National Association of State Mental Health Program Directors
66 Canal Center Plaza, Suite 302, Alexandria, VA 22314 (703) 739-9333 Fax (703) 548-9517

March 13, 2014

Hon. Tom Udall
U.S. Senate
110 Hart Senate Office Building
Washington, DC 20510

Re: S. 2009, Rural Veterans Improvement Act of 2013

Dear Senator Udall:

The National Association of State Mental Health Program Directors is writing to express its strong support for your legislation, S. 2009, the Rural Veterans Improvement Act of 2013, filed earlier this month.

NASMHPD is the only member organization representing the state executives responsible for the $37 billion public mental health service delivery system serving 7.2 million people annually in all 50 states, 4 territories, and the District of Columbia. NASMHPD operates under a cooperative agreement with the National Governors Association.

Of the more than two million service members deployed to Iraq or Afghanistan since September 2001, a February 2012 Congressional Budget Office report found that approximately 21 percent suffered from post-traumatic stress disorder (PTSD) on return from deployment, and an additional two percent returned with symptomatic traumatic brain injury; five percent suffered from both conditions.[1] The 2013 National Survey on Drug Use and Health found that 9.3 percent of veterans between the ages of 21 and 39 (312,000 persons) had experienced at least one major depressive episode in the previous year.[2]

The number of male veterans under the age of 30 who lost their lives to suicide jumped by 44 percent between 2009 and 2011, and suicide rates for female veterans increased by 11 percent, according to data released in February 2013 by the Department of Veterans Affairs (VA). The suicide rate among veterans was found by the VA to be well above that for the general population, as it has been since 2004, with an estimated 22 former servicemen and women dying by suicide every day in 2010.[3]

Research shows that returning veterans may go months if not years without obtaining mental health care, and when they do, their care is often fragmented. A study published in the September 2012 *Psychiatric Services* found that only 34 percent of returning soldiers with PTSD or other mental

Board of Directors

Michael Maples, L.P.C., L.M.F.T.
President
Texas

Scot L. Adams, Ph.D
Vice President
Nebraska

Lisa Clements, Ph.D.
Secretary
Colorado

Terri White, M.S.W.
Treasurer
Oklahoma

Kevin Huckshorn, Ph.D., R.N., M.S.N., C.A.D.C., I.C.R.C.
Past President
Delaware

Patricia Rehmer, M.S.N.
At-Large Member
Connecticut

Lynda Zeller
At-Large Member
Michigan

Tracy J. Plouck
Mid-Western Regional Representative
Ohio

Craig Stenning
Northeastern Regional Representative
Rhode Island

Doug Varney
Southern Regional Representative
Tennessee

Cory Nelson, M.P.A.
Western Regional Representative
Arizona

Robert W. Glover, Ph.D.
Executive Director
NASMHPD

DRAFT

health problems received treatment within their first three months stateside, and that percentage dropped to 27 percent among returning veterans between the ages of 40 and 70.[4] A separate February 2010 study of Iraq and Afghan war veterans who visited Veterans Affairs (VA) medical centers between 2001 and 2011 found that 51 percent had no mental health care visits in the year after receiving an initial mental health visit diagnosis, except in the case of diagnoses of PTSD. Non-PTSD diagnoses included depression, anxiety, adjustment disorder, alcohol use and substance use disorders, psychoses, and neurotic disorders. However, even among those diagnosed with PTSD, only about one-third received treatment from a VA mental health specialist and less than 10 percent attended the 9 or more sessions within 15 weeks of diagnosis recommended. Only 27 percent attended the recommended 9-session treatment regimen in the first year.[5]

The 2010 study found that living more than 25 miles from a VA facility was a strong correlate of not having received the recommended PTSD treatment regimen. The study noted that an earlier, 2008 study had championed increasing the number of mental health specialists in more rural community-based clinics, the goal of S. 2009. [6] When DoD and VA services are not readily available and acceptable, returning service members and their families may be forced to rely on a public behavioral health system that, as a result of more than $5 billion in budget cuts since the beginning of the recent recession, entails long waiting lists and limits on services. S. 2009 would serve to reduce the shifting of care and costs to the public health system.

S. 2009 address the difficulties veterans in rural and highly rural settings face in accessing crucial mental health services in a timely and effective manner by permitting veterans to access non-VA providers when personal or telehealth access to a VA provider is not possible, is impractical, or could be severely detrimental to the health of the veteran. In addition, the conditions under which a veteran would be eligible for services from a non-VA provider acknowledge and address the fact that far too often returning service members with behavioral health problems and their families become clients of the criminal justice system, family courts, child protective services, or unemployment services.

NASMHPD thanks you and your co-sponsors for your efforts in introducing this important legislation. NASMHPD believes that each of the provisions of S. 2009 constitutes an important step in building access for rural veterans to behavioral health services, including those provisions providing grants for transporting rural veterans to behavioral health services in community outpatient clinics, creating a pilot program to provide supplemental housing allowances to VA behavioral health care providers that accept assignment to rural and highly rural areas, incenting enlisted health care providers to accept employment with the VA on their discharge from active duty, and providing culturally competent training for providers in rural and highly rural areas.

If you should have further questions about NASMHPD's position on this legislation, please contact NASMHPD's Director of Policy and Health Care Reform, Stuart Gordon at stuart.gordon@nasmhpd.org or by telephone at 703-739-9333.

Thank you.

Sincerely

Robert W. Glover, Ph.D.
Executive Director

---

[1] The Veterans Health Administration's Treatment of PTSD and Traumatic Brain Injury Among Recent Combat Veterans, Pub. No. 4097, Congressional Budget Office, February 2012.

[2] http://www.samhsa.gov/data/2k8/veteransDepressed/veteransDepressed.htm.

[3] Suicide Data Report 2012, Department of Veterans Affairs, Mental Health Services, Suicide Prevention Program, February 2013, p. 15.

[4] Readjustment Stressors and Early Mental Health Treatment Seeking by Returning National Guard Soldiers with PTSD, Interian, A. et al, *Psychiatric Services,* September 2012, pp. 855-61 (2012).

[5] VA Mental Health Services Utilization in Iraq and Afghanistan Veterans in the First Year of Receiving New Mental Health Diagnoses, Seal, K. et al, *Journal of Traumatic Stress,* February 2010, pp. 5-16 (2010).

[6] Integration of Mental Health and Primary Care Services in the Department of Veterans Affairs Health Care System, Zeiss, A. & Karlin, B., *Journal of Clinical Psychology in Medical Settings,* pp.73-38 (2008).