



Hogg Foundation for Mental Health

THE UNIVERSITY OF TEXAS AT AUSTIN

House Select Committee on Mass Violence Prevention and Community Safety

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Thank you for allowing the Hogg Foundation for Mental Health to provide comments on this important issue. The foundation is part of the Division of Diversity and Community Engagement at the University of Texas at Austin. These comments will focus on the mental health workforce shortage in Texas. The COVID pandemic will have far-reaching impact on the mental well-being of Texans. Now more than ever, attention must focus on building healthy communities and ensuring mental health services and supports are accessible to those who need them.

The Intersection of Mass Violence and Mental Health

Before speaking directly to the issue of the Texas mental health workforce, we would like to address the intersection of mental health and mass violence. I'm sure you've heard over and over again that people living with mental illness are more likely to be the victims of crime than the perpetrators. That is true, but it doesn't tell you much about the perpetrators of these horrific acts, nor does it tell you about the victims – all the victims. Many of the victims are far removed from the actual events, yet they too require our attention.

The cause and effect between mass violence and mental illness is complex, but according to research done by Fazel and Friedman, “at the aggregate level, the vast majority of people diagnosed with psychiatric disorders do not commit violent acts—only about 4% of violence in the United States can be attributed to people diagnosed with mental illness.”^{1,2} Some of these violent acts are committed by people with mental illness; some are not. People ask, how could someone commit such a heinous act if they aren't mentally ill? This is where it is important to understand the difference between mental illness and societal mental wellness or well-being. Mental illness can be medically diagnosed and treated. Most incidents of mass violence are committed by individuals who are angry, sometimes isolated, and often living in despair. As we have seen here in Texas, racism is also a contributor. Anger, racism, and despair are not diagnosable mental illnesses. Rather, they are conditions brought on by societal drivers that create unhealthy communities and therefore unhealthy individuals. Psychotropic medications are not going to address this. Building healthier communities and focusing on mental wellness should be our priority. This distinction is important as you move forward in your policy development around preventing mass violence.

Notions of mental illness that emerge in relation to mass shootings frequently reflect larger cultural issues that become obscured when mass shootings come to stand in for all gun crime and when “mentally ill” ceases to be a medical designation and becomes a sign of violent threat...

...Our review ultimately suggests, however, that this framework—and its implicit promise of mental health solutions to ostensibly mental health problems—creates an untenable situation in which mental health practitioners increasingly become the persons most empowered to make decisions about gun ownership and most liable for failures to predict gun violence. Meanwhile, public, legal, and medical discourses move ever-farther away from talking broadly and productively about the social, structural, and, indeed, psychological implications of gun violence in the United States.

Jonathan Metzl, Kenneth T. MacLeish, *Mental Illness, Mass Shootings, and the Politics of American Firearms*

The Mental Health Workforce Shortage

Regardless of whether we are talking about an individual's diagnosable mental illness or a community that struggles with their mental well-being, mental health providers play an important role.

Approximately 214 Texas counties are designated as either full or partial Health Professional Shortage Areas for Mental Health (HPSA-MH).³ We know that approximately 173 counties in Texas did not have a single psychiatrist in 2019.⁴ Additionally, 32.8 percent of the mental health workforce is comprised of individuals over the age of 55.⁵ That means that we could lose close to a third of the workforce in the next 5 to 15 years.

While the HPSA designations are based primarily on the number of psychiatrists, the majority of mental health services are provided by mental health professionals other than psychiatrists. In many parts of our state, significant shortages of these providers also exist. This includes primary care physicians, nurses, social workers, physician's assistants, certified peer specialists and certified recovery coaches, family partners, community health workers, and counselors. It is important to note that primary care providers deliver more than half of all mental health services for common mental health conditions.⁶

Issues affecting the mental health/substance use workforce include:⁷

- Unwillingness of mental health providers to accept patients with Medicaid;
- Inequitable distribution of professionals across the state, primarily affecting rural areas;
- Aging workforce;
- Linguistic and cultural barriers – the workforce does not reflect the culture and ethnicity of the state's population. While more than half of our population is Hispanic/Latino, only 21 percent of our mental health workforce is Hispanic/Latino;
- Inadequate and inequitable reimbursement practices. Reimbursement rates are too low and the rating structure allows for different rates for the same services depending on the provider type;
- Limited internship sites and the cost of supervision for psychology, social work, and counseling.

Addressing the Shortage

A valuable resource, *Recruiting and Retaining Behavioral Health Workers in Rural America – A Toolkit for Action*, developed by the National Behavioral Health Workforce Research Center at the University of Michigan, is available at <https://chrt.org/wp-content/uploads/2020/02/Recruitment-and-Retention-of-BH-Providers-Toolkit-2.21.2020-.pdf>. This toolkit shares successful strategies from around the country. According to a study done at the Center, mental health workforce deficiencies should be addressed through three specific areas:⁸

- Financial incentives
 - Reimbursement rates
 - Tax credit programs
 - Loan repayment/residencies/internships/supervision stipends
- Education and training
 - Primary care training
 - Pipeline pathway programs
- Practice-oriented tactics
 - Telehealth expansion
 - Maximizing/expanding scope of practice
 - Regulatory changes

Strategic Plan

Over the past decade, there have been several studies performed and reports developed containing a multitude of workforce recommendations. Some progress has been made including loan repayment for mental health professionals in shortage areas, expansion of services through telehealth (especially during the COVID-19 pandemic), the advancement of peer support services in the public mental health system, and the creation of the Children's Mental Health Care Consortium. While work has been done, with 214 HPSAs remaining, it is evident that the problem is not yet solved.

While Texas has a Statewide Behavioral Health Strategic Plan, the state has not had a plan specific to address the mental health and substance use workforce shortage. Legislation directing HHSC to *develop and implement* such a plan passed both chambers of the legislature last session, but died when unfriendly amendments were added to it in the closing days. To their credit, HHSC decided to create a workgroup of both internal and external stakeholders to work together to develop a workplan. Some good work is currently being done and a workplan is expected to be released in September 2020. There is, however, no directive to implement the recommendations and no resources currently available to do so. Hopefully you will have the ability to take a serious look at those recommendations and be willing to direct action on many of them in the next legislative session. The workplan that is under construction will have recommendations that address six specific areas including:

- Recruitment and retention;
- High school pipeline (steering students in the mental health direction);
- Higher education;
- Innovative systems improvement;
- Licensing and regulation; and
- Medicaid administration

One workforce area that needs to be in the forefront of our plan to improve the effectiveness of the behavioral health workforce is the continued expansion of our ability to use the services of certified mental health peer specialists and certified substance use recovery coaches. Two sessions ago, Chairman Price passed HB 1486 (85th), which put into code the requirements for training, certification, and supervision of mental health peer specialists and substance use recovery coaches. This was a huge step in validating these services. Unfortunately, the reimbursement rates established by HHSC were grossly inadequate, and consequently makes it difficult for organizations outside of the local mental health authorities (LMHAs) to offer peer services. LMHAs can provide the services because they can bill for peer services under the mental health rehabilitation rate, which is 3-4 times higher than the Medicaid peer services rate. There is no similar rate for certified substance use recovery coaches.

Recommendations:

In 2016, the Hogg Foundation developed a policy brief, *The Texas Mental Health Workforce: Continuing Challenges and Sensible Strategies*. The brief can be viewed at <https://hogg.utexas.edu/project/the-texas-mental-health-workforce-continuing-challenges-and-sensible-strategies>. Workforce conditions have not changed significantly and the recommendations made in 2016 are still valid.

Some recommendations that continue to rise to the surface from past studies and reports include:

- Expand loan repayment programs for all mental health professions, especially in rural and HPSA locations.
- Expand telemedicine and telehealth service delivery for mental health and substance use services. This includes making many of the relaxed restrictions of the COVID-19 period permanent.

- Expand access to mental health and substance use peer support services for adolescents and young adults. Current rules require that certified peer specialists be at least 18 years old. However, to receive peer support services an individual must be 21 or older. This means that 18-, 19-, and 20-year-olds can deliver the services, but not receive the services. Consequently, middle school and high school students are not eligible for these important services. Mental health/substance use peer support services (provided by certified peer specialists who are 18 or older) should be made available to teens and young adults.
- Evaluate and improve mental health and substance use reimbursement rates. This should include the appropriateness of the rates and should ensure that reimbursement be based on the service provided and not be differentiated by provider type (one rate for each billing code).
- Ensure that professionals maximize their ability to provide services under the scope of their licensure; evaluate scope of practice and cross-state reciprocity rules.
- Consider requiring doctors who receive state GME or loan repayment benefits to provide some level of services to those in the public health system (Medicaid/LMHA) or in HPSA-MH geographic areas.
- Improve training of primary care physicians so that they have a better understanding of child/adolescent mental health, suicide prevention, and substance use.
- Increase training for educators on suicide prevention, trauma-informed practices, and mental health awareness.
- Support mental health professional internship sites and provide stipends for supervision to ensure that those educated to provide the needed mental health services have the opportunity to fulfill the supervision requirements for licensure.

Summary

We need to ensure that access to mental health and substance use services is available to those living with mental illness/substance use conditions, as well as those struggling with mental well-being. Mental health providers have so much to offer on the prevention side by collaborating with communities, schools, universities, faith groups, law enforcement, employers, and others to help us understand what is needed to prevent violence and to build healthier communities. A well-developed workforce requires a long-term commitment of resources. We are hopeful that you will consider the information offered during the interim and the recommendations that will be provided in the HHSC Workforce Workplan currently being developed.

[REDACTED]

[REDACTED]

Addendum to testimony in response to legislative question:

In recent years, we have seen the adoption of live/active shooter drills in public schools. There drills seem to vary across the board and there are concerns that these drills can cause post-traumatic disorder among other psychological and emotional disorders in children. Can you please explain or elaborate how these intense drills might impact the mental and behavioral health of developing children? And in your opinion, is there a better way to prepare or train children for these worst-case scenarios? Or are schools doing more damage than good with these types of active drills?

I will qualify my comments on this issue with the statement that while I work for a mental health foundation, I am not a clinician. My son is a high school teacher. Earlier this year I was a visiting teacher in his class at Memorial Early College High School in Comal County. He co-teaches in a classroom of 50-60

students. On one of the days I was visiting, as I started to teach a loud voice came over the classroom intercom system directing “LOCK-DOWN, LIGHTS OUT, OUT-OF-SIGHT! LOCK-DOWN, LIGHTS OUT, OUT-OF-SIGHT.” It was obvious that this was not a drill as the teachers were surprised and the fear in their eyes was evident. While the students went and crouched against the walls, hid in corners, and were quiet, it was obvious to us all that if a gunman started shooting, the walls would not stop the bullets. I have never witnessed so much fear in so many at one time. My heart ached for the students and the teachers, as the weight of their responsibility became so evident.

It turned out that it was an error. A new system had recently been installed and someone accidentally pushed the emergency button. One student left the room in tears, the rest were quiet for several minutes and then we shortly resumed class. But the damage was done. The reality that it could happen was forever sealed. It was a traumatic experience.

After seeing the trauma that an “unannounced” or “surprise” drill causes, I quickly sided with the child and adolescent clinicians who argue against these drills. I do believe that it is important to instruct the students on what to do and have them practice what to do, but unannounced drills instill terror and instilling terror in the absence of a true emergency stands to do more harm than good. A February 28, 2018 article in *The Atlantic*, “What Are Active-Shooter Drills Doing to Kids?” offers perspective on the impact of active shooter drills. The article can be found at <https://www.theatlantic.com/health/archive/2018/02/effects-of-active-shooter/554150/>.

¹ Fazel S, Grann M. The population impact of severe mental illness on violent crime. *Am J Psychiatry*. 2006; 163(8):1397–1403.

² Friedman R. A misguided focus on mental illness in gun control debate. *New York Times*. December 17, 2012: Health. Available at <http://www.nytimes.com/2012/12/18/health/a-misguided-focus-on-mental-illness-in-gun-control-debate.html>.

³ HSRA, (2020). Shortage Areas. Retrieved from: <https://data.hrsa.gov/topics/health-workforce/shortage-areas>

⁴ Texas Department of State Health Services. (2019). Psychiatrists by county – September 2019. Retrieved from <https://www.dshs.state.tx.us/chs/hprc/tables/2019/PSYCH19.aspx>

⁵ Hogg Foundation for Mental Health. (2016). The Texas Mental Health Workforce: Continuing Challenges and Sensible Strategies. Retrieved from <https://hogg.utexas.edu/project/the-texas-mental-health-workforce-continuing-challenges-and-sensible-strategies>

⁶ National Institute of Mental Health. (2017). Integrated Care. Retrieved from <https://www.nimh.nih.gov/health/topics/integrated-care/index.shtml>

⁷ Hogg Foundation for Mental Health. (2016). The Texas Mental Health Workforce: Continuing Challenges and Sensible Strategies. Retrieved from <https://hogg.utexas.edu/project/the-texas-mental-health-workforce-continuing-challenges-and-sensible-strategies>

⁸ Behavioral Health Workforce Research Center. (2019). Recruiting and Retaining Behavioral Health Workers in Rural America: A Toolkit for Action. The University of Michigan. Retrieved from <https://chrt.org/wp-content/uploads/2020/02/Recruitment-and-Retention-of-BH-Providers-Toolkit-2.21.2020-.pdf>