

# REPORT: TRAUMATIC BRAIN INJURY AND CRIMINAL JUSTICE/ JUVENILE JUSTICE SYSTEMS



**Alabama Department of Rehabilitation Services  
Alabama Head Injury Program**

## 2017

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A summary of lessons shared by states addressing traumatic brain injury in the criminal justice and juvenile justice systems during a 2017 meeting convened by the Alabama Department of Rehabilitation Services

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## **PREFACE**

In 2014, the Alabama Department of Rehabilitation Services (ADRS), as the lead state agency for traumatic brain injury (TBI), was awarded a four-year Federal TBI State Implementation and Partnership Grant administered by the U.S. Health Resources and Services Administration (HRSA). The HRSA TBI Program identified four common barriers to accessing care by individuals and families experiencing brain injury. These include: (1) a lack of information of services and supports with little or no assistance in accessing them (information and referral services); (2) a shortage of health professionals who may encounter individuals with TBI but lack relevant training (professional training); (3) the absence of a TBI diagnosis, or the assignment of an incorrect diagnosis (screening); and (4) critical TBI services are spread across numerous agencies resulting in services being difficult for families to identify and navigate (resource facilitation). Grantees were required to address these four barriers in grant proposals/projects.

Alabama grant proposal identified youth with TBI within juvenile justice systems as a priority population to address barriers to services, which includes screening, professional training, information & referral services and resource facilitation, as required by the federal grant program. The ADRS Head Injury Program is responsible for carrying out grant activities.

To assist ADRS with its grant project, the State Head Injury Program convened “An Interactive Workshop: Brain Injury and Juvenile Justice: Addressing Barriers and Challenges for Youth with Brain Injury in the Juvenile Justice System” with representatives from nine states held in August 2016 in Birmingham, Alabama. The purpose of that meeting was to review and discuss best practices related to programs and services for youth with BI/TBI in state juvenile justice systems. Participants consulted collectively to address barriers to accessing care for people with brain injury. Findings from this interactive workshop can be found in the 2016 REPORT: TRAUMATIC BRAIN INJURY & JUVENILE JUSTICE available at <http://www.alabamatbi.org>. The Summary and Considerations from the REPORT is located in the Appendices of this document.

## **INTRODUCTION**

The ADRS State Head Injury Program convened a second meeting: “Traumatic Brain Injury in the Criminal Justice & Juvenile Justice Systems” with representatives from ten states in December 2017 in Birmingham, Alabama. The purpose of this meeting was to share lessons learned and draw conclusions regarding challenges faced by states in addressing the four barriers identified by HRSA in delivering services for individuals with TBI in these systems. Additional topics addressed included data, strategies for collaboration, sustainability and long term planning. ACL State TBI Grantees and others engaged in addressing the problems of adults and youth with brain injury in the criminal justice and juvenile justice systems shared current findings and practices from their projects. The participating states targeted diverse populations and sites/locations including: juvenile justice involved youth, youth and adults both in probation and incarcerated, corrections, ex-offenders, incarcerated offenders, American Indian communities and veterans in the juvenile justice and criminal justice systems.

## Addressing the Barriers

### 1) Screening and Identification

Participants identified issues related to the screening process and protocols as a result of screening projects. Some states reported implementing screening at the time of intake for those who are entering the system, while others are conducting screening on all individuals already within a facility or a program. States screen at different points of involvement of youth and adults in the juvenile and corrections systems: for example everyone at an identified site is screened; individuals are screened at in-take as admitted into the correctional re-entry program; youth who enter juvenile detention facilities are screened as part of the initial intake process; youth may be screened at initial contact with the juvenile justice system.

Different rates of “positive” screens are found depending on the location of the individual (incarcerated adult, youth in detention, etc.) and where the individual is in the system. States have found that justice involved youth screened at the point of initial contact with the JJ system have a much lower rate of positive screens than youth in facilities and correction involved adults.

Most screening tools rely on self-reporting of lifetime report of head injury: they do not identify specific cognitive, behavioral other issues resulting from the TBI. Specific issues related to screening youth who may not have been previously identified as having a TBI are a concern. Screening tools generally require the individual to self-report. Most youth will not have access to their medical records, should the records even provide documentation with regard to treatment for a TBI in the emergency room (ER), hospital or physician’s office, as most may not have been treated medically at all. Additionally, children/youth are not reliable re: self-reporting and parents or caregivers are frequently not consistent and secondary gain/loss (perceived or real) may influence reporting.

Participants identified specific action needed to improve the screening process:

- There is a need to determine best practices for secondary screening/tools/process to identify behaviors resulting from the TBI in order to develop appropriate interventions and identity/access appropriate community resources.
- A decision matrix is needed for a secondary screen (frequently false positives are high on initial screening; when is neuropsychological screening/testing appropriate).
- Fidelity regarding implementation of the screening tool is essential: initial training for screening is needed as well as repeat training

Progress has been made in identifying and implementing secondary “screens”. Several states are using neuropsychological screens, a neurocognitive assessment test battery and other tools. One state reported having success in veterans units and site/location (corrections, prisons). States reported success in training social workers; one state has trained nurses to screen all new JJ intakes in a county. States have utilized on-line training to train JJ/CJ system staff on how to screen.

Other concerns and considerations identified by participants:

- Funding is needed to take the next step (secondary screening) or there maybe potential litigation.
- Timing of when screening occurs changes the outcome.
- Can funding (JJ) be directed to more appropriate sources such as for screening by JJ system staff?
- How can the cost of screening and additional testing be sustained?

- Which populations have access to screening?
- Can screening be embedded into JJ/CJ practices and protocols?
- Selection of appropriate tool to use: TBI vs. ABI should be considered.

## **2) Training**

HRSA identified one of the main barriers for individuals with TBI receiving appropriate services is a shortage of healthcare and other professionals as lacking relevant training to identify, assess and address their needs. Building a trained workforce is critical for addressing this deficit. Training is necessary in addressing all barriers: screening, I and R and Resource Facilitation and also in developing partnerships and collaboration. In general, participants reported positive experiences and successes in providing training for stakeholders. Education and training has been well received by staff and other professionals who are likely to come into contact with these populations. Cross-training between the TBI community and JJ/CJ systems has been effective. Juvenile Justice Web-based/archived trainings on various topics have been developed and shared; a set of on-line training modules has been created by one state; several states have developed training modules to draw from. Offering technical assistance has been successfully utilized. Participants identified concerns regarding provision of training including: staff changes; engagement of the audience; the need to repeat training numerous times and, time for JJ/CJ staff to attend training; customized training is needed for JPO's judges, others in the JJ/CJ systems.

Other concerns and considerations identified by participants

- Determining effectiveness and evaluation of training is needed: what does successful training look like; how is outcome measured?
- Best practices regarding training needs to be identified for preventing recidivism: this should guide training efforts.
- Change of modality for change in service providers (millennials).
- There is a need for a "home for training", i.e., a repository of resources.
- Cross training is needed between the CJ/JJ communities.
- Fidelity of training for a train-the-trainer model is essential.

## **3) Information and Referral Services (I and R) and 4) Resource Facilitation**

Participants identified issues related to I and R and Resource Facilitation. Getting individuals to service providers and receipt of services can be challenging; there is a need for customized services for these special populations; CJ/JJ system staff must be made aware of the availability of I and R, RF and specialized services available; frequently there is less than warm reception of JJ/CJ clients with community service providers (cognitive rehabilitation, SLT/OT/PT, therapists). Suggestions were made to: use current existing resources such as vocational rehabilitation, (WIOA) transition to get C/Y into programs; connect individuals to community services before release for more successful intervention; determine how to best work with JJ/CJ reentry already in place. One state reported success with implementing I and R and RF with the JJ/CJ systems by having monthly meetings to trouble shoot challenges as they arise, build buy-in among diverse stakeholders, maintain open lines of communication and celebrate successes. Some states routinely refer individuals who screen positive on the screening tool to the state brain injury advocacy organization. There is a recognition that states have different resources.

Other concerns and considerations identified by participants:

- Training regarding intervention and service provision should be provided to broaden the focus of JJ/CJ to include TBI community reentry.
- There needs to be a paradigm shift to allow for brain injury/frontal lobe challenges in CJ/JJ.
- Have TBI services, resources and infrastructure in place to support needs once the individual is released into the community.
- Evaluate the impact and outcomes of I and R and RF.

## **5) Additional Topics**

### **Data Collection and Management Decisions**

Data collection relative to grant projects continues to be a limitation for many states. Many states are collecting very limited data due to lack of technical resources and support within their agency for data collection. There is no uniform data collection across states resulting in lack of ability to compare programs and /or program outcomes. A few states have gathered an extensive amount of JJ/CJ project data. One of these states offered to develop (is developing) a Data Sharing Plan to initiate a common data element model across states in order to more easily compare data. The extensive amount of data already collected is being incorporated into this process. This state is in a position through a collaborative relationship with a university program to organize the research to analyze this data. This will benefit all states with recommendations coming from the research on Public Policy about brain injury in corrections and juvenile justice.

Other concerns and considerations identified by participants:

- Participants agreed that states need to develop a mechanism in order to collaborate on data collection and analysis to identify best practices and effectiveness of programs including screening, training, I and R, Resource Facilitation and outcomes.
- Encourage states to collaborate in the Data Sharing Plan that is being developed.

### **Collaboration**

States that have been successful reiterated that many collaborating partners are necessary to carry out and sustain the grant work, and that they were successful in obtaining buy-in from their state JJ/CJ systems and community partners. States have learned a great deal about how to collaborate to effectively deliver TBI-informed services. Participants reinforced the importance of collaboration with existing partners and development of new partners as the key component in effectively engaging with CJ and JJ systems and incorporating TBI services into these systems. They reported that positive interactions with professionals is “paying off” in terms of greater collaboration. Outreach is working: CJ/JJ communities are coming to the TBI community for assistance.

Other questions and concerns identified by participants for further attention include:

- Increase collaborations by establishing presence at state stakeholder meetings and conferences.
- Include CJ/JJ representation on State advisory councils.

## Conclusions, Sustainability and Long Term Planning

### Next Steps

There was consensus among participants that the HRSA/ACL TBI State Implementation Partnership Grants have provided the impetus for a number of states to address the often unrecognized problem of brain injury in the JJ/JC populations. The Brain Injury communities in these and other states has engaged with the JJ/CJ systems to highlight the needs of individuals with TBI in these populations. These grant projects have resulted in development of screening protocols, models of training approaches and tools, and the recognition of the need for specialized services for these populations. States have addressed diverse populations and communities, locations/sites and intervention approaches within JJ/CJ systems. There have been successes and progress related to addressing the barriers to services however, results indicate there is need for further research and evaluation of outcomes and development of best practices related to the barriers including data collection and analysis. This meeting resulted in sharing of information, identification of needs and action steps to move forward on improving outcomes for individuals and reducing recidivism in the JJ /CJ systems.

Participants suggested that the following strategies and action steps be implemented to improve outcomes for individuals in the criminal justice and juvenile justice systems. States are encouraged to share successes and participate in these activities.

- Collaborate with other states in the Data Sharing Plan that is being developed to organize the research and analyze existing state data to make recommendations on public policy about brain injury in JJ/CJ systems.
- Hold a national conference and/or develop a method for states to share progress in addressing the four barriers and present products such as: screening/assessment tools and protocols; intervention strategies /tools; training approaches and products such as on-line training, curricula and models; and methods used for I and R and resource facilitation.
- Develop a tool kit of best practices (standard of care).
- Develop a group publication to influence policy related to criminal and juvenile justice.
- Conduct a survey/literature review of best practices.
- Determine/develop a common screening tool.
- Advocate for mandatory screening at the federal level.
- Encourage mandatory training for DYS/DOC staff.
- Host a Stakeholders meeting with federal partners, DOJ, DOE, SAMHSA, DOL, ACL, CDC, NDRN, NCSL (National Association of State Legislators), NASHIA, NIDILRR.
- States should develop a collective vision.
- Engage with National Partnerships for Justice Services- NPJS getting TBI on the agenda.
- Rebrand brain injury for better awareness/education of public.
- Have a presence at P & A conferences.
- Provide training for P & A staff on TBI/JJ: partnership with States/NASHIA (NDRN)
- Establish a presence at State/Federal CJ/JJ councils, conferences.
- Apply to be on boards/ commissions that focus on criminal and juvenile justice.
- Use the ADA & Olmstead for access to services to this group.
- Develop strategies to reach a broader audience and diverse communities (e.g. documentation, stories, PSA).
- Develop collaboration with anti-incarceration groups.

**Appendices**  
**Criminal Justice/Juvenile Justice Summit**  
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## **REPORT: TRAUMATIC BRAIN INJURY & JUVENILE JUSTICE**

### **SUMMARY AND CONSIDERATIONS**

The Alabama Department of Rehabilitation Services convened a meeting in 2016 in Birmingham Alabama of representatives from nine states which had addressed or planned to address youth with TBI in juvenile justice in order to share lessons learned by states in addressing youth with traumatic brain injury in juvenile justice systems. The Summary and Considerations are conclusions from that meeting.

#### **Summary and Considerations**

States discussed various challenges with regard to obtaining collaboration and support with juvenile justice/correctional systems to screen, provide needed interventions/accommodations, and to link to TBI community services/resource facilitation. These JJ/correctional systems may be under budget constraints, have staff turnover, and the responsibility for programs and services which may be distributed among state, community, court, and county entities and jurisdictions. Similarly, TBI state programs may not have the necessary infrastructure to support the range of activities and are concerned about sustainability once federal funds end, particularly with regard to neuropsychological assessment once an individual screens positive, and resource facilitation in some states. Legal issues have also surfaced as to whether prosecutors, defenders, courts, and families should have access to the TBI screening/assessment information and to whether that should impact their adjudication/incarceration in the first place.

However, states that have been successful to date note that many collaborating partners are necessary to carry out the work and that they were successful in obtaining “buy-in” in from their state juvenile justice/corrections systems or community JJ providers. While states noted the potential for reducing recidivism by preparing JJ staff and providing necessary supports to adjudicated youth with TBI, it is still too soon in some states to discern the number of adjudicated youth with TBI and whether appropriate identification, services and assistance results in successful community integration.

Funding to continue the projects once the federal grant fund ends is also a concern to most. States that already have capacity through their existing state system are less worried about that aspect, but are concerned about ongoing screening and training within JJ systems.

#### **Other considerations:**

To implement and to continue activities it is helpful to:

- 1) Have a clear vision, purpose and anticipated outcomes for addressing youth/adults with TBI in JJ/corrections systems.
- 2) Have buy-in and support from JJ/Corrections systems and programs. Suggestions:

- Add or invite JJ/CJ key staff to participate on the state TBI advisory board/council
  - Develop relationships with individuals key to the project, including judges, courts, community JJ programs, and state systems
    - Present information on TBI at conferences sponsored by the JJ and legal community (e.g. judges conferences).
    - Invite JJ/CJ community/leaders to present at TBI conferences, council/board meetings to better understand these systems.
- 3) Establish a working group of key stakeholders to help develop, implement and oversee the project and activities on an on-going basis.
  - 4) Have time to develop relationships, to understand JJ/corrections systems, and key players to address adjudicated youth with TBI, and to identify needed policies and procedures which may need to be in place to implement screening, I&R, and resource facilitation; and with regard to release of information gathered in the process (e.g. who should or should not receive information if an adjudicated youth is diagnosed as having a TBI). A four-year grant may not be sufficient time to accomplish these tasks.
  - 5) Incorporate screening and staff training within JJ systems/community programs may result in the likelihood of these activities continuing.
  - 6) Start with a few identified sites, before expanding to statewide.
  - 7) Have TBI services, resources, and infrastructure in place to support needs once released into the community.
  - 8) Evaluation and follow-up measures need to be in place to determine if JJ/corrections staff training, I&R and resource facilitation have resulted in better community outcomes for those who were adjudicated or incarcerated (adults).
  - 9) How will information be reported to policy makers with regard to incidence/prevalence of TBI among JJ/CJ systems; staff and related expenses necessary to carry out activities; and outcomes or return on investment will need to be considered.

To help states continue this work, participants suggested on-going venues for sharing information through webinars, conference calls, shared Google drive to collect documents and perhaps another meeting. States expressed the need for direction and assistance for collecting and aggregating data across states to use for national and state policies. Finally, the role of the National Association of State Head Injury Administrators (NASHIA) was discussed with regard to developing a collaborative relationship with the U.S. Department of Justice, who administers juvenile justice grants to states. NASHIA can play a role in bringing the issues to the attention at the national and federal level.

## **ACRONYMS**

**ACL** -Administration for Community Living

**ADRS**-Alabama Department of Rehabilitation Services

**JJ**-Juvenile Justice

**CJ**- Criminal Justice

**I and R**-Information and Referral

**RF** -Resource Facilitation

**TBI** –Traumatic Brain Injury

**BI** - Brain Injury

**VR** -Vocational Rehabilitation

**WIOA** - Workforce Innovation and Opportunity Act

**HRSA** – Health Resources and Services Administration

**NASHIA** –National Association of State Head Injury Administrators