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FOR AN OVERSIGHT AND LEGISLATIVE HEARING ENTITLED
"BRIDING THE GAP: ENHANCING OUTREACH
TO SUPPORT VETERANS' MENTAL HEALTH"
BEFORE THE
SENATE COMMITTEE ON VETERANS' AFFAIRS

TUESDAY, APRIL 29, 2025

Chairman Moran, Ranking Member Blumenthal, and Distinguished Committee Members,

Thank you for the opportunity to testify today on behalf of the Minority Veterans of America (MVA). My name is Lindsay Church, and I have the honor of serving as the Executive Director of MVA. We advocate for veterans from underserved and minority communities—particularly women, LGBTQ+ individuals, veterans of color, and those in rural areas. Throughout this testimony, I will refer to "underserved populations," which includes not only those specific groups but also others who face significant barriers to accessing care.

At MVA, we are committed to addressing the unique challenges these veterans face, particularly in accessing the mental health resources and care they need. Our work focuses on ensuring these communities are not overlooked and that they receive the support they deserve after their service. The mental health needs of our veterans are urgent, and this Committee's work in improving outreach and care is invaluable, especially for those from marginalized backgrounds who often face additional barriers to care. We are deeply grateful for the Committee's efforts to address these issues, and we look forward to working alongside you to build a more inclusive, accessible system for all veterans.

Before addressing the legislation up for review today, I want to take a moment to acknowledge the thirteen veterans who have tragically lost their lives to suicide on VA property since October 2024, as well as the thirteen additional suicide attempts by transgender and nonbinary individuals between November 2024 and March of this year. The work we do is for them, to ensure no veteran ever faces such a crisis alone. I call on the Department to honor these veterans by taking immediate and meaningful action. This includes providing a detailed brief to minority-serving veteran service organizations outlining what went wrong, how the situation will be addressed, the timeline for implementation, and how their expertise will be integrated into the solution.

Veterans from underserved populations face unique challenges when seeking mental health care. The barriers these groups encounter include systemic discrimination, lack of culturally competent providers, and limited access to services—particularly in rural areas where geographical isolation is a significant hindrance. In addition to these practical barriers, there is a widespread stigma around mental health that discourages many from seeking help. This stigma is

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compounded by the absence of tailored resources designed to address the specific needs and experiences of marginalized groups:

- Women veterans often face gender-specific challenges, including a lack of trauma-informed care and underrepresentation within the veteran population. As a result, they frequently struggle to find services that address their unique experiences related to military service and reintegration into civilian life.

- LGBTQ+ veterans are at risk of discrimination and a lack of understanding from health care providers who may not be adequately trained to meet their needs. This creates an unsafe or unwelcoming environment that discourages them from seeking care, furthering their reluctance to access services in the future.

- Veterans of color experience racial and ethnic disparities in mental health care, including cultural misunderstandings and systemic biases. Many face a lack of providers who are sensitive to their needs, which often results in unequal care.

- Rural veterans face significant geographic and logistical challenges, such as limited access to care, long travel distances, and a shortage of mental health professionals, further exacerbating their ability to receive support.

The cumulative effect of these barriers demands urgent action. We must implement targeted outreach initiatives and develop supportive measures that specifically address the unique needs of these communities. Without specialized services and intentional outreach, many underserved veterans will continue to fall through the cracks. Culturally competent, accessible, and inclusive mental health services are not a luxury—they are an absolute necessity for these veterans. To ensure that all veterans receive the care they deserve, it is critical to expand and strengthen mental health programs designed to reach these populations. By doing so, we can help mitigate the mental health crisis affecting our most vulnerable veterans and provide the support they need to heal and thrive.

I. Discussion of Pending Legislation: *To amend the Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019 to modify and reauthorize the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program of the Department of Veterans Affairs*

The Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program, established under the *Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019,* is a critical initiative aimed at combating the suicide crisis among veterans. This program provides funding to community-based organizations that deliver culturally competent mental health services, particularly to underserved veterans who face systemic barriers to care. Notable examples of the program's impact include:

- Women veterans: Grants supported trauma-informed, gender-specific services, addressing challenges such as military sexual trauma (MST) and encouraging treatment engagement.

- LGBTQ+ veterans: Funding enabled organizations to train providers in LGBTQ+ cultural competency, creating affirming care spaces that reduce fears of discrimination and improve access to care.

- Veterans of color: Partnerships with clinics serving communities of color helped deliver racially responsive care and address disparities rooted in systemic biases.

- Rural veterans: Telehealth initiatives expanded access for veterans in remote areas, overcoming geographical barriers to care.

This proposed bill takes crucial steps to extend and improve the grant program by strengthening it through increased funding, extending its duration, and expanding the VA's ability to partner with local organizations embedded in the community.

A. Recommended Strategic Improvements

The success of the bill's intention will depend on thoughtful implementation. While it increases flexibility, it does not mandate equity-focused programming or require data collection based on race, gender identity, or other key demographics. The additional targeted provisions recommended below could greatly enhance the program's ability to address stigma, discrimination, geographic isolation, and cultural barriers, providing a path to significantly reduce suicide rates and improve outcomes for marginalized veterans.

- Prioritizing Equity in Grant Awards:

To ensure the program effectively serves the most underserved populations, the recommended funding for grants prioritizing women veterans, racial and ethnic minority veterans, LGBTQ+ veterans, and veterans residing in rural or frontier areas is $10,000,000. This funding will support approximately 20 additional organizations focused on these high-risk groups, with an average allocation of $500,000 per organization. These organizations are critical for providing targeted services such as trauma-informed care, LGBTQ+ affirmative practices, and outreach to rural and remote areas where veterans face additional barriers to accessing mental health care. This dedicated funding ensures that these groups receive the necessary resources to reach veterans who have been historically underserved by traditional VA programs.

    - *Suggested language to be added under Section 1, Subsection (c)(2)(A):* "In awarding grants under this section, the Secretary shall give priority to organizations that provide services to underserved veteran populations, including women veterans, racial and ethnic minority veterans, LGBTQ+ veterans, and veterans residing in rural or frontier areas."

- Creating Funding Set-Asides for Targeted Populations:

To address the unique needs of minority and rural veteran populations, we propose a set-aside of $15,000,000 from the total grant pool, which would represent about 30% of the overall program budget. This allocation ensures that these groups are not deprioritized during

competitive funding processes. The set-aside will help sustain programs that offer culturally competent services, such as multilingual counseling, culturally relevant mental health treatment, and mobile clinics for veterans in remote locations. This dedicated funding will also enable targeted outreach and build strong community partnerships that are crucial for engaging underserved populations effectively.

- *Suggested language to be added under Section 1, Subsection (f) or Section 1, Subsection (q)(4)(C):* "The Secretary may reserve a portion of appropriated funds for grants specifically targeting minority and rural veteran populations."

- Mandating Disaggregated Data Collection:

For robust program evaluation and to ensure that the suicide prevention efforts are effectively addressing disparities, we estimate that the cost of implementing disaggregated data collection and reporting across multiple demographics—such as race, ethnicity, gender identity, sexual orientation, and geographic location—will be $3,000,000 annually. This includes the setup costs for the data collection infrastructure, the hiring of additional staff to manage and analyze the data, and the technology to store and report the data transparently. By collecting and publicly reporting this data, the VA will be able to identify gaps in services and adjust funding priorities accordingly, ensuring that all veteran populations benefit equitably from the program.

- *Suggested language to be added under Section 1, Subsection (h)(2) or Section 1, Subsection (c)(2)(A):* "The Secretary shall collect and publicly report outcome data disaggregated by race, ethnicity, gender identity, sexual orientation, and geographic location, in order to evaluate disparities in suicide prevention outcomes and inform future policy."

- Requiring Culturally Competent Care:

Tailoring care is a policy of equity and effectiveness—not special treatment. Implementing mandatory cultural competency training for all grantees is essential for ensuring that care is both inclusive and effective. Based on estimates for program development, training costs, and follow-up assessments, we recommend $5,000,000 for this initiative. The funds will be used to cover the cost of training for 50 grantees, with an average of $100,000 per grantee for staff development and ongoing monitoring. This funding will enable providers to offer gender-responsive, racially equitable, LGBTQ+ inclusive, and rural-health-sensitive care. The impact will be improved engagement and trust from veterans who may have historically avoided seeking help due to concerns about discrimination or inadequate care.

- *Suggested language to be added under Section 1, Subsection (c)(2)(A) or Section 1, Subsection (h)(3)(L):* "The Secretary shall require that all grantees provide culturally competent care, including staff training on gender responsiveness, racial equity, LGBTQ+ inclusivity, and the unique needs of rural veterans."

- Strengthening Community-Based Engagement:

Given the significant trust deficit within underserved communities, it is essential to leverage community-based collaborations. For this purpose, we recommend allocating $7,000,000 to fund local partnerships. This funding will support 35 partnerships at an average of $200,000 each, aimed at local organizations such as tribal health centers, LGBTQ+ resource centers, and rural health clinics. These organizations have established trust within their communities and are uniquely positioned to engage high-risk veterans who might not seek help through traditional VA channels. This funding will ensure that these organizations can expand their capacity to deliver mental health services and effectively reduce the stigma associated with seeking care.

  - *Suggested language to be added under Section 1, Subsection (c)(2)(A) or Section 1, Subsection (h)(2):* "Each grant applicant shall include a plan for outreach and partnership with local organizations that serve underrepresented veteran populations, including but not limited to tribal health centers, LGBTQ+ resource centers, and rural health clinics."

B. Ensuring Every Veteran Has Access to Life-Saving Mental Health Care

MVA conditionally supports this bill as a crucial step in addressing the mental health and suicide prevention needs of underserved veterans. However, our full support depends on key modifications to ensure the bill effectively targets marginalized populations. The proposed measures would address disparities while enhancing accountability and transparency, ensuring funds reach vulnerable veterans and close service gaps. Veterans' trust in the VA is vital for the program's success. By prioritizing culturally competent care and inclusive outreach, the VA strengthens that trust and makes its benefits and services more responsive to all veterans' needs.

Supporting veterans' mental health must remain a national priority that transcends political divides. We owe a debt to those who have served, and that debt is paid through action, not just words. We call on the Committee and your colleagues in both chambers to incorporate the recommendations above and prioritize a bipartisan, commonsense solution that expands a vital suicide prevention program, grounded in the belief that every veteran's life is worth protecting.

II. Discussion of Pending Legislation: *Every State Counts for Vets Mental Health Act*

The *Act*—an amendment to the *Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019*—introduces a strategic update to how the Department awards suicide prevention grants. Under this provision, the VA must give priority consideration to grant applications from eligible organizations located in states that have not yet received funding. Until at least one grant is awarded in each state, applicants from those areas will receive scoring preferences. This measure promotes geographic equity, addressing disparities in regions with historically limited access to mental health services.

Importantly, the *Act* offers an opportunity to directly address long-standing disparities in care for underserved veteran communities, including women, LGBTQ+ individuals, veterans of color, and rural veterans. The bill can help mitigate these disparities by encouraging new applicants—especially from underserved states—to develop inclusive, community-tailored programs. Here's how the bill's provisions can benefit these groups:

- Women veterans often face difficulties in accessing gender-specific mental health services, especially trauma-informed care related to military sexual trauma (MST). The bill's expanded grant system gives local organizations the opportunity to develop services that address gender-specific needs, such as women-only spaces, specialized trauma care, and targeted outreach strategies.

- LGBTQ+ veterans experience disproportionately high rates of mental health issues and suicide, often exacerbated by discrimination and a lack of inclusive services. By prioritizing outreach in states that have not received prior funding, the bill creates opportunities for new providers, particularly those collaborating with LGBTQ+-focused organizations, to create services that are affirming of LGBTQ+ identities and experiences.

- Veterans of color face systemic barriers, including racial bias, language barriers, lack of culturally relevant care, discrimination in past VA interactions, and historical mistrust stemming from past discriminatory practices. The bill helps fund community-based programs that are culturally competent, multilingual, and led by providers who reflect the diversity of the communities they serve. It also emphasizes the need for demographic data collection to track and address racial disparities in care.

- Rural veterans face significant barriers to mental health services due to geographic isolation, limited infrastructure, and a shortage of local providers. With expanded grant access, the bill enables providers in rural areas to apply for funding to expand telehealth capabilities, launch mobile clinics, or provide transportation assistance, thereby bridging the gap between rural veterans and essential mental health care.

By expanding grant access and prioritizing outreach to underrepresented areas, the bill has the potential to transform how inclusive, responsive, and equitable veteran mental health care is delivered across the country.

A. Recommended Strategic Improvements

As Congress considers enhancements to the *Act*, it is essential to ensure that the legislation does more than just expand access by geography. True progress requires addressing the root disparities that shape how different veteran populations experience and access mental health care. We recommend the following provisions to ensure the bill targets underserved veterans effectively:

- Mandating Disaggregated Data Collection:

To evaluate program impact and ensure equity in outcomes, the VA must collect and publicly report outcome data disaggregated by key demographics. Without this level of detail, gaps in care for marginalized veterans will remain invisible and unaddressed.

  - *Suggested language to be added under Section 2, Subsection (a)(5) or Section 3, Subsection (b)(4):* "The Secretary shall collect and publicly report outcome data disaggregated by race, ethnicity, gender identity, sexual orientation, housing security, and geographic location to evaluate disparities in suicide prevention outcomes and inform future policy."

  - *Suggested appropriations language to be added*: "To carry out the purposes of [Section 2, Subsection (a)(5) or Section 3, Subsection (b)(4)], there is appropriated $1,500,000 for fiscal year [insert fiscal year] to fund the collection, analysis, and public reporting of disaggregated outcome data by race, ethnicity, gender identity, sexual orientation, and geographic location. This data shall be used to assess disparities in suicide prevention outcomes and inform future policy development."

This includes $500,000 for developing the necessary infrastructure, such as updating existing data systems to collect new types of data; $500,000 for data analysis, which will cover hiring statisticians and analysts to ensure the data's accuracy and reliability; and $500,000 for public reporting and dissemination, including creating accessible web platforms and producing annual reports to Congress. This comprehensive approach will allow the VA to assess disparities in suicide prevention outcomes and inform future policies aimed at achieving equity.

- Requiring Tailored Outreach to Underserved Veterans

Standard outreach efforts often fail to reach marginalized communities. The bill should require targeted, culturally responsive outreach for high-risk populations and formalize partnerships with trusted organizations already serving these communities.

  - *Suggested language to be added under Section 2, Subsection (b)(2) or Section 3, Subsection (c)(3):* "The Secretary shall implement targeted outreach strategies to underserved veteran populations, including women veterans, racial and ethnic minority veterans, LGBTQ+ veterans, and veterans residing in rural, insular, or frontier areas, in coordination with community-based organizations."

  - *Suggested appropriations language to be added*: "To carry out the purposes of [Section 2, Subsection (b)(2) or Section 3, Subsection (c)(3)], there is appropriated $2,000,000 for fiscal year [insert fiscal year] to implement targeted outreach strategies for underserved veteran populations, including women veterans, racial and ethnic minority veterans, LGBTQ+ veterans, and veterans residing in rural, insular, or frontier areas. This outreach will be done in coordination with community-based organizations and veteran-serving entities."

This funding will be used to develop culturally competent outreach strategies ($500,000), collaborate with community-based organizations to expand outreach in marginalized communities ($1,000,000), and support media campaigns focused on reaching these underserved groups ($500,000). These efforts will ensure that marginalized veterans are informed about available mental health services and can access support tailored to their unique needs.

- Requiring Culturally Competent and Inclusive Care

Veterans are more likely to engage in care when services are respectful of their identities and experiences. All VA providers should complete comprehensive cultural competency training to ensure care is trauma-informed and inclusive.

  - *Suggested language to be added under Section 2, Subsection (c)(1) or Section 3, Subsection (d)(2)):* "The Secretary shall require that all providers receive training in cultural competency, including military sexual trauma, racial equity, LGBTQ+ inclusivity, and rural health access, and that mental health services reflect these standards in practice."

  - *Suggested appropriations language to be added*: "To carry out the purposes of [Section 2, Subsection (c)(1) or Section 3, Subsection (d)(2)], there is appropriated $3,000,000 for fiscal year [insert fiscal year] to provide cultural competency training for all VA mental health providers, with a focus on military sexual trauma (MST), racial equity, LGBTQ+ inclusivity, and rural health access. Training shall be designed to ensure that providers understand the specific needs of underserved veteran populations and are appropriately equipped to incorporate these standards into their practices."

This funding would allocation would include $1,000,000 for the development of culturally competent training modules, including content focused on military sexual trauma, intimate partner violence, racial equity, LGBTQ+ inclusivity, and rural health access; $1,500,000 for delivering the training to VA providers, including logistics, platform costs, and trainers; and $500,000 for post-training evaluations to assess the effectiveness of the training and ensure that providers are applying the skills and knowledge gained. These efforts will help improve the quality of care for underserved veterans and ensure that services are sensitive to the needs of all veteran populations.

- Building a Representative Mental Health Workforce

With the current reductions in VA staffing, particularly as the VA faces challenges from the Department of Government Efficiency (DOGE), it is more important than ever to invest in recruiting and retaining a workforce that mirrors the diversity of the veteran population. Veterans trust providers who reflect their communities and understand their challenges. This ensures that even in times of staff shortages, the VA can maintain a strong, culturally competent workforce committed to serving in underserved areas.

- *Suggested language to be added under Section 2, Subsection (d)(3) or Section 3, Subsection (e)(4):* "The Secretary shall implement measures to recruit, train, and retain a diverse mental health workforce, including women, LGBTQ+ individuals, people of color, and clinicians serving rural and frontier areas."

- *Suggested appropriations language to be added*: "To carry out the purposes of [Section 2, Subsection (d)(3) or Section 3, Subsection (e)(4)], there is appropriated $4,000,000 for fiscal year [insert fiscal year] to support efforts to recruit, train, and retain a diverse mental health workforce that reflects the diversity of the veteran population, including women, LGBTQ+ individuals, providers of color, and clinicians serving rural and frontier areas."

This includes $1,500,000 for recruitment efforts, such as targeted campaigns to attract underrepresented applicants to VA mental health positions, and collaboration with schools and organizations that support diverse candidates. $1,500,000 will be used for onboarding and training new hires, ensuring that they are prepared to meet the specific needs of marginalized veterans through cultural competency training and specialized support. The remaining $1,000,000 will fund retention programs, including leadership development and wellness programs to support the long-term success of diverse staff and reduce burnout. These investments will help ensure that the VA has a mental health workforce capable of providing high-quality care to all veterans, especially those in underserved areas.

- <u>Strengthening Community-Based Partnerships</u>

Effective care delivery requires trust. Community-based and minority-serving organizations are often best positioned to connect with high-risk veterans. The *Act* should formally support these partnerships through sustained funding and collaboration.

- *Suggested language to be added under Section 2, Subsection (e)(2) or Section 3, Subsection (f)(5):* "The Secretary shall prioritize partnerships with minority-serving and community-based organizations to co-design and implement mental health and suicide prevention services and may allocate funding for such partnerships."

- *Suggested appropriations language to be added*: "To carry out the purposes of [Section 2, Subsection (e)(2) or Section 3, Subsection (f)(5)], there is appropriated $5,000,000 for fiscal year [insert fiscal year] to support partnerships with minority-serving and community-based organizations. This funding may be used for co-designing and implementing mental health and suicide prevention services tailored to the needs of underserved veterans, including funding for mobile clinics, telehealth access, and culturally relevant programming."

This funding would be used to develop partnerships with minority-serving and community-based organizations ($2,000,000), implement tailored services such as mobile clinics, telehealth access, and culturally relevant programming ($2,000,000), and evaluate the effectiveness of these partnerships ($1,000,000). The evaluation will track the outcomes of the

partnerships, ensuring that they reach underserved populations, improving mental health outcomes, and addressing disparities in care. These partnerships will be critical in providing veterans in underserved areas with the support they need to improve their mental health and prevent suicide.

B. Advancing Access to Mental Health Care for All Veterans

MVA offers its conditional support for this bill, again withholding full support for the thoughtful integration of key equity-centered provisions. By expanding access to culturally informed services and supporting community-based organizations, the bill presents a critical opportunity to advance mental health equity for underserved veterans, providing lifesaving and life-changing support where it's needed most. These measures are essential to ensuring the bill addresses, rather than perpetuates, long-standing disparities in veteran mental health care.

III. Discussion of Pending Legislation: *The Building Resources and Access for Veterans' Mental Health Engagement (BRAVE) Act of 2025*

The *BRAVE Act* represents a critical step towards addressing gaps in access, improving outreach, and reducing disparities in care for underserved veterans. The bill includes targeted services to address the unique needs of underserved groups, such as survivors of military sexual trauma and intimate partner violence, and updates the REACH VET program to include women-specific factors.

A. Current Barriers to Access for Underserved Veterans

Veterans from underserved communities—such as women, LGBTQ+, veterans of color, and rural veterans—face unique and compounded challenges when accessing mental health care. These barriers are deeply rooted in social, cultural, and systemic factors, which often discourage veterans from seeking or receiving the care they need.

- Cultural and Social Barriers: One of the most significant obstacles is stigma surrounding mental health. Marginalized veterans face additional stigma due to their identities and the misconception that seeking help is a sign of weakness. This is particularly pronounced for women veterans, who may feel pressure to meet gendered expectations of strength, and for LGBTQ+ veterans, who may fear discrimination or face a lack of affirming care in settings that are not culturally competent. These barriers not only prevent access to care but also contribute to deep mistrust in the system, especially for veterans who have experienced exclusion or mistreatment.

- Geographic Isolation: Rural veterans experience significant challenges due to their geographic isolation. Many live far from VA facilities or other mental health providers, making it difficult to access timely care. Even when services are available, the logistical challenges of traveling long distances, compounded with the emotional toll of seeking help in unfamiliar or uncomfortable settings, can deter veterans from pursuing care. Research consistently shows that rural veterans suffer from higher rates of suicide and

mental health struggles compared to their urban counterparts, exacerbated by a lack of local resources.

- Lack of Culturally Competent Care: A significant gap in care for marginalized veterans is the lack of culturally competent mental health services. Many providers lack the training necessary to address the unique needs of women, LGBTQ+ veterans, and veterans of color, leaving to feelings of alienation and disengagement from care. Without culturally competent care, these veterans are less likely to seek help, and when they do, they may not receive care that recognizes their distinct experiences. The shortage of providers who reflect the diversity of these groups further exacerbates the problem.

- Systemic Biases: Systemic and interpersonal biases—including racial and gender discrimination—permeate veterans' services, disproportionately affecting veterans of color and undermining their trust in the system. These biases contribute to unequal treatment in health care settings, erode trust in services, and deter veterans from seeking care. Veterans of color, in particular, often face microaggressions or overt discrimination, leading to poor mental health outcomes. Addressing these systemic issues is crucial to ensuring that every veteran feels safe and supported in seeking care.

B. Addressing Gaps in Outreach

Outreach gaps for underserved veterans are stark, with marginalized groups disproportionately affected by mental health challenges, risks of suicide, and limited access to care. Women veterans experience significantly higher suicide rates than their male counterparts, while LGBTQ+ veterans face heightened vulnerability due to past discrimination, a lack of inclusive services, and fear of rejection in care settings. Veterans of color face barriers such as lack of representation among providers and culturally insensitive care. Finally, rural veterans face significant barriers due to geographic isolation, which limits access to local mental health services and exacerbates feelings of loneliness and detachment from support networks. To address these gaps, several strategies should be implemented:

- Expanding Peer Support Networks: Peer support is a proven, effective tool for engaging veterans, especially those from underserved communities who may feel alienated or reluctant to seek care due to stigma. These networks foster trust and provide shared experiences that can reduce isolation and improve mental health outcomes. Research shows that peer support can be particularly effective in helping veterans who are reluctant to seek care due to stigma or past experiences.

- Community-Based Outreach: Local organizations should be empowered to engage veterans in their own communities. Community-based outreach programs, which connect veterans to services within their own communities, are especially effective in rural areas where veterans may lack access to VA facilities or other mental health resources. These programs can build connections that might otherwise be missed and offer tailored support for veterans who may feel disconnected from the VA system.

- Expanding Culturally Relevant Services: To ensure veterans receive the care they need, services must be culturally relevant and sensitive to the diverse identities of the veteran population. This includes hiring providers trained in cultural competency and expanding programs that reflect the lived experiences of marginalized veterans. Increasing funding for initiatives that support these services—such as targeted grants for underserved populations—is essential to bridging the care gap, ensuring equitable access, and providing every veteran with the care they deserve.

C. Strategic Recommendations

We propose several updates to strengthen this bill, both in general and for specific provisions, focusing on the unique needs of historically marginalized communities. These recommendations are designed to enhance the bill's effectiveness by promoting equity, inclusivity, and targeted mental healthcare.

i. In General

To effectively address veterans' mental health and suicide prevention needs, policies must acknowledge the unique challenges marginalized groups face, as well as the significant barriers they encounter in accessing care. Strengthening equity and inclusivity within veteran health care programs is essential. The following key recommendations focus on culturally competent care, targeted outreach, and data-driven solutions to reduce disparities and improve mental health outcomes for underserved populations.

- Inclusive and Culturally Competent Care: Mental health programs must include culturally competent, trauma-informed care, with specific training for VA staff on racial trauma, systemic bias, gender-specific care, and LGBTQ+ inclusivity. This training ensures that all marginalized veterans receive care that respects their identities and experiences. Additionally, data should be disaggregated by race, ethnicity, gender identity, sexual orientation, and rurality to identify and address care disparities, ensuring all veterans receive the support they need.

- Expanding Access in Rural Areas: To overcome geographic barriers, the Secretary should prioritize expanding telehealth infrastructure and mobile Vet Centers, especially in rural areas, where access to mental health services is limited. A Rural Veteran Mental Health Access Fund should be established to pilot innovative strategies like tele-counseling, mobile outreach, and peer navigators, improving access to care for rural veterans, who face higher suicide rates and mental health challenges.

- Trauma-Informed, Gender-Specific Care for Women Veterans: Programs should adopt a trauma-informed, gender-specific framework, addressing issues like military sexual trauma and intimate partner violence. Each VA facility and Vet Center should appoint a Women's Mental Health Liaison to coordinate care, ensuring that gender-specific resources are available and accessible to improve engagement and care for women veterans.

- Intersectional Data Collection and Program Evaluation: Data collection and program evaluations should adopt an intersectional approach, analyzing how factors such as gender, race, sexual orientation, and rurality intersect to influence veterans' mental health. This will inform the development of targeted, equitable solutions to address disparities and improve care outcomes.

- Strengthening Minority Veteran Community Partnerships: The VA should formalize partnerships with community-based organizations that specialize in serving minority, LGBTQ+, and rural veterans. These organizations should be eligible for grants and outreach contracts, enabling them to provide tailored, localized support and outreach to veterans who may be disconnected from the VA system. Such partnerships will help improve access to care and enhance the effectiveness of outreach efforts.

Ensuring equity in veterans' care requires deliberate and strategic policy reforms. By embedding culturally competent practices, expanding access for underserved populations, and applying data-driven approaches, the VA can build a more inclusive system that responds effectively to the needs of marginalized veterans. The proposed policy and language updates aim to dismantle barriers to care, boost engagement, and improve mental health outcomes—particularly for those historically left behind. These changes will not only enhance individual well-being but also strengthen the overall impact and effectiveness of the VA's suicide prevention and mental health care efforts.

ii. Section 102: Qualifications of appointees in occupations that support mental health programs.

Section 102 amends mental health staffing requirements by removing the time limitation on psychologist appointments and allowing the Secretary of Veterans Affairs to waive licensure requirements for licensed professional mental health counselors. While intended to address urgent staffing shortages and improve access, these changes raise serious concerns about care quality and safety—especially for minority veterans. To mitigate these risks, we recommend targeted amendments that ensure waivers are time-limited, subject to rigorous oversight, and accompanied by cultural competence requirements. These safeguards are essential to delivering equitable, trauma-informed care to all veterans.

- Quality of Care and Patient Safety

Licensure waivers may help fill provider gaps, but they must not come at the expense of care quality. Without proper oversight, veterans—particularly those requiring specialized support—could be treated by providers lacking necessary qualifications or training. We recommend that the bill limit licensure waivers to six months and require minimum provider qualifications, ongoing evaluation, and mandatory cultural competence training.

  - *Suggested language to be added:* "Licensure waivers should be time-limited (e.g., six months) and subject to regular reviews. All providers operating under a waiver must meet minimum qualifications, undergo cultural competence training specific to minority veterans (including training on racial trauma, gender-specific issues,

and military sexual trauma), and be re-evaluated regularly to ensure the provision of safe, effective, and culturally sensitive care."

- *Suggested appropriations language to be added:* "To carry out the purposes of this Section, there is appropriated $3,000,000 for fiscal year [insert fiscal year] to support cultural competence training for all providers operating under a licensure waiver. This training shall include specific focus on racial trauma, gender-specific needs, military sexual trauma (MST), and the unique challenges faced by minority veterans. Training shall be required for all providers operating under waivers and shall be conducted annually."

This funding is based on previous VA initiatives that have allocated $1,500,000 annually for specialized training programs, with an additional $1,500,000 required to expand and enhance training to address the unique needs of minority veterans. This funding will ensure that providers who receive waivers have the necessary knowledge to treat racial trauma, gender-specific issues, and other challenges that disproportionately affect minority veterans, especially those from underserved communities.

- Vulnerabilities of Minority Veterans

Marginalized veterans—particularly veterans of color, LGBTQ+ veterans, and women—have long experienced discrimination and mistrust in health care systems. The use of unlicensed or unfamiliar providers could further erode trust and discourage care-seeking. We recommend robust oversight of waiver usage, with reporting on impacts to minority veterans.

- *Suggested language to be added*: "The Secretary of Veterans Affairs must ensure that the waiver process includes rigorous oversight and reporting, with regular reports to Congress on the number of waivers granted, their duration, and specific outcomes for minority veterans. These reports should include data on care satisfaction and any disparities in mental health outcomes among minority veterans."

- Lack of Accountability and Oversight

Without transparent oversight, licensure waivers risk being misused or extended indefinitely, undermining care standards. Clear expiration timelines and quality monitoring are essential. We recommend biannual reporting by the Under Secretary for Health on waiver use, including evaluations of care quality and any disparities in outcomes.

- *Suggested language to be added*: "The Under Secretary for Health shall conduct regular oversight of the licensure waiver process and report to Congress every six months on the quality of care provided by waived providers. The report should include an evaluation of whether providers are meeting required standards and any disparities in care outcomes, particularly for minority veterans. Clear timelines for waiver expiration should be established to prevent waivers from

becoming permanent or excessively prolonged."

- *Suggested appropriations language to be added:* "To carry out the purposes of this Section, there is appropriated $2,000,000 for fiscal year [insert fiscal year] to establish a rigorous oversight process for licensure waivers, including the development of a reporting system to track the number of waivers granted, their duration, and the outcomes for minority veterans. Regular reports on waiver usage and quality of care provided by unlicensed providers shall be submitted to Congress every six months."

This amount is based on the estimated cost to develop and maintain a comprehensive tracking and reporting system, which includes personnel for data collection and analysis, IT infrastructure to support the system, and the development of reports for Congress. Previous oversight projects in the VA have typically required $1,200,000 annually, and an additional $800,000 is necessary to account for the added complexity of tracking waiver-specific outcomes, particularly with a focus on minority veterans' care satisfaction and mental health outcomes.

- Extended Telehealth Access

Waivers can help expand telehealth access—especially critical for rural and underserved populations. However, telehealth providers must be trained and evaluated to ensure culturally responsive and trauma-informed care. We recommend requiring specialized training and ongoing evaluation for all telehealth providers operating under waivers.

- *Suggested language to be added*: "Telehealth providers operating under a licensure waiver must receive specialized training in cultural competence, trauma-informed care, and the specific challenges faced by minority veterans, including veterans of color, LGBTQ+ veterans, and women veterans. Additionally, these providers should be subject to regular evaluations to ensure the continued quality and cultural sensitivity of the care they provide."

- *Suggested appropriations language to be added:* "To carry out the purposes of this Section, there is appropriated $2,500,000 for fiscal year [insert fiscal year] to support telehealth providers operating under licensure waivers. This funding will cover the cost of specialized training in cultural competence, trauma-informed care, and the specific challenges faced by minority veterans. Additionally, telehealth providers will be subject to regular evaluations to ensure the continued quality and cultural sensitivity of care."

This funding is based on the costs associated with scaling up telehealth training programs and ensuring that remote providers receive appropriate cultural competence and trauma-informed care training. The VA has historically allocated $1,500,000 annually for telehealth training, but an additional $1,000,000 is required to focus specifically on minority veterans, including veterans of color, LGBTQ+ veterans, and women veterans. The funds will also support the establishment of a continuous evaluation system to ensure the quality of care delivered via telehealth.

- Veteran-Centered Focus in Waiver Process

To ensure equity and transparency, veterans' voices—particularly those from marginalized communities—must be included in the waiver decision-making process. Formal consultations with veteran organizations representing underserved groups should be required prior to granting any licensure waivers.

  - *Suggested language to be added*: "Before any licensure waiver is granted, input should be solicited from veteran organizations representing marginalized groups to ensure that the needs of minority veterans are considered and that their care is not compromised by unqualified providers. This input should be documented and considered as part of the waiver approval process."

Ongoing evaluation is essential to ensure waiver-authorized providers meet high standards of care and that minority veterans are not disproportionately harmed.

  - *Suggested appropriations language to be added:* "To carry out the purposes of Section 102, there is appropriated $1,500,000 for fiscal year [insert fiscal year] to fund regular evaluations and reporting on the quality of care provided by providers operating under licensure waivers. The Under Secretary for Health shall report to Congress every six months on waiver usage, the qualifications of providers, and any disparities in care outcomes, especially for minority veterans."

This funding will support the necessary personnel, systems, and resources to ensure that waiver usage is monitored effectively, with a specific focus on any negative impacts on minority veterans. The cost is based on previous evaluations of similar programs, which typically cost $750,000 per year, but an additional $750,000 is necessary to incorporate the specific focus on minority veterans and the required data collection/reporting mechanisms.

  - *Suggested appropriations language to be added:* "To carry out the purposes of this Section, there is appropriated $500,000 for fiscal year [insert fiscal year] to solicit input from veteran organizations representing marginalized groups before any licensure waivers are granted. This input will ensure that the needs of minority veterans are considered and that their care is not compromised by unqualified providers."

This funding will be used to organize and facilitate consultations with groups that represent minority veterans, ensuring their voices are heard and that the waiver process remains transparent and accountable to the needs of these communities. Based on previous consultations and stakeholder engagement efforts, the VA typically spends $250,000 annually on similar outreach efforts. This funding will cover additional costs associated with the specific focus on marginalized groups and will include the creation of mechanisms to ensure that input is considered before waivers are granted.

iii. Section 203: Improvement of guidance and information to improve veteran outreach efforts by Vet Centers.

Concerns about Section 203 stem from the recent censorship and significant revision of the VA Recreational Task Force's congressionally mandated report, which removed equity-driven recommendations and references to marginalized groups. This incident highlights the risk of diluting or omitting provisions essential to addressing the unique needs of women veterans, veterans of color, LGBTQ+ veterans, and other historically underserved populations.

Without explicit, equity-centered language, outreach and service programs may fail to reach or effectively support these veterans. To ensure inclusive and culturally responsive outreach, Section 203 must mandate that Vet Center programs prioritize equity, address structural barriers, and incorporate data and accountability mechanisms to track impact across diverse veteran communities.

- Risk of Perpetuating Exclusion of Minority Veterans

Removing equity-focused language from official guidance undermines outreach to marginalized groups. Section 203 must explicitly direct that outreach, recruitment, and services center the experiences of women veterans, veterans of color, LGBTQ+ veterans, and rural veterans.

  - *Suggested language to be added*: "The Secretary of Veterans Affairs shall ensure that outreach, recruitment, and service programs specifically address the unique needs and barriers faced by minority veterans, through culturally competent, gender-affirming, and trauma-informed approaches."

  - *Suggested appropriations language to be added*: "To carry out the purposes of this Section, there is appropriated $5,000,000 for fiscal year [insert fiscal year] to develop and implement culturally competent, gender-affirming, and trauma-informed outreach, recruitment, and service programs specifically focused on women veterans, veterans of color, LGBTQ+ veterans, and rural veterans. These programs shall address the unique needs and barriers faced by these groups, ensuring their access to equitable services across all VA programs."

This calculation is based on the VA's historical expenditure on outreach and recruitment campaigns, where an average annual allocation of $2,000,000 is used for broad veteran engagement efforts. Given the need to create specialized programs to address the distinct needs of women, veterans of color, LGBTQ+ veterans, and tribal veterans, an additional $3,000,000 is necessary to build infrastructure, conduct targeted outreach campaigns, and develop culturally competent training for staff to provide equitable and specialized services. These funds will cover the cost of program development, training, staff salaries, marketing, and community partnerships.

- Vague Terminology on Gender and Lack of Clear Definitions

The VA's application of the term "sex" undermines efforts to provide inclusive services for certain LGBTQ+ veterans, who already face barriers in accessing care. The VA defines "sex" according to what is listed on a veteran's birth certificate. This may not accurately reflect a veteran's identity and/or medically relevant bodily differences given contrasts in state-level policies regarding the assignment of sex at birth for intersex individuals and the legal alteration of sex designations for intersex, transgender, and nonbinary individuals. Section 203 uses the term "gender," which is an improvement given the term's emphasis on current identity, its recognition of sexual diversity in humans that aligns with scientific evidence, and its capacity to encompass sexual variation across the life span. This clarification should be codified to provide guidance to Vet Centers on the collection of demographic data and to ensure that certain LGBTQ+ veterans who would otherwise be excluded by current applications of the term "sex" are appropriately recognized and supported within VA programs.

  - *Suggested language to be added*: "For the purposes of this section, 'gender' shall be defined as a spectrum of identities including but not limited to male, female, transgender, nonbinary, and gender nonconforming individuals."

  - *Suggested appropriations language to be added*: "There is appropriated $1,500,000 for fiscal year [insert fiscal year] to modernize VA language and materials to reflect an inclusive definition of gender. This shall include updates to internal policies, public communications, and staff training to align with current federal standards."

This funding amount is based on a cost breakdown of previous VA language updates in response to gender-inclusive reforms. The VA has allocated approximately $500,000 for similar projects in the past, which included updating documents, training staff, and revising public-facing materials. In order to reflect federal standards and ensure full inclusion, an additional $1,000,000 will be needed to revise internal documents across the 150+ VA locations, update digital and print materials, implement staff training on inclusive language, and ensure the integration of gender diversity into all outreach efforts. This total amount includes resource allocation for consultation with LGBTQ+ advocacy groups and experts to ensure best practices are followed.

- Insufficient Use of Disaggregated Data

Without disaggregated data, it is impossible to assess whether outreach is reaching all populations or whether disparities persist. Tracking participation and outcomes by race, gender, and other identity factors is essential for evidence-based improvements.

  - *Suggested language to be added*: "The Secretary of Veterans Affairs shall collect and report disaggregated data on the participation, service utilization, and outcomes of all programs under this section, including but not limited to race, ethnicity, gender, sexual orientation, and veteran status."

- *Suggested appropriations language to be added*: “To carry out the purposes of this Section, there is appropriated $2,000,000 for fiscal year [insert fiscal year] for the development and implementation of a data collection system that will track participation, service utilization, and outcomes disaggregated by race, ethnicity, gender, sexual orientation, and veteran status. The data will be reported annually to Congress and used to assess the effectiveness of programs and ensure equitable access for all veterans.”

This calculation is based on the VA's previous data collection efforts which typically require $1,200,000 annually for basic tracking systems, including veteran demographics and services accessed. However, in order to incorporate detailed disaggregation by race, ethnicity, gender, sexual orientation, and veteran status for accurate reporting on minority veterans’ participation, utilization, and outcomes, an additional $800,000 will be needed to build a robust data infrastructure capable of handling these metrics across all VA programs. This amount will support system upgrades, personnel for data analysis, and the integration of reporting capabilities to Congress.

- Weak or Ineffective Barriers Language

Removal of the previous Recreational Task Force’s report language addressing structural and attitudinal barriers diminishes efforts to reduce disparities. Section 203 must explicitly address the systemic barriers—such as discrimination, stigma, and bias—that affect minority veterans’ access to care.

- *Suggested language to be added*: "The Secretary of Veterans Affairs shall assess and address the structural, attitudinal, and systemic barriers that prevent minority veterans, including women veterans, veterans of color, and LGBTQ+ veterans, from fully accessing services."

- *Suggested appropriations language to be added*: “To carry out the purposes of this Section, there is appropriated $2,500,000 for fiscal year [insert fiscal year] to identify and address structural, attitudinal, and systemic barriers that hinder access to services for minority veterans, including women veterans, veterans of color, and LGBTQ+ veterans. This funding shall be used to support training programs, outreach campaigns, and consultations with community-based organizations focused on overcoming these barriers.”

This request is based on previous efforts by the VA to conduct similar barrier-reduction initiatives, which typically cost between $1,000,000 and $1,500,000 annually for staff training, outreach, and community consultations. Given the complex nature of the barriers faced by marginalized veterans—ranging from systemic discrimination to cultural insensitivity—a more comprehensive effort is required, necessitating $1,000,000 in additional funding. This will cover new staff hires for cultural competency training, partnership development with external advocacy groups, and the production of targeted outreach materials.

- Establish a Clear Accountability Framework

Outreach programs must include clear metrics for success and systems of accountability. Section 203 should require an annual report to Congress that evaluates outreach effectiveness, inclusivity, and participation rates among minority veteran groups.

  - *Suggested language to be added*: "The Secretary of Veterans Affairs shall submit an annual report to Congress detailing the effectiveness of outreach efforts, the inclusivity of services, and the participation rates of minority veterans in all programs under this section."

  - *Suggested appropriations language to be added*: "To carry out the purposes of Section 203, there is appropriated $1,000,000 for fiscal year [insert fiscal year] to establish a robust accountability framework. This includes the creation of an annual report submitted to Congress, detailing the effectiveness of outreach efforts, service inclusivity, and participation rates of minority veterans. This report shall include recommendations for improving services and addressing any gaps identified."

Based on previous accountability projects, the VA typically spends $500,000 per year on the infrastructure needed to track program effectiveness and develop reports. In order to provide detailed assessments on the inclusivity and participation rates of marginalized veterans, an additional $500,000 is needed for data analysis, report preparation, and ongoing coordination with external researchers and stakeholders. This funding will ensure that all program adjustments are data-driven and that clear recommendations for improvement are provided to Congress.

iv. Section 301: Study on effectiveness of suicide prevention and mental health outreach programs of Department of Veterans Affairs for women veterans.

Section 301 directs the VA to conduct surveys and host listening sessions with women veterans on key issues related to suicide prevention and mental health. While this is a vital step forward, the current language does not go far enough to address the specific needs of women veterans from historically underserved communities.

To ensure the success of Section 301, the VA must move beyond generalized engagement and commit to developing tailored, enforceable strategies grounded in the lived experiences of veterans of color, LGBTQ+ veterans, Native American veterans, and others facing intersectional barriers. Strong oversight, expanded demographic data collection, and equitable funding are essential to restoring trust and delivering effective, inclusive care.

- Restoring Trust Through Consistent, Inclusive Engagement

Past cancellations of engagement events—particularly those targeting women veterans—have eroded trust and reinforced perceptions of institutional neglect. Section 301 must mandate biannual, targeted outreach to build lasting relationships with marginalized communities.

- *Suggested language to be added*: "To rebuild and maintain trust in VA engagement efforts, the VA shall conduct regular, meaningful outreach efforts, including surveys, listening sessions, and town halls, specifically focused on women veterans, veterans of color, LGBTQ+ veterans, and tribal veterans. Such engagement shall occur at least biannually and be designed to actively address the unique challenges faced by these groups. The VA shall submit biannual progress reports to Congress, detailing the participation, representation, and feedback from minority veterans, and actions taken to integrate these insights into VA policies and programs."

- Addressing the Failure of a One-Size-Fits-All Strategy

The VA's universal approach to mental health and suicide prevention often overlooks the distinct needs of diverse veteran communities. Section 301 must require the development of tailored strategies to address group-specific challenges.

- *Suggested language to be added*: "Based on the feedback gathered through surveys, listening sessions, and outreach efforts, the VA shall develop and implement tailored strategies to meet the specific needs of women veterans, veterans of color, LGBTQ+ veterans, and tribal veterans. These strategies shall address challenges such as racial discrimination, lack of gender-affirming care, cultural insensitivity, and other unique barriers to care. The VA shall ensure that these strategies are enforced and regularly evaluated to ensure their effectiveness in meeting the needs of these groups. Clear, measurable outcomes shall be established to track progress."

- Closing Oversight Gaps

To ensure meaningful follow-through, Congress must hold the VA accountable. Without mandated oversight and enforcement mechanisms, Section 301's goals may be neglected or delayed.

- *Suggested language to be added*: "Congress shall exercise ongoing oversight of the VA's engagement efforts and the implementation of tailored strategies for minority veterans. The VA shall provide regular (biannual) progress reports to Congress detailing the specific actions taken in response to the input received from minority veterans, including updates on the participation and representation of minority veterans in these engagement efforts. These reports shall also include an evaluation of the effectiveness of the strategies and any adjustments made based on minority veterans' feedback."

- Expanding Demographic Inclusion

Current language does not require the collection of data on sexual orientation or tribal affiliation, which are critical for understanding disparities in care access and experience.

- *Suggested language to be added*: “Section 301 shall explicitly expand its demographic categories to include sexual orientation and tribal affiliation as part of the VA’s engagement efforts. The VA shall gather data on the unique challenges faced by LGBTQ+ veterans and Native American veterans, ensuring that services and policies are responsive to the specific needs of these populations. Outreach efforts and strategies shall be inclusive of these groups, explicitly addressing the barriers they face in accessing care and ensuring culturally competent support.”

- Naming and Confronting Intersectional Barriers

Veterans who belong to multiple marginalized groups face layered, compounding barriers that are often invisible to generic policy frameworks. Section 301 must explicitly name and address these intersecting challenges.

- *Suggested language to be added*: “The VA shall develop and implement strategies that specifically address intersectional barriers faced by minority veterans, particularly those who belong to multiple marginalized groups, such as women of color, LGBTQ+ Native American veterans, and others. The VA shall gather and incorporate feedback on these intersectional barriers through surveys, listening sessions, and outreach efforts. The VA shall ensure that policies and programs are developed to effectively meet the needs of these veterans. The VA shall be held accountable through specific enforcement mechanisms, including regular oversight and progress reports to Congress, detailing actions taken to address these intersectional challenges.”

- Funding to Ensure Real Change

Funding must match the ambition and complexity of Section 301. A minimum of $6,500,000 is necessary to support the outreach, analysis, and strategy development required to make this section impactful and equitable.

- *Suggested appropriations language to be added*: “Of the amounts appropriated to the Department of Veterans Affairs, not less than $6,500,000 shall be used to support expanded outreach, engagement, and policy development activities under Section 301. These funds shall be used for conducting biannual listening sessions, improving survey design and data collection protocols, developing tailored strategies for minority veterans, expanding demographic categories, and preparing biannual oversight reports to Congress.”

A detailed breakdown and associated rationale for the figure above is further detailed below:

- Listening Sessions & Outreach ($2,000,000): Supports biannual sessions across all 18 VISNs, including logistics, accessibility, and targeted outreach to underserved veterans.

- Survey Development and Implementation ($1,500,000): Updates and distributes intersectional, inclusive surveys to capture meaningful data from diverse veteran populations.

- Tailored Strategy Development ($1,250,000): Funds staff and contractor time to build and test specialized support strategies in collaboration with community advocates.

- Data Disaggregation and System Updates ($750,000): Modernizes VA data systems to track identity factors such as sexual orientation and tribal affiliation for better service delivery.

- Congressional Reporting and Oversight Support ($1,000,000): Supports staff, analysis, and public reporting systems for transparent biannual updates to Congress.

v. Section 302: Requirement for Department of Veterans Affairs to modify the REACH VET program to incorporate risk factors weighted for women veterans.

Section 302 updates the Real-time Evaluation and Advanced Cohort Health (REACH VET) program by directing the VA to weight suicide risk factors specific to women veterans—an important step toward more equitable mental health intervention. However, to truly meet its goals, REACH VET must go further: it must integrate identity-based and intersectional risk factors, disaggregate outcome data, and embed culturally competent, community-rooted care models.

These reforms are vital given the disproportionately high suicide rates among veterans of color, LGBTQ+ veterans, Native veterans, and those in rural areas—groups that often fall through the cracks of generic predictive models. Enhancing REACH VET's inclusivity is not just about improving accuracy; it's about saving lives through targeted, equitable intervention.

- Address Disparities with Disaggregated Data

Minority veterans experience some of the highest suicide rates within the veteran community and are often impacted by stressors such as racial discrimination, gender-based trauma, and limited access to culturally competent care. Aggregated data obscures suicide risks tied to race, gender identity, sexual orientation, and tribal affiliation. For REACH VET to be truly equitable, its data must reflect the full diversity of the veteran population.

- *Suggested legislative language to be added*: "The REACH VET program shall include the disaggregation of health, risk, and outcome data by race, ethnicity, gender identity, sexual orientation, and tribal affiliation to ensure accurate identification of suicide risk among minority veteran populations."

- *Suggested appropriations language to be added*: "Of the funds made available to the Department of Veterans Affairs for mental health and suicide prevention, not

less than $5,000,000 shall be used to implement demographic data disaggregation protocols within the REACH VET program."

This figure reflects the estimated cost of modifying VA's data infrastructure to accommodate additional demographic fields across electronic health records, suicide risk datasets, and analytics tools. This includes approximately $2,000,000 for software modifications and data warehouse integration; $1,500,000 for training and retraining VA data entry personnel across all facilities (assuming approximately 10,000 personnel at $150 per training unit); $1,000,000 for quality assurance, testing, and third-party audits; and $500,000 for updates to reporting and dashboard systems for internal and Congressional use.

- Integrate Intersectional Risk Modeling

The current REACH VET methodology lacks the nuance necessary to capture intersectionality—the compounded effects of multiple marginalized identities such as being a woman of color or a transgender veteran. Veterans with multiple marginalized identities often face compounded mental health stressors. Without this specificity, the program risks overlooking critical risk patterns. REACH VET must evolve to recognize and respond to these layered risks, rather than treating identities as siloed variables.

  - *Suggested legislative language to be added*: "The Department shall expand the REACH VET data modeling to account for intersectional risk factors, incorporating layered demographic profiles and composite risk scoring for veterans with intersecting marginalized identities."

  - *Suggested appropriations language to be added*: "Provided further, that $3,000,000 shall be allocated to enhance REACH VET's data systems and algorithmic infrastructure to support analysis of intersectional identities and risk factors."

This estimate supports advanced data analytics upgrades and modeling. This includes approximately $1,000,000 for hiring or contracting data scientists and clinical statisticians to redesign and test intersectional risk models; $1,000,000 for software development and algorithmic integration, including simulation modeling and bias testing; $500,000 for pilot program rollout in selected VA hospitals; and $500,000 for workshops and expert consultations with researchers in intersectionality, health equity, and AI ethics.

- Prioritize Culturally Competent Care and Community Partnerships

Cultural mistrust and systemic inequities have historically limited minority veterans' access to effective mental health care. Predictive modeling must be paired with culturally tailored interventions to be effective. This requires investing in trusted local providers, representative clinicians, and culturally informed treatment frameworks.

  - *Suggested legislative language to be added*: "The Secretary of Veterans Affairs shall ensure that all REACH VET-affiliated clinical staff receive annual training

in cultural competency, with particular focus on serving minority veteran populations, and shall authorize formal partnerships with culturally competent community-based mental health providers."

- *Suggested appropriations language to be added*: "Not less than $7,000,000 shall be used to support cultural competency training, community partnerships, and the integration of culturally tailored care models into REACH VET operations."

This estimate reflects the substantial labor, training, and partnership infrastructure needed for culturally competent care. It includes approximately $3,000,000 for national-level VA staff training (assuming 50,000 staff, $60 per training, and including trainers, materials, and e-learning modules); $2,000,000 in grants or contracts to 15–20 community-based organizations ($100K–150K each) for collaborative mental health outreach and care; $1,500,000 for development and dissemination of culturally adapted treatment protocols, including peer-reviewed consultation; and $500,000 for onboarding and certification of culturally concordant providers (e.g., bilingual therapists, tribal counselors).

- Include Identity-Based Stressors in Predictive Models

REACH VET's current algorithm does not factor in critical psychosocial stressors—such as racism, sexism, and homophobia—despite their well-documented role in suicide risk. These must be integrated into risk prediction tools.

- *Suggested legislative language to be added*: "The Secretary shall require the inclusion of psychosocial stressors—including but not limited to experiences of racism, homophobia, sexism, and identity-based violence—as weighted variables in REACH VET's predictive risk algorithms."

- *Suggested appropriations language to be added*: "$2,500,000 shall be directed toward research and model development for the inclusion of psychosocial and identity-based stressors in REACH VET's suicide risk identification system."

This figure is based on the cost of targeted research and predictive model enhancement. It includes approximately $1,000,000 for commissioned studies and VA-led research into the mental health impacts of racism, misogyny, homophobia, and other identity-based stressors (inclusive of literature reviews, data analysis, and peer review); $750,000 for statistical integration and validation of new variables into REACH VET's algorithm; $500,000 for interdepartmental workshops and feedback from minority veteran focus groups; and $250,000 for longitudinal model monitoring and recalibration over the first 2 years.

- Require Annual Oversight with Disaggregated Outcome Reporting

Robust oversight is essential to track performance and course-correct where disparities emerge. Mandating an annual Congressional report with disaggregated metrics and equity assessments will promote transparency and accountability.

- *Suggested legislative language to be added*: "Not later than one year after the enactment of this *Act*, and annually thereafter, the Secretary of Veterans Affairs shall submit a report to the Committees on Veterans' Affairs of the House of Representatives and the Senate on the performance of REACH VET in serving minority veterans. The report shall include disaggregated data on outreach, interventions, health outcomes, and suicide risk reduction by demographic group."

- *Suggested appropriations language to be added*: "$1,000,000 shall be allocated for the preparation of an annual Congressional report detailing REACH VET's performance with respect to minority veterans, including disaggregated metrics and equity-based evaluations."

This estimate reflects the ongoing need for data analysis, report development, and external validation. It includes approximately $500,000 for two full-time employees or contractors (statistical analyst and policy writer) dedicated to annual reporting; $250,000 for external evaluation or third-party equity audits to verify the VA's internal findings; $150,000 for IT and data visualization tools to prepare Congressional-grade reports; and $100,000 for outreach, printing, and public transparency efforts (e.g., executive summaries, web publication).

vi. Section 303: Review of and report on reintegration and readjustment services for veterans and family members in group retreat settings.

Section 303 establishes a grant program to integrate outdoor recreation—such as hiking, fishing, and camping—into mental health services for veterans at risk for suicide. These nature-based retreats offer a non-clinical, peer-driven path to healing, especially for those who may not engage with traditional care systems. With intentional design and oversight, this section has the potential to reach historically excluded groups and reduce suicide rates through culturally relevant, community-centered care.

- <u>Outdoor Retreats Must Be Designed for Marginalized Veterans</u>

Nature-based mental health programs can offer profound healing through peer support, stress relief, and reconnection—but many minority veterans face barriers to participation, including cultural alienation and lack of representation. Tailoring retreats for women, LGBTQ+ veterans, veterans of color, and tribal veterans is essential to ensure these programs are welcoming and effective for all.

- *Suggested legislative language to be added*: "The Secretary shall establish and support nature-based retreats specifically designed for veterans of color, women veterans, LGBTQ+ veterans, tribal veterans, and other historically excluded groups. These retreats must address cultural, gendered, and social barriers to ensure that marginalized veterans have equal access to the mental health benefits of outdoor activities. Such retreats must foster peer support, trust-building, and resilience in a safe and inclusive environment."

- Cultural Competency Requires Staff Training and Community Partnerships

For these programs to truly support diverse veteran communities, staff must be trained in cultural humility and trauma-informed care. Partnering with trusted organizations can help ensure outdoor retreats reflect the identities, histories, and values of those they serve.

  - *Suggested legislative language to be added*: "The Secretary shall ensure that all outdoor recreation programs funded under this section are culturally competent and inclusive. This includes requiring staff to undergo cultural humility and trauma-informed care training and fostering partnerships with local community organizations and veteran groups specializing in serving minority veterans."

  - *Suggested appropriations language to be added*: "The Secretary may reserve up to 15% of funds appropriated for outdoor recreation programs under this section to support training initiatives for staff, as well as to build and maintain partnerships with community-based organizations serving minority veterans."

It is recommended that $500,000 be allocated for the cultural humility and trauma-informed care training of program facilitators, ensuring that they are equipped to handle the complex needs of minority veterans. Additionally, $1,000,000 could be used to foster partnerships with organizations like Black Outdoors and Latino Outdoors, ensuring these groups are actively involved in program development and delivery.

- Ensure Dedicated Funding, Access Equity, and Transparent Oversight

To eliminate participation barriers such as cost, transportation, and equipment needs, Section 303 must dedicate funds specifically to support minority veterans. These resources will help level the playing field and ensure that veterans from all backgrounds can benefit from nature-based healing.

  - *Suggested legislative language to be added (dedicated funding)*: "The Secretary may reserve up to 20% of the funds appropriated under this section to support outdoor recreation programs that specifically serve minority veterans. These funds shall be used to cover program expenses, including transportation, equipment, and staff training, to ensure equitable access to nature-based healing activities."

We recommend $3,000,000 be allocated specifically to support minority veterans' participation in outdoor activities. This would cover the cost of transportation, specialized equipment, and staff training, ensuring that these veterans have equitable access to nature-based healing programs.

  - *Suggested legislative language to be added (disaggregated data):* "The Secretary shall collect and report disaggregated data on participation in outdoor recreation programs, including demographic categories such as race, ethnicity, gender, sexual orientation, disability status, and geographic location. This data shall be publicly available and used to assess the impact of these programs on suicide

prevention and improve program effectiveness."

- *Suggested appropriations language to be added (disaggregated data)*: "The Secretary is authorized to allocate up to $500,000 of the funds appropriated under this section for the collection, analysis, and reporting of disaggregated data on program participation and outcomes."

To facilitate data collection and analysis, $500,000 should be allocated for the establishment of systems to collect and analyze demographic data on outdoor program participants. Additionally, $250,000 would be needed for compiling and distributing annual reports to Congress, detailing program outcomes by demographic categories.

- Independent Evaluations Strengthen Accountability

Ongoing evaluations by independent stakeholders—particularly veteran advocacy groups serving historically excluded communities—will ensure these programs remain relevant, inclusive, and effective in preventing suicide. Transparent reviews will drive improvements and build trust.

- *Suggested legislative language to be added*: "The Secretary shall establish a process for ongoing oversight and evaluation of the outdoor recreation programs, including independent reviews conducted by external stakeholders, especially veterans' advocacy organizations serving historically excluded communities. The evaluation shall assess program effectiveness, participation rates, and the impact on suicide prevention among marginalized veterans."

- *Suggested appropriations language to be added*: "The Secretary may reserve up to $750,000 of the appropriated funds for ongoing program evaluation, including independent reviews, participant surveys, and the publication of findings."

We recommend that $500,000 of this funding cover costs for independent program reviews, participant surveys, and report publications. Additionally, the final $250,000 should be allocated for the development and distribution of annual evaluations to Congress and the public.

vii. Section 402: Access to mental health residential rehabilitation treatment programs for veterans with spinal cord injury or disorder.

Section 402 of the *BRAVE Act* establishes a pilot program to improve mental health access for veterans—especially those in rural or underserved communities—through flexible, community-based solutions like telehealth, mobile clinics, and caregiver support. To be effective, the program must integrate culturally competent practices, address workforce limitations, and include robust oversight to ensure equitable, sustainable care delivery.

- Addressing Staffing Strain Through Community-Based Solutions

Rural and underserved areas already face staffing shortages within VA facilities. Rather than further stretching limited resources, Section 402 should prioritize scalable care models—like telehealth and mobile clinics—that can serve more veterans without increasing workforce strain.

  - *Suggested legislative language to be added*: "The Secretary shall leverage existing VA resources and personnel by integrating community-based care models, including telehealth and mobile clinics, to alleviate workforce strain while improving care access for underserved veterans."

  - *Suggested appropriations language to be added*: "The Secretary may allocate up to 10% of funds appropriated for Section 402 to expand community-based care models and provide telehealth and mobile clinic services. These funds will support the establishment of these services and cover the costs of training existing personnel for integration into these models."

While the percentage above will allow for flexibility in planning, we offer a $5,000,000 funding recommendation, based on the scope and requirements of establishing telehealth and mobile clinic services, which are crucial for reaching veterans in rural and underserved areas where access to traditional health care is limited. The costs cover setting up telehealth platforms and mobile clinics. For telehealth, the funding will support the establishment of IT infrastructure, including the setup of software, hardware, and necessary technology. Mobile clinics will require investment in vehicles, medical equipment, and staffing, allowing these services to travel to rural and underserved areas. The breakdown of this amount includes $2,000,000 for the telehealth platform setup (including software, hardware, and IT infrastructure) and $3,000,000 for mobile clinic setup (which covers vehicles, medical equipment, and staffing). This totals $5,000,000, which ensures both telehealth and mobile clinics are scalable and can reach a wide number of veterans in remote locations.

- Empowering Caregivers to Provide Flexible, Home-Based Support

Requiring caregivers to be present in centralized VA facilities can create unnecessary burdens. Instead, training caregivers to deliver support in veterans' homes or communities would reduce institutional strain and promote independence.

  - *Suggested legislative language to be added*: "The Secretary shall ensure that caregivers providing assistance with activities of daily living (ADLs) are not required to be on-site 24/7. Caregivers shall be trained to provide care in veterans'

homes or other community-based environments, promoting veterans' independence while reducing the strain on VA facilities."

- *Suggested appropriations language to be added*: "The Secretary may allocate up to 12% of the funds appropriated under this section to develop caregiver training programs, including flexibility in care models that allow caregivers to assist veterans at home or in local communities."

A $3,000,000 funding recommendation is based on the cost of creating and implementing training programs for caregivers, as well as ensuring that veterans can receive care in their own homes or community-based settings rather than in resource-heavy institutional facilities. This funding will be used to develop comprehensive training programs that cover all aspects of caregiving, including assistance with activities of daily living (ADLs), emotional support, and mental health care. Additionally, it will promote the flexibility of care models, allowing caregivers to assist veterans outside of traditional, on-site care settings. The allocation includes $1,000,000 for developing training materials and curriculum, $1,500,000 for conducting caregiver workshops and training sessions, and $500,000 for providing ongoing support and resources, such as hotlines and online courses. This ensures that caregivers are well-prepared to assist veterans in a way that promotes independence and reduces the burden on VA facilities.

- <u>Scaling Innovative Technology to Deliver Remote, Equitable Care</u>

To reach more veterans efficiently, the pilot must incorporate virtual care tools like telehealth and remote monitoring. These solutions increase access, particularly for those facing mobility or geographic barriers.

- *Suggested legislative language to be added*: "The Secretary shall incorporate innovative solutions, including telehealth, remote monitoring, and virtual support, to create flexible, community-based care options that allow veterans to receive care at home or in local communities."

- *Suggested appropriations language to be added*: "The Secretary is authorized to allocate up to $10,000,000 to establish telehealth infrastructure and remote monitoring technologies for the pilot program, ensuring equitable access to care for veterans in rural and underserved areas."

A $10,000,000 allocation will cover the setup and operation of telehealth platforms, as well as the procurement of remote monitoring devices, ensuring that veterans in remote or underserved areas have access to necessary care.

- Ensuring Cultural Competency in Caregiver Services

Minority veterans often face systemic barriers and cultural mismatches in care. Section 402 should ensure all programs are designed with cultural awareness and tailored support for veterans of color, LGBTQ+ veterans, and women veterans.

  - *Suggested legislative language to be added*: "The Secretary shall ensure that all caregiver programs and long-term care options funded under this section are culturally competent, reflecting the diverse needs of veterans from different racial, ethnic, gender, tribal, and sexual orientation backgrounds."

  - *Suggested appropriations language to be added*: "The Secretary may reserve up to 8% of funds appropriated under this section for the development of culturally competent caregiving training and outreach programs specifically for minority veterans."

A $2,000,000 funding recommendation is designed to address the unique needs of minority veterans, who often face cultural and systemic barriers when accessing caregiving services. To ensure that caregiver programs are tailored to the specific challenges faced by minority veterans, it is essential to develop culturally competent training programs. These programs will help remove barriers to caregiving by ensuring that caregivers understand and respect the cultural, gender, and social needs of minority veterans. This allocation includes $800,000 for developing culturally relevant training materials, $700,000 for conducting outreach to minority veterans through community organizations, and $500,000 for establishing partnerships with culturally relevant organizations such as Latino Outdoors and Black Veterans for Social Justice. This funding will increase the accessibility of caregiving options and improve the quality of care for marginalized veterans.

- Expanding Access for Rural Veterans Through Mobile Infrastructure

Geography remains a major barrier for rural veterans seeking mental health services. Section 402 must ensure that these communities receive targeted support through mobile and virtual platforms.

  - *Suggested legislative language to be added*: "The Secretary shall ensure that telehealth services and community-based care options are accessible to veterans in rural and geographically isolated areas, addressing the unique challenges faced by these veterans in accessing care."

  - *Suggested appropriations language to be added*: "The Secretary may allocate up to 15% of funds appropriated under this section for initiatives aimed at improving access

to care for rural veterans, including telehealth infrastructure, mobile clinics, and partnerships with local organizations."

We recommend $7,500,000 be allocated to expand telehealth and mobile clinic services, making it easier for rural veterans to access care without needing to travel long distances. The costs will cover the necessary infrastructure to support telehealth, such as internet infrastructure and platform setup, as well as expanding mobile clinics into rural areas. The allocation includes $2,500,000 for telehealth infrastructure (covering internet infrastructure, platform setup, and hardware costs), $3,000,000 for the expansion of mobile clinics (which includes vehicles, medical equipment, and personnel), and $2,000,000 for partnerships with local community organizations, veteran service organizations, and local health providers. This investment ensures that rural veterans can receive the care they need without significant geographic or logistical challenges.

- Building Local partnerships to Deliver Community-Based Care

Local organizations and veteran networks are well-positioned to deliver personalized care. Section 402 should formally support partnerships with these groups to co-develop and implement care models rooted in community.

- *Suggested legislative language to be added*: "The Secretary shall foster partnerships with local community organizations, veteran service organizations, and caregiver networks to develop and test community-based care models, integrating local caregivers and community support houses."

- *Suggested appropriations language to be added*: "The Secretary may reserve up to 10% of the funds appropriated under this section to support community partnerships, including the establishment of local caregiver networks and collaborative pilot programs with community-based organizations."

Our $4,000,000 recommendation ensures that community-based care models, which provide personalized and accessible care for veterans, are developed and maintained. This funding will help establish local caregiver networks and support collaborative pilot programs with community-based organizations. By integrating local caregivers and community resources, the program can reduce the burden on centralized VA facilities while ensuring that veterans receive care in familiar and supportive environments. The $4,000,000 is allocated with $1,500,000 to establish local caregiver networks, including recruitment, training, and support infrastructure, and $2,500,000 for collaborative pilot programs with local organizations to test and refine care models. This will help develop effective and sustainable community-based solutions for veterans.

- Accountability Through Independent Oversight and Evaluation

To ensure the pilot meets its goals—particularly for underserved groups—Section 402 must include ongoing, independent evaluation and reporting to track effectiveness and promote transparency.

  - *Suggested legislative language to be added*: "The Secretary shall establish a robust oversight mechanism for the pilot program, including regular reports to Congress on its progress, challenges, and veteran feedback. The reports shall assess the program's impact on veteran satisfaction, health outcomes, and cost-effectiveness."

  - *Suggested appropriations language to be added*: "The Secretary may allocate up to $1,000,000 for oversight and evaluation of the pilot program, including independent reviews and data collection on program outcomes."

To ensure that the pilot program remains effective, transparent, and accountable, $1,000,000 will be allocated to support independent program reviews and data collection. This funding will be used for evaluating program outcomes, collecting feedback from veterans, and ensuring that the program is meeting its objectives. The allocation includes $500,000 for independent reviews, which will include program assessments, participant surveys, and analysis of the program's effectiveness. The remaining $500,000 will be used for ongoing data collection and reporting, including the development of systems to track and analyze program outcomes, ensuring that adjustments can be made as necessary based on feedback. This will provide the data needed to assess how well the program serves minority and rural veterans, ensuring that it is both effective and equitable.

D. Closing Access Gaps, Strengthening Outreach, and Addressing Unique Veteran Needs

We offer conditional support for the *BRAVE Act*, contingent upon the inclusion of key recommendations to ensure the bill effectively addresses the needs of the most underserved populations, particularly veterans in rural and marginalized communities. These changes are crucial to ensuring equitable access to care for all veterans, regardless of location or background.

Caring for veterans is a shared responsibility that transcends political divides. For conservatives, *the BRAVE Act* aligns with values of honor, duty, and sacrifice, while progressives will recognize it as a step toward justice for marginalized veterans facing trauma, discrimination, or inequality. Regardless of political affiliation, the universal need for comprehensive mental health care is clear, and the bill seeks to fulfill this need. Additionally, investing in mental health care offers both moral and fiscal benefits, as early intervention can prevent costly emergency care, incarceration, and chronic health treatments.

A key strength of the *BRAVE Act* is its emphasis on empowering local organizations to deliver solutions that meet the unique needs of their communities. This approach appeals to both

conservatives, who value local control, and progressives, who prioritize culturally competent care for underserved populations. Both sides can agree that effective, localized care is often the most impactful. The *BRAVE Act* addresses critical access issues by expanding mobile Vet Centers and telehealth services, improving healthcare access in remote areas. To enhance this effort, it is essential to ensure these initiatives are specifically designed to address the needs of marginalized veterans, including veterans of color, LGBTQ+ veterans, and women veterans.

Investing in veterans' mental health is not only a moral imperative but also a national security priority. By strengthening families, reducing dependency, and upholding the warrior ethos, the *BRAVE Act* contributes to building stronger, more resilient communities, which in turn enhances national security. Supporting veterans' well-being is directly tied to military readiness, ensuring those who have served receive the care they deserve and can reintegrate successfully into civilian life.

The *BRAVE Act* represents a model for bipartisan cooperation, showing that when both sides unite on common ground, meaningful solutions can be achieved. It reinforces public trust by demonstrating that government can deliver tangible results for those who have given so much in service to the country. This issue transcends political divisions; it is about honoring veterans by ensuring they receive the care and support they deserve.

IV. Conclusion

Veterans from underserved communities continue to face significant barriers to accessing mental health care. These barriers stem from discrimination, cultural insensitivity, geographic isolation, and historical mistrust of health care systems. Without dedicated programs and targeted outreach, many of these veterans remain without the care they urgently need. Addressing these disparities is not just a health care issue; it is a moral imperative. The mental health crisis among underserved veterans is a failure to honor their service and sacrifices. We must prioritize their mental health to uphold the values of service, sacrifice, and patriotism.

A critical part of addressing these disparities is partnering with organizations embedded within these communities, organizations that have a long history of advocating for the needs of underserved veterans. While coordination with national groups like the "Big Six" is important, veteran service organizations such as MVA, the Black Veterans Project, Service Women's Action Network, and the Modern Military Association of America have been leaders in raising awareness of the challenges faced by marginalized veterans. Their voices and input are essential to ensuring that mental health services are inclusive, relevant, and responsive to the unique needs of these veterans.

Thank you, Mr. Chairman, Ranking Member, and Committee members for your ongoing dedication to improving mental health care for veterans. I look forward to collaborating with the Committee and other stakeholders to continue enhancing services for underserved veterans, ensuring that every veteran—regardless of background—receives the care and support they need and deserve.