury. Mild TBI has been defined by the American Congress of Rehabilitation Medicine by the following criteria:

A patient with mild traumatic brain injury who has had a traumatically induced physiological disruption of brain function, as manifested by at least one or more of the following: (1) any period of loss of consciousness; (2) any loss of memory for events immediately before or after the accident; (3) any alteration in mental state at the time of the accident ([e.g.] feeling dazed, disoriented, or confused); and (4) focal neurological deficit(s) that may or may not be transient; but where the severity of the injury does not exceed the following: [1] loss of consciousness of approximately [thirty] minutes or less; [2] after [thirty] minutes, an initial [GCS] of [thirteen to fifteen]; and [3] posttraumatic amnesia (PTA) not greater than [twenty-four] hours.²³

There is nothing truly “mild” about mild TBI. Common symptoms include fatigue, headaches, visual disturbances, memory loss, poor attention/concentration, sleep disturbances, dizziness/loss of balance, irritability/emotional disturbances, feeling of depression, and seizures.²⁴ Symptoms persist up to one year in about fifteen percent of individuals.²⁵ Also, there can be cumulative effects of even relatively minor blows to the head with symptoms increasing in severity and persistence with each additional injury.²⁶ An extreme version of this effect, Chronic Traumatic Encephalopathy, results in wide ranging effects on personality, cognition, and motor functioning.²⁷

Moderate and severe TBIs are characterized by longer periods of loss of consciousness and worse cognitive and functional outcomes.²⁸ The Glasgow Scale is a fifteen-item scale that assesses basic motor responses, verbal responses, and eye opening.²⁹ Typically an injury is characterized as mild if the initial Glasgow Coma Scale (GCS) score is in the thirteen to fifteen range, moderate if the score is in the nine to twelve range, and severe if the initial score

²³ *Definition of Mild Traumatic Brain Injury*, INT’L CONG. PROMOTING REHABILITATION SCI. & PRACTICE (ACRM), available at https://www.acrm.org/wp-content/uploads/pdf/TBIDef_English_10-10.pdf (last visited Oct. 12, 2015).

²⁴ *Id.*

²⁵ *Mild TBI Symptoms*, TRAUMATIC BRAIN INJURY.COM, <http://www.traumaticbraininjury.com/symptoms-of-tbi/mild-tbi-symptoms/> (last visited Oct. 12, 2015).

²⁶ *See What are the Potential Effects of TBI?*, CTRS. FOR DISEASE CONTROL, <http://www.cdc.gov/TraumaticBrainInjury/outcomes.html> (last visited Oct. 12, 2015).

²⁷ *See Complications of Concussion, Chronic Traumatic Encephalopathy (CTE)*, CTRS. FOR DISEASE CONTROL, http://www.cdc.gov/concussion/HeadsUp/clinicians/resource_center/complications_of_concussion.html#five (last visited Oct. 12, 2015).

²⁸ *See Glasgow Coma Scale*, TRAUMATIC BRAIN INJURY.COM, <http://www.traumaticbraininjury.com/symptoms-of-tbi/glasgow-coma-scale/> (last visited Sept. 22, 2015).

²⁹ *Id.*

in less than nine.³⁰ Loss of consciousness for periods less than thirty minutes is characterized as mild, thirty minutes to less than a day as moderate, and greater than twenty-four hours indicates a severe injury.³¹ These initial injury severity characteristics assist with predicting functional and cognitive outcomes. Although the GCS does not provide much detailed information, it is relatively readily available if a client received medical treatment following a TBI. In general, the worse the initial injury severity, the more sustained the cognitive impairment.

Clients that have suffered a moderate to severe brain injury often will also have a sustained period of confusion surrounding the time of the accident that can continue for weeks. This period of confusion is called post-traumatic amnesia. Individuals with a moderate to severe brain injury may also demonstrate retrograde amnesia which impairs their ability to recall “old” personal memories that predate the accident and anterograde amnesia which impairs their ability to learn new information after the injury.

While TBIs can vary in their impact on cognitive and emotional symptoms, there are some common profiles. Individuals with a history of TBI are more likely to demonstrate impairment on measures of attention, processing speed, working memory, episodic memory, and tasks of executive functioning.³² These individuals are also more likely to show disinhibition, apathy, poor judgment, and limited insight into their disorder.³³

The neuropsychiatric sequelae from TBI cannot be overemphasized. Mood disorders, most commonly, major depression, are often seen in persons with brain injury.³⁴ The prevalence rates have been estimated to range from 15.6 percent to sixty-one percent.³⁵ Although mood disorders can occur with damage to either hemisphere of the brain, mania has been most often associated with right-sided frontal lobe damage, and depression can result from left-sided frontal lobe lesions. Psychosis, OCD, anxiety, PTSD, and personality changes are well-known sequelae of TBI.³⁶ This underscores the importance of competent, comprehensive neuropsychiatric assessment in defendants with suspected brain injury as neurologic etiologies are often overlooked by mental health professionals who focus solely on overt psychological symptoms.

³⁰ *Id.*

³¹ *What are the Effects of TBI?*, TRAUMATIC BRAIN INJURY.COM, <http://www.traumaticbraininjury.com/understanding-tbi/what-are-the-effects-of-tbi/> (last visited Sept. 22, 2015).

³² *Id.*

³³ Harold V. Hall, *Criminal-Forensic Neuropsychology of Disorders of Executive Functions*, in *DISORDERS OF EXECUTIVE FUNCTIONS: CIVIL AND CRIMINAL LAW APPLICATIONS* 63 (Harold V. Hall & Robert J. Sbordone eds., 1993).

³⁴ Edward Kim et al., *Neuropsychiatric Complications of Traumatic Brain Injury: A Critical Review of the Literature*, 19 *J. Neuropsychiatry & Clinical Neurosciences* 2, 114 (2007).

³⁵ *Id.*

³⁶ *Id.* at 107.

IV. TBI AND CRIMINAL LITIGATION: COMPETENCY TO STAND TRIAL

TBI can impact competency to proceed both by limiting a defendant's factual understanding of a case, and by potentially impacting his or her ability to assist counsel. Cognitive symptoms such as an inability to learn new information, slowed information processing, and retrograde amnesia (for events in the past), can impact a defendant both pretrial and in court.

The following hypothetical case illustrates some of the factors that may be important in considering an individual's competency to proceed to trial:

In November 2014, Mr. Smith had a motorcycle accident that resulted in a severe head-injury with loss of consciousness for about three weeks and an initial GCS of 5. He is accused of an assault that occurred in October 2014. Mr. Smith claims to have no recollection of the events in question. At issue currently is his ability to proceed, his motivation, and the possibility to recovery.

Mr. Smith demonstrated significant post-traumatic amnesia. His right eye was damaged resulting in loss of vision. Overall, while he has demonstrated significant recovery based on a review of his medical records, certain deficits persist in the areas of memory (retrograde and anterograde amnesia) and executive functioning that are consistent with these injuries and are likely to be relatively permanent. Mr. Smith was able to understand and produce language. He was able to attend to conversations.

In terms of memory, a significant head trauma can impact new learning (anterograde amnesia) and past learning (retrograde amnesia). Mr. Smith has difficulties learning new information. His performance in comparison to age matched norms on delayed memory tests (over twenty minutes) was at about the first percentile. However, he was able to learn some limited information and retain it, especially with repetition.

Mr. Smith's retrograde amnesia is significant. He reported that he was able to recall information from earlier in life, but that the past five years were "fuzzy". This description of a time gradient (older memories are more resilient than recent memories) is consistent with the literature on retrograde amnesia and head injury. Although he may recover some of these memories, the period of time just prior to the injury is the least likely to return. Mr. Smith is able to understand the current proceeding, but he has mixed findings regarding his ability to cooperate in a rational manner.

Mr. Smith's case poses a difficult challenge. Although it is the case that individuals may claim amnesia for the events in question rather than to claim, for example, intoxication, these individuals may be supplied with the facts of the case and retain them and as such are typically found to be competent to stand trial.

Mr. Smith has a history of significant head-injury that impairs not only his ability to recall information from the past (retrograde amnesia) but also to learn new information (anterograde amnesia). His ability to retain information over time was poor in comparison to age matched peers (first percentile). In his case, it will be much more difficult to compensate for his memory impairment.

Further, as it has been over a year since the injury, these deficits are likely to be essentially permanent. However, having said that, he was not completely amnesic and is able to learn and retain some limited information. His ability to assist counsel will therefore be limited in that he will not be able to provide a narrative of the events in question, nor will he be able to learn new information. This may be somewhat improved if information is repeated, and notes and transcripts are available to him.

V. TBI AND MENTAL STATE DEFENSES

Because TBI can result in confusion and other serious symptoms at the time of the brain-injury it is possible to have questions related to the impact of the brain injury at the time of the events in question. Given that common etiologies include car accidents, assaults, falls, and fights in the eighteen to thirty-year-old demographic, it is quite possible an individual's mental state may be impacted by an injury. Alternatively, an individual may have a past history of a TBI that continues to impair their judgment and reasoning and may be relevant to mental state defenses. Head injuries often produce coup/countercoup injury and axonal injury from shearing forces may result as well. As the frontal lobes of the brain, where executive functions are thought to reside, sit atop sharp bony processes on the interior of the skull, they are particularly vulnerable to head injury. Howard Hall lists the following symptoms that may result from frontal lobe injury:

Cognition

- Impaired temporal discrimination for recency and time span
- Defects in goal formulation
- Impaired ability to sustain attention
- Impaired ability to shift conceptual sets
- Difficulty in reversal of perspective
- Defects in planning behavior
- Spontaneous, florid confabulations with psychotic qualities
- Marked dissociation between verbalized intentions and actions
- Low creativity . . .

Affect

- Flat, blunt, or labile affect
- Violence occurring within background of flat affect
- Short-lived pleasure or pain
- Low frustration tolerance
- Shallow or inappropriate jocularity
- Inability to see the point in humorous pictures, anecdotes, cartoons, etc.

Individual Behaviors

- Marked perseveration
- Impaired self-control
- Incompetent or ineffectual behavioral productions
- Impaired ability to modulate or fine-tune complex behavior

Social-Interpersonal Behaviors

Marital or familial conflict centering around impairments
 Inability to obtain/maintain employment
 Low conformance to societal values/norms with no maliciousness
 intended
 Little spontaneous speech
 No maintenance of word flow, or difficulty turning off verbage
 Inability to make appropriate shifts of "principle of action" (e.g.,
 switching from attack to escape behaviors)
 Boastful, loud verbal productions
 Insensitivity towards others
 Sexual disinhibition
 Impaired ability to modulate emotional response during sustained
 social interaction.³⁷

As should be abundantly clear, frontal lobe injury can masquerade as “bad behavior” or “bad character” yet be wholly attributable to brain damage. The frontal lobes, among other functions, are thought responsible for our ability to effectively weigh and deliberate, understand the future consequences of behavior, impulse inhibition, working memory, and rationally sequencing our behaviors and actions. Persons with brain injury, and particularly frontal lobe damage, should be evaluated carefully for their ability to form the requisite mens rea for the crimes with which they are charged.

The following case is a teaching example of a mental state defense referral related to a reckless driving case shortly after the driver sustained a brain injury in an assault.

The results from the current evaluation are consistent with Mr. Garcia’s history of a concussion with a hematoma on February 14, 2013 based on a review of medical records and an in-person interview with Mr. Garcia.³⁸ A “concussion is a trauma-induced alteration in mental status that may or may not involve loss of consciousness.”³⁹ His injury would be classified as a mild traumatic brain injury with minimal loss of consciousness and the additional complication of a hematoma.⁴⁰

A hematoma is a collection of blood between the skull and the brain caused by traumatic forces. The location in this case was the right hemisphere between the frontal and parietal lobes, consistent with Mr. Garcia’s report of the assault and with his abrasion. The bleeding can put pressure on the brain and be life threatening. In this case, it appears that the hematoma resolved without surgical intervention.

At intake on February 14, 2013, a Glasgow Coma Scale was recorded as 13/15. This scale measures gross orientation and alertness, but indicated Mr.

³⁷ Hall, *supra* note 33, at 65.

³⁸ Mr. Garcia Mr. Jones is a hypothetical patient used in this article for explanatory purposes.

³⁹ MICHAEL A. MCCREA, MILD TRAUMATIC BRAIN INJURY & POSTCONCUSSION SYNDROME 24 (Greg L. Lamberty et al. eds., 2008).

⁴⁰ Ayub K. Ommaya & T.A. Gennarelli, *Cerebral Concussion and Traumatic Unconsciousness*, 97 BRAIN 633, 633 (1974).

Garcia was responsive. Also noted at the Medical Center were headaches, dizziness, nausea, and vomiting. These symptoms are classic signs of a mild head-injury.

Other common symptoms immediately following a concussion include: lack of awareness of surroundings, light headedness, poor attention and concentration, memory dysfunction, fatigability, irritability and low frustration tolerance, intolerance of bright lights or difficulty focusing vision, intolerance of loud noises, sometimes ringing in the ears, anxiety and/or depressed mood and sleep disturbance.⁴¹

Mr. Garcia reported many of these symptoms dating back to February 2013, including sensitivity to light and noise, poor attention and concentration, memory dysfunction, fatigability, irritability, ringing in the ears, fatigue and sleep disturbance, as well as changes in mood. In most cases, these symptoms remit within three to twelve months depending upon complications. Mr. Garcia did not evidence any significant cognitive symptoms throughout the current evaluation. Overall, his scores across the testing were roughly in the average range commensurate with estimates of his premorbid general intellectual abilities. Performance on tests designed to assess effort and motivation indicated good effort across the testing. However, Mr. Garcia continued to report significant non-cognitive symptoms such as depression, anxiety, and ringing in the right ear, which is common with this type of injury. Taken together, the medical records and interview data are consistent with a classic post-concussion syndrome. How would a concussion impact cognition and decision-making abilities at the time of the injury?

Although medical records document a concussion and hematoma, they do not specifically address Mr. Garcia's cognitive functioning in detail. It is noted that he was able to communicate and he was oriented to time at the time of admission to the hospital.

The defining characteristics of a concussion include headache, dizziness, nausea, sensitivity to light and noise, and alterations in mental status such as confusion, disorientation, amnesia, and poor concentration.⁴² It is likely that Mr. Garcia experienced some alteration in mental status such as confusion as well as the recorded nausea, dizziness, and headache. Mr. Garcia reported feeling as though he was in a fog, which is another common symptom of a concussion. His inability to accurately recall key details is also consistent with his injury.

VI. TBI AND MITIGATION IN CAPITAL AND NON CAPITAL CASES

As stated in the record review, TBI greatly increases the risk of substance abuse, homelessness, mental illness, and incarceration. An ability to describe how a particular injury may have impacted an individual's capacity to

⁴¹ *Practice Parameter: The Management of Concussion in Sports*, 48 *NEUROLOGY* 581, 582 (1997).

⁴² See *MCCREA*, *supra* note 39, at 24.

make good choices and to demonstrate reasonable judgment can be very helpful in criminal cases, especially in capital mitigation. In our experience, these cases ideally would demonstrate well-documented brain injuries, including medical records and be significant injuries in order to provide strong mitigation. Also, indication of a change in personality or functioning after the brain injury is also helpful to document.

The following case represented a summary of mitigation presented in a capital case. In this hypothetical case, a client with no serious criminal history commits a capital crime (murder) approximately eighteen months following a significant injury.⁴³

Mr. Jones, a twenty-five-year-old Latino man suffered from a moderate TBI as a result of a car accident on October 5, 2011 while in Mexico. Records from the treating medical facility indicated poor memory and orientating, difficulties communicating, and significant confusion with a GCS of nine at the scene. Currently it is approximately three years post injury. Mr. Jones has shown some indications of recovery including an ability to complete his activity of daily living (ADL) and to communicate with simple language. However, he unfortunately continues to demonstrate significant cognitive impairment as a result of his injury. Mr. Jones scored below the first percentile on all assessments of attention and memory. He had difficulty maintaining attention and retaining information. He performed at the fourth percentile on language measures (producing fluent speech) and at the third percentile on tests assessing visual spatial skills. Mr. Jones also performed at the first percentile on tasks assessing executive functioning. In addition, Mr. Jones's judgment and insight are limited. Family members noted difficulties with emotional regulation and extreme mood swings (lability). Prior to the accident he was described as "mellow" and good natured. They also reported that prior to the car accident, Mr. Jones had some history of substance abuse and alcohol use but that his drinking had worsened since the injury. His family reported poor judgment, reckless driving, and poor financial management after the injury. Mr. Jones had been able to support himself in the past, but was now unable to do so.

Mr. Jones suffered from a moderate traumatic brain injury that significantly and permanently impacted his thinking, personality, emotional regulation, and judgment. He is simply less able to regulate his emotions and impulsivity as a result of this brain injury.

VII. SUMMARY

Traumatic brain injury is a highly prevalent cause of neurocognitive and neuropsychiatric dysfunction among criminal defendants. The effects of TBI vary greatly depending upon the acute injury severity, the number of injuries that have occurred, and the time since the injury. TBI has wide ranging effects and can impact defendants at all stages of the judicial process. TBI may impact an

⁴³ Mr. Jones is a hypothetical patient used in this article for explanatory purposes.

individual's competency to proceed by impacting their memory, reasoning, judgment, and insight, which may impact both their factual understanding and rational abilities to assist counsel. TBI can be an important factor to consider in *mens rea*. Individuals who experience a TBI at the time of the instant offense may be confused or disoriented. Those that are post-TBI may have difficulties with impulse control and disinhibition following an injury. In terms of mitigation, explaining to a court how a TBI may have impacted the client's behavior and providing some context for their decision-making can be valuable information for the court to consider. Finally, in prison, a history of a TBI can impact a defendant's ability to comply with commands and regulate their impulses and emotions. Given the high prevalence of TBI in the criminal justice population, it is critical for forensic mental health professionals to, at the very least, screen for a history of TBI.

