S. HRG. 119–155

BREAKING BARRIERS: IMPROVING VETERANS' MENTAL HEALTH IN LOUISIANA

FIELD HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS UNITED STATES SENATE

ONE HUNDRED NINETEENTH CONGRESS

FIRST SESSION

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AUGUST 14, 2025

BREAKING BARRIERS: IMPROVING VETERANS' MENTAL HEALTH IN LOUISIANA

THURSDAY, AUGUST 14, 2025

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

This field hearing was held, pursuant to notice, on August 14, 2025, at 9:11 a.m., in Lac Ponchartrain Room, 2nd Floor, Student Life Center, Delgado Community College–City Park Campus, New Orleans, LA, Hon. Bill Cassidy, presiding.

Present: Senator Bill Cassidy

OPENING STATEMENT OF HON. BILL CASSIDY, U.S. SENATOR FROM LOUISIANA

Senator CASSIDY. Good morning, everybody. Thank you for being here. First, I have to apologize. I am dressed casually because I'm going on an alligator hunt——

[Laughter.]

Senator CASSIDY [continuing]. With President Trump's Secretary of Labor. Now, wearing a tie on an alligator hunt is, shall we say, not the way to do it. So, I apologize for being so casual because I have multiple responsibilities today.

But none of them is as important as this. This is actually a Senate Veterans' Affairs Committee hearing. This is something which will go into our record, and it is a chance for our veterans to communicate with me and with folks in the Veterans Administration upon issues important to us all. We're focusing today on mental health which we know is an issue.

President Lincoln, in his second notable address spoke of—well, I won't get it quite right, but we shall, we shall bind up the wounds of those who have served our country on the battlefield. But it's also the motto for the VA. Now, some of those words are unseen. And some of those wounds, nonetheless, even though unseen, affects somebody for their whole life. That is what we're addressing here today. And by the way, before I go further, I want to thank Delgado. Madam Chancellor, thank you very much.

[Applause.]

Senator CASSIDY. There's different issues. Our State is a rural State. We're in New Orleans. If you're in New Orleans, if you're Jefferson Parish, you can come to this area and you can get your care. But what if you're in Allen Parish? What if you're in Jackson Parish? What if you are in Lafourche Parish? How are we going to get those services there as well? That's number one.

Number two, we know that according to the Department of Defense, half of the overdose deaths in the military are related to fentanyl. So, that is a problem which afflicts all our society, not just veterans, and not just those in the Department of Defense. It afflicts us all. And so how do we address that?

Now, I will say, and I'm very proud of this, President Trump just signed into law my bill, the HALT Fentanyl Act, which gives law enforcement one more tool by which to go after fentanyl. But that is something which continues to afflict our communities, and we're going to hear from the VA how they may specifically be addressing that.

I would also like to point out that sometimes you need somebody from the outside looking in to help stimulate or get suggestions as to the reforms that are required. One piece of legislation that I have promoted is called the VetPAC. The VetPAC would be an independent board of the VA, which looks at the VA operations and make suggestions to Congress and to the VA how they can improve service.

I say this because this hearing should be part of an overall bigger effort to address these concerns. And this is modeled after something which is done for Medicare, it's called MedPAC, and for Medicaid called MACPAC, in which independent agencies are making suggestions to improve Medicare and Medicaid.

So, I'm hopeful that this hearing, that effort is part of, in partnership with the VA, improving the services that are delivered to those who have served our country. So, well, that's the goal.

Now, today, we get to hear from folks who can answer questions. And our first panel, Fernando Rivera, who is the director of the Southeast Louisiana Healthcare System. And now, you have VISN 16?

Mr. RIVERA. Yes, sir. In an interim role.

Senator CASSIDY. Interim. Scott McDougall has left. And so, he's actually over the whole VISN, which includes not just New Orleans, but also Shreveport, and other areas as well.

Mr. RIVERA. Yes, sir.

Senator CASSIDY. Second will be—he's accompanied by Catina McClain. We've decided that we're related through an ancestor who died in a drunken brawl——

[Laughter.]

Senator CASSIDY [continuing]. But that's another story—who is the chief mental health officer in VISN 16. And Laurel Harlin, who is the chief of psychology services at the Southeast Louisiana Veterans Healthcare System.

And also, very much appreciate Hon. Charlton Meginley, who is the secretary of the Louisiana Department of Veterans Care. And we'll hear from each of them, and then we'll open it up.

PANEL I

STATEMENT OF FERNANDO O. RIVERA, DIRECTOR, SOUTHEAST LOUISIANA HEALTHCARE SYSTEM AND NETWORK DIRECTOR, VISN 16 (INTERIM), VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS ACCOMPANIED BY CATINA MCCLAIN, MD, CHIEF MENTAL HEALTH OFFICER, VISN 16, VETERANS HEALTH ADMINISTRATION; AND LAUREL HARLIN, PHD, CHIEF, PSYCHOLOGY SERVICE, SOUTHEAST LOUISIANA VETERANS HEALTH CARE SYSTEM, VETERANS HEALTH ADMINISTRATION

Mr. RIVERA. Good morning, Senator Cassidy, and distinguished guests. Thank you for the opportunity to discuss the Department of Veterans Affairs efforts to support mental health and well-being of veterans in Louisiana, particularly in rural and underserved communities.

My name is Fernando Rivera, I serve as the interim network director for Veterans Integrated Service Network 16, VISN 16. Joining me today are Dr. Catina McClain, mental health lead for VISN 16, and Dr. Laurel Harlin, chief psychologist of the Southeast Louisiana Veterans Healthcare System.

Veterans in rural areas face unique challenges; long distances to care, limited provider availability, and social isolation. Across VISN 16, which spans large rural populations, we are committed to bridging these gaps, but we know that Louisiana Veterans face compounded challenges beyond PTSD, traumatic brain injury, and chronic illness.

Severe weather events such as hurricanes, often displaced veterans from their homes, jobs and support systems, and rural parishes, access to mental health care is limited and suicide risk remains high. Despite these challenges, we're proud of the strong integrated care we deliver statewide. VA facilities in Shreveport, Pineville, and New Orleans have served Louisiana for over 95 years.

Across our service area, nearly 5,800 VA employees provide care to over 151,000 veterans annually. Access remains a key concern, particularly for mental health, residential rehabilitation and treatment programs, or mental health RRTPs. These programs provide essential support to veterans with serious mental health and substance use conditions.

Currently, there are only seven VA mental health RRTP beds in Louisiana, limiting timely access to this level of care. Within VISN 16, we've begun implementing centralized screening for our RRTPs. As a result, we've seen a nearly 6 percent increase in veterans admitted within 72 hours of a referral. And this year, and the President's fiscal year 2026 budget proposes a $1.5 billion investment to expand our RRTP capacity nationwide.

We're also expanding virtual mental health services, such as VA Video Connect. Since the start of this fiscal year, Louisiana VA facilities have delivered nearly 10,000 virtual mental health visits. Many rural areas still lack broadband infrastructure, so we're committed to technology collaborations that enhance access to care regardless of the ZIP Code.

To address transportation challenges, VA's Veterans Transportation Service helps ensure veterans can reach the care they need. In VISN 16, we're expanding access to community-based outpatient clinics, and growing our network of more than 1,800 mental health providers and VA's Community Care Network.

The Veterans Community Care Program, or VCCP, enables eligible veterans to receive care for more than 1.4 million non-VA providers nationwide. This program is especially vital for those in rural Louisiana, providing high quality, timely care closer to home. We are proud of our community collaborations from local mental health providers and nonprofits, to educational institutions, and faith-based organizations.

These collaborations expand our reach and build capacity. Initiatives such as the veteran community partnerships involving churches, shelters, and nonprofits help us to upgrade at risk veterans before crisis occurs, our collaboration with the Louisiana Department of Health, Louisiana Department of Veterans Affairs, and local providers, helps close the service gaps and align suicide prevention strategies essential to executing Secretary Collins's vision for a unified veteran care across the Federal, the State, and community levels.

Senator Cassidy, thank you for the opportunity to speak today. Sir, we remain steadfast in our commitment to reaching and serving every veteran in Louisiana. And with your support, sir, we will continue delivering the care our veterans have earned.

[The prepared statement of Mr. Rivera appears on page 37 of the Appendix.]

Senator CASSIDY. Thank you. Secretary Meginley.

STATEMENT OF HON. CHARLTON MEGINLEY, SECRETARY, LOUISIANA DEPARTMENT OF VETERANS AFFAIRS

Mr. MEGINLEY. Senator Cassidy, I want to thank you, Chairman Moran, the Ranking Member, for holding this hearing today. On behalf of Governor Landry and Louisiana Department of Veterans Affairs, I'm very proud to affirm our state's unwavering commitment to serving our Louisiana veterans. I think as most people know, we are very passionate about doing this and veterans first. This is our job.

During my 19 months in this position, I'll tell you there's two numbers that have weigh very heavily on my mind. The number 17.5 and 150,000. 17.5 represents the estimated number of veterans who die by suicide each day, and the 150,000, is the estimated number of veterans who have died by suicide since 2001. And that's an estimate. I think the number actually just sit a bit higher.

Senator Cassidy, given the billions of taxpayer dollars that have been spent on veteran mental healthcare for the last few years, these numbers are not just unacceptable, they're unfathomable. The mental health of our veterans should not be simply a top priority, it must be the priority.

Nationwide, about 25 percent of veterans struggle with mental health issues, but Louisiana, that figure may be as high as 50 percent. The demands for services is increasing with 40 percent of all

VA appointments now addressing mental health. We must act now to close any gaps in care and ensure that our veterans receive the support they have earned.

As you'll see from our written testimony, the LDVA operates within two key environments, which we may encounter veterans with mental health issues, those veterans who are in our homes, and of course the veterans within the community. Our veteran homes face a critical and pervasive challenge with mental health disorders affecting a staggering 78 percent of our residents.

With 493 out of 632 individuals diagnosed with at least one condition, more than half of these residents grapple with multiple mental health disorders and diagnosis, compounding the complexity of their care. Furthermore, 435 residents, about 69 percent, rely on antipsychotic or psychotropic medications to manage their conditions.

Unfortunately, on too many occasions, we've had to deny admission to veterans with certain mental or behavioral health issues because we simply don't have the means to adequately take care of them or manage their needs. Over the last 2 years, 72 percent of our admission denials were due to mental and behavioral health issues.

These findings highlight wider challenges in the VA system. Some of the frequent comments that we receive from veterans around the State regarding VA services include; insufficient training in hospitals and clinics, community care coordination failures, long wait times, especially for psychiatric appointments. And most concerning that we hear that's often is the over-reliance on mental health-related medications without sufficient follow-up.

Senator Cassidy, with this said, I firmly believe that if you want to address the mental health needs of our veterans, you have to address the root causes. Why are so many veterans distressed? Underlying factors include exposure to combat trauma, PTSD and TBI, the stress of separation from family and support systems, difficulties transitioning to civilian life such as adjusting to new roles and isolation, legal issues, and co-occurring issues like substance use disorders, anxiety, and depression, exasperated by military demands. And of course, the experiences that some may have had with sexual assault or training accidents.

These causes are compounded in Louisiana by geographic isolation, rural poverty, and limited access to services. With respect to our 263,000-veteran community as a whole, we know that our Federal VA partners can't prevent suicide and address the mental health issues that veterans face by themselves.

Fortunately, they don't have to. There are an estimated 45,000 non-profit organizations nationwide that have stepped up to help veterans. In our written testimony, we've written we've highlighted just a few of these organizations that have made life and death differences in the lives of veterans.

There is one partner that I want to specifically acknowledge, and that is the University of Louisiana at Lafayette. An R1 institution, ULL is in the process of preparing a report that will undoubtedly shed some light on the extent of Louisiana's mental health crisis within its veteran community.

Preliminary findings from the survey are deeply concerning. While the national average for PTSD amongst veterans is 11 to 20 percent, our survey preliminarily is showing that that rate could be around 45 percent for Louisiana's veterans. Similarly, depression and anxiety rates are more than doubled than the national average according to, again, the preliminary results of the survey.

Factors include; geographic isolation, with 42 percent living more than an hour away from a VA clinic, transportation gaps, rural poverty, food insecurity, nation and neighborhood safety concerns. Many are Vietnam-era veterans with complex medical and mental health needs. Others are younger veterans dealing with combat trauma, TBI, and challenges transitioning to civilian life.

We plan to work with our ULL partners to conduct post-survey-focused discussion groups across the State to better understand the findings. I have probably a little bit more to go, but if you need me to stop, I will.

[The prepared statement of Mr. Meginley appears on page 45 of the Appendix.]

Senator CASSIDY. I see the time expired over there. And so, we'll allow you to develop some of that and go through the discussion.

Mr. MEGINLEY. Fair enough, sir.

Senator CASSIDY. Okay. Thank you. Thank y'all for that. Fernando, if I'm asking some of the folks out there, they're going to say you got a lot of turnover in your healthcare staff, and particularly in mental health. When I see the stats, I'll see in Washington, they'll tell us, oh, we've hired this many people, which it's a lot of people, but that tells me as well that you're filling a lot of positions and there's a little bit of a flow through.

So, I think one of the concerns would be why so much turnover and what can be done to limit the turnover as a physician. I know the therapeutic relationship is something which has to be developed, and if it's changing on a regular basis, that's difficult. What can you inform people?

Mr. RIVERA. Well, thank you for that question, Senator Cassidy, as usual, extremely insightful, and open for quite a bit of discussion. We've always balanced, in the VA, the opportunity of serving and providing healthcare services to veterans. And then also, preparing and educating the future providers of those healthcare services.

At the VA here in New Orleans, we have a huge education mission. We're privileged to be one of only 15 VA hospitals across the country that's co-located with more than one medical school, and as a result, we're able to draw specialty care providers. We're able to associate Louisiana future providers who are enrolled in this freshman class at your alma mater, and encourage them to stay to learn about veterans.

70 percent of the doctors that graduate from a United States medical school rotate through a VA hospital for some of their training. This year, over 2,300 trainees in associated health programs and programs related to nursing, dental care, pharmaceutical care, and the like, psychologists of course. And in that sense, we we're finding that roughly about 50 percent of the staff of the students

tend to stay in the State. They tend to go back to the communities that they serve.

Senator CASSIDY. I get that. But I think that the issue is that people feel like the doctor that they're seeing, the psychologists whom they are seeing, the nurse, et cetera, is different on a—there's a turnover there. And I accept that some of them may be resident physicians, and that's true. But there also seems to be a turnover in terms of the psychiatrist, for example.

Is there a root cause of that, and is there something that can be done to change that? Because as we spoke, you have a therapeutic relationship, and all of a sudden, somebody is gone.

Mr. RIVERA. Yes, sir. There's a shortage. We can't get around the fact that the predictions are roughly 100,000 physicians nationwide, 200,000 registered nurses nationwide in our State. We don't have an overabundance of mental health providers.

Senator CASSIDY. Now, let me ask you, because one thing that's been done for optometrists, for example, is that if there is a sudden opening, an optometrist scheduled, there is a program that will take somebody who needs an eye examination and they will do it by internet. And they may be talking to someone in Wisconsin, even though they live in Jackson Parish. And it fills in that gap.

So, knowing that some cities have an overabundance of psychiatric support and others not so much, and the rural areas, not at all. Is the VA, or is our VA, embarking on any sort of virtual scheduling and other visits that will allow their sudden opening to be filled with somebody who needs acute care here?

Mr. RIVERA. Absolutely. And our telehealth program continues to grow in the mental health division. It has grown more than probably in other areas. We experience using telehealth to stay connected and maintain continuity of care.

Almost every year with hurricane seasons, our mental health providers will work from home. We will work with other mental health providers at other sites. I'm going to ask Dr. McClain to talk a little bit about our clinical contact centers because that is one of the real opportunities that we have not only to support VA hospitals that may be serving rural communities, but to support them through periods where they may have had staff turnover where we may have only had one or two psychiatrists and one has taken ill, another one has relocated because their spouse now works somewhere else. So, Dr. McClain.

Dr. MCCLAIN. Thank you, Mr. Rivera. And thank you, Senator, for the question. We are very fortunate in VISN 16 that we do have a clinical contact center where veterans can call and make same day linkages with mental health providers. May not be their provider, though.

And so, we also have a clinical resource hub. If a provider is ill, a provider retires, leaves VA for whatever reason, we're able to assign one of our virtual psychiatrists to pick up the care of that veteran and fill that gap until another permanent psychiatrist can be hired by the local facility.

Other steps that we've taken to try to reduce turnover include the establishment of a virtual on-call telepsychiatry program within the VISN. We were hearing anecdotes from some of our departing psychiatrists that they were taking positions in where the on-

call burden was less than in VA. And so, while we've not eliminated on-call responsibilities, we have been able to alleviate some of the burden of that for our psychiatry staff.

Also, VA has taken steps to adjust the physician pay scales. For example, VA has done special salary surveys for our psychologists. So, lots of things underway to try to reduce that turnover.

Senator CASSIDY. So, there could be a systems issue, but y'all attempting to address it?

Mr. RIVERA. Yes, sir. And there is an opportunity to incentivize future providers to stay in Louisiana and return to the communities where they serve.

Senator CASSIDY. And you also mentioned, and I would be interested, I'm not sure everybody kind of caught this, but I think I got it. The mental health residential and rehabilitation treatment program, did you say there's 7 or 17 beds?

Mr. RIVERA. Seven.

Senator CASSIDY. Seven. And describe for people like what that actually means, because when Charlton is saying he's got a limited ability to take care of people with severe psychosis, and I'm presuming that veteran might get a referral to you and this sounds like a wraparound service. Describe what these beds are please.

Dr. MCCLAIN. So, residential rehabilitation beds are established where we can give evidence-based therapies in a more concentrated manner that can be achieved on an outpatient basis. The RRTP beds are in layman's terms, I suppose, sort of the in between outpatient, full outpatient care and acute inpatient care.

Services include: substance use treatment, general homeless domiciliary programs, PTSD, residential care. Veterans in these programs receive intensive services, evidence-based therapies, state-of-the-art psychopharmacology, if indicated. And then, it helps them to transition to that more stable condition where they're able to manage successfully on an outpatient basis.

Senator CASSIDY. So, wraparound services that restore somebody to wholeness, but it's a more intense environment than just the outpatient. So, there's only seven beds. What is the waiting list for entry into these drugs?

Dr. MCCLAIN. The number of veterans, I don't have the exact number of veterans. One of the things that we have done across the VISN is to try to leverage our RRTP resources to serve Louisiana veterans. Given the low number of RRTP beds available, we have established single screening so that if a veteran is screened in Louisiana, that is good enough for Mississippi or Arkansas, for example, to accept that veteran into a residential program there.

We're also leveraging our community partners. We've outsourced a number of veterans this year, about 313 referrals, to our community partners for residential care. Our wait time has improved. We are shifting that curve to the left so that more of our veterans are getting into our RRTP care within 72 hours of the referral, about a 6 percent improvement over fiscal year 2024 for that group. Another 6 percent improvement in the number getting in within four to seven days. So, we've had about a 12 percent increase in the number of veterans accessing that level of care within a week of referral.

Senator CASSIDY. That's great. So, I'm very happy about that. By the way, I'm not blaming you if there's a shortage. It's up to Congress to kind of, I'm learning from you, redirect resources to expand those number of beds.

Dr. MCCLAIN. Yes.

Senator CASSIDY. So, Charlton, your testimony didn't go there, but we know that mental health is oftentimes tied to transition to the community, is tied to getting a good job that makes you feel good about yourself. I once heard a testimonial from a Marine who had been in Fallujah. He came back, and he tried to commit suicide. And he said over there I was part of a unit, and I was a Marine. And here, I was, you know, whatever it was, wasn't fulfilling to him.

And so, there was that transition of all the things that are implied in that. What can your agency do, and how do you manage that? And how do you work with the VA Federal?

Mr. MEGINLEY. Well, that's a great question, Senator Cassidy. I've only been retired from the military for a little over two and a half years, so I think a lot of folks even still consider me to be a transitioning vet. And so, the first thing that comes to my mind when I was thinking about when I hit the retirement button was, "What am I going to do with myself?" You know, "Where am I going to work?"

Well, in Louisiana, we have two incredible partners that actually get to the core root of what you're talking about right now. One of them is a program called The Boot, and one of them is Next Op. And their entire mission, both of them, is to put the transitioning service member to work. So, they have forged relationships with various companies and entities.

They've gone in the house, said, "We've got a ready-made employee ready for you. They're trained, they're disciplined, and they may not have the skills that you're looking for, but we know that you can train them because they've already been trained." And they help kind of ease that transition to get to that point where that individual is put to work, getting a good paying job, and can kind of start moving away from their military time back to transition into the civilian world.

And so, both The Boot and the NextOp, again, they've been incredible partners, and this is their sole mission. This has been a focus of ours since we came in; is what do we do for that young 22-year-old soldier who wants to say, "I really like it here in Louisiana, but there's no jobs." We're telling them, "No, there actually are plenty of jobs here. We're going to help you find one."

Senator CASSIDY. And implicit in that, is that if you can get them plugged into a job, they're more likely to find community and they're more likely to be mentally whole——

Mr. MEGINLEY. That's correct.

Senator CASSIDY [continuing]. Because you don't have the vacuum left from that camaraderie, from being in the service.

Mr. MEGINLEY. That's right. And those of us who were in for extended periods of time will tell you, when you're in the military, there is a certain process. There is a certain code of discipline, essentially. There is a certain way of acting. And when you get into civilian world, it's not like that.

Oftentimes, the discipline and the structure that you had oftentimes does not exist. And so, you expect more of your civilian counterparts. Oftentimes, that doesn't come. And so, these programs help kind of ease our service members back into what real life is.

Senator CASSIDY. Now, there's lots of folks here from veterans service organizations, and thank y'all for being here. Now, as it turns out, we know a lot of veterans will never knock on your door, on his door, on my door, but they will show up and play pool with somebody in a VSO.

Can you tell us how you can work with those organizations? So, if someone sees a buddy who's having a problem, he can say, or she can say, listen, "We know where to direct you." How do you disseminate your information to them? You see where I'm going with that?

Mr. MEGINLEY. So, I'll tell you the State gave us a car, and we've put over 30,000 miles on it in the last 11 months. All we do is travel. We go into the VFWs, we go into the Legions, we go into DAV, and we're talking to the veterans who feel like no one's listening to them. You can't live behind a desk in Baton Rouge. And I think myself and my deputy, you know, at least once or twice a week, we're out there talking to the veterans and trying to understand what their issues are.

But I'll tell you something else. There's a really important component to this, and that is the gentleman sitting down here at the end, and then Mr. Crockett's in here, Mr. Dante's in here, the VAMC directors, anytime I call them with a veteran issue, they respond. And sometimes it's just a matter of making the phone call to them because the veteran doesn't know how to get to them.

You know, one of the complaints that I get about the VA is phones. If someone would just answer the phone, most of the time the issue gets resolved. Okay? I will leave that up to the VA to determine and how to figure that out. But once that veteran calls me, and I get them to the right person, most of the time the issue is taken care of.

So, the VSOs, it's important for everyone to know this. I can't do my job without the VSOs. I don't have a State budget for mental health. But for me to get the VSOs to trust me and to trust our team, we have to go to them. And that's what we've been doing. And it's not just the Legion, it's not just the DAV, it's also the other partners, the 501(c)(3) partners that we have, the folks who are dealing with homelessness, the other ones who are dealing with mental health care. And it's forging those bonds, those partnerships, that allow them to kind of pick up where the VA may not understand or be able to capture those issues.

I'll give you one example. There's an organization called Objective Zero. They have an app that deals strictly with mental health for veterans, and the veteran has a live person to talk to. They may not want to go to the VA, but they have a resource right then and there that they need to talk to someone and chat with someone. It's there.

Supporting those types of partnerships and those types of entities who are getting in the mix, really at the grassroots level, is really important for the VA and Congress to start to understand and to fund, in my opinion.

Senator CASSIDY. So, the audience is here. They are motivated. They are here because they care about veterans' issues. So, ask first, you, then Fernando, or your staff. If somebody is needing services from the VA because of homelessness, or because of job transition, or because of mental health issues, fill in the blank. And one of the folks in this room can finally tell me how that would work. Just lay it out for—give a do this, do this, do this, for if the person lives in an urban area, like say Jefferson Parish or a suburban area like St. Tammany, or if they live in a rural area. So, chop, chop, chop, tell them what they should do.

Mr. MEGINLEY. From the DVA point of view, we have 74 counselors spread out throughout the entire State. So, if there's a veteran who's having an issue, they've got a parish counselor right then and there. Oftentimes that phone call is made——

Senator CASSIDY. How do they reach that? Is it on the internet? How do they know where to find that person?

Mr. MEGINLEY. So, our website is brand new. We just completely renovated it. It's updated. All you got to go to the website. Phone numbers are there for every VAC office.

Senator CASSIDY. Give them the website.

Mr. MEGINLEY. vetaffairs.la.gov

Senator CASSIDY. Veterans?

Mr. MEGINLEY. vetaffairs.la.gov

Senator CASSIDY. La.Gov?

Mr. MEGINLEY. Yes, sir. And so, you go to the website, it has the phone number and it has the contact information for that local veteran affairs office. And so if that individual, that veteran calls one of our guys and lets us know, we can get them to the proper local authorities if we need to or get them to the big VA if that's necessary.

Senator CASSIDY. I'm in Cameron Parish. I can go to vetaffairs.la.gov, I'll find the local person in Cameron Parish who I can call. Maybe they come visit, and they can intervene, and they can be a navigator for this person to reach your services through you or through Federal VA?

Mr. MEGINLEY. That's correct. And then at the campuses, we have 32 college campus navigators. So, if there's a college student who's having some sort of distress, a veteran college student, we have campus directors, campus navigators who are there to help our college students as well.

Senator CASSIDY. So, Fernando, how would you build upon that?

Mr. RIVERA. The average piece, sir is very much about seeing the fabric, the veteran family, across the Louisiana Department of Veterans Affairs, the Federal Veterans Affairs, the veteran service organizations, spiritual leaders in our communities. So, our outreach programs are designed to connect at all of those levels, to not only be partners in outreach activities, but to have our own outreach activities.

Our facilities and clinics so far this year have conducted nearly 3,000 outreach visits. Whether those outreach visits are being conducted on a daily basis by a team of homeless veteran outreach providers, social workers primarily who are going out every day to shelters, verifying whether there are any veterans there, making sure those veterans are connected to a program.

Senator CASSIDY. So the VA sends people to shelters on a daily basis looking for veterans who are homeless?

Mr. RIVERA. That's correct, and we are in that level of communication. We work closely with the student veteran associations at the universities as well. We stay connected.

My personal practice for 20 years now is to give every veteran that I have the privilege to serve my cell phone number, my email address. And often, I get phone calls. Every one of these individuals who know me have my cell phone number. They know how to find me. We view this concept of expanding our outreach program and developing it even further as critical.

When we're talking specifically about high-risk mental health patients being able to make that connection, whether it's because we have inclement weather coming and we need to know where our patients who are at risk for suicide are, and how we can stay connected with them so that there is continuity of care, whether we're talking about a veteran who is homeless, who is also having mental health illness. How do we connect them to those services?

This piece is very much a community piece. We all have skin in this game. We all have to know and be better at recognizing veterans in distress, understanding how to help that veteran, whether that veteran is sitting next to you in church, or he's in front of you at the Walmart, or he is next to you in a clinic.

Senator CASSIDY. Okay. So, hang on. I was not aware of this. Do y'all actively go out to pastors, priests, to rabbis, to Imans, you name it, and say, listen, here's our phone number, sir.

Mr. RIVERA. Yes, sir. We hold mental health stand downs. We invite spiritual leaders and other key stakeholders.

Senator CASSIDY. Now, what is the participation. To what degree does everybody who attends such an organization—I'm in the church. Do I need to knock on the door of my pastor and say, "Pastor Kevin, are you aware of this? And if so, are you making a referral?" So, how much uptake do you have from the faith-based community to be your liaison?

Mr. RIVERA. The short answer, sir, is not enough. When we're talking specifically about suicide, statistics are showing that 60 percent of that 17 are not enrolled in the VA. And they may be very well entitled to receive mental health care in the VA. So, reaching to that 60 percent that isn't even connected to the VA healthcare system is critical.

Senator CASSIDY. So, one thing everybody in this room can do, if they're based in any sort of civic organization, whether it's faith-based, Rotary, is the leadership of that node. If there is in our community someone who needs help, what number would they call? I mean, what is the specific point of entry into the services required?

Mr. RIVERA. The 24/7 service is the Veterans Crisis Line, which I, myself, called on behalf of a veteran two nights ago. And VA was able to provide care for that veteran. And then there's the medical center number. There are the community-based, our clinic numbers that can be reached.

Senator CASSIDY. So, the Veterans Crisis Line?

Senator CASSIDY. Yes, sir.

Senator CASSIDY. What is that phone number?

Senator CASSIDY. 988

Senator CASSIDY. 988. Okay. And that seems like something which like—well, let me ask you, Charlton, after speaking of that, people download, what's the name of that app?

Mr. MEGINLEY. Objective Zero.

Senator CASSIDY. Objective Zero.

Mr. MEGINLEY. The objective being no suicides

Senator CASSIDY. And I presume it could also link there. Correct?

Mr. MEGINLEY. They do have contact information for the Veterans Crisis Line.

Senator CASSIDY. By the way, going back to the job transition programs and the job training programs, do y'all also connect veterans with those programs?

Mr. RIVERA. We do, and we work with NextOp in our outreach. When we do outreach out of our facilities, it's usually a multi-professional team. We will have mental health providers on that team, but we'll also have human resources staff who can teach veterans about employment, how to seek employment, not just within the VA or the Federal Government, but other opportunities.

Senator CASSIDY. Now, again, if somebody wants to access those services, because a good job is good for somebody's mental health. And if you can look at the so-called deaths from despair, they're concentrated among men, principally men, but also women, who feel like the economy has left them behind.

And by the way, I asked one of the previous VA secretaries if some of the suicide in the VA was just representative of this broader societal phenomenon. He said he thinks so. And so, it's an influence back and forth.

So, if somebody wants those job training resources, and we're all listening, and people who are watching by other means are listening, so I'm asking to speak to them as well. I'm trying to transition out, I want a better job. I think their job training programs out there, and I don't think to call the State, I want to call the VA, what number would they use? How do they reach?

Mr. RIVERA. They would call the medical center's number, sir, and each medical center has its own number, and request assistance.

Senator CASSIDY. And so I can call and say, I would like information on job training. I'm a veteran. I'm eligible for benefits. Where do I call next?

Mr. RIVERA. They would be able to refer to either our human resources department that would be able to refer to our veterans' experience officers and all of them would be able to make that connection.

Mr. MEGINLEY. I think it's important though, for veterans to know the VA's website as well. The website has tremendous amounts of information.

Senator CASSIDY. Va.Gov?

Mr. MEGINLEY. Yes, sir. And when I was in my process of getting out, I spent almost a day just going through the VA's website seeing, "Okay, what may I qualify? How am I going to start preparing for my exit out?" And I learned so many things the VA was doing I had no clue.

And so just sitting there and going through everything, as I would've expected, especially with training and education opportu-

nities once I was done and how to use my GI bill, the best way possible for my kids.

So, that's my biggest encouragement for any veteran. Go spend some time on the VA website. You will learn a tremendous amount about the veteran benefits. There's a benefit not too long ago that I learned, I didn't even know about. One of my counselors said, "oh, did you know about this?" I'm like, "no." And it was just like, "yes, here it is." I'm like, "wow, that's amazing."

Senator CASSIDY. Yes. By the way, I was once explained, again, in fairness to the VA and the DoD, I asked if they walked through the process of somebody leaving from Fort Polk and how would they transition out? And they said, we have a whole day in which we tell them everything. I'm thinking, yes, but you're 26 years old, you're super excited. You want to move. And you're sitting there thinking——

Mr. MEGINLEY. You might strike a nerve on this one. For those of us who have walked out in recent times, I had a TAP, it was 5 days. The one thing that I was told, if you listen to nothing else, Friday, 9 o'clock, VA briefing was the most important thing. And I was lucky enough, I did pay attention, it helped me out a lot.

But TAP is shotgunned at you and you're just sitting there saying, "I don't understand a lot of what you're talking about." And you're getting it within 6 months of walking out of the service. You're just worried about getting a job. That's what I want to know. How are you going to put me to work when I'm walking out, right? If I have medical benefits, how am I going to access those when I walk out?

And so, to me, the TAP program does need to have some reformation done to it. Not just the shotgun approach, "Hey, here's some tools, good luck," because that's what I think a lot of service members, and now veterans, will tell you that's what they got out of the program. Was, "Here's some stuff. Thanks for serving. Good luck."

Senator CASSIDY. So, I just got a note. I'm supposed to wrap up this panel and go to the next, thank y'all very much.

Mr. MEGINLEY. Yes, sir.

[Applause.]

Senator CASSIDY. Okay. Thank y'all for being here. In the second panel, we're going to have veterans and leaders of the community that have been doing outstanding work regarding mental health on behalf of our veterans such as community care provider, providing state-of-the-art clinical care for veterans, faith-based homelessness center.

And I'll just let them introduce themselves. And so again, I thank you for being here, and thank you for contributing to this dialogue. Ms. Magee-Baker, please introduce yourself, and please make your remarks.

PANEL II

STATEMENT OF DR. CHERYL MAGEE–BAKER, DIRECTOR, HOPE CENTER, INC.

Dr. MAGEE-BAKER. Good morning. I am Dr. Cheryl Magee-Baker, the director of the Hope Center, Incorporated. So, good morning, Senator, and Members of the Committee. And since this is a testimony, I cannot let it pass without being honored to say I'm thankful to God for the grace He has given us in my Lord and Savior Jesus Christ.

I'm honored to represent Hope Center, which is a faith-based organization headquartered in Gretna, Louisiana, of Jefferson Parish. It is an outreach ministry of the Hope of Glory Church under the extraordinary leadership of Dr. W. Ron Walker, President. I'm here today to speak about the lifesaving work we've done under the Staff Sergeant Gordon Parker Fox Suicide Prevention Grant Program, and the Supportive Services for Veteran Families Program. This is about our unwavering commitment to the veterans and military families who call Louisiana home.

Let me begin with a truth we all know too well. Suicide among veterans is a public health crisis, and for far too long, too many have slipped through the cracks. But I'm proud to say that in our corner of the country, we're doing something about it. The work of suicide prevention and ending homelessness is our opportunity to reach veterans and their families with help and hope.

At Hope Center, we touch the lives of 123 veterans and service members through the SSG Fox Grant Program. And not one, not a single one, has been lost to death by suicide. This is the impact of timely outreach, culturally competent care, deep rooted community trust. And on the homelessness side, in the past 13 years, Hope Center has served over 5,425 veteran households.

The work is not easy. We must address mental health concerns and move from trauma-informed care to healing center engagement if we want the best outcomes. Over the past year, Hope Center has conducted outreach across six parishes in Southeast Louisiana in libraries, churches, barbershops, and coastal communities where veterans live in isolation.

Through these grassroots efforts, we've engaged over 530 veterans and service members, many of them for the first time. We've connected 26 individuals to the VA who had never accessed their benefits, and I can imagine there are more. And then there was another 42 who are on the rolls at the VA, but not accessing VA benefits or services or VA healthcare.

These are men and women who served our country with honor, but carried their battles home in silence. And silence, Senator, can be deadly. The stigma of admitting suicidal thoughts keeps many from speaking openly even when they come to us asking for help. We've seen veterans on suicide watch unable to check a box on a form. What they really need is someone to sit down, look them in the eye and say, "You matter. We are not going anywhere. We are here with you." That's the heart of what we do.

Our peer support specialists, veterans themselves, offer more than services. They offer hope. They hold healing circles. They

walk into someone's living room at 6 p.m. on a Friday. They host the *Still Standing Podcast* where listeners hear real stories from real people who walked through darkness and made it out on the other side.

We build partnerships with the VA Suicide Prevention team meeting weekly to coordinate care Veteran. And Hope Center is working to inform and educate the community by training faith-based organizations to open up veteran welcome centers in their houses of worship.

Senator CASSIDY. Dr. Magee, can you wrap up?

Dr. MAGEE-BAKER. Yes, sir. So, we urge the Committee to continue to expand the SSG Fox and SSVF Programs, including re-engaging veterans who are on the rolls but not using VA services.

[The prepared statement of Dr. Magee-Baker appears on page 61 of the Appendix.]

Senator CASSIDY. Thank you. Ms. Meyers.

STATEMENT OF EMILY MEYERS, LPC, CHIEF EXECUTIVE OFFICER, LONGBRANCH RECOVERY AND WELLNESS

Ms. MEYERS. Hi, my name is Emily Myers, and I'm a licensed professional counselor in the State of Louisiana. I have dedicated my career developing programs to support individuals and their families recover from the mental health and substance use disorders.

Today, I proudly serve as the Chief Executive Officer of Longbranch Recovery and Wellness. We are a part of the Community Care Network, and it's both an honor and a profound responsibility to be here today to speak on behalf of an issue that's deeply personal to me; showing timely, effective, and equitable access for behavioral healthcare for veterans.

I want to begin my testimony by expressing my respect and admiration for the Veterans Health Administration and its dedicated employees. We work very closely with them. In my experience, the VA staff care dear equally for the veterans. They serve and work tirelessly within their 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 and 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 mistakes. Veterans struggling with substance abuse and mental health issues 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.

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 experience of veterans. We worked with the feedback of the local VA staff to develop both a separate male and female extended care program

for veterans. These programs address the veterans' clinical issues coupled with the developing life skills and 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 working with this population. For example, all of our clinicians are trained in interventions such as prolonged exposure therapy and cognitive processing therapy for PTSD, or post-traumatic stress disorder, that is a very common co-occurring diagnosis for our veterans.

We also have collaborated with the research within the VA on improving approaches such as yoga therapy for veterans with substance use disorders and chronic pain. These results have shown very promising outcomes for a significant reduction in a variety of symptoms that we survey across the treatment process.

Longbranch offers a full spectrum of care from detoxification, to residential to extended care, intensive outpatient long-term monitoring medications, assisted treatment, and aftercare. We are one of the few programs that offer services to families for our patients through workshops, counseling services, and aftercare support groups because family involvement could substantially improve patient outcomes.

We take pride in exceeding not only VA, but our third-party administrator Optum standards, and also, the requirements of the State licensing bodies, and national accreditation agencies.

Lastly, Longbranch employ many veterans who are in recovery, which is something that our leadership team is extremely proud of. While the MISSION Act and the COMPACT Act were landmark steps toward improving access, implementation for veterans with substance use disorders has been inconsistent and those inconsistencies can be deadly for this population.

Different VA Medical Centers or VAMCs interpret the same policy in vast different ways. In some locations, veterans are offered a choice of community providers and the opportunity for those providers to educate the VAMC staff on available services or resources and others that choice is restricted or absent. Some VAMCs maintain strong ongoing communication with the community partners. Others do not.

These variations result in delays, confusion, and sometimes in cases, the loss of the short willingness window when a veteran is ready to enter treatment. I'll give you an example of what might a veteran have to navigate under the current status quo. This is cited from Veterans report, VA staff, VA policy, and VA literature.

The veteran must schedule an appointment to see their provider to discuss their substance use issues and that might have a wait time. Then, they're 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 the time of the original appointment, that doctor's referral must be reviewed by another provider and approved.

Once the substance use disorder assessment is completed or referral to treatment is approved, the staff first look for a VAMC residential treatment bed. If the VA residential treatment bed is not available, the veteran may be referred to community care, but only

if the wait time is expected to be 20 to 30 days. This process from the first phone call to actual placement commonly can exceed 30 days as the clock times does not start until they come in for the original appointment.

There are numerous phone calls and back and forth for appointments to get care. And as you might be able to tell, this process can be confusing to navigate for anyone, especially someone with an active substance use disorder. This process can also vary from VA Medical Center to VA Medical Center based on resources and staffing, so veterans giving veterans the accurate information for the VAMC they're connected to of how to get help when they reach out to us, can be unclear.

For veterans with substance use disorders, 20 to 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 the VA staff who are doing their best are forced to follow a process that works against the urgency of substance use disorders treatment. It's not a matter of the individual performance, but a policy that does not count for the acute risks of substance use disorders. And unless the veteran is actively suicidal, they're lost in the gap between the MISSION Act standards and the COMPACT Act standards.

[The prepared statement of Ms. Meyers appears on page 63 of the Appendix.]

Senator CASSIDY. Mr. Jackson.

STATEMENT OF JACKSON SMITH, JD, EXECUTIVE DIRECTOR, BASTION COMMUNITY OF RESILIENCE

Mr. SMITH. Thank you, Senator Cassidy, for the privilege of testifying here today. And I also want to start by saying thank you to the representatives of the 15,000 strong veteran population of this city who fill this room. I'm acutely conscientious that I testify up here, not on my own behalf, but on behalf of you.

My name is Jackson Smith. I'm the Executive Director of the Bastion Veterans Community here in New Orleans, and a Marine combat veteran. My experience with the most pressing issues facing our veteran population began in 2010 in Helmand Province, Afghanistan. I spent eight months there in high-intensity frontline combat with the 78 Marines and Sailors of Third Platoon, India Company, 3/6.

And over those eight months, I watched virtually every one of those Marines experience multiple, in some cases, dozens of brain-injuring events like landmine explosions and firefights. And in the years since then, I have seen how few resources there are out there for the hundreds of thousands of veterans with experiences.

Just like the Marines of Third Platoon, suicide, PTSD, traumatic brain injury, overdoses, deaths of despair, these problems are growing worse for our veterans, not better. In the last two years of available data, we have seen the veteran suicide rate here in our State of Louisiana increased by nearly 35 percent, while the civilian rate has stayed relatively flat.

The Wounded Warrior Project's 2025 Community Survey, some of the most detailed data that we have available on post-9/11 disabled veterans, shows that homelessness among this population has doubled between the last two surveys. We've heard today about continuing to lose nearly 18 veterans per day to suicide. But that number grows to 44 when we account for overdoses and other self-induced deaths. That means during the course of this hearing alone, we will lose as many as four more veterans. Four right now as we speak.

But the news is not all bad. Initiatives like the Staff Sergeant Fox Grant are an important first step toward delivering the innovation and care that our veterans so desperately need. But it is only that a first step. I have heard witnesses before this Committee in previous hearings testify that the primary purpose of the Fox Grant is outreach, connecting with those veterans who are otherwise slipping through the cracks.

And I agree, but outreach requires presence, boots on the ground in the communities where these veterans live and in their lives. And at less than two Fox grantees per State today, and seven states with no grantees at all, we are not cutting it. The Fox Grant program should be expanded significantly, including the availability of significantly more grants for first-time applicants.

In the last cycle, more than 80 out of 93 Fox Grants went to existing grantees making the pool of available funds for new initiatives vanishingly small. Thus, for small community organizations like Bastion, it is difficult to justify the significant effort required to even assemble a Federal grant application. And that really matters because it's organizations like ours on the ground that are often best to deliver that follow-through, that in-person care, eyeball to eyeball that can make the difference.

Organizations like Bastion are already working furiously to innovate and fill gaps in the continuum of care. Bastion's Headway program, funded since its inception by the Wounded Warrior Project, is a perfect example. One of the first long-term no cost community-based rehabilitation programs for veterans dealing with traumatic brain injuries.

An expanded Fox Grant, particularly one that specifically incentivizes programming for brain injury affected veterans, could help to deliver programs like headway at the scale that is required.

I also urge this Committee to consider renewing or replacing the Assisted Living-TBI Pilot Program. That program was terminated in 2017 without replacement for a variety of reasons, including that it was deemed prohibitively expensive. But I would submit to this Committee, respectfully speaking, that given that there is no alternate or replacement program in place, expensive compared to what? I believe that we owe it to these veterans to deliver the care that they need regardless of cost, just as they raised their hand and swore to defend this Nation and their Constitution, regardless of cost, even that of their lives.

I would also submit to this Committee that in terminating that program without replacement, we have merely passed on the cost to our veterans and their families with stark consequences. Today, the suicide rate for long-term caregivers of non-seniors is as high as 20 percent. We can do better, and we must.

I will leave this Committee with the words said to me just last week by one of our head of veterans, "This program saved my life." To hear those words from a fellow veteran is a gift that I lack the words to properly describe other than to say to my friend, if he's listening, "I'm proud of you."

But when I hear those words, I cannot help but to think of how many more veterans we have not yet reached. How many of my brothers and sisters we have already lost because we could not reach them in time. How many more will we lose if we wait another year? How many more will we lose today? Too many. Organizations like Bastion can make the difference in the lives of these veterans. We prove it every day, but we need your help and your resources to turn the tide. Thank you.

[Applause.]

[The prepared statement of Mr. Smith appears on page 66 of the Appendix.]

Senator CASSIDY. And next is Kirk Long. Kirk Long is the one who said to me, "Hey, when you go out on that boat today, don't fall off."

[Laughter.]

Mr. LONG. Don't fall out the boat, Doc.

STATEMENT OF KIRK LONG, FORMER CHIEF EXECUTIVE OFFICER, CRESCENT CITY SURGICAL CENTRE

Mr. LONG. Good morning. My name is Kirk Long, and I appreciate Senator Cassidy's invitation to speak with you today. I'm also a United States Marine Corps veteran, and the proud father of an active-duty Marine, currently serving in Camp Pendleton, California.

I have been a hospital developer and operator for over 30 years. With the last 15 years being spent as a Chief Executive Officer of Crescent City Surgical, located in Metairie Louisiana. Crescent City Surgical is a licensed general acute care hospital focusing on a broad array of specialized care to include neurosurgery, orthopedics, surgical oncology, pain management, and mental awareness. Our provider network is large and is augmented by a partnership with LCMC Health, the largest hospital system in the New Orleans region.

Initially, I was asked to speak on the barriers to entry with the Community Care Network. Put simply, unless you know someone in Congress, you'll not receive a return phone call. Then, when and if you do, you will be presented with a boilerplate contract with lower than market payment rates. There's no room for negotiation. All of this combined with the immense difficulties of dealing with the VA in general, present little to no incentive for private network providers to engage.

However, these challenges encouraged our team to propose the creation of a pilot program that would augment the current VA system. Specifically, our intent was to address the egregious wait times many veterans encounter, especially if they need specialized care. We learned that the NOLA VA Medical Center was faced with many staffing shortages, especially in the surgical specialties.

Since our network does have access to these specialists, we are confident that we will be able to successfully reduce these wait times and treat the veterans in a timely manner. We have presented this project to Members of Congress and have been encouraged by the response, and we look forward to seeing it to fruition.

Additionally, we are encouraged by the ACCESS Act legislation currently making its way through Congress. It is apparent that the Members of Congress, such as you, Senator Cassidy, as well as other Members of the United States House and Senate VA committees, have heard about the many challenges of working with the community care networks and are working hard to address them. We applaud this.

We are also encouraged by the renewed focus within the new ACCESS Act legislation to address the dire mental health issues currently faced by our veteran community. I would like to take this opportunity to announce the creation of a new mental health facility in New Orleans, the Crescent City Behavioral Health Center. The comprehensive care provided at this new center will include both inpatient, outpatient, and partial hospitalization mental health services in a safe and comfortable environment.

The center will also be committed to the treatment of chronic pain, including the myriad of organic and degenerative diseases contributing to the mental illness. We will also recognize the need for additional substance abuse disorder services and intend to include this in our services.

I'll be happy to discuss any of the further details or answer any questions at your convenience. Thank you.

[The prepared statement of Mr. Long appears on page 68 of the Appendix.]

Senator CASSIDY. And then, Paul, please.

STATEMENT OF PAUL HERMANN, EXECUTIVE DIRECTOR, DISABLED AMERICAN VETERANS, DEPARTMENT OF LOUISIANA

Mr. HERMANN. Yes, good morning. My name is Paul Hermann. Senator Cassidy, Members of the Committee, thank you for the opportunity to appear before you today as we discuss how we can improve mental health care for veterans in Louisiana across the country.

On behalf of the Disabled American Veterans, Department of Louisiana, I'm honored to offer testimony in support of one of our organization's top legislative priorities for the 119th Congress; eliminating persistent gaps in veterans' mental health care and suicide prevention, particularly for service-disabled veterans in rural, remote, and underserved communities.

Now, I want to be clear, VA has done a lot over the years to improve mental health services. They built strong programs for PTSD, depression, anxiety, substance abuse, and military sexual trauma. But even with all that, too many veterans are still falling through the cracks. And that's especially true for veterans who historically have been overlooked, like women veterans, rural veterans, and those dealing with MST and intimate partner violence.

Here's one example. VA has a suicide prevention model that helps identify veterans at crisis. It's a smart tool and it's saving

lives, but originally it did not include MST or intimate partner violence despite evidence that both are major contributors to veteran suicide. We are very pleased that VA has addressed the issues and recently rolled out REACH VET 2.0, which includes MST and IPV. Same goes for the community care.

VA trains its own staff in things like suicide prevention, lethal means safety, trauma-informed care. But once you send a veteran to a proper provider in the community, those requirements disappear. That's just not good enough. If we're going to trust the community providers with veterans' mental health care, they need to understand where veterans are coming from and be trained accordingly. We need to make sure that all providers, VA or not, are prepared to meet the veterans where they are with understanding with the right training and with consistency.

The last part, consistency is a huge issue. Veterans often finally build up the courage to open up to a therapist or a psychiatrist only to find out that that person has left and moved on. Then, they've got to start over again with someone new. Trust doesn't come easy when you've been through trauma. Losing a trusted provider can set someone back months and sometimes years.

Another thing we've got to address is how we deliver care in the rural areas. Look, not every veteran can or wants to do therapy over video. Some veterans live in areas where there is no reliable internet. Others just don't feel comfortable talking about trauma on a screen. They want to see someone face to face, not feel like they're just another face on the monitor.

After Hurricane Katrina, the VA sent out mobile clinics to serve veterans where they are. Why not do the same for mental health? Let's bring psychiatrists care to rural veterans, even if it's just a few days a quarter. The mobile units could run out of the VA medical centers in New Orleans, Alexandria, and Shreveport, and rotate throughout the rural parishes. That kind of regular in-person contact could make a real difference, especially for veterans who are isolated and don't have transportation.

Now, when we talk about MST, we have to understand it's a different kind of trauma than combat.

Senator CASSIDY. Just for a second, MST is military sexual trauma.

Mr. HERMANN. Yes, sir.

Senator CASSIDY. Yes, so everybody knows what you're talking about.

Mr. HERMANN. I'm sorry. MST survivors shouldn't be placed in group therapy with combat veterans. They need tailored support, and that goes for any mental health issue. We have to meet veterans as individuals, not try to treat everyone the same way.

Finally, I want to emphasize something simple but important. Veterans need to know they matter. They're not just a number. They need to be heard, believed, and treated with dignity. When veterans feel like they're being passed around, rushed through appointments, or pushed to the side, it can feed into the hopelessness that we are trying to prevent. One suicide is too many. We have to do better.

So, here's what we're asking; continue to update the suicide risk tools to reflect real veterans' experiences, make suicide prevention

and trauma-informed care training mandatory for all providers who see veterans, and invest in face-to-face rural outreach, especially for mental health. If we can do that, we can start closing the gaps, and truly show veterans that their lives and their well-being are worth fighting for.

On behalf of DAV, Department of Louisiana, and the veterans we serve, thank you for your leadership and continued commitment to this mission. I'm happy to answer any questions you may ask.

[The prepared statement of Mr. Hermann appears on page 69 of the Appendix.]

Senator CASSIDY. Thanks, Paul. Again, thank you all and I'll just kind of go down some lines, some questions I came up with. Doctor——

Dr. MAGEE-BAKER. Yes.

Senator CASSIDY. Fernando really emphasized coordinating with faith-based institutions, and obviously you're one of them.

Dr. MAGEE-BAKER. Yes.

Senator CASSIDY. What can we do to improve the understanding of, you name it, mosque, church, synagogue, that this resource is here, you do it within a faith-based setting, but the VA? You see where I'm going with that? How can we improve that? Because I'm not sure my—I have to ask my pastor, but Fernando suggested that it's not as wide a place as it should be, because he says it's not as much as it should be. How do we improve that?

Dr. MAGEE-BAKER. Well, we've improved our relationships with connecting with houses of worship and faith-based organizations. And let me just tell you, Director Rivera has been very open-hearted on, but I think inviting those institutions of faith into the VA and welcome them in, I think sometimes what happens is because of, you know, the religious pact and different things like that in the separation of church and State that sometimes is operated under, that leads houses of worship to think that they're not wanted in government.

So, one part is inviting them in to see the facility, to explore the needs. And part of our work is working with those other faith-based organizations and houses of worship to recognize because some of them don't even know that they have those who served in the military veterans or who are the military families within their local congregations. So, as we reach out to them, they become more aware.

Senator CASSIDY. Sean, are you still here? Sean is one of my staff here in Baton Rouge, and he interfaces with a lot of the VSOs. They have a very active program to help veterans. Sean is available 24/7. He's a bachelor. You can call him day or night.

[Laughter.]

Senator CASSIDY. If you wake him up, who cares?

[Laughter.]

Senator CASSIDY. But, Sean, on our website, we need to put information for veterans. Somehow, we need to begin communicating to these faith-based organizations that the VA wants to work with. And so just think about that.

I want my office to pick up the same challenge I've given to everybody. How do we help Fernando better connect with those faith-

based organizations? Because they're oftentimes the person who knows the need.

Emily, you used the word navigation. It almost seems like there needs to be a navigator to take somebody through this process. Any thoughts on that?

Ms. MEYERS. Thank you for question, Dr. Cassidy. I appreciate it. Yes, I know there are patient experience officers within the VA. So, we try as a community care partner, when a veteran reaches out to us in crisis or their family, to get connected. We try to direct them to the Veterans Experience Office——

Senator CASSIDY. But you were speaking really fast.

Ms. MEYERS. Yes.

Senator CASSIDY. And even speaking really fast, it takes a really long time for someone to potentially work through the process. And I'm a doctor who used to work with patients with liver disease, and some patients with liver disease have a history of addiction. On the other hand, everybody in here knows somebody who's had a history of addiction. And the willingness window, we know that exists. We know that willingness, and you can catch them then, and if not, they are back on.

So, how do we shorten that process to get to see a community provider if the VA's not there for someone in that willingness window?

Ms. MEYERS. Yes, I know that there is that current legislation that was referenced earlier, the ACCESS Act. They're talking about that for substance abuse, because again, navigating that process for a mental health or substance abuse crisis can be very challenging for them. And so, what I had proposed kind of—I didn't get to, even though I talk fast—was looking at prioritizing a rapid placement for veterans with substance use disorder, and especially with detox needs, and finding a way that maybe we could supplement the VA while they're waiting for an RRTP bed.

And I know there is a VA up in North Dakota that's done that, where they work with a community partner for rapid placement, and then they coordinate the long-term step down to a residential bed within the VA system. So, that could potentially be a solution long-term to assist those veterans in crisis that don't meet acute inpatient criteria.

Senator CASSIDY. Now, why do we need legislation if North Dakota's already doing it?

Ms. MEYERS. I think it's that kind of gap between the Federal legislation and sometimes like the specific VA has ability to negotiate contracts. So, I think there's that confusion between the community care process now that exists and then the specific VA negotiating a contract because there's a gap in services in their area.

I know North Coast is pretty rural, so that could be part of the reason they're doing that as well. But I think New York also has a similar program.

Senator CASSIDY. Paul, you mentioned specifically the rural areas. Thank you for emphasizing that, sir. And it does seem like somebody in a rural area by definition lives far away from another person.

Mr. HERMANN. Yes, sir.

Senator CASSIDY. And so what do we do for outreach that those people know that they can access the VA, or va.gov is a nice place to be. But as you point out, sometimes there's not even good broadband there for the services. By the way, in my legislation I've worked in the bipartisan infrastructure bill, I'm hoping it's soon implemented, there'll be access to high speed, affordable internet for everybody in Louisiana, no matter where they live. So, we're trying to confront that.

But that said, how do we connect those people, anyone who might have that need, when they're in a rural area for that initial visit?

Mr. HERMANN. I think a lot comes from family or friends checking on them, other veterans checking on them. The VA has a program that they're supposed to check on them so many times when they first get out. But I believe that if we brought the—like I was talking about the buses, we did it in Katrina, bring them out to a local area and these people can——

Senator CASSIDY. So, let me ask you, because I've been told that there's a stigma, and that some people in rural areas do not want to go to a mental health clinic because small towns talk.

Mr. HERMANN. Correct. Some of them don't even want to admit they have the problem.

Senator CASSIDY. Now, but they have more likely to admit because you stressed you need to have an appropriate setting for the appropriate issue.

Mr. HERMANN. Correct.

Senator CASSIDY. So, if you bring the kind of VA mental health clinic to small town, does that push people away? You follow? I'm saying mental health clinics.

Mr. HERMANN. I follow you, but I don't—I honestly believe if we started this program, that veterans would come to it because now they can see somebody face to face and talk to somebody face to face. And even if even if the bus came and they had groups working with PTSD clients or MST clients, because again, they're PTSD, but it's not the same. Combat and sexual trauma are two different things.

So, it's just the only way to—we've got to figure out a way to reach them. And I believe that that could possibly be a way to do that or find someone in the local community for them to get together, you know, at a barber shop, whatever it is, and have someone there that's trained in these types of traumas so that they're talking to somebody.

One of the biggest things veterans don't want to do is talk to somebody that doesn't have a clue what they're going through. I mean, that's the bottom line, too. Iraqi veterans don't want to necessarily talk to Vietnam veterans because they don't think it was the same type of war, but it's still war. So, we've got to get people to talk to other people that are in their age group or they suffered the same type of trauma.

And like I said, to me it's find a local area that we can send someone to. The VA sends people out locally to help with claims. So, why not do the same thing with mental health?

[Applause.]

Senator CASSIDY. Chronic pain. Chronic pain, brother, that drags you down. Once I had a neck pain for about three months, I had a pinched nerve, and I mean, all my emotional energy went to managing that pain and eventually the nerve died and that—so, I hear what you're saying. So, is the chief barrier the ability to contract with the VA in order to provide those services?

Mr. LONG. So, one of the main barriers, Senator Cassidy, is the community care networks are statutorily limited in how the VA is allowed to pay the private providers if a veteran is able to utilize a community care network. And that was one of the frustrating things that we ran up against was that even though the community care networks are administered by Optum, Optum is owned by UnitedHealthcare. We as a provider had a contract with UnitedHealthcare, but Optum was not allowed to offer us the basic same rates.

Senator CASSIDY. And these are just fair market rates. And so, I was actually talking to Fernando before we came up here, and one of the suggestions that we had was add some language in some of this legislation that would allow the negotiation for fair market payment rates through the Community Care Network.

So, if you're a veteran and you need to go see a neurosurgeon, and a local VA does not have a neurosurgeon available within two or three months, you're able to go outside the VA system. You go see a neurosurgeon. Well, as we all know, a lot of times, we've discussed it here today, the veterans are usually a fairly complicated case.

They don't just go because they've got back pain. They go because they have back pain. They also have five other comorbidities. They have COPD, they might have cancer, they might have addiction issues, they might have some sort of mental health issue, but they might have intractable pain that causes them mental anguish.

And so, these cases require a lot more time, and effort, and resources by the private provider. All we would ask to just be paid fairly for that. Not anything more or less, just a fair market negotiation. And I think that would really open up the success and provide for many more positive outcomes via the Community Care Network, which is a great idea.

It's just there's some communications issues with it. There are continuity of care issues with it. And I think the ACCESS Act addresses several of those from the version I saw. And we applaud that. And I think that with the addition of some sort of fair market payment negotiation, that availability would really go along way.

Emily, in the initial stages of the fentanyl epidemic, people spoke about how someone would come in with pain and be given oxycodone, and that would—they would maybe have a genetic predisposition or whatever—but they would transition from taking one oxycodone every three days to escalating doses.

Of those who are addicted that you see, how many of them begin with a chronic pain kind of precursor and it leads to that? Of course, not all, believe me, I don't want to put a stigma on anybody with chronic pain. Period. Don't do that. Just like we don't want a stigma on veterans regarding mental health, but for those who have that issue, we want to acknowledge it. So, how many of those.

Ms. MEYERS. Well, thank you, Dr. Cassidy, for that question. So, a lot of people, I don't have the exact number on top. I can get that for you in the post hearing. But most of our veterans come in with two diagnoses for addiction, is going to be substance—or sorry, alcohol use disorder is the primary or opioid use disorder is the primary. So, those are usually our two diagnoses.

Now, what I will say is that every single person, we pretty much drug test any illicit drug they're taking now. Anything they get off the street which is a common thing for chronic pain. When they start with prescriptions and then they navigate to street drugs, everyone is testing positive for fentanyl.

So, it's every single patient pretty much we drug test that uses illicit drugs. But yes, many of our veterans especially have chronic pain issues. And we try to address that holistically with yoga therapy, coupled with medication-assisted therapies, as well as helping them work through those issues with other models.

Senator CASSIDY. Jackson, my staff confirmed the original bill, the original legislation that you're describing for the TBI was my legislation. The Veterans Traumatic Brain Injury Care Improvement Act passed when I was announced representative. And as you're speaking of it and the effectiveness of it. Of course, I like that if you sponsor something, do we have longitudinal data?

As a doctor and then as a Senator, if I'm going to make the case that this needs to be reinstituted, you want to have the outcomes that shows, wow, it did improve lives and by improving lives, you may think it was expensive up front, but it saved a lot of money on the back end. Do we have that data for this program?

Mr. SMITH. Sir, I don't believe that we have that data to show effectiveness at the outset. What we have instead is a quickly growing body of evidence as to the negative outcomes that we're heading toward absent intervention. And as I've stated in my testimony, my overriding concern is that there is no replacement in place for that permit.

Senator CASSIDY. I'm with you on that. But let me ask, it's a lot easier to make the case, and you're kind of making it, it's the absence of it. Now we're seeing the untoward effects.

Mr. SMITH. Yes, sir.

Senator CASSIDY. But it would be good to catalog what those might be. For example, this VetPAC that I'm proposing, Senator Hirono from Hawaii is proposing as well, an outside evaluator. They could look at this program which has been terminated, and then see the results, and then they give advice back to the Congress and to the VA that this program should be reinstated. You with me?

Mr. SMITH. Yes, sir.

Senator CASSIDY. So, if you're telling me that the folks who formally were in the program who are now not in the program are having this and all of that bad, then that's also helpful. So, I'm going to ask you, if you can, working with others, however you can do it, and we'll provide resources if you can document that, because it's easier for me to make a case.

You notice I explored with Emily the relationship with someone beginning on opioids because of chronic pain, but it's easier for me to make a case for her position if we establish that some of what

she's catching is related to the absence of effective therapy. Are you with me?

Mr. SMITH. Yes, sir.

Senator CASSIDY. That's not a big stretch.

Mr. SMITH. No, no, not at all. What I can say right now that we already know, we've talked a lot about veteran suicide today. For individuals with moderate to severe TBIs, they are experiencing suicide and excess mortality across all causes at 11 times the rate of their non-injured counterparts. Numbers that are that stark combined with the caregiver statistics that I mentioned. That, to me, is a flashing red fire alarm. And it tells me that we have to put intervention and resources into this now.

And given how early we are in this process, we've done this pilot, that's true. Our understanding of the nature of brain injury and brain health has advanced considerably even since 2017 when that program was terminated, especially in terms of understanding how many more veterans there are out there with these kinds of conditions.

Things like blast exposure and training. I was talking with my fellow Marine over here about shooting mortars. Every one of those has a brain injury in the back. Marines fire hundreds over the course of training alone. So, frankly, we are way behind the power curve here.

My overriding concern is that we start to pour resources to see what works. Because right now we're really not even at that stage yet. Programs like Headway at Bastion have demonstrated efficacy. We have almost five years of data now on individual participants in that program, and "knock on wood," we have yet to lose one of those veterans to suicide.

But across the population, nationally, we are drastically behind. And when we look at the things that are coming out of conflicts like Ukraine and Gaza right now, the next war is going to be horrific in its effect on the brain health of our service members.

Senator CASSIDY. I'm going to ask each of you, Fernando was so gracious, he is there and I'm here. So, both Congress and the VA. If you had to each give like one piece of advice that you would want us to hear on behalf of the veterans, I'm going to just go to start with you, Paul, and it may be reason something you've already said, but just emphasize that one thing, then let us hear it and let us take it back.

Mr. HERMANN. The one thing I would say is competent psychiatrist and psychologist to deal with the issues that veterans are dealing with. Don't stick somebody that has depression with a combat veteran, or an MST patient, or an IPV patient. It is totally different. You need to train those doctors and psychologists in those fields.

Senator CASSIDY. So, MST versus combat and have competent physicians, psychologists trained for those.

Mr. HERMANN. Trained for combat MST and IPV, the interpersonal violence to be able to help the veterans deal with that. And it's not just women veterans. Remember, military sexual trauma does include men veterans.

Senator CASSIDY. That's one thing I've heard that believe me, there's more of a stigma associated with that and the men are less likely to come forward.

Mr. HERMANN. Yes, sir.

Senator CASSIDY. But when you do it, you find it.

Mr. HERMANN. Yes, sir.

Senator CASSIDY. If I had to say one thing, I would say let's make it easier for the VA to utilize the private sector and the private providers that are currently out there that currently have the capacity, the bandwidth, and the runway to take care of these veterans. It wouldn't be difficult. It will be a small jump. I'm going to ask you to be offline later. Communicate that directly because Emily spoke about how there's this kind of folding over of combat admission and somehow sometimes things free fall between. And so, later you have my contact. Send me something specific in regards this is what you would do. There's been a great deal of discussion and testimony today around outreach. Outreach requires presence. It requires presence in person and on the ground.

Mr. SMITH. There are no remote jobs in the military. There are no one person jobs in the military. We have talked about that veteran living rurally or struggling at home alone with mental health issues. All of the new things that we're rolling out; telehealth apps, those are important steps toward access. But I have been that lonely veteran, and I have gotten on the app, and I was as lonely when I got off as when I got on. I might have gotten some good advice. I might have gotten some counseling to help me with some of the other things that I'm dealing with. But if I am alone and isolated to be at the beginning of that call, I'm isolated at the end.

Community organizations, like the ones filling this room, are already doing the work. We talk about faith groups. When Bastion's new facility opens, the first thing that we are doing is going to every one of our local churches because we know, they know where the veterans are and where the struggling veterans are.

You give $1,000 to the DAV, you'll get $1,000 worth of outreach and serving veterans. I guarantee, same thing for the VFW. Same thing for all of our community organizations who are face to face with these problems every day. And right now, resources are not getting down to those ground level organizations from the pots of truly life changing, game changing resources like the Federal Government, the VA.

Organizations like ours are not built to compete for a Fox grant as it is currently configured at 11 grants available per year nationwide in the last cycle. I just can't justify. I have no shot competing against organizations that can hire an entire outside company just to assemble that grant. Organizations like our VSOs, our DAVs, our American Legions, it's the same thing. We don't have time to do that because we are face to face with that veteran.

So, we need avenues of funding that are more accessible. And that can mean in smaller amounts, a $750,000 Fox rate is a big deal, especially if you're counting on it renewing next year. It doesn't have to be that it could be a $50,000 grant, it could be a $25,000 grant. But with an application process that is navigable for these community-based organizations, we need the resourcing to

further the work that we are already showing we are capable of doing.

Ms. MEYERS. So, what I would say is the biggest issue and what I would ask for help with is basically when a veteran reaches out for help that phone call is really challenging for most people with substance abuse issues and veterans especially asking for help is really challenging. And so, we want to help them urgently navigate the process. So, developing consistent guidelines of implementation for getting them into.

Senator CASSIDY. Did you mention that VA's have different processes, so what you're saying there needs to be one which is common for all VAs?

Ms. MEYERS. And kind of what they mentioned with VISN 16, developing an outreach center. You know, I didn't know they had fully had that yet, and online. So, that's great for me to know so I can direct them to the right place. Because sometimes them making a second phone call or a third phone call, they get lost through the cracks and that's what we, none of us in this room want. So, finding a way to maybe let us help them urgently and in crisis and then help them get back to you as a healthier, a little bit more stable so that we can, we can continue long-term wraparound care. Veterans with substance abuse issues and co-occurring mental health disorders are very complex cases. They usually have a lot of medical comorbidities. They have a lot of mental health comorbidities.

There is, as we talked about, MST, PTSD sorts of very challenging mental health diagnoses and they deserve care and really quality communication between us and them. And I know most of the community partners that I know in the substance abuse world and addiction world are willing to coordinate and talk and work together to get them back to you guys. Get them back to utilize services more effectively. Help set up aftercare appointments with, with the VA and also give records and coordinate. So, developing that consistent implementation across VAs would be really helpful.

And second on that same note, is how do we engage with the VA can vary from place to place. So, is it a weekly staffing meeting? Is it an email? Is it a fax? Is it a you know, just how do we engage? Can we discuss resources that are available for the community care office? So, what they get a veteran that doesn't know where they want to go or what they want to do. You guys know where to send them. Not every veteran's right for us, right? There's other places that are better or might be a better fit for that patient.

So, we want to make sure they get to the right place, they get the right care at the right time and the right level of care.

Senator CASSIDY. Doctor?

Dr. MAGEE-BAKER. And just to piggyback, many of the things that we hear from our veterans is about navigation. Where to begin in the VA you know, telling them a call and waiting on hold. Not being able to really explain or know what they need or what department they need to get to is important. So, what we would recommend is stronger navigation and VSOs and community-based organizations can be that resource when funding to help veterans walk them step by step in navigating how to access VA resources, how to access veteran benefits as well.

Senator CASSIDY. Thank you. You all join me in thanking our panelists.

[Applause.)

Senator CASSIDY. This has been very helpful to me. I'm sure it's been helpful to you, Fernando. I thank you all for being here. And truly me, Sean will make himself available. If there's something that you think that you've got a personal story that's going to help us serve others better, we would ask that you would reach out to my office. And we're also on the internet, of course. And with that, I conclude the hearing. Thank you.

[Whereupon, at 10:56 a.m., the hearing was adjourned.]

A P P E N D I X

Prepared Statements

STATEMENT OF
FERNANDO O. RIVERA,
INTERIM NETWORK DIRECTOR,
VETERANS INTEGRATED SERVICE NETWORK (VISN) 16
VETERANS HEALTH ADMINISTRATION (VHA)
DEPARTMENT OF VETERANS AFFAIRS (VA)
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
FIELD HEARING ON
"BREAKING BARRIERS: IMPROVING VETERANS' MENTAL HEALTH IN LOUISIANA"

AUGUST 14, 2025

Good morning, Senator Cassidy, and distinguished guests. Thank you for the opportunity to discuss VA's extensive efforts to enhance the mental health and well-being of Veterans in Louisiana. My name is Fernando Rivera, and I am the interim Network Director of Veterans Integrated Service Network (VISN) 16. I am accompanied today by Dr. Tina McClain, Mental Health Lead for VISN 16, and Dr. Laurel Harlin, Chief Psychologist from the Southeast Louisiana Veterans Health Care System (SLVHCS) in New Orleans. We recognize the critical role Congress plays in shaping Veteran mental health policy and appreciate your ongoing efforts to ensure access to care.

We understand that a disproportionate share of Veterans live in rural America and that they have difficulty accessing health services for reasons similar to other rural residents. Our efforts throughout VISN 16, and in particular Louisiana, continue to provide real solutions that increase access to mental health care for Veterans despite geography or availability of services. I appreciate the opportunity to discuss key initiatives within VISN 16 and the SLVHCS that demonstrate our commitment to Veterans' mental health, particularly addressing the challenges faced by Veterans in rural and underserved areas in Louisiana. Of the estimated 16.5 million Veterans living in the United States and its territories, approximately 4.2 million reside in rural areas.

Veterans in rural areas enroll in VHA health care at a higher rate (66%) than their urban counterparts (46%). Out of the 8 facilities in VISN 16, 5 serve populations where nearly or more than 50% of the enrolled Veterans are from rural areas, including the Alexandria and Shreveport VA Medical Centers (VAMCs).

In VA, we rely on collaborations, innovation, and community care to deliver mental health care to Veterans who reside in rural communities. From implementing advanced telehealth services to fostering community collaborations and supporting VHA's Office of Rural Health (ORH) enterprise-wide initiatives (EWI), VA proactively works to continually bridge the gap in mental health care access for Veterans living in rural areas.

Our goal across VA, and certainly here in VISN 16, is to ensure that no Veteran is left behind, regardless of where they live.

Veteran Health Care in Louisiana

Veterans face unique health challenges, including a high prevalence of trauma-related conditions like posttraumatic stress disorder (PTSD) and traumatic brain injury (TBI). In areas like Louisiana, severe weather events such as hurricanes compound these issues by displacing Veterans from their homes, jobs, and essential community resources. Veterans from underserved communities face disproportionate risks due to disparities in access to mental health care and social isolation in rural areas exacerbates the risk of suicide and hinders recovery. Additionally, high rates of chronic health conditions among Veterans, such as diabetes, heart disease, substance use disorder, and obesity, which often interact with mental health issues, complicate the need for comprehensive care.

While these challenges exist, we are also proud of the comprehensive range of health care services, including inpatient mental health and outpatient care, that we provide to Veterans throughout VISN 16. Our 3 Louisiana facilities (Overton Brooks VAMC in Shreveport, Alexandria VAMC in Pineville, and SLVHCS in New Orleans) have been serving the state of Louisiana for over 95 years. We employ nearly 5,800 health care professionals across our service area and deliver care to 151,000 Veterans annually who are enrolled and receiving care from VA throughout the state. We are

committed to expanding rural health access across our great state and reaching Veterans in both urban and rural areas in all 64 parishes.

Meeting Access Challenges in Rural Areas

Access to mental health care within the VA system can be a significant challenge in rural Louisiana, particularly in central counties, which lack sufficient mental health providers and integrated care approaches. In Louisiana, there are only seven VA mental health residential and rehabilitation treatment program (MH RRTP) beds, limiting Veterans' access to that level of care. MH RRTPs offer evidence-based therapies in a structured environment and are essential components of the mental health continuum of care. Given that MH RRTP services are not readily available at each of our VAMCs, VA's fiscal year (FY) 2026 President's budget request puts Veterans first by proposing a $1.5 billion expansion of MH RRTP. This funding aims to close the care gap, ensuring timely and enhanced access to critical mental health and substance use disorder treatment for Veterans for MH RRTP care in the community. At the same time, VA will be increasing its internal capacity to deliver high quality residential care [1] In VISN 16, implementation of centralized MH RRTP screening has helped us expedite referrals and admissions. For Veterans in Louisiana in FY 2025 to date, there has been a 6.5% increase in Veterans admitted to MH RRTPs within 72 hours of referral and a 4.7% increase in admissions within 7 days.

We understand that geographic and transportation barriers, along with insufficient broadband and technology infrastructure, hinder both in-person and virtual care services. Limited access to high-speed internet prevents effective utilization of telehealth services both within and external to VA care. That is why VA is committed to modernizing access points for rural Veterans and why we will continue to seek out collaborations, programs, and opportunities to build technology infrastructure that would extend mental health services for Veterans in hard-to-reach communities.

Additionally, to address transportation challenges, VA has launched several assistance programs, such as the Veterans Transportation Service (VTS) to help Veterans reach the care they need. Other services used in VISN 16 include virtual

[1] https://department.va.gov/wp-content/uploads/2025/06/FY26-Mental-Health-Residential-Rehabilitation-Treatment-Programs.pdf

mental health services that have become pivotal tools, particularly in rural and remote areas where access to care can be challenging. Significant investments in virtual health infrastructure, including VA Video Connect (VVC), enable Veterans to connect with mental health providers without the need for lengthy travel, supporting continuity of care and better management of mental health conditions. In FY 2025 to date, across our 3 main Louisiana facilities, VA has provided nearly 10,000 virtual mental health appointments. Additionally, we are working to expand mental health services at community-based outpatient clinics (CBOC) and increase the number of mental health community care providers – beyond the nearly 1,800 that currently participate in our Community Care Network in Louisiana. This network furnishes care through the Veterans Community Care Program (VCCP).

The VCCP is critical to helping meet the needs of all Veterans, particularly those in rural or underserved areas, by ensuring they receive timely, high-quality care closer to home. Using a network of over 1.4 million non-VA providers, VCCP delivers essential hospital, medical, mental health, and specialty care services to eligible Veterans. VA has taken steps to address geographic and transportation barriers, streamline referrals, improve care coordination, and enhance oversight of community providers to maintain continuity and quality of care. The integration of community care reflects VA's commitment to Veteran-centered, timely, and high-quality care.

Innovative Collaborations Making an Impact

VISN 16 has established several initiatives aimed at improving mental health care for Veterans, with a special emphasis on rural Louisiana. These programs leverage local resources and community organizations to provide comprehensive support. For example, the SLVHCS collaborates with local mental health providers, non-profit organizations, educational institutions, rural faith-based organizations, and Federally Qualified Health Centers to deliver integrated care and support services to build local capacity for mental health care delivery. These efforts are essential in overcoming geographic and socio-economic barriers to care and are part of VA's broader strategy to embrace public-private collaboration to meet Veterans where they are. Additionally, local VA facilities have strengthened community collaborations through Veteran Community

Partnerships (VCP) involving churches, shelters, and nonprofits to reach at-risk Veterans.

Effective Coordination to Meet Needs

In addition to these collaborations, effective coordination between VA, state, local entities, the Louisiana Department of Health, and local mental health authorities is crucial for helping us meet the needs of our Veterans. This coordination is also critical to helping prevent Veteran suicide – a key clinical priority for us in Louisiana and for the Department. Improved information sharing between VA, the Louisiana Department of Health, and local providers helps close service gaps and align suicide prevention strategies. Such collaboration is essential to executing Secretary Collins' vision for unified Veteran care across Federal, state, and community levels.

Coordination is also a vital part of our outreach to Veterans with elevated suicide risk, such as those who recently left active duty, are homeless, or are justice-involved. We employ shared care navigators to assist Veterans transitioning between VA and community services, particularly in areas without full-service VA facilities.

Conclusion

Thank you, Senator Cassidy, for the opportunity to discuss VA's efforts to improve mental health care for Veterans in Louisiana. Addressing access challenges, particularly through innovative collaborations, infrastructure, multi-level government coordination, and community care, is essential to this mission. With the continued support of the Committee, we are dedicated to transforming the way we serve Veterans in rural and underserved communities in Louisiana, ensuring they receive the mental health services they have earned and deserve.

Department of Veterans Affairs

Senior Executive Biography

Fernando O. Rivera, FACHE

Interim Network Director
Veterans Integrated Services Network (VISN) 16

Fernando O. Rivera, FACHE, has dedicated his career to improving Veterans' health care and well-being. He has a passion for understanding and delivering first-class service to patients and employees alike. Mr. Rivera is a celebrated Department of Veterans Affairs (VA) leader with over 30 years of experience in championing cutting edge solutions that transform the VA health care system.

Over the course of his career, Fernando Rivera has distinguished himself as a servant leader, he is a recipient of the 2024 Service to the Citizen Award winner, 2023 VHA Innovative Award for Exceptional Experience for Employees, 2021 Distinguished Executive Presidential Rank Award, the 2009 Meritorious Presidential Rank Award, and the 2021 VHA John D. Chase Award for Executive Excellence in Healthcare. Notably, Mr. Rivera was honored with the 2018 AMVETS Silver Helmet Award, the 2017 Secretary of Veterans Affairs Outstanding Achievement in Service for Homeless Veterans, and the 2017 DoD Secretary Extraordinary Employer Support Award. Recognition of Mr. Rivera's impact, in 2016, he was the recipient of the Federal Executive Board Outstanding Agency Head, 2015 Recipient of the Secretary of DoD Employer Support Freedom Award, 2014 VHA Mentor of the Year Award, 2012 VHA Preceptor of the Year, and 2012 The American College of Healthcare Executives Federal Health Care Executive Award.

CAREER CHRONOLOGY:

2025 – Present	Interim Network Director, Ridgeland, MS
2015 – Present	Director, VAMC, New Orleans, LA
2015 – 2016	Acting Director, VISN 16, New Orleans, LA
2010 – 2015	Network Director, VISN 5, Linthicum, MD
2013	Acting DUSHOM, Washington, DC
2007 – 2010	Director, VAMC, Washington, DC

EDUCATION:

1988 Master of Business Administration, University of New Orleans, New Orleans, LA
1983 Bachelor of Science Civil Engineering, University of New Orleans, LA

Department of Veterans Affairs

Senior Executive Biography

Catina (Tina) McClain, M.D.

Chief Mental Health Officer
VHA VISN 16

As CMHO Dr. McClain has the overall responsibility for implementing, planning, organizing, directing, coordinating, reviewing, evaluating, and improving the operations of Mental Health (MH) Services within the VISN. She participates in the development, coordination, review, and evaluation of VISN-wide MH programs, policies and procedures and as a delegate of authority of the VISN Network Director (ND) has the authority to ensure implementation, as well as to maintain and improve the operations of VISN MH services. The CMHO supports facility reporting effectiveness and monitors achievement of MH performance measures. Dr. McClain serves as a subject matter expert for VISN leadership on all MH matters and has a strong working relationship with the Office of Mental Health (OMH) and other national program offices with overlapping missions.

CAREER CHRONOLOGY:

2022 – Present	Chief Mental Health Officer, VHA VISN 16
2016 – 2022	Chief of Staff, Central Arkansas Veterans Healthcare System (CAVHS)
2014 – 2016	Acting Chief of Staff, CAVHS
2013 – 2014	Deputy Chief of Staff, CAVHS
2009 – 2013	Associate Chief of Staff for Mental Health, CAVHS

EDUCATION:

1997 Residency in Psychiatry, University of Arkansas for Medical Sciences, Little Rock, AR
1993 Medical Doctor, University of Arkansas for Medical Sciences, Little Rock, AR
1989 Bachelor of Science in Biology, Ouachita Baptist University, Arkadelphia, AR

Department of Veterans Affairs

Senior Executive Biography

Laurel Harlin, PhD

Chief, Psychology Service
Southeast Louisiana Veterans Health Care System

In addition to serving as the Chief of the Psychology Service, Dr. Harlin provides direct patient care and supervises PhD candidates who are learning evidence-based psychotherapies (EBP) for Post-Traumatic Stress Disorders (PTSD). Alongside her clinical role, Dr. Harlin has conducted research in the assessment and diagnosis of trauma-based symptoms and disorders. She has been the Primary Investigator or Co-investigator on numerous grant-funded projects, resulting in over 150 peer-reviewed publications and presentations at National and International conferences.

In 2021, Dr. Harlin received the Louisiana Psychological Association's (LPA) award for her Contributions to Psychological Science. In 2022, she was honored as the Mentor of the Year by the South-Central Mental Illness Research, Education, and Clinical Center (MIRECC). Dr. Harlin has been actively involved in the Psychology Training Committee and considers her most significant contribution to be the mentorship of trainees, many of whom have gone on to become her esteemed psychology colleagues at SLVHCS and beyond.

CAREER CHRONOLOGY:

2023-present Chief, Psychology Service, Southeast Louisiana Veterans Health Care System (SLVHCS), New Orleans, LA

2022- 2023 Acting Chief, Psychology Service, SLVHCS, New Orleans, LA

2021- 2022 Interim Team Lead, Posttraumatic Stress Disorder Clinical Team, SLVHCS, New Orleans, LA

2019- 2022 Assistant Chief, Psychology Service, SLVHCS, New Orleans, LA

2018- 2019 Interim Chief, Psychology Service, SLVHCS, New Orleans, LA

EDUCATION:

2000- 2002 Postdoctoral Psychology Fellow Brown University, Alpert School of Medicine/Rhode Island Hospital, Providence, RI

1999- 2000 Pre-Doctoral Clinical Psychology Intern New Orleans Veterans Affairs Medical Center (APA accredited), New Orleans, LA

1995- 2001 Doctorate of Philosophy in Clinical Psychology Pacific Graduate School of Psychology (APA accredited), Palo Alto, CA

1993- 1995 Masters of Science in Clinical Psychology University of South Alabama, Mobile, AL

1989- 1993 Bachelor of Arts Loyola University, New Orleans, LA, Major: Psychology

Statement of
Secretary Charlton Meginley, Colonel, USAF (ret)
LOUISIANA DEPARTMENT OF VETERANS AFFAIRS (LDVA)
Before the
SENATE VETERANS AFFAIRS COMMITTEE (SVAC)
AUGUST 14, 2025

Chairman Moran, Ranking Member, Senator Cassidy, and distinguished members of the SVAC, thank you for the opportunity to provide written and oral testimony for the Senate Committee on Veterans' Affairs field hearing entitled, "Breaking Barriers: Improving Veterans' Mental Health in Louisiana." On behalf of Governor Jeff Landry and the Louisiana Department of Veterans Affairs, I am proud to affirm our state's unwavering commitment to serving our Louisiana veterans. We are passionate about serving those who have served.

Our mission is to relentlessly advocate for Louisiana's 262,000 veterans and their families to ensure they receive superior customer service and support by connecting them to the benefits they have earned, while meeting the economic, educational, and employment needs of transitioning service members looking to make Louisiana their home. Our vision is that Louisiana will be the most veteran-friendly state in the nation! We serve all generations of veterans with dignity and respect through four cornerstone operations: contact assistance, education, long-term care, and burial honors.

The mental health needs of our veterans must be a top priority for the Department of Veterans Affairs (VA). The VA faces a critical shortage of over 6,000 mental health providers, severely limiting its ability to serve those in need. Nationwide, about 25% of veterans face mental health challenges such as PTSD, depression, or anxiety, while in Louisiana, this figure may be as high as 50%. In 2022, 6,392 veterans died by suicide —an average of 17.5 per day— with only half of them receiving VA care. Moreover, the demand for mental health services is surging, with 40% of VA appointments now addressing mental health concerns. Immediate action is essential to close this gap and ensure veterans receive the care they deserve. We are honored to be here today to discuss the Louisiana Department of Veterans Affairs' role in enhancing the mental well-being of Louisiana's veterans.

A. Overview of the LDVA's role in Mental Health of Louisiana's Veterans

1. State Veterans Homes

The LDVA operates within two distinct environments when engaging with veterans who may have mental health disorders. The first environment is our State Veterans Homes, where the Department assumes primary responsibility for the care and management of residents, including the treatment of mild to moderate mental health conditions. The second environment involves our Veterans Assistance Counselors (VACs) and our LaVetCorps Navigators, who may encounter veterans with mental health disorders in community settings

during outreach and support activities. In both contexts, we maintain a close and collaborative partnership with the three VA Medical Centers in Louisiana, which ensures high-quality, comprehensive care delivery supporting our Louisiana veterans.

The LDVA State Veterans Homes provide a unique environment where veterans can live alongside their brothers and sisters in arms. These facilities are a cornerstone of our mission to provide exceptional care, dignity, and support to Louisiana's veterans requiring long-term care. Through rigorous oversight, dedicated staff, and adherence to the highest health and safety standards, we ensure that our homes deliver compassionate, high-quality services tailored to the unique needs of our veteran residents.

LDVA operates five State Veterans Homes, supporting our nearly 262,000 veterans. Our State Veteran Homes are strategically placed across Louisiana with facilities in Bossier City (NW Louisiana), Monroe (NE Louisiana) ((both aligned to Shreveport VAMC)), Jackson (North of Baton Rouge), Reserve (SE Louisiana) ((all aligned to New Orleans VAMC)) and Jennings (SW Louisiana) ((aligned to Alexandria VAMC)). Our current census as of July 17, 2025, is 632. FY '26's cumulative projected budget for the five homes is $82.5 million. Our average occupancy rate amongst all five homes is 85%.

We currently have 572 men and 60 women residing in our homes. Under state law, spouses and Gold Star families have access to our homes. Additionally, Act 132 (2025) was signed into law in this past legislative session, which expands admission to National Guard members, easing time in service requirements. To maintain and grow our census, each home employs a Marketer who attends civic organization meetings, veteran service organization meetings, job fairs, and all community Veteran events to highlight our facilities.

Over the past 10-15 years, we've observed a shift from World War II to Vietnam veterans, with 67% of our residents now from the Vietnam era. We expect Vietnam veterans to remain the majority over the next decade, but after 2035, we anticipate a transition to predominantly Persian Gulf War veteran admissions.

Louisiana State Veterans Homes: Demographics

SVH	Vietnam War	Peace Time	Korean War	Spouses	Persian Gulf War	WWII	Total
Bossier City	74	6	23	13	8	6	130
Jackson	67	9	11	1	7	1	96
Jennings	85	19	18	9	5	8	144
Monroe	86	15	9	2	10	3	125
Reserve	98	9	12	10	5	3	137
Total	410	58	73	35	35	21	632

Mental health disorders are pervasive in our veteran homes. Currently, 493 of 632 residents, or 78%, have at least one mental health diagnosis, and over 50% of residents have multiple mental health diagnoses. Of these residents, 435 (69%) are on antipsychotic and or psychotropic medications. Our medical directors are comfortable managing mild to moderate mental health conditions, but are not comfortable managing severe or complex mental or behavioral health issues. This presents two key challenges for us.

Diagnosis	Jackson	Monroe	Jennings	Bossier	Reserve	Totals	% of Residents
Dementia/ Alzheimer's w/ behaviors	43	52	92	80	32	299	47%
Schizophrenia	12	11	11	9	19	62	9.8%
Bi-Polar Disorder	13	8	22	73	26	142	22%
Anxiety	42	44	83	82	53	304	48%
Depression	56	61	89	88	13	307	49%
PTSD	22	20	23	9	5	79	12.5%
Delusions Hallucination Impulsiveness	18	17	0	44	25	104	16%
Number of Residents w/ Any MH Diagnosis	69	113	126	110	75	493	78%
Number of Residents w/ Multiple MH Diagnoses	56	58	93	65	54	326	52%
# Prescribed Antipsychotic / Psychotropic Medication	68	38	157	113	59	435	69%

First, our long-term care facilities are not equipped to care for psychiatric/behavioral health residents in the acute phase. Subsequently, these residents are typically referred out of LDVA care to private geriatric psychiatric facilities. Frequently, these facilities do not treat the underlying cause of the acute psychiatric/behavioral health issues. They typically treat symptoms with high doses of antipsychotic medications and return residents to the LDVA facilities. Follow-up with treating psychiatrists is lacking, continuity of care suffers, and opportunities to address the root cause seldom occur. Consequently, subsequent acute psychiatric exacerbations occur again (a revolving door of sorts). Over the last two years, there were 134 episodes of veterans transferred to an acute mental health facility for management of several behavioral or psychiatric disorders.

Secondly, the presence of some behavioral or mental health issues, either due to type or severity, can result in admission denial if the clinical team deems they are not able to manage them appropriately. Over the last two years, 72% of our facility admission denials were due to behavioral or mental health issues we were not adequately equipped to manage.

To help address this pervasive problem and enhance our capability to better manage the increasing mental and behavioral health challenges in our facilities, LDVA has recently contracted with Senior Psych Care (SPC) from Houston, TX. SPC is a trusted provider of psychiatric and psychological services for senior citizens in nursing facilities across Texas, Louisiana, New Mexico, and Oklahoma. SPC employs seasoned psychiatrists, psychologists, psychiatric nurse practitioners, physician's assistants, licensed social workers, mental health counselors, and other therapy staff to provide a broad spectrum of evidence-based, multidisciplinary approaches to cognitive and behavioral healthcare. This team also tracks clinical outcomes and works to partner closely with the medical director and clinical staff within our homes to optimize the care of our residents. SPC conducts 99% of all visits face-to-face, ensuring personalized support and meaningful connections with our residents. Senior Psych Care goals are in alignment with LDVA's strategy to keep our residents in our facilities and provide continuity of care that includes residents, their families, and LDVA staff. We believe that this strategic partnership with SPC will enhance our ability to meet the needs of our current and future residents.

2. LDVA Benefits Division

In addition to managing the mental health of the residents of our State Veteran Homes, the LDVA has staff members who serve veterans in all 64 parishes in the state. Their work is at the very core of our mission —connecting veterans with the benefits they have earned in service to our country. Our federal VA-accredited veterans assistance counselors (VACs), all veterans themselves, staff 74 veteran service offices throughout the state to fulfill our mission. They file claims to the federal VA on behalf of Louisiana veterans, free of charge, and educate veterans about state and federal benefits. In addition to our veteran assistance counselors, our appeals team assists veterans with appeals pending before the federal VA's Board of Veterans Appeals, including representation at hearings. In the course of their daily work, any of these VACs may encounter a veteran with a known or suspected mental health issue. When this occurs in the non-urgent setting, they would generally advise them to speak with their VA doctor if they have one, or if not, we would recommend them to go to the nearest VA healthcare facility and seek help for that issue. In case of a more urgent scenario, say the veteran expresses that he/she needs help immediately, the VACs generally reach out to a VA social worker or Patient Advocate to advise the veteran in real time. VACs have also called the Suicide and Crisis Lifeline - #988 and put the veteran on the phone while they were there to assist. Finally, our VACs are trained to dial 911 for emergency assistance for any critical health, mental, behavioral, or medical situations.

3. LaVetCorps

In addition to our Veteran Assistance Counselors, our LDVA LaVetCorps currently has Memoranda of Understanding (MOUs) with 32 college and university campuses across the state, representing institutions within the LSU, UL, Southern, and Louisiana Community Colleges and Technical Schools (LCTCS) Systems. At each of these campuses, LaVetCorps Navigators serve in veteran centers as peer mentors, supporting student veterans as well as family members who receive VA education benefits through programs such as Chapter 35. These Navigators have unique access to thousands of veterans, not only on campus but also in the surrounding communities. While they are not licensed mental health professionals, they have some training to identify signs of distress and connect individuals to appropriate resources, whether that be on-campus support services, which are often paid for through student fees, or specialized VA mental health services, including those targeted toward PTSD, anxiety, moral injury, and other veteran-specific concerns. Being peer mentors, they can often be the first ones to identify warning signs that a veteran is dealing with something unusual. Similar to our VACs, our LaVetCorps Navigators are equipped with the knowledge to direct their peers to the right resources and reinforce a culture of early intervention and support.

It's essential to recognize that college life can present new and unexpected stressors for veteran students. Many are transitioning from structured military environments to the comparatively unstructured world of higher education, which can amplify existing mental health concerns or introduce new ones. Ensuring that these students have access to adequate mental and behavioral health support is not just a moral imperative—it is a strategic one. In recent years, Louisiana's institutions of higher education have received nearly $200 million in G.I. Bill funding, underscoring the scale and significance of the veteran student population in our state. By continuing to support efforts like LaVetCorps—and by integrating mental and behavioral health awareness at every level of veteran engagement—we can better ensure the success, retention, and well-being of those who have served our nation.

B. Various Underlying Causes of Mental Health Issues among Veterans

- **Transition Stressors**: The shift from military to civilian life often engenders significant stress, anxiety, and depression as veterans navigate identity reformation and employment challenges (SAMHSA, 2022).
- **Combat-Related Trauma**: Traumatic brain injuries (TBI) and post-traumatic stress disorder (PTSD) affect 14–16% of veterans deployed to Iraq and Afghanistan, with lasting psychological impacts (StatPearls, 2023).
- **Systemic Barriers**: Geographic isolation, with 41.7% of Louisiana veterans living over an hour from a VA medical facility, and transportation limitations exacerbate access to care. Environmental factors, such as perceived neighborhood safety, further compound mental health challenges.

- **Legal Issues**: Civil and criminal legal challenges are significant triggers for mental health crises, often exacerbated by limited access to legal aid and insufficient Veteran Treatment Courts (VTCs).
- **Military Sexual Trauma (MST)**: Survivors of MST require specialized, trauma-informed care to address long-term psychological effects, with community-based models like Bastion proving highly effective.

We commend the Federal Department of Veterans Affairs (VA) for its exemplary efforts in addressing veteran homelessness. The Louisiana Department of Veterans Affairs (LDVA) has collaborated effectively with Veterans Affairs Medical Centers (VAMCs) in Louisiana to ensure our veterans receive both immediate, short-term housing solutions and sustainable, long-term housing options. The appropriate management of veteran mental well-being demands a comprehensive, multi-disciplinary approach that integrates clinical interventions with solutions addressing social determinants of health in our communities. We believe it is necessary to address the mental health needs of both our residents and the veterans of our state as a whole. This requires a broader collaborative network of community, VA, and state resources.

We believe that prioritizing and enhancing veteran mental health can significantly reduce suicide rates by addressing root causes such as PTSD, depression, and substance abuse. Implementing comprehensive mental health programs—including accessible therapy, community-based peer support, and early intervention—could substantially lower the U.S. veteran suicide rate, currently estimated at 17 per day (2020 VA data). Integrating evidence-based treatments like cognitive behavioral therapy and personalized medication management with well-researched alternative therapies could further reduce suicide risk in high-risk groups. Increased funding, reduced stigma, and holistic care systems would amplify these efforts, potentially saving thousands of lives annually.

C. LDVA Public & Private Partnerships

Federal Veterans Health Administration

The Veterans Health Administration, especially the three VA Medical Centers in the state, remains our strongest partners in addressing the healthcare, including mental healthcare needs of our veterans. LDVA Secretary and Deputy Secretary are in regular contact with leadership from all three VAMCs, whether in person, by email, or by phone. We have frequent, open communications, which are mutually supportive with a forward-leaning approach. From the State Veteran Home's perspective, this relationship is further strengthened when the VAMC appoints a single liaison (LNO) assigned to the homes in the VAMC catchment area. With backup assigned, this single point of contact (POC) allows for home-specific, robust, and personal relationships with VAMC LNO and our homes' clinical leadership. The VA continues to play a pivotal role in the credentialing and oversight of our State Veteran Homes.

Our LDVA Assistant Secretary for outreach is also closely connected with the outreach teams from all three VAMCs. Event attendance is mutually supportive, with rare exceptions. This has directly strengthened our state's response in addressing key issues like veteran mental health, homelessness, and suicide. Leadership remains in constant communication with each National organization (National Association of State Directors of Veterans Affairs (NASDVA) and National Association of State Veterans Homes (NASVH) and major veteran service organizations. In addition to close connectivity to our VA partners and the federally chartered Veteran Service Organizations, there are a number of community partners that have demonstrated a deep desire and unrelenting commitment to serving veterans.

Veteran Service Organizations (VSO)

In addition to the stress of transitioning from military to civilian life, many veterans may have combat-related injuries, those seen and those unseen, which may adversely impact their mental well-being. Yet, outside of federal funding, the LDVA has limited state funding, and like many states, we do not have a dedicated appropriation to address the mental health needs of our veterans. As such, we rely heavily on 501(c) organizations and our congressionally chartered veteran service organization partners to help fill our gaps when identifying distressed veterans. The Veterans of Foreign Wars (VFW) (of which both the Secretary and Deputy Secretary are "Life" members), the American Legion, Disabled American Veterans (DAV), the Military Order of the Purple Heart (MOPH), the Marine Corps League, Catholic War Veterans, Vietnam Veterans of America (VVA), and Military Officers of America Association (MOAA), are just a some of the VSO's we work closely with to make sure our veterans have the support they need and deserve. Make no mistake, no state DVA can do its job effectively without VSO support.

University of Louisiana at Lafayette

To better understand the needs of our veterans, the LDVA partnered with the University of Louisiana – Lafayette to conduct a groundbreaking needs assessment survey entitled, "Bridging the Gap: Louisiana Veterans' Mental Health and Support Needs. The study is being administered by the Louisiana Center for Health Innovation (LCHI), University of Louisiana at Lafayette.

This preliminary report presents early findings from an ongoing statewide survey of Louisiana veterans, conducted between May 5 and July 7, 2025, with data collected from 410 respondents to date. The survey closed at the end of July 2025, and complementary focus groups are scheduled to begin in early September. Current findings point to a deeply concerning mental health crisis among the state's veteran population. Over half of the respondents reported diagnoses of depression and/or anxiety, and nearly half reported being diagnosed with post-traumatic stress disorder (PTSD). These figures significantly surpass national averages reported by the U.S. Department of Veterans Affairs and the Substance Abuse and Mental Health Services Administration (SAMHSA). Nationally, PTSD prevalence among veterans ranges from 11% to 20%, depending on the conflict era. The prevalence of

depression and anxiety hovers around 24%. By contrast, the Louisiana veterans surveyed thus far report a PTSD rate of 45.6% and a depression/anxiety rate of 54.1%, more than double the national figures.

These findings must be understood within a broader context of systemic barriers and social determinants of health. A staggering 41.7% of Louisiana veterans live over an hour from the nearest VA hospital, and 10.2% lack reliable transportation. Older veterans experience even more significant access challenges. Compounding these barriers are environmental stressors, such as perceived neighborhood safety and proximity to essential services, which are closely correlated with adverse mental health outcomes.

While the current dataset provides essential insights, it represents only a portion of the whole picture. The survey's final results, along with qualitative findings from upcoming focus groups, will provide a more comprehensive understanding of the challenges facing Louisiana veterans and refine the strategic recommendations outlined here. In the interim, we will continue to work closely with our VA partners and local community partners to address the needs of our veterans as efficiently and as completely as possible.

Other Partners

The Louisiana Department of Veterans Affairs (LDVA) enhances veterans' mental well-being by leveraging a network of community partners, each offering specialized services that complement LDVA's mission. Close coordination with these partners, alongside federal Veterans Affairs Medical Centers (VAMCs) and national veteran organizations, creates a robust support system addressing critical issues like mental health, homelessness, and suicide prevention. Below is a brief overview of how some of our community partners contribute to veterans' mental health and well-being:

- *Acadiana Veteran Alliance (Lafayette, LA)*: Operates the *Heal Program*, which provides innovative treatments like stellate ganglion block (SGB) injections for PTSD relief. It also supports job placement and community-building events, fostering a sense of purpose and connection for veterans in the Acadiana region.

- *Bastion Community of Resilience (New Orleans, LA)*: Operates a 5.5-acre intentional community in Gentilly for post-9/11 veterans and families, particularly those with traumatic brain injuries (TBI) or neurological conditions. Funded in part by the Wounded Warrior Project, Bastion's Headway day program fosters peer support and recovery through community living, reducing isolation and promoting mental resilience.

- *Bayou Veterans Advocacy (BVA) (Monroe, LA)*: A Louisiana nonprofit dedicated to supporting and advocating for the rights of Louisiana veterans. BVA works to pair veterans at risk of suicide with peer support mentors who provide relatable guidance during crises. Additionally, BVA connects at-risk veterans with VA community care resources for professional treatment. To strengthen the veteran-mentor relationship, BVA

engages subject matter experts to address common stressors—such as financial, legal, and relationship challenges—that can trigger crises. By proactively tackling these issues, BVA helps equip veterans with the tools and resources to manage stressors before they become overwhelming.

- *The Boot*: A pioneering Louisiana-based 501(c)(3) nonprofit organization, dedicated to recruiting, retaining, and returning military service members to Louisiana after their term of service. The Boot provides comprehensive support to transitioning veterans to facilitate their integration into civilian life in Louisiana. The Boot offers a veteran-led initiative in Louisiana, offering peer-to-peer support, outdoor recreational programs, and community events to combat isolation. We especially note that *The Boot* is working closely with officials from Fort Polk and Barksdale AFB to assist those service members who are currently stationed in Louisiana in their transition needs.

- *Elizabeth Dole Foundation*: Supports military and veteran caregivers through its Hidden Heroes Campaign, which Louisiana joined as the 12th state in 2024. The foundation offers resources, training, and community support to caregivers, reducing their stress and indirectly bolstering veterans' mental health by ensuring stable home environments.

- *Face the Fight against Veteran Suicide*: A USAA initiative focused on reducing veteran suicide through awareness campaigns, funding mental health programs, and connecting veterans to crisis resources like the Veterans Crisis Line. It emphasizes destigmatizing mental health care and promoting early intervention.

- *Longbranch Recovery Center (Abita Springs, LA):* A private treatment facility in Louisiana offering comprehensive mental health and substance abuse services, including therapy for PTSD, depression, and anxiety. It provides veterans with personalized care plans, often integrating holistic approaches like mindfulness and outdoor activities to support mental well-being.

- *Next Op*: Focuses on veteran employment and transition support, offering job placement and mentorship programs. By aiding veterans in finding meaningful work, Next Op reduces financial stress and enhances self-esteem, key factors in mental well-being.

- *NORBA (Northshore Off-Road Bicycling Association)*: the LDVA has been working NORBA to promote outdoor therapy for veterans through the use of mountain biking. Outdoor therapy (or nature-based therapy), can be a game-changer for veterans dealing with mental health or personal challenges. For veterans, outdoor therapy may offer benefits that traditional therapies can't offer. A 2019 study in the Journal of Veterans Studies found that veterans participating in outdoor recreation programs reported significant reductions in PTSD symptoms, depression, and anxiety. We commend Mr. Tony Cortez for his dedication to our veteran community through his work with NORBA. The LDVA has met with other groups, such as Eight Belles, which uses equine therapy to help veterans.

- *Objective Zero*: A nonprofit providing a mobile app and peer support network to connect veterans with mental health resources, including suicide prevention tools and trained peer responders. It empowers veterans to seek help anonymously, addressing barriers to mental health care.

- *Songs for Survivors (SoS)*: Led by Mr. David St. Romain, SoS uses music therapy and creative arts to help veterans process trauma and improve mental health. By engaging veterans in songwriting and performance, it fosters emotional expression and community connection, reducing symptoms of PTSD and depression.

Through these partnerships, LDVA amplifies its outreach, delivering targeted mental health services, peer support, and innovative therapies. The collaborative ecosystem ensures veterans receive holistic care, addressing both immediate crises and long-term well-being, while constant communication with national and local organizations aligns efforts to maximize impact.

D. Strategies to Enhance Veteran Mental Health Support

Enhance Mental Health Services for Louisiana State Veteran Homes

1. LDVA Mental/Behavioral Health Psychiatric Pilot Program Proposal

    A. The Cleland-Dole Act of 2022 had initially planned to fund a pilot program to explore the expansion of inpatient, acute psychiatric care within State Veteran Homes. Funds were diverted to assess tele-behavioral health capability, which would not appropriately address the need for acute psychiatry services.

    B. The LDVA aims to improve mental and behavioral health care for veterans by converting one wing of the LDVA State Veteran Home in Jackson, LA, into an inpatient acute psychiatric ward. This pilot program addresses the limitations of current long-term care (LTC) facilities in managing acute psychiatric and behavioral health episodes, reducing reliance on external private geriatric psychiatric facilities, and ensuring continuity of care for Louisiana's veterans.

    C. Jackson is centrally located in Louisiana to serve all five LDVA veteran homes, with ample land and space for development, including a currently unused wing within the home. A board-certified psychiatrist supported by mid-level providers will be on-site to deliver specialized psychiatric and psychotherapeutic care. This would allow for stabilizing of residents through the acute phase of mental illness, utilizing evidence-based, best clinical practice tailored to their specific needs. Once stabilized, we could then transition residents back to their respective LDVA LTC facilities. With SPC and our organic capabilities, we

could provide better continuity of care, from acute phase to chronic care. Enhanced care with better follow-up should help reduce future acute episodes.

D. This facility may also be able to accept veterans from the community with acute psychiatric needs, reducing LTC admission denials due to unaddressed mental health issues. This capability would facilitate admission to the LDVA State Veteran.

E. By establishing an inpatient acute psychiatric ward at the Jackson Home, the LDVA will provide targeted, high-quality care, reduce the cycle of readmissions, and ensure that Louisiana's veterans receive the specialized mental health support they deserve within a unified care system.

2. Congressional passage of H.R. 1970, "Providing Veterans Essential Medications Act." We encourage Congress to act on this legislation, which would reimburse a covered State veteran home for a costly medication or furnish such costly medication to the covered State home. This would allow our homes to free up other assets and redirect other resources to fund the mental health needs of our residents.

Enhance Mental Health Services for all Louisiana Veterans

1. Continue to support our VA partners

A. *Continue to appropriately fund our three VA Medical Centers within the state, especially, ensure the long-term viability of the Alexandria VAMC.* We firmly believe that a review of organic VA inpatient treatment center capacity is warranted. At this time, there are only 7 beds at the Alexandria VA medical center dedicated to male inpatient substance use disorder rehabilitation. There is funding for the expansion of this capability to 25 beds with the intent to utilize the existing 7 beds for "Women only rehab". As the Alexandria VAMC serves primarily a rural veteran population, expansion must be considered.

B. Continue to work together to identify and address the rare instances where veteran care falters, either within the VA medical system or within the community care network.

C. Enhance incentives/opportunities for medical students to join the VA staff, particularly in rural areas. Much like the military pays for the medical education of some of its doctors (who in turn incur a service commitment), we believe a similar program should exist in the VA. While the VA does offer some student loan repayments, and while there are a few programs offered by the VA, including the Mental Health Provider Education, Health Professional

Scholarship Program (HPSP), National Educational Program, it appears that many students are unaware of the programs.[1]

2. Enhance Mental Health Treatment for Veterans

   A. While we strongly endorse evidence-based traditional therapies, including Cognitive Processing Therapy (CPT), Prolonged Exposure (PE) therapy, and Eye Movement Desensitization and Reprocessing (EMDR), alongside carefully tailored pharmacotherapy, we acknowledge that these approaches may not be effective for all veterans. To better address diverse needs, the availability of complementary and integrative health therapies—such as mindfulness-based interventions, acupuncture, and yoga—must be significantly expanded within veteran care programs.

   B. The Louisiana Department of Veterans Affairs (LDVA) supports the continued evaluation and adoption of alternative therapies to treat veterans with post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), and other mental health conditions. Complementary therapies, including acupuncture, medical massage therapy, and chiropractic care, should continue to serve as adjunct treatments for PTSD. Non-traditional approaches such as yoga, meditation, art therapy, music therapy, equine therapy, and outdoor therapy can enhance, and in some cases replace, conventional PTSD treatments. Additionally, alternative treatments like stellate ganglion block and hyperbaric oxygen therapy (HBOT) should be further explored and implemented when appropriate.

3. In the 2025 session, the Louisiana Senate passed Senate Resolution 186, authored by Senator Patrick McMath, establishing the "Task Force on Alternative Therapies for Veterans" to evaluate the potential benefits of alternative therapies, including certain psychedelic therapies, for Louisiana veterans. These therapies, which may address mental health or other medical conditions but are not widely available, include 3,4-methylenedioxymethamphetamine (MDMA), psilocybin, and ketamine. The LDVA emphasizes that extensive, long-term research is necessary before endorsing these therapies. This continued assessment of alternative treatments is an important step in addressing the concerning issue of polypharmacy and the persistent issue of overmedication.

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[1] We note Section 1720D(a)(1) of 38 U.S.C. requires the VA to operate a program under which VA provides counseling, appropriate care and services to former members of the Armed Forces who the Secretary determines require such counseling, care and services to treat a condition, which in the judgment of a VA health care professional employed by the Department, resulted from a physical assault of a sexual nature, battery of a sexual nature or sexual harassment that occurred while the former member of the Armed Forces was serving on duty, regardless of duty status or line of duty determination (as that term is used in 10 U.S.C. § 12323). Section 1720D(d) requires VA to carry out a program to provide graduate medical education, training, certification and continuing medical education for mental health professionals and other health care professionals who provide counseling, care and services under VA's Treatment Authority for Military Sexual Trauma.

4. Passage of H.R. 2605 and S. 1441, the *Service Dogs Assisting Veterans (SAVES) Act*, based on Resolution No. 134: Service Dogs for Injured Service Personnel and Veterans with Mental Health Conditions. Passage of this act would establish a five-year pilot program at the Department of Veterans Affairs to provide grants to nonprofit organizations that train and place service dogs with eligible veterans, cover the cost of service dog training tailored to the veteran's specific needs, and provide veterinary insurance to ensure lifelong care and well-being for these highly trained service animals.

Enhance Legal Assistance and Veteran Treatment Courts

1. A primary root cause of mental health issues for veterans are legal matters. With the exception of disability appeals, the LDVA does not have the authority or resources to assist with general legal matters. If a veteran contacts us, we refer the veteran to local legal aid groups. We currently have a long-standing partnership with Southeast Louisiana Legal Services (SLLS) and the National Veterans Legal Services Program. We also refer veterans to Acadiana Legal Services. Nonetheless, with respect to civil legal issues, many veterans who rely solely on VA compensation/pension do not meet the income requirements for assistance.

2. With respect to criminal matters, many veterans are prime candidates for admission into a Veteran Treatment Court. However, there are only a few Veteran Treatment Court programs in the state: 14th, 19th, 21st, and 22d Judicial Districts each have robust and dedicated staff (judges, prosecutors, counselors) who help veterans address not only their legal issues, but also their behavioral health issues. Data suggests that Veteran Treatment Courts (VTCs) have lower recidivism rates compared to traditional court systems. These specialized courts provide treatment and mentoring services to veterans with mental health and substance abuse problems, aiming to keep them out of the criminal justice system and help stabilize their lives.

3. Recommendations to enhance legal support to veterans:

    A. Expansion and continued funding for Veteran Treatment Courts

    B. Additional funding for community-based legal assistance that specifically helps veterans.

    C. Funding for law schools that implement Veteran Law Clinics. Veteran Law clinics act as "force multipliers," exposing students to the legal needs of the veteran community while gaining valuable experiences in fundamental legal assistance matters, such as marital, commercial, and housing issues.

    D. We note that the LSU Law Veteran clinic has worked with the LDVA on veteran disability appeals and discharge upgrades

Reshaping Louisiana's Veteran's Mental Health Support System

4. Based on our preliminary study data, there is a potential need to reshape Louisiana's veteran mental health support system by:

    A. Expanding Local Care Infrastructure: Increase the availability of community-based outpatient clinics and mobile mental health units in rural and underserved regions. These facilities should be co-located with existing community services when possible to improve accessibility and trust.

    B. Military Sexual Trauma (MST) survivors face unique and complex challenges that require comprehensive, trauma-informed care to address both short- and long-term effects. Inspired by the success of Bastion—a community-driven model that fosters healing through connection, purpose, and wellness—we propose an enhanced, holistic approach to support

    C. MST survivors. By adapting Bastion's framework, this model creates a safe, inclusive community that integrates evidence-based mental health interventions, peer support, and holistic care to promote recovery and resilience.

    D. Invest in Tele-Mental Health Literacy: Identify key partners to develop and train the veteran community on the benefits of using the telehealth ecosystem that enables seamless virtual care delivery. This requires investing in digital literacy training for veterans and ensuring broadband access across all parishes.

    E. Launch a Louisiana Veterans Wellness Innovation Fund: Establish a state-level fund to support innovative mental health programs led by local organizations. Focus areas should include PTSD treatment, trauma recovery, integrative therapies, peer-led support groups, and community reintegration initiatives.

    F. Integrate Mental Health with Other Services: Enhance one-stop hubs through the development of key partnerships with community stakeholders that enable veteran assistance counselors (VACs) to collaborate with their community on improving benefits navigation and raising awareness about where veterans can access mental health screenings alongside housing, employment, legal aid, and VA benefits counseling. Case management models should be employed to coordinate wraparound services.

    G. Strengthen the Workforce Pipeline: We recommend that the Federal VA boost partnerships with Veteran and Military Student Services at public universities, community colleges, and health systems to improve behavioral health training programs. Develop literacy training on how to access incentives such as tuition

reimbursement or loan forgiveness for providers who commit to serving in high-need veteran communities.

H. Engage Veterans as Peer Navigators: Develop a peer support model that trains veterans to serve as navigators, mentors, and advocates. These peers can bridge cultural gaps, reduce stigma, and provide trusted guidance through the care continuum. Peer Navigators may work closely with Veterans Assistance Counselors (VAC) to develop local partnerships, improve benefits literacy, and increase access to VA benefits.

I. Support Longitudinal Data Collection and Evaluation: Establish a statewide framework to track veterans' health outcomes over time. Use this data to evaluate program effectiveness, adjust interventions, and support continuous quality improvement. Launch campaigns to raise awareness about Louisiana veterans' mental health challenges, using the 2025 survey data to secure funding and policy changes. Advocate for policies like the Justice for America's Veterans and Survivors Act, introduced in 2025 to improve data collection on veteran suicides.

Conclusion

Louisiana's veterans face a profound mental health crisis, with rates of depression, anxiety, and PTSD far exceeding national averages. Despite significant federal and state investments, systemic barriers—such as geographic isolation, limited access to specialized care, and insufficient legal support—continue to hinder our ability to deliver the comprehensive, timely assistance our veterans deserve. The Louisiana Department of Veterans Affairs (LDVA) is committed to addressing these challenges through strategic partnerships with the Veterans Health Administration, Senior Psych Care, Bastion Community of Resilience, Longbranch Recovery Center, Acadiana Veteran Alliance, and other dedicated organizations. These collaborations are vital for bridging access gaps, delivering innovative treatments, and fostering community-based support systems.

To build a more resilient and veteran-friendly Louisiana, we propose a multifaceted approach: expanding community-based mental health infrastructure, enhancing telehealth access and literacy, establishing a Veterans Wellness Innovation Fund, and strengthening peer navigator programs. Additionally, we advocate for increased funding for Veteran Treatment Courts, enhanced analysis of alternative therapies through the Task Force on Alternative Therapies for Veterans, and legislative measures such as the Providing Veterans Essential Medications Act and the Service Dogs Assisting Veterans (SAVES) Act. By integrating mental health services with housing, employment, and legal aid, and leveraging longitudinal data to drive evidence-based outcomes, we can create a holistic support system that addresses both immediate crises and long-term well-being.

The LDVA remains steadfast in its mission to passionately supporting veterans and making Louisiana the most veteran-friendly state in the nation. With continued federal and state

support, robust partnerships, and innovative strategies, we can break down barriers, reduce veteran suicide rates, and ensure that Louisiana's 262,000 veterans receive the care, respect, and opportunities they have earned through their service. Together, we can transform Louisiana's veteran mental health support system into a national model of excellence.

Cheryl Magee-Baker: Representative of Hope Center
Before the United States Senate
Presented to: The Honorable Senator Bill Cassidy, M.D.
Subject: Impact of the SSG Fox Suicide Prevention Grant Program
Date: August 14, 2025

Good morning, Senator Cassidy and members of the committee. I'm honored to represent **Hope Center**, a faith-based organization headquartered in Gretna, Louisiana, an outreach ministry of The Hope of Glory Church under the leadership of Dr. W. Ron Walker, President. I'm here today to speak about the life-saving work we've done under the **SSG Fox Suicide Prevention Grant Program and the Supportive Services for Veteran Families Program (SSVF)**, and our unwavering commitment to the Veterans and military families who call Louisiana home.

Let me begin with a truth we all know too well: **suicide among Veterans is a public health crisis**—and for too long, too many have slipped through the cracks. But I'm proud to say that in our corner of the country, we're doing something about it. The work of suicide prevention and ending homelessness provide an opportunity to reach Veterans and their families with help and hope.

At Hope Center, we've touched the lives of **123 Veterans and service members** through SSG Fox grant program. And not one—**not a single one**—has been lost to suicide. That is the impact of timely outreach, culturally competent care, and deep-rooted community trust. On the side of addressing homelessness among Veterans, we have served in our last 13 years over 5425 households. The work is not easy, and we need to recognize, as we do this work, that we must address mental health concerns and move from just being trauma-informed care to healing-centered engagement to see the best possible outcomes.

Over the past year, we've conducted outreach across **six parishes**, hosting events, walking into libraries, churches, barber shops, and coastal communities where Veterans live in isolation—some disconnected from the VA, others never enrolled at all. Through these grassroots efforts, we've engaged over **534 Veterans and service members**—many of them for the very first time.

We've **connected 26 individuals to the VA who had never accessed their earned benefits**, and **re-engaged 42 more who were on the rolls but not utilizing VA healthcare**. These are men and women who served our country with honor but carried their battles home in silence.

And silence, Senator, can be deadly. The stigma of admitting suicidal thoughts keeps many from speaking openly—even when they come to us asking for help. We've seen Veterans on suicide watch unable to check a box on a form, but what they really need is someone to sit down, look them in the eye, and say, "You matter. We're not going anywhere."

That's the heart of what we do.

Our **Peer Support Specialists—Veterans themselves—offer more than services. They offer hope**. They host healing circles. They walk into someone's living room at 6 p.m. on a Friday. They host the *Still Standing Podcast*, where listeners hear real stories from real people who've walked through the darkness and come out the other side.

We've built partnerships with the **VA Suicide Prevention team**, meeting weekly to coordinate care **Veteran**. We are training faith-based organizations to open **Veteran Welcome Centers** in their churches. And we've launched **mini retreats**, where families come together to reconnect and begin to heal.

This work isn't glamorous—but it's sacred.

It's the mother who called and said, *"You saved my son's life."*
It's the Veteran who said, *"I didn't know how close I was to the edge until someone pulled me back."*

Senator Cassidy, we are grateful for your leadership on mental health and your commitment to suicide prevention in Louisiana and across the nation. But there is more to be done. The leadership teams at SSG Fox and SSVF National Offices have listened to what we are seeing on the ground and made adjustments as they can within regulations. What needs to change is that SSG Fox Veterans and Service Members should not have to say I am suicidal to gain the array of services that the program can offer, but the fact that they reached out for help and hope should be sufficient. In Louisiana, we need to form a statewide and local coalition of providers and local governmental agencies to develop a seamless network to address mental health concerns and suicide prevention efforts. We need funding and support to build the coalition, establish a response team, and launch a campaign to destigmatize asking for help. We urge the committee to support and advocate to **continue and expand the SSG Fox Grant Program and SSVF Program**, to fund local, trusted organizations who are on the ground, in the communities, doing this critical work. Secretary Allen also needs to include in the focus for the SSG Fox SPGP not only the focus on connecting Veterans who never access VA services, but also to include in that focus Veterans who are on the rolls but don't utilize VA services, to reengage with the critical help and services that the VA provides. Veterans often cite the disconnection as stemming from the lengthy wait and arduous process, which exacerbates the issue, leading many to leave without receiving any help. Hope Center has dedicated staff who will assist in making appointments and spending lots of time to get appointments for both mental health care and physical healthcare. We are pleased to say that through the implementation of the SSG Fox program we have a point of contact to escalate Veterans in getting appointments and mental health crisis teams get to Veterans quickly and also the implementation of Veterans being able to walk in during a crisis as SSG Fox provides support for transportation is working but it is only the beginning.

Because when we show up with empathy, when we provide real resources, and when we lead with dignity, we save lives.

Thank you for the opportunity to speak today. And thank you for standing with us—and with every Veteran who deserves to not just survive, but truly live.

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.

Testimony Submitted by Jackson Smith
Senate Veteran Affairs Committee
14 August 2025

Thank you Chairman Moran, Ranking Member Blumenthal, and Senator Cassidy for the privilege of testifying before this committee today. My name is Jackson Smith, I am the Executive Director of the Bastion veterans community here in New Orleans, and a Marine combat veteran. My experience with the most pressing issues facing the veteran population began in 2010 in Helmand Province,Afghanistan. I spent eight months in high intensity, frontline combat alongside the 78 Marines and Sailors of Third Platoon, India Company, 3/6. Throughout this time virtually every one of those young men experienced multiple, in some cases dozens of brain-injuring events. I remember a Marine experiencing three separate IED blasts in one day. And in the years since then I have seen how few resources there are for the hundreds of thousands of veterans with experiences just like the Marines of Third Platoon. Simply put, we are not doing enough, and we are not prepared for the still-growing magnitude of these threats to the lives of our veterans. (1:00)

TBI, suicide, PTSD, substance abuse, deaths of despair. These problems are growing worse for our veterans, not better. Here in Louisiana between the two most recent years of veteran suicide data we have seen a 35% percent increase in veterans taking their own lives, while the civilian suicide rate here has remained relatively flat. The Wounded Warrior Project's 2025 Community Survey, the most detailed data set available on post-9/11 disabled veterans, shows that homelessness among disabled veterans doubled between 2022 and 2023. Disabled veterans experience anxiety and depression at up to eight times the rate of their civilian counterparts. Nearly 18 veterans per day are still taking their own lives. But that number increases to 44 when accounting for overdoses and other self-induced deaths. That means during the course of this hearing alone we will lose as many as four more veterans. Four, right now, as we speak. (2:00)

But the news is not all bad. Programs like the SSG Fox Grant are a first step towards innovation and delivery of care at the scale we need. But it is only that, a first step. I have heard witnesses before this committee assert that the primary purpose of the Fox Grant is outreach- engaging those veterans who are otherwise falling through the cracks, like the 10 out of 17 veteran suicides per day who never had any contact with the VA at all. But outreach requires presence. Boots on the ground. And right now, with less than two Fox grantees per state and 7 states with no grantees at all, we are not cutting it.

The Fox Grant should be expanded significantly, including the availability of significantly more grants for new applicants. In the last cycle, 82 out of 93 grants went to existing grantees, making the actual pool of funding available for new initiatives vanishingly small. For small, community-based organizations like mine, it is difficult to justify the significant effort required to even assemble a federal grant application in light of these numbers. And that matters, because it is organizations like mine who are best positioned to deliver the outreach, connection, and follow through that our veterans need and deserve. Organizations like mine are working

furiously to fill gaps in the continuum of care with truly innovative solutions. Bastion's Headway Program, funded since its inception by the Wounded Warrior Project, is a perfect example- one of the first programs in the country to deliver long term, community-based, no-cost rehabilitation for TBI-affected veterans. An expanded Fox Grant program, particularly one that specifically incentivizes programming for brain injury-affected veterans, could facilitate the replication of programs like Headway at genuine scale nationwide. Until we are able to implement such solutions, I fear we will continue to see our most troubling statistics move in the wrong direction. The VA should make a greater number of grants available, including at lower funding levels and with less burdensome application processes, to seed and advance the innovation that organizations like Bastion are already undertaking.

I also urge this Committee to renew or replace the Assisted Living-TBI Pilot Program. This program was discontinued in 2017 without replacement. I have heard various reasons for the termination of this program, including that it was prohibitively expensive. I would respectively ask this Committee, given that there is no replacement or alternative program in place - expensive compared to what? I believe we owe it to this population to deliver the support they need regardless of cost, just as they swore an oath to defend their nation and Constitution regardless of whether it might cost their lives. I would also submit that the choices we have made in terminating this program without replacement have merely passed the cost on to the families of our veterans, with stark consequences: The suicide rate among long term caregivers of non-seniors is as high as 20%. One in five. We can do better, and we must.

I will leave you with the words said to me by one of our Headway participants just last week. "This program saved my life." To hear that from a fellow veteran is a gift I lack the words to properly describe. But when I hear them, I cannot help but to think of how many more veterans there are out there just like him, who we cannot yet reach. How many of them will we lose if we wait another year? How many will we lose today? Too many. Organizations like Bastion can make the difference for these veterans. We prove that every day. But we need your help to turn the tide. Thank you.

Good morning. I am Kirk Long and I thank Senator Cassidy for his invitation to speak today. I am also a United States Marine Corps veteran, and the proud father of an active-duty Marine currently serving at Camp Pendleton, California.

I have been a hospital developer and operator for over 30 years, with the past 15 years being spent as the Chief Executive Officer of Crescent City Surgical Centre, located in Metairie, LA. Crescent City Surgical Centre is a licensed general acute care hospital focusing on a broad array of specialized care, to include neurosurgery, orthopedics, surgical oncology, pain management, and mental awareness. Our provider network is large and is augmented by a partnership with LCMC Health, the largest hospital system in New Orleans region.

The barriers to access the Community Care Network are particularly onerous. Put simply, without the help of a congressional office, it is very unlikely to receive a returned phone call. Then, when and if you do, you will be presented with a "boiler plate" contract with lower than market payment rates. There is no room for negotiation. All of this, combined with the administrative difficulties of communicating with the VA in general, present little to no incentive for private network providers to engage.

However, these challenges encouraged our team to propose the creation of a pilot program that would augment the current VA system. Specifically, our intent was to address the egregious wait times many veterans encounter, especially if they need specialized care. We learned that the NOLA VA Medical Center was faced with many staffing shortages, especially in the surgical specialties. Since our network does have access to these specialists, we are confident that we will be able to successfully reduce these wait times and treat the veterans in a timely manner. We have presented this project to various stakeholders in Louisiana, and have been encouraged by the response.

Additionally, we are encouraged by the ACCESS ACT legislation currently making its way through Congress. It is apparent that the members of Congress such as you, Senator Cassidy, as well as the other members of the US House and Senate VA committees, have heard about the many challenges of working with the Community Care Networks, and are working hard to address them. We applaud the good work being done.

We are also encouraged by the renewed focus within the new ACCESS ACT legislation to address the dire mental health issues currently faced by our veteran community. We are especially encouraged by the call for a number of new mental health pilot programs. I would like to take this opportunity to announce the creation of a new mental health facility in the New Orleans region, the Crescent City Behavioral Health Center. The comprehensive care provided at the new center will include both inpatient, outpatient, and partial hospitalization mental health services in a safe and comfortable environment. The center will also be committed to the treatment of chronic pain, including the myriad of organic and degenerative diseases contributing to the mental illness. We also recognize the need for additional substance abuse disorder services, and intend to include this in the services we will offer.

I will be happy to discuss any of the further details or answer any questions at your convenience.

Senate Committee on Veterans' Affairs Field Hearing
Breaking Barriers: Improving Veterans' Mental Health in Louisiana.
August 14, 2025

Chairman Moran, Ranking Member Blumenthal, and Members of the Committee:
Thank you for the opportunity to appear before you today to discuss how we can improve mental health care for veterans in Louisiana and across the country. On behalf of the DAV (Disabled American Veterans) Department of Louisiana, I am honored to offer testimony in support of one of our organization's top legislative priorities for the 119th Congress: eliminating persistent gaps in veterans' mental health care and suicide prevention—particularly for service-disabled veterans in rural, remote, and underserved communities.

Veterans' Mental Health and Suicide Prevention: Persistent Gaps

The Department of Veterans Affairs (VA) has made commendable progress over the past decade in expanding access to mental health services and investing in suicide prevention. Veterans struggling with post-traumatic stress disorder (PTSD), depression, anxiety, military sexual trauma (MST), and substance use disorders have more resources than ever. However, serious gaps remain in both the equity and continuity of that care—especially for women and rural veterans and those veterans affected by MST or intimate partner violence.

According to VA's most recent 2024 National Veteran Suicide Prevention Annual Report, 6,407 veterans died by suicide in 2022. Of those deaths, nearly 74% involved firearms. Veterans are significantly more likely than their civilian peers to use a firearm in a suicide attempt—69.6% more likely for men and 144.4% more likely for women. These data points reinforce a critical truth: we must do more to tailor VA suicide prevention strategies to the known risk factors affecting different segments of the veteran population.

Unfortunately, VA's innovative suicide risk predictor model—designed to flag veterans at elevated risk—originally did not include MST or intimate partner violence, despite robust evidence that both are major contributors to veteran suicide. This omission was addressed in DAV's report *Women Veterans; Journey to Mental Wellness* and VA recently announced that it was updating its model to include these critical risk factors.

Another important issue relates to training. While VA providers receive training on lethal means safety counseling and trauma-informed care, community care providers—who serve a growing portion of VA-referred veterans—are not required to meet the same standard.

Community Care Must Meet VA Standards for Training

VA is increasingly reliant on non-VA, community-based mental health providers, particularly in rural areas like large swaths of Louisiana. However, these providers often lack the same level of training in veteran-specific care, including trauma-informed approaches, suicide prevention, and cultural competence in understanding military-related trauma.

DAV believes it is essential that VA require all community providers to receive training in:

- Suicide prevention, including firearm safety counseling;
- Trauma-informed care, consistent with VA's own clinical protocols; and
- Gender- and trauma-specific care, including MST-sensitive approaches.

Congress could also act to mandate these standards in statute if VA does not amend its community care contracts accordingly.

Meeting Veterans Where They Are

One of the greatest barriers to accessing mental health care in Louisiana is geography. Rural and remote veterans often live far from VAMCs and do not have consistent broadband or cellular access to use VA's telehealth options. In some cases, veterans lack access to transportation altogether. In these situations, telehealth is not a viable substitute for care and is another real barrier for many veterans.

To truly break down these barriers, VA must invest in mobile outreach units capable of delivering in-person mental health care in underserved areas. After Hurricane Katrina, VA deployed mobile medical buses to serve displaced veterans across the state. A similar approach should now be used for behavioral health outreach. We recommend that VA implement quarterly mobile mental health outreach clinics, operated out of the three Louisiana VAMCs in New Orleans, Alexandria, and Shreveport.

This would allow VA to reach veterans where they live, restore trust in the system, and provide consistency in care—especially for veterans who struggle to develop rapport with a rotating cast of clinicians. Trust takes time, and many veterans disengage when forced to repeatedly "start over" with new mental health professionals. Provider retention and continuity of care are essential components of effective mental health treatment.

Gender-Specific and Trauma-Informed Care

DAV's 2023 report, *Women Veterans: The Journey to Mental Wellness*, documents persistent shortcomings in VA's ability to fully address the mental health needs of women veterans. According to VA, one in three women veterans report experiencing MST. Many women do not feel safe or supported in mixed-gender treatment environments. MST survivors should never be placed in group therapy settings designed for combat trauma—they are not the same, and must not be treated as such.

We urge VA and its community partners to expand access to gender-specific mental health programs that acknowledge and accommodate the unique experiences and preferences of MST survivors, including access to female providers and private therapy options where appropriate.

Policy Recommendations

To close the gaps in mental health access and suicide prevention, we respectfully urge the Committee to consider the following actions:

1. Require VA to continually access its suicide risk prediction model to include known risks factors that could help prevent suicide;
2. Mandate that all VA community care mental health providers be trained in suicide prevention, lethal means safety counseling, and trauma-informed care;
3. Fund quarterly mobile mental health outreach clinics to serve rural veterans across Louisiana and other underserved states; and
4. Expand gender-specific mental health programming for women veterans, including those who have experienced MST and/or intimate partner violence.

Conclusion

Improving veterans' mental health care is not just about increasing access—it's about restoring trust, tailoring care, and removing every barrier that prevents a veteran from seeking help. Veterans need to see that their lives matter. They need continuity, cultural competence, and the confidence that the clinicians understand what they've been through.

On behalf of DAV Department of Louisiana and the veterans we serve, thank you for your leadership and continued commitment to this mission. I am happy to answer any questions the committee may have.

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