**Mental Health and Substance Use Disorder Treatment (MHSUD Tx) Committee**

**Meeting Minutes - June 10, 2025**

**Attending:** Lacie Scofield, Tremaine Sawyer, Helen Tripp, Donna Rosser, Roshanna Parker, Kristen Patterson, Marc Strange, Margaret Slade, Carolyn Crowder, Quanesha Archer, Kimberly Barbosa, Chenelle Mclnnis, Vera Reinstein, Dee Gray, Kay Sanford, Deborah Weissman, Erin Namovicz

**Minutes Approved**: Vera Reinstein motioned to approve the minutes from the last meeting (May). The motion was seconded by Kristen Patterson, and the minutes were approved.

**Presentation:**

**Erin L. Namovicz and Director Deborah M. Weissman, Criminalized Survivor, Detention, and Justice Clinic at the University of North Carolina School of Law**

“Repeated Victimization, Repeated Criminalization: The Criminal Legal System’s Treatment of Survivors of Co-occurring Intimate Partner Violence and Brain Injury, and Their Needs Upon Reentry”

45% of people who have been implicated in the criminal legal system have a history of brain injury. Incarcerated women have a 5-7% higher rate of a brain injury than incarcerated men.

**How do brain injuries occur?**

Objects striking head or neck, strangulation, asphyxiation, collision with walls or other surfaces, violent shaking, and pushed downstairs or out of cars.

**IPV and Brain Injury**

Studies show that up to 75% of victims of intimate violence have suffered a corresponding brain injury. However, brain injury is underdiagnosed among victims of intimate partner violence. Why?

* Stigma
* Access to medical care
* Conflation of symptoms with symptoms of PTSD and drug use.
* Effects of the brain injury itself.

**Symptoms:**

1. Memory loss
2. Light sensitivity
3. Blurry Vision
4. Dizziness
5. Emotional Dysregulation
6. Impaired Decision Making
7. And more…

**Intimate Partner Violence, Brain Injury, Substance Abuse**

How could **intimate partner violence** contribute to substance abuse?

* Coping mechanism for physical and emotional trauma.
* Coercion from abusive partner
* Higher exposure to prescription medication from IPV-related injuries

How could brain **injury contribute** to substance abuse?

* Prescribed opioids to manage BI symptoms
* Difficulty complying with instructions for use of prescribed opioids
* Memory lapses -> take medication twice
* Impaired judgment and impulsivity.

**IPV- related Brain Injury may lead to criminalized behavior**

Symptoms such as **depression, hypervigilance,** and **poor judgment** may lead to increased **impulsivity** and **risk-taking** behaviors.

Impaired executive functioning from brain injury can also **cause difficulty assessing consequences** of actions**, decision-making**, and **compliance** with instructions.

Additionally, as both IPV and BI increase the risk of **substance abuse,** these women face increased criminal legal involvement for drug offenses and **drug-related offenses.**

**Experience During Incarceration**

Memory deficits and difficulty focusing make it hard to focus on required task or respond to directions given by a Correctional Officer.

Slow verbal and physical responses, irritability, anger, and impulsive behavior may be misinterpreted as deliberate defiance.

This leads to denial of access to programs, disciplinary actions by jail or prison staff, and loss of sentencing credit.

**How can we help?**

Screening!

1. The county jail is a de-facto triage point
2. Early screening allows for implementation of accommodations during incarceration and connection with services upon reentry
3. Identification of IPV history should trigger screening for brain injury

**Accommodate Brain Injury**

* Dimmable lights or sunglasses
* Earplugs
* Large text or low contrast docs
* Provide frequent breaks during activities and keep instructions brief
* Combine tactile tools during discussions and meetings
* Slow down explanations and repeat info
* Maintain consistent schedules and provide reminders
* Provide incentives and be patients
* Many others (see presentation slides)

**Reentry Programming Needs**

* Detailed, individualized reentry plans and case management
* Pre-release Medicaid enrollment and SSI enrollment.
* Connect eligible individuals who receive a BI diagnosis
* Job Training Programs in fields traditionally dominated by women
* More transitional housing for women, including housing which permits children

**What’s Next?**

* Screen clients, especially those with IPV history, for potential brain injury
* Brain injury Association of North Carolina NC Brains Initiative
* Screening, awareness, and data collection campaign

**Committee Member Updates:**

Vera Reinstein announced that RI is closing the outpatient treatment program at the Durham Recovery Response Center on June 20th.

Lacie Scofield added that there are around 100 patients currently getting therapy and/or Suboxone treatment there. Unfortunately, the program is coming to an end and the staff are being let go. The RI crisis unit and the CLC peer support program will stay in that building and will continue to operate. The CLC Peer Support Specialists are working to find alternative treatment providers for all of the clients currently receiving treatment through the outpatient program. They have made appointments for people at Morse Clinic, Lincoln, Freedom House, and other local providers. The peers will continue to provide peer support to clients at DRRC and may also meet with them at their new treatment homes.

Vera and Lacie also mentioned that Josefs Pharmacy is now providing syringe services and has also agreed to host a naloxone vending machine provided by Durham County Dept of Public Health.

Kay Sanford mentioned a recently published research study on the benefits of receiving MOUD after a nonfatal opioid overdose. The study publication will be shared with the committee.

**Next Meeting:**

As in past years, we have decided to cancel the July MHSUD Tx Committee meeting due to many committee members having summer vacation plans.

Our next meeting will be **August 12th at 3:00-4:30 pm**.