House Select Committee on Mass Violence Prevention and Community Safety
Written Testimony

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Duty #4: *Evaluate the ongoing and long-term workforce needs of the state related to cybersecurity, mental health, law enforcement, and related professionals.*

NAMI Texas is a nonprofit 501(c)3 organization founded by volunteers in 1984. We are part of the nation's largest grassroots mental health organizations and we exist to help improve the quality of life for individuals with mental illness and their families. Around the state, we have 27 local NAMI affiliate organizations and nearly 2,000 members.

Risk Factors for Mass Violence

Numerous social, emotional, and psychological factors contribute to risks associated with mass violence. The average active shooter experiences 3.6 different acute and chronic stressors in the year prior to an attack, including financial strain, job related stress, interpersonal conflict, sexual frustration, and grief.[1] Stressors associated with mental health are also indicated as increasing risk of mass violence, but the association is modest. In fact, when controlling for other variables, only 4% of violence in society can be directly attributed to mental health. There is insufficient evidence to suggest that mental illness in and of itself is a root cause of mass violence.

To prevent mass violence, increased emphasis should be placed on identifying specific behaviors that increase risk. Studies have shown:

- 41% of perpetrators have a specific target in mind prior to an attack[2]
- 52% of perpetrators harbor grievances related to work, school, finances, or interpersonal relationships[1]
- 78% of perpetrators exhibited behaviors that elicited concerns from others prior to an attack[1]

[1] National Council for Behavioral Health. (2019). *Mass Violence in America.* Retrieved from <https://www.thenationalcouncil.org/wp-content/uploads/2019/08/Mass-Violence-in-America_8-6-19.pdf?daf=375ateTbd56>
[2] National Threat Assessment Center. (2019). *Mass Attacks in Public Spaces - 2018*. U.S. Secret Service, Department of Homeland Security. Retrieved from <https://www.secretservice.gov/data/press/reports/USSS_FY2019_MAPS.pdf>

Greater emphasis should be placed on assessing and mitigating concerning behaviors to reduce risk and incidence of mass violence.

Workforce Shortages and Mass Violence

Primary care providers, behavioral health providers, educators, law enforcement, and the court system are integral components in assessing and managing acute and chronic stressors associated with violence risk. Unfortunately, workforce shortages may jeopardize the ability to provide the proper care and attention required to prevent mass violence. With respect to mental and behavioral health, the Health Services and Resources Association (HSRA) states that workforce shortages and uneven workforce distribution limits access to essential services.[3] Further, workforce shortages are exacerbated by high workforce turnover, an aging workforce, and low compensation.

Mental health workforce shortages are exacerbated by Texas' growing population and vast rural landscape. According to the Health Resources and Services Administration, 206 out of 254 counties in Texas qualified as full or partial Health Professional Shortage Areas (HPSA). Partial HPSA generally occurs in urban areas where the mental health workforce is unevenly distributed.[4] Additional research has shown[5]:

- 185 counties in Texas did not have a single licensed psychiatrist
- 149 counties in Texas did not have a single licensed psychologist
- 40 counties in Texas did not have a single licensed social worker

Without a comprehensive plan to increase access and availability of mental health services, workforce shortages in Texas will likely persist.

Mental Health Workforce Solutions

To address workforce shortages, NAMI Texas recommends policies that improve mental health system capacity, mental health services coverage, and integration of mental health and law enforcement.

Mental Health System Capacity:

Peer Support / Family Partner Services / Family and Peer Education + Support Groups—Peer Support Specialists utilize lived experience to provide non-clinical services that promote shared understanding, respect, and mutual empowerment with those they serve.[6] Recipients of peer support experience increased social networks and improved mental health outcomes.[7] Similarly, family partner support services have been shown to improve social support and guidance to parents and caregivers of children

[3] Health Resources & Services Administration. (2019). *Behavioral Health Workforce Projections, 2017-2030*. Retrieved from https://bhw.hrsa.gov/health-workforce-analysis/research/projections/behavioral-health-workforce-projections
[4] U.S. Department of Health and Human Services, Health Resources and Services Administration. (2015). Health Professional Shortage Area Data Download. Retrieved from http://datawarehouse.hrsa.gov/data/datadownload/hpsaDownload.aspx
[5] The Hogg Foundation. (2016). *The Texas Mental Health Workforce: Continuing Challenges and Sensible Strategies.* Retrieved from <https://hogg.utexas.edu/wp-content/uploads/2016/07/2016_policybrief_workforce.pdf>
[6] Substance Abuse and Mental Health Services Administration. (2018). *Core Competencies for Peer Workers in Behavioral Health Services – 2018.* Retrieved from https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/core-competencies_508_12_13_18.pdf
[7] Walker, G., & Bryant, W. (2013). Peer support in adult mental health services: A meta-synthesis of qualitative findings. *Psychiatric Rehabilitation Journal, 36*(1), 28–34

and adolescents living with mental illness.[8] Greater emphasis should be placed on the integration of Peer Support Specialists and Family Partners into clinical and non-clinical settings to improve early identification of behaviors associated with an increased risk for mass violence. Policy options for better utilizing peer and family services include increasing the Medicaid reimbursement rate for Peer Support Services, establishing a Medicaid billing option for Family Partner, and providing direct funding for family and peer-led mental health education and support programs, such as NAMI's Family-to-Family, Peer-to-Peer, Connection, Basics, and Family Support Group.

Telehealth—Telehealth increases access and availability of mental health services to underserved populations and has been shown to be as effective in diagnosis and assessment as face-to-face interventions.[9] Telehealth can also promote treatment continuity for individuals living with underlying medical conditions that increase risk for severe illness from infectious exposure, such as COVID-19.[10] Secondary benefits include mitigation of risk to public health, reductions in healthcare system utilization, and the preservation of the healthcare workforce. Texas should make permanent the emergency exemptions for telehealth services in response to COVID-19, which create parity in reimbursement, expand allowable platforms for service delivery, and limit service documentation to that which is sufficient for in-person services.[11]

Mental Health Information Disclosures—Family members are valuable supports in the recovery of individuals with mental or behavioral health concerns. For individuals with serious mental health diagnosis, such as schizophrenia, bipolar disorder, and major depression, family members can also serve as valuable sources of information on the efficacy of current or previous treatment interventions. Unfortunately, Texas statute can hinder mental health providers in providing family members relevant and helpful information. Texas should empower family members to participate in the treatment and recovery process by aligning mental health disclosure laws with HIPAA federal guidance to reduce barriers in accessing information.

In cases where a person poses a risk of harm to themselves or others, Texas should consider amending Health and Safety Code 611.004 to explicitly permit disclosure of information to mental health professionals, family members, and others who can mitigate the risk (see HB 461 and HB 3519 from 86R).

APRN Full Practice Authority—Access to comprehensive care can be difficult for rural or underserved communities. Advanced Practice Registered Nurses (APRNs) make up the fastest-growing segment of healthcare providers in the United States.[12] However, restrictions in scope-of-practice limit the quality and quantity of care APRNs can provide to communities most in need. Research demonstrates that granting full practice authority to Advanced Practice Registered Nurses (APRN) will likely increase access to healthcare services, including mental and behavioral healthcare, and may improve quality of care without an associated cost increase.

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[8] Substance Abuse and Mental Health Services Administration. (2017). *Family, Parent and Caregiver Peer Support in Behavioral Health.* Retrieved from <https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/family-parent-caregiver-support-behavioral-health-2017.pdf>

[9] Hilty, D., Ferrer, D., Parish, M., Johnston, B., Callahan, E., & Yellowlees, P. (2013). The effectiveness of telemental health: A 2013 review. *Telemedicine Journal and e-Health, 19(6),* 444-454

[10] Centers for Disease Control and Prevention. (2020, June 10). *Using Telehealth to Expand Access to Essential Health Services during the COVID-19 Pandemic.* Retrieved from <https://www.cdc.gov/coronavirus/2019-ncov/hcp/telehealth.html>

[11] Texas Department of Insurance. (2020, July 8). *Telemedicine Emergency Rule.* Retrieved from <https://www.tdi.texas.gov/news/2020/ telemedicine-emergency-rule.html#:~:text=Under%20the%20emergency%20rule%2C%20state,including%20covered%20mental% 20health%20services>

[12] Martsolf, G., Auerback, D., & Arifkhanova, A. (2015). The impact of full practice authority for Nurse Practitioners and other advanced practice Registered Nurses in Ohio. *Rand Corporation*

Mental Health Services Coverage:

Student Loan Forgiveness—Clinical mental health licensure often requires completion of an accredited graduate or doctoral program. The cost of obtaining an advanced degree in conjunction with low compensation rates can discourage students from seeking the knowledge and skills needed to apply evidence-based mental health modalities. Mental health student loan repayment programs, such as those administered by the Texas Higher Education Coordinating Board (THECB), can incentivize students to complete the required study and training to better assess and mitigate risk of behaviors associated with mass violence. The relatively small appropriation for the THECB program should be increased, given that in past cycles THECB has received more eligible applications for some professions than they were permitted to award.[13] An increase in the supply of licensed mental health providers will improve access and distribution of the mental health workforce to underserved communities.

Health Care Coverage—Texas has the highest uninsured rate in the nation and the rate is projected to increase due to factors associated with COVID-19.[14,15] In order to reduce coverage gaps, Texas should open up Medicaid eligibility to low-income adults and ensure adequate coverage for vulnerable communities by providing adequate funding, ensuring proper oversight, and improving support services for enrollees and providers. To date, 38 states have adopted this form of expansion of Medicaid eligibility, with Oklahoma and Missouri being the two most recent states. Additionally, Texas should mandate commercial health plans to provide robust coverage for mental health services as well as continuity of coverage and oversight for medication. This includes the passage of HB 501 (86R), relating to the requirement and study of insurance coverage for serious emotional disturbance of a child.

Coverage Parity— As required by HB 10 (86R), insurance treatment limitations on mental and behavioral health services should be comparable to and no more stringent than insurance treatment limitations on medical and surgical services. Despite HB 10 requirements, individuals with mental health conditions continue to suffer from disparate application of treatment limitations by insurance plans.[16] Ensuring parity in health plans will improve treatment outcomes, reduce costs associated with proper service utilization, and promote greater access to and availability of mental health and substance use services. Furthermore, it will better support and cultivate the mental health workforce. To enforce parity, HHSC and TDI should:

- develop and maintain standardized compliance tools that align with best practices to evaluate parity compliance with all products. The compliance tools adopted should align with those recommended by the HB 10 Parity Workgroup at HHSC.
- require commercial plans and to complete a parity analysis using the standardized tool and submit to the appropriate regulatory authority.
- Empower regulators to identify any parity compliance violation, require corrective action, and deter future violations.

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[13] https://www.texasstateofmind.org/wp-content/uploads/2017/05/MMHPI_PolicyBrief_SB239_LoanRepaymentProgram_FINAL05022017.pdf

[14] United States Census Bureau. (2019). *Health Insurance Coverage in the United States: 2018.* Retrieved from <https://www.census.gov/library/publications/2019/demo/p60-267.html>

[15] Garfield, R., Claxton, G., Damico, A., & Levitt, L. (2020). Eligibility for ACA health coverage following job loss. *Kaiser Family Foundation.* Retrieved from <https://www.kff.org/report-section/eligibility-for-aca-health-coverage-following-job-loss-appendix/>

[16] Texas Department of Insurance. (2018). < Study of Mental Health Parity to Better Understand Consumer Experiences with Accessing Care> Retrieved from <https://www.tdi.texas.gov/reports/documents/Final-draft-HB-10-report-8.31.18.pdf>

Collaborative Care Model—Primary care providers are often the first to identify mental health concerns. Implementing a Collaborative Care Model that incorporates mental health services into primary care can help providers identify behaviors associated with an increased risk for mass violence and suicide. A 2020 report by the Meadows Mental Health Policy Institute projects that universal access to collaborative care to treat major depression could reduce the number of suicide deaths by between 725 and 1,100 deaths per year in Texas. Texas should prioritize integrated health care programs by establishing a Medicaid billing code for collaborative care and promote integration as a value-based care outcome metric or incentive strategy for Medicaid Managed Care.

Coordinated Specialty Care—First Episode Psychosis (FEP) impacts the health and wellbeing of approximately 3,000 Texas children and young adults each year. Coordinated Specialty Care (CSC) is the best practice in FEP treatment, providing team-based, multi-disciplinary approach that promotes patient-choice and shared decision making. Unfortunately, limited access and availability of CSC may delay the receipt of services, worsen mental health outcomes, and jeopardize quality of life and achievement. Only approximately 20% of the needed CSC capacity in available in Texas. Texas should invest additional resources to increase CSC program capacity (only 24 of 39 Local Mental Health Authorities have these programs) as well as mandate commercial health plans and insurers to adequately reimburse all CSC disciplines either individually or as a service package. NAMI Texas can provide bill language that would requirement commercial health plans and insurers to cover the elements of CSC.

Integrated Mental Health and Law Enforcement:

Integrated Crisis Response Teams—Law enforcement is often called to assist individuals experiencing a mental health crisis. Unfortunately, police officers often lack the specialized training, resources, and community connections to effectively implement or incorporate evidence-based crisis interventions. Integrated crisis response teams comprised of police officers, mental health professionals, and paramedics have been shown to be effective de-escalating crisis situations, diverting individuals with mental health disorders from the criminal justice system, and connecting individuals with mental health concerns to the appropriate community resources.[17] NAMI Texas supports initiatives that promote greater integration between clinical mental health services and criminal justice.

Emergency Detention Warrants—Texas law currently allows physicians to submit application for emergency detention warrant when a person in their care is experiencing a mental health crisis and presents as an imminent risk to themselves or others. Unfortunately, a physician may not always be available at the time when such a warrant is needed. Consequently, individuals experiencing a mental health crisis may not receive adequate care, which may lead to subsequent interactions with law enforcement or additional utilization of emergency medical services. Granting authorization to licensed professionals with advanced mental health training and education may improve treatment outcomes for individuals experiencing a mental health crisis, reduce utilization of law enforcement in crisis situations, and decrease reliance on emergency medical services. Texas should expand Health and Safety Code section 573.012 to provide physician's assistants, nurse practitioners, psychologists, and certain master's-level mental health professional counselors or social workers the ability to submit applications for emergency detention warrants.

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[17] Lovitt, Matthew. (2020). *Integrated Crisis Response Teams to Improve Mental Health Outcomes in the Community.* Retrieved from <https://3394qh4fg22b3jpwm94480xg-wpengine.netdna-ssl.com/wp-content/uploads/sites/12/2020/07/NAMI-Texas-Integrated-Crisis-Response-Teams-Policy-Position.pdf>

Jail Diversion—Approximately 40% of prisoners and jail inmates have experienced mental illness.[18] The physical and psychological consequences of imprisonment often worsen mental health, prolong sentences, and increase rates of homelessness, emergency service utilization, substance use, and recidivism.[19] The cumulative effect is to transform the criminal justice system into the primary provider of mental health services in Texas. Jail diversion and reentry programs for individuals with mental health disorders can improve engagement in mental health services, reduce criminal justice involvement, and decrease rates of crisis or emergency service utilization.[20]

Regarding Active Shooter Drills

With respect to Representative Blanco's questions regarding active shooter drills, we would like to quote Dr. Laurel Williams, Chief of Psychiatry at Texas Children's Hospital in Houston. Dr. Williams said, "*It's psychologically distressing for a young child to practice active shooters coming into your area. It's not clear to them that the drill is not real. The younger the child, the less likely they are to understand that an act of violence is not occurring during a drill. If you're constantly given the viewpoint that the world is scary and unpreventable things happen, it pervasively makes us less secure as a society. We see everyone as suspicious, and it changes the way we act around people*."

School staff should be provided with trauma-informed training on how to respond to school shootings. We do not recommend that students be included in these trainings/drills. However, if students are included in these trainings/drills, we advise that the trainings/drills be required to align with Best Practice Considerations for Schools in Active Shooter and Other Armed Assailant Drills, as promulgated by the National Association of School Psychologists and the National Association of School Resource Officers.[21]

Conclusion

Numerous social, emotional, and psychological factors can increase mass violence risk. To better address these factors, NAMI Texas recommends policies that focus on enhancing risk assessment and mitigation, by remedying workforce shortages that compromise the delivery of healthcare services. Improving mental health system capacity, increasing mental health services coverage, and integrating mental health services with law enforcement can help to improve the quality of care provided to those most in need.

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[18] Bureau of Justice Statistics. (2017). *Indicators of Mental Health Problems Reported by Prisoners and Jail Inmates, 2011-12.* Retrieved from <https://www.bjs.gov/content/pub/pdf/imhprpji1112_sum.pdf>

[19] Zgoba, K., Reeves, R., Tamburello, A., & Debilio, L. (2020). Criminal recidivism in inmates with mental illness and substance use disorders. *The Journal of the American Academy of Psychiatry and the Law Online, 48(2)*. Retrieved from <http://jaapl.org/content/early/2020/02/12/JAAPL.003913-20>

[20] Meadows Mental Health Policy Institute. (2016, February 10). *Texas Mental Health Landscape – Brief Overview*. Retrieved from <https://www.texasstateofmind.org/wp-content/uploads/2016/02/Brief-Overview-of-Landscape.pdf>

[21] National Association of School Psychologists and National Association of School Resources Officers. Best Practice Considerations for Schools in Active Shooter and Other Armed Assailant Drills. Retrieved from < https://www.nasponline.org/resources-and-publications/resources-and-podcasts/school-climate-safety-and-crisis/systems-level-prevention/best-practice-considerations-for-schools-in-active-shooter-and-other-armed-assailant-drills>