S. HRG. 119–60

BRIDGING THE GAP: ENHANCING OUTREACH TO SUPPORT VETERANS' MENTAL HEALTH

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

ONE HUNDRED NINETEENTH CONGRESS

FIRST SESSION

APRIL 29, 2025

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BRIDGING THE GAP: ENHANCING OUTREACH TO SUPPORT VETERANS' MENTAL HEALTH

TUESDAY, APRIL 29, 2025

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

The Committee met, pursuant to notice, at 10:36 a.m., in Room SD–106, Dirksen Senate Office Building, Hon. Jerry Moran, Chairman of the Committee, presiding.

Present: Senators Moran, Boozman, Cassidy, Tillis, Blackburn, Cramer, Tuberville, Sheehy, Blumenthal, Murray, Hirono, Hassan, King, Duckworth, Gallego, and Slotkin.

Also present: Senator Mark R. Warner.

OPENING STATEMENT OF HON. JERRY MORAN, CHAIRMAN, U.S. SENATOR FROM KANSAS

Chairman MORAN. All right. Good morning, and welcome. Before we begin the hearing, I want to highlight that today at 3 o'clock in Emancipation Hall, a Congressional Medal that was authorized by the Senate and the House will be presented to The Six Triple Eight, the African American women who in World War II delivered the mail by the millions.

And we would welcome you to participate, to attend, or at least honor those women today who served our country, and in it is a really touching story. I think a number of networks across the country have carried this story about these women who rolled up their sleeves and got the mail delivered to service members during World War II.

Today, we're on the topic of mental health and veterans' well-being. Nearly 5 years ago, the Commander John Scott Hannon Veterans Mental Health Care Improvement Act was signed into law. I led the introduction of this legislation with the help and support of many of the veterans and advocates that are here today. I also would indicate that this was a piece of legislation that Senator Tester was hugely engaged in.

The Commander Hannon Act directed better collaboration between the VA and the Department of Defense, and made improvements to the VA's mental health workforce, and directed cutting edge precision health research. This landmark legislation also developed an authorized federal funding for the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program, which focuses on bolstering community organizations providing nonclinical suicide prevention services to veterans.

It was the goal of Congress, and this Committee, specifically, for the VA to work more seamlessly with veterans serving community organizations to provide veterans lifesaving clinical care and nonclinical support services they deserve. This morning, we are here to discuss the nonclinical suicide prevention services and to hear directly what has worked well and what needs to be altered, with the goal of reauthorizing this impactful program.

We will hear from the VA to receive the Department's perspective on implementation of this grant program. We'll also hear from advocates who represent grantee organizations from their perspectives, and from veterans who have benefited from the program.

Additionally, we will be receiving input from the VA and feedback from advocates on four bills, which include Helping Optimize Prevention and Engagement, the HOPE Act, which is my legislation, the Building Resources and Access for Veterans Mental Health Engagement, the BRAVE Act, sponsored by the Ranking Member Blumenthal, the bill to reauthorize and modify Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program, sponsored by Senator Boozman and Warner. And Every State Counts for Vets Mental Health Act, sponsored by Senator Cramer and Senator Coons.

With that, I yield to the Ranking Member, Senator Blumenthal for his opening remarks.

OPENING STATEMENT OF HON. RICHARD BLUMENTHAL, RANKING MEMBER, U.S. SENATOR FROM CONNECTICUT

Senator BLUMENTHAL. Thank you, Mr. Chairman. Thank you for convening this hearing on this critically important topic. We're here today to discuss the issue of veterans' mental health, including their access to care from a safe, reliable provider. A safe, reliable provider who has the expertise and trust to provide the best possible care for each individual veteran.

I welcome our colleague, Senator Warner, to testify on behalf of the Staff Sergeant Parker Gordon Fox Grant Program. It's been a game changer for so many veterans. It's geared toward meeting veterans where they are, providing access to services from trusted community partners and targeting underserved communities. And my hope is we'll have bipartisan support for reauthorizing the Fox Grant Program, and we will have bipartisan consensus on a couple of really essential points.

The rate of veterans' suicide, 17.6 a day, is absolutely intolerable. The level of services to veterans for mental health is woefully lacking. The efforts underway to address the lack of mental health are completely inadequate. And my bill on today's agenda, the BRAVE Act, reauthorizes the Fox Program, but it goes further, and I hope we'll have bipartisan support to ensure, not only that this program, but others to address these issues are fulfilled.

The fact is the Veterans Crisis Line has seen a dramatic impact in call volume, largely from veterans who are either terminated from the federal workforce, or who are concerned about losing their benefits, or both. And at a time when veterans are uniquely anxious, and apprehensive, and need our support the most, we're seeing the Trump/Musk/Collins conglomerate slashing and trashing their way through the Federal Government.

Employee assistance programs and mental health support contracts for the VA workforce have been canceled. Some have been reinstated, but not before employees were left high and dry, and forced to choose between paying out-of-pocket or canceling their appointments due to contract cancellation. World-class researchers studying mental health and substance use disorders are among the ones who've been terminated. Makes no sense. It's nonsensical, it is shameful, and disgraceful.

On the issue of privacy, a recent memo obtained by NPR, recommended VA mental health providers tell their patients, "While I will do my utmost to maintain your privacy, I cannot guarantee complete confidentiality." They're telling veterans they can't maintain privacy or confidentiality due to space limitations caused by a rushed and reckless return-to-office mandate. Again, disgraceful, shameful. Concerns about privacy will destroy the hard-won trust VA has spent decades building.

After this memo was disclosed, VA backtracked to say it was temporarily delaying its return-to-office requirements for telemental health providers. I want to note these providers haven't been exempted from the return-to-office mandate. The facilities have simply been asked to confirm their return-to-office spaces are private. This strategy of cut first-plan later, fire first-analyze later, terminate, cut, freeze, ask questions later apparently is continuing. And this failure of leadership is at the expense of veterans. And we have yet to hear in this Committee from the Secretary of the VA, despite my repeated requests for him to tell us what the rationale and reason is for these massive cuts and firings.

So, we all know that even before the Trump administration's crusade against veterans, the VA projected a 59 percent increase in inpatient and outpatient mental healthcare demand in the coming years—59 percent increase. The Department was already suffering from critical mental health staffing shortages. There were already 40,000 open positions in the VA, some of them for mental health professionals.

In his confirmation hearing, the Secretary claimed, he claimed, suicide prevention was a priority. But instead of bolstering access to life-saving mental health, he's fired thousands of critical employees, including veterans crisis line employees. Some have been reinstated, others have found new employment. That's understandable because they have bills to pay, they have lives to live and waiting for the administration to correct yet another unforced error can't be their burden.

We have to make sure that the administration answers our question. Our responsibility is oversight, and scrutiny, and to prevent the firing of another 83,000 VA employees over the coming months. We know from this Committee, we've all been on it for a while, that outreach is essential to bring veterans into mental health. We can't rely only on veterans calling a crisis line or coming to the VA facilities.

There has to be outreach. 10 of those 17 per day average veterans taking their own lives, 10 of them, have had no contact with the VA. If we can reach more, we can save more. If we fire the counselors and others who are doing outreach, it will cripple efforts to save veterans from suicide, including the Fox Program.

So, while we're here today, I hope to hear from our witnesses about the importance of outreach and how it can be bolstered and strengthened. Thank you, Mr. Chairman.

Chairman MORAN. Ranking Member, thank you. We are now delighted to have before the Veterans Committee, on a temporary basis, the Senator from Virginia, Senator Warner, one of our esteemed colleagues. And this is a rare occasion when other Senators not on the Committee appear before us. But you are welcome to be here, Senator Warner.

STATEMENT OF HON. MARK R. WARNER,
U.S. SENATOR FROM VIRGINIA

Senator WARNER. Well, thank you, Mr. Chairman, and Ranking Member Blumenthal. This is obviously a very important topic. You've given me 4 minutes. I'll try to get it under 4 minutes, so I actually get asked back. But very much appreciate the work of this Committee. I know the issue of mental health of our veterans is extraordinarily important.

And this is something I think we all realize is part of a core commitment. This is not a nice to do. This is an obligation we owe to the men and women who've served us. It is not charity. It is something that we must fulfill. And unfortunately, as the Chair and the Ranking Member, and I know, all the Committee members realize, veterans' suicide is a scourge that has to be addressed.

For the past several years, Staff Sergeant Fox Suicide Prevention Grant Program, I think, has been an invaluable tool for the VA to use. Senator Boozman and I came up with an initial legislation back in 2019, a number of Members on this Committee were firm supporters. That turned into an effort that ultimately led to the Staff Sergeant Fox Grant Program.

In that time, $150 million has gone out in my home State of Virginia. $4.5 million of that has gone out to organizations who are providing the kind of critical outreach to make sure that veterans who are in duress know that the services are available as Ranking member Blumenthal mentioned. We have a huge concentration of veterans down in Hampton Roads, and the fact that of these 17 suicides today, the fact that literally 10 of those never interact with the VA, is a challenge that we have to overcome.

This program was a temporary grant program. It is time for its permanent reauthorization. I've joined again with Senator Boozman on legislation to do that. I know the Chair, and the Ranking Member, and others on this Committee have similar legislation. I just want to add my voice that this is something we have to get done. The sooner, the better. Literally, veterans' lives depend upon it. And if any, in any way, I can, as an off-Committee member helping these efforts, please count me as one of your allies.

I appreciate the opportunity, and I will note Mr. Chairman, that I'm seating back a minute and 40 seconds.

Chairman MORAN. A message. It's an opportunity for Senators to learn from Senator Warner. A message well delivered under the time allowed.

Senator WARNER. Thank you, Mr. Chairman.

Chairman MORAN. Thank you, Senator Warner. Thank you for joining us today. I remember the hard work that you and Senator Boozman did early on to get this legislation in place.

Testifying on today's first panel is Dr. Thomas O'Toole, the Acting Assistant Under Secretary of Health for Clinical Services of the Veterans Health Administration. He's accompanied by Michael Fisher, Chief Officer of Readjustment Counseling Service of the Veterans Health Administration. Thank you both for being here.

Dr. O'Toole, you're now recognized for your testimony.

PANEL I

STATEMENT OF THOMAS O'TOOLE, MD, ACTING ASSISTANT UNDER SECRETARY OF HEALTH FOR CLINICAL SERVICES AND DEPUTY CHIEF MEDICAL OFFICER, VETERANS' HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS ACCOMPANIED BY MICHAEL FISHER, CHIEF OFFICER, READJUSTMENT COUNSELING SERVICE, VETERANS HEALTH ADMINISTRATION

Dr. O'TOOLE. Thank you, Chairman Moran, Ranking Member Blumenthal, and Members of the Committee. Thank you for inviting us here today to present our views on several bills that would affect VA programs and services, particularly the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program. Joining me today is Mr. Mike Fisher, Chief Officer of the Readjustment Counseling Service.

The Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program enables VA to provide resources toward community-based suicide prevention efforts to meet the needs of veterans and their families through outreach, suicide prevention services, and connections to VA and community resources.

In alignment with VA's National Strategy for Preventing Veteran Suicide, this grant program assists in further implementing a public health approach that blends community-based prevention with evidence-based clinical strategies through community efforts. The grant program is part of the Commander John Scott Hannon Veteran Mental Health Care Improvement Act of 2019, that was signed into law on October 17th, 2020.

The Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program began on September 19th, 2022 when VA awarded $52.5 million to 80 community-based organizations in 43 states, the District of Columbia, and America Samoa. Since its launch in September '22, VA has awarded $157.5 million to 95 organizations across these 43 states, U.S. territories and tribal lands.

Early results show that 33 percent of participants are new to VA services, and 75 percent of participants who complete services show improvement in mental health status, well-being, social supports, and financial stability, as well as a decrease in suicide risk. All of the bills on today's agenda would hold, or in part, mend the authority for the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program.

VA strongly supports the reauthorization of this program as it is critically important for sustaining and expanding the progress we

have made so far. The initial grants have already shown promising results, and continued congressional support will be essential for ensuring that we can reach even more veterans in need.

We greatly appreciate the Committee's interest in continuing this program and stand ready to implement the extension of this authority as soon as possible, because it's important to continue this work in fiscal year 2026. We welcome the opportunity to meet with the Committee to ensure that any amendments to the terms of the grant do not interrupt operations or delay these awards. The Department's position for each bill is detailed in my written statement.

This concludes my statement, and we are happy to answer any questions you or other Members of the Committee may have.

[The prepared statement of Dr. O'Toole appears on page 47 of the Appendix.]

Chairman MORAN. Doctor, we'll begin a round of questions by the Members of the Committee. Let me start by asking you, as Congress looks to reauthorize, it's really pleasing, I think this has broad support in Congress and certainly strong support from the Department. But as we do this process and work to improve this program, what's the VA learned about grantee performance and outcome data so far? And what are the lessons that have been learned in shaping your approach to suicide prevention?

I would add before you answer that, one of the challenges highlighted in the Hope for Heroes Act is a lack of awareness among VA staff about the Fox Grant Program. And I would ask, how is the VA working to make certain its own employees, and especially those in high needs areas, are fully aware of the program and collaborating with grantee organizations making this program even better?

Dr. O'TOOLE. Thank you, Senator. As noted, the 3-year authorization for this grant program has really allowed us to be on a learning curve to try to do a better job. As has been noted, any suicide by a veteran is one too many. And so, we very much view this grant as an important part for reaching those veterans that we are not reaching.

The lessons learned to date, and much of this is captured in the MITRE report that provided a snapshot view of early experiences, highlighted several areas that we need to continue to improve on. Obviously, enhancing our outreach and engagement, particularly for those disconnected veterans is critical. And I think ensuring that our grantees have all of the services they need as well as the expectations and skills that they require to be able to effectively engage not only in outreach, but in the services is critically important.

The other area that I think is essential is making sure that the VA is there, ready, and has capacity, and a clear path for ensuring that mental health care is available to those veterans who need it. And obviously, that incorporates several different elements, but one of which you mentioned, which is an awareness of the programs by the grantees. It's something that we acknowledge, and I know it's addressed in several of the bills going forward as well.

Chairman MORAN. Let me ask you. You used the word capacity, clear path. So, how would you indicate that the Department of Veterans Affairs is prepared and capable on a clear path to reduce suicide by veterans in the country just more broadly than this legislation? Tell me about the capacity and capabilities.

Dr. O'TOOLE. So, the capacity is we have a very robust mental health services program within VA that incorporates tiered levels of care, including screening throughout the agency and in our healthcare settings, not only just in mental health; integration of mental health care within our PACT or primary care teams through the PHMI program, behavioral health teams providing more intensive care as well as specialized services for higher need, higher risk veterans, including inpatient care and residential treatment programming.

It's a continuum of care and continuum of services that, you know, as noted in Senator Blumenthal's statement, requires maintenance, requires an ongoing, you know, capacity to effectively serve the veterans in need. But it is also, I think, a more robust service than oftentimes we can find elsewhere. And it's one that, you know, I think our veterans benefit from greatly.

Are there things we can do better? Absolutely. Are there things we need to be improving on? Absolutely. And, you know, I'm not here to try to defend things that aren't working, but more importantly, you know, be here to commit to our ongoing work with the Committee to do a better job.

Chairman MORAN. What would be those things that you could do that you see you can do a better job aside from what we've talked a lot about, which is outreach?

Dr. O'TOOLE. Right. I think that, you know, the Veteran Crisis Line, I think has been a lifeline for a lot of veterans. We need to continue to be able to support that and do the best we can. What's critically important is clearly making sure that we have pathways to treatment and to ensuring safety for those veterans who do screen positive. And we actually do well in that capacity and support.

Our ability to reach those veterans who are transitioning from the military is a critically important focus and capacity and interest. And I know it's one that our agency is working on several different efforts to try to improve and enhance. That becomes, I think, a critical piece, an element to it.

It's also important to note that suicide risk extends beyond strictly a mental health approach and status. Oftentimes, there are economic drivers, there are social drivers, and others. And taking a whole-health approach to the veteran is critical to really ensuring that not only the immediacy of a suicide risk is addressed, but sometimes the underlying issues and drivers of that suicide are also being considered.

Chairman MORAN. I would note that I have utilized Senator Warner's extra minute and a half, and I now recognize Senator Blumenthal.

Senator BLUMENTHAL. Thanks, Mr. Chairman. I want to begin by thanking you both for being here, and for your service to our country and to the veterans of America. I know that this time in your professional careers is probably one of the most challenging that

you have encountered, not because of anything you've done, but because the leadership at the VA is slashing positions, and freezing hiring, and cutting funding that is necessary for you to do your jobs and accomplish the mission you've devoted your lives to doing. And to you and all of the professionals at the VA, just offer my thanks for continuing to persevere in this very difficult time.

Dr. O'Toole, you would agree with me that outreach is critical in preventing veteran suicide, and enabling them to what you have called a pathway to treatment.

Dr. O'TOOLE. Yes, sir.

Senator BLUMENTHAL. And that takes human beings on the phone or in a meeting. It can't be done by an automated message machine. Correct?

Dr. O'TOOLE. Yes, sir.

Senator BLUMENTHAL. What rationale, what reason could there be to cut those positions as is now happening?

Dr. O'TOOLE. Well, thank you, Senator, and I appreciate one, your kind words as well as the attention that you're focusing on this issue. I am happy to report that, actually, the Veteran Crisis Line staffing numbers have gone up and not down since this last January. This is a, as you know, an exempted position from both return-to-office and along with 300,000 other direct care positions exempt from any hiring freeze, or any hiring, or any firings.

Senator BLUMENTHAL. Those returns or reinstatements were done after vocal protest from myself, others on this Committee, in Congress, and across the country. So, yes, that's good news, but it's not just the crisis line, it's positions in the West Haven facility outreach counseling. There already were 40,000 vacancies before this administration took over. Would you agree with me that a lot of those positions in the field are open now, and some people in those positions have been terminated?

Dr. O'TOOLE. Thank you. And I'm just up the road from you in Providence, Rhode Island. So, I can appreciate the challenges of local staffing and local issues. Quite honestly, our challenges in maintaining the workforce in healthcare extend beyond this administration. The challenges that we're facing now, a lot of them——

Senator BLUMENTHAL. Well, I'm going to interrupt because I'm going to run out of time if I don't interrupt, so I apologize. But the fact is there are challenges in recruitment. Correct?

Dr. O'TOOLE. Yes, sir.

Senator BLUMENTHAL. And those challenges in recruitment are deeply and dramatically aggravated when the prospect of firing 83,000 employees is raised. Why I go to work for an institution that's about to fire probationary employees, the newest among them, when there are opportunities in the private sector where you get paid more, I mean, duh, you know, I know you're not in charge of personnel, but isn't that a recipe for disaster?

Dr. O'TOOLE. Well, sir, I can't say that 300,000 positions, which are the direct care positions, are exempted from any hiring freeze. And this is a critically important element to trying to ensure that we are retaining and ideally growing our workforce as best we can.

Senator BLUMENTHAL. I am about to have my time expire, but I just want to say that we know that there have been firings of researchers, counselors, outreach personnel. There is simply no way

to save veterans. And I've heard nothing here that would convince me otherwise if we engage in this slash and trash approach to the VA. And again, my thanks to all the professionals, to you, Mr. Fisher, and Dr. O'Toole, for what you're doing. And I have not gone over my time.

[Laughter.]

Chairman MORAN. Only by 3 seconds. Senator Cramer.

HON. KEVIN CRAMER,
U.S. SENATOR FROM NORTH DAKOTA

Senator CRAMER. Thank you, Mr. Chairman, Ranking Member, for this important hearing. And thank you to our witnesses as well for your service, and for being here.

I'm going to get right to the specific point that's addressed in legislation that I've introduced, an amendment to the Act before we reauthorize it, that I've introduced with Senator Coons. And to be clear, what resulted in this is the fact that as important as this program is, and it is important, and I strongly support it, neither North Dakota nor Delaware received any of the funds despite a very, very good application, particularly the one I'm most familiar with; the State of North Dakota through the North Dakota Department of Veterans Affairs. Important I stress the North Dakota Department of Veterans Affairs because of the five criteria that meets five of them, the five criteria for the grant.

And so, we're a little disappointed, of course, that North Dakota's application was rejected. I don't know if it was not qualified, but at least wasn't prioritized. And so, I want to I'd like to have you, you know, maybe explain to me a little bit about why that happened. And then, also, you know, we received the testimony yesterday that the VA is opposing my language and my amendment, and I just want to give you an opportunity to explain that before I try to explain my position better.

Dr. O'TOOLE. Thank you, Senator. And while I can't speak to the specifics of that individual grant application and the decision to it, I think it's important, first, thank you for your support of this. It's support that we're very appreciative of, and we share in our need, and want, and desire to really grow this program and grow these efforts. I think our challenge and our concern with an approach to increasing the number of grantees, which we acknowledge is important, and it's an essential aspect to being able to reach more veterans, engage more veterans, and get more veterans into care and services, is going to be—it's a shared objective.

Having two potentially different or a prioritized pathway would be difficult to logistically administer, if we have two tiers. Our larger concern is that we want to make sure that all of the projects and all of the grants that are being approved are meeting the high-quality universal standard. And our concern was we do not want to create two standards for how a grant would be approved.

Senator CRAMER. And I appreciate all of that. I would state, however, that in the case of states and just to be so that people know what our bill does, Every State Counts Act, it recognizes that a couple of states didn't receive funds from the program, and we want to prioritize states that haven't received funds previously. It's

a one-time deal. We want to get these other states in the loop, so to speak, and then clear the deck, particularly very rural states.

I mean, North Dakota's a big state, 350 by about 200 miles rectangle in the middle of the North American continent, literally, we have a monument to prove it. And a lot of miles between veterans, but 55,000 of them that need this service. We think that's pretty important criteria. I've done this before with other bills that—Senator Heinrich and I did something similar when the discretionary grant programs at the Department of Transportation weren't reaching some rural states. We fixed that, got them back in the loop, and it's worked out very well.

I would just state that, particularly, again, I've read that the objections, some of them reference, you know, multiple applicants within the state, the competitive nature, all the things that you've highlighted. But I think when it comes to an entire state, regardless of the small population, it is after all why there are two Senators from every one of them. Every state does matter. Our Founders made sure that.

I just think it's worth fixing in a way that prioritizes states that have not received funding previously. And just adding that as a—it's not complicated. I know that testimony says it's complicated. It's not complicated. It's very simple. And we want to make it simple. If we make it simpler, we would like to do that.

Dr. O'TOOLE. Thank you, Senator. And we agree we are very interested in working with the Committee to figure out a good way to approach it because we share that same——

Senator CRAMER. And I suspect more resources would be helpful.

Dr. O'TOOLE. Yes, sir.

Senator CRAMER. All right. I yield 10 seconds since we're keeping track.

[Laughter.]

Chairman MORAN. Senator Murray.

HON. PATTY MURRAY,
U.S. SENATOR FROM WASHINGTON

Senator MURRAY. Thank you, Mr. Chairman, and thank you to both of you for being here. I think it's really important that in order to improve our mental health care outreach, we need to hear, all of us Members of Congress, need to hear from both veterans and VA providers about their experiences and the issues that they face every day.

However, last week, the Trump administration denied VA Puget Sound in my state, the ability to both host and participate in my women veterans roundtable. I held the roundtable anyway at a local VFW, but VA would not participate. And the conversation certainly lacked, in my opinion, a much-needed perspective. I have never seen this sort of blatant barrier to outreach before in my entire time of Congress.

Dr. O'Toole, can you explain why having both the VA and veterans together is important for a robust conversation?

Dr. O'TOOLE. Well, thank you Senator, and I appreciate it. I'm not familiar with the situation you're describing, so unfortunately, I can't comment to that and to the specifics, or to the approval, or lack of. But absolutely, we are informed by our veterans. It helps

us to be a better agency and a better organization, and it's something we try to encourage in as many capacities as we can.

Senator MURRAY. Well, do you know if the new policy that prevents elected officials from meeting with veterans at VA facilities comes from within VHA, or does it come from political leadership at VA central office?

Dr. O'TOOLE. You know, I would have to defer that to our leadership in terms of describing it better than I can myself.

Senator MURRAY. Okay. Well, Mr. Chairman, this is really important, and I really hope that Secretary Collins, who says he is running the most transparent VA in history, decides that VA can be transparent enough to let a Senator hold the discussion about VA healthcare onsite at the local VA as I have done for over 30 years, and I know other members have as well. So, I am not done with this topic.

Let me ask you, though, Dr. O'Toole, even though women are more likely to seek care through VA, they're also more likely to be dealing with depression, and anxiety, or sexual trauma. In 2022, suicide rates for women veterans with histories of military sexual trauma, were 75 percent higher than those without. So, getting into contact with these veterans and providing them the resources they need can truly be life or death.

However, in February, President Trump and Musk fired more than 2,400 VA employees, including dedicated health professionals who staff the phones at the VA's Center Veteran Crisis Line. What steps is VA taking now to reach out to survivors of military sexual trauma?

Dr. O'TOOLE. Thank you, Senator. Well, first, in relation to the Veteran Crisis Line, that decision was reversed and we have actually seen a net increase in staff working in the Veteran Crisis Line. And, you know, I'm happy to report that outcome.

The outreach and specific efforts for women who are victims of military sexual trauma has been incorporated into our REACH VET and REACH VET algorithm so that we are specifically identifying and engaging those women to make sure that we are providing better care. I'd like to defer to Mr. Fisher, who can also speak specifically to some of the efforts at the veteran resource centers as well.

Mr. FISHER. And thank you, Senator, for the question. So, Vet Centers have historically gone out and reached out to any veteran cohort and service member cohort that's eligible for Vet Center services. That includes women veterans, that includes individuals who experience military sexual trauma. We've continued to do this since the change of the administration.

Our outreach staff, as well as our counseling staff at Vet Centers are exempted from any hiring freeze. And what we can say specific to women veterans is that we every year see increases in the number of women veterans that are coming into Vet Centers. We also see high trust scores with women veterans who received Vet Center services. Last year, it was at 93 percent.

Senator MURRAY. Okay. And I'm running—almost out of time, but I don't see how 80,000 more employees being removed will help the VA provide services. I just wanted to ask about the return-to-office policy. I have been talking to a number of VA providers who

tell us about VA's new rule that forces them to work in person. Those providers have been working remotely since before the pandemic, and now instead of being able to take video calls in private offices, they're speaking with veteran patients in open floor spaces where there's no privacy. This is a violation of veterans' privacy. It's a violation of HIPAA. It is leading doctors and counselors to look elsewhere for work.

I am almost out of time. I just want to say that the elimination of telework agreements is really affecting our veterans access to mental healthcare, and we need to have a further conversation with you about how we can fix that.

Chairman MORAN. Senator Blackburn.

HON. MARSHA BLACKBURN,
U.S. SENATOR FROM TENNESSEE

Senator BLACKBURN. Thank you, Mr. Chairman, and thank you for being here and for approaching this subject today. This is one—the veterans that are a part of our team talk with me about this access to mental health services all the time, and the grief that people experience when there is that loss of life of someone that they have served with. And putting attention on the mental health needs is something that, we, each and every one should spend more time doing and making these services available that our veterans need. This is something that is also very important.

Dr. O'Toole, I want to come to you because we've talked about this, and thank you for your testimony. We've talked about what you're doing to make services available. What you have not addressed is the fact that there seems to be inconsistency of access, and there seems to be gaps in this service. So, if you would build that out a little bit. How are you addressing those gaps in the inconsistencies and what is the strategy for moving forward so that people know that at the VA there is a standard of care that they can expect?

Dr. O'TOOLE. Thank you, Senator. I appreciate that, and I appreciate the way you framed it. I think this really underscores the importance of the Fox Grants. And, you know, I think it is important to put into context of the 17.6 veterans that complete a suicide every day, 10 of them have no contact with the VA, as has been noted earlier.

We need to be doing a better job of engaging those veterans in care. We need to be able to reach out to them. We need to be able to meet them on their terms, in their homes, in their home communities, to be able to provide those services. And this is what the Fox Grants are providing for us. And this is what the preliminary evidence of the Fox Grant grantees to date are showing progress in.

So, I think your question is spot on, but it very much underscores the strategic public health approach we have to really using these grants and these grantees to create that connection. And use then those connections to facilitate the trust that's needed to break down the barriers that individuals may have to actually being able to engage in care, which the Vet Centers are a great example of that occurring.

Senator BLACKBURN. So, how do you simplify the ability for individuals to access that care in their communities? Because we know

the telehealth is important. We know that easy access is important when you're dealing with the mental health issues, but if you've got to wait on the VA and a caseworker to make up their mind, then it is something that delays you getting the care. So, talk to me about simplification of that access.

Dr. O'TOOLE. Well, I think one of the best examples of the—there's two points, actually three points, I'd like to bring up with that. The first, is the issue of outreach and engagement, which again, is critical to those 10 veterans a day who are committing suicide without having connections to the VA. The second, is ensuring that we are effectively screening those veterans that do receive care in the VA to make sure that we are determining if they are at risk for suicide. And our risk ID, you know, universal screening of all veterans is very much that strategy.

The third issue that is critically important is that when veterans are in crisis, that we are able to effectively and meaningfully respond. And this is where I would highlight the successes of the Veteran Crisis Line that truly provide that safety net for veterans in crisis.

And, you know, both the uptake and increased utilization of the Veteran Crisis Line and the responsiveness of the Veterans Crisis Line to be able to engage individuals in care are great examples. Is this saying that it's perfect? By no means. Can we do better? We have to. But I'm saying those are our three strategic approaches.

Senator BLACKBURN. Well, I appreciate that. I also am concerned, and I'll send you a question for the record on the continuum of care from active duty to veteran status with those EHRs. And Mr. Fisher, I'm certain you deal with this every single day, and people trying to make certain they have access to their records so that they can get the care that they need. Thank you all for being here.

Chairman MORAN. Thank you Senator. Senator Hirono.

HON. MAZIE K. HIRONO,
U.S. SENATOR FROM HAWAII

Senator HIRONO. Thank you, Mr. Chairman. So, as you testify about the need to reach out and provide the kind of services that you need to—for that, you need workers and the VA has always had thousands and thousands of positions that have been needed to fill, to be filled then to the point where we enacted legislation to make it easier for the VA to hire people faster.

And so, my colleagues have pointed out several, and I'm going to add to that because does it make sense to you, this is for Dr. O'Toole, that at a time when there are some 300,000 positions that need to be filled, and you have 2,500 or so already fired, another 83,000 to be fired. Does it make sense to you that this is happening to the VA?

Dr. O'TOOLE. Well, thank you, Senator. And just a clarification, the 300,000 positions in the VA are positions that are exempt from any hiring freeze.

Senator HIRONO. Well, then, can you tell me how many positions are needing to be filled in the VA?

Dr. O'TOOLE. I don't have that information readily available.

Senator HIRONO. But we're talking about thousands and thousands, I can tell you. So, does it make sense to you that this is an environment that you have to live with to provide the kind of services that you're talking about, which need workers. Does it make sense to you that this is happening to the VA? Yes, or no?

Dr. O'TOOLE. Well, ma'am, we are trying to do the best that we can with the resources that we have. The focus of the cuts to date have been of administrative personnel and not direct care providers.

Senator HIRONO. Let's face it. There's utter chaos going on as far as I can see in the VA. So, we know that a lot of veterans make up the workforce. We know that the slash and burn of the federal workforce has also impacted veterans. We know that the VA's 2024 annual report on veteran suicide identify financial loss as a significant risk factor for suicide.

Do you know which veterans have lost jobs in the Federal Government, knowing that some 30 percent of federal employees are veterans, and knowing that loss of a job is a risk factor for suicide? Do you know the veterans who have lost their jobs in this administration who have been fired?

Dr. O'TOOLE. I do not, ma'am. And we can—I can defer that to leadership that may.

Senator HIRONO. Well, it's amazing to me that how are you supposed to help these veterans with a significant risk factor, which is a loss of job, if you don't even know who they are. So, it really concerns me that as you talk about the need to outreach and suicide prevention, which is an ongoing issue that with homelessness to the VA, that you don't have the kind of information that, in my view, you should have to provide the support that you need to provide.

So, with everything that's going on, and with the tariffs, and the impact on our communities of the fear that the tariffs and the potential for tariffs and the impact, do you have a sense of what the impact will be on the veteran community, of which we have millions and over 100,000 just in Hawaii? Do you know what kind of impact the tariffs situation is having on the cost of everything for the veteran community?

Dr. O'TOOLE. I do not have that information. No, ma'am.

Senator HIRONO. Well, you can see that this is the kind of information that I would think that you would have to prepare for this hearing.

For again, for you Dr. O'Toole. So, as I mentioned, veteran suicide and homelessness is an ongoing issue for the VA. And knowing that the loss of economic security would increase homelessness among the veteran community, do you think that what is happening to the veterans in terms of loss of their jobs, et cetera, that homelessness among veterans will increase? And what are you doing about it?

Dr. O'TOOLE. Well, thank you, ma'am. So, this obviously shifts gears a bit to the Homeless Program Office. I'm happy to speak to some of the different——

Senator HIRONO. Well, I would say the homelessness also has an impact on veteran suicide.

Dr. O'TOOLE. Absolutely, it does. And as a social determinant of health and economic stability, it's critically important. We do have several programs in place for those veterans. I think our supportive services for veterans and families, and the bridge support that provides our vocational rehab programming, and others are clearly intended to provide greater economic supports for those veterans who are at risk. And clearly there is an overlap between suicide risk and economic instabilities associated with homelessness.

Senator HIRONO. Oh, the thing is, Mr. Chairman, with all the chaos that is going on, not just to the VA, but every single department, except for possibly the DOD, which is actually seeing increase in potential funds, there's going to be an increase in the risk factors that would lead to veteran suicides, I have to say so. So, there you have it. Thank you.

Chairman MORAN. Senator, thank you. Senator Boozman.

HON. JOHN BOOZMAN,
U.S. SENATOR FROM ARKANSAS

Senator BOOZMAN. Thank you, Mr. Chairman, and thank you, Senator Blumenthal, for calling this hearing. I was really proud to have partnered with Senator Warner years ago to introduce legislation that would eventually become the Staff Sergeant Fox Suicide Prevention Grant program. This program created out of a dire need to improve community-based resources to address the veteran suicide crisis.

While veteran suicide remains a critical issue, the VA's work and success with the Staff Sergeant Fox Suicide Prevention Program deserves recognition. Veterans who battle mental health challenges respond best to support from those that they know, and trust, and needs this program is critical in meeting. I look forward to discussing how we can reauthorize and update this support for veterans and communities across the country.

Dr. O'Toole, it's great to hear from VA how successful the program's been. In your testimony, you mentioned that VA supports increasing the authorized funding for the program. What kind of an impact would this funding increase have on the program, and what results should we hope to see?

Dr. O'TOOLE. Thank you, Senator, and thank you for your work and efforts to get this legislation passed. Initially, our hope with a reauthorization and appropriations is that we would be able to expand the number of grantees that that expansion of the grantees would both cover all of our states and geographic need areas, particularly those where access to care, access to VA care may be particularly thinned. And also, to ensure that the grantees are able to effectively engage specific population groups that may be at higher risk for suicide as well. And that is our hope and aspiration with the reauthorization and appropriations.

Senator BOOZMAN. What aspects of the program do you think have made it such a success story, and where do you see the program going?

Dr. O'TOOLE. I think the fact that these are community groups that have credibility in the communities where veterans live. These are peers. These are also organizations that are engaging families of veterans are all critical to this. The wraparound and holistic ap-

proach to really supporting those veterans is complementary to what VA does, and it really, again, creates a public health strategy and complements a public health strategy for how we're looking at suicide in a way that reflects the complexity of all that goes into it.

Senator BOOZMAN. The legislation that Senator Warner and I introduced included reporting requirements for VA. What metrics would VA likely identify as important to collect and share with Congress?

Dr. O'TOOLE. I think the measurement dynamic is obviously critical. We need to be good stewards of the resources that Congress provides to us, and make sure that the money is going where it needs to go and is having an effect.

The key as we see it, is not just in terms—it's obviously important that as many veterans are being reached as possible, but we also want to make sure that it's not just a throughput for lots of veterans, but without also looking at the quality of the care that they are getting, the comprehensiveness of the screening so that the care and the services they are getting is matched to the need. And also, that we are outcome driven.

We have to be focused on using this grant mechanism to be making a difference in these communities. How many of those veterans are doing better as a result? How many of those veterans are connecting in VA for VA services, or in the community for community services as healthcare would require?

But these are the accountabilities. These are the trackable metrics that we need to be really looking at.

Senator BOOZMAN. Very good. Well, that's good to hear. I agree with you 100 percent, I think, as does to the rest of the Committee. Thank you, Mr. Chairman.

Chairman MORAN. Senator Hassan.

HON. MARGARET WOOD HASSAN,
U.S. SENATOR FROM NEW HAMPSHIRE

Senator HASSAN. Well, thank you, Mr. Chairman, and Ranking Member Blumenthal for this hearing. And thank you, Dr. O'Toole, and Mr. Fisher for the work that you do to serve our veterans.

Dr. O'Toole, over the past few months, I've been asking VA officials and nominees if they can guarantee that the Trump administration's plan to fire 80,000 VA employees will not result in longer wait times for veterans to get appointments and receive care.

In response, the administration's nominees have told me that wait times at the VA have been increasing and reform is necessary, but they've never explained how firing 80,000 employees will help solve that problem. That's indicative of the way the administration has approached things these past few months. They have been making drastic changes without, as far as any of us can tell, any analysis or plan.

Dr. O'Toole, you've worked at the VA for almost 20 years, and you're currently the VA's top doctor. Has anyone asked for your analysis on how firing 80,000 employees will affect veterans care?

Dr. O'TOOLE. Thank you, Senator. And I appreciate the question. I do not—I am not involved in that—those discussions. And it is—

I will say that we actively monitor and track wait times. We actively monitor and track access.

Senator HASSAN. I understand that. And, again, my time is short, but the answer to my question is no, they haven't asked you for your analysis. And, obviously, wait times is a piece of this, but affecting veterans care, you know, if somebody's been laid off who orders supplies, and a doc runs out of critical supplies, that affects veterans' care. Right? So, have you seen or been provided with any analysis as to how firing 80,000 VA employees might affect veterans care?

Dr. O'TOOLE. I have not, ma'am.

Senator HASSAN. Have you been directed to perform or oversee any analysis as to how firing 80,000 VA employees might affect veterans care?

Dr. O'TOOLE. Well, again, ma'am, I will say, you know, I am prepared here to be able to speak to this grant. I don't have the information you're asking to that.

Senator HASSAN. Right? But I'm taking that you would know if you have been directed to perform or oversee an analysis. So, I'm going to take that as a no as well.

Last year, the VA's Inspector General released a report on several occupational staffing shortages within the VA. These are jobs that the VA was having the hardest time filling. The IG's report stated that the top clinical job in the VA with a severe staffing shortage was psychology. A whopping 61 percent of Veterans Health Administration facilities reported having such a shortage. Psychiatry came in third place; 47 percent of Veterans Health Administration facilities reported psychiatry as a shortage.

As a career VA doctor, can you please discuss the role that mental health professionals, like psychologists and psychiatrists, play in supporting our veterans?

Dr. O'TOOLE. Thank you, ma'am. They are critical. I think that goes without saying. And the complex needs and care requirements of our veterans, obviously, require the engagement of a very robust mental health service.

Senator HASSAN. Yes. I continue to be concerned then about the Trump administration's policies of hiring freezes, firings, and general disruption. You've talked about the exemption for about 300,000 employees, but it's really difficult to see how the chaos that is churning is going to help recruit and retain mental health professionals that our veterans really deserve access to. And you've just acknowledged, and Mr. Fisher, too, has, about how important they are to our veterans.

Last question Dr. O'Toole. You were the founding director of the VA's Homeless Patient Aligned Care Teams program, HPACT. This program utilizes clinics with co-located medical staff, social workers, mental health, and substance use counselors, nurses and homeless program staff that form a team to provide veterans with comprehensive individualized care. I really want to thank you for your leadership on this important work.

Can you please discuss the benefits of holistic wraparound care like this, and how this model utilizes expertise across a variety of fields within the VA?

Dr. O'TOOLE. Well, thank you, Senator. I appreciate those kind comments. And I think the hosting of that initiative in the VA speaks to a culture in the VA of trying to reach the veteran where they are, and meet them and their comprehensive needs on their terms, not necessarily our terms. And I think the HPACT successes in engaging those veterans, and really providing that stability that allowed them to move on with their lives, and engage more fully in programming reflects it. And it reflects, I think, a culture of the VA that I'm very proud to have been a part of.

Senator HASSAN. And I think it does, too. And I think one of the things we could really work on with that culture in place with so many veterans being willing to do peer-to-peer outreach, is reaching those veterans who haven't engaged with the VA who we are especially concerned about as we look at the suicide statistics. So, thank you very much. Thank you, Ranking Member Blumenthal.

Senator BLUMENTHAL [presiding]. Thanks, Senator Hassan. Senator King.

HON. ANGUS S. KING, JR.,
U.S. SENATOR FROM MAINE

Senator KING. Thank you, Doctor O'Toole, and thank you for your long service, and your dedication to veterans. One of my mottoes in life is that implementation is as important a vision. And we're talking about the vision now of the Fox Program, but the question is, what are the implementation steps, and how is it working?

One of the things I've heard from the field is that the intake process is intrusive and burdensome, and we're losing veterans who are just basically dropping out of the process. For example, in Maine, we've had 311 veteran screened since they started the program. 96 of those 311 refused to participate because of burdensome paperwork or the required VA connection. Veterans who make it through the initial screening, 5 percent have stopped partway through because of the intrusive questions.

Here's a practical implementation. One of the feedback I've gotten is, don't ask all those questions at the first interview. Let the professional establish a relationship. And I understand the screening is important, but we're losing some very at-risk people through the implementation process. Can you discuss this problem?

Dr. O'TOOLE. Well, thank you, Senator, and I appreciate the perspective you bring to this, because obviously implementation is the—you know, a great vision. But if it can't be implemented, it doesn't do as much good. I think it's important to put in context these findings. You know, this program was established as a 3-year temporary grant program to really learn from this. And those types of observations are critical.

You know, we need to find that balance between ensuring that we are asking the right questions to determine risk, and to match those needs to the services, and be able to engage as much as possible. But being able to do so without scaring people away and without turning them off from those care and services is critically important.

And, you know, I would defer to my colleague, Mr. Fisher, because I think the Vet Centers have been working in that space for

quite some time. But these are the lessons we have to be using to learn to get better and do better.

Senator KING. That's my suggestion. We are talking about reauthorization. Let's talk about examining. And, I mean, this isn't a malicious process. It's to try to determine the risk factors and the qualification. But if that in itself ends up knocking somebody out of the process, that seems to me that's a problem, should be considered and addressed as we're talking about reauthorization, and then re-implementation.

I would suggest, and this has been discussed to some extent, outreach is critically important. If 10 out of the 17 suicides are people with no connection to the VA, that tells you something. And we need to connect those people, and we need to reach out to them. And for whatever reason, they're not reaching out themselves. So, again, it just hits me. That's a piece of data.

I want to turn to one other point. 74 percent of veteran suicides involve firearms. With female veterans, it's even higher. Senator Sheehy from Montana, and I, have a bill that basically would have the VA provide a free lockbox to veterans who ask for them. They don't have to be connected to the VA, they just have to be veterans.

It's a voluntary program. But the whole idea is, I'm sure you realize, is to have some space between the idea of suicide, and I almost said the execution, that's not the right word, but going through with it, and lockboxes are one way to do that. Is this something that makes sense to you?

Dr. O'TOOLE. It is, Senator, and I think anything we can do to create space between the idea and the action is critically important. And the literature and the data support that. I know that's not one of the bills that we're here to discuss today, but the notion of lethal means safety and strategies for how to best facilitate that, including the use of lockboxes, is something that the VA is very interested in working with the Committee to identify.

Senator KING. I'm hoping to get that bill in the next, in the next round. But it just seems to me that the glaring number, 74 percent, involve firearms that gives us a place where we need to focus, it seems to me.

Dr. O'TOOLE. Fully agree.

Senator KING. Thank you very much for your testimony, and for your hard work on behalf of America's veterans. Thank you.

Senator BLUMENTHAL. Thank you, Senator King. Senator Duckworth.

HON. TAMMY DUCKWORTH,
U.S. SENATOR FROM ILLINOIS

Senator DUCKWORTH. Thank you, Mr. Chairman, Ranking Member. Three months of unjust, unconstitutional attacks on our veterans and against critical services of the United States Department of Veterans Affairs have divided this traditionally bipartisan Committee, sadly. I hope that today's focus on a matter that should transcend Presidential loyalty; ensuring that our veterans have access to robust mental health and suicide prevention resources will reflect a new, renewed commitment that this Committee will once again faithfully fulfill its constitutional responsibility to serve as an independent check on any Presidential administration.

Under normal times, the renewal of the Fox Grants Program will be an important step in enabling the VA to continue providing critical community-based suicide prevention resources for veterans, and to reach even more veterans who need this lifesaving care. However, I am concerned that the Trump administration's policies continue to undermine the mental health and well-being of those patriotic Americans who have served our Nation honorably. For the mass reductions-in-force of federal workers, including veterans working on the crisis line, to canceled contracts, and continued attacks on veterans belonging to underserved communities, Donald Trump and Elon Musk are intentionally attacking morale and exacerbating the Department of Veterans Affairs mental health workforce shortages.

This threatens the ability of the VA to distribute the Fox grants rapidly. We're talking about real lives, someone's parents, child, sibling, aunt, or uncle, grandparent, friend. We cannot endure more chaos at the risk of delaying the provision of mental health care and suicide prevention services.

Dr. O'Toole, what specific steps are you taking to ensure that there are sufficient staff and resources on-hand to administer the Fox Grant Program and to provide timely care for veterans seeking Fox Grant resources?

Dr. O'TOOLE. Thank you, Senator. And thank you for your service, as well as for your advocacy for our veterans. It's much appreciated. You're absolutely right. This is about ensuring that we have resources in place and a commitment to making sure that the grantees are going to be as effective as possible.

The Suicide Prevention Program reports to me. I have a weekly meeting with their leadership team. These are some of the things that we discuss, and this is a priority for us. You know, if we're going to have to—if it's going to work, we have to make sure that we have people in place to work it.

Senator DUCKWORTH. Well, what are you doing to ensure that they are there? I mean, my own office worked a case of several folks who work on the Veterans Crisis Hotline who were in that mass firing. Two of them have gotten their jobs back, but one of them still hasn't. And we're talking about people who, you know, may not be the ones answering the phones. We're talking about the trainers, the people who train the other folks, the supervisors, some of them still have not gotten their jobs back. What are you doing to make sure that there's enough people to work those hotlines and the suicide prevention programs?

Dr. O'TOOLE. Well, as I mentioned Senator, with the Veteran Crisis Line, that is exempt from any hiring freeze. And we've actually seen a growth in the numbers of employees on the Veteran Crisis Line, something though that we have to stay vigilant in ensuring that direct care is not impacted, and these programs are able to function at their highest capabilities.

Senator DUCKWORTH. Will you commit to hiring some of those people back that were fired by Elon Musk?

Dr. O'TOOLE. Well, we're happy to follow up with you on any specifics, by all means, ma'am.

Senator DUCKWORTH. Oh, I think it should be more than just the one people being handled by my office. There are many people

across the country who have now been laid off, who've worked on veterans' mental health programs. Those people need to have their jobs back, especially if they themselves are veterans. Do you commit to safeguarding and strengthening VA mental health workforce, including making sure they have the appropriate resources and work spaces?

Dr. O'TOOLE. Yes, ma'am. I'd like to speak a little bit to that in more direct terms. It's been referenced several times in terms of the return-to-office and the impact on confidentiality. We are very committed, and our leadership within VHA, has been very committed to ensuring that privacy is maintained and confidentiality is maintained, including ensuring that if employees need dedicated private workspace for engaging in telemental healthcare services and other services that require confidentiality and HIPAA rules are being complied with.

When those are not being able to be met, we have processes in place to work with the facility to ensure that either space is found or that there are appropriate pauses to the return to office. This is critically important. We cannot let this compromise the care we provide to our veterans.

Senator DUCKWORTH. Well, will you commit to advocating for protecting these mission-critical staff from adverse administrative actions, especially if they report that they're not getting the resources that they need?

Dr. O'TOOLE. Yes, ma'am. And we do that now.

Senator DUCKWORTH. Okay. Because I, again, we've dealt with people who've had to take phone calls in their cars in the parking lot because there was no confidential space for them to do their work, their jobs.

Dr. O'TOOLE. And we have mechanisms in place to try to ensure that that is not happening. And if those are happening, you know, we need to know about it.

Senator DUCKWORTH. Okay. Thank you, Mr. Chairman.

Senator BLUMENTHAL. Thank you, Senator Duckworth. Senator Gallego.

HON. RUBEN GALLEGO,
U.S. SENATOR FROM ARIZONA

Senator GALLEGO. Thank you. I was just going to ask, moving on to Mr. O'Toole, following President Trump's executive order on the return to work, the VA issued its return-to-work mandate requiring most employees to return in-person work.

So, kind of following up on the therapists who are hired as remote workers and kind of what Senator Duckworth had just said. Have you heard of any instances where therapists have had, had awkward and/or, I would say, not professional settings when they're having their healthcare or when they're having their—the veterans are having the therapy sessions?

Dr. O'TOOLE. I have not heard specific situations where that may have occurred. I have obviously heard it second- or third-hand. We have a mechanism and process in place. Those work environments and work scenarios are not acceptable to us. That's not appropriate care standard for the VA. And if they do occur, we have mechanisms to ensure that they can be remediated.

Senator GALLEGO. Okay. And then just kind of along the lines, there's an 83,000-person cut of VA workers coming. Is there a standard of who is going to be in that cut? You know, how many will be therapists? How many are going to be different professions, because that will also obviously affect the healthcare outcomes?

You know, it's hard to get some of these therapists into this job. Some of them can be much better paid in the private sector. So, losing therapists to these arbitrary cuts, in my opinion, it's going to be very detrimental to the mental health of these men and women.

Dr. O'TOOLE. I do not have specifics on that information. It would have to defer. And we'll have to get back to you on that.

Senator GALLEGO. Yes. I mean, for example, my Phoenix VA, the VA that I've belonged to, has a memo out that they have to cut 15 percent. But what does that mean? You know, who is that that they're cutting?

Mr. Fisher, I'm sorry, I can barely see your name. I have bad eyesight. So, I placed a blanket hold on all President Trump's nominees to the VA, especially following the fact that they're cutting 83,000 jobs because I just don't see how it's possible for the VA to fire so many of their employees without it affecting care for veterans, especially in mental health care.

You lead the office of the VA in charge of helping veterans transition from military to civilian life, which is extremely important. Right? If we can make that transition, the likelihood of people falling into some bad times, you know, reduces tremendously. So, it's extremely important work.

Now, do these cuts, veterans can lose access to that mental healthcare and potentially, you know, creating and rising instances of suicide. What directions have you received specifically from the Trump administration in order to enact these cuts to the VA workforce when you commit to ensuring that the VA mental health providers are not among those fired or other positions that are very important in kind of keeping that network together of a very important job that you have and we all have here?

Mr. FISHER. Thank you Senator for the question. Similar to what Dr. O'Toole brought up, I have not received guidance. Our focus at Vet Centers has been the hiring of our counselors as well as our outreach staff. We continue to do that in locations where we have a hard time hiring those. We leverage all existing authorities, whether that's our scholarship program or other special incentives to be able to ensure we're bringing those staff into Vet Centers.

Senator GALLEGO. And just to be clear, you haven't received any directive and any orders from VA Collins or anyone else from the VA saying you have to cut X amount of people by X amount of date from the programs you guys oversee. Is that correct, Mr. O'Toole?

Dr. O'TOOLE. That that is correct.

Senator GALLEGO. Okay. And then, Mr. Fisher?

Mr. FISHER. Same answer. Yes.

Senator GALLEGO. Okay. And from your general understanding, what is the deadline that the VA has set for them to cut these 83,000, let's say, positions?

Dr. O'TOOLE. Sir, I don't know, and I would have to defer on that.

Senator GALLEGO. Mr. Fisher, do you know?

Mr. FISHER. I would have to defer as well, sir.

Senator GALLEGO. Okay. Well, my concern is because in Arizona, the memo that was laid out was that they wanted cuts to go into effect by July 1st, and were already in May. And, you know, such sudden cuts, especially when it comes to kind of mental health care clinics, VA clinics and suicide prevention, could be extremely damaging since you're trying to recruit people into this very hard work. And at the same time, they're hearing about these firings. It's going to be hard to recruit and retain.

And I don't know if you've had any conversations with some of these potential therapists that are asking questions about whether or not they can come on board with the assurances that they're not going to be fired or let go later? And Mr. O'Toole, have you heard anything from potential employees, please?

Dr. O'TOOLE. I have not. I will note, though, that the direct care providers of whom therapists are exempted currently from any of the hiring freezes that are taking place.

Senator GALLEGO. So, they're exempted from the hiring freeze, but not necessarily from the attrition or from the potential elimination?

Dr. O'TOOLE. I'm not—again, sir, I would have to defer on that because I'm not aware.

Senator GALLEGO. Okay. So, I yield back my time. Thank you.

Senator BLUMENTHAL. Thanks Senator, Gallego. I have a few questions while we're waiting for the Chairman to return and start the second panel. And I don't know whether—I don't think anyone has asked about this fact, but the veteran suicide rates in Connecticut seem to have been highest among veterans who are over 75 years old, lowest in the age group, 18 to 54. Is that true nationally?

Dr. O'TOOLE. I don't know, sir. I'd have to look at that. There is a bimodal nature to the incidence of suicide. We see it very high in the 18 to 39 range for different reasons than we see it in the older populations where chronic disease, chronic pain, and other factors can play in a more active role. But I don't have the specific data that you're referencing. I would have to take it for the record.

Senator BLUMENTHAL. Could you try to provide that data? I assume that if it's available for Connecticut, it's available elsewhere. And is there any explanation for disparities between different parts of the country or different states so far as you're aware?

Dr. O'TOOLE. Again, I'd have to defer that to our subject matter experts. It's an important questions. It has a lot to do, I think, with levels of engagement, lethal means availability, and so forth. But I would prefer deferring that and we can get that information to you.

Senator BLUMENTHAL. I think it's an important question, both of those are important question. Because if there are lessons to be learned from some states and what they do in preventing veteran suicide, maybe they can be adopted more broadly.

And I want to just finally ask you to have a look at the BRAVE Act. You know, if we had a few hours more for this panel, I could go through each of the provisions. The standard response of the VA to many of these provisions was to oppose it because they said it

was not necessary. Now, an example would be to give more priority to women's health, mental health care. And they're saying to me that, for example, the requirement for the Department of Veterans Affairs to modify the REACH VET program to incorporate risk factors weighted for women veterans, it's not necessary because we are already on top of it. We got that problem.

Well, I'm not so sure that's accurate. If it ever was correct, it certainly is not. Now, I would ask you, Dr. O'Toole to please go back and look at the BRAVE Act and perhaps speak with your colleagues about giving me some more, maybe different, and more constructive reactions to the BRAVE Act.

Senator BLUMENTHAL. Thanks, Mr. Chairman.

Chairman MORAN [presiding]. Thank you, Ranking Member. Senator Slotkin.

HON. ELISSA SLOTKIN,
U.S. SENATOR FROM MICHIGAN

Senator SLOTKIN. Thank you, Chairman. And thank you to our nominees for being here. I'm a former CIA officer. I did three tours in Iraq alongside the military. I've served very proudly both Democrat and Republican administrations as a civil servant before I was elected to Congress. And I think everyone on this panel, Democrat or Republican, believes that when we make the choice to send men and women into war, we have a responsibility when they return, and that veterans deserve the gold standard of care.

And as I've been on this Committee, and I was on the VA Committee in the House, it seems like every time there's a threat to veterans' care or we need to expand veterans care, it's veterans who are pushing and advocating for that change. It doesn't happen in a big bureaucratic system just by sitting there.

I'm concerned that mental health occupations are the ones where we have significant vacancies across the VA. Over 60 percent of VA facilities report shortages of psychologists, and nearly half reported shortages of psychiatrists. And I was just at the VA hospital in Saginaw this past week, and there's definitely shortages across the mental health architecture. And there's no way for me to square that with the threat of potentially cutting 70 to 80,000 VA employees. I don't understand how we can add by subtracting.

And while I keep hearing from the Secretary of the VA that we're not going to cut the hospitals and the nurses and all that kind of stuff, all those support steps, the suicide hotline, all the folks who process claims so that veterans can get care, they are quite literally seem to me to be on the chopping block.

So, tell me, what are you going to do Mr. O'Toole, in this moment of subtraction from the VA, to actually ensure that our veterans get the mental health care that they need?

Dr. O'TOOLE. Thank you, Senator, and I appreciate the comments and the observation. And it's shared. You know we have the healthcare workforce, not limited to the VA, is struggling to fill needed positions across the board. And, you know, long before this past year, we've actively tried and have been trying to continue to attract people to work at the VA, which is, I've been here for 20 years, you know, it's where I choose to work.

The commitment is to ensure that direct care is provided and not compromised by these cuts. I am not privy to the decisions, and the discussions, and would have to defer on the specifics to that. But just as I mentioned in relationship to telehealth care, our utmost and absolute commitment is to providing the best care possible and not compromising it by any means in the process of the changes underway.

Senator SLOTKIN. I do not doubt not for one minute your mission and your belief in this mission. It's my concern is that you could be overseeing a component of the VA when you say we don't want to compromise care. In fact, we have an obligation as a country not to compromise veterans' care. And yet, we're talking about cuts of potentially 80,000 people.

And the Secretary of the VA refused to dismiss those cuts when he came to Howell, Michigan a few weeks ago. He was asked directly and he said, "well, difficult choices essentially are going to have to be made." So, I'm not seeing how the math is going to work out there.

I also want to note that in the 2024 National Veteran Suicide Prevention Annual Report, which you may have had a hand in it, said that most veteran deaths by suicide are among veterans who have not had access to VA care in the prior two years. Right? That if you're kind of in the system getting care, you have a better chance of being helped. But if you're out, you're not connected to the VA.

So, I would actually posit that we need to be getting to more veterans. We need to be doing better outreach. The VA needs to be talking to people when they separate and getting them in the routine of accessing all those services. So, in fact, on this mission, not only are we understaffed right now, but I think the mission is greater than what the VA is already doing. So, I would just note you are going to be the guy in the room when these cuts come down from on high.

Mr. Collins sat in your very seat and said, "I'm not going to let anything compromise care," and then seems to be supportive of 80,000 cuts. I'd ask you to stand up for veterans. It's bigger than any one administration. We have a responsibility, and I know you care about that mission. So, appreciate that and appreciate you being here.

Chairman MORAN. Thank you, Senator. Dr. O'Toole, let me just ask a quick question. It's a bit outside, I think, the realm, but there's been a lot of conversation about staffing at the VA from my colleagues and I, and I want to highlight the importance of community care. The MISSION Act, in the way I look at things, is a way that in fact choice came about in an effort to help further staff the VA, and particularly in mental health, where there's a shortage of mental health providers everywhere. It would be comforting to me for you to confirm the value of the MISSION Act and community care.

Dr. O'TOOLE. Thank you, Senator. And absolutely, community care provided in settings that are not VA for our veterans is very much part and parcel of the package of care that we provide, and needs to be considered because the bottom line is we want our veterans to get care.

Chairman MORAN. Thank you. We'll dismiss Dr. O'Toole and Mr. Fisher. Thank you for your testimony. Thank you for your service to veterans, and for your appearance here today. And we'll call the second panel to the table.

Testifying on today's second panel is Jim Lorraine, the President and Chief Executive Officer of America's Warrior Partnership. Gilly Cantor, Director of Evaluation and Capacity Building, D'Aniello—there's no reason for me to make a fool of myself one more time, so, thank you for being here. She is with the Institute for Veterans and Military Families, Syracuse University.

Steffen Crow, Staff Sergeant Parker Gordon Fox Program Manager, Oklahoma Veterans United, Heather Barr, U.S. Marine Corps veteran, assisted by a grantee organization, and Austin Lambright, U.S. Marine Corps, a veterans assisted by a grantee organization, and Lindsay Church, Executive Director and co-founder, Minority Veterans of America. Thank you-all for being here. And Mr. Lorraine, let's begin with you.

PANEL II

STATEMENT OF JIM LORRAINE, PRESIDENT AND CEO, AMERICA'S WARRIOR PARTNERSHIP

Mr. LORRAINE. Chairman Moran, Ranking Member Blumenthal, and esteemed Members of the Committee, thank you for the opportunity to testify today on behalf of America's Warrior Partnership.

You're considering four important bills that impact the well-being of all veterans. I'll focus on the impact of the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program, commonly known as the Fox Grant. At AWP, we view suicide and deaths of despair prevention, not as a single program, but as an outcome of veterans restored sense of purpose and improved quality of life. Our model is rooted in proactive outreach and engagement, trust building, and sustained relationships, which we do at scale. We strive to forge these connections before the crisis begins. That's where the Fox Grant has been essential.

Of the 545 veterans we've screened who reported suicide risk, 94 percent were not initially seeking mental health support. They face challenges such as economic insecurity, navigating the VA system, and fractured personal relationships. The importance of asking the right questions early and having someone listen cannot be overstated. Thanks to the Fox Grant, we've interviewed or we've intervened early, connected veterans to local resources and remained a consistent presence.

Just halfway through this grant year, AWP's screened 1,300 veterans, with 10.8 percent disclosing suicide risk. Since the grant's inception, that number has totaled 2,100, with 25 percent of the people that are veterans that we talked with and screened, disclosing some level of risk. These are not just statistics. They are lives saved because someone cared enough to ask and listen. However, there is room for improvement.

While the HOPE Act makes great strides, outreach must be reestablished as the program's singular focus. We must get upstream and follow the data of who is at greatest risk. The who is so impor-

tant. Our study, Operation Deep Dive in partnership with Duke University School of Medicine allows us to follow the data of the "who" is most at risk based on the community where they live in.

The pathway from community identification to VA must be more transparent, quicker, and less burdensome. Congress should require the VA to establish a simplified intake process for veterans already screened by grantees, one that avoids redundant questions in respects to the veteran's time in a critical situation.

We also support codifying the emergent suicide care section. In many cases, AWP uses the 988 Crisis Line for veterans for immediate need. Formalizing this connection enhances safety and saves lives.

Accountability is another key. AWP holds itself to the highest standards; routine audits, transparent reporting, and a sharp focus on Title 38 beneficiaries. Title 38 funding must focus on veterans and their families. We recommend that Congress require verifiable metrics from all grantees, and a regular reporting to ensure the taxpayer's trust is upheld, and that those not meeting the standard are reevaluated.

We support the use of the Columbia Protocol as the sole requirement screening tool. The current requirement of multiple follow up assessments is overwhelming and deters engagement. Let's reduce bureaucracy and focus on care. We strongly support the provisions in the HOPE Act, and that allow the Fox Grant funds to be used for transportation. We do a survey every year, and the lack of transportation is the top barrier veterans face, especially when those are in crisis.

Grantee funding is another consideration. AWP could double its outreach efforts if the funding ceiling was increased to $1.5 million. While this isn't necessary for every grantee, organizations that have proven outcomes and capacity should be empowered to do more provided the metrics and reporting structure are in place.

Regarding the BRAVE Act, we support a deeper analysis of veteran suicide and its risks factors. Still, discussions also must address the role of traumatic brain injury, a silent killer we are not doing enough to confront. Finally, we support the Every State Counts Act to expand the Fox Grant access to underserved states. In the meantime, AWP stands ready with our national network to assist when necessary.

Members of the Committee, thank you for your continued leadership, and support your efforts to saving lives. At AWP, we stand ready to keep doing our part to serve, to listen, and to ensure the vets are known. Together, we can do better.

[The prepared statement of Mr. Lorraine appears on page 67 of the Appendix.]

Chairman MORAN. Mr. Lorraine, thank you. Ms. Cantor.

STATEMENT OF GILLY CANTOR, MPA, DIRECTOR OF EVALUATION AND CAPACITY BUILDING, D'ANIELLO INSTITUTE FOR VETERANS AND MILITARY FAMILIES (IVMF), SYRACUSE UNIVERSITY

Ms. CANTOR. Mr. Chairman, Ranking Member, Members of the Committee, thank you for the opportunity to offer testimony on be-

half of the D'Aniello Institute for Veterans and Military Families at Syracuse University.

The IVMF perspective is rooted in research, along with more than a decade of experience working with 26 communities across the country. These communities are connected by a common goal, improving coordination between organizations that provide clinical and non-clinical care. So, together, we can help veterans thrive.

So, what have we learned? As we know, the rate of suicide among veterans remains too high, higher than among civilians. Data has also shown that each additional non-clinical stressor, such as financial and housing instability, is linked to increases in the likelihood of suicidal ideation. States, counties, and community-based organizations can often best address these needs.

In a study we conducted with the VA, we found a majority of veterans served by our partners were also enrolled in VA healthcare. For these veterans, their stressors were most effectively addressed when communities and VA medical centers worked together. At the same time, the study demonstrated that communities are in fact reaching many veterans not connected to VA healthcare, a group that represents over half the veterans that died by suicide.

The Fox Grants Program recognizes and leverages the role communities play in suicide prevention. It creates new formalized avenues into clinical care, and it supplements that care with wrap-around services so that we can address root causes, at the same time. We are grateful to this Committee for looking upstream as part of the Hannon Act to invest in this evidence-based coordinated approach.

The reauthorization currently under consideration is therefore critically important. Since the program's launch, the IVMF has offered ongoing support for 11 of our partners who have been awarded these grants. They have stress-tested this program and identified its strengths and challenges. While there's always more that can be done, many of the proposed changes directly respond to their feedback.

There are three main target areas that I'd like to address today. First, program coverage and expansion. Increased funding, both overall and for administrative and incidental costs, will enable grantees to scale and reach more veterans in a way that builds trust in non-clinical settings. These individualized peer-based approaches to outreach are both backed by evidence and just common sense.

A simple gathering over pizza or coffee can open the door for a veteran to reach out for help. Allowing reimbursement for transportation and ride-shares to appointments will also be beneficial. Whenever possible, the cost of an Uber ride should not be the barrier that stops a veteran from getting the critical care that might save their life.

Second, screening and eligibility. While some of our partners support the Columbia Protocol as the main required screening, others would prefer more nuance on when and how it's used. The proposed training on the tool will mitigate some of these difficulties. But overall, we hope that the intake process can balance evidence-based assessments with burden considerations for both veterans and program staff.

And third, VA collaboration and compliance. Most importantly, we strongly support the provisions designed to hold the VA accountable for their role in making this program successful. Our partners have routinely experienced inconsistencies in awareness and compliance by their local VA medical centers. Once a veteran has been deemed eligible for the program, VA enrollment must be streamlined with a dedicated process such as an automatic high priority group assignment.

We also appreciate the proposal to expand emergent suicide care coverage if the VA is not responsive. This provision will ensure grantees can effectively help veterans get the care they need.

In conclusion, the evidence for reauthorizing the Fox Grants Program is clear, and the proposed legislation aligns with many improvements sought by our partners. We deeply appreciate the Committee's steadfast commitment to increasing our investment in prevention so that this critical program can reach more veterans before they're in crisis. Thank you.

[The prepared statement of Ms. Cantor appears on page 75 of the Appendix.]

Chairman MORAN. Thank you. Steffen Crow.

STATEMENT OF STEFFEN CROW, SSG PARKER GORDON FOX GRANT PROGRAM MANAGER, OKLAHOMA VETERANS UNITED

Chairman, Ranking Member, and Members of the Committee, thank you for the opportunity to testify today. My name is Steffen Crow, a retired gunnery sergeant of Marines with tours in Afghanistan, Asia, Africa, Europe, and Central America. I now serve as the Program Manager for the Staff Sergeant Parker Fox Suicide Prevention Grant at Oklahoma Veterans United.

Our program exists to prevent suicide among our Nation's veterans by removing barriers to care. The Fox Grant was created precisely because the system was not working for too many veterans. Through the Fox Grant, OKVU has built a statewide veteran-centric approach that reaches across rural and urban communities. Over the past three years, we have engaged over 5,000 veterans and supported or led more than 800 outreach events.

We have formal collaborations with major veteran employers across the state, consistent engagement at Fort Sill, and we hosted the first multi-grantee veterans stand down in the country alongside the Cherokee and Choctaw Nations, drawing veterans from across Oklahoma and five other states.

At the core of our work is sustained trust and empowerment. Veterans who succeed often ask, how can they help others, proving that when we lift one, they turn to lift many. However, we face significant barriers. Chief among them, is the required use of the Columbia screening tool. Though well-intentioned, it often drives veterans away.

At a recent grantee conference, it was reported by one grantee that 13 veterans died by suicide after either refusing to complete the Columbia or answering no to every question despite the clear need these veterans were in. Worse, grantees are instructed not to track veterans deemed ineligible for the program, which creates a very dangerous survivorship bias.

Another persistent challenge is the absence of a national referral process between grantees and the VA. No two facilities operate the same way, and even within a single state, these can differ dramatically. Local VA staff often defer to central office guidance, which is not materialized into actionable support.

Veterans like Parker found solace in physical activity and music. Yet, grantees are restricted from funding low-cost gym memberships or instruments despite VA's own research supporting these therapies. VA guidance currently prevents us from delivering the very solutions their studies endorse. Transportation remains another major barrier. Guidance recommends Uber and Lyft. Yet, these services are non-existent in rural communities, and these are the areas that we primarily serve.

We currently need a national community of practice to unify efforts, and I can say Oklahoma Veterans United has already developed internal models for cross-county collaboration, and is ready to lead this initiative across the Nation. Another great benefit that would be a good add to this program would be the ability for grantees to hire an LPC or an LCSW to be that gap fill whenever there is a wait time for veterans to get care at their local VAs.

We think that in a 2-month period, four to six sessions with an LPC or LCSW in our direct team could be a very critical gap fill that would get someone into VA, and let them have the patience to wait for those appointments to materialize.

In the military, I was taught, if you see something, say something. For three years, we have raised these concerns to VA leadership without meaningful action. Veterans mistrust of the VA did not happen overnight, and winning it back requires a real tangible change. If the rate of 17.6 veteran suicides per day is accurate, then we have lost over 16,000 veterans since this grant started. Yet when a veteran stabilizes, the first thing they ask is, "How can I pay it forward?" Veterans want to be the champions of the system, and if the system works for them, I guarantee they will be.

The VA has good intentions, but they lack timely execution and consistent communication. We believe that with clear guidance, national coordination, and policies grounded in real-world realities, we can save lives and help veterans live lives worth living. We believe Parker's legacy must guide the future of this program. If he had access to these tools we propose, he might have remained with us longer. Let us not waste the opportunity to honor him through this meaningful change.

And thank you for your time, and your commitment to our Nation's heroes.

[The prepared statement of Mr. Crow appears on page 80 of the Appendix.]

Chairman MORAN. Thank you. Ms. Barr.

STATEMENT OF HEATHER BARR,
U.S. MARINE CORPS VETERAN

Ms. BARR. Good afternoon, Mr. Chairman, good afternoon, Members of the Committee, thank you for this opportunity to share my story about this program and how it helped.

My name is Heather Barr. I was a sergeant in the Marine Corps, served for just over five years, did two deployments; one to the Middle East, one to the Indo-Pacific. I was honorably discharged from the Marine Corps in September 2023. I went on terminal leave a month before that. So, this was two months post-deployment. Turned from a deployment next week, transition seminar, and then was out in two months.

I had no plan, no idea what I was supposed to do. Just was moved back into my family's home in South Carolina. Felt like I was back at square one, basically. Living with my mother, no prospects for the future, and didn't know what I was doing.

I ended up reaching out to the local Vet Center to try to find counseling and a therapist for mental struggles that hit me during deployment, and then just were expedited and grown by transitioning out of the Marine Corps. They then pointed me to the Upstate Warrior Solutions who are in Greenville, veterans' organization who are partially funded by the Staff Sergeant Fox Program.

While I was there, I was screened, found at risk, and they set me up for success, basically. Made sure I was continuing to go to therapy and things like that at the Vet Center. Were able to actually provide a way for me to get a job. Showed me ways to do that. That was the first employment out of the military, thanks to Upstate Warrior Solutions.

Part of the big change in transitioning for me was being completely disconnected from the military lifestyle and people I had been around for the past five-plus years. Coming back from a deployment, trying to transition to just normal military life and then to civilian is what put me in just a tailspin. It felt like I was just drowning, and was pointless, and purposeless without any guidance.

So, Upstate Warrior Solutions Staff Sergeant Fox Program helped provide that to me. They helped me get a job, made sure that I was engaging with veterans in community where I could actually relate to, and I could realize that I wasn't actually completely alone, and there were other people who actually understood what I had was going through or had been through. So, I was extremely, extremely grateful for that.

My scenario is an ideal scenario. My family was available for me to move back in with. Financial struggles were there, but thankfully, within a few months of getting out of the military, I was set up with Upstate Warrior Solutions in the program.

That is not always the case. I know many people who have gotten out, they do not have families to go back to. They have either poor relationships, or they're just non-existent. So, mine is basically the best-case scenario. I had family to go back to, but not all do. And regardless of if you're an enlisted officer, female or male, you have dependents, don't have dependents, all these things add up. Both financial difficulties, and then some have PTSD, anxiety, stress-related things that just compound on the already trying time that transitioning out of the military is.

And the Upstate Warrior Solutions and the Staff Sergeant Fox Program was definitely a life ring that I was very, very fortunate to be provided. It did take a lot of searching, but I was very, very fortunate to be thrown that life ring that not all people are.

I finished—completed the Staff Sergeant Fox Program in August 2024. When I left the state, they reached out to me multiple times, even though I was out of the program, actually showing they cared, dependent or not, if I was relying on them for anything, they wanted to make sure that I was taken care of as a veteran. I'm very, very grateful for that.

Since 2022, UWS has also completed the Staff Sergeant Fox Program with 20 other veterans, and currently have 164 active members within their program. And it's just a great outreach for those who have struggles finding other outlets, or just need help when they need. So, thank you. I appreciate.

[The prepared statement of Ms. Barr appears on page 102 of the Appendix.]

Chairman MORAN. Heather, thank you for your service to our country, and thank you for your testimony. Austin.

STATEMENT OF AUSTIN LAMBRIGHT,
U.S. MARINE CORPS VETERAN

Mr. LAMBRIGHT. Good afternoon, Chairman Moran, and Members of the Committee. My name is Austin Lambright. I just want to start by thanking everyone for the opportunity to be here. I'm deeply humbled not only for the opportunity to serve my country, the greatest country in the world, but also to be here and speak on behalf of the veteran community, and offer some insight on support based on my experiences.

I'm here from South Carolina. In 2006, at the age of 18, I enlisted in the Marine Corps to serve as an infantry machine gunner. I did two deployments; to Iraq in 2007, and then 2008 and 2009, and I was honorably discharged from the Marine Corps in 2010 at the rank of corporal as a squad leader.

During my time in the Marine Corps, I completely engulfed myself with the mentality of going to combat during the peak of two wars in the harshest conditions possible that Marines are sent to. I earned my Combat Action Ribbon when I was 19 years old in Ramadi. I was just a kid and at the time, I felt about as close to invincible as I could possibly feel. Although foolish, that was my feeling.

I had a purpose and a driven focus for my life with the support from loved ones at home that projected me into being a successful Marine and squad leader on my second deployment. Both of my deployments were to combat zones. I'm very fortunate to have the family that I have at home. Very hardworking father. He's a deacon at church and a mother that's as close to an angel as any human that I've ever met.

When I transitioned out of the Marine Corps in 2010, I moved back to my hometown in Easley, South Carolina, bought my first house, and I was somewhat of a reckless wrecking ball at first. I was mad at the world from my experiences, the outcomes of how the war played out, and just the current state of Americans in my generation.

In those 18 months' time from my EAS, I had been arrested three times for driving under the influence. I went to jail a handful of times on violent-related charges, and I had an unexpected child

who is now 12 years old; my son. During this time of those 18 months, one of my Marines had committed suicide. The first experience that I had with a Marine of mine committing suicide actually happened on my second deployment where Lance Corporal Robert Ulmer took his own life in our living quarters.

So, during this time when I was struggling really bad with some of the decisions that I was making, that 17.6 per day suicide number really started creeping in the back of my mind and became an option. In fact, five guys, five Marines that I deployed with to Iraq since we've gotten out, have committed suicide to this date.

Moving forward, you know, I said I had an unexpected child. So, my child, Jackson, he gave me a new purpose, and made suicide feel like it just couldn't be an option because I would leave my son alone in this world. My son's birth was a turning point in my life, and it's when I became connected with Upstate Warrior Solutions.

I began reaching out for help to better myself because I wanted to be the best father I could for my son. I quickly made common connections with other veterans at UWS, for example, Nate, back here, and another gentleman named Scott Hicks. Both of them I had strong connection to because of similar experiences, and they had been through some of the dark tunnels that I was going through at the time. However, they had made it through and were living very successful lives, good fathers, and they had something that I really wanted.

I found a commonality and mindset. I felt as if I was not just alienated in the general public. I was able to be real about my problems with these gentlemen and gain advice from them who have experiences similar to mine, but overcome the same struggles. I learned that I'm not invincible by any means. My choices and decisions moving forward directly influenced my way of life and leadership for my son.

This was the key period in my journey that really turned the course positive. I would've been suicidal or landed myself in prison or the grave. Surely enough, had I continued down the road I was on before my son was born, and I got connected with UWS. As time progressed, I went through a divorce, job changes that really got me in the dumps at times. And these times, I would reach out to UWS for support to keep my head on straight. I was invited to and participated in golf tournaments, dinners, hikes, other events that gave me a sense of positive community that I could take a pride in being a part of.

In October 2022, Upstate Warrior Solutions helped me get connected to the Vet Center for mental health counseling. I was in one of my darkest ruts at the time. I was suicidal for months. And in February 2023, I reached out to Upstate Warrior Solutions for help again, and agreed to participate in the Staff Sergeant Fox Program.

As a Staff Sergeant Fox participant, I received inpatient and outpatient care from both VA facilities and non-VA. I received care for PTSD and alcohol abuse, with a lot of time and focus spent on post-combat stress and my personal experiences. I also participated in Upstate Warrior Solutions's recreational programs, and received peer support from them. When I went to get inpatient mental health therapy, I missed my son's 10th birthday. However, the way

I explained it to my son and the mentality I had was, I can either miss his 10th birthday, or I can miss all of them.

So, I took that opportunity and it was one of the best things I ever did. I also want to note that I've always claimed to be a Christian man since I was saved at 12 years old. However, I never truly followed the lifestyle and choices that Jesus had directed me by his actions and words in the Bible. Last year, in April 2024, I was rebaptized in the presence of my son, my mother and father, and my life drastically changed.

Seeking God's purpose for my life and putting all my focus and energy on that cause for myself has been life changing for the better. The care and help that I received through the Staff Sergeant Fox Program saved my life. I had been out of the Marine Corps for 12 years before I asked for help. It took me 12 years to get to rock bottom. And at rock bottom was the untouched trauma that I experienced while I was in the Marine Corps, and the losses I experienced since that time as well. Loss of veteran friends, loss of marriage, loss of purpose.

For over two years, my mental health and well-being were made a priority by the VA, Upstate Warrior Solutions, and my community, but most importantly, by me. I exited the Staff Sergeant Fox Program in April of this year. When families, friends, local organizations, and fellow veterans actively participate in creating a supportive environment, it helps build a strong network of care and understanding. This sense of connection and shared responsibility makes a profound difference in the lives of veterans, reminding veterans that they're not alone, and that our lives really do matter.

Completing the program gave me the tools not only to take better care of myself, but to be there for my brothers and sisters in arms. I'm proud to have taken that step because asking for help is a strength, not a weakness. I hope and pray that this program, the Staff Sergeant Fox program, will not only be continued, but also expanded to include other avenues of resources like legal assistance, financial literacy, that will also include veterans with eligibility limitations.

Thank you for your time, and God bless.

[The prepared statement of Mr. Lambright appears on page 104 of the Appendix.]

Chairman MORAN. Thank you for your presence here today, your ability to tell us your story, and thank you for your service to our country. Thank you.

I'm going to go vote. I'm going to call on Lindsay Church, and then I'm going to yield my time to Senator Tuberville, and then Senator Blumenthal will chair the meeting until I return from the vote. So, Lindsay Church.

STATEMENT OF LINDSAY CHURCH, EXECUTIVE DIRECTOR AND CO-FOUNDER, MINORITY VETERANS OF AMERICA

Ms. CHURCH. Thank you. Chairman Moran, Ranking Member Blumenthal, and Members of the Committee, thank you for the opportunity to testify today.

My name is Lindsay Church, and I'm the Executive Director of Minority Veterans of America. Our organization serves veterans

who have been historically excluded and underserved; women, people of color, LGBTQ+ individuals, religious minorities, folks with disabilities, and those living in rural communities. We're not side stories in American military service, we're central to it. Yet, when we return home, we face systems not designed with us in mind.

Today's hearing acknowledges a crisis many of us have been warning about for years; the growing distance between service and survival, especially for those at the margins of visibility. Since October of last year, we know of at least 13 veterans who died by suicide on VA property. Another 13, transgender, non-binary, and intersex veterans have attempted suicide compared to just one last year. If this rate continues, we're on pace to exceed the highest number of veteran suicides recorded on VA campuses in a single year.

These aren't isolated incidents. They're a reflection of a system that is not only broken, but actively weakened by policy choices that erase the unique experiences and barriers faced by our Nation's most vulnerable veterans. Instead of fostering trust, transparency, and targeted services, we've watched as this administration has taken steps that endanger the veterans most in need.

In the past 100 days, VA rescinded VHA Directive 1341, eliminating protections for respectful, clinically informed care for transgender and intersex veterans, as well as access to crucial lifesaving healthcare. Critical language, acknowledging race, gender, sexual orientation, disability status, and accessibility was stripped from the forthcoming congressionally mandated report of the Outdoor Recreation Task Force for Veterans, which we sit on, effectively erasing marginalized veterans from national policy recommendations.

Outreach materials, acknowledging LGBTQ+, veterans, women, veterans of color, and disabled veterans have been sanitized or eliminated altogether. Efforts to suppress data collection on sexual orientation, gender identity, race and ethnicity have intensified making disparities easier to ignore and harder to address. These aren't bureaucratic oversights. They're deliberate choices with deadly consequences.

When we erase identity, we erase risk. When we erase risk, we erase responsibility. When we erase responsibility, veterans die. We confront these realities every day. Not in theory, but in lived experience. That's why our organization provides transitional housing for LGBTQ+ veterans experiencing homelessness. We deliver flexible financial assistance to veterans in crisis. We train minority veteran leaders and providers in culturally competent care, and we create spaces, indoors and outdoors, where veterans can heal without hiding who they are.

These interventions are suicide prevention. We've learned that connection saves lives. That trust saves lives. That access to mental care, healthcare that affirms identity rather than denying it, saves lives. That's why the bills before you today matter. They offer opportunities to not just bridge gaps, but repair the foundation of trust that's been so badly damaged.

That opportunity will be lost if we fail to embed equity at every step. We must prioritize equity in grant funding, not as a bonus, but as a core requirement. Mandate cultural competency training

for all providers serving veterans. Require disaggregated data collection so we can identify and address the disparities that put minority veterans at greatest risk. Invest in partnerships with trusted community-based organizations already doing this work.

Outreach without intention isn't outreach, it's optics. Access without safety isn't an access, it's abandonment. And visibility without action isn't progress, it's betrayal. We're not simply facing an outreach problem when veterans drive onto VA campuses and take their lives in their cars, or when transgender veterans struggle to walk into VA clinics because they're afraid to reveal their identities. It's not just an outreach problem when women veterans report being re-traumatized by providers who don't understand gender-based trauma.

We must acknowledge it that we're facing a systems design failure, one worsened by political decisions to erase the identities most in need of protection. We cannot afford half measures or sanitize language that hides disparities behind one-size-fits-all solutions. We cannot afford to lose another life to silence, indifference, or fear. This isn't just a matter of mental health policy, it's a test of whether our government is willing to see and serve all who have served.

Veterans deserve more than visibility. We deserve systems that are worthy of our trust, our lives, and our sacrifices. This is our chance, right now, to build these systems. To not only acknowledge veterans like me and those sitting behind me, but to fight for us regardless of our identities. Not with empty promises, but with bold action, bold enough to save our lives.

Thank you for the opportunity to testify. I look forward to your questions.

[The prepared statement of Ms. Church appears on page 106 of the Appendix.]

Senator BLUMENTHAL [presiding]. Thank you. Senator Tuberville.

HON. TOMMY TUBERVILLE,
U.S. SENATOR FROM ALABAMA

Senator TUBERVILLE. Thanks Senator. Good morning everybody. Thanks for being here and thanks for those of you that have served this great country. Thanks for your service.

Since I've been on this Committee now going on five years, we have not improved prevention of suicides. Matter of fact, in a lot of areas it's gotten worse. I know in my State of Alabama, you know, you can throw all the money at it you want, but at the end of the day, it's about attitude. It's about the people that work in these hospitals and these care units that show care and humility for the veteran.

I've had friends that have committed suicide. I've had friends that have almost committed suicide. It's a sad state of affairs. But again, I think it's more about people. We have to have people that's going to do the right thing. Veterans, there's no area that we need to concentrate more in our country, other than obviously our economy and things that are going on, but the care of the people that have put their life on the line for our, for our country.

Mr. Lorraine, opportunity for oversight on these grants. Do we have enough oversight, in your eyes, for the grants that we're putting out of the Fox Grants?

Mr. LORRAINE. Thank you, Senator. I think if there is oversight, it's not transparent. We do participate. America's Warrior Partnership participates in all the meetings that the VA holds. We provide our reports, we just don't know how we rack up against others, and we don't understand where we are, you know, how we can improve what we're doing.

So, if the outcome of oversight is to change the process and improve the process, we're seeing it a little bit. The technology system that the VA was using previously has improved greatly, but, I would say it's not exceeding expectations and oversight.

Senator TUBERVILLE. How can this VA and this administration stop the bad actors from taking these grants away from people who actually need these grants?

Mr. LORRAINE. Well, sir, you know, there's an example of a grantee in the Northeast who was prosecuted for taking $50,000 from the grant. I think that type of oversight is needed. We just went through our audit. We did very well with it. But I think more audits—I hate to say that, but I mean—I think more audits for organizations with clear guidelines that don't just look at how many hours are you spending doing the work, but what are the outcomes of the work that you're doing?

Senator TUBERVILLE. Yes. And the data that we get, a lot of it is not accurate. How can we overcome? How can we get better if we don't get accurate data? Are you seeing, any of you, are you seeing a better use of data that we're accumulating? Ms. Cantor? Anybody?

Ms. CANTOR. Thank you. I think that the types of measures that we've historically looked at in similar models, but not necessarily only models connecting people to VA care, but ones making referrals to organizations for services, have also included things like timeliness and accuracy of those referrals and whether they were referred for the right thing. And then if they were treated successfully.

So, to me, it's on a continuum of how many people are you reaching through your outreach, converting to how many people are you screening, converting to how many people successfully get to VA, converting to how successful is their treatment? So, it's really following that path. I think it's possible with a lot of the systems that many of us have used. I just think it's not, to Jim's point, as transparent as it could be about what information is available, particularly as a nongrantee, we know very little about how things are going.

Senator TUBERVILLE. Yes. I'll ask you this question. Do you think merit-based system of people that are showing better data, better accomplishments, you know, more positive outfluences and influences, do you think they should get more grants?

Ms. CANTOR. You're asking that to a seasoned program evaluator. So, I'm going to say absolutely, yes. And I think some of the provisions account for that in the new legislation. Allowing for potential additional funds to people who, like Jim, who have dem-

onstrated good performance or like Steffen's team that could serve more with more funds.

Senator TUBERVILLE. You know, the grant program started what in 2020, set to expire this fiscal year if we don't re-up it. Any of you want to answer this question? Are there any other suicide methods that we've seen? I'll ask the veterans. Any other suicide methods that we've seen to help to prevent suicide? Anything that you'd like to suggest in your experiences? Any of you want to answer anything that you've seen?

I have personally offered up to this Committee about hyperbaric chambers. People say that helps in some areas with PTSD, some people say they don't. Well who cares. If they help anybody, if they help one person, we should use them. Anybody want answer that question through experience?

Mr. LAMBRIGHT. There are a couple of non-conventional ways that I've experienced personally that have helped. I don't know if you're familiar with DMT or psychedelics, but those helped me quite a bit using those, personally, just to be able to get past the trauma and be able to—you know, it gives you a supernatural way to kind of look at yourself and get over the things that haunt you so bad. I think those work in general. I think anybody could use those to their advantage.

Senator TUBERVILLE. Were they provided by the VA?

Mr. LAMBRIGHT. No, sir. I don't think it was an option.

Senator TUBERVILLE. Yes, probably not.

Mr. LAMBRIGHT. While I'm here, I wanted to mention one thing. You know, there's been multiple comments from Senator Moran and others about the VA and funding, and the budget cuts due to the amount of funding. I just want to give you one example from me personally. When I went to Willingway Hospital that the VA sent me to in Statesboro, Georgia, I saw the bill that ended up getting sent to the VA from Willingway Hospital. It was $90,000 for a 30-day inpatient program. The exact same person who got the exact same care, but not billed through the VA, instead billed through their insurance, was $21,500.

So, I think there's a lot of irresponsible, maybe invoicing or spending. That's just one example. You know, if 50 guys go to the same program, you're talking about a substantial amount of money. So, there's—I feel like just the audits, like we were just talking about that was brought up, I think that'd be a really good situation just to mitigate all the unnecessary spending or maybe careless spending that that goes on. That way there's more funds available for veterans that need and could use it.

Senator TUBERVILLE. Yes, I think our VA Secretary now is on top of that. We've got to stop the fraud and the theft. We don't do that. We don't have money for people that actually deserve that. Thank you, Senator.

Senator BLUMENTHAL. Thanks Senator. I have a few questions for Ms. Barr and Mr. Lambright. Both of you as Marine Corps veterans went to Upstate Warrior Solutions. You didn't call the VA directly. You didn't call the Veterans Crisis Line. Could you talk about why you went there and not to the VA directly?

Ms. BARR. Thank you, Senator Blumenthal. So, I, myself, actually searched through the VA first to reach out to try to find any

type of mental health, anything. Something I had been trying to get into through the VA while I was in. Just try to get it worked out prior to getting out, and kept getting phone numbers for people who were no longer in service, or no longer connected to the VA, or just stonewalled over and over again through them.

I thankfully found a Vet Center in town, and they were actually the ones who pointed me to Upstate Warrior Solutions. And the Upstate Warrior Solutions were the ones to keep working through that. I think part of it is partially just due to, like in our area there in Greenville, South Carolina, there's a very large veterans presence. And the VA does not reach out very much nor does it announce its capabilities as often. It's definitely very much up to the veteran to try to find resources.

Upstate Warrior Solutions is one that presents itself and puts itself out there more so than the VA and the Vet Centers do. So, I think that's most likely the reason most people have found Upstate Warrior Solutions before the VA, just because they're out there putting themselves out to help and present themselves instead of making it a chore or an extreme task to try to make their way through the VA process of getting help, so.

Senator BLUMENTHAL. Thank you. Mr. Lambright?

Mr. LAMBRIGHT. Thank you for your question, Senator Blumenthal. I think what you had asked was why did I go to Upstate Warrior Solutions and not the VA. I had in fact went to the VA first. In South Carolina, there's multiple outpatient clinics, but there is one main VA hospital in Columbia where the state capital is.

So, when I was first initially struggling with suicide, I went through divorce, and I drove myself to Columbia, unbeknownst to my family or anybody, and checked myself in where they have a mental health facility there in Columbia. So, they basically took my clothes, put me in a gown and some foam slippers. And for five days I played Scrabble, and it was basically a waste of time.

When I left, I was more upset and in a worse place than when I got there. I discussed that with Upstate Warrior Solutions, which provided me the insight and the direction to use another facility, like a civilian facility if the VA can direct me there, where I can get the care that I needed.

So, I did in fact, go to the VA first. However, I had a relationship with Nate and with Scott Hicks, that I mentioned, and they had experience with other veterans that were in a similar position that had gotten help from a civilian entity. So, I chose that route instead, and honestly, it was the best decision I ever made, and I owe my life to these guys.

Senator BLUMENTHAL. Thank you. Thank you both for your service and for being here today. Mr. Lorraine, have you seen evidence yet of the VA cuts in staffing so far as it affects veterans?

Mr. LORRAINE. No, sir, we haven't. We haven't seen any.

Senator BLUMENTHAL. How about other members of the panel? Have you seen—and when I say evidence of the cuts, I don't mean only people leaving, I mean also the sense of anxiety, worry, and so forth.

Mr. CROW. I would say I have heard that just in phone conversations, following up, trying to build more program agreeances be-

tween us and VA, and just in general asking. I mean, they're our peers, we care about them as well, so we ask how they're doing and what's going on. And there's definitely some mixed anxieties and some fears. We just haven't seen personally any of that come to fruition yet.

Senator BLUMENTHAL. Have you heard veterans discuss it?

Mr. CROW. It's definitely asked about, sir. I mean, veterans that come into our programs or that we talk to at events. They are curious. It's in the news, so they ask about it. With us just being a grantee, I don't really have the expertise to tell them anything. I may mainly just direct them over to like public affairs offices and things like that to field those questions. But it's discussed.

Ms. CHURCH. Can I jump in, Chairman, or recommend—excuse me, Ranking Member?

Senator BLUMENTHAL. Thank you.

Ms. CHURCH. First, and anecdotally, you are seeing that the centralized services that VA relies on for things like their operator services, you can call—in order to reach the VA providers, you have to call them main central, like, operator. Took me seven and a half minutes to get to the operator the other day. It normally takes 12 seconds. Just sitting there waiting, on hold, trying to get a hold of anybody to get you to the dental clinic. You are trying, because that's the only way that you can call the actual hospital.

You have providers who are worried because their schedulers are getting cut and are getting riffed. You have providers who are worried because anybody that helps support them to deliver the services are starting to get those. While the providers themselves might be exempt, the people that support them, and the support staff, and the schedule of the billing, all of those things are now landing on the provider's desk.

And to the point that was made earlier today, VA does not pay well enough to make them do three or four jobs in support of delivering these services. So, there's a ton of anxiety, a lot of frustrations, people making impossible decisions about whether or not to take the deferred resignation, to take the early retirement, to take it and/or to chance whether or not they're going to have a job in a few months.

So, there's a lot of anxiety, which to the point earlier, talking about VA employees being veterans themselves, you've got a dual crisis happening here. You have veterans who in our community most of us are worried about what's going to happen with the future of this agency that provides most of our healthcare.

Then you turn to the actual side of people who work for VA. They're experiencing the mental health crisis of the VA maybe being dismantled, but also, they have to work for the agency, worry about their jobs. Many of them work in billets that are now outlawed in the agency themselves. You've got a surging crisis underneath the underbelly of the veteran community that we are going to see in next year's suicide report.

Senator BLUMENTHAL. Thank you. I want to thank all of you for being here today. The Chairman, Senator Moran, has another obligation, so, I'm going to finish the hearing. Thank you for your participation. Been very meaningful and important to the Committee.

The hearing record will remain open for five legislative days should any Committee members want to submit additional statements or questions for the record. And I'm going to ask all of our witnesses if there are any questions, to please respond to them.

And once again, thank you all for being here. This hearing is adjourned. Thank you.

[Whereupon, at 12:54 p.m., the hearing was adjourned.]

A P P E N D I X

Prepared Statements

STATEMENT OF
THOMAS O'TOOLE, M.D.
ACTING ASSISTANT UNDER SECRETARY OF HEALTH FOR CLINICAL SERVICES
VETERANS HEALTH ADMINISTRATION (VHA)
DEPARTMENT OF VETERANS AFFAIRS (VA)
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
ON

BRIDGING THE GAP: ENHANCING OUTREACH TO SUPPORT VETERANS MENTAL HEALTH

April 29, 2025

Chairman Moran, Ranking Member Blumenthal, and other Members of the Committee, thank you for inviting us here today to present our views on several bills that would affect VA programs and services, particularly the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program (SSG Fox SPGP). Joining me today is Mr. Mike Fisher, Chief Officer, Readjustment Counseling Service (RCS).

The SSG Fox SPGP enables VA to provide resources toward community-based suicide prevention efforts to meet the needs of Veterans and their families through outreach, suicide prevention services, and connection to VA and community resources. In alignment with VA's National Strategy for Preventing Veteran Suicide (2018), this grant program assists in further implementing a public health approach that blends community-based prevention with evidence-based clinical strategies through community efforts. The grant program is part of the Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019 (the Hannon Act) (P.L. 116-171), signed into law on October 17, 2020.

The SSG Fox SPGP began on September 19, 2022, when VA awarded $52.5 million to 80 community-based organizations in 43 States, the District of Columbia, and American Samoa. Since its launch in September 2022, the SSG Fox SPGP has awarded $157.5 million to 95 organizations across 43 States, U.S. territories, and Tribal lands. Early results show that 33% of participants are new to VA services, and 75% of participants who complete services show improvement in mental health status, well-being, social supports, and financial stability, as well as a decrease in suicide risk.

All the bills on today's agenda would, in whole or in part, amend the authority for the SSG Fox SPGP. The reauthorization of the SSG Fox SPGP is critically important for sustaining and expanding the notable progress we have made thus far. The initial grants have already shown promising results, and continued Congressional support will be essential for ensuring that we can reach even more Veterans in need. We greatly

appreciate the Committee's interest in continuing this program and stand ready to implement the extension of this authority as soon as possible to continue this important work in fiscal year (FY) 2026. We also want to ensure that any amendments to the terms of the grant program do not delay these FY 2026 awards.

S. 609 BRAVE Act of 2025

The BRAVE Act of 2025 consists of 4 titles and 14 sections. Each section will be discussed separately.

Title I: Improvement of Workforce in Support of Mental Health Care

Section 101(a) would state Congress' findings that VA reviews market pay surveys in each RCS District to compare the salaries of RCS employees, including licensed professional mental health counselors (LPMHC), social workers, and marriage and family therapists, to the salaries of similarly situated employees in VA and the private sector. Section 101(b) would require VA, not later than 180 days after enactment, to submit to Congress a report on the findings specified in subsection (a), including (1) an assessment of pay disparities between RCS employees and similarly situated employes within VA and the private sector, and (2) an identification of pay-related staffing challenges, and if they exist, a determination if each RCS District has initiated a review of third-party survey data for the identified occupations. Section 101(c) would require each report submitted under subsection (b) to include reports from all RCS Districts, including areas that are geographically diverse, rural areas, highly rural areas, urban areas, and areas with health care shortages. Section 101(d) would require each report submitted under subsection (b) include an assessment of pay based on third-party survey data, geographic location, equivalent qualifications (licensure, education level, or experience), and short-term incentives.

VA does not support this section.

VA does not support this section because it is unnecessary. Coordinated pay assessments are important and will ensure RCS staff are compensated at rates competitive with similarly situated employees in VA and the private sector. However, this section would not alter RCS' recruitment and retention authorities, it would merely require VA to submit a report to Congress. This section, particularly considering other sections in this bill (and existing provisions of law), would require RCS to prepare several reports within a short time period, which would divert resources from supporting Vet Centers and eligible beneficiaries. If pursued, VA would request input to ensure that market pay surveys accurately capture total compensation packages. A pure salary comparison does not capture the numerous benefits and advantages that Federal service brings and that greatly increases the value of Federal employment. This includes benefits such as a basic benefit retirement plan (retirement annuity for life) that is in addition to a thrift savings plan (401K) matching, childcare subsidies, annual leave increasing up to 26 paid days per year plus Federal holidays, and numerous special pays that significantly increase the value of Federal employment.

VA does not have a cost estimate for this section.

Section 102(a) would amend 38 U.S.C. § 7402(b)(8)(C), which currently allows psychologists to be appointed without licensure of certification in a State for a period not to exceed 2 years on the condition that the psychologist provides patient care only under the direct supervision of a psychologist who is licensed or certified in a State. Instead, the Under Secretary for Health (USH) could recommend that psychologists without licensure or certification in a State be appointed for a reasonable period of time. Section 101(b) would amend 38 U.S.C. § 7402(b)(11)(B), which currently requires LPMHCs to be licensed or certified to independently practice mental health counseling. The amendment would allow VA to waive this requirement for licensure or certification for an LPMHC for a reasonable period of time recommended by the USH.

VA supports this section.

VA supports this section because it would provide consistency across disciplines for considering candidates not yet licensed. It also would provide VA the flexibility to be consistent with State licensing standards.

VA does not have a cost estimate for this section.

Section 103(a) would require VA, not later than 60 days after enactment, to submit to Congress a report regarding coordination between VHA's clinical care system and RCS. Section 103(b) would require this report to include an adherence assessment to VHA policies—which state that each Veterans Integrated Service Network (VISN) Director must ensure that a VA support facility is laterally aligned with each Vet Center to provide supportive administrative and clinical collaboration to better serve Veterans eligible for Vet Center services, particularly those at high risk for suicide—from each VISN Director. Section 103(c) would require the report to include an analysis of whether: (1) Vet Center staff in the local area of a VA medical facility have the updated contact information for appropriate staff at the medical facility to ensure proper coordination of care; (2) the external clinical consultant and suicide prevention coordinator (SPC) of a VA medical facility are providing Vet Center counseling staff in the local area professional consultation not less frequently than monthly through regularly scheduled peer case presentations onsite at the Vet Center or via virtual or telephone consultation as necessary to fully support the coordination of care of patients, particularly those at high risk for suicide; (3) the external clinical consultant and SPC are documenting any such consultation; and (4) the USH is coordinating with the outreach specialist at each Vet Center to ensure active duty members of the Armed Forces who are participating in the Transition Assistance Program receive information regarding Vet Centers and their available services. Section 103(d) would define the term "Vet Center",

for purposes of this section, as having the same meaning given that term in 38 U.S.C. § 1712A(h).

VA does not support this section.

VA does not support this section because VA already complies with many of the requirements this section would establish. However, if this legislation moves forward, VA recommends, in the context of item (2), above, referring only to other VA mental health professionals instead of SPCs specifically. This would ensure that appropriate staff can provide these consultations while not adding to the SPC's workload, whose time and experience may not be needed (although where needed, SPCs could participate). Regarding item (3), above, VA also would recommend removing the requirement that the SPC document such consultation to reflect the prior recommended change.

As part of the mandatory Benefits and Services course, all Service members participating in the Transition Assistance Program are provided information on Vet Centers and their available services, website, and phone number, as well as resources to find their nearest Vet Center. The Benefits and Services course also encourages transitioning Service members to take the Vet Centers Military Life Cycle module, which transitioning Service members can do at any time. The module also describes how transitioning Service members and other eligible individuals can connect with local Vet Centers as a confidential resource at no cost to them.

VA does not have a cost estimate for this section.

Title II: Improvement of Vet Center Infrastructure and Technology

Section 201 would define the term "Vet Center", for purposes of this title, as having the same meaning given that term in 38 U.S.C. § 1712A(h).

VA has no objection to this section.

VA has no objection to this section because it would simply define a term consistent with current law.

This section would not result in any additional cost.

Section 202(a) would require the Comptroller General, not later than 1 year after enactment, to submit to Congress a report assessing the model RCS used to guide the expansion of the real property footprint of Vet Centers. Section 202(b) would require the report assess whether: (1) this model adequately accounts for the demand for Vet Center services in rural areas; (2) the frequency with which VA is reassessing areas for potential expansion of Vet Center services is often enough to address any population shifts; (3) such model adequately considers the needs of Veterans in areas with high

rates of calls to the Veterans Crisis Line (VCL) or high rates of suicide by Veterans or members of the Armed Forces; (4) such model adequately accounts for trends in usage of mobile Vet Centers in a given area; and (5) such model considers the unique needs of Veterans and members of the Armed Forces in areas being assessed. Section 202(c) would define the term VCL, for purposes of this section, as the hotline established under 38 U.S.C. § 1720F(h).

VA does not support this section.

VA does not support this section because the Comptroller General has only recently completed a November 2024 report, "Opportunities Exist to Improve Asset Management and Identification of Future Counseling Locations" (Government Accountability Office (GAO)-25-106781), and VA is currently working to implement its recommendations. In this regard, requiring the Comptroller General to conduct a second report in such a short period would seem inadvisable.

VA does not have a cost estimate for this section.

Section 203 would require VA, not later than 180 days after enactment, to (1) ensure each Vet Center has demographic data (e.g., age, gender, race, ethnicity) for individuals eligible for Vet Center services in the Vet Center's service area; this demographic data would be used to tailor outreach activities, including data on Veterans who have recently transitioned from service in the Armed Forces; (2) provide Vet Centers with guidance for assessing the effectiveness of outreach activities, including guidance on metrics for those activities and targets against which to assess those metrics to determine effectiveness; (3) develop and implement a process to periodically assess the extent to which Veterans and members of the Armed Forces who are eligible for services from Vet Centers experience barriers to obtaining such services (including a lack of awareness about Vet Centers and challenges accessing Vet Center services); and (4) develop and implement a process to periodically assess the extent to which Vet Center staff may encounter barriers to providing services.

VA does not support this section.

VA does not support this section because, while we agree that Vet Centers should have access to this information, it is not clear that the bill would actually address this concern effectively.

Initially, VA is unsure whether this demographic data exists, and if it exists, how easily accessible it would be. VA can access information in the VA/Department of Defense (DOD) Identity Repository (VADIR), but VADIR does not include all information for all individuals that would be covered by this section. Vet Center eligibility requires specific conditions of service to be met, which is determined based on specific pieces of information that would not likely be viewable in any demographic dataset. This could

limit the utility of this intended requirement. VA is also already assessing much of the information that would be required by items (2), (3), and (4), above.

We would welcome the opportunity to discuss the concerns prompting this section with the Committee to determine what can be done under current authority and where VA may require new authority.

VA does not have a cost estimate for this section, but we anticipate that there would be information technology (IT) costs associated with implementation.

Section 204 would require VA, not later than 60 days after enactment, to submit to Congress a report identifying: (1) whether VA is retaining or replacing the current IT platform, the RCS Network (RCSNet), which is currently used to manage certain parts of the daily work of RCS employees and RCS operational data and management function; (2) if VA intends to keep RCSNet, the rationale for that decision and an identification of the steps VA is taking to maintain or improve the functionality of RCSNet and the timeline for those steps; and (3) if VA intends to replace RCSNet, the rationale for that decision and an identification of the steps VA is taking to implement that replacement, including a timeline for that replacement.

VA does not support this section.

VA does not support this section because it is unnecessary.

Several months ago, VA began compiling a full needs assessment based on input from both Vet Center and Office of Information and Technology staff. In this regard, we anticipate we will have the information needed to make a decision this year. We do not believe a statutory requirement to report to Congress is necessary; VA can brief Congress on its decisions when they have been made.

VA does not have a cost estimate for this section.

Title III: Women Veterans

Section 301(a) would require VA, not later than 240 days after enactment, to conduct surveys and host listening sessions with women Veterans to determine: (1) how women Veterans perceive and accept suicide prevention, lethal means safety (LMS), and VA mental health resources and messaging campaigns; (2) whether women Veterans find those resources and messaging campaigns effective and sufficiently tailored towards them; (3)whether the integration into those resources and messaging campaigns of information pertaining to military sexual trauma (MST), intimate partner violence (IPV), and trauma-informed health care would make those resources and messaging campaigns more effective for women Veterans; (4) if VA could make additional improvements to those resources and messaging campaigns, including the

Women's Health Transition Training Program, to make those resources and messaging campaigns more effective for women Veterans; and (5) if VA programs and services are targeted at women Veterans of different ages and eras of service, racial and ethnic backgrounds, and geographical areas. Section 301(b) would require VA to conduct these surveys and listening sessions in urban and rural areas, ensuring surveys and listening sessions are targeted at different demographics. Section 301(c) would require VA, no later than 1 year after the surveys and listening sessions are complete, to submit to Congress a report on the findings of such surveys and listening sessions, which would have to document the steps VA intends to take to refine the VA suicide prevention, LMS, and mental health resources and messaging campaigns based on the feedback from such surveys and listening sessions to ensure VA is utilizing the most effective strategies.

VA does not support this section.

VA does not support this section because existing law already requires VA to integrate and evaluate suicide prevention and mental health messaging and resources for women. This section would duplicate the existing requirement to include in each contract to develop media relating to suicide prevention and mental health materials and campaigns a requirement that the contractor convene focus groups of Veterans to assess the effectiveness of suicide prevention and mental health outreach. *See* section 401(e) of the Hannon Act. In addition, section 402(a)(6) of the same Act requires an annual report on VA's progress in meeting the goals and measurable targets established to evaluate the effectiveness of the mental health and suicide prevention media outreach campaign. These current laws appear sufficient to address the intended aim of this section.

VA does not have a cost estimate for this section.

Section 302 would require VA, not later than 60 days after enactment, to modify the Recovery Engagement and Coordination for the Health-Veterans Enhanced Treatment program (REACH VET) to incorporate into such program risk factors weighted for women, such as MST and IPV.

VA does not support this section.

VA supports the intent of section 302; it is important to reevaluate and update the REACH VET model to optimize performance for men and women. However, VA has already updated the REACH VET model to include new additional predictor model variables that are more commonly experienced by women, such as MST and IPV, as well as other predictors that are newly recognized as potential risk factors. Therefore, legislation is not needed for an update VA has already made.

VA does not have a cost estimate for this section.

Section 303(a) would require VA, not later than 60 days after enactment, to review all requests for reintegration and readjustment services for Veterans and their family members in group retreat program settings under 38 U.S.C. § 1712A(a)(1)(B)(ii) to determine if current retreat programming meets demand. VA would need to specifically review requests for women only retreats, disabled access retreats (particularly wheelchair accessible retreats), and retreats for Veterans with specific medical needs. Section 303(b) would require VA, not later than 120 days after enactment, to submit to Congress a report on whether VA's provision of reintegration and readjustment services for Veterans and their family members in group retreat program settings should be increased and made permanent, including women only retreats, disabled access retreats (particularly wheelchair accessible retreats), and retreats for Veterans with specific medical needs.

VA does not support this section.

VA does not support this section because this would be another reporting requirement due within a short time period and is unnecessary. VA currently reports on RCS activities pursuant to an annual reporting requirement under 38 U.S.C. § 7309(e); if Congress needs additional information about these retreats specifically, VA can brief the Committee as needed. Regarding the requirement to review whether retreats are wheelchair accessible, VA already requires contractors supporting retreats to ensure both the retreat settings and transportation are compliant with the Americans with Disabilities Act.

VA does not have a cost estimate for this section.

Title IV: Other Matters

Section 401 would amend section 201 of the Hannon Act, which authorized the SSG Fox SPGP, in two ways. First, section 401 would increase the maximum amount of each grant award from $750,000 to $1 million; second, it would extend the duration of the SSG Fox SPGP from 3 years after the date of the first award to 6 years after the date of the first award.

VA supports this section, subject to amendments and the availability of appropriations.

VA supports this section, subject to amendments and the availability of appropriations, because it would provide needed flexibility to continue and enhance the SSG Fox SPGP. However, as discussed in more detail in VA's views on S. 793 and S. 1139, the Helping Optimize Prevention and Engagement (HOPE) for Heroes Act of 2025, VA believes additional edits are needed to give effect to the intent of this section, particularly by increasing and extending the authorization of appropriations. VA

prefers the longer extension the HOPE for Heroes Act of 2025 (S. 1139) would grant through FY 2030, instead of only until September 19, 2028.

VA estimates the bill, if amended, and the authorization of appropriations is increased, would cost approximately $110 million in FY 2026, and approximately $590 million from FY 2026 through FY 2030.

Section 402(a) would require VA, not later than 60 days after enactment, to submit to Congress a plan to ensure access to VA mental health residential treatment programs for Veterans with spinal cord injuries or disorders (SCI/D). The plan would have to include: (1) a staffing plan for how VA would incorporate staff from other facilities to support a pilot program required by subsection (b) and ensure adequate staffing to support the needs of Veterans with SCI/D; (2) an assessment of medical equipment needs; and (3) an assessment of the best location to deliver treatment and health care under VA mental health residential treatment programs, including through the use of SCI/D centers and SCI/D spokes. Section 402(b) would require VA, commencing not later than 120 days after enactment, to carry out a pilot program to provide access to VA mental health residential treatment programs for Veterans with SCI/D at not fewer than three VA medical facilities. Section 402(c) would require VA, not later than 1 year after enactment, to submit to Congress a report on the implementation of the plan required by subsection (a), the initial results from the pilot program under subsection (b), and plans to expand VA's mental health residential treatment programs to address demand for the highly specialized treatment provided under such programs for Veterans with an SCI/D.

VA does not support this section.

Although VA supports the intent of this section, VA is concerned it would be unable to execute the legislation as written within the time frames defined. Specifically, the time frame of 120 days to carry out a pilot program at three (or more) locations of care introduces risks given the need to hire or realign staff with appropriate competencies to meet the needs of Veterans during admission; there is also the potential need for infrastructure modifications, which would take more time. VA believes current authority provides sufficient flexibility to provide residential treatment for Veterans with SCI/D and would welcome the opportunity to discuss other options to meet the intent of this section.

VA assumes the references in this section to "mental health residential treatment programs of the Department" is intended to refer to VA mental health residential rehabilitation treatment programs, or MH RRTPs. It is less clear, though, whether the reference to "programs of the Department" is intended to only apply to VA facilities or if it is intended to include non-VA facilities. If Congress does not alter this language, we would interpret it only to apply to VA facilities.

VA does not have a cost estimate for this section.

Section 403(a) would make technical corrections to the 38 U.S.C. § 1167 related to mental health consultations to instead be codified at 38 U.S.C. § 1169. It would also make amendments to the table of contents to reflect this change. This statute requires VA, not later than 30 days after the date on which a Veteran submits to VA a claim for compensation under chapter 11 for a service-connected disability relating to a mental health diagnosis, to offer the Veteran a mental health consultation to assess the mental health needs of, and care options for, the Veteran. VA is required to offer such a consultation without regarding to any previous denial or approval a claim for a service-connected disability relating to a mental health diagnosis for the Veteran and ensure the Veteran offered a mental health consultation can elect to receive such consultation during the 1-year period beginning on the date on which the consultation is offered (although VA can provide a longer time period if appropriate).

Section 403(b) would amend the re-designated 38 U.S.C. § 1169 to clarify that the current subsection (a) would refer only to initial mental health consultations. Section 403 would insert a new subsection (b) that would require VA, not less frequently than annually, to offer to each Veteran who is receiving compensation under chapter 11 for a service-connected disability relating to a mental health diagnosis a mental health consultation to assess the mental health needs of, and discuss other mental health care options for, the Veteran. VA would also have to conduct annual outreach to each such Veteran regarding the availability of mental health consultations and other mental health services from VA. Current subsections (b) and (c) would be redesignated as subsections (c) and (d), respectively. Section 403 would add a new subsection (e) that would require VA, not later than 1 year after enactment and not less frequently than once every 2 years thereafter, to review the efficacy of VA's outreach with respect to consultations under this section and submit to Congress a report on the findings of this review and the plans to address these findings. To facilitate the review, VA would have to ensure Veterans could provide VA feedback on its outreach and the mental health consultations and analyze the feedback. Each review would have to cover Veterans' feedback, consultations sought pursuant to offers under this section and matters that deter Veterans from seeking consultations offered under this section.

VA supports this section, subject to amendments and the availability of appropriations.

VA supports this section, subject to amendments and the availability of appropriations. In particular, VA supports the technical corrections in section 403(a) as this would provide clarity to the U.S. Code.

VA partially supports section 403(b), subject to amendments and the availability of appropriations. VA currently offers an annual screening to enrolled Veterans for commonly occurring mental health conditions. Veterans who screen positive receive further evaluation and treatment, if they are willing to engage in care. In the first quarter

of FY 2025, 73% of Veterans receiving compensation under chapter 11 for a service-connected disability relating to a mental health diagnosis were enrolled in VA health care and receive the annual mental health screenings described above.

Instead of requiring annual offers of mental health consultations to those Veterans receiving compensation as described above, VA believes it would be more appropriate only to conduct annual outreach to such Veterans advising them of VA mental health services and how to access them. Veterans who elect to enroll, or to seek care without enrolling (if eligible), would receive a mental health assessment as part of an initial appointment. If mental health needs are identified, the Veteran will also receive information about treatment goals and options. This would connect Veterans directly to existing mental health services, and every VA health care facility must screen Veterans requesting mental health services for urgent needs and immediately address them.

VA also has concerns with the reporting requirements section 403(b) would establish. Compliance would require significant resources in terms of dedicated staff and would likely affect other important monitoring and evaluation efforts. Although 38 U.S.C. § 1167 does not currently require reporting, VA is developing data capabilities to track the number of mental health consultations offered and the number of consultations provided. Veterans' satisfaction with mental health services is assessed through several existing mechanisms. We recommend allowing these efforts to develop before codifying new requirements.

VA would appreciate the opportunity to discuss other technical issues with the Committee regarding current 38 U.S.C. § 1167 (regarding mental health consultations) and section 2068 (regarding mental health consultations for Veterans entering Homeless Programs Office programs). VA has been working to implement these authorities since their enactment, but we believe Congress could facilitate this implementation with additional revisions to these statutes.

VA does not have a cost estimate for this section.

Section 404(a) would require VA and DOD, not later than 180 days after enactment, to jointly submit to Congress a report on the actions taken, or that will be taken, by each Department (either independently or jointly) to improve the effectiveness of VA and DOD programs that promote access to mental health services for members of the Armed Forces transitioning from service in the Armed Forces to civilian life. Section 404(b) would require this report to include an assessment of the status of the response by VA and DoD to the Comptroller General's recommendations in the July 2024 report entitled "DOD and VA HEALTH CARE: Actions Needed to Better Facilitate Access to Mental Health Services During Military to Civilian Transitions" (GAO-24-106189). Section 404(c) would require the report to Congress to identify any duplicative efforts or gaps in services and recommend changes to VA and DOD

programs to address such duplicative efforts or gaps, including recommendations for legislative action.

VA does not support this section.

VA does not support this section because it is unnecessary. VA is currently working to respond to the Comptroller General's recommendations to the July 2024 report referenced above. In this context, requiring an additional report would be unnecessary and duplicate these efforts.

We note as a technical matter that this section would require VA and DoD submit a report on their programs regarding members of the Armed Forces, but the Coast Guard, which is included within the definition of the term "Armed Forces" in 38 U.S.C. 101(10), does not fall under DoD's jurisdiction

VA does not have a cost estimate for this section.

S. 793 Modifying and Reauthorizing the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program

This bill would make seven amendments to section 201 of the Hannon Act, which authorized the SSG Fox SPGP. Specifically, the bill would:

1. Remove references to the President's Roadmap to Empower Veterans and End a National Tragedy of Suicide (PREVENTS) Task Force.
2. Increase the maximum amount of grant funds that could be awarded from $750,000 to $1,250,000 per fiscal year.
3. Require VA to develop measure and metrics, as appropriate, to accurately reflect the aims of the SSG Fox SPGP; provide accountability to Congress related to grant funds; and reflect lessons learned from interim reporting on and evaluation of the SSG Fox SPGP.
4. Require VA to provide to the appropriate personnel of each VA medical center (VAMC) within 100 miles of the primary location of a grantee a briefing, not less than once per year, about the grant program to improve the coordination between a grantee and VAMC personnel.
5. Extend the authority to carry out this program until September 30, 2028.
6. Authorize appropriations of $285 million for FYs 2026-2028.
7. Expand eligibility to the SSG Fox SPGP for two cohorts of individuals currently eligible for RCS, namely individuals who participated in a drug interdiction operation as a member of the Coast Guard (regardless of the location of that operation) and individuals who received counseling under 38 U.S.C. § 1712A before the date of the enactment of the National Defense Authorization Act (NDAA) for Fiscal Year 2013 (January 2, 2013).

VA supports the bill, subject to amendments and the availability of appropriations.

VA supports five of the amendments this bill would make, specifically:

1. Removing the reference to the PREVENTS Task Force, which is no longer operational.
2. Increasing the maximum award from $750,000 to $1.25 million.
3. Extending the duration of the SSG Fox SPGP through FY 2028.
4. Increasing the authorization of appropriations to $285 million for FYs 2026-2028.
5. Expanding eligibility to two additional cohorts of individuals currently eligible for RCS.

VA supports extending the authority for the SSG Fox SPGP (item 5, above) so that grantees can continue to provide critical support for eligible Veterans, former Service members, and individuals eligible for RCS at risk for suicide. VA supports increasing the maximum award amount (item 2, above), which would allow current grantees seeking renewal grants to keep pace with inflation and ensure there is no reduction in support for eligible individuals and their families. Similarly, VA supports the increase in the authorization of appropriations (item 6, above), which would permit scaling the program to a nationwide effort; however, we recommend the increased authorization of appropriations appear as a new paragraph (2) under subsection (p), with the current content (authorizing appropriations of $174 million for FYs 2021-2025) being designated as a new paragraph (1) to avoid any questions regarding the authorization of appropriations for FY 2025 that may arise if this bill is enacted before the end of FY 2025. This increased authorization of appropriations may also address more effectively the concern that appears to be the basis for S. 1361 (Every State Counts for Vets Mental Health Act), as this increased authorization of appropriations, if fully supported with appropriations, would allow VA to provide more grants in more areas, including applicants from States in which no entity has been awarded a grant under this section. Increased resources would address this need more effectively than attempting to alter the scoring standards, as discussed further below.

VA also supports expanding the population of eligible individuals (item 7, above), as this would address what VA believes was an inadvertent change in scope resulting from two separate laws that were enacted within days of each other in 2020. As originally enacted, the Hannon Act established as eligible individuals those persons described in clauses (i) through (iv) of 38 U.S.C. § 1712A(a)(1)(C). The Hannon Act was enacted on October 17, 2020. On October 20, 2020, the Vet Center Eligibility Expansion Act (P.L. 116-176) was signed into law. This law created new clauses (iv) and (v) in section 1712A and redesignated the existing clauses (iv) and (v) to be clauses (vi) and (vii). As a result of this, for 3 days during October 2020, well before VA could implement the SSG Fox SPGP, individuals who received counseling under section 1712A before the date of enactment of the NDAA for Fiscal Year 2013 were eligible for the SSG Fox SPGP but are not currently eligible unless they meet another condition of eligibility under section 201(q)(4) of the Hannon Act. While we anticipate this would affect only a small number of individuals, we believe amending the Hannon

Act to include this population would be fair to them and more consistent with Congressional intent.

Regarding the proposed change to incorporate additional measures and metrics for the SSG Fox SPGP, VA generally has no objection to this requirement. We understand and support Congress' interest in understanding the value and efficacy of this grant program, and we appreciate the flexibility this language would provide VA in defining those measure and metrics.

VA does not support the required annual briefings to VAMCs, as these would likely require resources disproportionate to the value that would be realized from sharing this information. VA currently provides information to facilities and staff to support coordination, and we believe these efforts are sufficient. Further, the specification of not more than 100 miles from the primary location of a grantee is less useful than the service area of the grantee.

VA continues to appreciate Congress' support of the SSG Fox SPGP, and we look forward to Congress reauthorizing the program; we also appreciate the opportunity to meet with the Committee to discuss the concerns we identify below.

We would be happy to provide technical assistance to the Committee, including specific line edits, to address these recommendations.

VA estimates that S. 793, as drafted would cost $285 million over the three-year period FY 2026-2028 (equal to the authorization of appropriations).

S. 1139 HOPE for Heroes Act of 2025

This bill would make 15 amendments to section 201 of the Hannon Act, which authorized the SSG Fox SPGP. Specifically, the bill would:

1. Change the requirement for the Secretary to consult with the Office of Mental Health and Suicide Prevention in carrying out this program. The Secretary would instead be required to consult with the Assistant USH for Clinical Services.
2. Increase the maximum amount of grant funds that could be awarded from $750,000 to $1,000,000 per fiscal year. It would also authorize VA to award additional amounts based on the number of individuals who go through the intake process to receive suicide prevention services from the grantee, although VA could not award more than $500,000 in additional amounts per grantee per fiscal year.
3. Restrict grantees from using more than 30% of the grant funds for administrative costs, and it would also provide that no more than 5% of grant funds could be spent on food and beverages.
4. Amend subsection (e)(3), which generally establishes requirements for grantees to coordinate with VA or participating Veterans, to require grantees to coordinate with VA to develop a plan for communication between the entity and local suicide

prevention coordinators regarding whether Veterans receiving assistance under this section from the entity are attending appointments to ensure continuity of care.

5. Amend subsection (g), which generally establishes requirements regarding training and technical assistance, to require VA to provide training and technical assistance to grantees on how to properly use the Columbia Protocol (also known as the Columbia-Suicide Severity Rating Scale (C-SSRS)).
6. Amend subsection (g) further to require VA to provide training to VA employees on this grant program.
7. Require VA to provide to the appropriate personnel of each VAMC within 100 miles of the primary location of a grantee a briefing, not less than once per calendar quarter, about the grant program to improve the coordination between a grantee and VAMC personnel.
8. Extend the authority to carry out this program until September 30, 2030.
9. Amend subsection (k), which requires VA to provide reports to Congress on the SSG Fox SPGP, to include a description of VA's compliance with the requirement to train employees under subsection (g), as added by the 5thchange described above.
10. Amend subsection (n), which requires VA to provide behavioral and mental health care to eligible individuals when clinically necessary, to state that if VA does not provide mental health or behavioral health care within 72-hours following a referral from a grantee, the eligible individual must be treated as eligible for emergent suicide care under 38 U.S.C. § 1720J.
11. Amend subsection (p), which authorizes appropriations of $174 million for FYs 2021-2025, to extend this period to FY 2030.
12. Make two technical changes to the definition of emergency treatment in subsection (q)(5).
13. Amend subsection (q)(8)(A), which generally defines the term "risk of suicide", to make this term mean exposure to, or the existence of, any of the following health, environmental, or historical risk factors to any degree.
14. Amend subsection (q)(11)(A)(ii), which defines "suicide prevention services" as including a baseline mental health screening for risk. The amendment would provide that, entities awarded a grant after enactment of this Act in conducting the baseline mental health screening for risk, must use C-SSRS.
15. Amend further the definition of suicide prevention services to include transportation and rideshare services for eligible individuals to use for appointments.

VA supports the bill, subject to amendments and the availability of appropriations.

VA supports four of the amendments this bill would make, specifically:

1. Extending the duration of the program through FY 2030.
2. Increasing the maximum award from $750,000 to $1 million,

3. The technical correction to the definition of emergency treatment (which would have no substantive effect on benefits for eligible individuals).
4. The inclusion of transportation and rideshare services for eligible individuals to use for appointments within the definition of "suicide prevention services."

Although VA strongly supports extending the duration of the program (the 8th change described above), and the bill would extend the period of the authorization of appropriations (the 11th change described above), the bill would not increase the amount of authorized appropriations. Without increasing the amount, VA would have no additional funds to carry out the program, which would frustrate the intent of VA and Congress. Consequently, VA recommends increasing the authorized amount of appropriations to reflect the extended time period in which the SSG Fox SPGP could operate. An increased authorization amount would also permit scaling the program to a nationwide effort. VA continues to appreciate Congress' support of the SSG Fox SPGP, and we look forward to Congress reauthorizing the program. We also appreciate the opportunity to meet with the Committee to discuss the concerns we identify below.

Regarding transportation, grantees can currently assist with emergent needs relating to transportation, under section 201(q)(11)(A)(ix)(IV), and grantees can also provide legal services to assist eligible individuals with issues that may contribute to the risk of suicide, including issues that interfere with the eligible individual's ability to obtain or retain transportation. See 38 C.F.R. 78.80(d) and (g). However, non-emergent needs for transportation are not covered. We note that if grantees are providing transportation directly, VA would likely need to establish requirements or conditions on such transportation to ensure safety and the appropriate use of resources.

VA has concerns with some of the changes this bill would make and seeks amendment to these provisions.

First, the proposed additional amount of $500,000 per grantee per fiscal year does not align with the way Federal assistance through grants is operated by funders and recipients. Applicants propose the number of Veterans to be served and estimate their costs within their application. It would be difficult to implement this type of additional amount, as it would require significant reconciliation based on the actual versus projected number of eligible individuals served. Furthermore, any upward adjustments at the end of the year would likely have little effect in terms of further outreach or support. It is also not clear that increasing award amounts based purely on the number of individuals who go through the intake process to receive suicide prevention services is actually "performance-based", as this does not consider the quality or quantity of services provided to eligible individuals, or their effect on an eligible individual's status.

Second, the required quarterly briefings are redundant, as VA currently provides information to facilities and staff to support coordination, and we believe these efforts are sufficient.

Third, VA is concerned about codifying the use of the C-SSRS, which is currently a tool VA uses as one component of eligibility screening, in that it identifies individuals with suicidal thoughts and behaviors. Placing this in statute would prohibit VA from adopting another more effective tool should one be identified as more appropriate for the community-based setting. VA is invested in robust program evaluation to measure long term outcomes and ultimately identify and scale best practices for maximum benefit.

Fourth, VA also has concerns with the proposed amendment to subsection (n) (the 10th proposed change described above) to state that if VA does not provide mental health or behavioral health care within 72 hours following a referral from a grantee, the eligible individual must be treated as eligible for emergent suicide care under 38 U.S.C. § 1720J. This raises significant concerns over its potential inadvertent effects. The term eligible individual, for purposes of the SSG Fox SPGP, already overlaps significantly with eligibility under section 1720J(b), as Veterans (under 38 U.S.C. § 101) and individuals described in section 1720I(b) (referring generally to former Service members with Other-Than-Honorable discharges) already qualify for both programs. Including the 72-hour limitation in section 201 of the Hannon Act could be read to infer that these individuals are not eligible under section 1720J until the 72-hour period has lapsed.

Additionally, the SSG Fox SPGP provides support and services to individuals who screen at low-, moderate-, and high-risk for suicide, and participants are already referred to VA for routine mental health assessments and care. Consequently, the mental and behavioral health care VA would provide may not even rise to the level of emergent suicide care. Emergent suicide care under 38 U.S.C. § 1720J is available only for Veterans experiencing acute suicide risk. Given the overlapping authority, most SSG Fox SPGP participants are already eligible for emergent suicide care under section 1720J. Another potentially positive effect that could result from this provision would be the inclusion under section 1720J of members of the Armed Forces who are eligible for RCS under 38 U.S.C. § 1712A(a)(1)(C)(i)-(iv). It is unclear, though, if this is the intent; if it is, it would seem simpler to amend section 1720J itself, or else only those individuals who are referred through the SSG Fox SPGP would be eligible. For Veterans or former Service members described in section 1720I(b), VA provides same-day care and assessments for mental health issues. In this context, current authority and programs seem to meet or exceed what the bill would provide.

Fifth, VA has reservations about the proposed change to the definition of “risk of suicide.” Given that eligible individuals must be “at risk of suicide”, changes to this definition would directly affect eligibility for participation in the SSG Fox SPGP. We would appreciate the opportunity to meet with the Committee to better understand the intent behind this proposed change to determine whether it raises any significant concerns.

Sixth, VA is concerned about the language that would authorize grantees to use up to 30% of the grant funds for administrative costs. This would be a significant increase from current practice, Current regulations at 38 CFR 78.140 require that costs

for administration by a grantee must be consistent with 2 CFR part 200. We believe this is a more appropriate limitation than allowing all grantees to use up to 30% of a grant award for administrative expenses.

Beyond these concerns, several of the amendments this bill would make are unnecessary.

First, regarding the proposed amendment to VA's reporting requirement under subsection (k), while VA generally has no objection to reporting on its training of its employees, the bill would amend the requirement for the interim report, which VA has already submitted. We believe a technical change to include this as a requirement in the final report would be more appropriate.

Beyond these comments on the bill as drafted, VA also recommends including additional amendments to section 201 of the Hannon Act in this bill. VA recommends removing the requirement to coordinate with the PREVENTS Task Force because it is no longer operational.

VA also recommends amending the definition of eligible individual in section 201(q)(4)(C) as it relates to individuals eligible for RCS. S. 793 would include such language.

We would be happy to provide technical assistance to the Committee, including specific line edits, to address these recommendations.

VA estimates the bill, if the authorization of appropriations is increased, would cost approximately $110 million in FY 2026, and approximately $590 million from FY 2026 through FY 2030.

S. 1361 Every State Counts for Vets Mental Health Act

This bill would amend section 201(d) of the Hannon Act, which generally sets forth how VA will distribute and award preferences to grant applicants. Specifically, the bill would create a new paragraph (3) establishing additional priority for States that have not received a grant. The bill would require VA to prioritize consideration of any eligible entity located in a State in which an entity has applied but not received a grant under the SSG Fox SPGP. It would further provide that if no entity in a particular State has received a grant under the SSG Fox SPGP, VA would have to give all eligible entities in that State that apply for such a grant a scoring preference until at least one grant was awarded to an eligible entity in that State.

VA does not support this bill.

VA understands the intent of this bill but believes it is unnecessary and would result in unnecessary complications that could result in worse outcomes for Veterans.

Currently, VA awards grants under the SSG Fox SPGP based on a careful, objective analysis of five aspects of an application: (1) the applicant's background, qualifications, experience, and their past performance (and any identified community partners); (2) the program concept and suicide prevention services plan; (3) the applicant's quality assurance and evaluation plan; (4) the applicant's financial capability and plan; and (5) the applicant's area linkages and relations. VA has set forth and defined these five aspects in regulation at 38 C.F.R. § 78.25, which is how VA exercised the authority delegated by Congress in section 201(h)(1) of the Hannon Act. VA has also complied with the requirements currently in section 201(d) of the Hannon Act regarding prioritization of and preference for certain applicants.

VA is concerned that the bill's amendments to section 201(d) of the Hannon Act would result in unnecessary complication and could worsen outcomes for Veterans and other eligible individuals. It is unclear exactly how VA could operationalize the proposed subsection (d)(3). Subparagraph (A) would require VA prioritize "consideration" of any eligible entity located in a State in which an entity has applied but not received a grant under this section. It is not clear, though, how exactly VA would prioritize such consideration. Subparagraph (B) presumably clarifies this, as it would provide that VA would have to "give all eligible entities in [a State where no entity has received a grant under this section] that apply for such a grant a scoring preference until at least one grant is awarded to an eligible entity in that State." However, this language is unclear as to whether the "scoring preference" VA would have to give would require VA, during one award cycle, to continue increasing the preference given to applicants from States where no entity has received a grant until such an entity qualifies for award, or if this would instead require VA to give a set preference during each award cycle until an entity was chosen to receive a grant from that State. Under either scenario, applicants who have scored lower on objective measures would receive funding before better qualified applicants. This process could delay awards, which could jeopardize continuity of support, and result in current grantees losing their award, which would end support for eligible individuals and their families currently receiving suicide prevention services. Depending on when this bill was enacted, such a change could also disrupt an awards cycle already underway if VA had already published a Notice of Funding Opportunity setting forth the scoring criteria for the SSG Fox SPGP. Such a disruption could also result in delays in awards that could threaten grantees' ability to provide suicide prevention services to eligible individuals and their families. VA has some experience in ensuring that different States receive awards for ongoing projects in the context of the State home construction grant program (under 38 U.S.C. § 8135); however, that statute and program set forth the various criteria and how VA is to award funds much more clearly than this bill would for the SSG Fox SPGP.

Moreover, VA awards grants currently to entities that provide services in multiple States; the requirement that a grantee be "located in a State" does not necessarily mean that the grantee only provides support within that State. By focusing on where the grantee is located instead of where the grantee is providing suicide prevention services, the bill appears to place more emphasis on residence than performance. This could also result in poorer outcomes for Veterans and other eligible individuals.

VA believes a better approach that could increase the number of States where grantees are located would be to increase the amount and authorization of appropriations. With additional resources, VA could award more grants in more locations (when there are several qualified applicants). This would not interrupt an award cycle already underway at the time of enactment and would still ensure that only the most qualified applicants receive support. In this regard, S. 793 appears to offer a better solution to this problem, and VA prefers that approach. VA notes that in the past, when there was concern from Congress regarding how State home construction grants were awarded, rather than altering the priority list criteria, Congress allocated more resources to ensure more projects were funded. Such an approach would seem the appropriate solution here as well.

As a matter of interpretation, VA notes that it has defined the term "state" in section 201 of the Hannon Act to mean any of the several States of the United States, the District of Columbia, the Commonwealth of Puerto Rico, any territory or possession of the United States, or any agency or instrumentality of a State exclusive of local governments. See 38 C.F.R. § 78.5. VA would apply this interpretation, which is consistent with the definition of the term "state" in 38 U.S.C. § 101(20), if this bill were enacted.

VA does not have a cost estimate for this bill.

Conclusion

This concludes my statement. We would be happy to answer any questions you or other Members of the Committee may have.

Written Testimony of
Jim Lorraine
President and CEO
America's Warrior Partnership (AWP)

U.S. Senate Veterans Affairs
April 29, 2025
10:30 A.M.
106 Dirksen Senate Office Building

Oversight and Legislative Hearing

"Bridging the Gap: Enhancing Outreach to Support Veterans Mental Health"

Chairman Moran, Ranking Member Blumenthal, and esteemed members of the Committee, thank you for the opportunity to testify before the Senate Veterans' Affairs Committee. Today, you are considering four important pieces of legislation. My remarks will focus primarily on the HOPE Act and the BRAVE Act since the other proposed bills are interconnected and rely on the continued authorization of the SSG Parker Gordon Fox Suicide Prevention Grant Program (SSG Fox Grant).

At *America's Warrior Partnership (AWP)*, we approach suicide prevention not as a standalone effort but as the outcome of enhancing veterans' quality of life and restoring their sense of hope. Our model is grounded in relationship-building and trust, essential elements in connecting veterans to the right support at the right time.

Since the inception of the Fox Grant in October 2022, of the 545 veterans who screened positive for suicidal risk within 30 days of engaging with AWP, 94% were initially seeking help for non-mental health-related challenges. These included economic distress, difficulty navigating VA systems, and the breakdown of personal relationships. While behavioral health remains a crucial component, it is not the sole factor in preventing suicide.

The SSG Fox Grant has been instrumental to AWP's success. It allows us to connect meaningfully with veterans and their families, often before a crisis occurs, and to work collaboratively with local partners to build individualized, community-based solutions. AWP's strength as a grant recipient stems from this broad, holistic, relationship-based approach to outreach, not one focused narrowly on clinical mental health services. We aim to maintain a trusted relationship with individual veterans and their families on their journey to an improved quality of life. In the last year, we have continued this relationship with the majority of veterans who screened positive to ensure they do not take their own life.

Both the HOPE and the BRAVE Act, as well as the bill proposed by Senators Boozman and Warner to reauthorize the SSG Fox Grant, are a terrific start. AWP is grateful for your efforts to continue the success of the SSG Fox Grant. To optimize the SSG Fox Grant program, we offer a few observations and suggestions:

Program Overview

As one of 91 SSG Fox Grant recipients, we have done significant outreach with the program since its inception.

This grant year alone, AWP produced results:

- 1,325 warriors screened for suicidal ideation using the Columbia-Suicide Severity Rating Scale
- 10.8% disclosed some level (low, moderate, high) of suicide risk (144)

In the less than three years since the inception of the grant, AWP has produced results:

- 2,137 warriors screened for suicidal ideation using the Columbia-Suicide Severity Rating Scale
- 25% disclosed some level (low, moderate, high) of suicide risk (545)

The SSG Fox Grant Program is working. Veterans outside the VA and VSO system who need assistance are being identified. Relationships are being built, and connections with resources are being made. As noted earlier, since the Fox Grant Inception, 545 veterans entrusted AWP with their thoughts of suicide. Only 6% of those warriors were seeking assistance for a mental health-related issue based upon the initial screening. This is a success story, and asking "the question" works. AWP, the VA, and Congress have all played an integral part in saving these veterans, but more can be done.

Coordination:

AWP appreciates the inclusive language that directs briefings for VA employees about the SSG Fox Grant program. Organizations in the community and the VA must coordinate. We hope grant recipients will be invited to these briefings and work together to improve communication and "warm hand-offs" of individual cases as they arise. Many VA staff members were not aware of the SSG Fox Grant or why grantees were calling asking for assistance with a "Fox Participant." Ensuring a solid working relationship with local Suicide Prevention Coordinators

and VA staff is essential, as there is more education for frontline staff on the SSG Fox Grant.

Screening Questionnaires:

The inclusive language in the HOPE Act reduces the redundancy and bureaucracy of screening processes. As AWP stated in previous testimony, veterans rarely complete all the questionnaires, and the Columbia Protocol (C-SSRS) has proven to be the most inclusive and comprehensive set of questions necessary to ensure that those at risk are identified quickly and easily.

Legislation mandates C-SSRS as the only required screening protocol, however, AWP recommends including language to make the six follow-up assessments optional. The emphasis should be on ensuring veterans have access to resources rather than answering redundant questions.

Crisis Intervention:

The section on "Emergent Suicide Care" is a substantial addition to the HOPE Act. In many instances, AWP has used the 988-emergency crisis line to help veterans identified through Fox Grant outreach. This language helps codify support and resources available to those unable to obtain services in the crucial 72-hour window after first contact.

Clearly Defined Pathway for Eligible Individuals:

The addition of the Emergent Care section in the HOPE Act is invaluable. To further its impact, AWP recommends adding a section that lays out the expectations for the program itself and identifies boundaries for the VA and organizations. While AWP does all it can to provide connections to referrals and resources, it is not a direct service provider. This is clearly outlined in the scope of the grant proposal. However, the line has become muddied, and expectations are often unclear.

Adding a section that requires a specific program "on-ramp" for veterans identified by grant recipients who need VA care would amend this issue by making the process less complex or burdensome. Since grant recipients have already asked the required questions and processed the information, passing along the information to the VA without burdening the veterans themselves again with tiring, frustrating, redundant questions (which sometimes involve discussing traumatic experiences) would dramatically increase the success rate of the program as well as assist the veteran more efficiently.

This can be done in several ways. For example, requiring that after grantees go through the required screening procedures, eligible veterans must be connected with the 988-crisis line or their local VAMC for expedited care when necessary. Congress could also mandate that the VA create a dedicated phone line for intakes from grantees that would offer expedited care.

Accountability:

The SSG Parker Gordon Fox Suicide Prevention Grant Program has been effective. For its continued success, we must ensure all organizations receiving grants are held accountable. The $750,000-plus of grant funds come from the trust Congress and the American taxpayers have in our organization, and AWP holds that trust in the highest regard by conducting regular audits and reviews. Work hard to ensure these funds are maximized efficiently to find veterans in the community and serve them.

At AWP, we hope all other grantees hold themselves accountable with the same high standards. To ensure this, Congress and the VA must be responsible for holding organizations accountable through verifiable metrics. This grant's limited Title 38 (Veteran) funds must be used solely for Title 38 beneficiaries. Other departments can develop a mirror program for their beneficiaries. AWP recommends adding a section requiring the VA to develop accountability metrics that report outreach, referrals, status, etc., and then require regular reports to Congress. It is the only way to identify organizations not fulfilling their responsibility under the program.

Accountability and metrics are vital to the success of this program. Previously, AWP reported concerns surrounding the Data Collection To and its implementation, which required participants' social security numbers and date of birth. The VA has been able to modify the tool to honor the spirit of anonymity promised by grantees requesting data from our veterans. The current version of the Data Collection Tool allows grantees to enter data more efficiently and accurately when veterans are willing to participate. These changes have also increased VA's program oversight and ability to track grantees' progress.

Measuring Success:

If the Secretary is going to establish performance metrics for the SSG Fox Grant, the success goals need to be agreed upon because success is defined differently depending on whether you're in Congress, the VA, or an SSG Fox Grant grantee.

America's Warrior Partnership views SSG Fox Grant's success as outreach with veterans in the community at large, with a focus on upstream prevention for veterans at risk for suicide and those not currently utilizing VA services to provide holistic support that improves their quality of life and hopefulness.

We believe broad outreach leads to intake, intake leads to screening, screenings lead to assessment, assessment leads to service, service leads to improved quality of life. We believe success starts with outreach.

However, in response to our testimony before the House VA Committee on October 31, 2024, regarding the SSG Fox Grant, the VA Suicide Prevention Office wrote a rebuttal letter to America's Warrior Partnership and stated, ***"Outreach was never intended as a singular focus. It is one of many allowable services per the Hannon Act. The only service required by all grantees is baseline mental health screening. Beyond that, grantees develop their program concept for delivering services in their local communities based on that community's assessed need."***

We feel Congress needs more legislative clarity on expected outcomes for the SSG Fox Grant.

BRAVE Act:

We support deeper analysis into veteran suicide and its connection with factors that increase the likelihood of risk. Still, we also feel that anytime we talk about veterans and mental health, the conversation must also include the concomitant exacerbation of traumatic brain injury. We are not doing enough to address a truly silent killer in TBI.

Every State Counts Act:

We support ensuring that the SSG Fox Grant is awarded to programs in states currently without a grant program. While this is resolved, America's Warrior Partnership's Network, a central call center where any veteran or community can request assistance and advocacy, stands ready to assist communities without the resources to serve at-risk veterans.

Transportation:

We strongly support the initiative under the HOPE Act that would allow SSG Fox Grantees the ability to fund transportation and ride-share services to use for appointments. America's Warrior Partnership's Annual Community Integration Survey has found the ack of reliable transportation one of the greatest needs among the most hopeless of veterans. When a veteran is hopeless to the point of ending their life, being unable to obtain transportation to receive life-saving services is compounding the problem.

Grantee Funding:

The only limitation to AWP's success with the program is funding. If the ceiling on the grants were doubled overnight, so would AWP's outreach efforts.

Accordingly, while the proposed limit on SSG Fox Grants is $1.5M with performance achievements, organizations, like AWP, have successfully utilized the grant and could do more with more. While not for all organizations, raising the ceiling could be beneficial if done correctly. Again, it would require metrics and reporting, which should be measured by metrics beyond the number of hours spent

serving veterans. We would recommend considering the number of clients and a pre- and post-quality of life or hope measurement to demonstrate, combined with the absence of suicidal ideation.

Members of the committee, thank you again for the opportunity to testify today. We look forward to our continued work together and thank each of you for all your hard work and dedication to those who served in our nation's armed forces.

Bridging the Gap: Enhancing Outreach to Support Veterans' Mental Health

Prepared for:
Senate Committee on Veterans Affairs

Testimony by:
D'Aniello Institute for Veterans and Military Families (IVMF) at Syracuse University

April 29, 2025

Introduction

Mr. Chairman, Ranking Member, and distinguished Members of the Committee, thank you for the opportunity to provide testimony today about community-based suicide prevention efforts and the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program (SSG Fox SPGP) on behalf of the D'Aniello Institute for Veterans and Military Families (IVMF) at Syracuse University.

About the IVMF

The IVMF was founded in 2011, as higher-education's first interdisciplinary academic institute singularly focused on advancing economic, social, and wellness outcomes on behalf of the nation's military, veterans, and their families. Each year, more than 20,000 individuals participate in IVMF programs and services, from entrepreneurship and career training to connecting individuals with local resources in their communities.

The IVMF's programs are underpinned by our sustained and robust data collection, applied research on the most pressing issues impacting veteran well-being, and evaluation services for public and private partners who also serve the military-connected population. Accordingly, the IVMF's policy priorities are directly informed by insights from our programmatic, research, and evaluation efforts, as well as from engagements with the IVMF's external partners that include the public sector, higher education, national and community nonprofits, philanthropy, and the private sector.

Our Role in Community-Based Suicide Prevention

As part of our support to communities, for over a decade the IVMF has provided technical assistance to organizations and government agencies seeking to improve access to health and non-clinical services for veterans and their families. These organizations work alongside the IVMF to share learnings, best practices, and identify opportunities for growth and sustainability.

These combined efforts have demonstrated the power of a coordinated approach between the Department of Veterans Affairs (VA) and communities in the fight to prevent suicide. We are grateful for the persistent focus of this Committee to advance and make helpful improvements to these critical policies and programs. We greatly appreciate the opportunity to share the evidence we have gathered from research, evaluation, and practice toward this shared goal.

Relevant Suicide Prevention Evidence

Veteran Suicide Risk

While this committee, the VA, and community-based care organizations have taken significant steps toward addressing the complex issue of veteran suicide prevention, the most recent VA National Suicide Prevention Report shows that the rate of suicide among veterans is still too high. On average, 17.6 veteran suicides happened each day in 2022, the most recent year for which we have statistics. Furthermore, the rate of suicide among veterans remains significantly higher than the civilian population. In 2022, 13.4% of those who died by suicide in the U.S. were veterans, despite the fact veterans are only 6% of the U.S. total population.

Further, research has shown that each additional unmet stressor, such as unemployment or housing instability, is highly correlated with increases in the likelihood of suicide ideation among veterans. These needs frequently require resources beyond the scope of what the VA alone can provide, reinforcing the key role of communities in delivering assistance for non-clinical risk factors.

Our own research in partnership with the VA reinforced the value of community-based wraparound support in several ways. First, we found that 30% of the veterans served by our community partners in the study were not connected to VA healthcare (VHA). Evidence has consistently shown that the rate of suicide is higher for veterans not enrolled in VHA. Second, this finding means 70% of veterans served by these organizations were, in fact, enrolled in VHA, regardless of whether there was any formal partnership with their local VA Medical Centers (VAMCs). However, our study showed that veterans' stressors were better addressed when community organizations and VAMCs worked together.

The Importance of the SSG Fox SPGP

This committee is to be applauded for establishing the Commander John Scott Hannon Veterans Mental Health Care Improvement Act, in particular the SSG Fox SPGP, to address the persistent issue of veteran suicide. As a partnership between the VA and community-based organizations, it has become a critical upstream effort to reduce the frequency of veteran suicide. Specifically, by allocating funding for veteran serving organizations and agencies, communities have been empowered to offer a dedicated program that focuses on root causes of veteran suicide in addition to providing referrals for clinical care.

Furthermore, the SSG Fox SPGP increases broad access to treatment programs for veterans. As previously mentioned, given that those who die by suicide are less likely to be using VHA care, this program fills the fundamental gap we currently face in reaching veterans do not utilize VHA regularly or at all. In other words: the SSG Fox SPGP has created an essential mechanism to provide vital suicide prevention care to veterans who are high-risk.

Importantly, the SSG Fox SPGP also empowers flexible interventions that can be tailored to an individual veteran's needs. If a veteran is facing financial stressors, such as unemployment, grantees can help the veteran find jobs in the local market. If, at a later point, they are facing homelessness, the grant allows organizations to assist the veteran with securing shelter. In other words: the SSG Fox SPGP allows community-based organizations the flexibility to meet veterans where they are and provide the help that they require, often before the point of acute crisis.

Improvement Areas

Background

At the outset of the program, the IVMF pulled together eleven of our partners who are also SSG Fox SPGP recipients to offer additional technical assistance, resources, and space to connect with one another about the administration of the program. These partners represent nine states and the District of Columbia and range from regional veteran-serving organizations to statewide organizations and agencies. For almost two years, we gathered on a regular basis to discuss successes and challenges, share information, and provide training. This effort is not funded by the grant and is provided at no cost to our partners in addition to the support they receive as grantees of the program.

What these conversations have made clear is just how valuable the community has found the grants to be to those they serve. It has also illustrated clearly that a few simple changes could make the program that much more comprehensive and effective, ultimately helping us all meet our shared goal of serving more veterans and saving more lives.

As the SSG Fox SPGP is considered for reauthorization, we are grateful that legislative proposals have taken into consideration much of the feedback from advocates and grantees like us and our partners – feedback based on individual veteran experiences obtaining access to what can be lifesaving services. Below we have outlined some of the main areas of focus shared by our partners, and the provisions that we think best support key improvements.

Program Coverage and Expansion

First, potential added funding and covered services will empower the most successful grantees to scale their efforts. The provision that would increase the allowance for administrative and incidental costs (like food and beverage) acknowledges two important aspects of program operations: the need to augment staff outreach and screening activities. With this change, our

partners will be empowered to reach more veterans who require services the grant can provide, do so in a way that builds trust in non-clinical settings, and screen them for eligibility. More individualized, peer-based approaches to outreach are backed by the evidence and are just common sense. A simple gathering over pizza or coffee can build trust and open the door for a veteran to reach out for help.

Additionally, the IVMF and our partners appreciate proposed changes in legislation that would provide financial reimbursement to veterans for transportation and ride-shares to appointments. The cost of an Uber ride should not be the barrier that stops a veteran from getting the critical care that might save their life.

Taken together, these provisions that may be critical for program expansion, outreach, and addressing access challenges for veterans will not only result in more veterans obtaining the mental help support they may need, but also open the door to other services grantees provide directly or indirectly through referrals to partner organizations.

Screening and Eligibility

The proposed training on the Columbia-Suicide Severity Rating Scale (C-SSRS, or Columbia Protocol) for grantees is also important. While some of our community partners support adoption of the Columbia Protocol's as the main required screening, others would prefer more guidance on implementing the Protocol or an adjustment to when and how it is used within the program. Most essentially, grantees have expressed that while evidence-based risk assessments are necessary, they hope that moving forward, the intake and screening process can balance standards with burden considerations for both veterans and program staff.

VA Collaboration and Compliance

Some of the most necessary proposed changes to the legislation are the provisions designed to increase support of the program by the VA, and to hold the VA accountable for their role in making this program successful. Our partners have routinely experienced inconsistencies in awareness and compliance by their local VAMCs once a veteran has been deemed eligible for the program, and by extension VA care. Training for the VA is essential to ensure that the SSG Fox SPGP is implemented appropriately across the enterprise. This implementation must include ongoing, formal collaboration and streamlined enrollment processes between VAMCs and grantees.

Therefore, the proposed reports back to the committees monitoring these activities are a welcome add. We would encourage strengthening this area to the greatest practical extent so that oversight can be exercised when the program is not being carried out in alignment with congressional intent.

At the same time, we appreciate the proposal to allow veterans to be covered by emergent suicide care coverage if the VA is nonresponsive. This provision will ensure grantees can effectively help veterans get the care they need. Relatedly, the Committee may wish to ensure grantees can offer

interim mental health support while veterans are waiting for appointments, particularly in regions that have limited resources in the VA or otherwise.

Conclusion

The evidence for reauthorizing this program is clear, and the proposed changes address key improvements sought by our partners. We deeply appreciate the Committees' steadfast commitment to increasing the VA's investment in prevention so that we can reduce the number of veterans in crisis and ensure they thrive in their post-service lives. We reaffirm our own dedication to sharing insights from our research and practice, ensuring our community partners can provide feedback of their "boots on the ground" experiences, and ultimately contribute to this critical shared mission.

Written Statement

Senate Veterans Affairs Committee Hearing

SSG Parker Fox Suicide Prevention Grant

Prepared by: Steffen Crow

Program Manager, SSG Parker Fox SPGP

Oklahoma Veterans United (OKVU)

www.oklahomaveteransunited.org

Date: 20250410

Testimony: Senate Veterans Affairs Committee Hearing on the SSG Parker Fox Suicide Prevention Grant

I. Statement for Written Testimony

Highlighting Program Impact: Oklahoma Veterans United and the SSG Parker Fox Suicide Prevention Grant

Since receiving the SSG Parker Fox Suicide Prevention Grant, Oklahoma Veterans United (OKVU) has leveraged its deep community roots and cross-sector partnerships to create one of the most engaged, responsive, and veteran-centric suicide prevention initiatives in the region. In just three years, our team has connected with over 5,000 individual veterans—many of whom were previously unengaged with traditional support systems—and participated in or led more than 800 veteran-centered events throughout Oklahoma. These outreach efforts range from intimate peer support meetups and health check-ins to large-scale stand-down events, each designed to build trust, identify risk early, and connect veterans with lasting resources.

Our presence on military installations has also proven essential. At Fort Sill, we have been welcomed to present at SEPS and TAPS briefings and maintain a regular presence on base. This allows us to connect with transitioning service members before crisis arises and to establish continuity of care as they reintegrate into civilian life. These on-base engagements are key not only to suicide prevention but also to fostering relationships that last beyond the uniform.

The Oklahoma Veterans Calendar, developed by our subcontractor Eagle Ops, has become an essential outreach tool for the veteran community across Oklahoma. Designed to centralize veteran-related events, resources, and opportunities, the calendar has dramatically increased access to information for veterans and their families. In the past year alone, the website hosting the Oklahoma Veterans Calendar

recorded over one million hits. This remarkable level of engagement highlights not only the effectiveness of the platform but also the ongoing need for accessible, comprehensive outreach tools that strengthen community connections and promote veteran well-being across the state.

Another area of success has been our strategic engagement with veteran-focused employers across the state. OKVU works directly with several of Oklahoma's largest companies, delivering presentations to their Veteran Resource Groups (VRGs), offering guidance on crisis navigation, and helping employers develop responsive internal protocols to better support their veteran workforce. In doing so, we help normalize mental wellness conversations in the workplace and empower peer leaders to identify and respond to signs of distress before they escalate.

Our partnerships with the Cherokee and Choctaw Nations have been transformative. Together, we co-hosted Oklahoma's first **multi-grantee veteran stand-down**—a milestone event not just for OKVU, but for the entire grant program. Held in 2024, this event brought together veterans, service providers, and representatives from five states in addition to Oklahoma, underscoring how regional coordination and tribal-nonprofit alignment can drive national-level impact. The event offered immediate services, benefits navigation, peer support, and direct mental health engagement in a setting that honored the dignity and strength of every veteran present.

What sets OKVU's model apart is not just the volume of engagement, but the way we maintain contact. Veterans are not simply seen once—they are followed up with, invited to engage again, and often, encouraged to take on peer leadership roles. Many of those who stabilize through our efforts come back and ask how they can help. This transformation—from needing support to offering it—is the true outcome of the SSG Fox initiative when it is locally driven, trust-based, and mission-aligned.

In a time when national suicide rates remain deeply concerning, our experience shows that consistent, embedded community action saves lives. OKVU is proud to stand as proof that with the right support and partnerships, transformation is not only possible—it is happening now.

Areas of Concern

From our perspective as a frontline grantee administering the SSG Parker Fox Suicide Prevention Grant, certain implementation policies—while well-intended—have unintentionally created barriers for the veterans they aim to support. Chief among these is the mandatory use of the Columbia Suicide Severity Rating Scale (C-SSRS) for entry. This tool has acted less as a bridge to care and more as a barrier. Veterans with prior traumatic experiences in healthcare settings often decline services solely because of this requirement. **"Veterans are less likely to engage in care when standardized assessments are perceived as impersonal or triggering, especially during the initial stages of help-seeking"** (VA Mental Health Services Evaluation, 2019). In fact, the strong emotional reaction some veterans have to the C-SSRS form itself is often a clear indicator of past suicidal ideation or crisis, meriting immediate attention—not exclusion.

Despite raising these concerns consistently in national grantee meetings since the inception of this program, VA Central Office has remained firm in its directive. Suggestions of alternative screening methods that are trauma-informed and responsive to veteran preferences have been submitted for discussion—yet never formally considered. **"Cultural tailoring and clinical flexibility are essential to avoid disengagement in at-risk populations, including rural and Native American veterans"** (Lewis-Fernández et al., Psychiatric Services, 2017). This resistance to adaptation, even when presented with viable solutions, continues to limit the program's ability to meet veterans where they are.

A second critical challenge has been the absence of a national referral mechanism linking grantees to VA clinical services. In Eastern Oklahoma, our attempt to build a working relationship with the local VA Medical Center resulted in only a single meeting. Promised follow-ups never occurred. **"Timely and structured handoffs between providers are critical in suicide prevention, especially during points of care transition"** (VA Office of Mental Health and Suicide Prevention, 2021).

In contrast, our coordination with the Oklahoma City VA has been a model for what collaboration can achieve. The difference lies not in funding or staffing levels, but in leadership that values proactive engagement and the integrity of assigned roles. In OKC, a dedicated SSVF-HUDVASH-SUDS liaison was hired and embedded directly into our program. She works from our office one to two times per week and plays an active role in facilitating warm handoffs, coordinating referrals, and improving continuity between Fox and VA services. This is a clear example of staff being allowed to fulfill the function they were hired for, thereby enhancing veteran outcomes and eliminating service delays.

Unfortunately, that has not been the case in Tulsa. While the same position was reportedly hired, the liaison was never permitted to support community collaboration as initially described. Instead, this employee was reassigned to answer phones on the crisis line and manage the walk-in clinic—roles that, while important, diverted this employee entirely from their original purpose. This employee vacated the position over a year ago, and the replacement had not set foot in our Fox or SSVF offices until Mid-April 2025. This delay has significantly impeded our ability to establish the same streamlined referral pipeline in Eastern Oklahoma that has proven so effective in Oklahoma City. **"Inconsistent implementation across regions undermines the uniformity and reliability of veteran suicide prevention efforts"** (VA Suicide Prevention Annual Report, 2020).

Another pressing limitation is the narrow scope of allowable expenses under this grant. We were initially told by VA representatives during a national conference that the purchase of firearm safes was permitted—provided trained personnel were in place. We fulfilled that requirement and procured appropriate storage equipment, which has since been used multiple times when veterans in crisis voluntarily requested that we safeguard their firearms during periods of acute distress. Later, over the phone, we were informed that the previous guidance was incorrect and that these expenses would be denied. Instead, we were instructed to create internal billing mechanisms and reclassify these items as storage service costs.

This reversal placed an unnecessary administrative burden on our team and forced us to divert staff time from direct veteran care. This is not an isolated occurrence; changes in what is considered allowable versus unallowable have happened multiple times. These reversals consistently require backtracking, reclassification, and often the shifting of already stretched internal resources. Veterans in Oklahoma—and particularly in rural regions—often possess more than one firearm. Creating the ability to store these items during a mental health crisis has directly prevented harm. **"Means safety interventions—including voluntary firearm storage—are recognized by the VA as best practices for preventing suicide"** (VA Suicide Prevention Toolkit for Safe Firearm Storage, 2021). Yet the tools to facilitate this response have been denied after the fact.

Similarly, funding guidance has prevented us from providing gym memberships or covering costs for music therapy tools—despite clear evidence of their positive mental health outcomes. In response, we worked directly with fitness partners to secure deeply discounted memberships—bringing monthly costs down to just $30 per veteran. This has allowed us to engage a larger number of participants and has had a profoundly positive effect on self-esteem, energy levels, and mental health stability. Veterans consistently report improved mood and reduced stress as a result of participating.

These observations are consistent with a growing body of VA-supported research. **"Structured physical activity improves PTSD symptoms, emotional regulation, and cognitive functioning among veterans"** (VA Research Currents, 2022). **"Participants in the Gerofit program demonstrated improved mobility, elevated mood, and reduced anxiety"** (VA Geriatrics and Extended Care, 2022). These results reinforce that wellness-centered services—such as affordable fitness memberships—can dramatically increase access, engagement, and outcomes in veteran suicide prevention.

In our ongoing efforts to establish effective warm handoffs for veterans experiencing crises, we have worked to coordinate with the Veterans Mental Evaluation Team (VMET) under the Eastern Oklahoma VA system. However, the VMET team has been rendered non-mission capable due to persistent staffing shortages, leaving it unable to perform its intended crisis response role. As a result, the SSG Fox team has been compelled to step into a role outside its scope, responding to high-level crises in coordination with local law enforcement. It must be emphasized that SSG Fox team members are not licensed clinicians and are neither equipped to diagnose nor authorized to mandate emergency mental health detainment. Our function in these critical situations is limited to establishing basic communication with veterans and encouraging voluntary engagement with services, often under hazardous and unpredictable conditions. Despite multiple formal requests for follow-up communication with the VA Eastern Oklahoma Mental Health Chief, no meaningful response has been provided over the course of several months. Congressional inquiries have similarly yielded only general assurances that the VMET team "functions as needed," a claim that stands in direct contradiction to the reality on the ground.

At the same time, local agencies are demonstrating that effective alternatives are both possible and operational. The Broken Arrow Police Department has established a crisis response team, deploying a police officer and a Licensed Clinical Social Worker

(LCSW) from Grand Mental Health to respond jointly to a variety of crisis calls, including veteran suicide crises. This unit operates two 10-hour shifts with plans for full 24/7 coverage within the year, and has already begun successfully referring veterans to care. Despite being fully aware of this available and proven resource, the VA in Eastern Oklahoma has made no substantive efforts to collaborate with the Broken Arrow team or integrate local solutions into their crisis response planning. This ongoing refusal to leverage available community-based resources continues to leave critical service gaps unaddressed, to the detriment of the very veterans the system is meant to serve.

Outreach remains another challenge. We are prohibited from using low-cost, high-impact tools such as QR-coded stress balls or wristbands that would allow veterans to discreetly request a callback. Other VA outreach departments, nonprofits, and for-profit partners freely utilize such items. **"Non-clinical engagement strategies, especially those that leverage discreet digital prompts, are shown to increase veteran engagement in follow-up services"** (VA Innovation Ecosystem, 2020). This imbalance places grantees at a disadvantage even though we share the same mission.

Outreach Performance Metrics: OKVU vs. Traditional VA Outreach

Event Type	*Avg. Attendance*	*Engagement Quality*	*Notes*
VA PACT Act / Claims Clinics	~30–50 Veterans	Low engagement; few follow-ups	Often more vendors than veterans in attendance.
Eagle OPS Rally Points & VetFests	330–850 Veterans	High engagement; ongoing case openings	Structured around evenings/weekends with peer/family involvement.

OKVU Proposed QR-based Outreach Items	>1,000 QR hits/yr	Strong callback rates; private and discreet	Low-pressure engagement enables follow-up weeks later.

Veterans reached through OKVU's subcontractor Eagle OPS were 4x more likely to follow up within 72 hours compared to those attending VA outreach events. From my perspective this is because we first work on trust and are intentional about meeting veterans on hours when they and their families are available, which are nor during VA business hours.

Finally, we strongly believe in the value of hiring licensed professional counselors (LPCs) or licensed clinical social workers (LCSWs) as part of our overall teams. An LPC/LCSW on staff would provide clinical triage, early stabilization, and assist with building trust before a veteran even enters the VA system. In areas with long clinical wait times or limited transport options, the LPC/LCSW could act as an early point of support, allowing a veteran to begin the healing process immediately while awaiting formal care. **"Embedding clinical personnel within community organizations improves both timeliness and quality of mental health interventions for veterans"** (VA Community Care Expansion Brief, 2021).

The intention of the SSG Fox Grant is to save lives. But to do so effectively, grantees must be empowered to respond to real-world needs with the tools and staffing that work. The flexibility to address transportation issues, short-term wellness solutions, and early clinical intervention must be embedded into the policy—not negotiated retroactively. If this program is to reach its full potential, we need consistent, transparent guidance, reliable referral systems, and permission to deploy proven strategies without unnecessary redirection.

We ask not for less oversight, but for greater consistency. Veterans deserve a system that adapts to their reality—not one that requires them to fit into rigid frameworks that weren't designed with them in mind.

Looking Ahead: Our Requests

1. Allow grant funding for gym membership, music tools, equine services (popular in rural areas, and effective).
2. Use GIS data and collaborate with local and national department of mental health to improve VA suicide prevention targeting.
3. Embed licensed clinicians into grantee teams to provide early intervention and increase access.
4. Replace the mandatory C-SSRS with a veteran-centered, trauma-informed option and allow grantees to propose or develop their own screening tools that get approved by a panel of grantees and VA.
5. Create a closed loop national digital referral system for SSG Fox grantees to VA.
6. A National Community of Practice: Grantee-Led, Veteran-Centric, and Mission-Aligned

A Veteran-Centered Model vs. a Policy-Centered Model

Characteristic	*VA Model*	*OKVU Proposed Model*
Entry Tool	C-SSRS	Low barrier to entry and clinical tools are only used to assess not block entry

Hours of Operation	Weekday business hours	Weekday business hours and Evenings/weekends via community outreach
Spending Flexibility	Narrow; prone to reversal	Veteran needs regarding holistic health and quality of life issues
Communications	Email/VistA	Warm handoffs with follow up and an easy to use referral process that is the same nationally and can be used to follow up that a veteran attended care
Outreach Strategy	PACT Act/claims events	GIS-targeted, community-driven events/40+ vendors, targeted social media, more flexibility with outreach items
Peer Involvement	Minimal	Field-integrated and grant-allowable under current guidance, however some states are behind in certification issues
Tracking & Evaluation	Data driven system that doesn't track outcome	Real-time CRM and dashboards and outcome driven systems e.g. Greenspace
Veteran Experience	Often confusing, fragmented	Personal, consistent, respectful, expedient, results driven

II. Expanded Supplement: Fitness, Music, Outreach Effectiveness, and Peer Engagement

The Role of Structured Wellness Activities in Suicide Prevention

Staff Sergeant Parker Fox, the grant's namesake, was known for his dedication to physical fitness and his deep connection to music. These were not hobbies—they were

vital coping mechanisms that contributed to his emotional stability during difficult periods. The omission of such wellness services from eligible grant expenses undermines the very spirit of the program that bears his name.

In our program, veterans who participate in discounted gym memberships frequently report increased self-esteem, energy, and reduced symptoms of anxiety and depression. Likewise, access to music tools has led to breakthroughs in emotional expression. These are not luxuries—they are tools for survival.

Supporting VA research includes:

- "Exercise improves PTSD symptoms, emotional regulation, and cognitive functioning among veterans." (VA Research Currents, 2022)
- "Participants in the Gerofit program demonstrated improved mobility, elevated mood, and reduced anxiety." (VA Geriatrics, 2022)
- "Music therapy has significant emotional self-regulation benefits in veterans with PTSD." (VA HSR&D News, 2022)

These wellness-based strategies also support long-term sobriety, reengagement with family life, and successful employment transitions. Veterans who participated in both gym and music therapy options often told us, "This is the first time I've felt like myself again."

III. A National Community of Practice: Grantee-Led, Veteran-Centric, and Mission-Aligned

Across all SSG Parker Fox Suicide Prevention Grant recipients, the demand for real-time collaboration, evidence-based policy refinement, and peer-supported problem-solving has grown increasingly urgent. The current landscape is fragmented.

Grantees operate in silos, with limited access to each other's tools, strategies, or field-tested insights. To resolve this, Oklahoma Veterans United (OKVU) proposes to lead the implementation and facilitation of a National Community of Practice (CoP)an infrastructure that supports sustained learning, rapid innovation sharing, and structured engagement with VA Central Office.

Groundwork Already Laid: OKVU's Preparedness to Lead

1. Over the past two weeks, I have developed internal models for cross-county collaboration, senior program manager moderation, real-time dashboards, and veteran-centric intake processes. These systems mirror the proposed CoP format:
2. Dedicated digital infrastructure: Our internal Teams-based collaboration already segments discussions by function—case management, outreach, compliance, and referral pipelines.
3. Moderated channels: We have designated senior leads to guide onboarding for new staff and offer policy clarification, which can be easily scaled to support national grantees.
4. Outreach dashboards: We currently track callback rates, follow-up conversion, and county-level suicide risk indicators using real-time metric successes that would inform shared CoP dashboards.
5. Regional insights: Our use of GIS mapping in counties like Pawnee and Muskogee to identify "silent crisis zones" has informed high-impact outreach placement, demonstrating how field-level intelligence can drive national strategy.

OKVU is not proposing a theoretical model. We are building this already.

CoP Functional Structure and Strategic Partnerships

The CoP would be hosted on a scalable platform such as Microsoft Teams or Slack, structured into function-based channels moderated by senior program managers from across the grantee network:

1. #intake-and-screening: Sharing trauma-informed alternatives to the Columbia Suicide Severity Rating Scale (C-SSRS), including field-approved models developed by Native-serving grantees.
2. #outreach-tools: Featuring QR-based materials, digital prompts, GIS-informed planning, and successful low-pressure engagement tactics.
3. #warm-handoff-success: Highlighting effective VA liaisons, referral practices, and embedded staff case studies.
4. #lpc-integration: Guidance on onboarding clinicians within grant teams for triage and stabilization.
5. #policy-feedback: Creating a real-time channel for grantees to inform VA Central Office of field barriers and suggested adaptations.

OKVU further recommends a strategic partnership with the Institute for Veterans and Military Families (IVMF) at Syracuse University to support the CoP's academic rigor, data infrastructure, and long-term sustainability. IVMF's experience managing veteran-focused CoPs and outcome modeling offers a natural extension to this platform.

Proposed Phases of Implementation

Phase I – Platform Launch: OKVU will build and moderate the initial platform, inviting grantees nationally and structuring working groups.

Phase II – Regional Moderators: Experienced grantees will facilitate each track, providing localized insight and elevating systemic concerns.

Phase III – Repository Development: OKVU will lead the creation of a centralized document library with intake forms, audit templates, and rural engagement tools.

Phase IV – Learning Collaboratives: Quarterly national CoP meetings with grantee presentations, technical training, and structured Q&A.

Phase V – Policy Feedback Loop: A structured system to feed field insights into VA guidance in a transparent, evidence-based process.

Integration into the Broader Grant Strategy

This CoP is not a side project, it is a force multiplier for every strategy detailed in this testimony. For example:

1. Outreach Optimization: The CoP can disseminate this strategy nationally.
2. Cultural Flexibility: Instead of siloed feedback about the ineffectiveness of tools like the C-SSRS, the CoP creates an aggregated body of evidence to recommend vetted alternatives.
3. Peer Learning: Rather than waiting for top-down guidance, the CoP allows rapid peer validation and adaptation of emerging solutions.

A National Standard Set by the Field

Veterans deserve a system that learns as fast as it acts. This CoP is that system. It is not bureaucratic, it is organic. It is not oversighting is operational excellence. OKVU stands ready not just to participate, but to lead this transformative effort.

By formalizing this network, we harness the collective intelligence of every grant-funded veteran advocate across the nation. The stakes are too high for isolation. Let us move forward as a unified force—field-informed, veteran-centric, and committed to saving lives.

We believe Parker's legacy must guide the future of this program. If he had access to the tools we now propose, he may have remained with us longer. Let us not waste the opportunity to honor him by making meaningful changes now.

IV. Grantee Perspective on the Use and Implementation of the Columbia Suicide Severity Rating Scale (C-SSRS)

As both a grantee and a veteran receiving care through the VA, I want to speak candidly about what I've experienced with the Columbia Suicide Severity Rating Scale. There is a belief that more training on the C-SSRS will improve how it's administered. I disagree. I've sat across from VA nurses who were visibly uncomfortable using the tool—avoiding eye contact, stumbling through questions, and clearly unsure of how to speak to me as a veteran. I had to reassure them. I had to let them know I recognized they were administering the Columbia. Only then did they relax and begin to connect with me as a person. That wasn't a training issue—it was a human connection issue. The Columbia is not inherently difficult to administer, but when it's reduced to a box-checking formality, it becomes a wall between provider and patient.

And more concerningly, it becomes a **wall between access and care**. At the March 2025 SSG Fox grantee conference in San Francisco, a colleague from Arizona shared that **13 veterans who had come into contact with their program died by suicide**. These veterans either **answered "no" to every question on the Columbia—** despite clearly being in need of support—or **refused to complete the tool and were deemed ineligible for services**. Let that sit for a moment: thirteen deaths. These were not oversights in documentation. These were lost lives—veterans whose risk was not caught by the very tool designed to prevent it.

When the Columbia is used as a gatekeeping tool for program entry, we must ask: is it doing more to help or to harm? Because in this context, **access denied is trust broken**—and in suicide prevention, broken trust is one of the most difficult things to repair.

This leads to an even deeper concern—**survivorship bias**. Currently, we are not required—and in fact have been told not—to submit data on veterans who are deemed ineligible. That means any veteran who refuses to engage with the Columbia, who walks

away, who is turned down at intake, is never entered into the data system. They are rendered invisible. And if they later die by suicide, that tragedy is unaccounted for in our outcomes. As a result, the program appears more effective than it actually is—not because it saved lives, but because we stopped counting those we could not reach.

This is the textbook definition of survivorship bias: we're studying and drawing conclusions only from those who passed through the system successfully, while the experiences—and outcomes—of those who didn't are left out entirely. It creates a false sense of security, and worse, it creates a policy environment where critical weaknesses go unexamined.

I've asked about this at multiple national convenings. Early on, we were given mixed messages about whether to track and report veterans who were not enrolled. Some VA staff said yes, others said no. Eventually, the guidance became clear: **do not submit data on ineligible veterans**. That silence has consequences. How many of those veterans died by suicide after being screened out? How many could have been saved with a follow-up call or alternative intake method? How do we justify denying care based on refusal to complete one form?

The truth is, many veterans have been traumatized by systems before. Some don't want to answer invasive questions in a scripted format. Others know what the Columbia is and associate it with prior negative experiences—detainment, hospitalization, or loss of autonomy. When a veteran declines to complete the form, that should be an alarm—not a disqualification.

In our line of work, the first interaction with a veteran often determines whether there will be a second. If the system's first offer is a form that feels clinical, cold, or compulsory, we may lose the chance to help altogether. If we deny services based on that one moment of resistance, we are not practicing suicide prevention—we are practicing exclusion.

What we need is flexibility. Clinical tools are important, but they must never become barriers. When a veteran is hesitant, we should have the discretion to continue engagement, build trust, and find a path forward. We are not asking to replace the VA—we are asking to be **a bridge to it**. Let us use our connection, our credibility, and our compassion to do what this program was designed to do: save lives.

V: Expanding Impact – A $1.5 Million Strategic Investment Proposal

If awarded $1.5 million in continued and expanded funding through the SSG Fox Suicide Prevention Grant Program, Oklahoma Veterans United (OKVU) would take decisive steps to increase our reach, deepen our service offerings, and fortify long-term infrastructure across the state. Our proposal centers on high-impact investments in personnel, regional expansion, peer-based recovery networks, and outreach scalability.

1. Expand Service to Six Additional Counties OKVU will grow its current service area to include six more counties surrounding Oklahoma County—excluding Canadian County, which is already covered by another grantee. This expansion will increase our footprint from 14 to 20 counties. These adjacent counties include Lincoln, Pottawatomie, Cleveland, Logan, McClain, and Grady. Each of these counties has a demonstrated veteran population with limited access to specialty mental health care and high rates of unaddressed suicide risk, making them ideal targets for expanded outreach and prevention efforts under this funding proposal. Each of these areas represents a combination of underserved rural populations and high-density veteran populations with limited access to suicide prevention resources.OKVU will grow its current service area to include six more counties with elevated veteran suicide risk, expanding our footprint from 14 to 20 counties. The target areas would be identified using existing VA suicide data heatmaps and prioritizing counties where few community mental health resources exist.

2. Hire Three Additional Case Managers Three new case managers will be placed strategically—two in rural counties and one in Oklahoma City—to accommodate

increased caseloads, provide consistent follow-up, and allow current staff to focus more deeply on recovery planning, family integration, and coordination with the VA. This would reduce burnout and enhance veteran-specific responsiveness.

3. Create a Supportive Services, Compliance, and Data Specialist Role A dedicated full-time staff member will manage grant compliance, eligibility tracking, audit readiness, and service coordination. This individual will bridge field-level operations with documentation requirements, manage shared dashboards, and ensure service consistency across regions.

4. Launch a Statewide Peer Support Network Peer support is the connective tissue of sustainable recovery. OKVU would establish a statewide peer support program, modeled after evidence-based principles of mutual aid, where veterans with lived experience of mental health challenges, trauma, or suicide risk are trained and deployed as co-navigators. This team would provide phone-based and in-person support across all counties, focusing on high-risk veterans, transitions from incarceration, and post-hospital discharge.

5. Add Two Outreach Staff in Oklahoma City to Cover Western Counties To sustain our rapid growth, we would hire two new outreach team members under our subcontractor Eagle OPS, specifically assigned to Oklahoma City and neighboring western counties. These outreach staff would lead the expansion of Eagle OPS Rally Points—monthly and quarterly veteran and family-focused events designed to meet veterans where they are: evenings, weekends, and in community spaces that foster trust and connection. These rally points are structured intentionally to engage working veterans who may be unavailable during traditional business hours—a critical gap the VA cannot fill due to limited evening/weekend service availability.

Ultimately, while VA outreach efforts at claim clinics and PACT Act events have yielded consistently low veteran turnout—often with more vendors than veterans

present—Eagle OPS's community-integrated VetFests routinely engage 330 to 850 veterans and families per event. **"Community-based outreach events that integrate peer networks and veteran families have shown significantly higher engagement rates than traditional VA-led enrollment efforts"** (VA Center for Strategic Partnerships, 2021). These numbers reflect the clear impact of relationship-centered outreach. With dedicated funding and staffing, we can replicate this success across western Oklahoma, using proven engagement strategies to guide more veterans into care and connection.

6. Technology and Infrastructure Investment We will continue to use technology to our advantage—not just for operations, but as a proactive outreach and strategy tool. Our team will leverage GIS platforms to plot publicly available data related to suicide deaths, including from county coroners' offices, to gain spatial insight into high-risk zones. This data visualization allows us to identify patterns in veteran suicides and locate areas that may benefit from additional 988 crisis signage, localized outreach campaigns, or pop-up event strategies. **"Data mapping allows for better targeting of suicide prevention strategies by identifying geographical clusters and enabling intervention at the community level"** (VA HSR&D, 2021).

This same GIS infrastructure also enables strategic placement of outreach events in zones with higher veteran concentrations or lower known VA utilization. **"Geospatial analysis has proven effective in helping veteran-serving organizations identify service deserts and coordinate mobile outreach efforts accordingly"** (VA Innovation Ecosystem, 2020). By layering historical service usage, demographic trends, and mortality data, we can ensure our interventions are both targeted and measurable.

This strategic expansion positions OKVU not only to meet the grant's intent—but to exceed it. By expanding to new counties, strengthening staff capacity, and anchoring peer-based recovery support across the state, OKVU will reach thousands more veterans with timely, culturally responsive, and outcomes-driven care.

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Good morning. My name is Heather Barr. I served in the Marine Corps for just over 5 years as an intelligence specialist and analyst. I deployed twice during that time, once to the middle east and once to the INDOPACOM.

I was honorably discharged from the Marine Corps in August of 2023, less than two months after returning from my last deployment. I didn't have a job or plan as to what I would do when I got out, other than that I would move back in with my mother until I did figure it out. When I moved back to South Carolina, I felt extremely alone. My family was there and would help where they could, but none of them are prior military nor could they understand the transition from both a taxing deployment and from the military lifestyle I had been living for over 5 years.

When I removed from the military community that I had been part of for so long, I lost connection to those around me. I had no idea what I was doing, what I was supposed to be doing, or how to do it. I was drowning in civilian life and didn't know how to swim. I struggled greatly with feeling as if I were at square one, right where I was when I left for the military – living with my mother with no prospects for the future.

I looked for mental health resources and counseling through the VA and went to a local VET center to get connected with a transition counselor. They then pointed me to Upstate Warrior Solutions (UWS) for help. In October of 2023, I met with Serg Mcavoy at UWS and completed the Staff Sergeant Fox screening that day. I screened at risk for suicide and agreed to participate in the Staff Sergeant Fox Program, just 60 days after transitioning out of the Marine Corps.

I was connected to resources for job searching. I was connected to someone to help with my VA disability claims, and I was informed of events and things I could go to and spend time with other veterans. I found my first job out of the military thanks to Shannon Sports at UWS and was connected with other veterans through different events, such as archery, skiing, surfing with Warriors Surf Foundation, white water rafting and many more outings. This all helped me to realize that I wasn't totally alone and there were others who had gone through, or were going though, the same or similar things as me and they too were making it through. After less than one year of participation, I completed the Staff Sergeant Fox Program in August of 2024.

I moved away from South Carolina, in July of 2024. Although I was not there to take part in events any more or use the resources available through UWS and the Staff Sergeant Fox Program, individuals from Upstate Warriors Solution have continued to reach out to me and ensure that I am doing well and am being taken care of when needed. They have shown a true care for the veteran community that I am extremely fortunate to have had when I needed it the most. I was thrown a life ring and was given connections that I will be forever grateful for.

Transitioning out of military service is a challenging and complex process for most veterans. As we shift from a structured, disciplined environment into civilian life, we often face a range of emotional, psychological, and practical difficulties. Common struggles include finding meaningful employment, adjusting to a less regimented lifestyle, and reconnecting with family and community life. Additionally, navigating benefits, healthcare systems, and translating military skills into civilian job qualifications can be overwhelming without adequate support.

These examples are common for every transitioning service member whether male or female, officer or enlisted, single or married with dependents, and no matter their service branch. They can be coupled with aggravating circumstances like finances and/or relationship issues. And unfortunately, many transitioning service members also deal with lingering mental health issues such as PTSD, anxiety, or depression, which can complicate reintegration.

These challenges highlight the importance of comprehensive transition programs and community-based support systems to help veterans adapt and thrive after service. I am one example of the success of the Staff Sergeant Fox Program and as long as the program exists, there will be others.

Thank you for your time today and thank you for taking a part in saving veteran lives.

Good morning/afternoon, ladies and gentlemen.

I'd like to start by thanking you for the opportunity to speak to you today. My name is Austin Lambright, and I am here from South Carolina. In 2006, at 19 years old, I enlisted in the Marine Corps. I served as a Machine Gunner for two deployments to Iraq. I was honorably discharged from the Marine Corps in 2010 at the rank of Corporal.

During my time in the Marine Corps, I completely engulfed myself in the mentality of going to combat at the peak of two wars and in the harshest conditions possible. I earned my combat action ribbon at the ripe age of 19, just a kid that felt nearly invincible. I had a purpose and driven focus for my life, with support from loved ones at home that projected me into a successful Marine and Squad Leader on my second deployment. Both of my deployments to combat zones.

When I transitioned out of the Marine Corps, I moved back to my hometown Easley, South Carolina. I was somewhat of a reckless wrecking ball at first - mad at the world for my experiences, outcomes, and the current state of Americans in my generation. In 18 months time, I had been arrested three times for Driving Under the Influence, went to jail multiple times due to violence, and had an unexpected child.

During this time, one of my Marines committed suicide. Another one of my Marines had chosen suicide while on deployment in our living quarters. Suicide became an option in the back of my mind.

My child gave me a new purpose and made suicide feel like I would leave my son alone. This was a turning point in my life, and when I became connected with Upstate Warrior Solution. I began reaching out for help to better myself as a father for my son, and I quickly made common connections with the other veterans at UWS. I found commonality of mindset, felt as if I was not alienated in the general public, and was able to be real about my problems and gain advice from those who have experienced and overcome similar struggles.

I learned that I am not invincible by any means, and my choices and decisions moving forward would directly influence my way of life and leadership for my son. This was a key period in my journey that really turned the course positive. Without it, I would have been suicidal and landed myself in prison or the grave, surely enough had I continued down the road I was on before my son was born and connecting with UWS.

As time progressed, I went through a divorce and job changes that really got me in the dumps at times. In these times, I would reach out to UWS for support and keep my head on straight. I was invited to and participated in golf tournaments, dinners, hikes, and other events that gave me a sense of a positive community that I could take pride in being a part of.

In October of 2022, Upstate Warrior Solution helped me get connected to the Vet Center for mental health counseling. I was in one of my darkest ruts, suicidal for months. In February 2023, I reached out to Upstate Warrior Solution for help again and agreed to participate in the Staff Sergeant Fox Program. As a Staff Sergeant Fox participant, I received in-patient and outpatient care from both VA facilities and non-VA facilities. I received care for PTSD and alcohol abuse, with a lot of time and focus spent on post combat stress and my personal experiences. I also participated in Upstate Warrior Solutions' recreation program and received peer support from them.

I also want to note that I have always claimed to be a Christian man since I was saved at 12 years old. However, I had never truly followed the lifestyle and choices that Jesus directed by his actions and words. Last year in April of 2024, I was rebaptized in the presence of my son and mother and father, and my life has drastically changed. Seeing God's purpose for my life and putting all my focus and energy on that cause for myself has been life changing for the better.

The care and help that I received through the Staff Sergeant Fox Program saved my life. I had been out of the Marine Corps for 12 years before I asked for help. It took me 12 years to get to my rock bottom, and at that rock bottom was the untouched trauma that I experienced while in the Marine Corps and the losses I have experienced since that time as well. Loss of veteran friends, loss of marriage, loss of purpose.

For over two years, my mental health and wellbeing were made a priority by the VA, Upstate Warrior Solution, and my community but, most importantly, by me. I exited the Staff Sergeant Fox program in April of this year.

When families, friends, local organizations, and fellow veterans actively participate in creating a supportive environment, it helps build a strong network of care and understanding. This sense of connection and shared responsibility can make a profound difference, reminding veterans that they are not alone and that our lives matter.

Completing the program gave me the tools to not only take better care of myself, but to be there for my brothers and sisters in arms. I'm proud to have taken that step—because asking for help is a strength, not a weakness. I think the program should not only be continued, but be expanded to reach those who struggle with similar issues as myself.

Thanks and God bless.

STATEMENT OF LINDSAY CHURCH[1]
EXECUTIVE DIRECTOR OF THE MINORITY VETERANS OF AMERICA (MVA)

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

TUESDAY, APRIL 29, 2025

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

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

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

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

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

[1] For additional information, please contact Andy Blevins, Policy Director, at ablevins@minorityvets.org.

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Recommended Strategic Improvements

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

- Prioritizing Equity in Grant Awards:

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

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

- Creating Funding Set-Asides for Targeted Populations:

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

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

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

- Mandating Disaggregated Data Collection:

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

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

- Requiring Culturally Competent Care:

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

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

- Strengthening Community-Based Engagement:

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Recommended Strategic Improvements

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

- Mandating Disaggregated Data Collection:

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

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

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

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

- Requiring Tailored Outreach to Underserved Veterans

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

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

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

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

- Requiring Culturally Competent and Inclusive Care

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

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

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

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

- Building a Representative Mental Health Workforce

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

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

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

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

- Strengthening Community-Based Partnerships

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

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

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

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

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

B. Advancing Access to Mental Health Care for All Veterans

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

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

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

A. Current Barriers to Access for Underserved Veterans

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

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

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

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

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

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

B. Addressing Gaps in Outreach

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

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

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

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

C. Strategic Recommendations

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

i. In General

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

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

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

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

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

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

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

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

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

- Quality of Care and Patient Safety

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

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

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

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

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

- Vulnerabilities of Minority Veterans

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

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

- Lack of Accountability and Oversight

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

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

becoming permanent or excessively prolonged."

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

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

- Extended Telehealth Access

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

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

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

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

- Veteran-Centered Focus in Waiver Process

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

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

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

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

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

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

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

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

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

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

- Risk of Perpetuating Exclusion of Minority Veterans

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

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

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

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

- Vague Terminology on Gender and Lack of Clear Definitions

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

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

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

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

- Insufficient Use of Disaggregated Data

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

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

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

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

- Weak or Ineffective Barriers Language

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

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

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

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

- Establish a Clear Accountability Framework

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

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

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

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

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

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

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

- Restoring Trust Through Consistent, Inclusive Engagement

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

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

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

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

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

- Closing Oversight Gaps

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

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

- Expanding Demographic Inclusion

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

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

- Naming and Confronting Intersectional Barriers

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

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

- Funding to Ensure Real Change

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

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

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

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

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

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

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

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

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

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

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

- Address Disparities with Disaggregated Data

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

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

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

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

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

- Integrate Intersectional Risk Modeling

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

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

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

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

- Prioritize Culturally Competent Care and Community Partnerships

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

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

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

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

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

- Include Identity-Based Stressors in Predictive Models

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

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

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

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

- Require Annual Oversight with Disaggregated Outcome Reporting

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

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

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

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

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

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

- Outdoor Retreats Must Be Designed for Marginalized Veterans

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

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

- Cultural Competency Requires Staff Training and Community Partnerships

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

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

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

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

- Ensure Dedicated Funding, Access Equity, and Transparent Oversight

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

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

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

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

prevention and improve program effectiveness."

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

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

- Independent Evaluations Strengthen Accountability

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

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

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

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

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

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

- Addressing Staffing Strain Through Community-Based Solutions

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

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

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

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

- Empowering Caregivers to Provide Flexible, Home-Based Support

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

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

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

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

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

- Scaling Innovative Technology to Deliver Remote, Equitable Care

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

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

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

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

- Ensuring Cultural Competency in Caregiver Services

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

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

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

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

- Expanding Access for Rural Veterans Through Mobile Infrastructure

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

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

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

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

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

- Building Local partnerships to Deliver Community-Based Care

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

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

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

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

- Accountability Through Independent Oversight and Evaluation

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

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

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

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

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

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

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

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

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

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

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

IV. Conclusion

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

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

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

Questions for the Record

Department of Veterans Affairs (VA)
Questions for the Record Submitted to
Thomas O'Toole, M.D.,
Acting Assistant Undersecretary for Health for Clinical Services and
Deputy Chief Medical Officer
From the Committee on Veterans' Affairs
United States Senate
Bridging the Gap: Enhancing Outreach to Support Veterans' Mental Health

Tuesday, April 29, 2025

Questions for the Record from Senator Jerry Moran:

Question 1: We've consistently heard concerns from grantees, especially smaller and rural organizations, about the administrative burden of the program's reporting requirements. Do you believe there's a role for additional technology or support from VA to streamline this process and help these grantees focus more of their time on serving veterans? Is VA currently exploring any solutions to reduce these barriers?

VA Response: Data obtained as part of the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program (SSG Fox SPGP) grantees' suicide prevention service delivery are necessary for oversight of program operations. We have also heard concerns from numerous stakeholders regarding grantee accountability and effectiveness, and want to ensure responsible stewardship. Grantees are therefore required to report on the effect of their services on recipients and submit an annual report describing the projects carried out and evaluation criteria. See P.L. 116-171 §§ 201(e)(4), (5) (the Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019 (hereinafter "Hannon Act"; 38 U.S.C. 1720F § note).

VA provided a web-based data collection tool (DCT), which grantees have reported is a significant improvement over the original approach. The DCT tracks outreach; participant demographic and baseline mental health and post assessment data; services provided; and referrals made with the ability for both the grantee and VA to assess trends over time. VA is seeking to expand on current efforts to minimize missing data and grantee burden, such as offering technical assistance for data collection, minimizing the amount of data collected, and streamlining processes, based on grantee feedback where appropriate. For example, the monthly service attendance form in the DCT was recently updated to streamline the grantee workflow and reduce time and burden in reporting. VA will continue to collaborate with grantees to explore reduction of program-wide barriers and support individual grantee program change requests (such as budget and staffing) that may further optimize grantee operations and, ultimately, the Veteran experience.

Questions for the Record from Senator Angus King:

Question 1: I have heard from the Maine Bureau of Veterans' Services (MBVS) and Health Affiliates Maine (HAM), who are Fox grant recipients in my state, about some of concerns with the program. In particular, they have concerns that there is no way to report when veterans present as homicidal/suicidal, or are involved in police stand-offs, or veterans who intend to die by suicide by cop. These kinds of situations have been top of mind in Maine since October 2023, when our state dealt with the mass shooting and veteran suicide in Lewiston, when 18 people died and 13 more were injured. Since that tragic incident, MBVS and HAM took it upon themselves to start tracking these incidents—they specifically are tracking homicidal/suicidal veterans, police stand-offs involving domestic or sexual violence, or the intent of suicide by cop. Since October 2023, they have tracked at least five incidents in Maine that meet these criteria. I'm concerned that these events are being overlooked and could actually provide some valuable insight into veterans' mental health and motive, lack of connection to benefits, and more.

Has the VA considered adding or updating the Fox grant reporting dashboard to include these incidents? Does VA have the authority to make this change on their own or do you believe such a reporting requirement would need to be required by Congress?

VA Response: Grantees report deidentified suicide screening and psychosocial risk factor data to VA for all SSG Fox SPGP participants. Grantees submit critical incident forms to VA for suicides, homicides, allegations of criminal activity by agency and subcontractor staff, and all incidents that receive media attention.

As required by §§ 201(e)(3), (m), and (n) of the Hannon Act, grantees work in coordinated partnership with their local VA medical center (VAMC), particularly around referral and linkage to VAMCs for clinical mental health assessment and services. Any Veteran suicidal behaviors, including those involving law enforcement ("suicide by cop") are required to be reported by VAMC suicide prevention coordinators (SPCs). Per the Program Guide, SSG Fox SPGP grantees notify the local VAMC SPC of suicidal behaviors reported in the past 90 days or suicide deaths of any time frame. Once an individual is engaged within VAMC care or known to a VAMC suicide prevention coordinator, there are robust assessment and reporting processes for suicidal ideation and behaviors, and incidents involving police or media. SSG Fox SPGP participants are, of course, free to decline referral to VA clinical care, and grantees are required to have local policies and procedures for referrals and crisis management in these instances.

Communities are tracking local incidents outside the VA system at various levels, such as through local suicide prevention coalitions, Governor's Challenge action items, mental health boards, or the newly VA-funded suicide mortality review boards. SSG Fox SPGP grantees are often engaged with several of these. Updating the SSG Fox SPGP dashboard may be duplicative of other efforts and not represent a national data set

since SSG Fox SPGP grantees are not in every community. VA will consider recommendations and resources that can support grantees in engaging with and increasing their community's capacity for such incident tracking.

Questions for the Record from Senator Marsha Blackburn:

Question 1: Transitioning from active duty to veteran status is a significant challenge for a lot of our veterans. Many veterans face difficulty accessing the services they need, particularly when they transition from military healthcare to VA or community-based providers, which can exacerbate the mental health challenges our veterans are facing.

Dr. O'Toole, are there any systems currently in place through the VA's EHRM initiative to ensure continuity of care during transitions, specifically for mental health care?

VA Response: On May 26, 2025, Secretary Collins and Secretary Hegseth signed a memorandum to strengthen the partnership between VA and the Department of Defense (DoD) with a focus of delivering quality health care and the seamless delivery of benefits and services. As stated in the MOU, VA and DoD are committed to working together to identify transitioning Service members, who may be at higher risk for mental health challenges, and ensuring they are not only referred to care, but warmly handed off to providers at VA.

In addition, VA has instituted several initiatives to support Veterans transitioning from active duty to VA or community care. One significant advancement with the new Federal Electronic Health Record (EHR) system is the creation of a single, shared medical record across both agencies. For Service members to have their military health records transferred to VA, they need to apply for VA health care or file a claim with the VA. Historically, this process was manual and could take several weeks or longer. However, with the new Federal EHR, Service members' medical records are now quickly accessible to VA (often immediately, or at most within a few days) upon application or claim filing. These records include important documentation of mental health conditions diagnosed and treatments received during military service, allowing Veterans to promptly engage with VA mental health providers without needing to start from scratch.

Another significant enhancement to Service member and Veteran transitions resulting from the Federal EHR is the increased capacity for closer collaboration between agencies. The Veterans Health Administration (VHA) VA Liaison Program staff and the Post-9/11 Military2VA (M2VA) Case Management Program staff can review Service members' DoD medical records to expedite post-deployment assessments and mental health care referrals to the VA. This utilization of shared resources has substantially accelerated the transition from Military Treatment Facilities (MTF) to VAMCs for many transitioning Service members and recently separated Veterans.

Some other VA initiatives for ensuring continuity of care for Veterans with mental health needs are applicable to both of VA's EHRs. One such initiative is a National Case Management Protocol that alerts VA when Service members may have been treated for opioid use disorder while in DoD care or through DoD-funded community care. The Post-9/11 Transition and Case Management (TCM) national team, aided by an Office of Mental Health population management tool within the Stratification Tool for Opioid Risk Management (STORM) suite of data reports, will identify Service members and new Veterans who received treatment associated with an OUD diagnostic code while in the military once they are enrolled in VHA care. Post-9/11 TCM alerts the VA Liaison for Healthcare or Post-9/11 M2VA Case Management team to ensure that each transitioning Service member or recently separated Veteran who may have been treated for OUD by DoD is assessed by a VHA provider for opioid use disorder and receives appropriate follow-up treatment and risk mitigation.

Question 2: Does the relationship between DoD and VA need improvement and what steps would you recommend ensuring transitioning service members don't face obstacles in accessing care and benefits?

VA Response: Each year, approximately 200,000 Service members transition to civilian life, a period often marked by uncertainty and stress for them and their families. All transitioning service members are able to apply for VA health care up to 365 days before discharge. To better support this transition, the Department of Defense (DoD) and the VA are working to enhance collaboration and utilize available resources effectively. Key areas of focus include the VA Military Transition Liaison program, the Transition Assistance Program, and various outreach strategies such as targeted email and text messaging campaigns. These efforts aim to reduce barriers to care and benefits, providing a seamless transition and ensuring timely support for service members during and after their military service.

Question 3: In TN, one of our local providers has a clinic directly across the street from the VA, and there are instances where the VA staff will walk a veteran across the street to receive mental health services. One of the bills I am working on, which Rep. Bost has already introduced on the House side, is the *Recognizing Community Organizations for Veteran Engagement and Recovery Act (RECOVER Act).* This bill would establish a three-year pilot program to provide evidence-based mental health care for veterans through community organizations.

How can legislation like the RECOVER Act help build capacity in our communities to serve veterans in need of mental health care services, while also continuing to foster collaborative partnerships with the VA to ensure no one falls through the cracks?

VA Response: VA appreciates the interest in advancing mental health services for Veterans. We would be happy to review the proposed bills, provide technical assistance and ensure VA qualifies any additional appropriations that might be needed for VA to achieve new programing.

U.S. Department of Veterans Affairs
September 2025

Submissions for the Record
(From Minority Veterans of America)

To: Outdoor Recreation Task Force for Veterans
From: Lindsay Church, Minority Veterans of America
Date: April 1, 2025

Subject: Response to Substantive Changes Between Original and Revised Congressionally Mandated Report on Outdoor Recreation for Veterans

Overview

This memorandum outlines the most sweeping and consequential revisions made to the Congressionally Mandated Report (CMR) from the Interagency Task Force on Outdoor Recreation for Veterans. The original draft, completed in May 2024, was a bold, equity-centered blueprint grounded in data, lived experience, and a commitment to serve all veterans—especially those long marginalized by systemic barriers. Under the direction of the current administration, that blueprint was gutted. The final report, issued in March 2025, reflects a profound shift—not just in tone, but in purpose. Through the systematic erasure of language acknowledging race, gender, disability, sexual orientation, and other critical identities, the revised report abandons the very veterans it was meant to uplift. What remains is a hollowed-out version of our original vision—one that retreats from equity, obscures truth, and fails to meet the moment or the mandate and letter of the law.

1. Substantive Changes: A Shift in Focus and the Erasure of Equity

The revisions made to the Congressionally Mandated Report reflect a dramatic shift—not in the data or needs of the veteran community, but in the political will to name and address them. Under the current administration, the report was reframed in ways that diminish its ability to serve the very populations it was created to support.

The original CMR, completed in May 2024, was grounded in evidence, lived experience, and the legislative intent of the bipartisan Veterans COMPACT Act. It was not political—it was principled. It named the disparities faced by underserved veterans and proposed thoughtful, targeted solutions to close those gaps. It centered equity not as a partisan ideal, but as a necessary framework to ensure all veterans could benefit from outdoor recreation opportunities, regardless of race, gender identity, disability, or other historically marginalized identities.

In contrast, the revised version systematically removes references to equity, inclusion, diversity, and minority populations — language that was central to acknowledging and addressing real barriers that veterans face in accessing the outdoors. It eliminates identity-specific terms such as "gender," "sexual orientation," "transgender," "nonbinary," and "race," effectively erasing the specific needs of historically excluded communities.

Where the original report identified populations like women veterans, LGBTQ+ veterans, veterans of color, and veterans with disabilities, the revised document obscures these groups behind vague phrasing like "Veterans with limited access to care" or "all Veterans." This flattening of experience prevents meaningful action and hides the disproportionate burdens borne by many.

Additionally, the report no longer references intersectionality or the importance of representation, both of which were essential to the original report's understanding of how overlapping identities affect access, outcomes, and trust in federal programs.

Finally, the revised document adopts a neutralized framing, emphasizing wellness in the abstract while ignoring the structural barriers that continue to exclude marginalized veterans from these spaces. By refusing to name inequity, the report fails to confront it — and in doing so, it undermines its credibility, integrity, and impact.

2. Granular Revisions and Erasures

The revised report does not merely shift tone — it rewrites the narrative. Specific, purposeful language that once centered equity and acknowledged the lived realities of marginalized veterans has been stripped away and replaced with vague, sanitized terminology.

Phrases such as "culturally responsive," "underserved," and "intersectionality"—which grounded the original report in both accuracy and accountability — were replaced with hollow alternatives like "local" and "community-based." This revisionary language dilutes the specificity and urgency of the original recommendations and distances the report from those it was designed to uplift.

The revised version removes targeted recommendations that explicitly called for outreach to women, LGBTQ+ veterans, veterans of color, and other historically excluded groups. By erasing these references, the report disregards the reality that these populations continue to face heightened barriers to access and engagement in outdoor spaces.

Most alarmingly, all discussion of systemic barriers — including discrimination, racism, sexism, homophobia, transphobia, and ableism — has been eliminated. This omission is not neutral; it is a conscious choice to ignore the structural forces that shape veterans' lives and limit their access to health-promoting resources. The absence of these acknowledgments renders the report both incomplete and complicit in the ongoing marginalization of the very communities it was intended to support.

Word Deletions (with Frequency)

Word/Term	Frequency Removed
gender	9
sexual	4
orientation	3
minority	5
equity	4
diversity	1
inclusion/inclusive	6
race	3
transgender	2
nonbinary	2
intersectional	1
underrepresented	2
accessibility	2
disability	1
mobility	1
woman	2

4. Impact of the Revisions

The consequences of these revisions are not theoretical — they are tangible, measurable, and deeply harmful.

- **Dilution of Intent**: The revised report abandons the moral and legislative clarity of its original purpose. By presenting a sanitized and decontextualized view of the veteran experience, it ignores the very real, deeply embedded barriers that marginalized veterans face in accessing outdoor spaces. The result is a document

that reads as risk-averse and politically convenient — one that fails to speak truthfully about the inequities it was tasked with addressing.

- **Loss of Accountability**: The removal of demographic specificity — terms like race, gender identity, disability, and sexual orientation — renders invisible the populations most impacted by exclusion. Without this clarity, agencies and stakeholders are left without a framework to measure outreach, assess disparities, or track progress toward justice. The absence of data is not benign; it is a method of deflecting responsibility.
- **Breakdown in Program Design**: The original report offered actionable, community-informed strategies grounded in cultural competence and intersectional understanding. These models were not just inclusive — they were effective. The revised version offers no such guidance. In erasing the specificity of need, it also erases the ability to design programs that work.
- **Erosion of Trust**: Perhaps most damaging is the message these changes send to the very communities this initiative was meant to serve: that their identities are too inconvenient to name, and their barriers too political to confront. This erasure is not just disheartening — it is alienating. It risks deepening the divide between marginalized veterans and the institutions that have already too often failed them.

5. Conclusion

These revisions are not mere editorial adjustments — they are a deliberate and deeply concerning departure from the original mission and moral clarity of this Congressionally mandated effort. It is censorship. The erasure of equity, identity, and inclusion from the final report represents a significant political and cultural regression in how the government chooses to acknowledge — and more critically, how it chooses to ignore — the systemic disparities faced by marginalized veteran communities.

The original report was a principled, nonpartisan effort to address real, measurable inequities with integrity and accountability. It was rooted in Congressional intent as outlined in the bipartisan Veterans COMPACT Act of 2020, which explicitly called for recommendations informed by the unique needs of underserved populations. The revised version abandons that charge. It diminishes the voices of those most impacted. It weakens the impact of our work. And it sends a dangerous signal: that naming injustice is optional, and that the needs of minority veterans are negotiable.

This cannot stand. It is immoral, unjust, and likely illegal.

We urge oversight bodies, lawmakers, advocates, and all invested stakeholders to reject this revisionist approach. Equity must not be treated as a political liability — it must be re-established as a foundational principle. The recommendations of this Task Force should reflect the full truth of who our veterans are, what they face, and what they deserve. Nothing less will do.

minorityvets

April 1, 2025

To Whom It May Concern,

It is with a heavy heart that I submit my resignation and withdraw my organization's support for the Interagency Task Force on Outdoor Recreation for Veterans.

When I joined this Task Force, I did so with the belief that we could build something powerful — a set of recommendations that didn't just promote outdoor recreation, but addressed the deep, systemic inequities that prevent so many veterans, service members, and their families from accessing healing in nature. We were tasked not only with considering access, but with ensuring inclusion, equity, and representation for those who have historically been excluded — women, LGBTQ+ veterans, veterans of color, veterans with disabilities, and others pushed to the margins of our systems.

The original draft of our final Congressionally Mandated Report reflected that commitment. It named inequity, it spoke of truth. It highlighted communities that continue to face barriers. It offered targeted, thoughtful, and inclusive solutions. **The redacted report no longer does this.**

Under the direction of the new administration and their priorities, this document has been fundamentally altered, gutted of the very essence of our Task Force's work. Equity-centered language has been erased. Identity has been sanitized. Whole communities — whose needs we centered in good faith consultation — have been made invisible. The removal of terms like "gender," "race," "sexual orientation," "disability," and "intersectionality" is not just editorial. It is ideological. And it is dangerous.

I cannot, in good conscience, allow my or my organization's name or labor to be associated with a report that so thoroughly undermines the principles of equity and justice that this work demands. Veterans deserve better — especially those whose service and sacrifice have too often been met with silence, exclusion, or harm.

I am proud of the original work we produced. I remain committed to advancing outdoor equity for all veterans, without condition.

With deep gratitude and unwavering resolve,

Lindsay Church (they/them)
Executive Director, Minority Veterans of America
Proud Transgender Navy Veteran

DEPARTMENT OF VETERANS AFFAIRS

Congressionally Mandated Report:

VETERANS COMPREHENSIVE PREVENTION, ACCESS TO CARE, AND TREATMENT (COMPACT) ACT OF 2020

INTERAGENCY TASK FORCE ON OUTDOOR RECREATION FOR VETERANS

Final Report

September 2024

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EXECUTIVE SUMMARY

In December 2020, the Veterans Comprehensive Prevention, Access to Care, and Treatment (Veterans COMPACT Act of 2020) Act of 2020 (P.L. 116-214) was enacted. Pursuant to section 203 of the COMPACT Act, the Secretary of Veterans Affairs is to establish an interagency task force known as the Task Force on Outdoor Recreation for Veterans, to report on and make recommendations regarding use of public lands or other outdoor spaces for medical treatment and therapy for Veterans. The work of the Task Force on Outdoor Recreation for Veterans (henceforth referred to as Task Force) was guided by consultation with appropriate Veteran Outdoor Recreation Groups (VORGs), Federal stakeholders, and Veterans Service Organization (VSO) members. Through regularly recurring meetings and a plethora of diverse presentations, the Task Force identified preliminary findings submitted in the Congressionally Mandated Report titled ***Interagency Task Force on Outdoor Recreation for Veterans – Preliminary Findings***, published October 2023. The Task Force is grateful for the opportunity to provide a final report with recommendations, pursuant to section 203. Through submission of this report, The Task Force submits 26 recommendations to Congress, with five ranked as key recommendations. These 26 recommendations are critical to facilitate use of and access to public lands, outdoor spaces, and nature-based experiences (defined as activities occurring in an outdoor natural environment) for Veterans, their families, and caregivers. The recommendations promote physical and mental health, overall wellness, and nature-based experiences integrated into each Veteran's personal health plan to support the delivery of whole health. Over the course of one calendar year following submission of this report, the Task Force will continue to meet as needed to fulfill the third-year requirements as outlined in the legislation. The Task Force looks forward to Congressional responses and further engagement, based on submission of this report.

INTRODUCTION

Recent research supports that a lack of engagement with natural environments, due to a combination of access and lifestyle choices, has negative impacts on people across their lifespans (Bratman et al., 2019; Engemann et al., 2019; Hartig et al., 2014). As a result, some clinicians have recommended to increase the amount of time that people spend in nature and nature-based experiences (Müller-Riemenschneider et al., 2020). For example, the Parks Rx America program is used by clinicians to encourage parents to help their children spend more time in nearby parks for physical and mental health (https://parkrxamerica.org). Improved immunity, restoration of attention, enhanced relaxation, psychological well-being, and reduced blood pressure have all been linked with nature-based experiences.

There is a long history of using nature to support Veterans (Poulsen et al., 2017). Nature-based programming has been used to support reintegration, recreation, healing,

and skill building. The research literature indicates that activities which are nature-based, whether it be a garden or glacier, have been shown to result in positive changes in attentional capacity, brighter mood, and tranquility. Specific studies using fly-fishing, river-running, yoga, hiking, and horseback riding have all demonstrated improvements in well-being and psychological health in Veterans with various psychiatric diagnoses, including post-traumatic stress disorder (PTSD; Anderson et al., 2018; Bennett et al., 2017).

Therapeutic horticulture as a healing tool for Veterans has also been studied, particularly the role and efficacy of horticulture therapy programs which have been operationalized in several U.S. Department of Veterans Affairs (VA) facilities (Eichholtz, 2020). A nature-based therapeutic intervention has been manualized, approved, and disseminated by VA for use with Veterans. This intervention has been used by Veterans, particularly those residing in rural areas who may be able to spend time more easily in nature seeking to address mental health and quality of life concerns (Austen, 2023). Community partnerships between VA and local, state, and Federal land agencies have proven successful as a means of expanding access and opportunities for Veterans who are patients at VA facilities to spend time in nature and resulted in the dissemination of best practices for facilities nationally (Gartland, 2023).

In December 2020, the Veterans Comprehensive Prevention, Access to Care, and Treatment (Veterans COMPACT Act of 2020) Act of 2020 (P.L. 116-214) was enacted. Pursuant to section 203 of the COMPACT Act, the Secretary of Veterans Affairs is to establish an interagency task force known as the Task Force on Outdoor Recreation for Veterans, to report on and make recommendations regarding use of public lands or other outdoor spaces for medical treatment and therapy for Veterans. The legislation requires establishment of the Task Force no later than 18 months after the date on which the national emergency declared by the President on March 11, 2020, pursuant to the National Emergencies Act (50 U.S.C. § 1601) with respect to the Coronavirus Disease (COVID-19), expires. The National Emergencies Act ended when the President signed a bipartisan congressional resolution on April 10, 2023. The Task Force was established and launched on September 27, 2022. The Task Force's initial report was submitted to Congress and published in October 2023.

The Task Force is charged with three duties. The first duty is to identify opportunities to formalize coordination between VA, public land agencies, and partner organizations regarding the use of public lands and other outdoor spaces, toward facilitating health and wellness for Veterans. The second duty of the Task Force is to identify barriers that exist to providing Veterans with opportunities to augment the delivery of services for health and wellness, through use of outdoor recreation on public lands and other outdoor spaces. Thirdly, the Task Force must develop recommendations to better facilitate the use of public lands and other outdoor spaces for promoting wellness, and facilitating delivery of health care and therapeutic interventions, for Veterans. In addition, the duties of the Task Force are to be carried out in consultation with appropriate Veterans

Outdoor Recreation Groups (VORGs), to help inform the work and ultimately the recommendations of the Task Force.

Through submission of this report, the Task Force submits 26 recommendations to Congress, with five identified as key recommendations. These recommendations are critical to facilitate use of and access to public lands, outdoor spaces, and nature-based experiences (defined as activities occurring in an outdoor natural environment) for Veterans, their families, and caregivers. The recommendations promote physical and mental health, overall wellness, and nature-based experiences integrated into each Veteran's personal health plan to support the delivery of whole health.

TASK FORCE MEMBERSHIP

The Task Force is co-chaired by the Secretary of VA and the Secretary of Department of the Interior (DOI), or their designees. Other Federal partners on the Task Force include the Secretaries of U.S. Health and Human Services (HHS), U.S. Department of Agriculture (USDA), U.S. Department of Defense (DoD), U.S. Department of Homeland Security (DHS), and Chief of the U.S. Army Corps of Engineers (USACE), or their designees. The Task Force includes Federal land management agencies that, although created at different times with unique missions, share duties of managing our country's natural resources on Federal lands. As such, HHS oversees the U.S. Public Health Service (PHS), and DHS oversees the U.S. Coast Guard (USCG). DoD oversees active-duty Service members and military retirees and manages Federal public lands.

Section 203 of the COMPACT Act also requires at least two Veteran Service Organization (VSO) representatives be included on the Task Force. VA reached out to 19 VSOs to provide information on proposed objectives and duties of the Task Force, and to inquire interest in serving as a member. The following four VSOs responded with interest and agreement to serve on the Task Force: Minority Veterans of America (MVA); Paralyzed Veterans of America (PVA); Team Red, White & Blue (TRWB); and Veterans Outdoor Advocacy Group (VOAG). Table 1 lists the membership of the Task Force.

Table 1 – Composition of Representatives on the Task Force on Outdoor Recreation for Veterans

Agency or Organizations	Representative
U.S. Department of Veterans Affairs, Co-chair	Maureen Elias, Deputy Chief of Staff (September 27, 2022 – January 30, 2024) Maria D. Llorente, Deputy Assistant Under Secretary for Health for Patient Care Services (January 30, 2024 – Current)
U.S. Department of the Interior, Co-chair	Charles F. Sams, III, Director, National Park Service

U.S. Army Corps of Engineers	Jeffrey F. Krause, Chief of Natural Resources Management
U.S. Department of Agriculture	Gordon "Gordie" Blum, Director, Recreation, Heritage, and Volunteer Services USDA Forest Service
U.S. Department of Defense	Kristen C. McManus, Program Analyst, DoD, Military Community & Family Policy
U.S. Department of Health and Human Services	Rear Admiral Susan M. Orsega, Senior Advisor to the Assistant Secretary for Health and Surgeon General (September 27, 2022 – September 26, 2023) Yvonne Santiago, Commander, United States Public Health Service (September 26, 2023 – Current)
U.S. Department of Homeland Security	Matthew F. Perciak, MWR Program Manager, U.S. Coast Guard
Minority Veterans of America	Lindsay Church, Executive Director
Paralyzed Veterans of America	Fabio Villarroel, Director of Sports & Recreation
Team Red, White & Blue	Aaron Wolf, Area Director
Veterans Outdoor Advocacy Group	Josh Jespersen, President and Founder

OVERVIEW

The Task Force is responsible for providing two Congressionally Mandated Reports (CMRs). The first CMR is titled ***Interagency Task Force on Outdoor Recreation for Veterans: Report of Preliminary Findings (RPF)***, which was published and sent to Congress in October 2023. The RPF included consultation obtained from a broad range of appropriate Veterans Outdoor Recreation Groups (VORGs) obtained through a Federal Register Notice. The respondent VORGs identified opportunities to support Veteran use of public lands as well as barriers they face regarding use of and access to public lands and other outdoor spaces, toward facilitating health and wellness for Veterans. Information from scientific literature reviews, VORG consultations, and diverse presentations as presented in the Task Force's 2023 CMR include the following: (1) consultation with appropriate VORGs; (2) a brief overview of Federal public lands and waters as well as existing opportunities for Veteran outdoor recreation on Federal lands;

(3) key findings from a survey of Task Force members regarding opportunities and barriers to facilitate the use of public lands to benefit Veterans; (4) outreach efforts to engage VSOs in the work of the Task Force; (5) review of the scientific literature on benefits of nature exposure and outdoor recreation that included consultations from VA and non-VA researchers and subject matter experts in this area; (6) Veteran services and discounts available when accessing public lands managed by states, territories, or the District of Columbia (DC); (7) examples of existing partnerships between VA and managers of public lands that offer outdoor nature-based experiences for Veterans; (8) Park Prescription Programs under the National Park Service; (9) architectural barriers (PVA presentation); and (10) findings from a review of relevant vocational opportunities for Veterans interested in outdoor career opportunities. Since its establishment, the Task Force has utilized and built upon this information to develop recommendations through bi-monthly meetings that are organized around the specific duties required by the legislation. These meetings were co-chaired and co-hosted by VA and DOI, via hybrid in-person and virtual attendance options for both members and presenters. The second CMR, due to Congress no later than one year after RPF submission, is this Final Report, providing the recommendations of the Task Force.

Consultation from appropriate Veterans Outdoor Recreation Groups

To fulfill the legislative requirement for the Task Force to perform its duties in consultation with appropriate VORGs, VA published a Request for Information (RFI) in the Federal Register. This method provided an equitable framework for a wide array of responses from VORGs to offer consultation to the Task Force. The RFI went through the formal concurrence process as required by the VHA Rulemaking and Non-Legislative Federal Register Notices Under the Administrative Procedure Act (38 U.S.C. § 501, 7301(b)). The Notice of Federal Register publication of this RFI was widely disseminated to stakeholders within VA, Congress, Federal partners, VSOs, professional organizations, and public land manager points of contact for states, territories, DC and Commonwealth, State Veterans Affairs offices, and outdoor recreational groups. The RFI posting was opened for public comment from February 23, 2022, to March 25, 2022.

Survey Respondents

A total of 120 submissions were received. Fifty-two respondents fully completed the survey, 16 respondents partially completed the survey, and 52 submitted only general comments. Respondents who either partially or fully completed the survey (N=68) were then contacted and given opportunity to discuss their responses in further detail. Of these 68 respondents, 40% completed the detailed follow-up telephone-based interview. Results of those interviews were then included in the data analysis. As stated in the RPF, all groups and individuals who were consulted and surveyed agreed that increasing Veteran exposure and access to outdoor recreation in meaningful ways is a beneficial endeavor. Public land managers recognize that outdoor recreational activities and

experiences facilitate human health and well-being and are especially attuned to the potential benefits for active-duty Service members and Veterans.

Presentations Provided to the Task Force

During the course of the Task Force's two years of work, members were provided a wide range of presentations from a diverse group of subject matter experts that included VSOs, community and Federal public lands partners, researchers, national program offices from various Federal agencies that provide Veteran-specific programming, and clinicians who manage nature-based experiences and therapeutic services at various Veterans Health Administration (VHA) facilities. Related complementary presentations revealed significant barriers to Veterans seeking to establish or expand their use of public lands for health and quality of life. A complete list of presentation types is provided in Table 2.

Table 2 – List of Presentations Delivered to the Task Force, the Type of presentation and which organization presented.

Presentations to Inform Task Force	Type of Presentation VORG Consultation Partnerships Informative TF Process & Duties
Consultation from Appropriate Veterans Outdoor Recreation Groups, Duty A, Partnerships	VORG Consultation through Request for Information (RFI)
Consultation from Appropriate Veterans Outdoor Recreation Groups, Duty B, Barriers	VORG Consultation through RFI
Addressing Barriers Discussion	VORG Consultation through RFI
Consultation from Appropriate Veterans Outdoor Recreation Groups, Duty C, Recommendations	VORG Consultation through RFI
Team River Runner Kayaking Program	Palo Alto VA & Team River Runner
San Francisco VA Wellness and Resilience Incorporating Outdoor Recreation (WARIOR) Program	San Francisco VA & Golden Gate National Parks Conservancy
New York City Veteran Outings Group	New York Harbor VA & Sierra Club Military Outdoors in NYC
Sierra Nevada Treks: A VA Nature Based Therapy Program	Sierra Nevada Health Care System VA & Achieve Tahoe, Urban Roots, Environmental Traveling Companions, Washoe County Parks & Recreation Services
Community Partnerships for Veteran Health and Wellness	Capt. James A. Lovell Federal Healthcare Center & Brushwood Center at Ryerson Woods

Nature Rx: The Power of Parks for Health	Office of Public Health, National Park Service, Department of Interior
Architectural Barriers: Veterans Use of Public Lands	Paralyzed Veterans of America
Utilizing USDA Forest Service: Managed Lands for Health and Well-Being	Travel, Tourism, and Interpretation, Forest Service, US Department of Agriculture
Addressing Equity Gaps in the Outdoors	Minority Veterans of America and REI
Recreation Area Visitor Surveys	US Army Corps of Engineers
Socioeconomic and Visitor Monitoring in the National Park System	Social Science Program, National Park Service, Department of Interior
Outdoor Recreation & Role of Department of Transportation	Program Development, Office of Federal Lands Highway, Department of Transportation
Nature-Based and Outdoor Recreation Experiences Scientific Literature Review	Patient Care Services National Program Office, Department of Veterans Affairs
Partnership Opportunities for Communications - VA	Patient Care Services National Program Office, Department of Veterans Affairs
VHA Recreation Therapy and Creative Arts Therapy Service Overview	Recreation Therapy National Program Office, Department of Veterans Affairs
National Veterans Sports Programs & Special Events: VA Adaptive Sports and Arts	National Veterans Sports Programs and Special Events, Department of Veterans Affairs
Exploring a New Reality: Nature-Based Virtual Reality Demonstration	Indianapolis VA Medical Center, Office of Research & Development, Department of Veterans Affairs
VHA Vocational Rehabilitation Service: The Value of Employment as a Therapeutic Intervention in Health Care	VHA Vocational Rehabilitation Service, Department of Veterans Affairs

SUMMARY OF PRELIMINARY FINDINGS

The Task Force consolidated its findings from the Survey of Federal Task Force Members, review of the literature, consultations with VORGs, presentations to the Task Force, and summaries of public land services and discounts across States, Territories, and DC. These preliminary findings were formalized in the first CMR, published in October 2023.

Guided by the collective perspectives of VORGs, Federal stakeholders, and VSO members, the Task Force's preliminary findings on addressing barriers confronting

Veterans regarding use of public lands for health and quality of life centered on four main themes: increasing awareness, improving communication, collaborative planning, and facilitation of engagement. Additionally, the current body of literature on this subject remains relatively new and emerging, with further long-term studies needed to clarify health benefits for diverse populations. All who were consulted and surveyed agreed that increasing Veteran exposure and meaningful access to outdoor recreation is a beneficial endeavor. Public land managers acknowledged that outdoor recreational activities and nature-based experiences facilitate human health and well-being and were especially attuned to these potential benefits for active-duty Service members and Veterans. Lack of interagency coordination for these programs was acknowledged.

Duty A: Opportunities to formalize coordination.

1. While there are many outdoor options specifically for Veterans, coordination is limited and sometimes siloed:
    a. There are Federal agencies that offer outdoor recreation and nature-based activities with specific focus on Veterans, their caregivers, and survivors.
    b. VA health care facilities do offer outdoor recreation and nature-based experiences via locally initiated and managed programs. In other words, such activities are not available at all locations. Management of these activities can be highly variable, depending on which department is involved. Recreation Therapy, Patient-Centered Care & Cultural Transformation (also known as Whole Health), Mental Health, and Substance Use Disorder Treatment teams exemplify different approaches to programming outdoor recreation and nature-based activities. Of note, VA does not require its facilities to participate in or offer such programming.
    c. Many VORGs offer a wide array of programs focused on nature-based experiences for Veterans. However, VORGs express challenges delivering these services in coordination with VA health providers.
    d. Similar concerns are noted with regard to limited coordination between groups offering Veterans outdoor programs, and Federal agencies providing healthcare and information to active-duty Service members and Veterans (such as VA, DoD, PHS, and USCG).
    e. Federal agencies agree that closer, collaborative interagency partnerships would improve communications about existing programs for Veterans, families, and survivors.
    f. There is consensus that policy changes and staffing expansion would be required for further coordination.

2. Education for Veterans, their families and friends, and clinicians may prove beneficial:
    There was consensus among Task Force members that education and communication would be beneficial for Veterans, caregivers, and survivors as well as their providers on the benefits of outdoor recreation. This education could focus on:

a. Providing existing toolkits and guide manuals for providers on how to prescribe nature-based experiences, including outdoor activities in clinical settings.
b. Discussions between providers and Veterans for consideration of nature-based experiences and outdoor recreation activities as adjuncts to health and wellness treatment plans.
c. Methods to communicate nature-based experiences for Veterans in their local areas, including how to get there (modes of transportation), and what types of activities are available (peaceful meditation, hiking, canoeing, camping, fishing, etc.)

3. Further deepening of available evidence:
    a. An emerging medical and psychosocial literature evidence base indicates potential physical, mental and cognitive health benefits from nature-based experiences and outdoor recreation.
    b. There are gaps in the evidence base that could be explored with further research and data collection:
        i. Women and minorities are underrepresented in outdoor activities.
        ii. Optimal "Nature Dosing" is unknown. There is a need to better understand the dose of nature (how long and how often should someone spend in nature) that is shown to help improve overall health and wellness.
        iii. Insufficient data regarding benefits of nature-based experiences on physical health outcomes.
        iv. Better understanding of Veterans who use and access public lands and outdoor spaces, as well as Veterans who would like to access public lands but do not do so (and the reasons why).

4. Apprenticeships and Work Therapy:
    a. Opportunities exist to further develop apprenticeships, internships, and other forms of compensated work therapies in areas of Renewable Energy, Agriculture, Responsible Stewardship of Natural Resources, and Recreation.

Duty B: Barriers

1. The most frequently cited barriers identified by VORGs are:
    a. Cost
    b. Transportation
    c. Awareness of Programs
    d. Access
        i. Access to Public Lands
        ii. Accessibility due to Physical Disability
    e. Permits and Regulations
    f. Stigma (Mental Health/Cultural)
    g. VA Support
    h. Help from VSOs and Public Land Managers

2. Variability exists in the services and discounts offered to Veterans in the public lands managed by States, Territories, and the District of Columbia.

3. Assessing and addressing architectural barriers would facilitate access to and use of public lands, not only by Veterans, but by the American population as a whole.

4. The "adventure gap" or "nature gap" is the consistent finding that people of color, women, and marginalized persons are less likely than their white counterparts to participate in outdoor recreation or visit natural spaces, such as parks. These groups experience unique barriers to accessing nature-based and outdoor experiences and will require focused action to improve diversity of access to these outdoor opportunities.

METHODOLOGY USED TO DEVELOP TASK FORCE RECOMMENDATIONS

Submission of Draft Recommendations

Based on presentations, information, and resource materials as summarized in the Task Force RPF, Task Force members began discussing potential recommendations. A template was developed for use, and 42 initial recommendations were drafted. Every Federal agency and VSO Task Force member submitted at least one recommendation.

Review of Draft Recommendations

All 42 first-draft recommendations were considered and placed into one of nine categories for ease of review. The draft recommendations were initially reviewed on January 30, 2024, during a COMPACT Act Section 203 Task Force meeting. Each Task Force member participated in one of three workgroups. Workgroup 1 included DOI, VA, USACE, USDA, and VOAG. Workgroup 2 included DoD, USCG and MVA. Workgroup 3 included HHS, TRWB, and PVA. As such, VSO representation within each workgroup was assured. Each workgroup received one-third (14) of the 42 draft recommendations for review.

The moderated workgroups had two primary aims: (1) identify any recommendations that were sufficiently similar for purposes of merging or combining into a single recommendation; and (2) identify those recommendations that should remain as standing alone. No recommendations were eliminated. This first-pass review allowed for consolidation down to a total of 28 second-draft recommendations. Discussion and questions from the full Task Force continued to the March Task Force meeting.

Finalizing the Recommendations

At the March 26, 2024, Task Force meeting, members participated in a facilitated discussion regarding the 28 second-draft recommendations. All 28 recommendations that resulted from the January 2024 Task Force meeting received full consideration. The Task Force made the decision to separate one of the recommendations into two separate recommendations. Every recommendation received real-time technical review and was ratified by concurrence of all eleven members of the Task Force, with a consensus declaration at the end of each individual recommendation. The resulting 29 recommendations were then further reviewed by the Task Force at the May 2024 meeting.

Identification of Key Recommendations to Highlight

The Task Force further discussed and agreed to highlight five key recommendations from the final set of 29. Each Task Force member reviewed and ranked the recommendations from 1 through 29 (with 1 being the recommendation the Task Force member's organization ranks as most critical to highlight, and 29 as least critical to highlight). At the May 21, 2024, meeting, the five highest ranked recommendations were reviewed and upon further discussion, the Task Force agreed to combine six similar topic recommendations into three. This led to a final total of 26 recommendations, with 5 highlighted as key, and herein described in rank order. Table 3 summarizes all 26 recommendations, organized according to preliminary finding and primary duty addressed by each recommendation. In addition, the Task Force recognizes that some of the recommendations may require legislative initiatives, regulatory or policy changes, staffing, and additional appropriations. These are also summarized in Table 3; the five key recommendations are identified by a double asterisk (**).

There was consensus among the Task Force members that the work of this group is extremely valuable to the overall health and wellness of Veterans and should continue beyond the legislated required three years. Two of the ranked key recommendations address this and the Task Force made the decision to combine them into a single recommendation. In addition, there were two different recommendations that addressed Infrastructure, and upon further deliberation, the Task Force agreed that these should be combined into a single recommendation as well.

Prior to the May 2024 meeting, the Task Force members reviewed an electronic draft of the CMR. At the meeting the Task Force members either verbally or by show of hands that the draft CMR provided a correct summary of the preliminary findings, accurately captured the culmination of the work of the Task Force, and provided a true representation of their recommendations to Congress.

Table 3. Summary of Recommendations and Resources Needed for Implementation

	PRELIMINARY FINDING ADDRESSED	RECOMMENDATION	TASK FORCE MEMBER	REQUIREMENTS TO IMPLEMENT			
DUTY A - FORMALIZE COORDINATION BETWEEN VA AND PUBLIC LAND AGENCIES	Build Partnerships and Improve Coordination			Legislation	Regulation or Policy	Additional Staffing	Additional Appropriations
		Conduct an Inclusive Outdoor Nature-based Pilot	MVA/PVA	X		X	X
		**Establish New VA Outdoor Recreation National Program Office	TRWB, USCG, VA, DHS	X		X	X
		**Continue the Work of the Task Force by establishing TF as a Standing Workgroup and Adding VA as Member to FICOR	MVA/DOI/USACE	X			
		Improve Utilization/Access Data Collection on Federal Public Land Surveys	MVA/USDA/VA	X	X		X
		Develop Communities of Practice on Veterans Outdoor Recreation for Federal Public Land Agencies	USACE				
		Improve Engagement with Veterans through Special Use Permit Programs	USDA		X		
		Develop a Resource Guide to Facilitate VA Partnerships	PVA, TRWB			X	
	Education			Legislation	Regulation or Policy	Additional Staffing	Additional Appropriations
		Develop Training for VA Providers and Federal Public Land Agency Staff	PVA/VA/VOAG			X	
		**Develop Education and Enhanced Outreach for Veterans	MVA/TRWB/VA	X		X	X
		Conduct Outdoors Outreach for Active duty as they separate from service on outdoor recreation information	USDA	X		X	X

DUTY B: FACILITATE USE OF AND ACCESS TO PUBLIC LANDS BY ADDRESSING BARRIERS	Research Expansion			Legislation	Regulation or Policy	Additional Staffing	Additional Appropriations
		Develop a Comprehensive Outdoor Recreation Research Agenda	MVA	X	X		X
		Build Evidence of Health Impact of Outdoor Recreation	DOI	X	X		X
	Apprenticeships & Work Therapy			Legislation	Regulation or Policy	Additional Staffing	Additional Appropriations
		Expand Climate and Fire Corps	DOI	X		X	X
		Expand VA GI Bill	USDA	X	X		
		Increase Veteran Hiring	USDA	X	X	X	X
		Expand Entitlements Under CFR Chapter IX	VOAG	X			X
	PRELIMINARY FINDING ADDRESSED	**RECOMMENDATION**	**TASK FORCE MEMBER**	**REQUIREMENTS TO IMPLEMENT**			
	Barriers: Cost, Transportation, Awareness, Permitting, Stigma, VA Support			Legislation	Regulation or Policy	Additional Staffing	Additional Appropriations
		Expand Title 38 to Include Outdoor Recreation Grant	DOD, MVA, VOAG	X	X	X	X
		Conduct Veteran Outreach Events	DOI, USDA, DHS, USACE, VA	X		X	X
		Expand Military and Veteran Pass Eligibility to include US Uniformed Services	HHS	X	X		X
		Expand Federal Pass Distribution	MVA, USDA	X		X	X
		Promote Access to Federal Public Lands Through a Wellness Challenge for Veterans	DOI				
	Variability in Programming			Legislation	Regulation or Policy	Additional Staffing	Additional Appropriations
		Conduct and Environmental Scan of VA Outdoor Recreation Opportunities	VA			X	

		Create a VA Centralized Database & Communication Strategy of Outdoor Recreation Opportunities	VA	X		X	X
		**Establish a Centralized Website for Federal Public Lands Outdoor Recreation Programs	TRWB	X		X	X
		Promote Early Engagement in Outdoor Recreation through Integration of Outdoor Experiences in Military	MVA	X		X	X
	Architectural Barriers and Nature Gap			Legislation	Regulation or Policy	Additional Staffing	Additional Appropriations
		**Increase Access through an Accessibility Assessment and Associated Enhanced Infrastructure in Federal Public Lands.	PVA/MVA	X		X	X

** KEY RECOMMENDATION

FIVE KEY RECOMMENDATIONS

The five key recommendations are listed here in order of highest rank.

1. Establish New VA Outdoor Recreation Program Office

VA will explore establishing a Veterans Health Administration (VHA) Outdoor/Nature-based experiences national program office. The duties of the office could include, but are not limited to:

- Establishment of a Military Veterans Outdoor/Nature-based experience liaison at the VA
- Collaboration with Veterans Outdoor/Nature-based experience liaisons established at other Federal agencies that manage public lands, including U.S. Department of Interior, U.S. Department of Agriculture and U.S. Army Corps of Engineers
- Collaboration with Veterans Outdoor/Nature-based experience liaisons established at other Federal agencies that focus on support for Veterans including U.S. Department of Defense, U.S. Department of Health and Human Services and U.S. Department of Homeland Security
- Collaboration with appropriate VOAGs and VSOs to publicize resources and outdoor programs on public lands for VHA enrollees, and develop regular VSO briefings
- Develop educational materials for clinical providers and Veterans on the benefits of outdoor and nature-based experiences
- Propose a communications plan to disseminate information to Veterans, their families and external stakeholders on benefits of outdoor and nature-based experiences, as well as how to obtain an America the Beautiful lifetime pass
- Determine staffing and other resource needs to carry out the duties of the office
- Grants Management
- Collaborate with Federal public lands managers to develop a plan for data gathering and environmental scan on currently available veteran specific programming at relevant Federal Agencies

2. Continue the Work of the Task Force Through Two Mechanisms – by establishing the Task Force as a Standing Workgroup and by adding VA as a Member of the Federal Interagency Council on Outdoor Recreation (FICOR). FACT SHEET: Biden-Harris Administration Launches Effort to Create More Affordable and Equitable Outdoor Recreation Opportunities | The White House https://www.whitehouse.gov/briefing-room/statements-releases/2022/07/21/fact-sheet-biden-harris-administration-launches-effort-to-create-more-affordable-and-equitable-outdoor-recreation-opportunities/ While similar, the objectives of these two mechanisms are different and complementary. Establishing the Task Force as a permanent Interagency Workgroup will ensure close VSO participation and

partnership. Adding VA as a member of FICOR will ensure that Veteran-specific initiatives are integrated into the work of FICOR and formalize coordination between VA and Federal public lands managers.

(a) Establish Task Force as a Standing Workgroup: The Departments of Veterans Affairs, Defense, Interior, and USDA, in collaboration with pertinent Veterans Service Organizations (VSOs), should establish a sustained working group to build upon the efforts of the Outdoor Recreation Task Force for Veterans. This standing working group is designed to ensure ongoing dedication and concentrated efforts across all involved agencies and VSOs. Its primary responsibilities should include monitoring the progress and effective implementation of the Task Force's recommendations, and ensuring sustained commitment and accountability in advancing outdoor recreation initiatives for Veterans.

(b) Add VA as a Member to FICOR: Establish formal partnership between VA and the Federal Interagency Council for Outdoor Recreation (FICOR), by adding a representative from the Department of Veterans Affairs to serve on FICOR. Purposes of partnership will be advancing development of recreation programs for underserved Veterans groups, eliminating duplication of effort, and leveraging each other's expertise. Areas of focus could include outdoor recreation programming, new accessible infrastructure development, online clearinghouse of opportunities, and/or transportation grants.

3. **Increase Access through an Accessibility Assessment and Associated Enhanced Infrastructure in Federal Public Lands.** This can be accomplished through two simultaneous efforts.

(a) Appropriate additional funds to enhance infrastructure on federal and public land management agencies to focus on the implementation of universally accessible amenities. This includes but is not limited to accessible trails, picnic areas, campgrounds, restroom facilities and gender-neutral restroom. Ensure that these enhancements comply with the Architectural Barriers Act (ABA) standards.

(b) Collaborate with relevant stakeholders, including Veteran organizations, to ensure a thorough understanding of specific challenges faced by minority Veterans and Veterans with disabilities. Using those findings, conduct a comprehensive assessment of public lands and facilities designated for recreation to identify potential barriers to accessibility and complete a comprehensive physical inventory of gender-neutral restrooms and single-stall shower facilities across all sites for Veterans. The physical inventory will provide a detailed and accurate overview of the current infrastructure and empower federal land management

agencies to strategically plan to ensure future improvements include the expansion of these facilities. To enhance transparency and empower visitors with crucial information, the inventory findings should be made publicly available via a centralized database or platform where individuals can access information about accessibility for Veterans with disabilities, and availability and location of gender-neutral restrooms and single-stall shower facilities across federal lands.

4. **Establish a Centralized Website for Outdoor Recreation Programs:** Develop a centralized public facing website/clearing house to search, filter, and locate local nature-based programs, self-guided interpretive trails, information centers, etc. This will also facilitate the normalization of NatureRx within prescribing ranks of VA providers.

5. **Develop Education and Enhanced Outreach Materials for Veterans**
   (a) Develop educational materials on the physical and mental health benefits of outdoor recreation and nature-based experiences for active-duty service members, Veterans, family members, caregivers, and Gold Star family members.
   (b) Create Tailored Materials for racial, ethnic, gender, sexual, and religious minorities, as well as Veterans with disabilities (especially Veterans with mobility limitations). Veterans and VSOs should be included in the co-creation of these materials to ensure they are effective and can reach the focused communities.
   (c) Partner with and/or Contract Outreach Specialists and organizations who have an expertise in reaching underrepresented and underserved military and Veteran populations. Outreach should be tailored and focused on ensuring that underserved Veterans are made aware of the benefits and programs that are available to them for outdoor recreation.
   (d) Collaborate with VSOs and provide mutual support for their efforts and connections. For targeted outreach, collaborate and resource minority-focused organizations who have established trusting relationships with their members and communities.

Following are the 21 additional Task Force recommendations described in detail, organized by duty category. Please note these are not listed in order of rate or ranking.

RECOMMENDATIONS THAT ADDRESS DUTY A:

TO FORMALIZE COORDINATION BETWEEN VA AND PUBLIC LAND AGENCIES

A. Conduct an Inclusive Pilot Outdoor Nature-based Program

Establish a pilot outdoor/nature-based program at five VA facilities specifically designed to serve as a centralized hub, for dissemination of information about

available outdoor recreation programs and offerings and be inclusive for Veterans with disabilities, women Veterans, and minority Veterans. These nature-based programs may include adaptive sports, guided nature walks, and outdoor therapy sessions.

The five pilot sites should have existing staff who have experience managing outdoor recreation access programs and can provide Veterans with information and resources to facilitate their engagement with the outdoor activities. Engagement resources may include options for Veterans to obtain lifetime America the Beautiful National Parks and Federal Recreational Lands passes and explore establishment of an outdoor activity gear locker for Veterans to check out limited equipment. The design and selection of pilot sites should use an equity-informed lens and, ideally, will include one facility in each of the five regions (VISNs) with the highest concentration of women and/or minority veterans. These pilots may also leverage collaboration with local Veteran outdoor recreation groups, as well as Federal public lands partners, to tailor programs to meet the unique preferences and needs of the Veteran community.

B. Improve Utilization/Access Data Collection on Active-Duty Service Members and Veterans in Federal Public Land Surveys

Data collection efforts should be enhanced to include data on Veteran and military status, race and/ or ethnicity, gender identity (including transgender, nonbinary, and other gender diverse individuals), and sexual orientation. Additionally, Federal public lands managers should provide annual or bi-annual reports to Congress on utilization of Federal lands by military and Veteran status, and disaggregated by the above identities, to better understand who is currently utilizing national parks and other Federal lands.

In addition to demographic questions regarding race and/ or ethnicity, gender identity (including transgender, nonbinary, and other gender diverse individuals), and sexual orientation of Federal recreational public lands visitors, the following questions to Visitor Surveys conducted by Federal public land managers should be added (including the DOI, USDA (Forest Service's National Visitor Use Monitoring (NVUM)) and USACE):

- "Are you now or have you ever served in the U.S. military?"
- "Are you a member of a Gold Star family?"

1. Develop Communities of Practice on Veterans Outdoor Recreation for Federal Public Land Agencies

Federal public land management agencies (DOI, USDA, DoD, and USACE) should develop communities of practice to introduce Veterans Outdoor Recreation Groups (VORGs) to existing partners at national, regional and local levels. Where strong partnerships exist, introducing VORGs provide an opportunity for national and or local engagement with partners already engaged in recreation access. Those partners

would have direct best practices and technical/logistical assistance that already exists without major changes in Federal agencies policy or procedures.

2. Improve Engagement with Veterans through Special Use Permit Programs

Federal public lands management agencies will explore ways to better engage with Veteran organizations through the recreation special use permit programs (outfitter/guide, recreation events, etc.) by working with active-duty service members and Veterans. Partnerships with Military and Family Welfare programs that provide outdoor recreation experiences could be developed to accomplish this recommendation. Some of these programs are operated by DoD civilian employees, but often face unique permitting issues. A focus on Service members could lead to an increase in Veteran participation once they leave the military. It could also focus on increasing awareness (direct engagement) with VORGs on the permit process, steps, policy, etc.

3. Develop a Resource Guide to Facilitate VA Partnerships

Develop a guide regarding the process to establish a formal agreement between VA and managers of public land agencies, and partner organizations, regarding the use of public lands and other outdoor spaces for facilitating health and wellness for Veterans pursuant to COMPACT Act § 203 duty A.

A sample guide is the Prescribing Vitamin N from USDA. The purpose of the guide is to clearly define policies and processes to establish formal agreements in order to build and maintain partnerships between VA, managers of public land, and partner organizations, to increase Veteran engagement with public lands for (1) physical, emotional, and spiritual health and (2) to amplify the impact of accessibility initiatives and continually improve accessibility measures.

Guides may include:

- VA POCs/departments to contact to initiate request for formal agreement
- Link to VA outdoor recreation website, when developed
- Formal agreement templates when available
- List of information needed to submit a request for formal agreement

C. Develop Training for VA Providers and Park Staff

Develop training for VA clinical providers and non-clinical federal public lands staff on knowledge and skills to best promote outdoor and nature-based experiences for Veterans. Considerations during development may include:

- Consultation with relevant clinical subject matter experts in outdoor recreation and nature-based experiences for overall health and wellness to develop an up-to-date curriculum.

- Consultation with relevant non-clinical subject matter experts in outdoor recreation and nature-based experiences for overall health and wellness, such as VSOs and appropriate VORGs.
- Provide continuing education (CE) accreditation options for clinical staff and clinical trainees.
- Make the training available internally for VA staff (in VA Employee Education System/Talent Management System) and externally for non-VA clinicians (VHA TRAIN, YouTube.)

The following topics could be included in the training:

- Benefits of nature-based experiences
- Process of prescribing nature-based experiences (for clinicians, e.g., Nature Rx and Parkers)
- Sensitivity training regarding mobility disabilities
- Sensitivity training regarding mental health diagnoses
- Unique needs of Veterans in context of outdoor environment
- Best practices for inclusive outdoor experience
- Best practices for accessible outdoor experiences

D. Conduct Outdoors Outreach for Active Duty as They Separate From Service on Outdoor Recreation Information

As an active-duty Service member separates from military service, include in their separation packet information regarding the Blue Star/America the Beautiful (BS/At) lifetime pass and literature about the different kinds of public lands and waters, and recreation opportunities available at those sites. Also links to resources like Forest Service and Park Service apps, and possibly info about Veteran recreation programs and opportunities in their region.

E. Develop a Comprehensive Outdoor Recreation Research Agenda

VA should integrate outdoor recreation into its existing and future research agendas, or alternatively, establish a dedicated comprehensive agenda. This agenda should aim to address current gaps in research concerning Veterans' access to outdoor recreation spaces, the utilization of public lands, the effects of nature on service members and Veterans, and the specific demographics and conditions most likely to benefit from outdoor recreation therapies.

The research agenda must prioritize equity and inclusion, adopting an intersectional approach across all aspects mentioned. This entails incorporating disaggregated

data and information based on race and ethnicity, gender, sexual orientation, and disability status. By doing so, VA can ensure a more nuanced understanding of the diverse needs and experiences within the Veteran community, leading to more targeted and effective outdoor recreation programs and interventions.

F. Build Evidence of Health Impact of Outdoor Recreation

Design and implement randomized controlled trials that evaluate the health benefits of nature-based programming and health care provider referrals to assess the biometric and mental health benefits of Veteran engagement in all public lands and waterways.

This requires collaboration between VA and other key partners such as Cooperative Ecosystems Study Units, Health and Nature Network, ParkRx America and the Trust for Public Lands, and universities conducting graduate and doctoral research on therapeutic use of the outdoors, for example.

G. Expand Climate Corps and Fire Corps

Expand Climate Corps and Fire Corps work opportunities for Veterans with nonprofit partners and Federal land management agencies.

H. Expand VA GI Bill

Provide and expand the authorized use of Post-9/11 GI Bill funds to eligible Veterans to cover costs of relocation, childcare, and/or living expenses, so they can afford to be in training programs, internships or other related positions in Federal agencies that manage public lands.

I. Increase Veteran Hiring in Federal Public Land Agencies through Partnerships for Services

USDA Forest Service will formally partner with well-known trusted non-government organizations (NGOs) to develop a crosswalk of military service experience to outdoor land management skills for resume development, job description, and employment opportunities. These particular services should be provided in areas where Veterans are likely to be gathered and interested, such as the Veteran Outreach Into the Community to Expand Social Support (VOICES) program. USDA will work with land management agencies that ensure:

- Hiring staff who are well versed in Veteran Hiring Authorities and HR processes are aligned to take full advantage of those direct hiring authorities expeditiously.
- Partnerships are with recognized NGOs who bring Veterans on as part of an established workforce development strategy.
- Veteran recruitment and hiring are a priority and funded "off the top." Formally partner with the Forest Service (or other land management agency) and NGOs to have VA provided wrap-around services (housing, mentoring, training and certification, transportation, etc.) for outdoor recreation and associated natural

resource internships, apprenticeships, and entry-level employment, toward transitioning honorably discharged Veterans into civilian outdoor-related career fields.

J. Expand entitlements under CFR Chapter IX

Expand 20 CFR Chapter IX – CHAPTER IX—OFFICE OF THE ASSISTANT SECRETARY FOR VETERANS' EMPLOYMENT AND TRAINING SERVICE, DEPARTMENT OF LABOR to include entitlements for Veterans seeking training, jobs, and certifications for employment in outdoor recreation. Department of Labor will work with VSOs and private sector entities in the outdoor education space in providing guidelines, requirements, and processes for accessing entitlements.

RECOMMENDATIONS THAT ADDRESS DUTY B:

TO FACILITATE USE AND ACCESS TO PUBLIC LANDS BY ADDRESSING BARRIERS

K. Grants: Title 38 Expansion

Expand Title 38 Chapter 1 of the Code of Federal Regulations to include "Part 80: The Outdoor Recreation Grant Program for U.S. Service Members, Veterans, and families" for Congressionally directed grant funding. The Purpose and Scope shall be a grant for Outdoor Recreation Programs, under which VA may provide federal financial assistance to eligible non-federal government entities with outdoor recreation expertise to (a) plan, develop, manage, and implement programs to provide outdoor recreation, and nature-based experiences, both as adjuncts to health care modalities and treatment protocols for therapeutic purposes, as well as for the use of stand-alone programming for overall health and wellness, and (b) conduct and/or make publicly available comprehensive assessment of trails on federal land for accessibility including (1) minimum trail width (2) average and maximum slope (3) average and maximum cross/side slope (4) surface type (5) trail length.

In conjunction with VA, law makers will consult and engage Veteran Service Organizations in the drafting of Title 38 Chapter 1 "Part 80." VA will work with federal public land management agencies such as Department of the Interior, Bureau of Land Management to streamline the permitting/access requirements for grant recipients who provide programming for veterans, such as Nature Rx and Park Rx. VA should ensure grants are prioritized for minority, women, underrepresented and other marginalized veteran groups. These grants should support programs that are not only culturally relevant but also responsive to the unique needs of diverse veteran populations. A key aspect of this recommendation includes collection and reporting of participant demographics ensuring transparency and accountability in reaching a wide

array of veterans. Additionally, an equity strategy should be an integral part of these programs and grants, emphasizing organizational commitment to principles of inclusion, access, and equity. Grant proposals should be prioritized based on their commitment to enhancing accessibility, particularly those that provide transportation assistance and offer programs at no cost to the veteran. By prioritizing these aspects, the grants contribute to eliminating potential barriers related to transportation challenges and financial constraints.

L. Conduct Veteran Outreach Events

(a) Federal public lands management agencies will hold at least two key annual events to issue Military Annual & Gold Star/Veteran Lifetime Military Passes, on days such as Memorial Day and Veterans Day, including offering overtime pay to staff to work the holiday.

(b) Federal public lands management agencies will develop internal system to track outreach efforts on passes.

i. Disparate efforts occur in the field; however, without a reporting mechanism, those efforts cannot be reported upward.

ii. This could be a new requirement in the annual information collection, to include development of a simple reporting mechanism or add to a Forest Service database such as Naturewatch, Interpretation, and Conservation Education (NICE).

(c) Modify point of sale system to allow for bulk issuance of passes and reduce administrative burden.

(d) Amend current Federal Bureau policies to explicitly allow for handling of accountable property (passes) by atypical employees (recreation technicians versus designated collection officers) in atypical environments (in the field versus an office).

M. Expand Military and Veteran Pass Eligibility to include US Uniformed Services

Expand the eligibility for the America the Beautiful Interagency Military pass, to include the Uniformed Services adding the Commissioned Corps of Public Health Service (PHS) and National Oceanic Atmospheric Administration (NOAA), in addition to those in active duty of the US Armed Forces. Similarly expand Veteran inclusion to include both Veterans of the US Armed Forces and individuals who have served in the US Uniformed Services, increasing eligibility for the Veteran lifetime interagency pass to PHS and Commissioned Corps NOAA Veterans. (38 U.S.C. § 101(2))

N. Expand Federal Pass Distribution

Increase access to the America the Beautiful lifetime passes by meeting Veterans where they are through joint VA/Federal land manager events at VHA facilities where the lifetime passes can be distributed by appropriate federal lands staff (DOI, USDA, ACoE) to offer an alternative to online requests or at a federal recreation site. Establish a pilot program at least one VHA facility per VISN to hold one of these joint events annually. The VHA facility will identify and designate a responsible office and official,

such as the service chief within the Center for Development and Civic Engagement, to execute this recommendation.

O. Promote Access to Federal Public Lands Through a Wellness Challenge for Veterans

The National Park Service will establish a Veterans Wellness Challenge modeled from the NPS Office of Public Health, Healthy Parks, Healthy People Wellness Challenge piloted in seven national parks in Missouri. This program provides easily accessible, self-led, appropriate opportunities for Veterans to engage in park-based health promoting activities across three categories: (1) physical wellness; (2) mental wellness; and (3) learning wellness. The challenge motivates continued participation by recognizing their accomplishments through electronic badges and passport stamps.

P. Conduct an Environmental Scan of VA Outdoor and Nature-Based Recreation Opportunities

Conduct a thorough environmental program scan (including but not limited to: Recreation and Creative Arts Therapy, Whole Health, Mental Health, Physical Medicine & Rehabilitation, Voluntary Service, Social Work) to identify existing outdoor recreation programs at each VA facility. This query should capture whether the offering is internal or external, include program type and cost to the participant.

Q. Create a VA Centralized Database & Communication Strategy of Outdoor Recreation Opportunities

Create a centralized database and determine a comprehensive communications strategy to enable Veterans to identify outdoor recreation programs available through each facility, using the data gathered from the environmental scan conducted by VA.

R. Promote Early Engagement in Outdoor Recreation through Integration of Outdoor Experiences in Military

To promote early engagement of Veterans in outdoor recreation programs and benefits, the Department of Defense and U.S. Coast Guard (DoD/CG) should integrate information on available programs and benefits for Veterans and their families into the transition process. This would raise awareness and encourage Veterans to leverage these opportunities from the outset of their lifespan as a Veteran. DoD/CG should collaborate with DOI to make information about benefits and resources, as well as applications for Parks Passes, available during Transition Assistance Program (TAP) classes and resource fairs.

CONCLUSION

The interagency Task Force on Outdoor Recreation for Veterans has completed its second year of intensive review and evaluation of relevant scientific data, VA field-based sample programs, Federal and VSO Veteran-specific programming, and consultative information from Veterans Outdoor Recreation Groups (VORGs), resulting in 26 recommendations. Of these 26 recommendations, Federal and VSO Task Force members collaboratively identified 5 key recommendations as critical force multipliers for Veteran engagement in outdoor recreation on public lands and waters. These 26 recommendations address preliminary findings contained in the Task Force's first CMR. Implementation of these recommendations will address current barriers and formalize coordination between VA and public land agencies, toward facilitating use of and access to public lands for the benefit of Veterans' overall health and wellness.

The Task Force thanks Congress for this directed opportunity to engage across Federal agencies, in collaboration with VSOs and consultation with appropriate VORGs. There is consensus among Task Force members that the recommendations will better serve Veterans through supported nature-based experiences to improve physical and mental health and overall well-being. The Task Force will remain intact for a third year to implement no-cost recommendations and would be happy to support Congress in technical review of any legislative actions to be proposed, based on the findings within this report.

ABBREVIATIONS AND ACRONYMS

DoD	U.S. Department of Defense
DOI	U.S. Department of the Interior
FICOR	Federal Interagency Council on Outdoor Recreation
HHS	U.S. Department of Health and Human Services
MWR	Military Morale, Welfare, and Recreation
NOAA	National Oceanic and Atmospheric Administration
NPS	National Park Service
PVA	Paralyzed Veterans of America
RPF	Report of Preliminary Findings
TAP	Transition Assistance Programs
Task Force	Interagency Task Force on Outdoor Recreation for Veterans
USACE	U.S. Army Corp of Engineers

USDA	U.S. Department of Agriculture
USDOI	U.S. Department of the Interior
VA	U.S. Department of Veteran Affairs
VHA	Veterans Health Administration
VORG	Veteran Outdoor Recreation Groups
VSO	Veteran Service Organization

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Statements for the Record

Statement for the Record
Submitted by Representative Sheri Biggs, U.S. House of Representatives
Lieutenant Colonel, United States Air National Guard
Board-Certified Family and Psychiatric Mental Health Nurse Practitioner
Former Administrator, State-Run Veterans Nursing Home

Before the United States Senate Committee on Veterans' Affairs
Hearing:
"Bridging the Gap: Enhancing Outreach to Support Veterans' Mental Health"
April 29, 2025

Chairman Moran, Ranking Member Blumenthal, and Distinguished Members of the Committee: It is an honor to submit this Statement for the Record. My name is Representative Sheri Biggs. I bring three decades of experience in clinical and administrative roles serving veterans and other vulnerable populations. My professional background includes work as a dual board-certified nurse practitioner in family and psychiatric mental health, a Air National Guard Lieutenant Colonel, and a former administrator and consultant of state-run veterans' homes. These experiences have shaped my understanding of the structural, clinical, and ethical demands required to care for aging and at-risk veterans. In both my clinical and community roles, I have personally worked with many veterans grappling with suicidal ideation and untreated mental health conditions. Tragically, in my district alone, eight veterans have died by suicide this year.

Community-Based Suicide Prevention and the SSG Fox Grant

Veteran suicide remains a national emergency. The most recent VA National Suicide Prevention Annual Report showed that an average of 17.6 veterans died by suicide each day in 2022. Veterans account for just 6% of the U.S. population, yet comprise over 13% of annual suicides (VA, 2024). These data reflect a persistent gap in proactive outreach, continuity of care, and upstream prevention.

The Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program (SSG Fox SPGP) has emerged as a key tool in closing that gap. Since its inception, the program has awarded over $157 million in funding to 95 organizations serving veterans in 43 states and territories. Early results are encouraging: more than one-third of participants were new to VA care, and three-quarters who completed the program reported improved mental health, stability, and quality of life (O'Toole, 2025).

There are active Fox Grant recipients in my own district in South Carolina, and I have witnessed firsthand the positive impact these programs have made in reducing isolation, promoting connection, and stabilizing the lives of at-risk veterans.

Community Connection as Clinical Infrastructure

I am not only a legislator who represents veterans; I am also a veteran and someone who continues to walk beside those navigating recovery and reintegration. In Anderson, South Carolina, I serve as a volunteer and member of a local group called Vets Helping Vets. There, I have sat in rooms with fellow veterans working through PTSD, family challenges, and the daily weight of transition. I have seen the quiet strength these peer-led spaces provide—and the early warning signs they help surface. These are not formal clinics, but they are frontline mental health infrastructure.

The power of these connections is reinforced by national findings. America's Warrior Partnership reported that 94% of veterans identified as suicidal through their programming initially sought help for non-mental health concerns, such as housing instability, financial stress, or strained relationships (Lorraine, 2025). This reflects what I have seen firsthand: veterans rarely lead with mental health as their presenting issue, but their broader needs often signal deeper risk.

According to the D'Aniello Institute for Veterans and Military Families, nearly one-third of veterans served by their community-based partners were not enrolled in VA health care at all, and many were unaware of available support systems (Cantor, 2025). These figures align with what I see locally—there remains a large, silent population of veterans who are disconnected from care but deeply in need of it.

What these networks provide is not just connection, but early intervention. They are often the first to recognize a change in mood, a missed appointment, or a quiet withdrawal. Their effectiveness is not anecdotal; it is measurable and backed by lived experience. And their reach into underserved communities—including rural veterans—is what makes them indispensable.

If we are serious about saving lives, these grassroots programs must be seen not as complements to the system, but as essential infrastructure. Oversight must ensure they are supported, integrated, and empowered to function in full coordination with the VA and other care systems.

Closing Gaps Between Systems

The oversight challenge is not just to track dollars or measure participation. It is to ensure that at every stage—outreach, referral, engagement, and follow-up—systems are built for coordination. Providers need timely access to suicide risk flags and discharge plans. Community partners must be treated as full participants in the care continuum, not peripheral actors.

My experience as a former administrator of a State Veterans Home underscores this. Many facilities operate with limited behavioral health integration and without clear

pathways for sharing critical risk information. Veterans in long-term care often face compounding conditions—cognitive decline, trauma, and isolation—that magnify their vulnerability. We cannot afford silos.

Behavioral Health and Oversight in State Veterans Homes

Drawing from my career administering a State Veterans Home, I bring a unique and grounded perspective on the critical role mental health care must play in these facilities. Veterans in SVHs face disproportionate mental health burdens, including high rates of depression, PTSD, dementia, and substance use. According to the VA Office of Inspector General, nearly half of veterans in long-term care carry at least one mental health diagnosis (VA OIG, 2024). Yet GAO found that over 40% of these facilities received repeat citations for failures in areas like suicide risk screening, highlighting systemic oversight failures (GAO-25-108441).

This oversight gap is compounded by lack of integration. Many SVHs operate without access to VA health records, behavioral risk flags, or adequate psychiatric support. Data from Louisiana showed that 58% of residents had multiple psychiatric diagnoses, but 72% of applicants with behavioral health needs were denied admission due to lack of resources (LDVA, 2025). These facilities are often the last line of care for aging veterans, and when behavioral health infrastructure is missing, lives are put at risk.

The 2021 RAND and University of Michigan study showed that veterans relying solely on private-sector care faced significantly higher suicide risk than those served through the VA (Smith et al., 2021). This underscores the urgent need to treat SVHs as a formal extension of the VA mental health system—integrated, accountable, and equipped for proactive care.

My work and writing in the veteran mental health space have emphasized that post-traumatic stress is not only an individual condition—it is a family condition. In my recent article, *"No Greater Love: PTSD's Impact on Spouse, Family of Veteran,"* I outlined how trauma from combat deployment reverberates through the veteran's home life. PTSD has been shown to directly contribute to relationship dysfunction, communication breakdowns, and mental strain on spouses and caregivers. Once it enters a household, only 3 in 10 military marriages survive long-term. These family dynamics follow our veterans into long-term care, where social withdrawal, unresolved trauma, and deteriorating family ties make treatment and recovery even more complex. If our system continues to isolate mental health treatment from the broader social environment veterans live in, we will continue to miss key risk indicators and opportunities for support (Biggs, 2023).

Conclusion

Veterans deserve a mental health system built not just on access, but on outcomes. That means respecting the knowledge of community-based providers, resourcing them equitably, and insisting on systems that share information and responsibility. It also means recognizing that effective care often begins with practical support—housing, transportation, social connection—and that prevention is not limited to clinical settings.

The testimony in this hearing affirms what many of us have long known: the solutions exist. What is needed is the sustained oversight, integration, and investment to ensure those solutions reach every veteran, in every community.

Thank you for your commitment to this mission.

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Statement for the Record of
Katherine B. McGuire, MSc
Chief Advocacy Officer
American Psychological Association Services, Inc.
to the
United States Senate
Committee On Veterans' Affairs

Re: "Bridging the Gap: Enhancing Outreach to Support Veterans' Mental Health"

April 29, 2025

Chairman Moran, Ranking Member Blumenthal, and Distinguished Members of the Committee:

American Psychological Association Services, Inc. (APASI) submits the following statement for the record in advance of the Senate Veterans Affairs Committee hearing regarding *Bridging the Gap: Enhancing Outreach to Support Veterans' Mental Health*. We appreciate the Committee's willingness to examine challenges surrounding the critical delivery of mental health care for our nation's veterans. Demand for VA mental health care has increased steadily over the past twenty years and continues to outpace other care within the VA. Meeting this demand while maintaining the VA's high level of clinical excellence is a priority.

American Psychological Association and its companion organization APA Services, Inc. (APA/APASI) serve as the nation's largest scientific and professional nonprofit organization representing the discipline and profession of psychology, as well as over 173,000 members and affiliates who are clinicians, researchers, educators, consultants, and students in psychological science. Psychologists and the profession have a rich history within the VA, serving veterans since World War II. As such, today we would like to address three issues important to the delivery of quality mental health care: 1.) ensuring demonstrated effectiveness for Fox Grant Program Reauthorization; 2.) protecting veteran privacy and confidentiality; and 3.) providing adequate mental health provider training and staffing.

Ensuring Demonstrated Effectiveness for Fox Grant Program Reauthorization

APASI applauds VA Secretary Collins for making veteran suicide prevention a top priority. Over many years, the VA has made tremendous strides in universal suicide prevention risk assessments and required trainings for providers of care, including but

not limited to training in suicide prevention, lethal means safety, military culture, and military sexual trauma. The demand for mental health care is growing across our entire nation's health care system, which also highlights the unique role and mission within the VA to train much of our nation's healthcare workforce. Whether in the VA, the VA Community Care Program (VCCP), or in the community at large, veterans deserve the best screening, trained professionals, and evidence-based treatments available, and our psychologists stand ready to serve them.

APASI understands that veteran suicide prevention requires a commitment from all of us and that the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program is an important part of this "all in" effort. As Congress looks to reauthorize this meaningful program, we must first review comprehensive outcome data collected to better understand participating community programs' effectiveness at reducing veteran suicide risk. The original bill rightfully called for the development of measurement tools to track both risk and effectiveness and to ensure the programs positively impact veterans' lives. The establishment of baseline mental health screening for outcome metrics in the law should be celebrated and the resulting data can be used to ensure that Fox grants to those successful participating organizations continue for years to come.

Increased investments in veteran suicide prevention have been impactful, but one veteran suicide *is* one too many. Continued VA investment is needed in mental health staffing, training, care coordination, and best practices. The VA has long provided veterans with a gold standard of care in mental health treatment. Whether leading the way in post-traumatic stress disorder (PTSD) or requiring access to evidence-based psychotherapy, the VA maintains a high bar[1] and consistently outperforms non-VA care in both quality of care and trust among veterans[2]. So having the VA analyze outcome data for the purposes of guiding renewed funding is not only warranted but ensures veteran safety and best practice while also protecting taxpayer investment.

There are several bills to renew the Fox Grant Program, whereby 80 grantees receive up to $750,000 annually. APASI has concerns that certain bill language currently being considered turns a blind eye to outcome measurement and demonstrated effectiveness. Given that the original law includes a Congressionally mandated MITRE Corporation 18-month evaluation, it stands to reason that Congress should release that report, confer with experts, and rely on its analysis for program improvement and reauthorization.

APASI calls on Congress to strengthen, not weaken, one of the original intents of the Fox Grant program, which is to utilize the pre and post data of veterans and their families to access effectiveness and future funding. The Hope for Heroes Act (S. 1139), for example, allows previously funded entities to be reauthorized for renewal "based on the number of individuals who go through the intake process to receive suicide prevention services from the grantee." Such limited criteria fail to measure a grantee's

[1] https://www.mentalhealth.va.gov/providers/sud/docs/uniformserviceshandbook1160-01.pdf
[2] https://news.va.gov/press-room/va-outperform-non-va-facilities-cms-ratings/
https://www.va.gov/initiatives/veteran-trust-in-va/

effectiveness. Screening for acute suicide risk and the collection of pre/post measurements of suicide risk factors not only invests in the evaluation of best care for our veterans but also protects those participating in these programs.

The Interim Report on the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program covering the first year of operation revealed that, of the 80 grant program recipients, 55 failed to report any post-service outcome measurements for participants. Twenty-seven percent of eligible participants did not complete even one instrument upon entering their program. The program must do better if data-driven policy decisions are to be made.

Another provision of S. 1139 changes existing wait time access standards for VA non-emergency mental health care for Fox Grantee veterans from the current 20-day standard to three days. This change is burdensome and unnecessary, as under the COMPACT Act, intervention for high suicide risk is already required to be immediate. The June 2024 Fox Grant Interim Report indicated there were thousands of "non-emergency mental health referrals" to the VA in the first year of the program. Given growing mental health care demands both within and outside of the VA, the best way to improve non-emergency care wait times is to invest in a healthcare workforce that can meet demands.

APASI believes that Fox Grant program reauthorization needs to focus on serving more veterans *and* ensuring demonstrated outcomes. This can only be done by staying the course and continuing to strengthen outcome measurement requirements. The Fox Grant program can and should be a critical part of the VA's approach to suicide prevention, but it is up to all of us to expect rigorous evaluation and proven benefit to veterans and their families.

Protecting Veteran Privacy and Confidentiality

A recent issue of significant concern for APASI is ensuring veteran privacy and confidentiality when delivering mental health care within the VA. The recent policy change requiring most federal employees to return to the office, including VA psychologists and other mental health care providers, is significantly impacting the delivery of confidential mental and behavioral health services. Many VA facilities lack sufficient private spaces to accommodate the influx of mental health providers who previously worked remotely. This has resulted in providers being asked to conduct sensitive therapy sessions in open office environments, cubicles, or shared spaces that fail to meet basic HIPAA confidentiality and privacy requirements for the delivery of mental health care services.

The VA has long used telehealth to reach isolated, disabled and rural veterans in need of mental health services and it further expanded access to telehealth services between 2020-2024 which allowed more mental health care providers to deliver care from private home offices. This allowed VA to expand its workforce to meet a growing demand. A side effect of the current return-to-office mandate is compromising access to care and

confidentiality standards that are key to effective mental health treatment. This needs to be addressed as plans are put into effect. Without ensuring adequate space to absorb the return of mental health providers, those providers could be facing difficult choices between violating ethical standards regarding patient confidentiality or facing disciplinary action for non-compliance with return-to-office mandates.

APASI has serious concerns regarding the timing and implementation of return-to-office mandates and other policies that may affect mental health providers' provision of services without adequate consideration of confidentiality and privacy. **We encourage the Committee to consider waivers for all mental health providers that would return to a shared space and phase in implementation, crucially taking veteran privacy and access to care into account.** Our concerns currently center on several key issues:

- Ethical and practice standards: Both the APA Ethics Code and VA professional standards require that psychotherapy be conducted in private settings that protect patient confidentiality. In many facilities, the current implementation of return-to-office orders without adequate office space availability appears inconsistent with these requirements.
- Patient confidentiality and trust: A strong therapeutic relationship depends on confidentiality. Veterans dealing with sensitive mental health issues require assurance that their disclosures remain confidential. Conducting therapy in shared spaces fundamentally compromises this trust.
- HIPAA compliance risks: Arrangements in some facilities may violate HIPAA privacy and security requirements if patient information can be overheard in shared spaces. This not only presents individual providers with legal liability and ethics concerns but would also constitute a HIPAA violation by the Veterans Health Administration itself.
- Veteran care impact: These challenges threaten to disrupt ongoing care relationships and may deter veterans from seeking or continuing needed mental health treatment in their preferred setting.
- Workforce retention concerns: Reports indicate that some mental health professionals are considering resignation rather than practicing under conditions they view as unethical and below an acceptable standard of care. This could worsen existing staff shortages in VA mental health services.

Many veterans experience trauma and sensitive mental health conditions. APASI supports long-standing policies that ensure the protection of patient confidentiality and privacy, including adequate physical space within VA facilities to provide private mental health services that prioritize patient needs.

Providing Adequate Mental Health Provider Training and Staffing

Finally, APASI continues to be concerned about adequate staffing to serve veterans of today and tomorrow. Psychology is again the number one clinical workforce shortage

area within the VA, with 85 of 139 facilities reporting psychology shortages[3]. With well over 400,000 new PACT Act Veterans Health Administration (VHA) enrollees, and 754,000 new enrollees overall since August 2022, continued investment into the VA mental health workforce is more important than ever.

The VA provides healthcare training, residencies, and fellowships to more than 120,000 trainees each year in over forty disciplines. Even today, 65 percent of all U.S. psychologists and 70 percent of physicians receive training in the VA. As Congress faces current Administration plans to reduce the size and scope of the VA, we ask that it not lose focus on one of VA's foundational missions dating back nearly 80 years - "To educate for VA and the Nation". Our nation's veterans and every American depends on this critical health care workforce pipeline.

Thank you again for your focus on mental health and the VA policies necessary for quality delivery of care. APASI stands ready to work with the Committee to ensure the best care for veterans.

For more information, contact K. Conwell Smith, APA Deputy Chief for Military and Veteran Policy at csmith@apa.org or (301) 875-8923.

[3] https://www.vaoig.gov/sites/default/files/reports/2024-08/vaoig-24-00803-222.pdf

SERVING
WITH
PRIDE

AMVETS

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April 25, 2025

Chairman Jerry Moran
United States Senate
412 Russell Senate Office Building
Washington, DC 20510

Ranking Member Richard Blumenthal
United States Senate
825A Hart Senate Office Building
Washington, DC 20510

Dear Chairman Moran and Ranking Member Blumenthal:

On behalf of AMVETS, our nation's most inclusive Congressionally-chartered veterans service organization, we write to express our strong support for the reauthorization and expansion of the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program.

Veteran suicide remains a national crisis, and the Fox Grant Program stands out as a model for how the VA can collaborate with community-based organizations to deliver meaningful, lifesaving care. By empowering local partners to provide innovative and effective services—including non-clinical, peer-led programs—the grant program meets veterans where they are and ensures no one falls through the cracks.

We applaud the bipartisan efforts to build on this success through the HOPE for Heroes Act, which would extend the program for five years, increase grant caps, and improve regional coordination and outreach. We also support key provisions in the BRAVE Act and S.1361, recognizing the need to expand care to underserved veterans nationwide.

Additionally, AMVETS encourages Congress to strengthen the grant program by expanding eligibility criteria so that no veteran in crisis is turned away. We also support giving high-performing grantees the ability to replicate their programs in multiple locations, helping to scale effective solutions to meet growing demand.

AMVETS is committed to advancing policies that reduce veteran suicide and improve access to timely, effective care. We urge the Committee to reauthorize and enhance the Fox Grant Program to ensure it reaches more veterans and continues to evolve with the needs of the community.

Thank you for your continued leadership and commitment to the well-being of our nation's veterans.

Sincerely,

JOSEPH R. CHENELLY
Executive Director

Testimony of Brooke Blaalid
Associate Director of Policy
before the
Senate Committee on Veterans Affairs
hearing on
Bridging the Gap: Enhancing Outreach to Support Veterans' Mental Health
April 29, 2025

Chairman Moran and Ranking Member Blumenthal, and distinguished Members of the Committee, thank you for the opportunity to provide testimony on "Bridging the Gap: Enhancing Outreach to Support Veterans' Mental Health."

Blue Star Families is the nation's largest military and veteran family support organization, with nearly 380,000 members in our network and impacting more than 1.5 million military family members every year. By cultivating innovative programs and partnerships, Blue Star Families seeks to ensure that our military and veteran families always feel connected, supported, and empowered to thrive, wherever their service takes them, in order to ensure military readiness, retention, and recruiting.

Blue Star Families' research calls attention to the unique experiences and challenges faced by military and veteran families. Our annual Military Family Lifestyle Survey (MFLS) — developed in partnership with Syracuse University's D'Aniello Institute for Veterans and Military Families (IVMF) and fielded since 2009 — is the largest annual comprehensive survey of military and veteran families, and is widely regarded as the gold standard among military family surveys. Data from the MFLS and other research by Blue Star Families has been used at every level of government to help inform those tasked with making policy decisions that impact our military-connected communities.

Blue Star Families maintains a nationwide footprint through 13 strategically located chapters, offering both virtual and in-person support to active-duty, Guard, Reserve, and veteran families. These chapters serve as trusted local hubs — delivering innovative programs, hosting community events, and providing essential services that foster connection and belonging. By building bridges between military families and their civilian neighbors, institutions, and local organizations, we work to ensure that those who serve

and their families are fully integrated into the communities where they live.

This past year marked a significant milestone in our efforts to enhance the well-being of veteran and military families. Craig Newmark, Founder of Craigslist, demonstrated extraordinary leadership and commitment by pledging $100 million to address urgent issues such as mental health and suicide prevention, housing and homelessness, and food insecurity. Blue Star Families is deeply honored to be among the beneficiaries of Mr. Newmark's generosity, which includes a direct investment in the establishment of three to five new chapters and 25 **Blue Star Families Outposts**.

These new outposts will build upon our existing chapter infrastructure and expand our reach into additional communities. Through partnerships with local organizations, we will bring programs, services, and trusted resources even closer to where veterans and military families live. This expansion represents the power of public-private collaboration to strengthen communities, improve mental health outcomes, and create a more connected and resilient support network for those who serve.

At Blue Star Families, we recognize that behind every data point lies a deeply personal story. It is an honor to bring both evidence and lived experience to this discussion as we examine veteran suicide prevention and highlight the impact of our community-based initiative, *Blue Star Support Circles | Upstream Solutions to Crisis.* Our work is grounded in both rigorous data and the real-world voices of those affected — and we believe both are essential to informing effective policy solutions.

Suicide Prevention

Preventing veteran suicide is a national imperative and a moral obligation we owe to those who have courageously served our country. The persistently high rate of suicide among veterans is not merely a data point — it is a sobering indication of the significant and often invisible challenges many face as they transition to civilian life. According to the Department of Veterans Affairs, suicide is the second-leading cause of death among veterans under the age of 45 years old,[1] who are "1.5 times more likely to die by suicide than their nonveteran" peers.[2] Additionally, findings from the 2024 MFLS revealed that

[1] Office of Suicide Prevention. (2024). *2024 National Veteran suicide prevention annual report*. US Department of Veterans Affairs. https://www.mentalhealth.va.gov/docs/data-sheets/2024/2024-Annual-Report-Part-2-of-2_508.pdf
[2] DeAngelis,T. (2022). Veterans are at higher risk for suicide. Psychologists are helping them tackle their unique struggles. *American Psychological Association. 53* (8), 56. https://www.apa.org/monitor/2022/11/preventing-Veteran-suicide

10% of veteran respondents reported having seriously considered suicide.[3] These figures underscore the urgent need for sustained, coordinated action to address the complex factors contributing to veteran suicide and to ensure that every veteran has access to timely, effective, and compassionate support.

Despite ongoing efforts to expand access to mental health care, veteran families continue to face significant barriers when seeking support during times of heightened stress and transition. The demand for mental health services is both clear and urgent, and it is essential that we strengthen the capacity of service providers within veteran communities to meet this need.

Equally important is the need to address the stigma that continues to surround mental health in military and veteran populations. Normalizing conversations about mental health, promoting help-seeking behaviors, and increasing awareness of available resources are critical steps toward reducing the reluctance some Veterans and their families may feel in pursuing care.

In recognition of the persistent access challenges, and the common reliance on informal support networks, we must also empower less formal sources of support — such as wellness centers, friends, and family members — to serve as vital extensions of the mental health care ecosystem. While these supports are not substitutes for professional mental health services, they can play a meaningful role in early identification and intervention when equipped with appropriate psychoeducation. Training these trusted individuals to recognize signs and symptoms of mental health challenges and engage in supportive dialogue can significantly enhance our collective response to the mental health needs of veterans and their families.

In 2022, Blue Star Families was awarded the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program established within the *Commander John Scott Hannon Veterans Mental Health Care Improvement Act*. Chairman Moran, we thank you for your leadership in developing this legislation and for working to enact this landmark law. You truly honored veterans' commitment, and prioritized and invested in comprehensive veteran suicide prevention measures. Through the SSG Fox Suicide Prevention Grant Program, Blue Star Families operates an innovative, community-based suicide prevention program — *Blue Star Support Circles | Upstream Solutions to Crisis*. Of the 100 grants awarded by the VA under this call in 2022, the *Blue Star Support Circles | Upstream Solutions to Crisis* program was the only one selected that focused on families of veterans as the primary intervention target; the rest proposed to provide direct services to veterans.

[3] Blue Star Families (2025). 2024 Military family lifestyle survey comprehensive report. [Unpublished data].

This initiative is designed to empower Veterans' loved ones with the tools, knowledge, and confidence to recognize early warning signs and intervene before a veteran's mental health challenges escalate into crisis.

While not a substitute for clinical care, this non-clinical, peer-centered model acknowledges the critical role that family members and close friends play in a veteran's support system. By equipping them to respond proactively, we address growing mental health concerns earlier — well before they reach a point of crisis.

The program provides facilitated, closed-group virtual cohorts that meet over eight weeks. These sessions offer participants peer-based connection, evidence-informed training, and access to essential resources and referrals. With the support of expert partners of **PsychArmor, American Red Cross, Spiritune, Veterans Yoga Project, and Tragedy Assistance Program for Survivors (TAPS)**, participants receive world-class instruction in how to recognize signs of distress, engage in supportive communication, and take meaningful steps to ensure safety and connection.

In addition to education and peer support, participants receive tangible tools — such as lockboxes for lethal means safety — and work with facilitators to develop personalized crisis plans. These plans prepare supporters to respond effectively should their loved one exhibit signs of suicidal ideation. By supporting families and loved ones through this program, we are expanding the reach of our nation's suicide prevention strategy and building a stronger, more resilient support network for our veterans.

In the fall 2024, *Blue Star Support Circles* successfully completed its second year of the program reaching 120 participants across 18 cohorts in years 1 and 2 that were recruited from our national network and partnering organizations.[4] Sessions consisted of 60-minute educational lessons with 30 minutes of debriefing and discussion amongst the facilitator and participants.

A comprehensive mixed-method evaluation was conducted by a team of researchers from the University of Alabama (UA) which concluded that the first two years are going "very well."[5] Participants were very satisfied with the program and reported they would recommend this program to a friend or colleague (9.2 out of 10 with 10 being "most likely").[6]

The quality and impact of *Blue Star Support Circles* is reflected in the numerous statistically

[4] Hamner, K., Bui, C., & Rodgers-Farris, S. (2025). Blue star support circles: Year 1-2 summary evaluation report January 1, 2023 - December 31, 2024. University of Alabama Office of Evaluation Research and School Improvement. http://evaluation.ua.edu/
[5] Ibid.
[6] Ibid.

significant pre-post changes in key outcome variables. More specifically, over the first two years, results showed the following statistically significant improvements:[7]

- Improved confidence in talking about suicide and suicide prevention.
- Increased knowledge of proper language to talk about suicide and suicide prevention.
- Improved use of available resources.
- Taught participants skills to reduce means and risk factors, including getting each participant to create firearms safety plans.
- Increased a sense of community among participants.

These quantitative findings are supported by the overwhelmingly positive participant comments in both the open-ended survey questions and the qualitative participant interviews.

Additionally, it was statistically significant that participants were less likely to think that they didn't have enough knowledge to talk about suicide with others (p=.001), and know where to reach out for help if myself or someone I knew were experiencing a mental health or suicide related crisis (p=.001).[8]

Participant Quotes

> *"I looked forward to the sessions and being with a group of peers and discussing not only how to help ourselves but help other individuals."*

> *"Myself, being a veteran, trained that you can handle it all or do it all. I would never have put myself or said that I was stressed or emotionally needing help so that's why I took some of the training sessions and recognized some of the signs in myself and said 'whoa'. Learning that I needed more personal care time for myself was a big help."*

> *"Many years ago, the whole thing was suicide was one of those things that you skirted around it enough times till someone finally said 'im not gonna kill myself.' Because there was always that fear of if I mention it maybe that is what they are going to think of, but with this course it was one of those things that they came direct out and said, you know what sometimes the best thing to do it to look at them and say are you planning to kill yourself?"*

Evaluation findings clearly demonstrate that the *Blue Star Support Circles* program is driving a meaningful shift in participants' knowledge, confidence, and engagement in suicide prevention efforts. Through active participation, individuals report a significantly

[7] Ibid.
[8] Ibid.

increased understanding of the complexities surrounding suicide, as well as a heightened sense of their ability to make a tangible difference in supporting at-risk veterans.

Importantly, the program fosters a strong sense of agency, equipping participants with the tools and confidence to take proactive, informed action in moments of concern. This empowerment is essential to reducing stigma, normalizing conversations around mental health, and cultivating a culture of prevention within the broader veteran community.

Beyond the individual impact, the *Blue Star Support Circles* program is strengthening the social fabric around veterans by creating a safe, peer-based environment for families and supporters. Participants consistently report that the opportunity to connect with others navigating similar experiences provides not only emotional relief, but also a critical sense of belonging and shared purpose. In this way, the program serves not only as a prevention tool, but also as a powerful community-building initiative — one that helps families feel seen, supported, and prepared.

As part of our work under the SSG Fox Suicide Prevention Grant Program, Blue Star Families launched the *Combat the Silence* awareness campaign — an initiative designed to address the urgent need for upstream mental health support within military and veteran communities. This campaign aims to break down stigma, normalize help-seeking behavior, and connect individuals with trusted resources before a crisis emerges.

By fostering a culture in which open dialogue and early intervention are recognized as strengths, *Combat the Silence* empowers veterans and their families to speak up, support one another, and actively engage in preventive mental health care. The public service announcement (PSA) received a total of 5.6M impressions in 30 separate markets. This initiative plays a vital role in the broader ecosystem of suicide prevention by promoting connection, increasing awareness, and encouraging timely access to support.

Blue Star Families respectfully recommends the continued robust Congressional oversight of the SSG Fox Suicide Prevention Grant Program to ensure effective implementation, transparency, and accountability. This oversight should prioritize the identification and evaluation of high-impact, community-based interventions, with the goal of timely reauthorization and sustained funding for programs demonstrating measurable success in preventing suicide among veterans. We are especially grateful to you, Chairman Moran, and to Senators Warner and Boozman for your leadership and bipartisan efforts to reauthorize this critical program.

In addition to supporting VA-led efforts, we strongly recommend the authorization of a complementary program through the Department of Defense (DoD) designed specifically to support military families with personalized, community-based approaches to suicide prevention. For such programs to be fully effective, participating organizations must have

appropriate access to military facilities and personnel. This requires DoD engagement and command leadership buy-in, particularly to support training and integration efforts. With DoD partnership, these upstream interventions can reach service members and their families before crisis develops, significantly strengthening our collective approach to suicide prevention.

The data is clear: upstream, community-based interventions — like *Blue Star Support Circles* and the *Combat the Silence* campaign—are making a measurable difference. We are reaching families before a crisis occurs, empowering trusted loved ones to take informed action, and fostering a culture of openness, connection, and resilience within the veteran community. These programs not only enhance suicide prevention efforts but also strengthen the overall well-being of the families who stand beside those who serve.

Veteran suicide remains one of the most urgent and heartbreaking public health challenges of our time. We know that no single program can solve it — but together, with continued Congressional leadership, sustained funding, and expanded collaboration between VA, DoD, and community organizations, we can build the systems of support our veterans and families deserve.

On behalf of Blue Star Families and the communities we serve, thank you for your commitment to bridging the gap and ensuring that every veteran and their family has access to the resources, support, and hope they need to thrive.

Chairman Moran, Ranking Member Blumenthal, and distinguished Members of the Committee, thank you once again for the opportunity to share the work and insights of Blue Star Families in support of our nation's veterans and their families.

Statement for theRecord
Josh Goldberg, CEO, Boulder Crest Foundation

Prepared for the
Senate Committee on Veterans Affairs

April 29, 2025

Chairman Moran, Ranking Member Blumenthal, and distinguished Members of the Senate Committee on Veterans' Affairs,

Thank you for your steadfast leadership and enduring commitment to the well-being of our nation's veterans and their families. It is a privilege to share our experience with the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program and to support its reauthorization. This program represents the kind of bold, swift action required to meaningfully address the ongoing crisis of veteran suicide.

We are especially grateful to Chairman Moran, Ranking Member Blumenthal, and Senators Warner, Boozman, Cramer, and Coons for your dedication to expanding the reach and impact of this critical initiative. Your continued investment in innovative and results-driven solutions speaks volumes about your commitment to the men and women who have served—and sacrificed—on behalf of our country.

At Boulder Crest Foundation, we are honored to work in service of those who serve us. Our mission is to help veterans and first responders rediscover purpose, connection, and strength in the aftermath of trauma. We believe in a world where healing is not only possible, but empowering—and we are deeply encouraged by your efforts to support that vision through the Fox Grant Program.

A Search for Effective Solutions

Our story began in 2013 when our founder and retired Navy bomb disposal expert, Ken Falke, established Boulder Crest Virginia—the first privately funded wellness center in the country solely dedicated to combat veterans and their families. From the start, our vision was clear: to offer a sanctuary where those carrying the invisible wounds of war could find real and lasting relief.

For nine months, we opened our doors to nonprofit partners from across the country to test a wide range of programs—both clinical and non-clinical—addressing everything from military sexual trauma to PTSD. While well-intentioned, many of these programs simply did not reach the depth of need we were witnessing. Our veterans deserved more—more than temporary coping strategies or symptom management. They deserved a roadmap to thrive.

We were forced to confront a painful truth: our nation lacked a reliable, effective model for helping individuals truly grow in the aftermath of trauma. The traditional mental health system, with its reliance on talk therapy and medication, was not enough. Veterans were falling through the cracks.

Leading medical journals echoed our experience. In 2015, the Journal of the American Medical Association (JAMA) called for new approaches to treating PTSD. Two years later, JAMA Psychiatry acknowledged the limitations of existing therapies. Then, in 2023, JAMA Neurology highlighted alarming suicide rates among veterans with traumatic brain injuries—underscoring the urgent need for a better path forward.

Even more concerning, we believe that mental health diagnoses themselves can contribute to elevated suicide and substance use risk, particularly when accompanied by feelings of hopelessness or stigma. We knew we had to act and create something different.

Warrior PATHH and the Power of Growth

From that call to action came Warrior PATHH—a peer-led, non-clinical training program designed to help veterans reclaim their lives. The program begins with a powerful 7-day immersive experience and continues over 90 days, with structured follow-up and continued learning and community engagement.

Today, Warrior PATHH operates at eight permanent locations and two mobile units, with 11 programs running each month. Since its first delivery in 2014, the program has expanded nationwide with the support of key partners such as the Avalon Action Alliance and the openings of Boulder Crest Arizona and Boulder Crest Texas, and six non-profit partners carrying out Warrior PATHH.

This year alone, we expect to deliver Warrior PATHH to more than 1,000 veterans. Since our founding in 2014, we have served 4,500 service members and veterans. Referrals flow in regularly from alumni, mental health professionals, and VA staff who have seen firsthand what is possible when healing is approached as a process of growth—not just recovery. Notably, 82% of Warrior PATHH applicants have previously sought traditional mental health support and found it unhelpful, counterproductive, or only temporarily effective. This underscores the urgent need for alternative models that empower veterans to rediscover strength and purpose on their own terms.

In 2016, with generous support from the Marcus Foundation, we conducted an 18-month longitudinal study of the program's impact. The results were extraordinary:

- PTSD symptoms reduced by 54%
- Depression reduced by 52%; anxiety by 41%; insomnia by 39%
- Substance use declined by 44%; negative emotions by 25%
- Spiritual and existential growth rose by 78%; deeper relationships by 69%
- Participants also reported marked improvements in physical activity, nutrition, financial health, and self-compassion

These outcomes have since been validated through continued research in partnership with Baylor University's Mind-Body Medicine Research Lab. Warrior PATHH works—not by treating veterans as broken—but by helping them see the strength, wisdom, and resilience already within them.

On May 16, we will proudly open Boulder Crest Texas at Eagle Oak Ranch—our third permanent facility. This new site will expand our capacity and ensure that more veterans and first responders across the country have access to these life-changing tools and training.

Our Experience with the Fox Grant Program

From 2022-2025, Boulder Crest Foundation was honored to receive three $725,000 Fox Grants to deliver 36 Warrior PATHH programs and complete all required reporting. Our partner organization, the Permission to Start Dreaming Foundation, was awarded funding for an additional 18 programs.

From the outset, our experience with the VA under this grant has been collaborative, focused, and remarkably effective. The VA's commitment to partnership, transparency, and capacity building has strengthened our work and allowed us to reach more veterans than ever before.

The Fox Grant Program represents a gold standard in public-private collaboration. It empowers community-based organizations to deliver results while maintaining rigorous accountability. It ensures veterans in crisis receive timely, effective care—not just clinical services, but true healing.

We are proud to be part of this effort and strongly support its reauthorization. Congress and this Committee have our deepest gratitude and our full support for the enhancements under consideration.

Support for Reauthorization

We endorse the HOPE for Heroes Act as a meaningful and forward-looking step to strengthen the program. Specifically, we support:

- Extending the program for five years, through 2030
- Increasing the maximum grant award from $750,000 to $1 million. While we strongly support increasing the grant funding beyond this amount to meet the growing needs of veterans, we also recognize that any additional investment will make a meaningful difference in the lives of those we serve.
- Requiring enhanced collaboration between the VA and grantees to improve regional coordination, continuity of care, and outreach to VA employees within 100 miles of funded programs

We also applaud the leadership of Senators Warner and Boozman for introducing S.793, which helped ignite this important conversation and refocus attention on the future of the grant program. We likewise support the goals of Ranking Member Blumenthal's BRAVE Act (S.609), and we look forward to working closely with congressional staff to ensure the program is reauthorized in a way that delivers meaningful improvements.

Regarding S.1361, we appreciate the intent of Senators Cramer and Coons to improve geographic equity and outreach. Boulder Crest serves veterans from all 50 states, both locally and through travel assistance, and we stand ready to collaborate on ways to reach underserved communities and close remaining access gaps.

While these legislative improvements are all important and deserving of support, the most critical objective remains the reauthorization of the Fox Grant Program itself. Without it, the lifeline this program offers to veterans across the nation would disappear. Ensuring the program's continuity is essential to preserving its impact and expanding its reach.

Other Recommendations

The Staff Sergeant Fox Grant Program has laid a strong foundation for innovation, accountability, and meaningful impact in the fight against veteran suicide. As we look to the future, we must continue evolving the program to reflect the realities veterans face and the lessons we have learned from the field.

To build on the program's success and ensure it meets the needs of all veterans, we respectfully offer the following additional recommendations:

- **Raise the funding caps.** We believe that the VA and our veterans receive immense value from high-performing partners. While many organizations have

underperformed with regard to the grant program, Boulder Crest has excess capacity and legitimate funding needs with a cost of roughly $7,500 per veteran. Allowing the VA to provide additional funding to high-performing programs will help more veterans access quality services.

- **Broadening eligibility criteria to recognize that veterans as a population are at heightened risk for suicide.** We recommend that veteran status and an expressed interest in programs addressing significant mental health challenges be sufficient to qualify for support.
- **Expanding eligibility for the grant program through more inclusive suicide risk assessments.** We urge the adoption of both the PHQ-9 and C-SSRS tools, rather than relying solely on one or the other. A dual-assessment model will ensure that no veteran in crisis or at serious risk of suicide is turned away.
- **Scaling what works.** Whether through a "train the trainer" model or VA-funded training initiatives, successful programs like Warrior PATHH must be expanded and replicated through collaborative partnerships across the country.
- **Allow successful reapplicants to reach more veterans nationwide.** If the VA determines that an applicant reapplying to the grant program has demonstrated successful outcomes, and operates multiple locations that provide consistent, effective programs to veterans nationwide, the organization should be eligible to apply for and receive funding for each site.

Conclusion

At Boulder Crest Foundation, we are proud to stand alongside you in the fight to prevent veteran suicide. The Fox Grant Program has given us the resources and partnership needed to deliver results—and most importantly, to restore hope for those who once believed it was out of reach. Our veterans are among this nation's greatest assets, and it is our moral obligation to ensure they have the opportunity to live healthy, purposeful, and fulfilling lives after their service.

We are grateful for your leadership and collaboration, and we look forward to continuing this critical work together. Thank you for the opportunity to share our perspective and for your unwavering commitment to saving veteran lives.

COMBINED ARMS

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STATEMENT FOR THE RECORD ON BEHALF OF COMBINED ARMS

Following the Senate Veterans Affairs Committee Hearing on April 29, 2025: "Bridging the Gap: Enhancing Outreach to Support Veterans' Mental Health"

Combined Arms, a collaborative network dedicated to connecting veterans with critical resources, commends the Senate Veterans Affairs Committee for its focus on strengthening mental health outreach through the SSG Parker Gordon Fox Suicide Prevention Grant. The April 29 hearing highlighted the potential of community-driven initiatives and the opportunity for continued work to refine and improve processes and collaboration to better serve at-risk veterans.

Combined Arms underscores the critical need for a closed-loop bilateral referral system to ensure seamless, accountable connections between veterans, community organizations, the VA, and other partners. This system would track referrals in real time, confirm service delivery, and provide follow-up care, preventing veterans from falling through the cracks. By fostering trust and continuity, a closed-loop system transforms one-time interventions into sustained support, empowering veterans to thrive.

Equally essential is strengthened collaboration between the public sector, VA, and community partners. Variations in VA engagement and policies limiting wellness supports, such as gym memberships or music therapy, can pose challenges to maximizing the impact of life-saving programs. Combined Arms urges the Committee to support standardized VA liaisons, enhance flexibility for grantees to implement proven solutions, and fund a National Community of Practice (CoP). This real-time digital platform would enable grantees nationwide to share best practices, innovate, and ensure the SSG Fox Grant adapts to veterans' evolving needs.

A closed-loop referral system and robust public-private partnerships are force multipliers, ensuring the SSG Fox Grant fulfills its mission to save lives. Combined Arms stands ready to partner with Congress, the VA, and stakeholders to implement these reforms, creating a system that meets veterans where they are and delivers consistent, high-impact support.

Thank you for your commitment to our nation's veterans.

Mike Hutchings
CEO, Combined Arms

Statement for the Record of

Seema Reza
Chief Executive Officer
Community Building Art Works

For a Hearing from the Committee on Veteran Affairs
S.793, Amendment to the Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019 to modify and reauthorize the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program of the Department of Veterans Affairs.

Tuesday, April 29, 2025

Dirksen Senate Office Building
Washington, D.C. 20002

On behalf of Community Building Art Works (CBAW) and the Veterans we serve, I am pleased to submit this statement for the record supporting the bipartisan legislation to reauthorize the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program (SSG Fox SPGP).

Loneliness is the single greatest risk factor associated with a Veteran suicide attempt.[1] Nearly 60% of Veterans report loneliness placing them at a **12-times greater risk for suicidal ideations** and **doubling their risk for a suicide attempt**.[2]

CBAW builds community and reduces loneliness through the language of creative expression to promote empathy, foster understanding, and build authentic community. In our expressive arts workshops facilitated by acclaimed professional artists, Veterans use writing, visual art, and music for self-discovery, improved self-expression, and greater emotional literacy. **Our workshops reduce Veteran suicide and associated mental health risks** by countering the devestating affects of chronic loneliness and social isolation experienced by many Veterans.

Thanks to support from the SSG Fox SPGP, CBAW designed and implemented *More Than One Story*, a community-based suicide prevention program centered on expressive arts, where participating Veterans connect through shared writing and visual arts experiences and build relationships that offer social and emotional support.

To date, 139 Veterans have experienced *More Than One Story.* Results from a study of the program's first year show that 68% of participants formed relationships with other Veterans that carry on outside of the program. More importantly, we found an **89% reduction in the rate of suicidal ideations** reported by participants after one year of the program.

The impact goes beyond numbers. One Veteran, severely injured in Operation Desert Storm and living in a VA assisted-living facility, credits *More Than One Story* with giving her the strength to overcome mobility restrictions and Post-Traumatic Stress Disorder (PTSD) symptoms deemed 'untreatable' by her medical providers. Today, she is employed for the first time in over a decade, tutoring schoolchildren with social and emotional learning deficits. Because of *More Than One Story*, "I have a voice. I have potential. I have true, stick-by-you friends," she says.

More Than One Story, the over one-hundred Veterans deeply impacted, and the research-backed lessons we can share, would not be possible without the SSG Fox SPGP. Support from the Department of Veteran Affairs (VA), is not only vital to fund our work but also provides us with

[1] Nichter, B., Stein, M. B., Monteith, L. L., Herzog, S., Holliday, R., Hill, M. L., Norman, S. B., Krystal, J. H., & Pietrzak, R. H. (2022). Risk factors for suicide attempts among U.S. military Veterans: A 7-year population based, longitudinal cohort study. Suicide & Life-Threatening Behavior, 52(2), 303–316.
[2] Department of Veteran Affairs. (2022). From Science to Practice: Loneliness and Social Isolation - Risk Factors for Suicide. Washington, D.C.: Department of Veteran Affairs.

a platform to share our results and lessons learned with clinicians, Veteran advocates, and other organizations that support Veterans, amplifying our impact across multi-disciplinary communities of practice. The SSG Fox SPGP is a valuable program and we enthusiastically support its reauthorization as part of this legislation. No Veteran should be so lonely or isolated that they die by suicide. With continued support from the SSG Fox SPGP, programs like *More Than One Story* can continue to build a world where Veterans are connected, healthy, and reintegrated into the society they fought to protect.

KEEPING OUR PROMISE TO AMERICA'S VETERANS

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STATEMENT OF
NAOMI MATHIS
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
FOR THE RECORD OF THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
APRIL 29, 2025

Chairman Moran, Ranking Member Blumenthal, and Members of the Committee:

Thank you for inviting DAV (Disabled American Veterans) to submit testimony on ways to strengthen mental health outreach and suicide prevention programs for veterans and to comment on bills under consideration by the Committee. As you may know, DAV is a Congressionally chartered non-profit veterans service organization (VSO) with nearly one million wartime service-disabled veterans. Our single purpose is to empower veterans to lead high-quality lives with respect and dignity.

Mr. Chairman, despite significant efforts in recent years to address veteran suicide, veterans still have disproportionately high suicide rates compared to the general population. According to VA's most recent *National Veteran Suicide Prevention Annual Report*, the *National Strategy for Preventing Veteran Suicide,* which was released in 2024, approximately 6,400 veterans died by suicide in 2022, reflecting an average of 17.6 veteran suicides per day. While this number is slightly lower than 12 of the past 14 years, it remains devastatingly high. Since 2001, veteran suicide rates have increased 49%, compared to a 36% rise among non-veteran adults. In this same period, the veteran population has declined by 28.4%, amplifying the significance of these numbers. The *2024 National Veteran Suicide Prevention Annual Report* highlights persistent risk factors, such as the use of firearms in suicides, isolation during military-to-civilian transitions, and co-occurring conditions like homelessness and substance use disorders (SUDs). Veterans transitioning into civilian life, particularly within their first-year post-separation, are especially vulnerable due to fragmented support systems and limited access to specialized care.

Women veterans face particular challenges. Suicide rates for women veterans remain 92% higher than those for civilian women, driven by military sexual trauma (MST), intimate partner violence (IPV), and other service-connected conditions. DAV's 2024 report, *Women Veterans: The Journey to Mental Wellness*, highlights the need for trauma-informed, gender-specific care to address these disparities. However, the challenges facing women veterans also point to broader systemic issues impacting all veterans, such as insufficient infrastructure, staffing shortages, and inequities in care delivery.

Despite these challenges, several successful initiatives provide hope. The Veterans Crisis Line has contributed to significantly reduced suicide rates among veterans who engage with its services. The Recovery Engagement and Coordination for Health – Veterans Enhanced Treatment (REACH VET) program, which uses predictive analytics to identify and intervene with high-risk veterans, demonstrates the VA's commitment to proactive prevention. Telehealth services have expanded access to mental health care, particularly for veterans in rural or underserved areas. Gender-specific care for MST survivors has improved, though gaps in resources and infrastructure continue to limit its reach.

While important progress has been made, barriers persist, including inconsistent standards within VA community care networks (VCCN), disparities in the quality of care, and staffing shortages in the VA's workforce. These challenges underscore the urgency of adequate resourcing and systemic reforms to improve access, increase capacity, and ensure equitable outcomes for all veterans.

DAV supports the implementation of recommendations outlined in the VA's *2024 Suicide Prevention Report*, *Suicide*, which include expanding access to Veterans Health Administration (VHA) services to ensure timely support for those in crisis and promoting integrated care models that address co-occurring conditions such as chronic pain, depression, and substance use disorder. VA should target interventions to assist high-risk groups, including younger veterans (ages 18–34) and those facing challenges like homelessness or mental health conditions. Additionally, VA must strengthen partnerships with community organizations to provide comprehensive support, enhance social connectedness, and reduce isolation among vulnerable groups, including older veterans and those transitioning from incarceration or residential care.

The report's recommendations further stress the importance of promoting firearm safety campaigns and educating veterans on secure and temporary off-site storage options to reduce suicide risks. Collaborating with veterans to develop personalized safety plans that address both physical and mental health needs is also highlighted as a priority. VA must continue leveraging data-driven strategies, such as predictive analytics and behavioral health autopsy reviews, to identify risk factors and tailor interventions for high-risk subgroups. Lastly, the reports emphasize the necessity of providing robust support for transitioning service members during the critical period following military separation to ensure a smooth transition and mitigate risks.

Mr. Chairman, as you know, DAV together with our veteran service organization (VSO) partners PVA and VFW, have published *The Independent Budget* (IB) for almost four decades, providing unbiased, needs-based estimates of VA's resource needs as well as policy recommendations. In the IB for FY 2026 and 2027, released in February, we called for VA to prioritize funding for initiatives aimed at improving mental health care and suicide prevention for veterans. We recommended $179 million plus up for workforce expansion of suicide prevention programs, focusing on the recruitment and retention of qualified mental health professionals to address staffing shortages identified in recent VA Inspector General reports. The IB also recommended an increase of 3,000

clinical social workers who have a rising workload of veterans with complex cases involving mental health issues, substance use disorders, and housing instability – all contributing factors for suicide.

The IB also includes recommendations to strengthen gender-specific programs, calling for $130 million plus up to enhance medical services for women veterans, including care for survivors of MST, intimate partner violence, and reproductive mental health needs as outlined in DAV's women veterans report. Together, these funding priorities reflect a commitment to strengthening the accessibility and effectiveness of mental health care for veterans across diverse backgrounds and communities.

Congress and the VA must work together to implement a multi-pronged approach to mental health and suicide prevention for veterans. VA must require standardized suicide prevention training for all community care providers, while simultaneously addressing internal workforce shortages through prioritized hiring, competitive salaries, and streamlined recruitment processes. Expanding telehealth services is also a priority, including the development of crisis telehealth options that provide immediate access to VA mental health providers for veterans in acute need. Additionally, VA must expand lethal-means safety campaigns to help educate veterans on firearm safety and secure storage, both proven to reduce the lethality of suicide attempts. Finally, VA must develop and expand programs that foster social connectedness and community involvement, which are essential to reducing isolation and its associated risks among veterans. Congress and VA must work together, in collaboration with VSOs and other stakeholders, to advance impactful strategies that address mental health and suicide prevention across the veteran population.

DAV is also pleased to provide our views and specific recommendations on the following bills pending before the Committee.

S. 609, the Building Resources and Access for Veterans' Mental Health Engagement (BRAVE) Act of 2025

The BRAVE Act is a comprehensive bill that, if enacted, would improve the mental health services provided by the VA in several key areas: workforce support, infrastructure and technology, women veterans' needs, and other important provisions.

Title I: Improvement of Workforce in Support of Mental Health Care

Today, the Readjustment Counseling Service (RCS) operates more than 300 Vet Centers, 83 Mobile Vet Centers, nearly 1,000 Community Access Points, and more than 20 Outstations nationwide. These centers provide free, confidential counseling, outreach, and referrals to eligible veterans, active-duty service members (including those with problematic discharges), and their families. Services include individual, group, marriage, and family counseling for challenges like post-traumatic stress disorder (PTSD), substance use disorder, suicidal ideation, and socio-economic issues. Vet

Centers also connect clients with VA benefits and provide bereavement counseling for families of those who died in active duty.

Recent legislation, including the *Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020* (P.L. 116-315), *Commander John Scott Hannon Veterans Mental Health Care Improvement Act* (P.L. 116-171), *Vet Center Eligibility Expansion Act* (P.L. 116-176), and *William M. (Mac) Thornberry National Defense Authorization Act* (P.L. 116-283), has broadened Vet Center program eligibility and enhanced services, ensuring greater access to counseling for veterans, service members, and their families. To sustain these improvements, competitive pay for mental health professionals is essential to attract and retain a skilled workforce capable of meeting the growing demand for high-quality, first-class care at VA.

Title I directs the VA Secretary to strengthen the VA's RCS workforce by addressing pay disparities for mental health professionals, such as counselors, social workers, and therapists, through improved assessments and market pay surveys. By promoting equitable compensation, the legislation would empower the VA to attract and retain high-quality mental health providers. It would also authorize greater hiring flexibility to bring in licensed mental health counselors, ensuring that Vet Centers are adequately staffed to meet growing demands. Moreover, the bill seeks to codify VHA Directive 1500(5), reinforcing efforts to enhance collaboration between the VHA clinical care system and the RCS. This partnership aims to ensure the seamless delivery of effective care, particularly for veterans at elevated risk of suicide. Additionally, the legislation emphasizes the importance of providing active-duty service members in the Transition Assistance Program with information about Vet Centers and their services, facilitated through coordination between the Under Secretary for Health and Outreach Specialists at each Vet Center.

According to a recent report of VA's Office of Inspector General (VA OIG 24-00803-222), *Determination of Veterans Health Administration's Severe Occupational Staffing Shortages Fiscal Year 2024*, psychology has been one of VA's top five reported clinical severe occupational staffing shortages since FY 2019 and was among the top five most frequently reported shortages in FY 2018, when VHA did not have a formal designation for clinical and nonclinical occupations.

We support strengthening staffing for mental health care, in accordance with DAV Resolution No. 196, calling for effective recruitment, retention and development of the VA health care system workforce and that VA applies best practices from the private sector to human capital management to include pay and benefits that are competitive with the private sector.

Title II: Improvement of Vet Center Infrastructure and Technology (IT)

Title II focuses on upgrading infrastructure and technology for the RCS. **Section 202** would mandate the Government Accountability Office (GAO) to evaluate and report

on Vet Center needs, especially in underserved and rural areas. It requires an assessment of whether the system should be retained or replaced, along with steps, timelines, and cost estimates for improvement. **Section 203** aims to improve outreach and service delivery by providing demographic data for tailored activities, guidance to assess outreach effectiveness, and processes to identify barriers for veterans and staff. **Section 204** addresses delays in the RCS Network modernization, and mandates a report on whether it will be retained or replaced, along with steps, timelines, and the costs for improvement or replacement.

In alignment with DAV Resolution No. 51, we support the modernization of Vet Center IT infrastructure and the implementation of secure digital information sharing protocols between the VA and the DoD.

Title III: Women Veterans

Mr. Chairman, nearly one million women veterans are currently enrolled in the VA health care system. This population has unique needs; research shows high rates of service-connected disabilities and medically complex health histories among women veterans. Women veterans use specialty care such as mental health and substance use disorder services at higher rates than men. The proportion of women veteran VHA users with a service-connected disability increased from 48% in FY 2000 to 73% in FY 2020. Many struggle with multiple, clinically complex health and mental health conditions, including trauma-related post-traumatic stress, depression, eating and mood disorders. As discussed above, the suicide rate among women veterans was more than 92% higher than for non-veteran women. Additionally, the VA reports a 154% increase in the number of women veterans accessing VA mental health services over the past decade.

Title III aims at improving mental health care and support for women veterans. By requiring studies and modifications to existing programs, it seeks to ensure that the VA's services are effective in addressing the unique challenges faced by this growing population, particularly concerning suicide prevention and successful reintegration into civilian life.

Section 301 of this title would mandate a comprehensive study to evaluate the effectiveness of the VA's existing suicide prevention and mental health outreach programs as they apply specifically to women veterans, including in the area of lethal means safety. This provision aligns with a recommendation in DAV's women veterans report, which calls on VA to assess whether current services adequately meet the distinct needs of this population and to identify any gaps that may exist.

Section 302 would enhance the VA's suicide risk identification efforts for women veterans through the REACH VET program. This section would require the VA to modify the REACH VET predictive analytics tool to incorporate risk factors that are specifically weighted for women veterans. The intent behind this requirement is to improve the program's accuracy and sensitivity in identifying women veterans who may be at a

higher risk of suicide, facilitating timelier and more proactive outreach and support. This is in direct alignment with recommendations from DAV's women veterans report. We have found that the current model uses male-baseline and overlooks factors like MST, a known risk factor that disproportionately affects female veterans.

The VA has been testing potential designs for an updated REACH VET. This new version is considering adding risk factors like intimate partner violence, MST, and specific medical conditions affecting women, such as pregnancy, fibroids, endometriosis, and ovarian cysts. The VA previously announced plans to roll out an improved REACH VET program in early 2025. We recommend that the Committee formally request an update from the Under Secretary for Health regarding the status and progress of the launch.

Section 303 of this bill mandates a review and report from VA on the effectiveness of group retreat settings for veteran and family member reintegration and readjustment services, with a specific interest in the benefits for women veterans. The report must assess whether these services should be increased and made permanent, including an examination of the potential value of specialized retreat formats such as women-only retreats, disabled access retreats (particularly wheelchair accessible ones), and retreats tailored for veterans with specific medical needs.

DAV supports all provisions within Title III, in accordance with our Resolution No. 39, calling for medical services and benefits for women veterans. This resolution seeks to ensure that the provision of health care services and specialized programs, including gender-specific services, by the VA to eligible women veterans is delivered to the same degree and extent as those provided to eligible male veterans. This includes counseling and psychological services related to combat exposure, intimate partner violence, or sexual trauma.

Title IV: Other Matters

Title IV addresses a range of important issues related to veterans' mental health care, including suicide prevention, access to specialized treatment, ongoing mental health support, and coordination between the VA and DOD.

This section includes an amendment and reauthorization of the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program, which supports nonprofit community organizations and government agencies working to serve veterans at risk of suicide. The Fox Suicide Prevention Grant Program is a three-year pilot initiative aimed at enhancing efforts to prevent veteran suicide. Its core mission is to identify and engage veterans who present one or more of 14 defined suicide risk factors. Once these at-risk veterans and their families are identified, they receive access to peer support, case management, benefits navigation assistance, and other specialized services designed to reduce suicide risks before they escalate into crises.

A March 2024 congressionally-mandated report by VA, *An Interim Report on the Provision of Grants through the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program,* noted under "Measurement Outcomes" that grantees spent much of the first year, since January 2023, building and staffing their programs before starting to provide services and screening potential eligible individuals.

Although limited, the data collected from Fox Suicide Prevention Grant Program grantees was considered to be beneficial for reporting, program management, and evaluation. VA indicated it is using the initial year's program data to assess the suitability of benchmarks for future performance standards. Over time, VA predicts an increase in available data and the potential for more program graduates. The final report will better assess the effectiveness, capacity, and the feasibility of expanding the grant.

Due to the limited data collected demonstrating its effectiveness, DAV recommends amending the reauthorization on an annual basis as determined by the VA Secretary.

The VA's Residential Rehabilitation Treatment Program (RRTP) provides comprehensive, intensive care to veterans with co-occurring mental health and substance use disorders, medical conditions, and psychosocial challenges such as homelessness and unemployment. With 24/7 nursing support and assistance for medication compliance, the RRTP delivers high-quality residential treatment services tailored to veterans' complex needs.

Section 402 reinforces this mission by requiring the VA to ensure veterans with spinal cord injuries or disorders have access to mental health residential treatment programs. This includes developing a staffing plan, assessing medical equipment and optimal treatment locations, and implementing a pilot program at a minimum of three facilities. The section further mandates reporting on the plan's execution, pilot results, and recommendations for expansion.

Recognizing the necessity of accessible care for veterans with catastrophic disabilities, DAV supports Section 402 and its measures to enhance facility access to this vital program.

Section 403 would require the VA to provide regular mental health consultations and proactive outreach for veterans with service-connected mental health disabilities. Furthermore, it mandates the VA to submit biennial reports to Congress on the implementation and effectiveness of these outreach and consultation efforts.

Section 404 would require the VA Secretary and the Secretary of Defense to include an assessment of the status of their response to the recommendations in their joint report on the effectiveness of programs that promote access to mental health services for transitioning service members. This would involve evaluating how each Secretary has addressed the recommendations outlined in the GAO's report *Actions*

Needed to Better Facilitate Access to Mental Health Services During Military to Civilian Transitions, GAO-24-106189.

In accordance with DAV Resolution No. 224, which calls for program improvement and enhanced resources for VA's mental health and suicide prevention programs, we support sections 403 and 404.

S. 1361, Every State Counts for Vets Mental Health Act

This legislation seeks to allocate Fox Suicide Prevention Grant Program grants to states that have not previously received funding. While expanding geographic access to services is valuable, prioritizing states with no prior grants may inadvertently benefit areas lacking established mental health infrastructure or experienced providers. Rural areas, in particular, face shortages of mental health professionals, leading to longer wait times and fewer specialized services.

To address this concern, we recommend ensuring that the Fox Suicide Prevention Grant Program allocation prioritizes organizations with proven expertise and established mental health service networks. Without stringent quality measures, funding could inadvertently flow to organizations unable to provide effective suicide prevention programs for veterans.

S. 1139, the Helping Optimize Prevention and Engagement (HOPE) for Heroes Act of 2025

This legislation would reauthorize and modify the Fox Suicide Prevention Grant Program by increasing maximum grant amounts and allowing for performance-based funding based on the number of individuals who complete intake services. The bill rightly emphasizes collaboration among VA grant recipients, further training for VA employees, and regular briefings to enhance coordination of suicide prevention efforts.

A crucial component of this bill is the integration of Columbia Protocol training—also known as the Columbia-Suicide Severity Rating Scale (C-SSRS). Ensuring accurate suicide risk assessment is vital, yet this tool is not currently incorporated into pre- and post-program evaluations. We recommend including it as a standard measure to enhance intervention efforts.

The VA Interim Report on the Fox Suicide Prevention Grant Program revealed substantial shortcomings in the program and highlighted critical areas in need of improvement. Of the 80 grant recipients, 55 failed to report any pre/post-service outcome measurements for participants. The remaining 25 grantees recorded just 196 participants who completed services, averaging only eight per program. This lack of measurable outcomes severely limits the ability to assess program effectiveness. We recommend implementing both internal VA and external MITRE program evaluations to thoroughly evaluate the impact of suicide prevention services.

Further concerns arise from the bill's 72-hour referral provision, which allows veterans to seek emergent suicide care in the community if the VA cannot provide direct care within the timeframe. However, without structured mental health assessments during emergent care, veterans may receive inconsistent evaluations and inadequate support. A GAO report, *Opportunities Exist to Improve Assessment of Network Adequacy for Mental Health*, GAO-24-106410, found that demand for VA mental health care has significantly increased, leading to more veterans seeking treatment in the community, where wait times average 44 days compared to 34 days for VA direct services. The rising cost of community care now accounts for nearly one-third of VA's total health care spending.

We recommend expanding telehealth options for veterans experiencing a mental health crisis, allowing them to connect directly with VA mental health providers for immediate support. This approach could ensure continuity of care, reduce unnecessary community referrals, and help to reduce wait times for mental health services.

S. 793, to amend the Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019 to modify and reauthorize the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program of the Department of Veterans Affairs

S. 793 would extend the authorization for the Fox Suicide Prevention Grant Program and make several changes intended to strengthen the program to better achieve its primary objective—reducing risk among veterans.

To maximize the program's effectiveness, we recommend requiring all grantees be required to provide or coordinate baseline mental health screenings for every eligible individual at the onset of services. These screenings should utilize validated tools to assess suicide risk and behavioral health conditions, ensuring early detection and intervention. Additionally, grantees and partner organizations must employ pre- and post-evaluations using validated measures to assess suicide risk and mood-related symptoms.

Funding reauthorization should be based on demonstrated improvements in veterans' outcomes. We recommend a carefully monitored, annual renewal process to ensure effectiveness with funding decisions guided by comprehensive data, verifying the program's impact. While the intent of extending the Fox Suicide Prevention Grant Program is commendable, DAV recommends strengthening the proposed legislation to ensure it meets its primary objective—reducing risk of suicide in this population.

Mr. Chairman, DAV remains steadfast in our commitment to improving mental health care and preventing suicide among veterans. Through sustained investments, systemic reforms, and collaborative efforts, we can honor the promise made to those who served.

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EveryMind.
Your mental wellness.
Our mission.

The Honorable Jerry Moran
Charman, Committee on Veterans' Affairs
U.S. Senate, Washington DC 20510

Copy:
The Honorable Mark Warner
703 Hart Senate Office Building
Washington, DC 20510

Subject: S.793 – A bill to amend the Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019 to modify and reauthorize the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program of the Department of Veterans Affairs

Dear Chairman Moran,

My name is Ann Mazur, and I serve as the CEO of EveryMind, a mental health nonprofit that has been proudly supporting the DC Region for nearly 70 years. Through funding from the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program, EveryMind provides dedicated suicide prevention support for veterans across Northern Virginia, Washington, D.C., and Maryland right in the nation's backyard, where the need is great and access to care can be uneven.

I write today in strong support of S.793, a bipartisan bill to reauthorize and expand the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program. This critical program, administered by the Department of Veterans Affairs, provides essential funding for mental health outreach and suicide prevention efforts tailored specifically for veterans.

In March of this year, *The Washington Post* reported a significant surge in calls to the Veterans Crisis Line, rising to approximately 80,000 each month. This growing volume underscores an increasing need for immediate, lifesaving support among veterans, many of whom are dealing with homelessness, suicidal thoughts, or crisis-level mental health challenges. As a trusted provider in the 988 network, EveryMind is deeply committed to meeting this growing demand.

S.793, introduced by Senator Mark Warner (D-VA) and Senator John Boozman (R-AR), strengthens a proven approach to veteran suicide prevention by supporting outreach, mental health treatment, and peer support services.

EveryMind has proudly participated in this grant program since its inception, receiving funding during its initial pilot launch in October 2022. Through this grant, we've been able to add a dedicated case manager to our staff and implement comprehensive tools, such as the Columbia Suicide Severity Rating Scale, to assess client risk and tailor services to those who need them most.

Clients who screen at Level 2, indicating acute risk due to factors like extreme anxiety, severe depression, or prior suicide attempts are offered intensive case management, including a personalized 30-to-90-day care plan, weekly check-ins, and connections to community resources. As one of only 80 organizations nationwide selected to receive this funding, we have seen firsthand how the Fox Grant

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bridges a critical gap, providing veterans with access to tangible supports and trusted advocates, no matter where they are in their journey.

We know that veterans are over 57% more likely to die by suicide than their civilian peers. By fully funding the Fox Grant Program, organizations like EveryMind can continue reaching veterans in distress offering support before a crisis escalates. The veterans we serve commonly seek help for urgent needs: housing, utility bills, food, and access to mental health care. But perhaps the most important thing we provide is trust. Many veterans feel forgotten or undeserving of help. It takes time, consistency, and compassion to earn their trust, and this program helps us show up, again and again.

Let me share the story of Maryanne, a local Air Force veteran and single mother of a daughter with Down syndrome. She is 100% disabled and reached out to EveryMind overwhelmed and alone. A failed installation of an accessible bathtub left her home damaged, her AC was broken, and running fans to stay cool had driven her utility bills beyond reach. She was battling PTSD and Military Sexual Trauma while caring for her daughter without support.

Our care coordinator screened Maryanne for Fox Grant eligibility and connected her with safety planning and case management services. With our help, she navigated home repairs, pursued financial assistance, and advocated with her warranty company. We helped her break down each challenge into manageable steps. Maryanne later shared how deeply grateful she was, not only for the solutions we offered, but for the emotional support, steady guidance, and the reassurance that she was not alone.

This is the story of one life, and we know there are many others in need. S. 793 will make a profound difference for those who once put their lives on the line for us, for this nation, now it's our turn to stand up for them.

Thank you for your time, your commitment to our veterans, and your leadership in supporting this life-saving legislation. EveryMind is proud to support S.793, and we urge the Committee on Veterans' Affairs to advance and pass this important bill into law.

Sincerely,

Ann Marie Mazur, CEO

Written Testimony of Modern Military Association of America

Before the **U.S. Senate Committee on Veterans' Affairs** hearing: *Bridging the Gap: Enhancing Outreach to Support Veterans' Mental Health* on April 29, 2025

Introduction

Chairman Moran, Ranking Member Blumenthal, and Members of the Committee, thank you for the opportunity to submit written testimony.

Modern Military Association of America is a nonprofit that serves as a united voice for LGBTQ+ military and veteran communities. Modern Military works to uphold and expand the civil rights progress made on behalf of LGBTQ+ service members, veterans, and their families through education, advocacy, support networks, and discrimination tracking.

In October 2024, Modern Military was awarded the Veterans Administration (VA) Staff Sergeant Parker Gordon (SSG) Fox Suicide Prevention Grant. This generous funding infusion enabled rapid growth to create and run new programs and offerings previously unavailable to veterans. This new program, Resilient Heroes, is designed to meet LGBTQ+ veterans and their families where they are in their mental health journey to reduce suicide risk and improve overall well-being. It features three primary components: peer support, education, and direct service with a mental health coordinator.

Bridging the Gap

Separation from the military is often described as a loss of identity—a break from routine, structure, and purpose. For LGBTQ+ veterans, this separation is compounded by years of service under policies that denied their identity or rendered them invisible. Many of our Resilient Heroes participants describe the transition out of the military as disorienting, triggering, and deeply isolating.

While VA support is available, it is not always accessible—especially for those who have experienced trauma, discrimination, or do not feel safe identifying as LGBTQ+ in clinical environments. The SSG Fox grant allows organizations like Modern Military to bridge that gap—offering culturally responsive, identity-affirming support that helps veterans stay connected to care.

Intersectionality & Suicide Risk

Veterans carry layered identities—race, gender, sexuality, trauma history, disability—and each of these intersect to either strengthen resilience or heighten vulnerability. Transgender veterans face disproportionate risks for mental health outcomes.

- According to the National LGBTQ+ Veterans Survey, 57 percent of transgender veterans reported suicidal ideation in the past year, and 66 percent reported past suicide plans or attempts. https://link.springer.com/article/10.1007/s11930-017-0120-7?

- Transgender veterans die by suicide at a rate of 5.85 times the general population and double that of their cisgender veteran peers. https://pubmed.ncbi.nlm.nih.gov/30946622/

These are not just numbers—they are lived realities.

At Modern Military, we support survivors who are not only dealing with the trauma of the assault itself, but also the shame, silence, and disconnection that follow. Peer-based support and trauma-informed programming funded by the SSG Fox grant are often the first safe entry point to care.

Voices from the Veterans

Resilient Heroes participants routinely communicated its life-saving value:

> "It's nice to have a space that's for LGBTQ and veterans. So, I feel safe here." – *Veteran, Resiliency Circle*

> "The VAs [sic] I'm connected to stopped offering support groups, so I lost most of my community. I was happy to find the program." – *Veteran, Welcome Call*

> "I don't have social supports [sic], but I know it's important for my mental health. So, I've been seeking out more online communities." – *Veteran, Check-in Call*

These words reflect what the statistics already tell us: connection saves lives. But connection has to feel safe, authentic, and affirming. The SSG Fox grant-funded program builds that bridge.

Final Thoughts

Veterans do not return home with only one story. They return with complexity—honor, pride, pain, trauma, and hope. Modern Military's Resilient Heroes program provides life-saving community-based suicide prevention programs that work—especially when they are shaped with care, cultural humility, and connection.

The SSG Fox Suicide Prevention Grant Program is not just a grant—it is a lifeline. And for many LGBTQ+ veterans, it's the first time they feel seen.

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STATEMENT FOR THE RECORD

PARALYZED VETERANS OF AMERICA

FOR THE

SENATE VETERANS' AFFAIRS COMMITTEE HEARING

ON

"BRIDGING THE GAP: ENHANCING OUTREACH TO SUPPORT VETERANS' MENTAL HEALTH"

APRIL 29, 2025

Chairman Moran, Ranking Member Blumenthal, and members of the committee, Paralyzed Veterans of America (PVA) would like to thank you for the opportunity to submit our views on one of the bills, the Building Resources and Access for Veterans' Mental Health Engagement (BRAVE) Act of 2025 (S. 609), before the committee today. No group of veterans understand the full scope of care and benefits provided by the VA better than PVA members—veterans who have incurred a spinal cord injury or disorder (SCI/D).

In April 2024, PVA testified before the committee in a hearing focused on women veterans. The concerns raised by PVA and other witnesses at that hearing were the starting point for the BRAVE Act, which has been reintroduced this year. We support this critical legislation, which seeks to address gaps in mental health care delivery for veterans, including those with SCI/D. In the paragraphs that follow, we will share our thoughts on sections of relevance to PVA and our members.

Section 101 directs a market pay survey that would yield needed statistics to help fill gaps in care experienced by Vet Centers. There is a mental health professional shortage across the country, and it's felt by more than just the VA. Understanding the economic factors and grappling with appropriate and measurable incentive programs will help build a sustainable workforce for VA's Vet Centers.

Section 102 addresses the qualifications of appointees for occupations that support VA mental health programs, such as telemental health. VA has led the way in telehealth innovation to make sure veterans can access care when and where they need it. This allows veterans with SCI/D to access health care services from the comfort of their homes, reducing their need to travel to a VA facility. Telehealth helps facilitate ongoing management of their conditions and virtual therapy sessions and telepsychiatry makes mental health services more accessible. Historically, PVA has supported licensure portability to support critical, direct care positions and mental health counselling is one such position.

Section 103 directs VA to submit a report to the House and Senate Veterans' Affairs Committees regarding any coordination between the clinical care system of the Veterans Health Administration (VHA) and VA's Readjustment Counseling Service (RCS). Several VA Office of Inspector General (VAOIG) reports highlight that noncompliance with required policies and procedures is rampant across VA's Vet Centers. More alarming is that the VAOIG found that many Vet Center staff were unable to adhere to policy because they lacked adequate contact information for staff at VHA.[1] Veterans should never be at increased risk due to VA staff not knowing who to call. A report on coordination of Vet Centers and VHA is critical in delivery of care, particularly for potentially at-risk veterans.

Section 202 directs VA to submit a report to the House and Senate Veterans' Affairs Committees assessing the model used by RCS to help guide the expansion of the real property footprint of Vet Centers. With more than 300 Vet Centers across the country and more being stood up each year, it is imperative that Congress and the VA understand the gaps in care delivery to serve veterans more effectively. The Government Accountability Office (GAO) should be asked to analyze the robust mental health services offered by the entire VHA system (existing Vet Centers, VA medical centers, community-based outpatient clinics, community care network referrals, and calls to the 988-line or the veterans crisis line) to determine their effectiveness. As new Vet Centers get introduced to the RCS inventory, it is vital that future Vet Centers fill a need in local communities and be fully accessible for veterans with SCI/D.

Section 203 seeks to improve veteran outreach efforts by Vet Centers. A GAO report published in May 2022, found that while Vet Centers use "psychosocial assessments and feedback surveys to assess individual client needs and whether those needs are being met throughout the course of counseling," the assessments and feedback are not being analyzed or assessed for efficacy.[2] Vet

[1] US Department of Veterans Affairs Office of Inspector General, Inspection of Select Vet Centers in pacific District 5 Zone 2, Veterans Heath Administration, September 2024.
[2] U.S. Government Accountability Office, VA Vet Centers: Opportunities Exist to Help Better Ensure Veterans' and servicemembers' Readjustment Services Needs Are Met, May 2022.

Center personnel told the GAO that it would be helpful for RSC to provide them with guidance that includes metrics and targets for assessing the effectiveness of their outreach.[3] Collecting data just for the sake of having it is useless unless that data can illustrate what is and what is not working. We are concerned that too much time is expended collecting data and tracking information that could be better spent serving clients.

Section 204 directs a study of the information technology system used by the RCS. It is common knowledge that VA's information technology (IT) systems have faced a myriad of problems in recent years. There seems to be a pervasive misunderstanding that IT products are sustainable indefinitely and that minimal funding and attention will ensure their longevity. Unfortunately, that is not the case. Massive IT platforms and products, like the ones VA relies on, require constant modernization and resources, and the RCS is not immune to either of these. The operating platform RCS relies on is more than 10 years old and is in desperate need of modernization.

Section 301 directs a study of VA's suicide prevention and mental health outreach programs for women veterans. Increased attention and outreach to women veterans is something long championed by veteran organizations and other advocates. Recent literature has shed light on the complex needs of women veterans, particularly when it comes to providing tailored mental health support that meets their needs[4]. Evaluating what is working and what does not is the most obvious first step to ensure that VA and Vet Centers are meeting the moment and addressing the needs of women veterans.

Section 302 directs VA to modify the Recovery Engagement and Coordination for Health–Veterans Enhanced Treatment ("REACH VET") program so it incorporates weighted risk factors for women, like military sexual trauma and intimate partner violence. Also, codification of existing VA practices for the REACH VET program would help ensure that practices that have proven to be effective are preserved in statute. In the April 2024 hearing before this committee, the VA said it was proactively taking steps towards improving outreach targeted to women veterans, particularly around suicide prevention measures. But without legislation guaranteeing this outreach, such efforts may not be sustained.

Section 303 directs a review of and a report on reintegration and readjustment services for veterans and family members in group retreat settings. The Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020 (P.L. 116-315) included the Deborah

[3] VA Vet Centers: Opportunities Exist to Help Better Ensure Veterans' and Servicemembers' Readjustment Counseling Needs Are Met, May 17, 2022.
[4] Women Veterans: The Journey to Mental Wellness, Disabled American Veterans (DAV), 2024.
Women Warrior Report, Wounded Warrior Project (WWP), 2023.

Sampson Act which created a pilot program that offered reintegration and readjustment services for veterans and their families in group retreat settings. Understanding the impact of these retreats would help Congress decide if reauthorization is worthwhile.

Section 401 would extend the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program for an additional three years and increase the amount available to grantees from $750,000 to $1,000,000. PVA supports additional resources to help reduce the number of veteran suicides but we also believe that robust data is needed illustrating the effectiveness of the programs run by the Fox Grant before considering increasing the grant amount per recipient.

Section 402 directs VA to submit a plan to the House and Senate Veterans' Affairs Committees that would ensure disability access to VA's mental health residential treatment programs for veterans with SCI/D. During the April 2024 committee hearing on women veterans, PVA testified about the difficulties veterans with SCI/D face when accessing residential rehabilitation treatment programs (RRTP). When a veteran acquires an SCI/D, their identity and place in the world shifts dramatically, and it is common for veterans to experience a range of negative mental health outcomes as a byproduct of catastrophic injury or illness. Significant medical comorbidities are also expected because of injury or trauma, which is especially true when discussing the lifecycle years beyond acute injury. These complexities make the holistic treatment of veterans with SCI/D critical for their independence and well-being. However, if a veteran needs assistance from a caregiver with an activity of daily living, they are unable to access RRTP, even within the VA.

One PVA member shared his experience of battling an opioid addiction for twenty years and the difficulties he faced in accessing an RRTP contracted facility. Injured in 1997, this member was left as an incomplete quadriplegic and during his treatment he was prescribed various medications to treat his pain. Medications have evolved since the late 90's and what began as a prescription for Percocet eventually became an Oxycontin prescription. Over time this veteran developed a codependence on medications prescribed by VA to help manage his pain. Despite his addiction, he successfully managed his own business and thrived in his community, until he realized his addiction was out of control.

The VA referred him to a contracted RRTP and after months of back-and-forth communication, he was set to enter treatment. The day before he was due to be admitted he called the facility to confirm when he should arrive, at which point he was informed that the facility could not accommodate him because they could not accommodate a wheelchair. The staff he spoke with on the phone casually mentioned that she'd never seen a wheelchair user in any of the programs the facility offered.

This veteran had refused to refill his prescription for pain medications due to the assumption that he would be involved in treatment when they ran out the day after his admission into the facility. Realizing that he was now going to have to quit "cold turkey," and without any additional mental health support or professional supervision, his detox fell on himself and his family to deal with. He later wrote about how difficult it was, and the strain placed on his wife, but he credits her with his success and fortitude when it came to finally freeing himself of this addiction.

There are thousands of veterans across the country who rely on a wheelchair and/or a caregiver to get through their days and have an independent life. The VA should be able to accommodate the most vulnerable veterans in their care, instead, veterans with significant injuries or illnesses are faced with physical and other access barriers, including policy barriers, that impede their ability to receive care and treatment across the country. The pilot program for SCI/D and other disabled veterans to access RRTP in section 402 must become law.

Section 403 seeks to improve mental health consultations and outreach on mental health services for veterans receiving compensation for disabilities relating to mental health diagnoses. Nearly three million veterans receive compensation for service-connected mental health conditions, however, they may not engage with the VA directly for mental health care. Data shows that veterans who do not engage with VA mental health supports are at greater risk for suicide in comparison to veterans who do receive care at the VA[5]. Increasing outreach to veterans with known service-connected mental health conditions and encouraging them to engage with the VA seems like a common-sense way to improve the likelihood of getting them connected to care. We are hopeful that such efforts will lead to progress in combating the veteran suicide epidemic.

Section 404 directs a joint report by VA and the Department of Defense on the effectiveness of federal government programs that promote access to mental health services for transitioning members of the armed forces. A complete analysis of services offered by both departments may shed light on critical gaps when supporting transitioning servicemembers.

PVA urges the committee to pass the BRAVE Act this Congress, particularly section 402, to help ensure that catastrophically ill and injured veterans can access all VA health care services. We thank the committee again for this opportunity to comment on many of the provisions of the BRAVE Act and look forward to working with you on this legislation.

[5] 2024 National Veteran Suicide Prevention Annual Report, Office of Suicide Prevention, Department of Veterans Affairs.

STATEMENT FOR THE RECORD
OF
SRI BENSON
HEALTH POLICY ANALYST
VETERANS' AFFAIRS AND REHABILITATION DIVISION
THE AMERICAN LEGION
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
ON
"BRIDGING THE GAP: ENHANCING OUTREACH TO SUPPORT VETERANS' MENTAL HEALTH"

APRIL 29, 2025

EXECUTIVE SUMMARY

LEGISLATION	POSITION
S. 609: Building Resources and Access for Veterans' Mental Health Engagement (BRAVE) Act (Blumenthal) *Pg. 4*	Support
S. 1139: HOPE for Heroes Act (Moran) *Pg. 5*	Support
S. 793: A bill to amend the Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019 to modify and reauthorize the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program of the Department of Veterans Affairs (Warner/Boozman) *Pg. 9*	Support
S. 1361: Every State Counts for Vets Mental Health Act (Cramer) *Pg. 10*	Support

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April 29, 2025

Chairman Moran, Ranking Member Blumenthal, and distinguished members of this Committee, on behalf of National Commander James LaCoursiere Jr., and more than 1.5 million dues-paying members of The American Legion, we thank you for the opportunity to offer our testimony for the record on pending and draft legislation.

The American Legion is guided by active Legionnaires who dedicate their time and resources to serve veterans, servicemembers, their families, and caregivers. As a resolutions-based organization, our positions are directed by more than 106 years of advocacy and resolutions that originate at the post level of our organization. Every time The American Legion testifies, we offer a direct voice from the veteran community to Congress.

It cannot be overstated how crucial it is to discuss and destigmatize mental health challenges within the military and veteran community. Mental health and suicide prevention remains one of the top legislative priority areas for The American Legion.

Veterans do not exist in a vacuum. Veterans have families, financial obligations, gender-specific needs, complex medical diagnoses, and exist within a civilian-majority world that often does not fully understand their unique challenges. The American Legion recognizes this broad scope and is proud to approach this effort with hope and optimism—by Winning the War Within. Not only is this commitment demonstrated through The American Legion's robust programmatic efforts but is personal to our national staff and volunteers who have first-hand experience with this issue.

This year, we have increased our efforts to empower Legion Family and community members to help veterans in crisis by providing resources through our Be the One Suicide Prevention program. The program offers training to help individuals intervene safely and confidently when a veteran is at risk. This training include the Columbia Lighthouse Project, QPR (question, persuade, refer) protocol, and VA S.A.V.E. All these resources can be found on our Be the One webpage at no cost. Currently 19,000 individuals have been trained in the Columbia protocol or QPR. It is the goal of The American Legion to have 60,000 Legion Family members trained in suicide prevention by the end of the year. The American Legion is pleased to see Congress taking the national issue of veteran suicide seriously and looks forward to discussing the following legislation.

S. 609: Building Resources and Access for Veterans' Mental Health Engagement (BRAVE) Act

To improve mental health services of the Department of Veterans Affairs, and for other purposes.

The American Legion is proud to support the BRAVE Act. This legislation covers many areas that fall within the legislative priorities of The American Legion. This includes ensuring the Department of Veterans Affairs (VA) has the resources necessary to strengthen its mental health care workforce, infrastructure, and services. Additionally, this legislation addresses gaps in services tailored to women veterans and those suffering from spinal cord injuries or disorders.

Sec. 101 of this legislation calls the Secretary of VA to review market pay surveys to determine if the salaries of VA employees are similar to the private sector. The American Legion supports Sec. 101, 103, and 202 of the BRAVE Act through Resolution No. 115: *Department of Veterans Affairs Recruitment and Retention* which supports legislation addressing the recruitment and retention challenges at the VA regarding pay disparities and urges the VA to work more comprehensively with community partners to fill critical shortages within the VA ranks. In recent years, the VA prioritized the hiring of more providers and administrative employees to meet the needs of veterans.

Sec. 202 and 203 aim to improve Vet Centers by calling on the Comptroller General to submit a report to the Department of Veterans Affairs to guide the expansion of the real property footprint of Vet Centers. The American Legion supports these sections through Resolution No. 130: *Vet Centers Expansion to Rural Communities* which calls for the expansion of Department of Veterans Affairs' Vet Centers geographic locations to maximize the reach to rural veterans. The American Legion agrees that Vet Centers are an integral part of VA's service offerings. In a message from The American Legion's past National Commander to the membership, Vincent Troiola called on Congress to support the funding, implementation and continued expansion of VA and community-based mental health services through Vet Centers.[1]

The American Legion was especially pleased to see attention given to the unique needs of women veterans by incorporating weighted risk factors to the Recovery Engagement and Coordinator for Health-Veterans Enhanced Treatment program (REACH VET) such as MST and intimate partner violence. National Commander James LaCoursiere highlighted this key section in his quote of support, stating,

> *"On behalf of the 2.5 million veterans, family members, and caregivers in The American Legion family, we are proud to support the BRAVE Act. We applaud Senator Blumenthal for continuing this important work to ensure veterans and their families have access to comprehensive and robust mental health care. This bill was built on the very real and traumatic experiences that veterans, especially women, face during and after their service. We look forward to working with the Congress and our partners in the VSO community to see that this becomes law."*

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[1] The American Legion. "Vet Centers as a Mental Health Solution." *The American Legion*, April 2023. https://www.legion.org/information-center/news/commander/2023/april/vet-centers-as-a-mental-health-solution.

In 2024, The American Legion conducted a System Worth Saving (SWS) visit to the Department of Veterans Affairs (VA) Phoenix Health Care System, also referred to as Carl T. Hayden Veterans Administration Medical Center. While attending the town hall meeting hosted by The American Legion Phoenix Post 001, a local Legionnaire described her experience seeking treatment for her military sexual trauma (MST). She had a sense of gratefulness mixed with frustration regarding her experience with the mental health services she received at the in-patient mental health ward on the fifth floor of the hospital. She was grateful for being seen immediately with a warm handoff from her battle buddy, a fellow Legionnaire, but noted frustration with the lack of gender specific treatment options in the inpatient ward. Mindy spoke of how uncomfortable she felt receiving treatment relating to her MST in a co-ed mental health ward, and how beneficial it would be to create a women's ward. VA&R Chairman Jay Bowen agreed, citing our recent SWS visit to Tampa with a dedicated entrance for the women's health clinic, and a female specific wing in the inpatient mental health ward was identified as a best practice for Phoenix to consider.

The American Legion supports Sec. 301–303 of this legislation through Resolution No. 147: *Women Veterans* which urges that the needs of the current and future women veteran population be met and demands that VA provide full comprehensive health services for women veterans department-wide, including increasing treatment areas and diagnostic capabilities for women's health issues, improved coordination of maternity care, and increased availability of female therapists and women's group therapy to better provide treatment of post-traumatic stress disorder from combat and MST.

The American Legion supports Sec. 401–404 through Resolution No. 1: *Be the One Mental Wellness Committee* which established the Be The One Mental Wellness Committee, which is charged with examining recent trends of veteran suicide as it relates to traumatic brain injury, post-traumatic stress disorder, military sexual trauma, etc. and analyzing best practices in veteran suicide prevention and encouraging the Department of Defense and VA to adopt them. Supporting our women veterans is one such best practice.

The American Legion *supports* S. 609 the BRAVE Act as currently written.

S. 1139: HOPE for Heroes Act

To amend the Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019 to modify and reauthorize the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program of the Department of Veterans Affairs, and for other purposes.

This legislation outlines modifications and reauthorization of the Staff Sergeant Parker Gordon Fox Suicide Prevention Services Grant Program (SSG Fox SPGP) of the Department of Veterans Affairs. The American Legion has long supported the Commander John Scott Hannon Veterans Mental Health Care Improvement Act and the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program.

In 2019, Katie Purswell, Deputy Director for Health Policy for The American Legion, testified before the Senate Committee on Veterans' Affairs on the *Commander John Scott Hannon Veterans Mental Health Care Improvement Act*. During her testimony, she states, "our organization understands mental health care does not have a one size fits all solution in preventing suicide. It is

a complex problem that needs to be treated at an individual level as each veteran's situation is unique," Purswell said. "As a Legion member, and as a veteran who has been touched by this tragedy, I am proud to say the American Legion supports this bill in its entirety."[2]

When asked to testify on this subject before the House Committee on Veterans Affairs on December 17, 2024, Veterans Affairs and Rehabilitation Director Cole Lyle stated, "Fox grants have allowed organizations to coordinate initiatives related to post-traumatic growth, peer-support services, and cultural/faith-based programs." This upstream approach aligns with The American Legion's *Be the One* campaign and Buddy Check program, and we strongly support any effort by this committee to address the veteran suicide epidemic. But we also recognize Congress' duty to ensure taxpayer dollars are going to effective programs and organizations.[3] The American Legion strongly believes that community-based suicide prevention efforts are critical to addressing the national issue of veteran suicide.

The reauthorization provided by this legislation includes extending the maximum amount of Fox grant funding from $750,000 to $1,000,000, with additional metric-based incentives as determined by the VA Secretary, not to exceed a total of $1,500,000 per year. The House companion bill caps this amount at $500,000 but includes a per-veteran incentive which would match the full Senate grant after 50-100 program enrollees. The American Legion looks forward to working with Congress and the Veteran Service Organization community to determine which structure the final authorization will take. If the per-veteran structure of funding is chosen, it is important to only count veterans which have received both pre-program and post-program screening to ensure program effectiveness can be measured.

To improve coordination efforts between the VA and grant recipients, this bill requires the Secretary to provide VA medical centers (VAMC) within 100 miles of the "primary location" of grant recipients with a briefing of the services provided. The American Legion recognizes how this change will improve both coordination and outreach to veterans who could benefit from these programs, however we would like to identify additional improvements which could be adopted during markup.

First, this section identifies VAMCs "local to the primary location of grantees" but does not recognize many grantees have primary business locations in urban areas while conducting their programs in rural areas. Veteran Rites Inc., which provides spiritual healing through connection to nature for veterans, caregivers, and survivors, is one such grant recipient. Veteran Rites Inc. holds their primary business location near Tacoma, Washington but conducts many program events hundreds of miles away in eastern Washington and Oregon. Veterans who are local to program events but far from the "primary location" will not benefit under the current proposed language.

Second, only VAMCs within 100 miles are briefed on a grant recipient program. Some grant recipients are not within 100 miles of any VAMC and will not be included in this brief. Upstate Warrior Solution is a grantee which provides education, employment, justice, and spiritual support

[2] https://www.legion.org/information-center/news/legislative/2020/september/american-legion-testifies-on-bill-aimed-at-reducing-veteran-suicide

[3] The American Legion. "Legion Supports Requiring VA to Establish Clear Objectives for Suicide Prevention Programs." *The American Legion*, December 18, 2024. https://www.legion.org/information-center/news/legislative/2024/december/legion-supports-requiring-va-to-establish-clear-objectives-for-suicide-prevention-programs.:contentReference[oaicite:0]{index=0}

to veterans of South Carolina, however the nearest VAMC is 113 miles away, leaving them without a VA coordination partner.

These challenges are not insurmountable. One potential solution would be to allow grantees to select which VA facilities to partner with, provided those facilities employ "Suicide Prevention Community Engagement and Partnerships Coordinators" or similar staff. This flexibility would allow grantees to coordinate directly with VA personnel near their programs.

As noted in the Congressional Mandated Report (CMR-VA1-00189018),[4] follow up mental health screenings are not required, therefore only 9% of SPGP participants have completed post-program screenings, and only 31% of grantee programs have conducted any type of post-program screening. Due to the lack of statistically significant follow-up data, it is difficult to determine the effectiveness of the grantee's programs. However, the VA interim report predicted post-program screening participation will increase, and the lack participation is simply a product of the start-up process.[5]

Despite the lack of quantitative data detailing the effectiveness of the program, qualitative data strongly indicates a positive effect of these programs in the veteran community. The American Legion enthusiastically supports peer-led suicide prevention programs, especially those which bring veterans to the VA for follow up care. If the interim report is correct, and more actionable data will be available in the final report expected September 2025, The American Legion eagerly awaits more reported success in its conclusions.

In addition to providing innovative peer-led suicide prevention services to 3,204 veterans and family members, the SSG Fox SPGP referred 2,396 (69%) of those participants to additional VA programs.[6] This is the spirit of the SSG Fox SPGP, that whether a grantee offers equine therapy, neighborhood services, obstacle courses, group gaming, art therapy, or wilderness backpacking—all doors lead back to expert care at the VA.

Patriot Social Hours is a new initiative created by American Legion Department of Maryland Commander David Heredia, promoting the *Be the One* effort while offering outreach, fundraising opportunities, and services to veterans and their families. This initiative uses mission-driven outreach to bring the community into The American Legion posts and creates an informal welcoming space for veterans and non-veterans alike. Nearly 100 people showed up for the first Patriot Social Hour, and the momentum has continued to grow. These efforts have helped raise nearly $150,000 that will assist veterans and their families by supporting VA medical centers throughout Maryland, providing emergency financial assistance during times of crisis, expanding outreach efforts to reach underserved veterans, enhancing access to mental health services, and training of veteran service officers (VSOs) to expedite the VA claims process.

The American Legion's *Be the One* initiative and other peer support initiatives are having a tangible impact on veterans across the nation. One such veteran, John Brouse, was experiencing mental health challenges and was on the brink of losing his job. He tried to re-enlist but was told he was too old. In a recent Legion article, John notes how grateful he is to The American Legion

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[4] U.S. Department of Veterans Affairs. *Congressional Mandated Report, CMR-VA1-00189018*. Washington, D.C.: U.S. Government Publishing Office, 2024. https://www.govinfo.gov/content/pkg/CMR-VA1-00189018/pdf/CMR-VA1-00189018.pdf.
[5] Ibid
[6] Ibid

stating, "I reached out to my local American Legion post, and not only did they help me, but they embraced me," he recalled. Brouse continued,

> "They took me in, they helped me every way possible. They helped me get my life back on track. I'm so grateful to them. They saved my life. When I got engaged with The American Legion, I was like a dying plant, and they fed me." [7]

There is clear synergy between the SPGP program and The American Legion's own peer support initiatives, and we fully support the HOPE for Heroes Act. Two sections could be adjusted for even better results.

Subsection (h) EMERGENT SUICIDE CARE of the bill has well-meaning intent; however, the actual language would require the VA to provide services within 72 hours to any SPGP program participant referred to the VA. The intent of this language applies to emergency services. However, according to USC 38 sect. 1720J, emergency suicide prevention services are already automatically granted as community care services. Because 75% of SPGP participants are referred to the VA for further services, this requirement would create an influx of community care waivers, greatly expanding the cost of the program.[8] 300 participants were referred to emergency services during the first year of the program, without any reported difficulty of applying 1720J for community care.[9] This language was changed September 18th of 2024 in H.R.9438– *No Wrong Door Act* of the 118th Congress to reiterate the application of 1720J for emergency services,[10] and The American Legion urges similar updates to S.1139.

Subsection (d) SUICIDE PREVENTION SERVICES requires the use of the Columbia suicide-severity rating scale (CSSRS) during assessments. This requirement was included in the 2024 House reauthorization bill for the SSG Fox SPGP but was updated in the 2025 version to allow the VA Secretary to select the assessment protocols. This change improves the flexibility of the program and does not require each grant recipient to all use the same screening protocols, which may not necessarily be an appropriate fit for their program.

The American Legion has been very closely following the SSG Fox SPGP and fully supports the reauthorization. The American Legion supports this legislation through Resolution No. 364: *Department of Veterans Affairs to Develop Outreach and Peer to Peer Program for Rehabilitation* which urges the President of the United States and the U.S. Congress to call on the Secretary of Veterans Affairs to develop a national program to provide peer to peer rehabilitation services based on the recovery model tailored to meet the specialized needs of current generation combat-affected veterans and their families.

Additionally, we support this legislation through Resolution No. 14: *Department of Veterans Affairs Suicide Prevention Programs* which urges VA and other collaborating organizations to

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[7] Howard, Henry. "'They Helped Me Get My Life Back on Track.'" *The American Legion*, March 28, 2025. https://www.legion.org/information-center/news/be-the-one/2025/march/they-helped-me-get-my-life-back-on-track.

[8] U.S. Department of Veterans Affairs. *Congressional Mandated Report, CMR-VA1-00189018*. Washington, D.C.: U.S. Government Publishing Office, 2024. https://www.govinfo.gov/content/pkg/CMR-VA1-00189018/pdf/CMR-VA1-00189018.pdf.

[9] Ibid

[10] U.S. House of Representatives. Committee on Veterans' Affairs. *Amendment to H.R. 9438, No Wrong Door for Veterans Act, offered by Ms. Miller-Meeks of Iowa.* 118th Cong., 2nd sess., September 18, 2024. https://docs.house.gov/meetings/VR/VR03/20240918/117647/BILLS-118-9438-M001215-Amdt-1.pdf

conduct research to evaluate the harms of current crisis responses, particularly among high-risk veteran subpopulations to identify novel solutions for responding to crises and to evaluate the effectiveness of promising new approaches.

The American Legion *supports* S. 1139 the HOPE for Heroes Act.

S. 793: A bill to amend the Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019 to modify and reauthorize the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program of the Department of Veterans Affairs

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

This legislation outlines modifications and reauthorization of the SSG Fox SPGP of the Department of Veterans Affairs. This includes extending the maximum amount of grant funding from $750,000 to $1,250,000.

This legislation is similar to the HOPE for Heroes Act addressed earlier in this testimony, and much of our previously stated support and recommendations for the reauthorization of the SSG Fox SPGP are the same for this bill.

However, this bill does not include some of the additional improvements for reauthorization, including support for transportation and miscellaneous technical corrections.

American Legion recognizes the SSG Fox SPGP as an important part of the suicide prevention ecosystem for American veterans and eagerly awaits the consolidated version of the bills for reauthorization of the program.

The American Legion supports this legislation through Resolution No. 14: *Department of Veterans Affairs Suicide Prevention Programs*, which supports our collaborative partners in conducting research to evaluate the harms of current crisis responses. Identifying novel solutions is the primary goal of this resolution, and the SSG Fox SPGP is the gold standard for this initiative.

The American Legion also supports this legislation through Resolution No. 364: *Department of Veterans Affairs to Develop Outreach and Peer to Peer Program for Rehabilitation* calls upon the Secretary of Veterans Affairs to develop a national program to provide peer to peer rehabilitation services based on science driven recovery models. Many SSG Fox SPGP grantees are operated by veterans themselves, and some of the most exciting and effective programs rely on peer support to reach other veterans in crisis.

The American Legion *supports* S. 793: A bill to amend the Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019 to modify and reauthorize the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program.

S. 1361: Every State Counts for Vets Mental Health Act

To require the Secretary of Veterans Affairs to give priority in the consideration of suicide prevention grants to entities located in States that have not received such a grant, and for other purposes.

The Every State Counts for Vets Mental Health Act seeks to expand the SSG Fox SPGP by incentivizing programs in states which do not yet have any registered grantees. It is important to recognize the SSG Fox SPGP is a pilot program, with the final report scheduled to be released September 2025.

In all current drafts of the reauthorization for the SSG Fox SPGP, VAMC's are briefed only on grantees with a primary location within 100 miles of the VA facility. However, because many grantees serve multiple states, some states, such as Idaho, may receive only partial "coverage" from a grant award, if a program operates in the state but has no primary business presence there. This could be remedied by revising the bill's language from "If no entity in a particular State has received a grant under this section, the Secretary shall give all eligible entities in that State..." to "If no entity *with a primary location* in a particular State has received a grant under this section, the Secretary shall give all eligible entities *with primary locations* in that State...". This would ensure every state is appropriately considered for coverage by organizations headquartered there during the grant review process, rather than covered by entities operating primarily in another state.

Our rural veterans face unique challenges, especially when we consider the compounding effects of isolation and suicidality. Many SSG Fox SPGP grantees provide services using the healing power of nature, and these programs are uniquely suitable for the rural veteran who may be less willing to seek traditional counseling.

The American Legion supports the initiative to expand the geographic scope of the SSG Fox SPGP.

Through Resolution No. 119: *Support More Service Programs Benefiting the Rural Veteran,* The American Legion supports legislation which aims to better serve rural veterans.

The American Legion *supports* S. 1361 Every State Counts for Vets Mental Health Act *as currently written.*

CONCLUSION

Chairman Moran, Ranking Member Blumenthal, and distinguished members of the Committee, The American Legion thanks you for your leadership and for allowing us the opportunity to provide feedback on legislation.

If this country wants to maintain an all-volunteer service, it is imperative to ensure that veterans will be cared for during and after their service. Veterans do not exist in a vacuum and their challenges—both psychological and physiological—demand a multi-faceted and dynamic approach. By tackling these issues head on through comprehensive legislation, we can reduce the epidemic of veteran suicide and demonstrate to the next generation of warfighters that they will be cared for in their worst moments.

Winning the war within is and remains The American Legion's number one priority. The American Legion looks forward to continuing this work with the Committee and providing the feedback we receive from our membership. Questions concerning this testimony can be directed to Bailey Bishop, Senior Legislative Associate, at b.bishop@legion.org.

If you or a loved one are experiencing a mental health crisis or struggling with thoughts of suicide, immediate help is available. You can contact the Veteran Crisis Line by dialing 998 or texting 838255. The Veterans Crisis Line serves Veterans, service members, National Guard and Reserve members, and those who support them.

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April 29, 2025

The Honorable Jerry Moran
United States Senate
521 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Moran,

The American Legion and our 1.6 million dues-paying members are proud to support the legislation introduced by Senators Warner and Boozman to reauthorize and expand the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program (S. 793). This bipartisan legislation would modify the program and increase the maximum amount of grant funding from $750,000 to $1,250,000.

Winning the War Within has been - and remains - one of The American Legion's top legislative priorities. Veterans dealing with service-related challenges exist within a civilian-majority world that often does not fully understand them. Our commitment to these men and women is routinely demonstrated through The American Legion's robust programmatic efforts but is also personal to our national staff and volunteers that have first-hand experience.

Last year, The American Legion highlighted the importance of the grants before the House Committee on Veterans Affairs. Our Veterans Affairs and Rehabilitation Director Cole Lyle stated, "Fox grants have allowed organizations to coordinate initiatives related to post-traumatic growth, peer-support services, and cultural/faith-based programs." This upstream approach aligns with The American Legion's Be the One campaign and Buddy Check program, and we strongly support any effort by this committee to address the veteran suicide epidemic. But we also recognize Congress' duty to ensure taxpayer dollars are going to effective programs and organizations. The American Legion strongly believes that community-based suicide prevention efforts are critical to addressing the national issue of veteran suicide.

We understand that you have introduced similar legislation reauthorizing the program at a different appropriation level. The American Legion proudly supports the reauthorization of the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program and therefore has expressed support for both proposals. As these proposals move through the legislative process, The American Legion looks forward to working with the Committee to determine the appropriate funding rate.

We commend Senators Warner, Boozman, and the Committee for their unwavering commitment to our nation's veterans and their families. The American Legion stands ready to assist in ensuring this critical legislation become law.

Sincerely,

Mario A. Marquez
Executive Director
Government Affairs

TRAGEDY ASSISTANCE PROGRAM FOR SURVIVORS
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April 29, 2025

Chairman Jerry Moran
United States Senate
Washington, DC 20510

Ranking Member Richard Blumenthal
United States Senate
Washington, DC 20510

Dear Chairman Moran and Ranking Member Blumenthal,

The Tragedy Assistance Program for Survivors (TAPS) is writing to express our strong support for **S. 793**, a bill to amend the *Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019* and to modify and reauthorize the **Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program**.

Suicide among veterans remains a national tragedy that demands continued, targeted action. By increasing the maximum grant amount from $750,000 to $1,250,000 and reauthorizing funding through fiscal year 2028, S. 793 will ensure that local community-based organizations have the resources they need to continue providing life-saving mental health services. These organizations are often best positioned to reach at-risk veterans, particularly those who are not actively engaged with the VA system.

The bill's provisions to improve coordination between grantees and nearby VA medical centers and to enhance accountability through additional metrics are both timely and essential. These changes will pave the way for more effective interventions, competent care, and efficient use of taxpayer dollars, ultimately saving more lives.

We also commend the bill's flexibility in allowing the Secretary of Veterans Affairs to collaborate with a broader range of stakeholders, as opposed to being limited to the PREVENTS Task Force. This pragmatic approach reflects the evolving landscape of veteran support services and promotes innovation and responsiveness at the local level. TAPS asserts that postvention is a critical component of suicide prevention, underscoring the importance of supporting veterans impacted by suicides of comrades, as well as that of a dependent spouse or child, as such exposure significantly increases their own risk for suicide.

S. 793 is a vital step forward in our shared mission to end veteran suicide. TAPS urges the Senate Committee on Veterans' Affairs to swiftly advance this legislation and the full Senate to pass it without delay.

On behalf of the 120,000-plus surviving families TAPS is honored to serve, including more than 28,000 who lost a military or veteran loved one to suicide, we thank you for your time and consideration. On behalf of our military survivor community, TAPS appreciates your leadership in ensuring the best possible future for our veterans, families, caregivers, and survivors.

Respectfully,

Bonnie Carroll
President and Founder, Tragedy Assistance Program for Survivors (TAPS)

STATEMENT OF

MEGGAN COLEMAN, ASSOCIATE DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

FOR THE RECORD
UNITED STATES SENATE
COMMITTEE ON VETERANS' AFFAIRS

WITH RESPECT TO

Bridging the Gap: Enhancing Outreach to Support Veterans' Mental Health

Washington, D.C. April 29, 2025

Chairman Moran, Ranking Member Blumenthal, and members of the committee, on behalf of the men and women of the Veterans of Foreign Wars of the United States (VFW) and its Auxiliary, I would like to thank you for the opportunity to present our views on legislation pending before this committee.

S. 609, Building Resources and Access for Veterans' Mental Health Engagement (BRAVE) Act of 2025

The VFW supports this legislation to enhance mental health services for veterans. This comprehensive approach includes improvements to the Department of Veterans Affairs (VA) workforce capabilities, upgrades to infrastructure, targeted initiatives for women veterans, and expansion of critical suicide prevention programs. Strengthening and expanding Vet Centers and outreach programs would ensure veterans have better access to vital mental health resources.

Women veterans encounter unique mental health challenges, but there is little research on the impact of military service on women and their mental health. This legislation would build on VA programs like Recovery Engagement and Coordination for Health – Veterans Enhanced Treatment (REACH VET) that analyze risk factors for veteran suicide and incorporate additional factors specific to women. This would help to effectively identify more at-risk veterans, connect them with the resources they need, and lower suicide rates in women veterans.

The VFW encourages Congress to look for additional ways to improve suicide prevention efforts for all underserved veteran populations. Moreover, improving the infrastructure and technology within the Veterans Health Administration would undoubtedly improve VA's service delivery and responsiveness to veterans' needs. The legislation also includes a comprehensive study of VA suicide prevention and mental health outreach programs, and a report on the effectiveness of VA and Department of Defense programs that connect transitioning service members to mental health services. These reviews are key to obtaining the data necessary to assess the successes of the programs and where adjustments should be made.

Helping Optimize Prevention and Engagement (HOPE) for Heroes Act of 2025

The VFW supports this legislation to improve access to mental health programs for veterans by increasing funding for VA's Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program, introducing performance-based funding metrics, mandating standardized screening methods using the Columbia Protocol, and ensuring better coordination with local services. The bill authorizes an increase from $750,000 to $1 million in funding and extends the program's duration to 2030. The legislation also includes training for VA employees and provides transportation assistance for veterans attending VA appointments. These measures aim to improve access to mental health resources and reduce suicide rates among veterans.

Every State Counts for Vets Mental Health Act

The VFW supports this legislation to require VA to prioritize the distribution of suicide prevention grants to states that have not yet received such grants. Currently, this would apply to North Dakota and Delaware. Veterans in rural locations often encounter difficulties accessing services due to long travel distances to medical centers and unreliable internet connections for telehealth. There should be a focused effort to provide grants to organizations that support veterans in these areas. While the goal of this legislation is to provide suicide prevention grants in all states, the current eligibility requirements and application process is essential to ensure that potential grantees meet the necessary qualifications. The distribution of grants to all states should never be at the expense of lowering the standards of the services provided to veterans. The VFW appreciates that this legislation would simply provide additional consideration to states without grants.

S. 793, To amend the Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019 to modify and reauthorize the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program of the Department of Veterans Affairs

The VFW supports this legislation to update and extend the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program through 2028. It would increase the maximum grant amount to $1.25 million, and enhance oversight to align with the program's goals. Additionally, it would improve coordination with local VA centers, ensure congressional accountability, and integrate lessons learned from evaluations and reports. The bill authorizes $285 million in funding for 2026 to 2028. It also grants VA greater flexibility in selecting partners, and introduces new performance measures. Additionally, the bill shifts the coordination of this suicide prevention effort from the original presidential task force to the Secretary of Veterans Affairs, and makes a technical correction in the current law regarding eligible individuals.

In conclusion, making improvements to the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program is essential for ensuring the program's effectiveness in the unique communities it serves. The VFW recommends that these pieces of legislation come together in a comprehensive package to more fully enhance veteran suicide prevention efforts.

Chairman Moran and Ranking Member Blumenthal, this concludes my statement. Again, thank you for the opportunity to offer our comments on this issue to the committee.

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