Thank you for the opportunity to provide comments and feedback to Chairman Darby, Representative Blanco, and to the members of the House Select Committee on Mass Violence Prevention and Community Safety. My name is Stephen Glazier and I currently serve as the Chief Operating Officer of the UTHealth Harris County Psychiatric Center (HCPC). HCPC is one of the two largest academic psychiatric hospitals in the United States and is one of the larger employers of mental health professionals in the State of Texas. Additionally I have been involved with mental health public policy issues in Texas for the past 7 years serving as a member of the Statewide Behavioral Health Coordinating Council, which drafted the first Texas Statewide Behavioral Health Strategic Plan, the Joint Committee on Access and Forensic Services, the Texas Hospital Association Behavioral Health Council and the Network of Behavioral Health Providers. These roles have given me a unique perspective on the workforce needs of the state related to mental health and I will address my comments to this topic.

The behavioral health workforce shortage in Texas has been well documented over the past decade. In 2019 the Health and Human Services Commission created the Behavioral Health Workforce Workgroup with the task of analyzing previous recommendations to address the state's behavioral health workforce shortages and providing action steps to move forward. In 2016 the Hogg Foundation published The Texas Mental Health Workforce: Continuing Challenges and Sensible Strategies which also addressed this important topic.

As of 2015, 206 out of 254 (81.1%) of Texas counties were designated as full or partial Mental Health Professional Shortage Areas (HSPA) and the problem has been growing. In 2011, 25 counties that were not previously designated as HSPAs were given that designation and 181 other counties that were Mental Health HSPAs in 2010 still held that designation. Further, 185 Texas counties did not have a single psychiatrist in 2015, which left 3 million Texans in counties without access to a psychiatrist. In 2015 there were 149 counties without a single licensed psychologist, and 40 counties did not have a licensed social worker. [1]

[1] Hogg Foundation. The Texas Mental Health Workforce: Continuing Challenges and Sensible Strategies. July 2016, 2nd printing.

Clearly a shortage of mental health professionals in the workforce is a contributing factor to a lack of access to care and improving access to care and treatment can ultimately help to reduce mass violence.

As one of the major employers of behavioral health professionals in the State, I would like to share a number of observations and recommendations for developing and maintaining an adequate mental health workforce for Texas. While many of these recommendations are drawn from the work of Texas state agencies, advocacy groups and public policy institutes, I have seen firsthand the efficacy and value of these recommendations.

- ***Expand the use of and access to telehealth services in mental health.*** One way to accomplish this is to ensure that telehealth and telemedicine mental health and substance use condition services are reimbursed at the same rate as are in-person services. Additionally, review the status of telehealth and telemedicine allowability based on licensing rules and regulations and identify opportunities for improvement. Expanding the use of telehealth services is one of the quickest and easiest ways to increase provider availability and reduce the disparity of providers between rural and urban areas of the state.
- ***Promote and expand the existing loan repayment programs.*** These programs are extremely successful in helping to recruit new mental health professionals both to the state and to our HSPAs. Opportunities to find alternative sustainable funding for the THECB loan repayment programs should be explored.
- ***Responsibly expand the practice capacity of ARNPs and other practitioners***. Evaluate reciprocity rules and scope of practice for each of the licensed professional groups within the Behavioral Health Executive Council (BHEC) and prioritize reciprocity rule changes based on available data.
- ***Create a High School Pipeline.*** Through THECB contracts create behavioral health programs similar to the Joint Admission Medical Program (JAMP) to include other careers and licenses such as social work, counseling, marriage and family therapy, nurse practitioners (with psychiatric specialty) and psychologists.

- ***Create incentives for practitioners to relocate to rural and underserved areas.*** Provide payment incentives for Medicaid-enrolled behavioral health providers working in rural or underserved areas.
- ***Expand the state's promotion of, and investment in, the certification of peer support specialists.*** Promote collaboration between HHSC, recovery community organizations and other stakeholders to expand training, credentialing and access to behavioral health peer specialists. Increase Medicaid reimbursement rates for services provided by peer specialists.
- ***Expand graduate education programs for behavioral health professionals including psychiatry, psychology, social work, counseling and nursing.***
- ***Provide adequate reimbursement rates for mental health services to increase the number of mental health professionals who accept Medicaid.*** HHSC should consider processes for allowing incremental increases in behavioral health reimbursement rates in fee-for-service and managed care over multiple years. This would improve reimbursement and lessen the impact on the state.

The Statewide Behavioral Health Coordinating Council recently created a behavioral health workforce subcommittee with the express purpose of completing a report inspired by the non-enrolled S.B. 429 (86-R) "Relating to a comprehensive plan for increasing and improving the workforce in this state to serve persons with mental health and substance use issues." This report, which will be released December 2020, contains a review of several major reports crafted by organizations to include Meadows Mental Health Policy Institute, Hogg Foundation for Mental Health, Department of State Health Services and the Health and Human Services Commission that included recommendations to address behavioral health workforce shortages. The subcommittee reviewed these recommendations and assessed progress with implementation, as well as factors contributing to non-implementation of recommendations.

This report contains a review and assessment of the best work that has been done on behavioral health workforce issues in the state over the past few years. It is thorough and actionable. I highly recommend it to this committee for consideration.

Stephen Glazier