Listening Session on TBI in Minnesota Correctional Facilities

SYSTEMS CHANGE FOR SUCCESSFUL RETURN TO AMERICAN INDIAN COMMUNITIES

Prepared by: The Improve Group

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The Listening Session and this report were supported by Health and Human services (HHS), Health Resources and Services Administration (HRSA), Maternal HRSA Grant #H21MC17234 from the US Department Child and Health Bureau (MHCB), and the State of Minnesota.

PARTICIPANT SUGGESTIONS ON POLICY:

- Mandate TBI education for chemical health and mental health licensed professionals.
- Inform law enforcement and community service providers when individuals are being released from correctional facilitates into the community.
- Ensure that TBI diagnosis is acknowledged and taken into account during sentencing, mental health assessment and child protection case investigations.
- Formalize and institutionalize inmate access to spiritual and cultural practices, including increased access to American Indian spiritual leaders.

Minnesota Department of **Human Services**

MINNESOTA DEPARTMENT OF CORRECTIONS

Prepared by: The Improve Group

Listening Session on TBI in Minnesota Correctional Facilities: Systems change for successful return to American Indian communities

Executive Summary

Event details

March 26 and 27, 2013 the Minnesota Department of Human Services (DHS) and the Minnesota Department of Corrections (DOC) held a listening session with representatives from American Indian communities to discuss the issue of successful return to community for previously incarcerated individuals with traumatic brain injury (TBI).

Attendees

Representatives from behavioral/mental health, chemical health, housing services, reintegration services, public safety, spiritual leadership, tribal leadership, vocational rehabilitation, and corrections release planning attended.

Listening Session attendees were from Bois Forte Band of Chippewa, DHS, DOC, Fond du Lac Band of Lake Superior Chippewa, Grand Portage Band of Lake Superior Chippewa, Leech Lake Band of Ojibwe, Lower Sioux Indian Community, Mille Lacs Band of Ojibwe, Red Lake Nation, White Earth Band of Ojibwe, and a variety of other service providers who work with American Indians who have been incarcerated.

Event goals

1. Provide information about brain injuries
2. Identify what's working and not working now in terms of relationships and supports
3. Begin to build vision for capacity building through dialogue and collaboration
4. Identify next steps and stakeholders to work with in the future

Bringing Tribal, urban and State people to discuss important issues affecting the Native American people... we need to do more of this, and come up with collaborative action plans to be implemented.

-Session Participant

Participant Suggestions from the Event on...

DAY–TO–DAY LIFE

erican Indians with traumatic brain injuries face the same employment, public & tribal housing, and transportation prohibitions as any released offender, especially in rural areas.

Psychoeducation for individuals with TBI can teach them how their brains work differently and to create realistic expectations for the challenges they will face. Family members and caregivers should be engaged in this and other treatment programming.

Other suggested treatment approaches include the Three Principles, ACT (Assertive Community Treatment), and the creation of sensory-rich training materials.

HEALTH

Additional tribal organizations and service providers need to be equipped to provide TBI screenings.

Cultural components need to be integrated into TBI treatment programming for American Indians. Current systems seem to ignore the cultural and spiritual aspects of health, and this impacts physical health.

Spiritual leaders need increased access to American Indian individuals while incarcerated to perform traditional healing ceremonies.

COMMUNITY REINTEGRATION

Work is needed to increase awareness of TBI and decrease stigma surrounding ex-offenders. Suggested strategies:

- Hold welcome home ceremonies
- Create culturally specific tracks and/or comprehensive treatment programs
- Implement community education around TBI
- Enhance connections between service providers within communities
- State and tribal governments jointly apply for specific funds to support re-entry collaboration

Capacity building among American Indian community organizations is critical, including:

- Greater awareness of the prevalence and impact of TBIs
- Training in services for those with a TBI.

Participants suggested cross-training with TBI service providers and American Indian reintegration service providers, as well as between DOC staff and tribal mental health and chemical health professionals.

PLANNING FOR RELEASE FROM PRISON

American Indian culture and traditional ceremonies are the foundation for preparing individuals for successful release.

All incarcerated individuals (including those on parole or probation) ought to be screened for TBI prior to release.

American Indian community providers and resources should be informed and engaged ahead of release by DOC so that they can develop personalized action and treatment plans and ensure continuity of care through a cross-disciplinary team.

Tribal participation is needed in the DOC transition fairs held for inmates nearing release.

Provide a point person to community members who are reintegrating; e.g. a tribal representative, an individual coach, or a more comprehensive mentorship program.

IDEAS FOR CONTINUING THE CONVERSATION

Listening Session attendees asked to be informed and engaged in future TBI grant efforts to support American Indians living with chronic brain injury and returning to their communities from correctional facilities. Suggested methods for managing these ongoing connections:

- Form small working teams to begin addressing the ideas and issues raised at the event
- Hold face to face meetings more frequently than once per year
- Use email to stay up to date on progress
- Hold a regular conference call with an accompanying webinar where guests share a program that is working in the field

Overall, participants stressed that it is important to have broad participation and input on big decisions.

Thanks to Listening Session networking, TBI training at an upcoming American Indian Council event is already planned. Many suggestions re raised for continuing the conversation over the next year, including the development of specialized training designed for an American dian audience.

The Listening Session and this report were supported by Health and Human services (HHS), Health Resources and Services Administration (HRSA), Maternal HRSA Grant #H21MC17234 from the US Department Child and Health Bureau (MHCB), and the State of Minnesota. Listening Session attendee ideas and opinions included in this report do not necessarily reflect the opinions of Minnesota State agencies or of other presenters.

INTRODUCTION

This report presents a summary of the ideas, opinions and stories gathered at a Listening Session in April 2013. Convened by the Minnesota Department of Corrections and Human Services, attendees included representatives from Tribal communities across Minnesota, as well as representatives from the Departments. The purpose of this session was to start a conversation and perhaps seed future work on the critical issues surrounding the supports needed for American Indians with Traumatic Brain Injuries who are returning to community life after being in prison. Many ideas were generated through rich discussion and story-telling; this report presents highlights and summary of participant contributions, and does not necessarily reflect the opinions of Minnesota State agencies or of other presenters.

OVERVIEW OF THE EVENT

BACKGROUND

In 2010 the Minnesota Department of Human Services (MN DHS) and Minnesota Department of Corrections (MN DOC) won a federal Traumatic Brain Injury (TBI) Program State Grant. This grant, titled *TBI in Minnesota Correctional Facilities: Systems Change for Successful Return to Community,* hopes to decrease recidivism rates for ex-offenders living with disabilities due to traumatic brain injury (TBI) across the state. The grant requires all applicants to identify a primary and a secondary target population that is at high risk for traumatic brain injury. Minnesota's application identified "offenders in the state prison system including those who are screened positive for TBI and have functional needs" as the primary population and a sub-population "incarcerated American Indians" as the secondary population.

Pursuit of the TBI Program grant and selection of these target populations was the result of another grant funded study the State conducted from 2006-2010 that measured the prevalence of TBI in Minnesota's state correctional facilities. The 2006-10 study found that 83% of all offenders had experienced one or more traumatic brain injuries (TBI). American Indians are over represented in Minnesota's state correctional facilities and on the Minnesota Department of Health TBI registry.[1] Because of this, the Listening Session was designed to identify ways in which the current grant can

[1] Since 1993 the Minnesota Department of Health has been mandated by state statute to maintain a repository of all hospitalized cases of traumatic brain injury.

partner with American Indian communities to build capacity for supporting the release and return of persons who have been incarcerated and who live with chronic brain injury.

Early grant work focused on developing effective processes for identifying incarcerated individuals with functional impairments tied to TBI and on building DOC staff capacity to address the unique concerns of these individuals. This work continues, and now includes the development of:

- Contracted training and support provided for DOC staff to enhance American Indian cultural competency.
- Contracted American Indian re-entry technical assistance and support.
- The MN DOC TBI Screening Tool. This tool is being incorporated into the MN DOC standard intake assessment process.
- Adapting MN DOC Chemical Dependency Treatment to better meet the needs of incarcerated individuals with functional impairments tied to TBI.
- A grant funded, dedicated TBI Release planner position.
- Tools and processes designed to increase DOC staff recognize and work effectively with incarcerated individuals with functional impairments due to TBI.

As the grant evolves increased attention is being given to strengthening community supports for previously incarcerated individuals. This work now includes: completion of a 67 page Minnesotan American Indian Transition and Resource Directory, provision of TBI training to a variety of groups including parole/probation officers and court personnel, specialized community resource identification and development, and convening of this Listening Session.[2]

EVENT DESCRIPTION

During March 26 and 27, 2013 the Minnesota Department of Human Services (DHS) and Minnesota Department of Corrections (DOC) held a Listening Session at Fortune Bay Resort at Bois Forte with representatives from American Indian communities across the state.

[2] Anyone interested in partnering or connecting with this grant should contact: Mary Enge, MN DHS Statewide Project Director at mary.enge@state.mn.us or Peter Puffer MN DOC Project Administrator at peter.puffer@state.mn.us.

The event had four overarching goals:

- Provide information about brain injuries
- Identify what's working and not working now in terms of relationships and supports
- Begin to build vision for capacity building through dialogue and collaboration
- Identify next steps and stakeholders to work with in the future

Invitees were identified through recommendations from tribal health directors, tribe websites, and the TBI grant committee, and with the help of Vern LaPlante and Alicia Smith, both with the Minnesota Department of Human Services. From the initial list of invitees, suggestions were requested and invitations extended through phone conversations until the event reached capacity[3]. Listening Session attendees were from Bois Forte Band of Chippewa, DHS, DOC, Fond du Lac Band of Lake Superior Chippewa, Grand Portage Band of Lake Superior Chippewa, Leech Lake Band of Ojibwe, Lower Sioux Indian Community, Mille Lacs Band of Ojibwe, Red Lake Nation, White Earth Band of Ojibwe, and from a variety of other service providers who work with American Indians who have been incarcerated. Representatives from behavioral/mental health, chemical health, housing services, reintegration services, public safety, spiritual leadership, tribal leadership, vocational rehabilitation, and corrections release planning attended.

The Listening Session structure included informal presentations with discussions around the basics of TBI, DOC release planning, TBI grant overview and implementation, and strategies for continuing the conversation after the event.[4] Small group discussions, a few short presentations, a talking circle, and story-telling helped the group share ideas, begin to understand individual experiences, and reflect on the current situation. Other activities generated reflections on what is working well now, opportunities for improvement in the current set of systems, and practices and relationships to support the successful release of American Indians with TBI.

After the event a group of spiritual leaders and healers gathered to discuss what they can do in their communities to assist reintegration after release. This was an unplanned exchange that brought forward a deeper sharing of experiences, reflections on what individuals can do, and systemic challenges in the DOC.

[3] A list of attendees with contact information is included in the appendices.
[4] A full agenda and complete presentation content are included in the appendices.

REFLECTIONS ON PRESENT AND FUTURE SYSTEMS AND PRACTICES

PLANNING FOR RELEASE FROM PRISON

Participants expressed that **American Indian culture is the foundation for preparing individuals for successful release; this can be built through cultural education and activities.** Traditional ceremonies, including pipe ceremonies and sweat lodges, were raised as critical elements for preparation for release and cultural reintegration. Further, participants suggested that a full immersion program could help American Indian offenders return to their culture; such a program might include deepening a connection to nature, engaging in identity development, and (re)learning culture and spiritual practices.

Richard Morrison and Ted Waukey lead a culturally specific release planning program called, Gaamiinigowiziyaamg for Upper Mississippi Mental Health. They are working on developing curriculum and resources that others can use with American Indians preparing for community reintegration to reduce recidivism. For more information contact Richard at geegwegigaboo@hotmail.com.

The current efforts by DOC to identify individuals at risk for TBI and to develop case plans are positive steps in the right direction. **Participants would like to see all incarcerated individuals screened for TBI prior to release, inclusive of individuals who are currently on parole or probation.** They would like for each individual to have a personalized action and treatment plan.

Another important suggestion is that **community providers and resources be informed and engaged ahead of release by DOC so they can arrange services and ensure continuity of care**. The vision is for a cross-disciplinary team that includes neuropsychologists, spiritual leaders, and families and caregivers in planning with the individual for release. Participants suggested that the DOC and reservation service providers could collaborate on identifying contacts for these release planning teams. If regulations allow, Rule 25 assessments could be completed prior to release, as the need for assessment post-release creates barriers to timely access to services. This team could assist incarcerated individuals in planning for their first day after release and discuss new routines that can be developed during their first two weeks back in the community. These plans should be in place prior to release and address community engagement, reintegration, and support systems, personal healing, chores, recreation, family, and work.

Finally, participants cautioned that current levels of funding will not support uninterrupted continuity of mental health, chemical dependency, and medical care as previously incarcerated individuals reintegrate into the community.

Past programs/organizations that have successfully integrated spiritual and cultural practices into programming for individuals reintegrating into communities:

- Red Road Home (based out of Bemidji, serving individuals from White Earth, Red Lake and Leech Lake) (Terry Kemper and Laurie Vilas continue the work voluntarily)
- Walks Tall (Leech Lake)
- Anishinabe Longhouse (a Minneapolis culturally specific Corrections halfway house)

Participants suggested that these practices and programs could be restarted with funding as they have proven effective at reducing recidivism rates and helping people to reintegrate.

Tribal participation is needed in the transition fairs that are held for inmates who are nearing release. Transition fairs are frequently planned by county based coalitions and participants noted that tribal service providers are not currently invited, informed, or included. This participation would allow providers to extend their resources to and build relationships with individuals who are re-entering tribal communities.

A tribal representative, individual coaching or mentorship program would be beneficial to give reintegrating community members a point person. It was suggested that the structure could be similar to an existing Goodwill/Easter Seals program and could begin prior to release.

HEALTH

American Indians with TBI face a number of challenges accessing health resources and many of these challenges are shared among many individuals with a TBI.

First, the TBI must be identified. Participants indicated that **more tribal organizations and service providers need to be equipped to provide TBI screenings.** Though participants were uncertain about which community organizations are best suited to evaluate TBI, suggestions included mental health staff, Rule 25 assessors, and chemical dependency program staff. Participants also wondered if a culturally specific TBI assessment tool was needed.

Second, treatment is complicated and multi-faceted. People often face a variety of additional health issues including but not limited to depression and anxiety. Participants discussed that individuals may be facing dual diagnoses with Fetal Alcohol Syndrome, which further complicates treatment.

As a final point, it was suggested that relapse prevention planning could assist individuals with TBI who also have chemical dependency issues.

To address health needs for individuals, Adult Rehabilitative Mental Health Services (ARMHS) are a good resource, but awareness of this resource (on the part of individuals or organizations which may refer to this resource) could pose a barrier to full utilization. Mental Health Crisis services are another important and effective resource for individuals with TBI.

Programs that participants shared are working well in the Twin Cities metro area include Volunteers of America which has re-entry programs and Accessible Space Inc. which has TBI homes with services. Vinland National Center offers comprehensive treatment programming specifically for persons with disabilities caused by brain injury.

Cultural components need to be integrated into TBI treatment programming for American Indians. Participants expressed that current systems ignore the cultural and spiritual aspects of health, which impacts physical health, and shared examples of powerful healing through traditional methods. Because access to spiritual and cultural ceremonies during and after incarceration is important for healing, spiritual leaders need to be available to American Indian individuals during incarceration. Participants shared the perspective that individuals may receive different abilities as a result of their injury, and this awareness was also important to healing.

Previously incarcerated individuals can be resources for newly released individuals, acting as counselors, advocates, and mentors. One idea was to tap into funds for peer mentor certification. Only those who have experienced prison can truly understand the impacts of the possible post-traumatic stress disorder or symptoms that may affect recently released individuals. Attendees emphasized that mental anguish cannot be overstated and shared personal accounts of inmates who became suicidal after release or who wanted to reoffend in order to go back to the facility to avoid life in the community. These issues are difficult for family and community members to acknowledge and understand.

COMMUNITY REINTEGRATION

Participants described that recently released individuals need community and family support for successful reintegration, but, depending on the type of offense, there are challenges to community acceptance. Tribal authorities and some providers may not want to engage in working with released offenders due to stigma around individuals who have been incarcerated. Participants noted that **work is needed to increase awareness about TBI and decrease stigma surrounding ex-offenders.** Ideas to start this work include:

- Hold welcome home ceremonies for persons when they are released from correctional facilities
- Create community education around TBI and its effects on individuals

- Enhance connections between service providers within communities.
- State and Tribal Governments could jointly apply for specific funds to support re-entry collaboration.

The vocational rehab programs at White Earth, Red Lake and in the metro were brought up as things that are working well. Areas for improvement include providing all inmates with resume writing, greater employment and skills training to assist in re-entering the job market.

Capacity building among community organizations working in American Indian communities will be critical. Many local providers and referral agencies do not know where to refer people diagnosed with a TBI, either locally or statewide, especially those that integrate cultural, spiritual, and religious practices. Further, local service providers in related fields (i.e. chemical dependency, mental health) need (1) greater awareness of the prevalence and impact of TBIs and (2) training in how to adjust current services or offer new services that better meet the needs of those with a TBI.

Attendees also emphasized the importance of law enforcement accessing training on strategies and techniques for working with individuals who have TBI. In addition, local law enforcement needs access to information about community members diagnosed with TBI to effectively implement their training.

Because reservation and tribal service providers have a limited capacity to respond to identified community needs, participants would like information about funding available for training and capacity building. In addition, ideas for how to get buy-in from program directors about the importance of engaging in training and enhancing services were also requested.

An opportunity exists for cross-training and cultural adaptations. Participants suggested cross-training with TBI service providers and American Indian reintegration service providers. They would also like to see cross-training between DOC staff and tribal mental health and chemical health professionals. Participants also recommended creation of a culturally specific track and/or a comprehensive treatment program for American Indian individuals with TBI.

Participants liked the Minnesotan American Indian Transition and Resource Directory, including the online version; a list of suggestions for additions is included in the appendices.

DAY–TO–DAY LIFE

American Indians with TBI face many of the same day-to-day challenges as any released offender: employers who will not hire felons, tribal and public housing prohibitions on residents with felonies, and transportation, especially in rural areas. However, specific preparations could also help released individuals with TBI prepare for daily life.

Psychoeducation for individuals with TBI can teach them how their brains work differently as a result of their injury, and to create realistic expectations for the challenges they will face in day-to-day life. Frequently this type of programming is also done with family members and caregivers to help them better assist the individual. Other suggestions that may be worth exploring when working with individuals with TBI are the Three Principles (mind, consciousness and thought), ACT (Assertive Community Treatment), and the creation of sensory-rich training materials. As has been noted throughout this report, participants stressed the importance of a culturally-informed service approach for American Indians.

> Ron Kingbird has a mental health program at a local jail in Red Lake that works to teach all inmates about how their brains work, to increase their understanding of their own triggers and bridges cultural components. He works with them to change their perceptions of their own behaviors and peer pressure. Since he has started the program, fighting has decreased significantly in the facilities and recidivism rates are down.

POLICY

People were glad to see that DHS and DOC were collaborating for the Listening Session; they would like to see more of this collaboration in the future. Participants had ideas of ways in which **policy could support some of the changes suggested above**.

- Mandate TBI education for chemical health and mental health licensed professionals.
- Inform law enforcement and community service providers (such as mental health and chemical dependency workers) when individuals are being released from correctional facilities into the community.
- Ensure that TBI diagnosis is acknowledged and taken into account during sentencing, mental health assessment and child protection case investigations.

- Formalize and institutionalize inmate access to spiritual and cultural practices, including increased access to American Indian spiritual leaders. This access should parallel opportunities given to inmates to practice other religions.

Participants described a number of current barriers to this access:

- Volunteers cannot have a felony conviction (except for with special exemption from the warden) and also cannot be on inmate visitation lists. This limits the pool of potential volunteers as many individuals have incarcerated family members and this excludes individuals who can serve as peer mentors or advisors.
- Mileage reimbursement for individuals offering spiritual services in the facilities was discontinued, and financial hardship has limited the volunteer availability to serve in correctional institutions.
- Allow professionals registered with facilities to also volunteer their time. Currently individuals are not allowed to be simultaneously registered with the DOC as a volunteer and a professional without explicit approval of the warden of the facility.
- A minor point, but a significant frustration after hours of travel, some past volunteers and spiritual leaders described that they have been denied entry when they were five minutes late to their appointment.

Throughout the session, significant discussion focused on the poor relationship between the Department of Corrections and tribes. Participants had a number of suggestions about ways to improve the relationship between DOC and the tribes:

Establish liaisons in key positions. Consulting with Rich Antell on the TBI grant was mentioned as a step in the right direction. DOC can reestablish the position of Indian Affairs Liaison, as many other state agencies have, to further coordination between tribes, DOC, and local resources. Such a liaison could help on difficult issues such as jurisdiction in Red Lake. (As Red Lake is a Nation State, probation officers cannot currently enter the reservation land which is a barrier to collaboration.)

White Earth Band of Ojibwe Human Services uses a universal release of information form that allows for departments to share information about participants and assists in service coordination. This model could be adopted for other agencies to allow greater collaboration in working with reintegrating community members.

In addition, a DOC advisory board of individuals representing the different tribes could further collaboration and open lines of communication. The Listening Session yielded several examples of issues on which such a group could work collaboratively with DOC, including the extent to which tribal communities can have a say in how violations are handled. Other suggestions included: (1) establishing a liaison from each facility to work with the tribes to recruit volunteers, make connections with spiritual leaders, attend relevant tribal meetings, and be a consistent point of contact and (2) extend an honored guest status to a representative from DOC from the American Indian Advisory Boards for Mental Health and Chemical Dependency.

Participants felt that corrections, parole, and probation officers need to better understand American Indian culture and values, including knowledge of sacred objects and significance of ceremonies. They would like to explore ways to make this cultural sensitivity training happen. There is a perception that persists in the community that parole and probation officers "hover" because they are waiting for released offenders to slip up and be sent back into the prison system.

DOC can ensure follow-up and transparency to repair relationships and build trust. Participants described a history of issues remaining unaddressed. For example, it was raised that a similar Listening Session was held in 1996 but suggestions were not acted upon by DOC following that event. There was a perception among participants that the information gathered from them at that event was used to further limit the spiritual practices of American Indian inmates. Participants discussed a similar experience at a meeting with wardens several years ago; participants felt that there was no agreement on appropriate follow-up and the relationships actually deteriorated further after the meeting. In general, participants expressed that DOC had not been reliable in follow-through or responsiveness to commitments made, so there was a negative sense of the quality of collaboration and skepticism about the potential for future positive collaboration.

LOOKING TO THE FUTURE

IDEAS FOR CONTINUING THE CONVERSATION

Attendees wanted to continue to be engaged and informed. They offered to work as part of smaller teams (described below) and to participate in other events that convene representatives from DOC, DHS, and the tribes. They requested that information on resources for those with TBI be distributed to

attendees, as well as any programs identified as successful. Finally, they look forward to more information from DOC about the prevalence of TBI among American Indian inmates.

How to continue working together: Small working teams were highlighted as a way to begin to address the many ideas and issues raised at the Listening Session. Examples of this idea included:

- Grassroots teams at a local level could work to address changes and planning to better serve re-entry specific challenges identified at this event.
- A small group could come together to work through the issues in the process of parole and service hand-offs as individuals are released; this group could also dig into the changes suggested here about records sharing.
- Small groups of interested individuals across Tribal communities could meet regularly, perhaps organized around a particular issue, professional field or other common interest, to facilitate community collaboration and idea sharing to address these difficult issues.

Finally, participants agreed that larger events, such as the planned DOC-Tribal Summit or another conference similar to the Listening Session, are valuable occasions for moving forward on these difficult issues and on the opportunities identified at the Listening Session.

Face to face meetings were brought up as being particularly important on a more frequent basis than annually, perhaps rotating to each reservation. Overall it was felt that emails or a listserv would be an effective way to keep up to date on progress, in between meetings, with some support for creation of a website. Another idea was to use the Indian Affairs State Council email listserv (indianaffairs@state.mn.us).

One suggestion was to hold a regular **conference call** where a guest shares a program that is working. The webinar/webex format was also suggested to enhance these calls, and as a format for additional training on TBI 101. Webinars could be made available publicly after the calls.

Who should be involved: Participants had many suggestions for others who could and should contribute to the ongoing conversation and in future meetings, including:

- Tribal Council Members
- DOC and DHS Commissioners
- Minnesota Correctional Facility wardens and assistant wardens
- Parole and probation officers
- Tribal police

- ARMHS workers
- Community teams in rural areas
- Case managers
- Representatives from treatment programs
- Minnesota Department of Health (MDH) staff
- Service providers and medical doctors who work directly with American Indians who have previously been incarcerated
- Additional DOC employees and representatives could be engaged in order to better understand the American Indian culture and way of life
- Minnesotan American Indian Advisory Groups including child welfare, mental health, chemical dependency
- Individuals with TBI and previously incarcerated individuals should be engaged, particularly in discussions around what services they would like and what works for them.

Decision processes: Participants stressed that it is important to have broad participation and input into big decisions. Though small working groups were mentioned above, participants recommended that DOC and DHS consult with Tribal communities in the formation of a decision. Though each Tribe has its own official processes, all have a process by which community input and perspectives can be considered. Tribal Councils and Decision processes should plan for that process in the timeline, and ensure that the decision has not actually already been made by the time Tribal leaders and the community are consulted.

NEXT STEPS

Thanks to Listening Session networking, TBI training at an upcoming American Indian Council event is planned. Additional specialized training designed for an American Indian audience may be developed over the course of the next year.

New Grant projects already planned for 2013-2014 include:

- Working with http://www.minnesotahelp.info/public/ to make this site more useful for ex-offenders and people with living with functional problems due to a brain injury. This work will include updating and adding information listed in the Minnesotan American Indian Transition and Resource Directory to the site.

- Updating web based TBI training developed with federal TBI grant funds and improving accessibility to this training to DOC partner agencies across the state. Examples of partner agencies include: tribal, state and county probation/parole officers and sheriff and police agencies and chemical dependency services.
- DOC staff and Minnesota Brain Injury Alliance are exploring opportunities to attend and present at the annual Minnesotan American Indian Institute on Alcohol and Drug Studies (MAIIADS) Conference in August, which aims "to provide education on alcohol and drug abuse that addresses the total well-being of the American Indian individual, family, and community that is sensitive to cultural healing traditions."

Additional ideas from the Listening Session include:

- Gathering more information about American Indian inmates with TBI to better determine their needs, to plan how to meet those needs and to help American Indians entering programs to understand the resources available to them.
- Creation of an American Indian TBI-specific resource directory or training to help families of TBI survivors and service providers know who is doing what and where in terms of services (those interested in working on this can contact Jamie Cyson at jcyson@yahoo.com). Including financial supports for families supporting individuals with TBI aside from Social Security Disability Income.
- Greater training on understanding TBI including extended 101 training, knowledge of screening, how it's done and where to incorporate it into practices.
- Training is needed on how to adjust treatment programs for mental health and chemical dependency to meet the needs of individuals with TBI.
- Relationship building between DOC release planners, local probation officers and tribal mental health and chemical dependency service providers.
- Bring a representative from the Minnesota Brain Injury Alliance to present to each of the tribes and members of each tribal council to raise awareness, provide education, and to share statistics of how many people in the correctional facilities and in their communities may be affected.
- Presentations or attendance by DOC mental health staff at the annual MN American Indian Mental Health Conference in June.

- Outreach could be done to American Indian professionals for the annual Minnesota Brain Injury Alliance Annual Conference for Professionals in Brain Injury to provide access to training and resources.
- Explore what can be done in terms of prevention for TBI and what high risk behaviors could become targets of education campaigns to inform communities of potential consequences. Inform parents about TBI including causes, warning signs and prevention through parenting classes, early childhood and Headstart.

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EVENT AGENDA

Day 1: Tuesday March 26th at Fortune Bay, Bois Forte, MN

12:30 Opening Ceremony

Introduction

Personal testimony panel presentation

Presentations and Discussions around TBI basics with Pete Klinkhammer of the Minnesota Brain Injury Alliance and Department of Corrections Release Planning with Angela Kibble of DOC

Presentations and Discussions around Traumatic Brain Injury (TBI) basics and Department of Corrections Release Planning

3:00 World Café round table discussions around what's working and what needs improvement in:

a. Release Planning and Preparation for Release
b. Health
c. Community reintegration
d. Policy
e. Day–to–day life

Hosts share highlights from discussion

5:10 Break for the day

7:00 – 7:45 Optional video screening:

The Critical Link – CHRs (Community Health Representative) & Brain Injury In Indian Country

Day 2: Wednesday March 27th at Fortune Bay, Bois Forte, MN

8:00 Small group discussions around surprises and reflections on World Café; volunteers to share reflections to larger group when invited

Grant overview /outcomes and concrete examples of changes made to programming for persons with TBI

Small group discussions around how to continue the conversation/ next steps

10:45 Come back into large group and give summary of findings from small group discussions

Participants write personal/professional follow-up commitments on cards and share with facilitator who shares some anonymously (box lunches provided)

11:45 Talking circles: What are the positive things going on/strengths that will be important to build on? If you have an idea for a change or strategy, please share it!

12:45 Closing ceremony

EVENT EVALUATION SUMMARY (N=39)

	Unacceptable	Poor	Fair	Good	Excellent
Overall quality of experience	0%	0%	8%	62%	31%
Organization and sequencing of the activities	0%	0%	26%	56%	18%
Opportunities to ask questions	0%	0%	15%	49%	36%
Opportunities to contribute ideas	0%	5%	8%	38%	49%
Opportunities to interact with the other participants	0%	0%	11%	45%	45%
Facilitation	0%	0%	3%	58%	39%
Location of the event	3%	3%	16%	34%	45%

	This week	In a month	In six months	In a year	In more than a year	Never	I do not know
When do you think you will have your first opportunity to use the knowledge from this event?	64%	21%	5%	0%	0%	3%	8%

	Strongly disagree	Disagree	Agree	Strongly agree
I learned new information.	0%	3%	49%	49%
I felt comfortable expressing myself.	0%	3%	60%	37%
I had conversations with people I did not know before this event.	0%	0%	46%	54%
I see myself contacting people I met at this event in the future.	0%	3%	51%	46%
Important issues were raised at this event.	0%	3%	29%	69%
Important issues were discussed at this event.	0%	3%	26%	71%

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OVERVIEW OF INVITATION AND AGENDA PLANNING PROCESS

Invitees were identified through recommendations from tribal health directors, contacts on tribal websites and the TBI grant committee, in particular from Vern LaPlante, and Alicia Smith, Minnesota Department of Human Services - Office of Indian Policy. Representation from each of the tribes in Minnesota was sought. A diverse group of professions was sought to foster conversation through a variety of perspectives and experiences. Invitations extended via email and during follow-up phone call conversations until the event reached capacity.

Phone conversations were had with most of the invitees prior to the event, and each attendee provided input on important topics to discuss and preferred formats. This information was used to design the event agenda. There were 57 attendees total. There were 13 additional people who were planning to come who could not make it at the last minute, including the Directors of Indian Policy for DHS and the Minnesota Department of Health. And a few others who notified us in time for us to extend invitations to others on the waiting list for the event.

PRESENTATIONS FROM THE LISTENING SESSION

PRESENTATION 1: ALTA BRUCE, TURTLE MOUNTAIN CHIPPEWA NATION, INSTITUTE OF MEDICINE

Indigenous Peoples'

- 566 federally recognized Native entities in the United States
- 200 Native languages and dialect
- 50% reside in urban areas
- 15% in rural remote non-reservation areas
- And 35% on reservation

Statement of Problem

- Between 1992-1996, Indian Health Service, Tribal, or contract care hospitals recorded 4,491 TBI related hospitalizations among AI/AN with an average stay of 4.7 day
- The major cause of hospitalizations for TBI were MVC at 24%
- Assaults 17%
- Falls 16%

Statement of problem (cont'd)

- Among American Indians the incidence of TBI's are believed to be underestimated. This may be due to inaccurate reporting, people not seeking and/or receiving medical attention, and a lack of

awareness. Thus, a need for research and stats are needed to address this paucity of data pertaining to American Indians specifically with traumatic brain injuries.

- Many American Indians are not being served under current health care system
- Immediate or extended family members are the primary caregivers without financial resources
- Currently American Indian Tribes are not receiving Federal or State TBI dollars or services
- The highest number of hospitalized TBI's among AI/AN were in the Northern Plains and Alaska (IHS 1999)
- Compared to all other racial groups combined, AI/AN experienced assault related TBI nearly twice as often (20.9% vs. 10.3%) conversely, the occurrence of falls in AI/AN was much less (19.3 vs. 33.2% (IHS 1999)

Indigenous Peoples' Brain Injury Association (IP-BIA)

- The IP-BIA was founded in 1994 and is a grassroots organization composed of survivors, families, and service providers working together to promote the healing process through a holistic approach with modern and traditional healing practice
- A traditional strength of the American Indian/Alaska Native community has been the extended family
- American Indian families are traditionally the backbone of client's lives. They rely on them for emotional and many times financial support (Marshall & Johnson, 1996)

IP-BIA cont'd

- Beginning in 1994 -2003 IP-BIA was able to have a conference for all tribes in North Dakota, Montana, South Dakota, and Canada with TBI's
- The purpose was to gather Indigenous Peoples' with TBI's to assist in advocating, tracking, educating, and most importantly providing support to survivors, families, and service providers
- In 2003 the First National American Indian Summit on Traumatic Brain Injury sponsored by Heath Resources Service Administration (HRSA)

American Indian Summit on TBI

- First step in getting perspective and direction from American Indians affected by TBI
- Native and Non-Native professionals working with and in Native communities

American Indian Summit 2003

- Through this year long planning process, it became clear that American Indians with TBI and their families have many needs to address
- Indigenous people from the Plains, Woodlands, Northwest, and Southwest cultural regions of the nation were in attendance
- American Indian Summit 2003
- In addition policymakers, medical, research, and service agencies were all in attendance
- Activities indicative to American Indians culture were incorporated such as an opportunity to participate in a sweat lodge and talking circles

Where to go from here?

- In conclusion, stories were shared, gaps and overlaps in services were discussed, policy makers were informed and the diverse needs of Indigenous peoples with brain injury were identified
- To improve the delivery and the quality of services; to establish favorable policy and legislation; and GUARANTEE SUSTAINED FINANICAL SUPPORT

Miigwetch
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PRESENTATION 2: ANGELA KIBBLE, DEPARTMENT OF CORRECTIONS, "RELEASE PLANNING SERVICES FOR OFFENDERS WITH BRAIN INJURY"

Why is this necessary?

Purpose

- Provide release and reintegration services for offenders identified as having a significant Brain Injury
- Ensure that offenders have adequate resources for successful transition back into the community

Why is this necessary?

- Reduction of recidivism
    - approximately 95% of persons incarcerated in jail or prison will be released at some point
- Improve quality of life in the community
- Increase knowledge of available resources

Who is eligible for services?

- A screening tool is being developed for use at the DOC intake facilities in St Cloud and Shakopee
- In addition, a case manager or mental health staff may also alert the release planner if a brain injury is noted

Who is eligible for services?

Criteria for further evaluation

- Loss of consciousness greater than 30 minutes

- Hospitalization due to assault, fall or auto accident
- Received prior services in community
- Deficient problem solving skills
- Medical issues or physical symptoms such as persistent headaches or seizures

Who is eligible for services?

- Coordinate with community providers and other DOC staff to gather relevant documents that substantiate the brain trauma
- Refer to neuropsychologists for cognitive testing (if not already done in previous 12 months)

Who is eligible for services?

Release planning will be offered to the offender if any of the following are detected in the neuropsych testing process:

- Inability to complete everyday living tasks
- Deficient problem solving skills
- Poor impulse control
- Short-term or long term memory lapses

What services are provided?

- Voluntary Service
- Limits of Confidentiality
- Review areas in which assistance can be obtained
- Obtain emergency contact

What services are provided?

American Indian offenders meet with Rich Antell

- contracted with DOC
- provides support and guidance
- focus on American Indian culturally specific issues

What services are provided?

A referral to the of Minnesota Brain Injury Alliance is offered for follow up and ongoing support in the community

- Resource facilitators assigned to each MN county
- Optional support and brain injury education provided to agents, family, friends as desired by offender

What services are provided?

Coordination of services to apply for Social Security Disability

- Referral phone call to SSA representative at 120 days prior to release
- Phone interview with offender in prison

What services are provided?

- Assistance in completing paperwork to establish disability status with the State of MN (State Medical Review Team)
- Completion of application for Medical Assistance.
    - sent to County in advance of release

What services are provided?

- Advocacy in applying for a TBI waiver through the County
- Provides funding for necessary services which may include:
    - Housing, such as foster care
    - Case management
    - Nursing services/medication monitoring
    - Transportation
    - 24 hr emergency assistance

What services are provided?

- Housing Placement
    - Through coordination with DOC case manager and field agent
    - Least restrictive environment possible focusing on safety needs of offender and community

What services are provided?

If Chemical Dependency treatment is expected upon release, the TBI release planner completes the Rule 25 assessment and coordinates that process with the case manager

What services are provided?

- Initial appointments with medical providers set up prior to release based on individual need
    - Medical
    - Neurology
    - Psychiatric/Therapy
    - Dental

What services are provided?

- Vocational /Employment needs addressed thru referrals or setting up an appointment
- Additional Community Supports
    - Crisis prevention plan including local 24 hour crisis hotline numbers provided
    - AA/American Indian meeting directories

- Transit information
- The essentials: clothing, food shelves, shelters

What have we done so far?

- July 2011-March 2013: 56 offenders had brain injury release plans completed. Of those, 15 were American Indian (AI)
- 9/15 American Indian's have remained in the community since their release date. One went out on expiration.

What have we done so far?

- Where they went upon release....
  - Seven went to a private residence
  - One went to a residential facility focused on serving brain injured persons
  - Two went to halfway houses funded by the DOC
  - Five went to inpatient CD treatment

What have we done so far?

- Creation of American Indian Resource Guide (Rich Antell)
  - electronic version developed for more efficient updating:
  - http://www.doc.state.mn.us
- Development/translation of brain injury material for other cultures/ethnicities
- Questions?

PRESENTATION 3: ADAM L. PICCOLINO, PSY. D., LP. ABN, "TBI IN CORRECTIONS BEYOND THE SCREENING PROCESS"

What did We Learn?

- We need a more refined process in place to identify offenders with TBI and TBI-related functional impairment
- Critical that the issue of TBI not be "put on the back burner" and that staff dedicated to TBI needed to be put in place in critical programs.
- Coordination of services to help with transition to the community and reduce rates of recidivism.
- We realized that our attention could be directed toward working with populations that continue to be underserved.

Strategy Moving Forward
"Wave Approach"

- Given the volume of offenders coming into the system on a monthly basis, how can we best identify those offenders who are likely to require TBI services during their incarceration and thereafter?
- How can we do this in a time-efficient manner?
- Diamond and colleagues (2007) reported that a one-item, self-administered screener used during admission to prison detected only 19% of the TBIs identified via structured interview.
- What happens when you ask one question in our system:
- Out of the 998 offenders participating in MN's prior TBI screening study, 1 reported a head injury during the nurse assessment and 9 reported head injuries during the psychological interview.

Refined Screening Process

- How to most effectively screen for TBI given the following challenges:
- 500 newly admitted offenders come into our system on a monthly basis (on average)
- 2186 Release Violators (2011)
- 82 % report a history of TBI
- TBI Screening instruments vary in regards to the amount of time to administer

American Indians and TBI

- From 1990-2007 American Indian's had the highest annual average of TBI-related death rates (Coronado et. al, 2011).
- Based upon statistics from national hospital discharge rates, rates of TBI were highest for American Indians and Alaska Natives (75.3/100,000) and Blacks (74.4/100,000)
- Age ranges of highest TBI rates for American Indians: 20-24 and 35-44.
- MV incidents were the leading cause of TBI (40.1% of cases) among American Indian's,
- American Indian's injured in MV incidents had higher BAC levels (Langlois et al., 1997).

Strategy Moving Forward
"Net-Wave Approach"

- "Net Approach": Develop a TBI screening process that is time efficient yet capable of catching the most likely TBI candidates.
- Realize that we will miss individuals but the "wave approach" will increase the likelihood of capturing those whom we initially miss.
- Discuss MN DOC TBI Screening Instrument
- Offenders who do not meet our initial criteria but are identified as having a TBI history will have this documented in their chart and an electronic record.

"Wave Approach"
Cont'd

- Positive hit sets in motion a review process:
- Neuropsychologist, TBI-release planner, and designated administrator that can help coordinate appropriate placement based on need and custody level status.

- Once placed in the appropriate program a more thorough evaluation may take place:
- Obtain collateral information
- Cognitive testing as needed
- Feedback given to treatment staff
- Referral to TBI Release planner as warranted

Second Wave

- Offender will be transferred out of the intake facility to their next facility
- Upon intake the offender is screened again for TBI
- Sometimes additional information is obtained
- Offender may be in the "grey area"
- Decision is made to refer for more in-depth assessment:
- Involves meeting with designated TBI professional
- Or TBI remains noted in the clinical record so as not to let this matter "Fall through the cracks".
- Case management identification of TBI-often too late to do anything effective

Strategic Placement of TBI Specialists

- Embedded two neuropsychologist in both the men's and women's dual-diagnosis programs.
- One doctoral level psychologist under the supervision of the neuropsychologist to work in the Mental Health Unit-recognition of co-morbidity, transfer facility for other facilities that do not have the resources to meet the grant's objectives.
- The reported prevalence of history of alcohol dependence in patients with TBI ranges from 50% to 60%
- 52% of female offenders and 41% of male offenders are under the influence of drugs, alcohol, or both at the time of their arrest

Strategic Placement of TBI Specialists

- A study commissioned by the Minnesota Department of Corrections noted that of the offenders entering Minnesota prisons in 2006, approximately 85 percent were determined to be chemically abusive or dependent.
- Approximately 1/3 of individuals incurring a TBI were intoxicated at the time of injury (Vungkhancing, Heinemann, Langley, Ridgely, & Kramer, 2007).
- Clinicians working with individuals with TBI and SA patients must be knowledgeable and skilled in understanding how both conditions interact. If only one condition is the focus of treatment, incomplete treatment and poor prognosis is are likely for either condition.

Ongoing Challenges

- TBI offender vs. staff ratio
- Inappropriate referrals
- "Buy in" from staff. Why is this important?
- Other specialties (e.g., psychiatry) are contract employees with high turnover
- Limited placement resources

- Disconnect between corrections and community corrections
- Even the best plans fail
- Is what we're doing having an impact?

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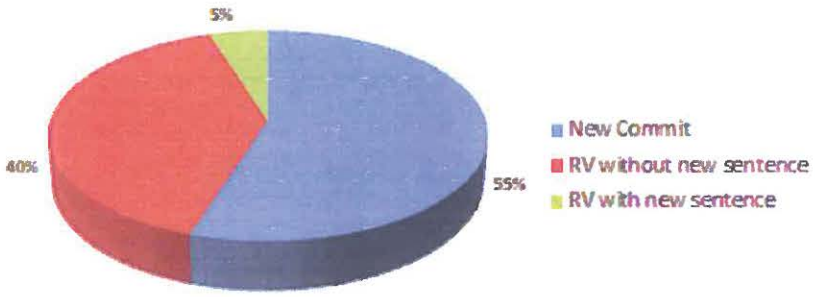
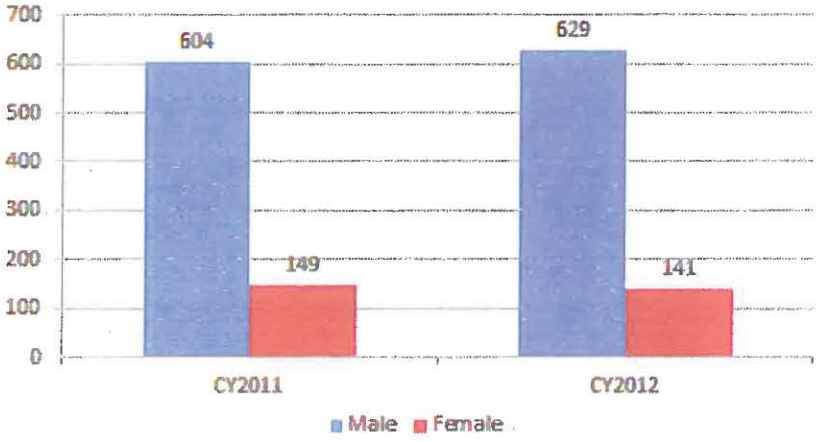
PRESENTATION 4: PETER PUFFER, DOC, "AMERICAN INDIAN PRISON ADMISSIONS"

Native American Prison Admissions*: 2011 - 2012



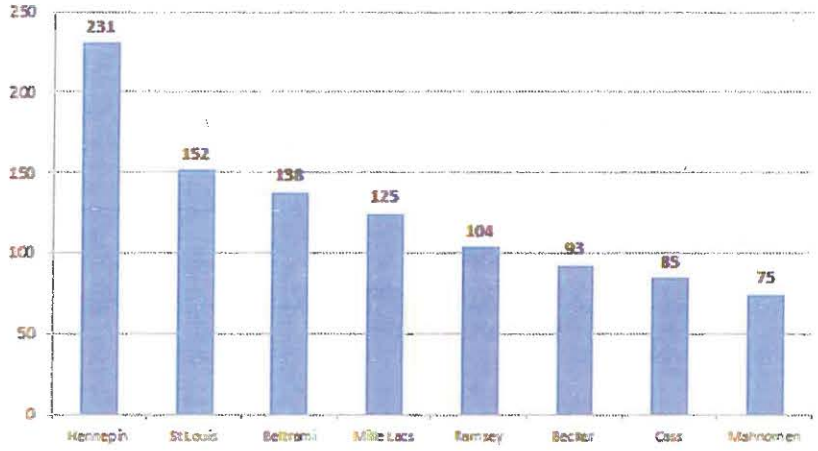
*1,281 Native American offenders had a combined total of 1,323 admissions during the two-year period

Native American Prison Admissions by Gender



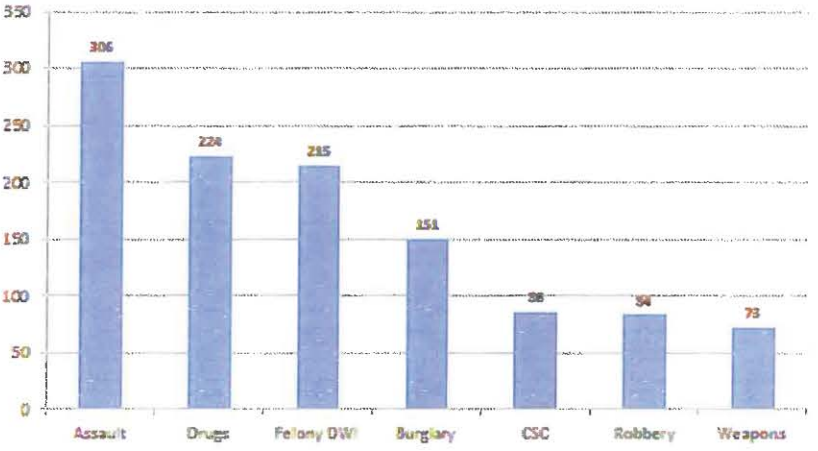
*1,281 Native American offenders had a combined total of 1,323 admissions during the period

Native American Prison Admissions 2011-12: Top 8 Committing Counties*



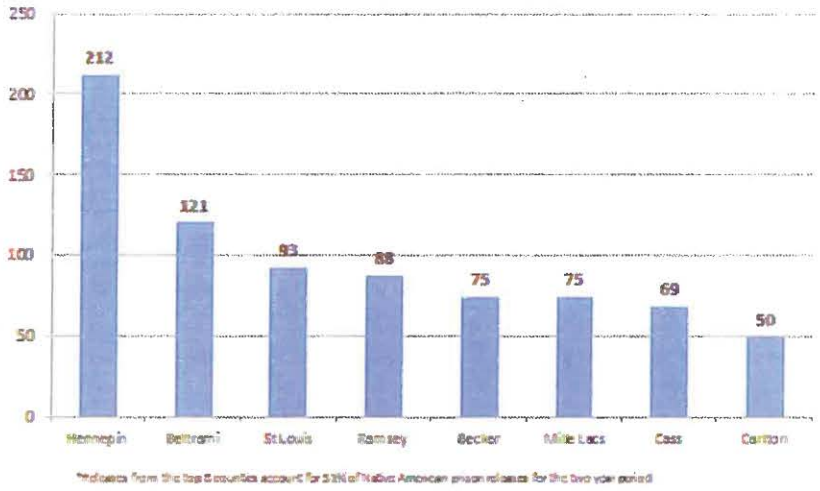
*Commits from the top 8 counties, represent 68% of Native American admissions over the five year period

Native American Prison Admissions 2011-12: Top 7 Offense Types*



*Top 7 offense types account for 72% of Native American admissions over the five year period

Native American Prison Releases: Top 8 Counties of Release*



*Releases from the top 8 counties account for 51% of Native American prison releases for the two year period

PRESENTATION 5: PETE KLINKHAMMER, THE MINNESOTA BRAIN INJURY ALLIANCE, "AN INTRODUCTION TO BRAIN INJURY AND THE MINNESOTA BRAIN INJURY ALLIANCE"

What is the Brain?

- The brain controls everything we do, say, feel and think. Through the brain we experience emotion and express ourselves.
- Brain tissue is very vulnerable to injury. The brain has the consistency of Jell-O and it's encased by the skull, which has some rough areas on the inside that may damage the brain.

What is Brain Injury?

- A brain injury refers to an injury in which an insult to the brain has caused damage. Because each injury does damage to a different part of the brain, each brain injury is unique.

TBI Statistics

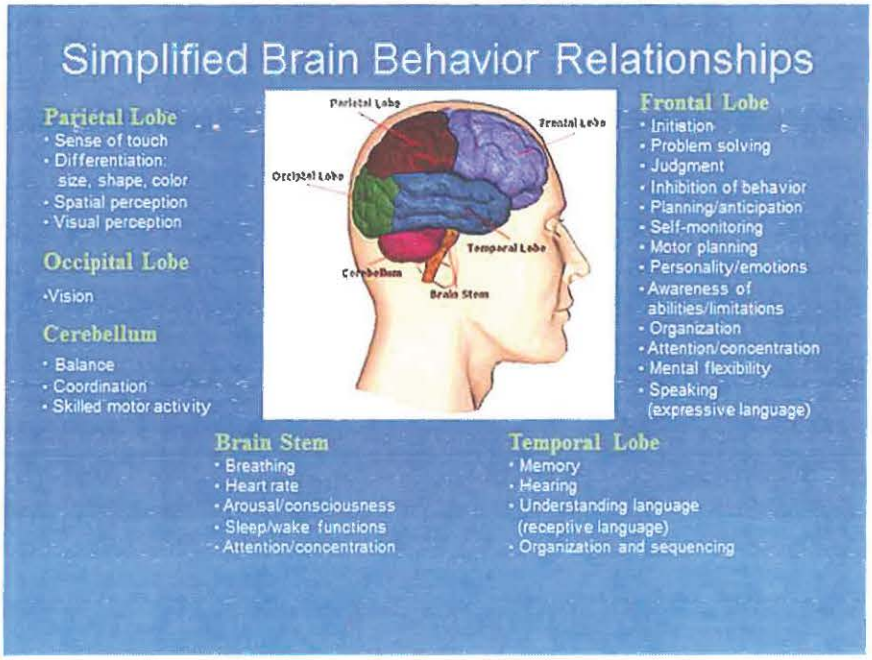
- An estimated 5.3 million Americans – a little more than 2% of the population – currently live with disabilities resulting from brain injury (Centers for Disease Control and Prevention (CDC)
- Estimated 100,000 Minnesotans live with effects of brain injury
- BI is the leading cause of death and disability among children and young adults, leading cause of death until age 44
- In Minnesota, 0-4 yo, 15-19 yo, 65+ yo---falls and MVA
- 5000 individuals in Minnesota sustain a TBI annually

Traumatic Brain Injury Defined

- A traumatic brain injury (TBI) is caused by a blow or jolt to the head or a penetrating object that disrupts the normal function of the brain. Not all blows or jolts to the head result in a TBI.
- The severity of a TBI may range from "mild," i.e., a brief change in mental status or consciousness to "severe," i.e., an extended period of unconsciousness or amnesia after the injury.

Acquired Brain Injury

- Acquired Brain Injury (ABI) is an injury to the brain which is not hereditary, congenital or degenerative.
- An acquired brain injury is an injury to the brain that has occurred after birth. Causes of ABI include anoxic/hypoxic injury (e.g., cardiopulmonary arrest, carbon monoxide poisoning, airway obstruction, hemorrhage), intracranial surgery, vascular disruption, infectious diseases, intracranial neoplasms, metabolic disorders and toxic exposure.



Mild Brain Injury

Characterized by:

- Brief or no loss of consciousness
- Feeling dizzy, nauseous or faint
- Blurred vision, headaches
- Weakness, shaking
- Trouble talking
- Concussion: length of time symptoms persist indicates mild to moderate injury

Severe Brain Injury

COMA

- In coma a person does not **purposefully:**
  - Move
  - Speak
  - Respond
- 2 Indicators of severity of COMA are the Glasgow Coma Scale (diagnosis) and the Rancho Los Amigos Scale (Function)

Who is affected by TBI?

- Brain injury happens to persons throughout all communities, regardless of race, ethnicity, sexual orientation, gender, socio-economic class, age or any other variable. American Indians and African-Americans, however, generally have a higher incidence of brain injury than others.

Leading Cause of TBI

- Falls-Nationally and in MN
- MVC-Motor Vehicle Crash
- Other-Sports Concussion, Shaken Baby Syndrome, Domestic Assault, Blast Injuries (Vets), Gunshot Wounds

Statement of Problem

- Between 1992-1996, Indian Health Service, Tribal, or contract care hospitals recorded 4,491 TBI related hospitalizations among AI/AN with an average stay of 4.7 day
- The major cause of hospitalizations for TBI were MVC at 24%
- Assaults 17%
- Falls 16%

Statement of problem

- Among American Indians the incidence of TBI's are believed to be underestimated. This may be due to inaccurate reporting, people not seeking and/or receiving medical attention, and a lack of awareness. Thus, a need for research and stats are needed to address this paucity of data pertaining to American Indians specifically with traumatic brain injuries.
- Many American Indians are not being served under current health care system
- Immediate or extended family members are the primary caregivers without financial resources
- Currently American Indian Tribes are not receiving Federal or State TBI dollars or services

Possible Changes after a Brain Injury

Thinking Changes

- Memory
  - Decision making
  - Planning
  - Sequencing
  - Judgment
  - Processing speed
  - Persistence
  - Organization
  - Self-perception
  - Perception
  - Inflexibility
  - Thinking

- Problem solving differences

Possible Changes after a Brain Injury

Physical Changes

- Motor coordination
- Hearing and visual changes
- Spasticity and tremors
- Fatigue and/or weakness
- MEDICATIONS
- Taste and smell
- Balance
- Mobility
- Speech
- Seizures

Personality and Behavioral Changes

- Depression
- Social skills problems
- Mood swings
- Problems with emotional control
- Inappropriate behavior
- Inability to inhibit remarks
- Lack of response to social cues
- Problems with initiation
- Reduced self-esteem
- Difficulty relating to others
- Difficulty maintaining relationships
- Difficulty forming new relationships
- Stress, anxiety & frustration

Complications Affecting TBI

- Alcohol is a Solvent
- After brain injury:
- Alcohol and medications have synergistic effect:
    - 1 + 1 = 4
    - or 1 beer = 3 beers
- Alcohol and drugs greatly increase risk of re-injury and seizure activity

Self-Awareness A

- Unaware the brain injury has caused changes.
- Thinks they do not need compensation techniques.

- Will not use them.
- Resists others telling of need to do things differently

Self-Awareness B

- Aware the brain injury has caused changes, but...
- Sees a need for compensation techniques, but...
- Is unable to use techniques without external cues.
- Accepts help from others

Self-Awareness C

- Aware the brain injury has caused changes, and...
- Sees a need for compensation techniques.
- Is able to use compensation techniques with/without cues, may come up with own strategies.
- Accepts help from others.

Neuropsychological Assessment

- An assessment determines:
- which functions of brain has been disrupted
- to what extent
- what these changes may mean in day-to-day life
- Typically done within 2-6 months of injury

Consistency/Routine

- Don't we all need change?
- For the individual, routine and consistency equal safety.
- Congregate settings...
- 1:1 with the person daily

ADDITIONAL RESOURCES

BrainLine.org, a website with many brain injury articles and resources, funded by the Defense and Veterans Brain Injury Center: www.BrainLine.org

Federal TBI Program (2010, February). Federal Traumatic Brain Injury (TBI) Program: Helping States Meet the Needs of Individuals and Families Living with TBI. Retrieved from: http://tbitac.hrsa.gov/

Federal TBI Program (2010, August). Overview of MN's Federal Traumatic Brain Injury (TBI) Program: System Change State Grant.

Harmon, K. (2012, February). Brain Injury Rate 7 Times Greater among U.S. Prisoners. Scientific American. Retrieved from: http://www.scientificamerican.com/article.cfm?id=traumatic-brain-injury-prison

Health Resources and Services Administration and the U.S. Criminal Justice System (2011, October). Traumatic Brain Injury. Retrieved from: http://www.disabilityrightsohio.org/sites/default/files/ux/hrsa-criminal-justice-fact-sheet.pdf

Health Resources and Services Administration and the U.S Department of Human Services. HRSA's Traumatic Brain Injury Program Flyer.

Minnesota Brain Injury Alliance. Their mission is to *enhance the quality of life and bring the promise of a better tomorrow for all people affected by brain injury.* http://www.braininjurymn.org/

Minnesota Department of Corrections (2013, January). Minnesota Department of Corrections Adult Inmate Profile. Retrieved from: http://www.doc.state.mn.us/aboutdoc/stats/documents/2011JanAdultProfile.pdf

Minnesota Department of Corrections. (2011, February). Backgrounder: Facility Reentry Programming. Retrieved from: http://www.doc.state.mn.us/publications/backgrounders/documents/Drugoffendersbackgrounder.pdf

Minnesota Department of Corrections. (2012, December). Backgrounder: Chemical dependency Treatment Services in Prison. Retrieved from: http://www.doc.state.mn.us/publications/backgrounders/documents/CDTreatment.pdf

Minnesota Department of Corrections. (2012, December). Backgrounder: Correctional Delivery Systems. Retrieved from: http://www.doc.state.mn.us/publications/backgrounders/documents/Deliverysystemsbackgrounder.pdf

Minnesota Department of Corrections. (2012, December). Backgrounder: Facility Reentry Programming. Retrieved from: http://www.doc.state.mn.us/publications/backgrounders/documents/ReentryBackgrounder.pdf

Minnesota Department of Corrections. (2013, January). Backgrounder: Mental Health Services. Retrieved from: http://www.doc.state.mn.us/publications/backgrounders/documents/MentalHealthBackgrounder.pdf

Minnesota Department of Health. Getting Better After Traumatic Brain Injury or Concussion. Retrieved from: http://www.health.state.mn.us/injury/pub/bibrochure.pdf

Minnesota Department of Corrections. American Indian prison admissions during calendar years 2011 and 2012. (No additional information).

MinnesotaHelp.info. Resource database offering information on a wide range of community services. Grant plans to add brain injury and ex-offender resources to this site in 2013-2014 http://www.minnesotahelp.info/

New Mexico's Aging and Long-Term Services Department. The Critical Link: CHRs and Traumatic Brain Injury in Indian Country. Retrieved from: http://www.brainline.org/multimedia/video/transcripts/old/HRSA_Critical_Link_CHRs_in_Indian_Country.pdf

Rutland, B., Wallace, D, Faul, M. & Langois J. (2005, May). Traumatic Brain Injury Hospitalizations Among American Indians/Alaska Natives. *Journal of Head Trauma Rehabilitation*, 20 (3).

Shiroma, E., Ferguson, P., & Pickelsimer, E. (2010). Prevalence of Traumatic Brain Injury in an Offender Population: A Meta-Analysis. *Journal of Correctional Health Care*, 16(2).

U.S. Department of Health and Human Services (2010, October). Treating Clients with Traumatic Brain Injury. Substance Abuse Treatment Advisory, 9 (10). Retrieved from SAMHSA.gov (search traumatic brain injury on the site): http://162.99.3.213/products/manuals/advisory/pdfs/Advisory_TBI.pdf

U.S. Department of Human Services and Centers for Disease Control and Prevention. Traumatic Brain Injury in Prisons and Jails: An Unrecognized Problem. Retrieved from: http://www.cdc.gov/traumaticbraininjury/pdf/Prisoner_TBI_Prof-a.pdf

U.S. Department of Human Services and Centers for Disease Control and Prevention. Traumatic Brain Injury: A Guide for Criminal Justice Professionals. Retrieved from: http://www.tbiwashington.org/professionals/documents/prisoner_crim_justice_prof.pdf

SUGGESTIONS FOR RESOURCES TO BE INCLUDED IN THE MINNESOTAN AMERICAN INDIAN TRANSITION AND RESOURCE DIRECTORY

- Tribal healers and spiritual leaders people including, but not limited to: (create a small table with contact info including the following individuals (contact information included on the list of attendees):
    - Terry Kemper and Laurie Vilas
    - Mike Smith
    - Richard Morrison and Ted Waukey
    - Larry Stillday
- Mille Lacs Band of Ojibwe service contacts. District 1: Mille Lacs Lake: 320-532-7773. District 2: East Lake 218-768-2431. District 3: Hinckley: 320-384-6696 and Lake Lena: 320-384-0195.
- Allow tribes to update info periodically to keep it updated and current.
- Extend an invitation to each Minnesota Tribal Human Services leader with info and instructions as to how to update/input resource info and links
- Create a National American Indian Resource Directory
- ARMHS and ACT teams for each of the Tribes
- Create a similar directory or add an addendum specifically for TBI issues and include:
    - Brief overview of TBI basics
    - Specific TBI contacts for each county or reservation including the waivers or others who work with persons with TBI
- Add a link to the Minnesota Indian Affairs Council
- The vocational rehabilitation programs tribal and state.
- Please continue to keep information in the directory up to date.