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FINAL REPORT OF THE SENATE STUDY COMMITTEE ON BRAIN INJURY RELATED NEUROBEHAVIORAL ISSUES IN GEORGIA

COMMITTEE MEMBERS

The Honorable Don Thomas, Chair
Senator, District 54

The Honorable Greg Goggans
Senator, District 7

The Honorable Lee Hawkins
Senator, District 49

The Honorable Valencia Seay
Senator, District 34

The Honorable Cecil Staton
Senator, District 18

Mr. Charles Fuller
On Behalf of Families

Mr. Dennis Skelley
On Behalf of Providers

Ms. Cynthia Hanna
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Ms. Susan Johnson
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I. INTRODUCTION

The Senate Study Committee on Brain Injury Related Neurobehavioral Issues in Georgia was created by Senate Resolution 788 during the 2008 Legislative Session. The Committee was charged with assessing the needs of Georgians with Traumatic Brain Injury, particularly those suffering from neurobehavioral issues, and was directed to make any recommendations, including suggestions for legislation, that it deemed necessary.

The Committee was composed of five members of the Senate: Senator Don Thomas, serving as Chairman; Senator Greg Goggans; Senator Lee Hawkins; Senator Valencia Seay; and Senator Cecil Staton. Additionally, the following non-legislative members served on the Committee: Mr. Charles Fuller, representing families of persons with Traumatic Brain Injury; Mr. Dennis Skelley, representing providers of services for persons with Traumatic Brain Injury; Ms. Susan Johnson, Vice Chair of the Brain and Spinal Injury Trust Fund Commission and Director of Brain Injury Services at the Shepherd Center; Ms. Cynthia Hanna, Georgia Department of Labor; and Ms. Catherine Ivy, Georgia Department of Community Health.

The following legislative staff was assigned to the Committee: Ms. Laurie Sparks, Legislative Assistant to Senator Don Thomas; Ms. Ginny Powell, Senate Research Office; and Ms. Kallarin Richards, Senate Press Office.

The Committee held four meetings at the State Capitol on August 15, 2008, September 11, 2008, November 14, 2008, and December 11, 2008. During its meetings, the Committee heard testimony from the following individuals: Mr. Craig Young, Executive Director of the Brain and Spinal Injury Trust Fund Commission; Mr. Charles Fuller, parent of a child with Traumatic Brain Injury; Ms. Laura Howell, parent of a child with Traumatic Brain Injury; Ms. Stephanie Lotti, Director of Data and Public Policy with the Brain and Spinal Cord Trust Fund Commission; Ms. Linnea Olsen, parent of a child with Traumatic Brain Injury; Dr. Gary Ulicny, President of The Shepherd Center; Ms. Kathryn Waybright, parent of a child with Traumatic Brain Injury; Ms. Susan Johnson, Vice Chair of the Brain and Spinal Injury Trust Fund Commission and Director of Brain Injury Services at the Shepherd Center; Ms. Bridgett Kelly, Director of Referral Relations at Restore Neurobehavioral Center; Ms. LuRae Ahrendt, Ahrendt Rehabilitation, Inc; Ms. Catherine Frasier, Board Member of the Brain Injury Association of Georgia and parent of a child with Traumatic Brain Injury; Ms. Cindi Johnson, Executive Director of Side by Side Brain Injury Clubhouse; Ms. Kristen Vincent, Consultant to the Brain and Spinal Injury Trust Fund Commission; and Ms. Juliet Haarbauer-Krupa, Research Scientist with Children's Healthcare of Atlanta.

II. COMMITTEE FINDINGS

A. Background Information - Traumatic Brain Injury

Traumatic Brain Injury (TBI) is a serious public health issue affecting the United States. With more than 1.5 million new TBIs occurring in our country each year, TBI remains the leading cause of death and disability for anyone under age 45. Six times more people experience TBI each year than MS, spinal cord injury, HIV/AIDS, and breast cancer combined.¹ Furthermore, according to the Centers for Disease Control and Prevention (CDC), approximately 5.3 million Americans—roughly 2 percent of the population—are currently living with a long-term disability relating to TBI. However, due to high costs, lack of screening and identification, and shortage of services, only 20 percent of persons with TBI are able to get the rehabilitation and care needed to aid their recovery.²

The CDC defines TBI as “an injury to the brain, not of a degenerative or congenital nature, but arising from blunt or penetrating trauma from acceleration-deceleration forces, that is associated with any of the following symptoms: decreased level of consciousness; amnesia; other neurological or neuropsychological abnormalities; skull fracture; or diagnosed intracranial lesions.”³ The severity of the injury may range from mild, i.e., a brief change in mental status or consciousness, to severe with an extended period of unconsciousness or amnesia after the injury. Impairments may be either temporary or permanent, and they can result in a partial or total functional disability. While the majority of TBIs are caused by car accidents and falls, other causes include sports injuries, violence, and work-related injuries. TBI has also been deemed the “signature wound” of the war in Iraq, as many soldiers are returning from the war with brain injuries caused by explosive devices.⁴ TBI should be distinguished from Acquired Brain Injury (ABI), which the CDC defines as “a post-birth injury to the cells of the brain typically caused by infectious diseases, toxic substances, stroke, or tumors.”⁵

Regardless of the cause of the injury, the economic consequences of TBI are astounding. TBI costs the United States an estimated \$56 billion annually in direct medical costs and indirect costs such as lost productivity.⁶ Furthermore, the average lifetime cost of care for a person with a brain injury can range from \$600,000 to \$1,875,000, with the costs for a severe TBI reaching as high as \$4,000,000.⁷ This does not include lost earnings of the injured person or family caregivers. Private insurers, Medicaid, and Medicare do not adequately cover the costs of care for TBI victims because many services are not considered “medically necessary.” Thus, brain injury often impoverishes families.

TBI is also creating a public health crisis in Georgia. The incidence of TBI in our state is increasing at an alarming rate, up 21 percent from 2004 to 2006.⁸ Data gathered by the Georgia Brain and Spinal Injury Trust Fund Commission’s (Commission) Central Registry for Traumatic Brain and Spinal Injuries indicates that approximately 45,000 to 55,000 Georgians suffer TBIs annually, with 3,000 of these injuries resulting in a permanent disability.⁹ In fact, nearly 187,000 Georgians are currently living with a permanent disability caused by TBI, and 3 to 10 percent (5,600 to 18,700) of those persons may require ongoing, intensive support because of severe behavioral problems.¹⁰

¹ Information provided by the Brain Injury Association of Georgia.

² Id.

³ Information provided by the Centers for Disease Control and Prevention.

⁴ See *Georgia’s Neurobehavioral Crisis: Lack of Coordinated Care, Inappropriate Institutionalizations*, Georgia Brain and Spinal Injury Trust Fund Commission, October 2007.

⁵ Testimony provided by Stephanie Lotti on September 11, 2008.

⁶ Id.

⁷ Id.

⁸ Id.

⁹ Testimony provided by Mr. Craig Young on August 15, 2008.

¹⁰ Id.

B. Neurobehavioral Issues Resulting from Brain Injury

Brain injuries can cause a wide range of physical and cognitive changes that affect thinking, sensation, language, and emotions. They can also cause epilepsy and increase the risk for Alzheimer's disease, Parkinson's disease, and other diseases that become more prevalent with age. Some conditions may be subtle and hard to recognize, while others may be more obvious. In addition to physical effects, such as seizures, dizziness, language difficulties, headaches, chronic pain, or fatigue, brain injuries can cause significant neurobehavioral issues. According to the Brain Injury Association of America, "neurobehavioral" relates to one's "ability to process thoughts or to think, behave socially, communicate, or control emotions."¹¹ Behavioral problems can include impulsiveness, depression, lack of motivation, irritability, and aggressive behavior. Therefore, a person suffering from neurobehavioral issues as the result of a brain injury may behave inappropriately sexually, exhibit physical aggression, be verbally disruptive, resist assistance from others, and threaten the safety of him or herself or others. During its hearings, the Committee heard numerous accounts of persons with TBI-related neurobehavioral issues who have jumped out of moving vehicles, assaulted their loved ones, and sexually molested others. These acts were committed by individuals who, prior to the brain injury, had no previous history of violent or deviant behavior.

Similarly, Dr. Wayne Gordon, Director of the Brain Injury Research Center at Mount Sinai School of Medicine, has determined that TBI is "an unrecognized major source of social and vocational failure."¹² Dr. Gordon's research staff has consistently found high rates of "hidden" brain injury when screening persons in New York schools, addiction programs, and within the general population. In fact, studies show that 54 percent of persons in alcoholism programs, 82 percent of homeless people, and 50 percent of children with learning disabilities or behavioral problems have a history of TBI.¹³ Consider also that children who sustain a brain injury are three times more likely to develop behavioral and emotional problems. However, because behavioral problems often do not manifest for many years due to the child development process, children are often classified as having a learning or mental disability rather than neurobehavioral issues caused by a TBI.¹⁴

Brain injuries and related neurobehavioral issues have a profound impact not only on the victim of the injury, but also on family members and loved ones. Personality changes and behavioral problems can be devastating, and family members experience a tremendous amount of emotional and financial stress. Neurobehavioral issues often impact a person's ability to return home, retain a job, maintain relationships, and resume community living. In addition, navigating a complex and fragmented service delivery system is often overwhelming. Finding appropriate services for TBI victims is both challenging and time consuming, especially for those suffering neurobehavioral problems. Studies show that at least 40 percent of those hospitalized with a TBI had at least one unmet need for services one year after their injury.¹⁵ The most frequent unmet needs are: improving memory and problem solving; managing stress and emotional upsets; controlling one's temper; and improving one's job skills.¹⁶

C. The Georgia Brain and Spinal Injury Trust Fund Commission

The Brain and Spinal Injury Trust Fund Commission was established by the General Assembly in 1998 with the purpose of providing services to both persons with TBI and Spinal Cord Injury (SCI).

¹¹ Information provided by the Brain Injury Association of America. See www.biausa.org.

¹² See *Hidden Trauma: Studies Cite Head Injuries As Factor in Some Social Ills*, Thomas M. Burton, Wall Street Journal, January 29, 2008.

¹³ Id.

¹⁴ Testimony provided by Mr. Craig Young on August 15, 2008.

¹⁵ Information provided by the Brain Injury Association of Georgia.

¹⁶ See *Perceived Needs Following Traumatic Brain Injury*, Journal of Head Trauma Rehabilitation, 2004.

Serving as the Lead Agency on traumatic brain and spinal cord injuries in our state, the Commission is the only state agency specifically dedicated to helping persons with TBI. The Commission is composed of 15 members, 10 of whom are appointed by the Governor, with the remaining 5 members appointed by the following state agencies: Georgia Department of Human Resources (DHR), the Department of Community Health (DCH), the Department of Education (DOE), the Department of Labor (DOL), and the Department of Public Safety (Public Safety). In addition, 7 members must have a traumatic brain or spinal cord injury or a family member with such a disability. Through its mission, the Commission seeks to improve the quality of life of Georgians with traumatic brain and spinal cord injuries by distributing funds and resources, and making policy recommendations to enhance the current service delivery system.

The Commission administers the Brain and Spinal Injury Trust Fund (Trust Fund), which is the only funding source dedicated solely to Georgians with traumatic brain injuries. Persons with TBI can apply for funding for services such as health care, personal assistance, transportation, respite care, rehabilitation, and recreation. However, because annual revenue for the Trust Fund, which is funded by surcharges on DUI fines, only averages around \$1.8 million annually, the Commission is limited in the number of people it can serve, particularly when it comes to the long-term care needs of individuals with neurobehavioral issues.¹⁷

In addition to the managing the Trust Fund, the Commission also maintains the Central Registry for Traumatic Brain and Spinal Injuries (Central Registry), the state's database that tracks the number of Georgians with TBI and SCI who were treated in a hospital setting and provides them with assistance in obtaining available resources and services. The Commission uses Central Registry data for long-term planning, distributing the Trust Fund, and for developing public policy. Unfortunately, the Central Registry only identifies Georgians seen in an emergency room or admitted to a hospital; those who are treated at a clinic, by a physician, or out of state are not reported. Additionally, the incidence of TBI in public and private schools, the juvenile justice system, correctional facilities, and with homeless persons, veterans, and victims of domestic violence is unknown. Although mandated by Georgia Law pursuant to O.C.G.A. § 31-18-4, the Central Registry is unfunded at this time.

D. A Coordinated System of Care

Policymakers and stakeholders who testified before the Committee repeatedly emphasized the need for a coordinated system of care for persons with TBI-related neurobehavioral issues. A structured, cross-agency network of effective services and supports is crucial to address the complex and changing needs of individuals with TBI and their families and caretakers. Sadly, Georgia does not have a coordinated delivery system for persons with TBI. Services are extremely difficult to access because there is no single point of entry into the state system, and even when individuals are able to obtain services, treatment is often disrupted due to the lack of funding and specialized providers in our state.

Moreover, very few resources are available for Georgians with TBI, particularly those with neurobehavioral issues. Programs specifically designed for people with TBI include: The Brain and Spinal Injury Trust Fund Commission; DOL's Rehabilitative Services and Roosevelt Warm Springs Institute for Rehabilitation; and five licensed brain injury facilities, including Restore Neurobehavioral Center, the only facility that specializes in providing neurobehavioral services. Additionally, DCH's Office of Medicaid, provides some funding to persons with TBI through its Independent Care Waiver Program (ICWP). However, slots are limited and there are 129 people currently on the waiting list (17 of whom have TBI). DHR's Division of Mental Health, Developmental Disabilities, and Addictive Diseases specifically excludes individuals with TBI, and the Division of Public Health does not include

¹⁷ Testimony provided by Mr. Craig Young and Ms. Stephanie Lotti on September 11, 2008.

a category for TBI in its Children's Medical Services program or within the Family Health branch. Other options for services include Independent Living Centers and private providers.

Ultimately, policymakers believe that a coordinated service system with a single point of entry would improve the lives of Georgians with TBI and neurobehavioral issues by allowing them to live in the least-restrictive and most appropriate setting possible, while also reducing the amount of state dollars used to pay for inappropriate services. The Committee identified three key components that are missing from our state's current system of care for TBI victims: Screening and Identification; Rehabilitation; and Long-Term Care.

1. Screening and Identification

Proper screening is a critical component of a system of care for persons with TBI, as it allows for identification of neurobehavioral issues and helps providers recommend rehabilitation and support services. It is critical that screening occurs as soon as possible after an injury; this prevents misdiagnoses, which can lead to inappropriate services and/or medications. Screening can also reduce the number of persons with TBI who are arrested, imprisoned, institutionalized, or homeless and can alleviate unnecessary burdens on state hospitals, prisons, homeless shelters, and special education programs.

Screening for neurobehavioral issues is typically accomplished through a formal neuropsychological evaluation using standardized tests to evaluate attention, motor performance, learning, and memory.¹⁸ Observing how a person interacts in "real-life" situations is also important to assess behavior and mood. Through this type of evaluation, professionals will identify specific neurobehavioral issues and cognitive impairments and develop a plan of care. Because individuals with TBI access services from a wide range of agencies and providers, screening and identification must be implemented in a variety of settings, including hospitals, mental health and developmental disability programs, schools, prisons, and homeless shelters. This requires collaboration and coordination between a number of agencies and providers.

Currently, Georgia does not have a systematic way of screening and identifying persons with TBI and neurobehavioral issues. Screening is fragmented across state agencies, and the professionals conducting the screenings often do not have the training and expertise that is necessary to identify brain injury.¹⁹ As a result, TBIs often go undiagnosed, particularly those injuries that are considered mild, resulting in inappropriate treatment, increased cognitive impairment, and academic and vocational failure.

2. Rehabilitation

Once a person has been screened and identified as having a TBI, it is imperative that he or she receive proper rehabilitation services. Rehabilitation is vital not only to recovery, but also to an individual's ability to live successfully in the community or in the least restrictive setting possible. For TBI victims with neurobehavioral issues, rehabilitation is different; it requires a highly structured approach that focuses on behavioral problems using: cognitive and behavior therapy; counseling and psychotherapy; transition services; therapy to improve functional skills; and pharmacological therapy.²⁰ However, although neurobehavioral problems are a common result of TBI, very few hospital-based rehabilitation programs are equipped to successfully treat them.

¹⁸ See *Georgia's Neurobehavioral Crisis: Lack of Coordinated Care, Inappropriate Institutionalizations*, Georgia Brain and Spinal Injury Trust Fund Commission, October 2007.

¹⁹ Testimony provided by Mr. Craig Young and Ms. Stephanie Lotti on September 11, 2008.

²⁰ Testimony provided by Dr. Gary Ulicny on November 14, 2008. See also *Brain and Spinal Injuries in Georgia: A Needs Assessment and State Action Plan*, Brain and Spinal Injury Trust Fund Commission, 2008.

Additionally, Medicaid and private insurance companies do not provide adequate coverage for neurobehavioral rehabilitation services. According to the Commission, this is because brain injuries are not easily recognizable; individuals with TBI may look and appear to be perfectly normal, but the damage to their brains will be evident in speech, behavior, and emotions. Many insurance companies view “recovery” as being medical or physical stabilization (i.e. walking) and therefore do not cover costly treatment for cognitive and behavioral problems.²¹ In most cases, a person with a TBI will have exhausted his or her insurance benefits long before receiving the maximum effects from rehabilitation. Similarly, with regard to Medicaid, it is very difficult for individuals to get approval for TBI rehabilitative services. Reimbursement rates for providers are very low, and hospitals are limited in the number of inpatient rehabilitation beds they offer to Medicaid patients. For persons who are not enrolled in Medicaid at the time of the injury, the process is extremely cumbersome, as it can take up to two years to get approval. As a result, people with neurobehavioral problems are often discharged from the hospital, transferred to nursing homes, or placed in psychiatric or other institutional settings without receiving the rehabilitative therapies they need.

During its hearings, the Committee learned that the majority of Georgians with TBI-related neurobehavioral issues are not receiving the rehabilitation that they desperately need. Data from the Central Registry indicates that only 185 out of the 6,611 persons hospitalized for TBI in Georgia in 2006 were discharged and sent to a rehabilitation facility.²² The majority of people were sent home, while others were sent to nursing homes and other facilities that lack the specialized training necessary to care for persons with these types of problems.

3. Long-Term Care

It is possible for people with TBI-related neurobehavioral issues to live successfully in the community, provided there is access to a range of long-term services and supports, including service coordination, counseling, community-based and in-home care, personal care, respite care for caregivers, options for community-based residential programs, and crisis management.²³ Several states, such as Alabama, New Hampshire, and New York, have developed collaborative models for providing TBI victims with specialized supports, specifically by using mobile resource and consultation teams that offer training, consultation, and crisis management to families and professionals who are caring for persons with TBI-related neurobehavioral issues.²⁴ Mobile resource teams typically include a neuropsychiatrist, neuropsychologist, pediatric psychiatrist, behavioral psychologist, case managers, and other providers of state and local services.²⁵

In some cases, individuals with severe TBIs may require long-term or lifelong structured residential treatment. Often, such persons may pose a threat to themselves and others and therefore need to reside in a residential setting that specializes in caring for persons with significant neurobehavioral problems by using cognitive, behavioral, and pharmacological treatments. However, there is only one facility in Georgia that specializes in providing such long-term care to persons with neurobehavioral issues, Restore Neurobehavioral Center. Restore is one of 5 licensed brain injury facilities in Georgia, but the only facility that provides neurobehavioral services through both an inpatient and a supported living program. Unfortunately, most Georgians with severe TBIs are unable to obtain services from Restore because Medicaid and ICWP do not adequately reimburse for the services, which are highly specialized and costly. However, according to testimony presented to the Committee, although Restore’s actual cost of care is around \$1200/day, it has offered to contract for discounted services of

²¹ Testimony provided by Dr. Gary Ulicny on November 14, 2008.

²² See *Brain and Spinal Injuries in Georgia: A Needs Assessment and State Action Plan*, Brain and Spinal Injury Trust Fund Commission, 2008.

²³ Id.

²⁴ Testimony given by Ms. Cindi Johnson on November 14, 2008.

²⁵ Id.

\$750/day for managed care providers. Still, ICWP is limited in the amount of slots it covers and will only pay an average of \$380/day.²⁶ This amount only covers counseling and behavior management services; it does not include room and board. Moreover, Medicaid and ICWP typically only cover 90-120 days of treatment, which is often an inadequate amount of time to address severe behavioral issues.

Unfortunately, our state is severely lacking in the availability of long-term care supports for persons with neurobehavioral issues caused by TBI, especially those who require more structured residential treatment and care. As previously stated, Medicaid and private insurance companies do not provide adequate coverage for TBI services, particularly long-term community supports, and most Georgians do not have the means to pay for such services. Furthermore, agencies that do offer long-term care assistance often do not have staff trained in dealing with neurobehavioral issues. With only one option for specialized long-term residential treatment for neurobehavioral issues, many Georgians with severe behavioral problems caused by TBI are inappropriately placed in institutions, such as nursing homes or state hospitals. Such facilities are both ineffective and costly, as they are typically ill-equipped to care for TBI victims who need behavioral and cognitive treatments. As a result, many Georgians who display severe behavioral problems are discharged with no where to go and often end up homeless, imprisoned, or sent to an institution out of the state.

IV. COMMITTEE RECOMMENDATIONS

After many hours of testimony and careful consideration of the information presented, the Committee agreed that TBI is creating a public health crisis in our state. The Committee further agreed that Georgia needs a coordinated system of care and support for persons with neurobehavioral issues caused by TBI. Such a system would significantly improve the quality of life for those persons, and it would reduce the amount of state dollars spent on ineffective and inappropriate services. The Committee recognizes that a coordinated system of care ultimately requires a network of effective services and supports organized to address the complex needs of persons with TBI and their families and caretakers. The Committee determined that Georgia's current system has significant gaps, specifically with regard to screening and identification of brain injury, rehabilitation services, and long-term care and supports.

➤ Recommendations for Increased Screening and Identification of TBI

The Committee recognizes that screening is a key component of the system of care for individuals with neurobehavioral issues resulting from brain injury. Screening efforts in Georgia are fragmented across state agencies, and there is a serious lack of expertise in identifying neurobehavioral issues resulting from TBI. Because persons with TBI access services from a wide range of agencies and providers, screening and identification efforts must be implemented in a variety of settings, such as hospitals, mental health and developmental disability programs, schools, prisons, and homeless shelters. The Committee therefore recommends that the General Assembly mandate proper screening for TBI across state agencies and service providers.

The Committee further recommends that the General Assembly support increased training of direct support staff, providers, educators, and other professionals to enhance awareness and expertise regarding behavioral problems associated with TBI. Additionally, the Committee encourages the development of an educational campaign that addresses both screening and prevention of TBI and increases public awareness of these issues.

Finally, the Committee recognizes that the Brain and Spinal Injury Trust Fund Commission currently operates the Central Registry, which is an unfunded legislative mandate. The Committee supports efforts to ensure timely reporting of critical information to the Central Registry. Moreover, although

²⁶ Testimony provided by Ms. Bridgett Kelly and Ms. LuRae Ahrendt on November 14, 2008.

Georgia is experiencing a significant budget crisis and is unable to offer funding for the Central Registry at this time, the Committee encourages the General Assembly to provide funding of up to \$150,000 for the operation of the Central Registry at a time in the future when it is able to do so.

➤ **Recommendations for Improved Access to and Funding for Rehabilitation Services**

The Committee understands that rehabilitation for TBI and neurobehavioral issues is unique and requires specialized training and supports. However, services in Georgia are limited, difficult to obtain, and costly. Therefore, the Committee encourages the General Assembly to work with the Commission in facilitating and supporting the development of a single point of entry for Georgians with TBI to access rehabilitative treatment and services. The Committee also encourages the expansion of funding sources and opportunities for rehabilitative services for individuals with neurobehavioral issues and recommends that DCH streamline the Medicaid approval process for eligible Georgians.

➤ **Recommendations for Expanding Long-Term Care Supports**

The Committee recognizes that many Georgians with severe TBI-related neurobehavioral issues need ongoing, specialized long-term care and support. Rather than being inappropriately institutionalized or placed in nursing homes, these individuals should be supported in specialized community-based neurobehavioral programs that use cognitive, behavioral, and pharmacological treatments. However, such programs are scarce in Georgia due to their specialized nature and high cost, and there is only one provider of long-term residential rehabilitative treatment for neurobehavioral issues. Therefore, the Committee encourages the General Assembly to promote increasing and expanding the network of long-term care providers in Georgia for individuals with severe neurobehavioral problems.

Furthermore, the Committee recognizes that Medicaid and ICWP do not provide adequate reimbursement for specialized neurobehavioral services, which prevents many Georgians from accessing this type of care. Therefore, the Committee encourages the General Assembly and DCH to consider reforming the ICWP program by increasing the rate of reimbursement for providers of neurobehavioral care and changing existing criteria to include coverage for neurobehavioral residential rehabilitation programs.

Finally, the Committee encourages the development of mobile resource teams to assist Georgians with TBI in accessing all available services and to offer training, consultation, and crisis management to families and professionals who are caring for persons with TBI-related neurobehavioral issues.

Respectfully Submitted,

**THE SENATE STUDY COMMITTEE ON BRAIN INJURY RELATED
NEUROBEHAVIORAL ISSUES IN GEORGIA**

**The Honorable Don Thomas, Chair
Senator, District 54**

**The Honorable Greg Goggans
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