8.24.25 Testimony Emily Meyers, LPC, CEO Hearing on Veterans Access to Mental Healthcare in Louisiana

Welcome and Introduction

My name is Emily Meyers, I am a Licensed Professional Counselor in Louisiana. I have dedicated my career to developing programs that support individuals and their families recover from mental health and substance use disorders (SUD). Today, I proudly serve as the Chief Executive Officer of Longbranch Recovery and Wellness which is a part of the community care network, and it is both an honor and a profound responsibility to be here to speak on an issue that is deeply personal to me; ensuring timely, effective, and equitable access to behavioral health care for our veterans.

I want to begin my testimony today by expressing my respect and appreciation for the Veterans Health Administration (VHA) and its dedicated employees. In my experience, VA staff care deeply for the veterans they serve and work tirelessly within the constraints of policy to deliver the best care possible. At Longbranch, we view ourselves not as critics of the VA, but as partners, standing alongside the VHA in its mission to ensure every veteran receives the highest quality care.

Since the inception of the Mission Act and more recently the Compact Act, our organization has worked hand in hand with the VA, responding whenever a veteran calls us directly or is referred to us by the VA staff. We understand the stakes. Veterans struggling with substance use and mental health challenges face an elevated risk of suicide, medical crises, and premature death. When they reach out for help, the window to act is short and the urgency is real.

About Longbranch Recovery and Wellness

Longbranch was founded in 2018 and provides evidence-based, holistic treatment for substance use and co-occurring disorders. Our company is clinician-led, trauma-informed, and tailored to the unique needs of each individual. Recognizing the distinct experiences of veterans, we worked with the feedback of the local VA staff to develop both a separate male and female veteran extended care programs. These programs address the veteran's clinical issues coupled with developing life skills in recovery for progressive autonomy. As Longbranch's CEO and COO positions are filled by clinicians, it is one of our guiding ethical principles to invest in the excellence of our clinical team to be trained and competent in working with this population. For example, all our clinicians are trained in interventions such as Prolonged Exposure Therapy and Cognitive Processing Therapy for Post-traumatic stress disorder as this is a very common co-occurring diagnosis. We have also collaborated through research studies with the VA on innovative approaches such as yoga therapy for veterans with substance use disorders; the results have shown promising outcomes for a significant reduction in symptoms across many spectrums we measure progress in treatment.

Longbranch offer the full continuum of care, from detoxification and residential treatment to extended care, intensive outpatient programs, long-term monitoring, medication-assisted treatment, and aftercare. Longbranch is one of the few programs to also offer services to the

families of our patients through workshops, counseling services and aftercare support groups as family involvement can substantially improve patient outcomes. We take pride exceeding not only VA and our Third-party administrator, Optum's standards, but also the requirements of our state licensing bodies and national accreditation agencies. Lastly, Longbranch employs many veterans who are in recovery which is something that our leadership is extremely proud of.

Where the Mission Act and the Compact Act Falls Short for Veterans with SUD

While the Mission Act and the Compact Act were landmark steps toward improving access, its implementation for veterans with substance use disorders has been inconsistent and those inconsistencies can be deadly for this population.

Different VA Medical Centers (VAMCs) interpret the same policy in vastly different ways. In some locations, veterans are offered a choice of community providers and the opportunity for those providers to educate VAMC staff on available services or resources. In others, that choice is restricted or absent. Some VAMC systems maintain strong, ongoing communication with community partners; others do not. These variations result in delays, confusion, and in many cases, the loss of the short "willingness window" when a veteran is ready to enter treatment.

I want to provide an example of what a veteran who needs help must navigate under the current status quo. This is cited from veteran's report, VA staff report, VA policy, and VA literature. The veteran must schedule an appointment to see their provider to discuss their substance use issue which usually has a wait time; then they are provided a referral to a substance use disorders clinic or staff to assess them for treatment needs. If their current provider believes they need treatment at that time of the original appointment, that doctor's referral must be reviewed by another provider and approved. Once the substance use disorder assessment is complete or the referral to treatment is approved, the staff look first for a VAMC residential treatment bed. If a VAMC residential treatment bed is not available, the veteran may be referred to community care but only if the wait is expected to exceed 20–30 days. This process typically from the first phone call to actual placement, commonly exceeds 30 days as the clock does not start until they come in for the original appointment. There are numerous phone calls back and forth and multiple appointments to get care. As you might be able to tell, this process is confusing to navigate for anyone, especially someone with an active substance use disorder. This process can also vary from VAMC to VAMC based on resources and staffing, so giving veterans the correct information for the VAMC they are connected to of how to get help when they reach out can be unclear.

For veterans with substance use disorder, 20–30 days is not simply a wait; it can be a fatal gap. During that time, they face heightened risks of medical emergencies, accidents, incarceration, suicide, or overdose; particularly given the dangers of today's fentanyl-laced drug supply.

The result is that VA staff, who are doing their best, are forced to follow a process that works against the urgency of substance use disorder treatment. It is not a matter of individual performance, but of policy that does not account for the acute risks specific to SUD. Unless the

veteran is actively suicidal crises, they are lost in the gap between the Mission Act standards and the Compact Act standards.

In quality community behavioral health facilities around the country, when someone or their family reach out for help, we all act swiftly and remove barriers to entry. Unfortunately, for our veterans they cannot benefit from that swift action due to the current processes and policy.

Opportunities for Improvement

We believe the VA and community partners can work together to improve the following:

1. Establish consistent national implementation guidelines for SUD referrals that reduce variability across VAMCs along with improved training for VA staff about the mission act criteria.
2. Institute a consistent policy surrounding engagement and education from community providers to VA staff to reduce confusion on behalf of both parties.
3. Prioritize rapid placement for veterans with SUD, especially for detoxification needs, even if they do not meet Compact Act criteria for suicidal crisis.
4. Enhance post-treatment supports, including extended care and housing, to prevent the cycle of relapse and repeated short-term residential admissions.
5. Strengthen communication channels, such as regular live case staffing between VA and community providers, to ensure seamless, wraparound care.
6. Update contracted housing programs criteria to meet current trauma-informed and recovery-supportive housing standards.

Substance use and mental health conditions are contributing factors to suicide and homelessness. Addressing these challenges quickly and comprehensively is essential if we are to reduce veteran suicide and improve long-term recovery outcomes.

Closing

The Mission Act and the Compact Act created an important pathway to care. Now we must ensure that pathway works as intended for veterans with substance use disorders without dangerous delays, without inconsistent interpretation, and without leaving veterans to navigate a complex system in their most vulnerable moments.

Longbranch is dedicated to its roles as a community provider, a partner to the VA, and as citizens is to be part of the solution. With consistent implementation, open communication, and a shared focus on timely access for these high-risk veterans, we can honor their service with the care they have earned.

Thank you for the opportunity to testify, and I welcome your questions.