Thank you for this opportunity to provide feedback to Representative Blanco and Chairman Darby. As a licensed clinical psychologist, Professor, Director of the Trauma and Resilience Clinic, and Vice Chair for Veterans Affairs in the Faillace Department of Psychiatry at UTHealth Houston, and director of the Telehealth Core of the National Mass Violence Victimization Resource Center, I feel that I can contribute in a useful manner. Below I include an overview of my research and an outline of the actions needed to address consequences, if not prevention, of mass violence, followed by a copy of each of the specific questions posed and my answer in italics to those with which I have an informed opinion.

The first part of my testimony addresses the CONSEQUENCES of mass violence events; that is, the depression and anxiety that affected individuals experience, and for whom ***evidence based*** *treatment is needed, but is rarely accessible due to logistical problems (e.g., traffic, travel time and cost, stigma),* ***and for which a viable solution exists in the form of home based telemedicine****. The second part of my testimony addresses the PREVENTION of mass violence events through expanded training to provide effective mental health care, and uses the term '****evidence-based psychotherapy'****, which you will see repeatedly in my testimony .*

For the past two decades, I have studied the effectiveness of, cost of, and user satisfaction with evidence-based psychotherapies provided via home-based telehealth. These studies include both clinic-based samples of veterans in my VA Post-Traumatic Stress Disorder Clinic, where I served as clinic director and oversaw the nation's first home-telehealth treatment program for PTSD. This program was available to rural veterans who would not otherwise have been able to obtain top quality, evidence based mental health care (see references below). These studies also include several Department of Defense and Department of Veterans Affairs research projects with (1) older adult veterans who were depressed; (2) combat veterans with PTSD; (3) women veterans who had experienced PTSD following military sexual trauma; (4) and veterans suffering from complicated bereavement. Our findings across both clinic and research clinical samples was the same:

- ***Home-based telehealth delivery of evidence-based psychotherapy was as good as the same treatment delivered via in person care.***
- ***Home-based delivery of evidence-based psychotherapy saved both the patient and the providing institution money and time.***
- ***Home-based delivery of evidence-based psychotherapy had higher consumer satisfaction ratings compared to in person care.***

It has thus extremely disappointing to observe, over the past decade, a complete failure of most third party payors, Medicare, and in some instances Medicaid to approve parity of reimbursement for the same mental health treatment provided via home-based telehealth as in person.

With limited exceptions, and excepting the time-limited expansion associated with the COVID19 pandemic, home-telehealth delivery of mental health care is either not reimbursed, or restricted to those in extremely rural areas, and requires patients to obtain services at satellite clinics, rather than their homes (i.e., Medicare). This is disappointing because, very rarely, do we actually have good services outcome data showing not only equal or better ratings of satisfaction, but actual outcomes and cost benefits! In other words, the data across several highly controlled federal studies (see references below) show home-based telemental health is as good as the same care delivered in person, cheaper, and more highly rated. Yet, I am, even today in the middle of this pandemic, having to call insurance companies and fight for reimbursement for this mode of service delivery. It makes little sense insofar as it is cheaper, equally effective, and, given that untreated mental health problems exacerbate other medical problems, can reduce other insurance company costs. Along these lines, I am currently working as a panel member on the Meadows Institute sponsored, National "Path Forward" efforts for mental health parity, and REIMBURSEMENT PARITY of telemental health vs. in person care is a central priority, insofar as if this parity is not achieved, we are dead in the water. As you review my answers to questions below, you will see the common theme underscoring the utility of telemental health delivered directly into patients' homes. You will also see the repeated

call for parity of reimbursement of this model, as a way to overcome barriers to mental health care such as stigma, rurality, low provider availability, travel time in urban centers, parking costs, etc.

The second area of emphasis I would like to highlight is the need to increase availability of evidence-based psychotherapy, particularly for underserved areas and populations, to prevent mass violence events. Note, there IS NO MASS VIOLENCE PERPETRATION PSYCHOLOGICAL PROFILE that can say who will, ***and who will not*** *engage in a mass violence event. Even if personality characteristics are present across many mass violence perpetrators, many many many more individuals with the same characteristics and profiles do not perpetrate mass violence events. Thus, it is more important to address other commonalities of perpetrators, the most frequently observed of which is* ***untreated mental health problems****. When I say untreated, I mean EVIDENCE-BASED psychotherapies were not available or obtained by the perpetrator. This is due largely to (1) access problems, for which home-based telemedicine, reviewed above, provides a solution and (2) professional training deficits in evidence-based psychotherapies in the counseling professions (psychologists, psychiatrists, social workers, and licensed professional counselors), for which additional training resources and funding could provide a solution. In other words, the only pragmatic way to prevent mass violence events is to address the mental health problems that precipitate such events, and the only way to do this is to leverage both home-based telemental health and widespread dissemination of evidence-based trainings. The VA has done exactly this, and has engaged in nationwide evidence-based psychotherapy trainings as well as nationwide rollout of home-telehealth delivered mental health care. This model could easily be adapted to existing infrastructure in Texas (e.g., the Office of the Attorney General VOCA VAWA program infrastructure), as outlined below.*

Overall, therefore, to address mass violence prevention, we need increased training in evidence-based psychotherapy combined with increased access to these psychotherapies via home telemedicine delivered evidence-based psychotherapy. To achieve the former, we should leverage the existing infrastructure (outlined below) of the State and provide resources to host these trainings; to achieve the latter, we should fight for parity policy changes that assure third party payors reimburse home-telehealth delivered, evidence based psychotherapy at the same rate they reimburse the same therapy when offered in person, and we should address gaps in insurance coverage with supplemental funding for mental health needs in this state.

Ron Acierno, PhD

General Questions for all Designated Parties from Representative Blanco:

1. **What specific statutory recommendations could you make to improve long-term workforce needs in your area?** *There are far more survivors of interpersonal violence (mass violence events, but also: child abuse, domestic violence, elder abuse, and assault) than there are counselors who provide* ***evidence based*** *mental health care to this group. This mismatch between need and resources is caused by (1) lack of funding for these mental health services, and (2) lack of funding for training to provide* ***evidence based*** *mental health services for these survivors, (3) proliferation of non-evidence based counseling programs which produce poor outcomes. Fortunately, an infrastructure already exists that has begun to address problems 1 and 2, but is underfunded: thus, I would recommend supplemental funding for Victims of Crime Act (VOCA) and Violence Against Women Act (VAWA) federal pass through service and training projects currently managed by the state's Office of the Attorney General, with specific reference toward training in and provision of* ***evidence based*** *mental health treatments for victims of violence.*
2. **What barriers of entry do you see in your field and do you have recommendations on addressing those?** *In addition to the problems related to funding and training outlined above, there are two additional primary barriers to delivering effective, evidence based mental health services. First, the extremely expensive and burdensome state clinical psychology licensing process, including the requirement of a two year provisional status, despite experience, limits providers willingness to relocate to Texas. Indeed, Texas is among the least clinical psychology friendly states for licensure. Second, the lack of parity reimbursement for telehealth services*

dramatically limits its use, and limits access for rural and even urban victims of violence, who must overcome long distances or traffic to obtain care, two factors that are eliminated by telemental health service delivery. This lack of reimbursement parity exists despite (1) several studies showing that telemental health delivery of evidence based treatment is as good as in person delivery of the same treatment (see Bibliography below), (2) victims of violence overwhelmingly prefer this mode of relatively more confidential service delivery and, (3) this mode of service delivery allows expertise to be given to victims of violence statewide, even in the most rural, and understaffed areas. The Governor and Medicare issued temporary parity requirements during the COVID19 pandemic, but these parity guidelines are set to expire, once again creating a massive barrier to care.

3. **Are there examples from other states that you have seen to help improve the long term workforce needs in your respective areas?** *I do not have examples from other states, but I do have direct experience with the Department of Veterans Affairs, where I am also employed part-time and served as the director of the Charleston, SC PTSD clinic. The VA provides a good example of using telemental health technology to address workforce needs, particularly for rural and underserved populations. Specifically, the VA implemented (1) a national training program in evidence based psychotherapies for trauma related mental health disorders, while at the same time (2) authorized my VA PTSD clinic to implement a home based telemental health pilot project to deliver these evidence based treatments via telehealth to overcome barriers such as stigma, distance, rurality, and time off work. This pilot program is now the standard nationwide, allows provider time to be allocated when and where it is needed from central urban sites directly to remote patient homes, and allowed many VA's to continue offering mental health care, largely uninterrupted, during COVID19 shelter in place restrictions. (NOTE: Before COVID 19 unfortunately, medicare and private insurance guidelines greatly limit the use of telemental health, and when it is authorized, it often is required to follow a hub and spoke model where a central provider office offers telemental health to a remote office, RATHER THAN A CITIZEN'S HOME. This is a rather restrictive system of non parity.)*
4. **How has the surge in gun violence, mass violence, domestic terror threats impacted the training and education of professionals in your areas? Is there any particular focus on addressing, preventing, or identifying these threats in your profession's education and training?** *Currently there is limited training in evidence based treatments for post traumatic stress disorder and depression secondary to interpersonal violence once it occurs. The aforementioned infrastructure under the Office of the Attorney General of Texas could provide an effective training venue to deal with victims of violence. Moreover, the National Mass Violence Victimization Resource Center, funded by the National Institute of Justice, and for which I direct the Telehealth Core, offers training and resources and could be contracted to help provide community response options for mass violence events to address mental health needs. With respect to preventing violence itself: there are very few evidence based interventions to address violence per se. However, data do indicate that most perpetrators of extreme violence have unmet mental health needs, and making mental health resources more generally available is probably the most effective way to minimize risk of violence.*
5. **What policy recommendations, based on your experience, training, and education, would you make to prevent or deter future mass violence incidences**? *The policy recommendation based on data is clear: more widely available mental health treatment, as virtually all perpetrators of mass violence events have a diagnoses mental health problem. One way to increase mental health reach is to assure reimbursement parity for telemental health delivered evidence based psychotherapy services*.
6. **Can you elaborate on the role your profession can play in helping prevent mass gun violence**? *My profession is clinical psychology. We have researched and disseminated effective treatments for depression, PTSD, substance use and a variety of other disorders. There are two ways to prevent mass gun violence: eliminate the guns or eliminate the motivation to mis-use them. The latter is far easier, and mental health treatments must be more easily accessible.*
7. **How can recent mass violence incidences inform or update the education and training requirements in your respective fields**? *There is no one 'mass violence perpetration profile'. This bears restating: such a profile*

is a myth. There is, however, a large prevalence of untreated mental health problems that could be treated and could reduce both general violence, domestic violence, and ultimately mass violence.

Question for Mental Health and Behavioral Professionals from Representative Blanco:

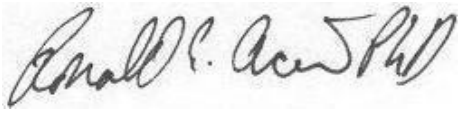
1. **In recent years, we have seen the adoption of live/active shooter drills in public schools. There drills seem to vary across the board and there are concerns that these drills can cause post traumatic disorder among other psychological and emotional disorders in children. Can you please explain 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 type of active drills?** *It is exceedingly unlikely that these drills will produce full blown PTSD such as that experienced by combat veterans or rape victims; however, it is very likely that they will produce significant anxiety in the children. However, this anxiety can be ameliorated if the context of the training were one of empowerment through training. In other words, if these trainings were framed as "things you can do to keep yourself safe" and the constant theme was things YOU CAN DO, then a sense of control is built up and underscores every activity. In other words, the framing of the training and how it is presented has EVERYTHING to do with how it is perceived and the effect it has on the person being trained. Framing the training as an empowerment exercise to keep oneself safe will cause some anxiety, but it will be worth it if safety is maintained.*

General Questions for all Designated Parties from Chairman Darby:

1. **What can the state of Texas do to invest in long-term solutions for law-enforcement, mental health, and cybersecurity workforces? Does Texas have shortages in your respective field**? *Shortages should not be looked at in terms of Texas as a whole, because many urban areas will not have shortages, where less urban areas will. Therefore, workforce shortages in mental health will likely be place-dependent within the state. As such, telemental health should be deployed to address these shortages, thereby moving the resources where they are to where they are needed at the least cost. However, this is only possible if reimbursement for telemental health is with parity for the SAME evidence based psychotherapy delivered in person.*
2. **Do you have any immediate recommendations for the Select Committee to address the education or training requirements in your specific field**? *Make reimbursement parity state policy for the same evidence based psychotherapy service offered via telemental health as compared to in person health. Leverage the existing grants infrastructure of office of the attorney general VOCA and VAWA programs and provide supplemental funding for (1) training and (2) EVIDENCE BASED psychological services via (3) telemental health.*

Thank you for this opportunity,

Ron Acierno, PhD



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