**WHAT:**

*$2,000,000 to support in-state neurobehavioral care*

**PATRONS AND ITEM NUMBERS:**

* + Del Mark Sickles: HB30, Item 313#6h
	+ Sen David Marsden: SB30, Item 313#17s

**WHY:**

The consequences of TBI are often devastating to the individual and their loved ones, and often results in chronic neurobehavioral sequelae, including cognitive deficits, changes in personality and increased rates of psychiatric illness. Individuals who exhibit extreme behaviors inevitably experience negative consequences in community and institutional settings. Research points to large numbers of individuals with brain injury who have been institutionalized in jails, prisons and mental health facilities because of their neurobehavioral complications. Virginia is no different; DARS’s surveys of 9 state funded programs indicated more than 300 of their clients are in need of and would benefit from intensive and/or specialized neurobehavioral treatment and services. A study by researchers at James Madison University revealed shockingly high numbers of people sent to Braintree Manor, a nursing home in Massachusetts at exorbitant costs to receive neurobehavioral care. Residents of the Commonwealth who face these challenges and their families would be better served with in-state, community-based treatment options to meet their significant needs.

**HOW:**

DMAS would receive an infusion of funds to repatriate every Virginian at Braintree Manor back to the Commonwealth, and raise reimbursement rates to incentivize the establishment of an in-state, residential neurobehavioral treatment program. For what DMAS is currently spending on out of state care, more cost effective treatment could be provided to more people.

**WHAT:**

$1,000,000 for increase to base brain injury funding to address workforce retention issues experienced by providers.

**PATRONS AND ITEM NUMBERS:**

* + Del David Bulova: HB30, Item 339#1h
	+ Sen Frank Ruff: SB30, Item 313#2s

**WHY:**

Since 2014, appropriations for brain injury funding have required the establishment of new programs rather than allowed investment in the workforce. As a result, starting salaries are below regional markets; in northern Virginia, they have fallen under the 25% percentile. Staff are leaving for more financial sustainable positions, and employee turnover rates are rising among all providers. Salaries are being named in exit interviews as the reason for seeking other employment, and attrition rates averaged 26% in FY19, an increase of 9% over FY17. Customer surveys conducted by the programs have begun to reflect a growing dissatisfaction; employee turnover that creates case manager “churn” and larger caseloads that leave case managers less time to serve their clients have been cited as the cause. The financial cost of replacing employees can total thousands of dollars a year, which only adds to increasing demands on already under-resourced programs; this is in addition to the lost expertise that can take years to replace and the negative effects on the morale of the remaining employees who are committed to our organizations and the populations we serve.

**HOW:**

Through a DARS Appropriation and existing processes, contracts for community based brain injury service providers would be increased to allow for adjustments that bring salaries in line with market demands.

**WHAT:**

*Inclusion of full-time employees of DARS’ state-funded Brain Injury Services program contractors in Item #474 U.1.d. of the FY2018-20 Appropriations Act.*

**PATRONS AND ITEM NUMBERS:**

* + Del Nick Rush: HB30, Item 313#1h
	+ Sen Creigh Deeds: SB30, Item 477#17s

**WHY:**

Since 1989, there have only been 11 years out of 30 when new funds were appropriated for brain injury services in Virginia. Most of these funds have been tied to the development of new programs rather than investments in current services. As a result, turnover rates are rising among all agencies, and staff are leaving for more financial sustainable positions; in southwest Virginia, the attrition rate has risen to 26% in FY19. This amendment would include brain injury services contractors for DARS in groups that are eligible to receive raises when they are given to state employees. For reference, the 2.0% raise provided in July 2019 would have provided approximately $93,000 to programs to offer salary increase to their staff and bring their pay more in line with market forces.

**HOW:**

Language in the Appropriations Act specifies full-time employees of Community Services Boards, Centers for Independent Living, secure detention centers supported by Juvenile Block Grants, juvenile delinquency prevention and local court service units, local social services boards, local pretrial services and comprehensive community corrections, and local health departments are eligible for base salary increases when they are provided to state employees. This request would require the addition of state funded brain injury service providers to this list.

**WHAT:**

*$1,900,000 to expand specialized community based brain injury case management services*

**PATRONS AND ITEM NUMBERS:**

* + Del Emily Brewer: HB30, Item 339#4h
	+ Sen Monty Mason: HB30, Item 339#7s

**WHY:**

According to estimates from the Brain Injury Association of Virginia, more than 285,000 Virginians are disabled as a result of brain injury. This funding would facilitate the hiring of an additional 21 case managers to serve approximately 850 Virginians with moderate to severe injury, who are estimated to be disabled as a result of the injury and who reside in unserved and underserved regions of the state.

**HOW:**

Through a DARS Appropriation and existing contract processes, community based brain injury case management services would be established in areas of Virginia where there are none now (Piedmont/Southern Va, Middle Peninsula/Northern Neck, Rappahannock County), and existing providers would receive funding to expand their service area or address waiting lists.

**WHAT:**

*$1,000,000 to provide supported living services to clients of state funded community based brain injury programs, and to establish a housing policy specialist for the brain injury community*

**PATRONS AND ITEM NUMBERS:**

* + Del Sam Rasoul: HB30, Item 339#3h
	+ Sen Jennifer McClellan: SB30, Item 313#6s

**WHY:**

Despite facing the same needs as those with intellectual and developmental disabilities, people with brain injury have little to no residential service options available to them within the Commonwealth. As a result of physical and cognitive challenges, people with brain injury often require support from a few hours per week up to 24 hours a day; the support includes assistance with basic and community based activities of daily living. The shortage in housing and support options for individuals with disabilities has reached crisis proportions, according to **Mary O’Byrne and Stephen W. Dale** of the Special Needs Alliance. Any investment in housing supports will be less expensive per person than any sort of institutional placement. Affordable, accessible, and appropriate housing is critical and integral to make community living a reality, and Virginia must create capacity to provide residential support services to those with brain injury.

**HOW:**

The appropriation would be provided to DARS to fund 1 FTE for each current state funded community based brain injury services program; the position would focus on providing supportive living services to enable their clients to live safely, securely and stably their respective service areas. It would also provide funding to the statewide advocacy organization to engage in policy and systems analysis and advocacy to effect change statewide; it will entail exploring the potential to expand more deeply into residential services with an informed approach that identifies how they could be funded, what policy/legislative barriers may exist, and what policy/legislative solutions could be developed.

**WHAT:**

*$400,000 for 2 yr pilot program to conduct a prevalence study of the rates of traumatic brain injury (TBI) among those who have experienced domestic violence, provide technical assistance to the staff working with complex cases, and develop effective TBI treatment and response options for clients and providers*

**PATRONS AND ITEM NUMBERS:**

* Del Dawn Adams: HB30, Item 339#7h
* Sen Ghazala Hashmi: SB30, Item 339#4h

**WHY:**

Undiagnosed and unrecognized brain injury is a risk factor for homelessness, involvement with the justice system and mental health challenges, and has been called the hidden cause of social failure. Several research articles have stated soldiers returning from war and athletes are regularly diagnosed with TBI, and many subsequently receive support and services for the condition. But domestic violence survivors have been largely left out of the picture. According to recent research:

* Warren (2016): Rates of TBI in women seen in the ER or in DV shelters is between 30 and 74 %; most occur from a direct blow to the head or from strangulation, which causes loss of oxygen to the brain.
* Zieman et al (2017): 81% of 115 patients reported loss of consciousness at the time of a domestic assault; only 21% sought medical help.
* Durand (2017): 71% of study participants reported more than three TBIs and 75% had no subsequent follow‐up for their TBI
* Sobowale (2019): 62% of the women had sustained their brain injury through domestic violence, and 33% had sustained their first injury prior to their first offence.
* Gorgens (2019) as many as [90%](https://psycnet.apa.org/doiLanding?doi=10.1037%2F0735-7028.33.1.39) of women seeking emergency or shelter services for domestic violence report have had a TBI

**HOW:**

DARS will contract with the Brain Injury Association of Virginia to work with 4 DV shelters and 4 brain injury service providers across Virginia to conduct screenings for TBI with current clients and new intakes.

**OUTCOMES:**

Early intervention can change the trajectory of lives of vulnerable individuals; this project will bring help, hope and healing to women who screen positive for brain injury. This project will include the development of screening and treatment protocols, brain injury education, and data collection and analysis culminating in a report for the General Assembly on the study findings and further action. Possible outcomes could include:

* + Referrals for comprehensive treatment for TBI symptoms, including but not limited to headache treatment, neuropsychiatry and neuropsychology and cognitive therapy to engage and support those individuals affected and help these women better understand and manage their brain injury symptoms
	+ Working collaboratively with DARS, DCJS and DJJ to develop specific plans for TBI screening and education for offender pathways and treatment programs
	+ Transition services for released persons that include specialized brain injury case management services and assistance with placement into community treatment programs

**WHAT:**

*Current Code Language modified: § 9.1-188. Crisis intervention team training: The Department, in consultation with the Department of Behavioral Health and Developmental Services, the Department for Aging and Rehabilitative Services, and law-enforcement, mental health and brain injury stakeholders, shall develop a training program for all persons involved in the crisis intervention team programs, and all team members shall receive this training. The curriculum shall be approved for Department-certified in-service training credits for law-enforcement officers from each crisis intervention team and shall include four hours of mandatory training in legal issues and a module on brain injury.*

**PATRONS AND BILL NUMBERS:**

* Del Tony Wilt: HB1231
* Sen John Edwards: SB494

**WHY:**

Given the high association between brain injury and involvement with the justice system, it seems appropriate to ensure law enforcement officers are familiar with the condition, and this amendment to existing law would provide consistent statewide training for crisis intervention teams.

* TBI is associated with higher impulsivity, aggressive behavior and negative emotion ratings (Farrer, Frost, & Hedges, 2013)
* Cognitive characteristics seen following a brain injury (e.g. impulsivity, poor problem solving and judgement, and slow processing speed, can result in legal challenges and, incarceration (Gordon and Hibbard, 2006).
* TBI in offender populations was reported to be 87% in a county jail setting. (Slaughter, Fann, and Ehde, 2003)
* Williams et al. (2010) revealed a TBI 65% prevalence rate in offender populations
* Ferguson, Pickelsimer, Corrigan, Bogner, and Wald (2012) found 65% of male inmates and 72% of female inmates reported at least one TBI resulting in a change in consciousness.
* Incidence of TBI in a mental health transition unit at a county jail among a sample of offenders with a co-morbid mental illness was found to be 96% (Gafford, McMillan, Gorgens, Dettmer, & Glover, 2015).