Brain Injury Association of Nebraska

Thank You, Sponsors!

Lunch Sponsor

ENable Savings Plan

Opening Keynote Sponsor

UnitedHealthcare Community Plan

Silver Sponsors

Bryan Health

Madonna Rehabilitation Hospitals

QLI Brain and Spinal Cord Injury Specialists

Bronze Sponsors

Caretech
We Bring the Care to You. Anytime. Anywhere.

CHI Health
A member of CommonSpirit

Nebraska Medicine
SERIOUS MEDICINE. EXTRAORDINARY CARE.

nebraska total care

Brookhaven NeuroRehabilitation Network
building a new future

Breaking Barriers, Building Futures: Harnessing Behavioral Health for Justice-Involved Youth

Erika Franta, PhD, LP, NCSP
Abril Rangel-Pacheco, PhD

UNMC | MUNROE-MEYER INSTITUTE

Objectives

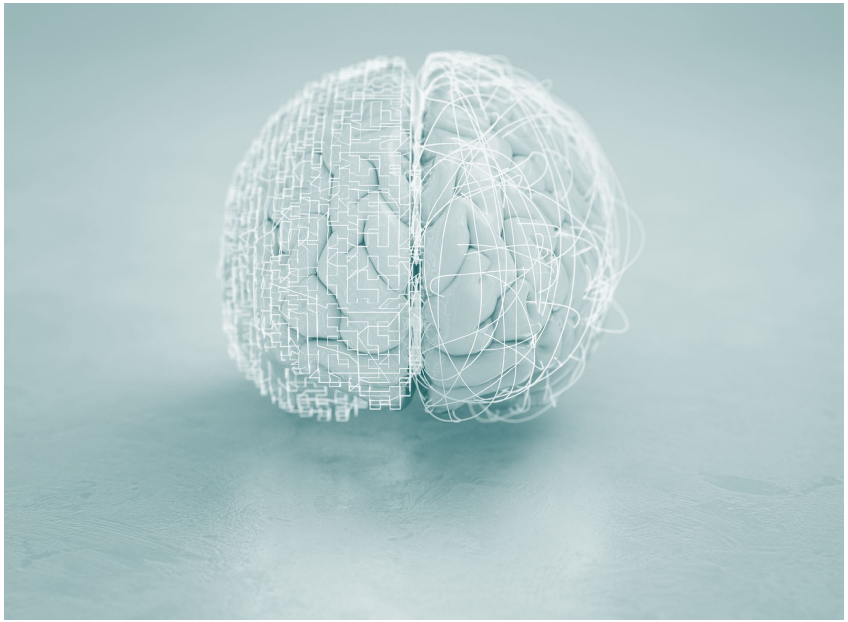
1. Describe the prevalence and impact of brain injury among justice-involved youth at a national and local level.
2. Apply best-practice strategies for screening, accommodations, and treatment.
3. Examine system-level approaches that strengthen identification, intervention, and support.

Meet your presenters…

Erika Franta, PhD
Assistant Professor
Licensed Psychologist
Nationally Certified School Psychologist

Abril Rangel-Pacheco, PhD
Psychology Fellow
Licensed Mental Health Practitioner

What do we mean by "brain injury"?



Any documented or likely traumatic or acquired injury identified through structured screening of a person's life events and resulting symptom

- **Event history** (external force, oxygen loss, medical events)
- **Symptoms & functional challenges** linked to injury history

(OBISSS, 2025)

What do we mean by "behavioral health"?

- The integration of students' **emotional well-being, social relationships, and behavioral patterns** as they influence **learning and day-to-day functioning.**

- Understanding **functions of behavior**, teaching skills within environments that are **responsive to neurodevelopment**, and support overall executive functioning and **flexible problem-solving.**

(NASP, 2022; PBIS, 2022; US Dept of Ed, 2021)

Justice-Involved Youth Populations

Children with neurodevelopmental differences are overrepresented in the JJ system.

ADHD

General population prevalence 5%; 18.5% for females and 11.7% for males in detention (Holland, 2023).

ASD

General population prevalence ~ 1.2 to 2.8%; estimated 15% prevalence in youth detention (Hughes et al., 2012).

IDD

General population prevalence ~2 to 3%; ~7 to 25% in the youth detention (Hughes et al., 2012).

Neurodevelopmental Considerations

Youth with ASD are more likely than their neurotypical peers to be charged for school-based incidents such as disturbing the school, carrying a weapon, assault and battery, or threatening a school employee (Cheely et al. 2012).

ADHD and temperamental difficulties (i.e., effortful control and negative emotionality) are significantly related to continued offending in justice-involved youth (Baglivio et al., 2017).

Learning Considerations

Justice involved youth tend to experience disruptions in their education (e.g., truancy, being detained), which may impact their academic learning and ability to engage with grade-level material.

- The academic achievement level of justice-involved youth has been consistently reported as 1 to 5 years below grade level in both reading and math (Cavendish et al., 2014).

Students with disabilities are overrepresented in the juvenile justice system, especially those with EBDs and OHIs (Kincaid & Sullivan, 2019).

- Justice-involved youth with disabilities are significantly less likely to earn a high school diploma than their peers without disabilities (Cavendish, 2014).

Trauma Considerations

Up to 90% of justice-involved youth report exposure to some type of traumatic event; 70% of youth meet criteria for a mental health disorder; 30% of youth meeting criteria for PTSD (Dierkhising et al., 2013).

- ~65% of youth are first exposed to trauma within their first 5 years of life.
- Early age of onset of trauma exposure is associated with mental health problems and related risk factors (e.g., substance use).

Brain Injury Considerations

Up to 67% of justice-involved youth report brain injury (Tennessee Disability Coalition, 2025)

Justice-involved youth are over 3x more likely to have had a prior BI than adolescents not involved in the justice system (Farrer et al., 2013).

- Children with a BI history are 2x likely to have behavioral health issues, social and academic difficulties, and ACE exposure compared with peers with no history of BI (Haarbauer-Krupa et al., 2015).

Developing brains are vulnerable & symptoms may be misinterpreted as "defiance" or "disengagement"

Executive dysfunction, emotional dysregulation, memory impairments impact compliance and decision-making (Reddy, 2025).

Justice-Involved Youth in Nebraska

Brain Injury Association of Nebraska

Breaking the Cycle: Brain Injury & Juvenile Justice Centers

As part of a project funded through the Sherwood Foundation, the Brain Injury Association of Nebraska (BIA-NE) collaborated with three juvenile justice centers: Douglas County Youth Center (DCYC), Lancaster County Youth Services Center (LCYSC), and RADIUS. While this project began in May 2025, all three previously worked with the BIA-NE. The project focused on two core elements: **systems change efforts** and **engagement with youth**. That work is also completed by a **Brain Injury + Juvenile Justice Advisory Group**. Data highlighted in this report focuses on efforts primarily between May and December 2025.

Systems Change

Training & Professional Development

BIA-NE will offer and promote Brain Injury 101 trainings and other professional development opportunities

Engage with Multidisciplinary Teams (MDTs)

BIA-NE will actively participate in MDT meetings to share results of screenings and potential strategie

Educational Records Review

Juvenile justice centers will integrate searching for key terms related to brain injury while doing reviews of youths' education records

Engagement with Youth

1 Screen Youth for Brain Injury

All youth in the juvenile justice centers will be screened for brain injury by the BIA-NE

2 Cognitive Screen for Youth with Possible/Probable Brain Injury

Following appropriate consents, youth with probable/possible brain injury may participate in a cognitive screening to better identify challenge and strategies

3 Additional Supports & Services

Supports and services are provided to the youth and potential family through the BIA-NE and the MDT

Engagement with Youth

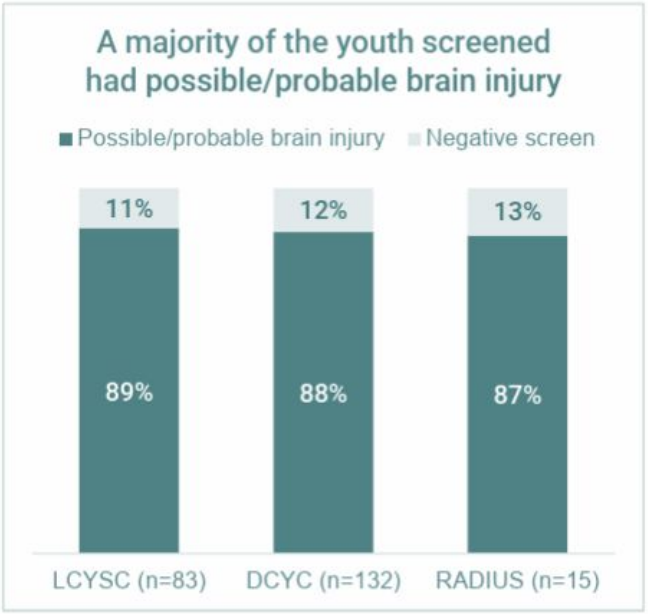
Screening Youth for Brain Injury

230

youth were screened using the Online Brain Injury Screening & Support System (OBISSS)

of those screened identified as male

Youth screened for brain injury were between the ages of 13 and 18, with the average age being 16[1]

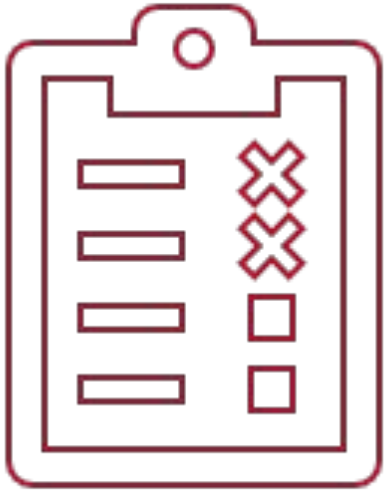


[1] This data is based on what has been entered into the Online Brain Injury Screening and Support System (OBISSS). Although youth as young as 12 have been screened for brain injury, that data cannot be entered into OBISSS.

Application for Behavioral Health Providers

Best Practices: Screening and Assessment

Screening



Validated Screening Tools

- Use brief, validated tools like the OBISS for efficient BI screening in early sessions.

Trauma-Informed Language

- Introduce screening with nonjudgmental, trauma-informed language to normalize questions and reduce stigma.

Early Screening Benefits

- Embed screening early to ensure timely BI identification and avoid misinterpreting symptoms as behavioral issues.

Follow-up and Intervention

- Document findings and consider referrals or tailored interventions based on screening outcomes.

Reframing Behavioral Symptoms Through a Neurocognitive Lens

Understanding Behavioral Origins

- Distinguish between intentional misconduct and behaviors caused by neurological impacts of traumatic brain injury.

Common Cognitive Impairments

- BI affects planning, inhibition, attention, working memory, & processing speed, impacting daily tasks and emotional regulation.

Neurocognitive Reframing Benefits

- Reframing behaviors neurocognitively avoids punitive responses and promotes practical support for youth and families.

Recognizing Variability and Triggers

- Youth with BI experience good and bad days; recognizing this reduces misinterpretation of behaviors as lack of effort.

Example Assessment Battery

Screening Measures

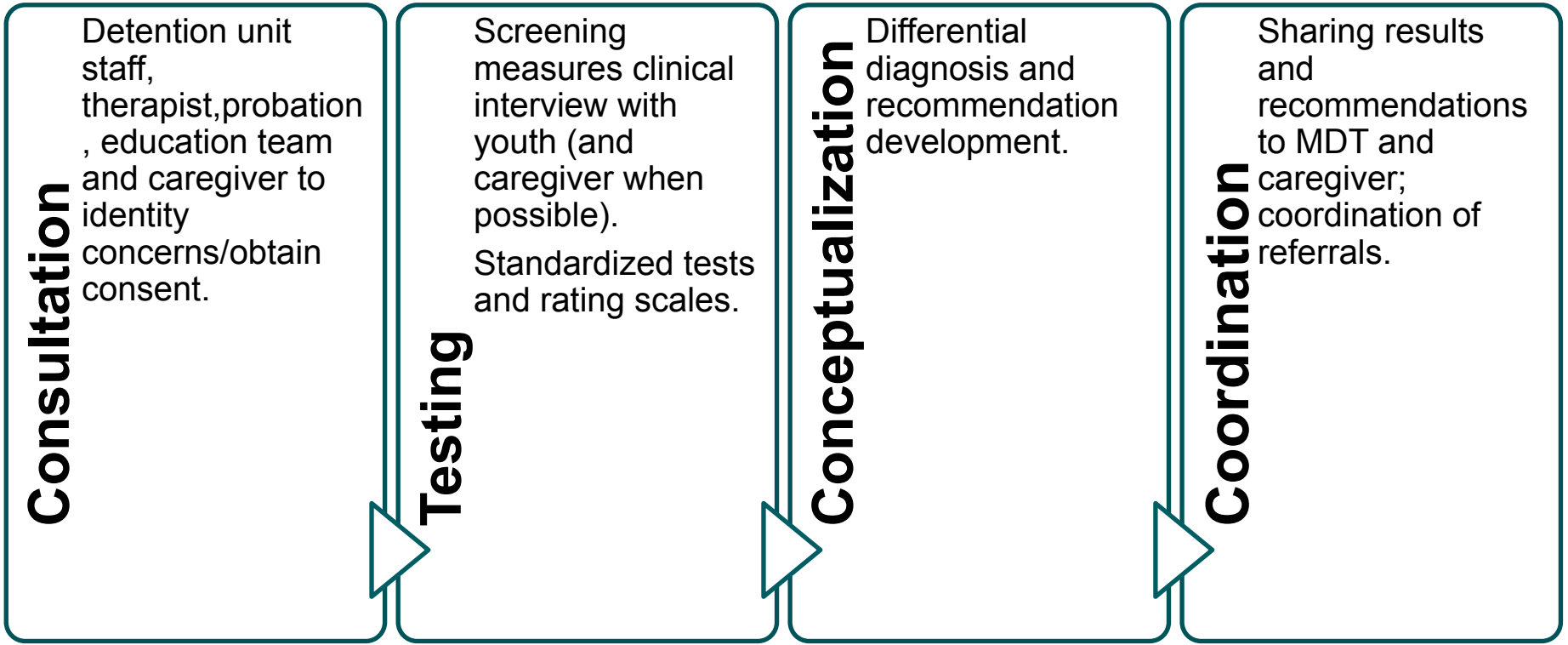
- Child and Adolescent Trauma Screen (CATS/CATS-2)
- Youth Pediatric Symptom Checklist – 17 (YPSC-17)
- **Ohio State University BI Screen**
- Generalized Anxiety Disorder – 7 (GAD-7)
- Patient Health Questionnaire – 9 (PHQ-9)

- **Self-Report Rating Scales**
  - Minnesota Multiphasic Personality Inventory – Adolescent (MMPIA)*
  - **Behavior Rating Inventory of Executive Function – 2 (BRIEF-2)***
  - Behavior Assessment System for Children, Self-Report*

Caregiver/Teacher Rating Scales

- Behavior Assessment System for Children – 3
- **Adaptive Behavior Assessment System – 3**
- Strengths and Difficulties Questionnaire
- **Behavior Rating Inventory of Executive Function – 2 (BRIEF-2)***
- Autism Spectrum Rating Scales*
- Conners-3*

Example Established Standard of Practice



Best Practices: Recommendations & Treatment

Behavioral Health Recommendations

Consider the learning needs of key areas of functioning: **academic, social, emotional, physical, behavioral, adaptive skills**.

Emphasize areas of growth and existing strengths

Name specific and discreet skills

Connect challenging behaviors to interventions that are intended to target specific outcomes

Consider **neurodevelopmental differences**

Identify behavioral interventions or empirically supported approaches for youth with neurodevelopmental differences

Example Recommendations

Individualized Education Support

- Academic accommodations to support executive functioning and learning
- Reteaching and presentation of academic content that is at current level until mastery

Individual and Family Therapy

- Trauma-focused/informed therapeutic services
- Individual social skills training/ communication training
- Parent management training

Behavior Based Interventions

- Establishing routines
- Clear contingencies
- Increased practice opportunities to demonstrate expected behaviors
- Frequent reinforcement

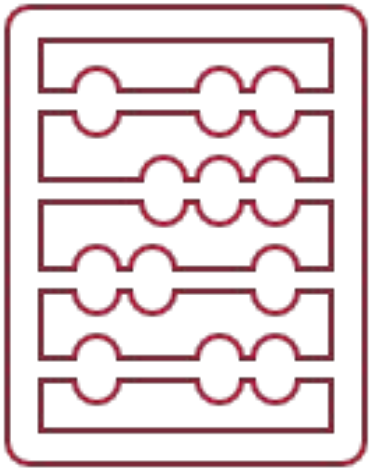
Psychiatry Referral

- Medication management
- Psychoeducation related to medication and identification of motivations for compliance (internal and external)

Re-Assessment of Symptoms

- Assessing symptoms, functioning, and adaptive skills once education and home settings have stabilized

Adapting Clinical Interventions for Cognitive Impairment



Session Structure Adaptations

- Shortening sessions and scheduling breaks help prevent cognitive overwhelm among youth with brain injuries.

Simplified Communication

- Using simple, concrete language and delivering one instruction at a time supports comprehension and reduces confusion.

Visual Supports and Repetition

- Checklists, diagrams, and color-coded cues reinforce memory; repetition strengthens skill acquisition.

Sensory Environment Management

- Minimizing noise, lighting, and distractions reduces sensory overload and improves focus during sessions.

Best Practices: Crossing Systems

Systems-Level Considerations

Pathways

- Behavioral dysregulation, social vulnerability & "invisible" disability (Riccardi & Ciccia, 2023).

Policy

- Universal screening, staff training, cognitive accommodations & cross-system collaboration (Davidson & Reed, 2024)

Gaps

- Lack of screening, limited staff training & inconsistent accommodations (Davidson & Reed, 2024).

Rehabilitation & Reentry

- BI impairs program participation; youth with BI 69% more likely to reoffend (Tennessee Disability Coalition, 2025).

Engaging Families & Coordinating Across Systems

Family Education and Support

- Psychoeducation helps families understand BI effects on memory, emotions, and behavior for better home support.

Caregiver Strategies

- Caregivers implement routines, simplified instructions, visual aids, and calm responses to improve youth functioning.

Cross-System Collaboration

- Coordinated efforts among schools, probation, medical, and behavioral teams ensure consistent BI-informed interventions.

Academic Advocacy and Consistency

- Advocating for accommodations and aligning expectations across settings reduces confusion and improves outcomes.

Supporting Transitions and Long-Term Stability

Proactive Transition Planning

- Effective transition starts before reentry, using step-by-step checklists and rehearsal to prepare youth for new routines.

Community Coordination and Warm Handoffs

- Behavioral health professionals enhance care continuity by connecting youth with community BI, mental health, and educational services.

Supportive Strategies for Youth

- Using memory aids, daily routines, and managing sleep and symptoms supports youth stability post-release.

Monitoring and Emotional Support

- Gradual exposure to new environments and monitoring during early reentry helps emotional regulation and reduces reoffending risk.

Cross-System Workforce Development

Build Core, Shared Knowledge on Pediatric Brain Injury

Equip professionals across mental/behavioral health, education, juvenile justice, medical, child welfare, and community services with a **baseline understanding**

Establish Consistent Screening, Identification, and Referral Pathways

Create uniform cross-agency protocols to screen youth with possible brain injury early

Develop a Shared Cross-System Communication & Coordination Framework

Cross-agency case conferencing practices, clear data-sharing agreements (FERPA/HIPAA compliant); defined points of contact in each system, processes for warm handoffs between agencies

Provide Skills Training in Brain-Informed, Strength-Based Interventions

Train staff across sectors to apply practical, brain-based strategies with evidence-informed tools/

Example Post-Evaluation Collaboration

1. Conduct feedback is conducted with appropriate care team members: a youth's caregiver, probation officer, and attorney (if applicable).
2. Consultation with detention center school to implement accommodations (e.g., academic and behavioral).
3. Consultation with detention center therapists to inform services (e.g., bolstering motivation for change, medication compliance).
4. Collaboration with care team and agencies to support community re-entry (e.g., psychiatry, education rights advocacy group).

Q + A
Discussion

References & Resources

1. Davidson, M., & Reed, K. (2024). Mind matters: Building a justice system that is inclusive and responsive to brain injury. Council of State Governments Justice Center.
2. Riccardi, J., & Ciccia, A. H. (2023). Training on brain injury for juvenile justice professionals: Findings from pre- and post-training surveys and focus groups. Journal of Applied Juvenile Justice Services.
3. Nagele, D., Vaccaro, M., Schmidt, M. J., & Myers, J. (2021). Brain injury in justice-involved youth: Findings and implications for juvenile service professionals. Brain Injury Association of Pennsylvania.
4. Tennessee Disability Coalition. (2025). Brain injury and the juvenile justice system [Infographic].
5. BI & Social Justice Lab, McMaster University. (n.d.). Traumatic brain injury and youth justice. BI Youth Justice.
6. Brainkind. (n.d.). Brain injury and the criminal justice system. https://brainkind.org/about-brain-injury/brain-injury-and-the-criminal-justice-system/
7. Centers for Disease Control and Prevention. (n.d.). Traumatic brain injury: A guide for criminal justice professionals. BrainLine. https://www.brainline.org/article/traumatic-brain-injury-guide-criminal-justice-professionals
8. Kelley, L. (2025). Study finds link between brain injury and criminal behavior. University of Colorado Anschutz Medical Campus News.
9. Reddy, K. J. (2025). Traumatic brain injury and criminal justice. In Foundations of criminal forensic neuropsychology (pp. 271–298). Springer.
10. Schubmehl, S. (2025). Overrepresentation of individuals with traumatic brain injury in the criminal justice system. Brain Injury Association of Colorado.
11. Dierkhising, C. B., Ko, S. J., Woods-Jaeger, B., Briggs, E. C., Lee, R., & Pynoos, R. S. (2013). Trauma histories among justice-involved youth: Findings from the National Child Traumatic Stress Network. European Journal of Psychotraumatology, 4, 10.3402/ejpt.v4i0.20274. https://doi.org/10.3402/ejpt.v4i0.20274
12. Haarbauer-Krupa, J., Daugherty, J., Nagele, D., Dettmer, J., Gorgens, K., Lyman, H., Ashley, C., Medina, A., Tomita, I., & Lambert, L. (2025). History of Childhood Traumatic Brain Injury and Potential Risk Factors for Future Incarceration 8268. Archives of Physical Medicine and Rehabilitation, 106(4), e12. https://doi.org/10.1016/j.apmr.2025.01.031
13. Farrer, T. J., Frost, R. B., & Hedges, D. W. (2013). Prevalence of traumatic brain injury in juvenile offenders: a meta-analysis. Child neuropsychology : a journal on normal and abnormal development in childhood and adolescence, 19(3), 225–234. https://doi.org/10.1080/09297049.2011.647901
14. Cavendish, W. (2014). Academic Attainment During Commitment and Postrelease Education–Related Outcomes of Juvenile Justice-Involved Youth With and Without Disabilities. Journal of Emotional and Behavioral Disorders. https://doi.org/10.1177/1063426612470516
15. Holland, L., Reid, N. & Smirnov, A. Neurodevelopmental disorders in youth justice: a systematic review of screening, assessment and interventions. J Exp Criminol 19, 31–70 (2023). https://doi.org/10.1007/s11292-021-09475-w
16. Baglivio, M. T., Wolff, K. T., Piquero, A. R., DeLisi, M., & Vaughn, M. G. (2017). Multiple Pathways to Juvenile Recidivism: Examining Parental Drug and Mental Health Problems, and Markers of Neuropsychological Deficits Among Serious Juvenile Offenders. Criminal Justice and Behavior. https://doi.org/10.1177/0093854817714810
17. Cheely CA, Carpenter LA, Letourneau EJ, Nicholas JS, Charles J, & King LB (2012). The prevalence of youth with autism spectrum disorders in the criminal justice system. Journal of Autism and Developmental Disorders, 42, 1856–1862.

UNMC℠ | MUNROE-MEYER INSTITUTE

UNIVERSITY OF Nebraska Medical Center