Geographic Availability of Substance Use Disorder Treatment for Veterans

The Need for Data-Driven Solutions

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Chairman Tester, Ranking Member Moran, and members of the committee, I want to thank you for your invitation to testify today on what is a pressing and urgent public health problem. My name is Dr. Jonathan Cantor. I am a policy researcher at the RAND Corporation. My training is in health policy research, and I have conducted extensive research on the geographic availability and accessibility of substance use disorder (SUD) treatment for veterans, military service members, and the civilian population.

During my almost seven-year career as a RAND researcher, I have sought to develop and improve the quality of metrics to measure and track the geographic availability of SUD treatment—both where treatment is located and whether those in need can actually access this care. I have examined the marketplace of SUD care provided by the U.S. Department of Veterans Affairs (VA) and non-VA providers. In 2018, I was a task lead for a study that calculated novel measures of geographic accessibility of SUD treatment for a national sample of

1 The opinions and conclusions expressed in this testimony are the author’s alone and should not be interpreted as representing those of the RAND Corporation or any of the sponsors of its research.

2 The RAND Corporation is a research organization that develops solutions to public policy challenges to help make communities throughout the world safer and more secure, healthier and more prosperous. RAND is nonprofit, nonpartisan, and committed to the public interest. RAND’s mission is enabled through its core values of quality and objectivity and its commitment to integrity and ethical behavior. RAND subjects its research publications to a robust and exacting quality-assurance process; avoids financial and other conflicts of interest through staff training, project screening, and a policy of mandatory disclosure; and pursues transparency through the open publication of research findings and recommendations, disclosure of the source of funding of published research, and policies to ensure intellectual independence. This testimony is not a research publication, but witnesses affiliated with RAND routinely draw on relevant research conducted in the organization.

3 According to Catherine McLaughlin and Leon Wyszewianski, “Availability measures the extent to which the provider has the requisite resources, such as personnel and technology, to meet the needs of the client. Accessibility refers to geographic accessibility, which is determined by how easily the client can physically reach the provider’s location” (Catherine G. McLaughlin and Leon Wyszewianski, “Access to Care: Remembering Old Lessons,” Health Services Research, Vol. 37, No. 6, December 2002, p. 1441. Emphasis in original).
U.S. veterans.⁴ We found that, while many veterans lived within a 15-minute drive of an SUD treatment facility, most lived around an hour from a VA facility that provided specialized SUD treatment. While these data are useful, our research highlights significant challenges to accurately measuring the geographic availability and accessibility of SUD treatment. These challenges include an inability to access data on the total capacity of a facility, the services the facility offers for veterans particularly, the approximate wait time to the next appointment, and the quality of care received. Today, I will discuss how existing data limit our ability to comprehensively measure geographic availability of SUD treatment for veterans. I will also discuss how existing data inhibit our ability to calculate disparities in access based on where veterans live, as well as their personal attributes, such as sex, race, and ethnicity.

In this testimony, I will first discuss the complexity of SUD treatment for veterans given the frequent existence of co-occurring mental health problems. Second, I will provide a brief overview of the geographic accessibility of SUD treatment for veterans based on our research. Third, I will describe why it is difficult to assess disparities in the geographic accessibility of SUD treatment for veterans. Finally, I will recommend a few ways to improve data collection and reporting on providers to better understand the geographic availability and accessibility of treatment for SUD for veterans and ways it can be measured over time.

SUD Treatment for Veterans Is Complex Because of Co-Occurring Mental Health Problems

In 2020, around 12 percent of veterans 18 years of age or older had an SUD, according to the National Survey on Drug Use and Health.⁵ Approximately 1.1 million veterans suffered from both an SUD and a mental illness.⁶ Most individuals who present with a co-occurring mental health problem and an SUD do not receive treatment for either condition.⁷ There are many possible contributors to this treatment gap. For example, addiction counselors lack awareness of mental health conditions and lack training on how to treat co-occurring disorders.⁸ Other possible

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⁶ Substance Abuse and Mental Health Services Administration, 2022.


⁸ Substance Abuse and Mental Health Services Administration, *Substance Use Disorder Treatment for People with Co-Occurring Disorders*, Treatment Improvement Protocol (TIP) 42, SAMHSA Publication PEP20-02-01-004, March 2020.
reasons for this treatment gap include personnel shortages and workforce burnout.9 Burnout among mental health staff compromises the quality of the patient-provider relationship and has led many to leave the workforce.10 In short, veterans may have more-complex requirements than nonveterans when seeking treatment for SUD, and they may seek treatment in the context of a more constrained workforce with limited expertise or capacity to provide them with effective care for their specific needs.

There are a multitude of other reasons why a veteran with an SUD would not receive the necessary care. First, some veterans who use substances do so to self-medicate their posttraumatic stress disorder (PTSD) symptoms.11 These veterans may be hesitant to seek treatment because of their treatment providers’ policies. For example, some behavioral health treatment programs will not accept a patient unless the patient is abstinent from substances for a certain period of time.12 Second, many veterans fear seeking mental health or SUD treatment because it could negatively affect their career advancement.13 In qualitative interviews, a sample of veterans told researchers that they find it difficult to balance their recovery, which would benefit from treatment, with vocational goals that may require that they disclose that they are receiving such care.14 Third, co-occurring disorders often go unidentified. A practitioner may identify an SUD or a mental health disorder but not necessarily both.15 Finally, the appropriate treatment for an individual with an SUD and a co-occurring mental health disorder is more complex than treating one or the other alone. Many treatment facilities that specialize in either mental health or SUDs are not equipped to address the needs of veterans with co-occurring disorders. There are not enough opportunities for formal training in the treatment of co-occurring disorders.

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10 Committee to Evaluate the Department of Veterans Affairs Mental Health Services, National Academies of Sciences, Engineering, and Medicine, “Mental Health Workforce and Facilities Infrastructure,” in Evaluation of the Department of Veterans Affairs Mental Health Services, National Academies Press, 2018.
disorders; thus, there are a limited number of providers able to provide evidence-based care for co-occurring disorders. This could be particularly pronounced in areas of the country with a dearth of behavioral health care providers—called Mental Health Professional Shortage Areas.

Fortunately, the Veterans Health Administration (VHA) appears to be addressing this problem. According to the 2018 National Mental Health Services Survey, more than half—around 56 percent—of VA medical centers (VAMCs) had a specialized treatment program for co-occurring disorders. More-recent data indicate that this percentage has been increasing.

Geographic Access to SUD Treatment Is Difficult to Measure with Existing Data Resources

Recent national research found that less than 10 percent of veterans with an SUD in 2020 received any treatment. A key determinant for whether an individual receives SUD treatment is how far they have to travel for care. To date, there have been few studies that have examined distance to SUD treatment (geographic accessibility) as a barrier to care for a national sample of veterans. A study of 266,301 female veterans who received any care from VHA in 2009 found that the longer the drive time to a provider, the less likely the veteran received outpatient care in the following two years. Distance also predicts whether veterans obtain step-down aftercare, which is incredibly important for achieving long-term treatment success, after discharge from inpatient SUD treatment. Less than half of patients who received inpatient SUD treatment and lived more than 25 miles from their nearest outpatient mental health care facility received any follow-up care.

Under the Maintaining Internal Systems and Strengthening Integrated Outside Networks Act (MISSION Act) of 2018, VA established an access standard of a 60-minute drive time for specialty care, including SUD treatment. In 2019, the Wounded Warrior Project (WWP) partnered with RAND researchers to understand geographic accessibility of co-occurring mental

18 Substance Abuse and Mental Health Services Administration, 2022.
We used two national databases to assess geographic accessibility of mental health and SUD treatment facilities nationwide. We linked these data with two different sets of data from the WWP, which included information on WWP alumni veterans’ zip codes of residence. Our calculations indicated that, on average, WWP alumni lived 12 minutes from a mental health facility that had a co-occurring SUD program and 11 minutes from the nearest SUD treatment facility that had a co-occurring mental health program. For these veterans, the closest VAMCs or VA-affiliated facilities that provided treatment for co-occurring mental health disorders and SUDs were, on average, 57.0 and 66.3 minutes from where the veterans lived, “for mental health and substance use treatment facilities, respectively.”

Our results were encouraging: Most WWP alumni veterans were able to access treatment programs for co-occurring mental health conditions and SUDs within the 60-minute drive time standard.

One major limitation of this line of research is that while a facility may be within a 60-minute drive time, it may not be able to accept the veteran as a patient. Our study did not incorporate measures of treatment capacity or wait times. Currently, there is no national database that includes these measures for all VA and non-VA facilities that provide SUD treatment. A second limitation of this work is that a veteran’s zip code is a pretty broad indicator of where the veteran lives, and our estimates would be more accurate if we used veterans’ specific addresses. Finally, our study was based on a sample of WWP alumni veterans, and whether these findings hold for all veterans is unknown.

Disparities Are Also Difficult to Measure Using Existing Data Resources

Figures 1 and 2 are heat maps that demonstrate the large variability in geographic accessibility of mental health and SUD treatment facilities with specialized treatment programs for co-occurring disorders and WWP alumni. Areas in white are zip codes that lack one of these facilities within a 60-minute drive time from the veteran’s zip code. The maps show that VAMCs and VA-affiliated facilities tend to be located in areas of the country with the largest number of non-VA facilities that serve veterans (as shown by the darker blue shading). In other words, facilities that serve veterans, be they VA or non-VA, cluster together. However, additional analyses by our research team indicated that, if we were to remove the VAMCs and VA-affiliated facilities from the maps, there would be less geographic accessibility for veterans to receive treatment, highlighting the critical role that VA plays in substance use treatment for veterans.

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23 Pedersen et al., 2020.
24 Pedersen et al., 2020, p. 74.
Figure 1. SUD Treatment Facilities with a Specialized Co-Occurring Disorders Program and a Specialized Treatment Program for Veterans

NOTES: Darker blue shading indicates increasing availability of facilities within a 60-minute drive time from the centroid of 2019 WWP Alumni Survey respondents' three-digit zip codes. White areas had no facilities within a 60-minute drive time. Areas with a hatch pattern had no survey respondents residing in them. Core-based statistical areas (CBSAs) with 200,000 or more veteran residents, according to the VetPop data, are labeled on the map, with the lines pointing to the CBSAs' centroids.

SOURCE: Reproduced from Pedersen et al., 2020.
Almost one-quarter of U.S. veterans reside in rural communities. There is a concern that it is more difficult for rural veterans to receive care given that they must travel farther than veterans who live in urban areas. Treatment services in rural areas have challenges that include a shortage of specialized providers and a lack of accessible public transportation. In one study of 15 VHA primary care clinics in eight Midwestern states, distance was listed as a significant barrier for rural veterans seeking health care. And the effect of distance can be compounded by other factors, such as a veteran’s health status, functional impairment, travel cost, and work or family obligations. In 2019, the U.S. Government Accountability Office examined whether there was a disparity in SUD treatment utilization based on whether the veteran resided in an urban or a rural locality. The study found that veterans in urban and rural localities used VA SUD treatment services at a similar rate. Thus, while there is a concern that there is a geographic disparity in health care access between rural and urban veterans, this disparity does


not appear to affect utilization rates for SUD treatment. But more work is needed to confirm this result.

The geographic accessibility of SUD care could also vary based on the sociodemographic characteristics of veterans. For example, women veterans, racial or ethnic minority veterans, or older veterans may disproportionately live in areas with fewer SUD facilities. Our study did not focus on these potential disparities. There are extensive data challenges in quantifying these differences. Such analyses would require detailed data on the addresses, or at least zip codes, of veterans, as well as data on their race/ethnicity, age, and gender. Finally, and perhaps most challenging, the data would need to include whether the veterans suffered from SUDs only or SUDs and mental health problems.

Recommendations

Drawing on my research and existing work, I have several recommendations. Each recommendation pertains to the relative dearth of detailed data that we have on providers or patients. For providers, it would be important for VA to consider updating its SUD programs website to include additional details on the specific types of SUD treatment that a particular facility provides. The existing information includes locations, names, addresses, and phone numbers of existing services, but it may be difficult for a veteran to identify the provider that best serves their unique needs. Veterans would benefit from knowing the types of services provided or the specific substances that the facility offers treatment for. Similarly, there is no listing of wait times or capacity for treatment that VA keeps detailed information for. Pieces of this information are included on other portions of the VA website, but it would be useful to have all the data integrated into one location.

VA’s SUD programs website refers individuals to the Substance Abuse and Mental Health Services Administration’s (SAMHSA’s) Behavioral Health Treatment Services Locator for treatment outside VA. This locator has historically been based on annual surveys of both mental health and SUD treatment facilities to understand the availability of treatment resources and to help patients identify a provider. (The surveys have since been combined into one.) SAMHSA could consider asking treatment facilities additional specific questions in its annual survey of providers that informs the locator. One approach would be to ask whether specific treatment approaches are available for veterans. Currently, the survey asks about the types of specialized treatment programs that are present at the responding facility. However, the questionnaire does not ask what treatment approaches are used within those programs. Using

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31 Substance Abuse and Mental Health Services Administration, Behavioral Health Services Locator, web resource, undated, www.samhsa.gov/resource/dbhis/behavioral-health-treatment-services-locator. See also Substance Abuse and Mental Health Services Administration, FindTreatment.gov, homepage, undated, findtreatment.gov.
2019 SAMHSA data, we identified 3,782 mental health treatment facilities that contained both a specialized treatment program for veterans and specialized treatment for PTSD and co-occurring disorders. Similarly, we found that there were 5,484 SUD treatment facilities that offered a specialized treatment program for veterans and specialized treatment for trauma and co-occurring disorders. However, SAMHSA’s data do not describe what the specialized treatment programs for each of these facilities entail. The most recent iteration of the National Substance Use and Mental Health Services Survey, the survey that the locator is based on, has supplementary questionnaires for substance use VA facilities and mental health VA facilities on specific treatment approaches related to suicide. This could be one model to use for asking more-detailed questions on treatments for co-occurring disorders. Separately, one recent audit study of the Behavioral Health Treatment Services Locator data asked targeted questions about residential treatment programs, including questions concerning the costs of services, average wait times, and travel-based inducements to receive treatment at the facility, such as car transportation. Many of these measures could be collected by SAMHSA in its annual survey or in audits of the responses of specific facilities in a given year. An eventual long-term goal should be to incorporate quality-of-care measures for these facilities.

A separate limitation of the SAMHSA Behavioral Health Treatment Services Locator data is that the information on the treatment services that the facility provides is outdated and not easily understandable by the user. Previous studies have found that contacting these providers and posing as a patient provides a more accurate measure of the payments accepted, treatments provided, and time to the next available appointment. Either SAMHSA or VA should consider conducting regular audit studies among non-VA facilities to get a more accurate understanding of the forms of treatment offered, approximate wait times to the next appointment, and total capacity of the facilities for SUD treatment.

Similarly, we lack information on disparities in geographic access to facilities based on sociodemographic characteristics of patients. Given that there may be differences in treatment approaches based on these characteristics, the audits should include calls to treatment facilities by individuals with different genders, races, and ethnicities.

Finally, it would be important for VA to consider alternative ways to expand treatment availability and accessibility of resources. Since the onset of the coronavirus disease 2019 (COVID-19) pandemic, there has been a rapid rise in the use of telehealth services. Preliminary work has shown that telehealth has increased treatment initiation for SUD in at least one VA

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32 Pedersen et al., 2020.
hospital outpatient alcohol and drug treatment clinic. While telehealth may increase retention for new and continuing opioid use disorder patients, it may do so differently based on characteristics of veterans. Research should continue to be conducted on the effectiveness of telehealth in the population of veterans with SUDs and co-occurring mental health problems to reduce geographic disparities.

Conclusion

Far too many Americans, and especially veterans, fail to receive treatment for SUD each year. I am confident that we can increase the number of veterans who receive treatment and prevent unnecessary drug overdose deaths, but that will require an infusion of funding to improve current data collection systems and ensure that veterans can access the information necessary to make treatment decisions. It will also require research on best practices for identifying high-quality providers that meet the needs of veterans. In my testimony today, I outlined several data limitations and how we might be able to address data gaps to understand the availability of SUD treatment resources for veterans. The lack of real-time measures on the capacity and wait times for both VA and non-VA providers for SUD treatment is a significant barrier that hinders our ability to monitor the availability of SUD treatment for veterans. Thank you for giving me the opportunity to speak on such an important issue, and I look forward to your questions.

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