UTHealth
The University of Texas
Health Science Center at Houston

McGovern
Medical School

Louis A. Faillace, MD, Department of Psychiatry
And Behavioral Sciences
Trauma and Resilience Center

September 30, 2021

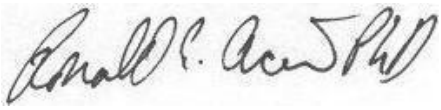
FROM: Ron Acierno, PhD, Director, UTHealth Houston Trauma and Resilience Center
TO: Commissioner Garcia, Harris County Precinct 2
RE: TRC Mental Health Services for Domestic Violence Victims and First Responders Affected by COVID19

Dear Commissioner Garcia,

Please find attached our proposal to offer best practice evidence-based psychotherapy to victims of Domestic Violence and First Responders, both groups have been disproportionately and negatively affected by the COVID19 pandemic, as is evident from the attached document. Please do not hesitate to call me with any questions or Mary Lopez, 713-486-2552 mary.lopez@uth.tmc.edu, Business Manager for the Department of Psychiatry, within which the TRC is located.

Thank you so much for your time,

Ron A.



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UTHealth Trauma and Resilience Center: PROPOSAL

Addressing COVID-19 Mental Health Needs and Requests for Direct Service Resources for (1) Un-and Under-Insured Domestic Violence Survivors, (2) First Responders (Police, Fire, EMT, Emergency Department)

The Trauma and Resilience Center (TRC) at UTHealth provides exclusively gold standard, evidence-based psychotherapy via home-based telemedicine (since before the pandemic, so as to address barriers to accessing care in our lower income populations) to survivors of trauma and extreme stress events. As such, we have become a local resource for both patients and providers seeking services that their existing employee assistance programs or general counselors cannot or do not provide. In a word, TRC sees the worst of the worst trauma related cases, and has created specialty tracks and funding for Veterans and their families, Elder Abuse, and First Responders (funding ending October 1). We also have specialty tracks (unfunded…creating a major equity problem) for family and domestic violence. We are trying to establish funding for this last group of domestic and family violence survivors, and to re-establish funding for first responders because the need is so great and exacerbated by COVID19 stresses (see below for data summary). In fact, in the past year, requests for TRC services have increased over 300%, exacerbated by COVID-19 related impacts.

COVID-19 related stressors have impacted the mental health of 2 major categories of patients requesting services from the UTHealth Trauma and Resilience Center: 1) **Victims of Family/Domestic violence**, particularly from lower income families who are un/under-insured; 2) **First Responders**, who are tasked to deal with an array of COVID-related impacts (police, fire, EMT and Emergency Department staff).

Considering the first category of family/domestic violence, since the beginning of the pandemic, fears about intensification of this problem have been raised (see Anurudran et al., 2020; Bradbury-Jones & Isham, 2020). Unfortunately, these fears have been justified, particularly among groups traditionally affected by health inequity (un and under insured, racial and ethnic minorities). A recently published meta-analysis by Piquero et al (2021) covering 18 studies and 37 epidemiological estimates showed a significant worldwide increase in domestic violence secondary to the pandemic, **with greatest increases observed in US studies (17-37% increases).**

Considering the second category of First Responders, a local, nationally recognized researcher, Anka Vujanovic (Vujanovic et al., 2021) recently completed a study of the impact of COVID-19 on first responder mental health and found significant negative effects. Specifically, she found increased alcohol use severity, increased anxiety (including PTSD) and increased depression among those dealing with COVID cases. Similarly, Shekhar (2021) found alarming mental health problems in EMS providers due to COVID stress to the extent that it was labelled a ‘pandemic within a pandemic’. Fully 70.9% of EMT’s surveyed reported that their mental health was either slightly or significantly worse than compared to non-pandemic times. Fully 33% were considering changing careers specifically due to the pandemic. This is a frightening statistic, given the difficulty in rapidly recruiting and training EMS staff. Considering Emergency Department staff: a study in Colorado

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(Wright et al, 2021) showed up to 30% of emergency and hospital personnel (N = 571) screened positive for mental health problems (traumatic stress, depression, anxiety, alcohol use, insomnia) in association with pandemic-related stressors. Emergency department and ICU personnel were similar except the emergency dept staffers reported even higher levels of sleep issues. Importantly, these rates are **consistent with rates shown after 9/11 and Katrina** (and worse than rates related to previous outbreaks of viruses like SARS). Indeed, Preti et al (2020) conducted a metaanalysis across studies and showed that direct contact with COVID-affected patients was a significant risk factor for all mental health outcomes.

Given these COVID related impacts on these groups, all of which are represented by significant minority populations in the Houston area, and the first of which (Family/Domestic Violence is represented by over 70% minority populations, resources and funding are needed. However, standard 'counseling' programs offering information and supportive counseling are ineffective in treating severe stress reactions (PTSD, Depression, Panic) in response to traumatic events such as those currently experienced. Moreover, many First Responders do not choose to receive counseling from 'in house' or work-connected or work insured programs, fearing limits to confidentiality.

As such, support is specifically needed for trauma focused, evidence informed protocol based, best practices interventions, such as that offered by the UTHealth Trauma and Resilience Center. This Center is a resource in the area for community partners who have patients with trauma histories and symptoms that exceed their capacity to serve. Our mission is to serve those most in need, and that is the un-/underinsured and patients experience even greater disequity in care and resources during the pandemic. Unfortunately, funding for services for these groups is limited.

See following page for request and performance metrics

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REQUEST 1: $200,000 per year

Use of additional funds would include

1. Covering costs of Direct service provision of best practices, evidence-based psychotherapy to victims of COVID19 related trauma impacts outlined above to domestic violence victims and First Responders.

We have no other requests. The TRC infrastructure is already in place and paid for (front desk, scheduling, administration, clinical supervision, evidence-based assessment automated system, staff training) and Dr. Acierno will donate his time to supervise the program. Note, these funds would be put to immediate use, there is NO startup delay. Services will begin immediately. Funds will not be directed to anything other than supporting direct service, and would be focused on un and under insured populations.

Performance Metrics:

1. **Technical Performance** refers to the 'products and deliverables' offered in response to funding. In this case, these relate to providing best practices, behaviorally focused psychotherapy to survivors of domestic violence and to First Responders.
   Anticipated Volume of Service: Several levels of service:
   *telephone-based information and referral (**1,750 new patient**s minimum);
   *televideo/in person intake and full psychological assessment in preparation for treatment: (**360 new patients**)
   *treatment initiation (**300 unduplicated**)
   *treatment sessions: each course of treatment is 12-25 weeks per patient. About 65% of the 320 will complete 10-15 weeks of treatment. This conservatively translates to: 300 patients x 10 weeks of treatment sessions x .65 = **2,000 treatment sessions per year.** At the current UTHealth rate, this would cost over $400,000. This program would be discounting costs by half, more or less, as all administrative, support, and infrastructure are being covered by UT in order to get the services to the community.

   Technical Performance will be Evidenced by quarterly Report of:
   a. Number of overall patients given information and referral information each quarter. Specifically, we will report the number of telephone and in person requests for information regarding mental health, mental health services, community options for these services, and general mental health inquires by domestic violence victims and first responders. These groups are often hesitant to begin formal psychotherapy, and these initial contacts are essential to building trust.
   b. Number of overall patients receiving best practices, protocol-based psychotherapy services each quarter. Each quarter, both existing and new patients will receive evidence-based psychotherapy for PTSD, Depression, Anxiety, and Substance Abuse. Protocol therapies include Prolonged Exposure Therapy for PTSD, Cognitive Processing Therapy for PTSD, Written Exposure Therapy for PTSD, Behavioral Activation for Depression, Cognitive Behavior Therapy for Pain, Cognitive Behavior Therapy for Insomnia, Stimulus Control Therapy for Substance Abuse, In Vivo Exposure Therapy for anxiety. Note: TRC staff have already been trained in all of these best practices, evidence-based psychotherapies.

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c. Number of new patients seen each quarter. In addition to the overall number of patients seen, the number of patients beginning therapy in each quarter will be reported, to give an idea of program reach.
d. Number of hours of clinical services delivered each quarter overall. Another metric of program impact and reach is the actual number of hours of therapy delivered. Many programs focus on information and referral, which takes only minutes per client. However, evidence-based psychotherapy ranges from 12-15 sessions over a corresponding number of weeks, and this information will also be reported.
*NOTE: Community need is simply too great to give unlimited sessions to any one person. Specifically, TRC provides only evidence-based treatment, which are 10 to 15 sessions per disorder. Therefore, a person with depression, PTSD, and insomnia will have 20-30 sessions.

2. **Financial Performance** in this present project refers to expenditure of funds in the context of service delivery. TRC existing infrastructure costs will be absorbed by the Department of Psychiatry, and include office space, front desk and scheduling staff, the computerized assessment system for patient symptoms, telemedicine equipment, intake staffing, and telephone contacts. Funds provided for this project, therefore, will only be used to pay for the counseling services for victims of domestic violence and for First Responders at the current UTHealth rates.
Financial Performance Will be Evidenced by Report of:
    a. quarterly expenditures for direct services to victims of domestic violence and to First Responders.
3. **Client/Patient Level Performance Measures: Satisfaction and Improvement**. Client / Patient level performance metrics refer to how satisfied those served by the program are with services (e.g., psychotherapy) and processes (eg, wait times) they receive or experience while receiving TRC services. Thus, in addition to the standard technical performance metrics focusing on numbers served, TRC also reports on patient level performance data illustrating patient experiences, and symptom improvement.
Client/Patient Level Performance Measures of Satisfaction and Improvement Will be Evidenced by Report of:
    a. Average improvement and score ranges across patients on PTSD scores from initial to final treatment session using the PTSD Clinical Scale (PCL), the gold standard treatment outcome measure for PTSD
    b. Average improvement and score ranges across patients on Depression scores from initial to final treatment session using the Public Health Questionnaire – 9, the gold standard treatment outcome measure for depression
    c. Average improvement and score ranges across patients in Sleep, Generalized Anxiety, Pain, and Substance abuse will be measured using the Pittsburgh Sleep Index, the GAD7, the NIH Pain Interference and Intensity Scales, and the AUDIT, respectively. Note, these measures will be used as appropriate to patient diagnosis (whereas all patients will receive PTSD and Depression assessment, only patients evincing sleep problems will receive sleep assessment, etc.)
    d. Average Process Satisfaction (e.g., Wait times, telemedicine convenience or technical problems). Satisfaction with treatment processes will be measured using the Charleston Outpatient Satisfaction Scale (CPOSS) developed specifically for outpatient psychotherapy settings
    e. Average Overall Satisfaction. Overall satisfaction with TRC psychotherapy, providers, convenience, and specific components of treatment will also be

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measured using the CPOSS, developed for this purpose. Each patient will complete this measure at the end of treatment, and average scores, along with ranges from low to high will be reported.

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