A GENDER-RESPONSIVE APPROACH TO NAVIGATING INCARCERATION AND REENTRY WITH A BRAIN INJURY

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I. Prevalence of Brain Injuries in Survivors of Domestic Violence

Research indicates that as many as 75% of victims of intimate partner violence (IPV) have sustained a brain injury at one point or another.[1] Blunt force trauma including slapping, hitting, punching, or pushing and strangulation are common causes of brain injury, which in turn, are common forms of abuse experienced by victims of IPV. A study conducted at Stanford Law School sampled a total of 649 women, representing 58.2% of the population of people incarcerated for murder or manslaughter in California women's prisons.[2] The results were startling. 85.6% reported being shaken or pushed by their partners, and 72% said that their partners hit them with their fist or an object.[3] 60% reported being strangled by their partner, and of those who had been strangled, 78.1% had been strangled more than once and reported that they had passed out, blacked out, or experienced dizziness.[4] More general studies employing a wide range of methodologies found that anywhere from 19 to 75% of women who are victims of IPV have suffered a corresponding brain injury (BI).[5] These numbers are even higher for victims of IPV who have suffered a head injury in particular—one study reported that 100% of IPV survivors that reported injury to the head suffered a BI.[6]

II. Consequences of Brain Injuries in Survivors of Domestic Violence

While the particular consequences of BIs vary, the impacts on survivors are consistently devasting. Effects can range from "mild" symptoms such as fatigue, depression, memory loss, or difficulty concentrating, to more severe, chronic health problems.[7] Research shows that among those still alive five years after a moderate to severe traumatic brain injury (TBI), 57% are moderately or severely disabled, 55% do not have a job, 33% rely on others for help with everyday activities, and 29% use illicit drugs or misuse alcohol.[8]

For criminalized survivors, these effects are often disastrous and can be directly or indirectly responsible the acts for which they have been incarcerated and the difficulties they are likely to experience with reentry. BIs impact "executive (e.g., decision-making) and inhibitory (impulse control) functioning."[9] Someone whose brain function is impaired often has more difficulty adjusting to new or stressful environments and struggles following through on guidance or recommendations from healthcare providers, social service advocates, and other professionals.[10]

III. Need for Jails, Prisons, and Reentry Programs to Screen for Brain Injuries

In order to treat and effectively mitigate the effects of BI, the first, and arguably most important step, is identifying a BI. Without identification and diagnosis, individuals are left with unanswered questions regarding their symptoms, oftentimes leading to a sense of lack of control. Jail, prison and reentry personnel who lack of awareness about a BI may unduly discipline individuals for unintentional conduct or actions largely out of their control. Behaviors such as missing appointments and slow verbal and physical responses, irritability, and impulsivity—symptoms of a brain injury— may be misinterpreted as deliberate defiance.[11] This could lead to the denial of access to programs, disciplinary actions by jail or prison staff, loss of sentencing credit, or probation violations.[12]

Adequate screening for IPV is crucial in identifying individuals to further screen for BI. The two are directly linked, since it is estimated that upwards of 70% of incarcerated women have been victims of IPV, and since as many as 75% of victims of IPV have experienced a brain injury.[13] Without screening for IPV upon arrival to jail or prison, an entire cohort of individuals who may have a brain injury are ignored and their needs unmet. At a minimum, standards are necessary to ensure that healthcare providers are regularly screening for IPV, and then regularly

assessing and documenting when an IPV patient has suffered an injury that could lead to a brain injury.[14]

Experts on IPV and healthcare recommend the following procedure for screening for BI:

> If a survivor discloses IPV, healthcare providers must inquire whether the survivor has previously been hit in the head, strangled, or lost consciousness.[15] If patient is says yes to any, provider should assess for neurological symptoms and then make any referrals as necessary.[16] Then, providers should use a validated BI screening tool, such as the Ohio State University Traumatic Brain Injury Identification Method, the Online Brain Injury Screening Support System (OBISSS)[17], the Brain Injury Screening Questionnaire, or the Brain Injury Screen Test.[18]

As the UNC Law Healthcare Provider Guide states, "the benefits of screening for. . . BI extend beyond a particular patient. Following recommended protocols helps to expand opportunities for research and advocacy, furthering efforts to prevent and remediate BI among IPV survivors."[19]

IV. Recommendations for Working with Survivors with Brain Injuries in Jails and Prisons

Screening and diagnosing brain injuries is essential for survivors. A diagnosis can validate a survivor's experience, explain long-standing symptoms, and offer a foundation for targeted treatment. While expanded screening protocols are the necessary first step, jails and prisons must also use this information to implement meaningful accommodations that help individuals navigate incarceration in a brain injury-informed way.

A. Symptoms Questionnaire

Brain injuries can cause a wide range of symptoms, including fatigue, memory loss, impaired motor skills, difficulty concentrating, and barriers to help-seeking.[20] Because symptoms present differently from person to person, identifying an individual's specific needs is critical.[21] A symptoms questionnaire is the most effective tool for this purpose. After someone screens positive for a brain injury, a provider should administer a questionnaire that captures how the injury affects their daily functioning.

For example, a Washington State symptoms questionnaire lists potential symptoms, such as "I tend to be impulsive," and asks individuals to rate both how often the symptom affects them and how severe it is.[22] Once a person identifies their most significant symptoms, jail or prison staff can tailor accommodations accordingly. If someone struggles with attention, for example, personnel should keep instructions short, provide information in writing, and allow breaks during meetings or appointments.[23] A symptoms questionnaire also empowers individuals by helping them better understand their challenges and identify accommodations they may need. By naming and isolating symptoms, survivors can advocate more effectively for themselves.

B. Educational Trainings for Staff

Ongoing education for carceral personnel is essential to supporting individuals with brain injuries. Trainings should cover the prevalence of brain injuries, indicators that someone should be screened, and best practices for working with individuals navigating incarceration with a brain injury.[24] These trainings must remain engaging, given the volume of training requirements staff already face.

A University of Washington pilot program integrated a 45-minute brain injury training into the state's mandatory Department of Corrections annual training, allowing nearly 7,000 staff to participate.[25] The training combined expert instruction with stories from correctional officers who themselves had sustained brain injuries, an approach that made the information more relatable and impactful.

State brain injury advocacy organizations can also support jails and prisons in developing or supplementing trainings. For example, the Brain Injury Association of North Carolina offers free online courses, webinars, conferences, and certification programs.[26] Partnerships between brain

injury experts and correctional leadership ensure practical, relevant, and intentional training that leads to more informed care for incarcerated individuals.

C. Facilitating Proper Reentry Contacts

Reentry and reintegration is challenging for all individuals leaving incarceration, but those with brain injuries face additional barriers. Cognitive and memory-related symptoms may make it difficult to manage appointments, such as probation check-ins, or maintain employment housing, or transportation.[27]

To support successful reentry, individuals who screen positive for a brain injury should be connected early to resources that match their specific needs.[28] For example, all individuals with a diagnosed brain injury should be connected to state resources directly tied to brain injury. In North Carolina, the Alliance of Disability Advocates operates a pilot reentry program for individuals with brain injuries.[29] However, the program depends on jail and prison staff within the system for referrals.[30] Without intentional referral practices, many eligible individuals never access the program. It is vital for internal reentry counselors to be aware of specific brain injury resources outside of prisons and connect individuals with them.

Reentry plans should also include symptom-specific referrals. For someone with a limited attention span, this may include identifying employment settings that allow accommodations like structured routines or frequent breaks. Intentional referrals increase the likelihood of a stable, successful transition back into the community.

V. Recommendations for Working with Survivors with Brain Injuries in Reentry Programs

Because brain injury screenings in jails and prisons are not yet widespread, reentry programs must also be prepared to identify and support individuals with brain injuries. Screening upon intake helps individuals name their experiences, understand their symptoms, and begin planning

for appropriate accommodations. As with carceral settings, reentry programs should pair screening with a symptoms questionnaire to inform a personalized reentry plan.

A. Educational Trainings for Staff

The recommendations for jail and prison staff that call for training, education, and generally being informed about a BI diagnosis are similarly important for reentry personnel in order to advocate and support affected individuals coming out of prisons. Reentry programs can tailor their educational trainings to the populations they serve. A women-focused reentry program, for example, could incorporate training on supporting survivors of domestic violence, rebuilding family relationships, and securing stable employment—issues that disproportionately affect women with brain injuries. When staff understand how brain injuries manifest and the accommodations that may be required, they can design reentry plans that are more realistic, individualized, and effective.

B. Gender-Responsive Support Groups

Reentry programs can also offer peer support groups for individuals with brain injuries. These groups allow participants to learn from one another, share strategies, and feel less isolated. The Mindsource Brain Injury Network offers a free, seven-session training titled "A.H.E.A.D.,"[31] designed to educate participants about brain injuries and build symptom-management skills. The curriculum is designed so that practitioners of any background can facilitate group sessions, and the sessions can be completed in a variety of settings.[32] Each session has training videos, group discussion time, and individual reflection.[33] Mindsource is an organization based in Colorado, a leading state for brain injury research and support.

Support groups provide crucial community connection and can be a powerful addition to reentry programming for individuals managing brain injuries.

C. Referrals to Brain Injury Resources

Reentry programs often have strong community networks and should use these relationships to connect individuals with brain-injury-specific services. In North Carolina, this includes the Department of Health and Human Services' (NCDHHS) Traumatic Brain Injury (TBI) waiver program, which provides community-based rehabilitative services and support for individuals with a brain injury.[34] The program is currently underutilized because of lack of awareness and administrative barriers, making intentional referrals especially important.[35]

Reentry programs should ensure that individuals with brain injuries are connected not only to injury-specific services but also to broader supports that may be more difficult to navigate, such as Medicaid enrollment, disability services, and transportation assistance.

Screening for brain injuries in carceral and reentry settings is a critical first step toward ensuring survivors receive the validation, accommodations, and support they need. But screening alone is not enough. Jails, prisons, and reentry programs must integrate symptom-specific tools, consistent staff training, and intentional referrals practices to create environments that recognize and respond to the unique challenges survivors face. When systems commit to brain-injury-informed practices, they reduce barriers that often lead to disciplinary issues, failed reentry, or recidivism and instead support safer, more stable pathways back into the community.

Key recommendations include:

- Expanding screening protocols
- Implementing symptom-responsive accommodations
- Providing ongoing, engaging staff trainings
- Partnering with state brain injury organizations
- Ensuring early and intentional referrals
- Incorporating gender-responsive programming
- Developing reentry plans grounded in symptoms-driven needs

Appendix: Brain Injury Resources in North Carolina

Brain Injury Association of North Carolina, https://www.bianc.net/.

Disability Rights North Carolina – NC BRAINS Initiative, https://disabilityrightsnc.org/our-work/tbi-nc-brains-initiative/.

Atrium Health – Brain Injury Program, https://atriumhealth.org/medical-services/specialty-care/rehabilitation/brain-injury.

Carolinas Traumatic Brain Injury Rehabilitation and Research System, https://atriumhealth.org/research-clinical-trials/carolinas-rehabilitation-research-laboratory.

Formerly Incarcerated Transition (FIT) Program – UNC School of Medicine, https://www.med.unc.edu/psych/cecmh/services/clinical-services/reach/fit/.

[1] DEBORAH WEISSMAN, MADELINE BAUER, MARIAH HARRELSON, & KAYTKI JOSHI, FROM THE CRADLE TO THE GRAVE: THE LIFELONG CRIMINALIZATION OF SURVIVORS OF GENDER-BASED VIOLENCE 2 (2024) [hereinafter FROM THE CRADLE TO THE GRAVE].
[2] DEBBIE MUKAMAL, ANDREA N. CIMINO, BLYSS CLEVELAND, EMMA DOUGHERTY, JACQUELINE LEWITTES, & BECCA ZIMMERMAN, FATAL PERIL: UNHEARD STORIES FROM THE IPV-TO-PRISON PIPELINE, STANFORD CRIMINAL JUSTICE CENTER 9 (2024).
[3] *Id.* at 10.
[4] *Id.*
[5] NICOLE AMALDOSS, KATHERINE CARTER & ERIN NAMOVICZ, DOMESTIC VIOLENCE AND BRAIN INJURY: A HEALTHCARE PROVIDER'S LEGAL GUIDE 4 (2025) [hereinafter HEALTHCARE PROVIDER GUIDE].
[6] *Id*.
[7] *Id*.
[8] *About Potential Effects of a Moderate or Severe TBI*, CDC (May 16, 2024), https://www.cdc.gov/traumatic-brain-injury/about/potential-effects.html#:~:text=Thinking%20and%20Learning,of%20dying%20from%20several%20causes.
[9] HEALTHCARE PROVIDER GUIDE, *supra* note 6, at 4.
[10] *Id*. at 4–5.
[11] NICOLE AMALDOSS & ERIC NAMOVICZ, Repeated VICTIMIZATION, REPEATED CRIMINALIZATION 8 (Mar. 21, 2025) [hereinafter REPEATED VICTIMIZATION, REPEATED CRIMINALIZATION].
[12] *Id*.
[13] *See* FROM THE CRADLE TO THE GRAVE, *supra* note 1 at 2.
[14] HEALTHCARE PROVIDER GUIDE, *supra* note 6, at 8.
[15] *Id*.
[16] *Id*.
[17] Welcome to NASHIA's OBISSS, NASHIA (2025), https://www.nashia.org/obisssprogram.
[18] HEALTHCARE PROVIDER GUIDE, *supra* note 6, at 9.
[19] *Id*.
[20] REPEATED VICTIMIZATION, REPEATED CRIMINALIZATION, *supra* note 11, at 5.
[21] *Id*. at 11 ("Gender responsive programming is that which is based on assessment of each individual's risks and needs and considers the gender-specific variables of incarcerated women.").
[22] *Traumatic Brain Injury (TBI) / Acquired Brain Injury (ABI) Self-Assessment Tool*, WASHINGTON STATE DEPARTMENT OF VETERANS AFFAIRS, https://www.dva.wa.gov/sites/default/files/2023-02/TBI%20Screening%20Tool%20Update%2001192023_0.pdf.
[23] HEALTHCARE PROVIDER GUIDE, *supra* note 6, at 13.
[24] *TBI and Correctional Facilities*, CDC, (Aug. 4, 2025), https://www.cdc.gov/traumatic-brain-injury/health-equity/correctional-facilities.html.
[25] *See Traumatic Brain Injury in Corrections,* UNIV. OF WASH., https://tbicorrections.washington.edu/.
[26] *Education & Training*, BRAIN INJURY ASSOCIATION OF NORTH CAROLINA, https://www.bianc.net/learning-center/education-training/.
[27] REPEATED VICTIMIZATION, REPEATED CRIMINALIZATION, *supra* note 11, at 12.
[28] *Id*.
[29] *Id*. at 12–14.
[30] *Id*.
[31] *A.H.E.A.D. Group*, MINDSOURCE BRAIN INJURY NETWORK, https://mindsourcecolorado.org/ahead/.
[32] *Id*.
[33] *Id*.
[34] REPEATED VICTIMIZATION, REPEATED CRIMINALIZATION, *supra* note 11, at 28.
[35] *Id*.