S. HRG. 118–252

# LEGISLATIVE PRESENTATION OF DISABLED AMERICAN VETERANS

## JOINT HEARING

BEFORE THE

## COMMITTEE ON VETERANS' AFFAIRS U.S. SENATE

AND THE

## COMMITTEE ON VETERANS' AFFAIRS U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTEENTH CONGRESS

SECOND SESSION

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SUBMISSIONS FOR THE RECORD

# LEGISLATIVE PRESENTATION OF DISABLED AMERICAN VETERANS

**THURSDAY, MARCH 7, 2024**

U.S. SENATE, AND
U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
*Washington, DC.*

The Committee met, pursuant to notice, at 10 a.m., in Room SD–G50, Dirksen Senate Office Building, Hon. Jon Tester, Chairman of the Committee, presiding.

**Present**:

Senators Tester, Brown, Blumenthal, Hassan, King, and Moran.

Representatives Bost, Luttrell, Self, Takano, Pappas, McGarvey, Ramirez, Landsman, and Budzinski.

## OPENING STATEMENT OF HON. JON TESTER, CHAIRMAN, U.S. SENATOR FROM MONTANA

Chairman TESTER. I call this hearing to order, and I want to wish you all a good morning, and I want to welcome you to the Senate and House Veterans' Affairs Committee hearing.

I am honored to welcome the national leadership of the Disabled American Veterans, and I want to extend a special welcome to the DAV members who traveled across this nation to be here, particularly those who have traveled from the great State of Montana. We are fortunate to have Joe Parsetich, a Montanan, and DAV's former National Commander here; Kevin Grantier, who is Commander of the Montana DAV; Chase Natalie, Adjutant of the Montana DAV. Thank you for being here, gentlemen. We appreciate it.

Each of us can always count on the DAV to let us know how Congress can best support our nation's veterans. DAV has been integral in helping us pass life-changing legislation like the Deborah Sampson Act, the Hannon Act, and most recently the PACT Act.

DAV was at the forefront of the effort to ensure Members of Congress did the right thing for multiple generations of toxic-exposed veterans and survivors by passing the PACT Act. This came as no surprise, as this was not the DAV's first rodeo. DAV has been helping Congress pass legislation to support veterans and their families for decades. That is why I am proud to have DAV's support for one of my top priorities this year, passing the Major Richard Star Act, to help deliver combat-injured veterans their full DoD and VA benefits.

We have also been working in a bipartisan and bicameral way to improve VA's Community Care Programs, respond to the mental

health needs of our veterans, and bolster long-term care services for aging and disabled vets. That legislation, the Senator Elizabeth Dole 21st Century Veterans Health Care and Benefits Improvement Act, will help our veterans access the care, benefits, and services they need and deserve, and we will need the continued support of DAV to help get it over the finish line.

We hold DAV's views in high regard here, and we will look to you to ensure that we have our priorities straight. So thank you for being here.

Now I want to turn it over to Chairman Bost, who I want to personally thank for him holding down the fort and sharing a good portion of yesterday's VSO hearing. Thank you, Chairman Bost. You have the floor.

**OPENING STATEMENT OF HON. MIKE BOST, CHAIRMAN, U.S. REPRESENTATIVE FROM ILLINOIS**

Chairman BOST. Thank you, Chairman Tester, and good morning to all of you, and thank you for being here. I would like to thank the DAV's National Commander, Ms. Nancy Espine—I am going to say it correctly—Espinoza. Yes, all right. That is pretty good for a deep southern Illinois boy—for being here today. Thank you. And I would also like to give a shoutout to DAV's Auxiliary National Commander, AnnMarie Hurley, and thank you also for being here.

[Applause.]

Chairman BOST. And I am pleased that there are folks here from the great State of Illinois as well. If you would raise your hand, we want to recognize you. From Union, Illinois, we want to also especially welcome Don Houghland from my district, and thank you for being here. Thank you for traveling here from our home state, and please, I already recognized you.

So being Chairman of this Committee is very, very personal to me, and I want to explain that. I explained it to the group yesterday. I am a Marine. There is an oorah out there. Yes, okay. And my grandfather on my mother's side was a Korean War Marine. My uncle was a Vietnam Marine, a victim of the ultimate oxymoron, friendly fire. He did survive but got hit in 1965, came home, woke up in Virginia about five weeks later. He got 100 percent disability but had a very successful life, thanks to the VA.

My son is a lieutenant colonel this time, and is a JAG. My grandson is an F–18 mechanic in Miramar, California. My dad's side of the family, they were all Army. We will not hold that against them. So as you can tell, it is really, really personal to me to make sure we are providing for you. And we want to say thank you for the sacrifices you have made, especially this group. All veterans we want to say thank you to, but especially this group.

Each of you have fought to protect our constitutional rights. However, for far too long veterans that merely needed a fiduciary from the VA to help them manage their benefits, including disabled veterans, have been wronged, for about 30 years. For years, VA has automatically stripped veterans with fiduciaries of their Second Amendment rights, a constitutional right they actually fought to keep in place.

Now, I am proud to report that the fiscal year 2024 MILCON VA Appropriations Act, which recently passed the House, just yesterday, will now protect all veterans' constitutional right to bear arms.

[Applause.]

Chairman BOST. By incorporating a bill that I have championed for years—and I thank Senators Moran and Tester for their work with me to get this fixed, and know that I will continue to ensure we enact a permanent fix. DAV plays a vital, important role to making sure we meet the needs of disabled veterans.

You, like me, understand the struggles veterans and their families and their survivors have. You know where the VA is falling short. DAV is a great advocate here in DC and across the country to make a difference for our veterans. You have my commitment that we will continue to fight for you and the voices you represent just as hard as you fought for us.

As you all know, the PACT Act is the largest expansion of health care and benefits for veterans and their families in recent history, and we are going to make sure VA gets it right. And when they make mistakes I will be the first one to hold them accountable and get answers back to you.

Looking ahead, I am focusing on making improvements where we can to modernize VA's delivery of health care services. We made great progress improving the VA claims and appeals process when we passed the Veterans Appeals Improvement and Modernization Act. But we must make sure VA is providing veterans with high quality disability compensation exams and timely decisions on their claims that they have earned, and we are going to keep pushing to make sure veterans can get the help that works for them, and where they need it and when they need it.

The bipartisan negotiations we are in right now to get a package of veterans bills to the President's desk will help us do that. This comprehensive package includes things like the Dole Act, VET TEC, and HOME Act. Strengthening the Community Care Program, the Dole Act would put veterans in control of where they want to live out the days of their lives. The HOME Act would help homeless veterans. And the expansion of the successful VET TEC pilot program would help veterans find high-paying jobs and more. We will get this package done in the coming weeks.

Now you may hear some discussion from my colleagues on the other side of the aisle that the House Republicans are somehow holding up this legislation. Nothing could be further from the truth. As long as I am Chairman, I will continue to work with my colleagues in both chambers to find bipartisan solutions to the problems, regardless of the action of others. Disabled veterans and all veterans deserve nothing less.

But make no mistake, our work is nowhere close to being finished, and my door has and will continue to always be open to you. I promise to keep up the fight. We are all in together. And now is not the time to take our foot off the gas, and I will assure that the VA gets the budget it needs to complete its goals.

I look forward to this meeting today and working on this mission alongside you, and I want to thank you again for being here today. And with that I yield back.

Chairman TESTER. I want to recognize Ranking Member Jerry Moran.

**OPENING STATEMENT OF HON. JERRY MORAN, RANKING MEMBER, U.S. SENATOR FROM KANSAS**

Senator MORAN. Chairman Tester, thank you. Chairman Bost, Ranking Member Takano, my House and Senate colleagues, it is a pleasure to be here with the DAV. Commander Espinosa, you should know that your team represents not only you but disabled American veterans and veterans generally across the country in a very admirable way and a very effective way. Their voice matters, it is heard, and it is acted upon.

And I want to thank all of you for being here, and thank particularly my Kansas members of DAV. I had an enjoyable and valuable visit with them yesterday, and I look forward to hearing what is said this morning in today's hearing. This is a valuable hearing, and the time that you are with us is something that we cherish.

Lots of critical pieces of legislation. I would highlight, as the Chairmen said, I was impressed, and members of DAV and the veteran community should be impressed, really, with all the work of our veteran service organizations when it came to the PACT Act. But particularly DAV was a leader in that effort, and absolutely, as a result of DAV's efforts, that PACT Act was able to advance, something that has been talked about and worked on for a long period of time, but without the success that we saw now, just a little more than a year ago.

I look forward to hearing what you have to tell me today. I would guess that you have suggestions how we address the backlog of disability claims within the Department. Too many veterans are waiting far too long to receive the benefits. This backlog not only delays critical support for those who need it but also creates unnecessary stress and so much uncertainty in veterans' and their families' lives.

Mental health remains a critical concern—PTSD, depression, substance abuse, and our continued battle against veteran and military suicide.

And finally, I appreciate DAV again for always being at the forefront of caregivers, family members, and in this case, our efforts with Senator Dole to see that we provide support for those who provide selfless care for ill and injured veterans. These caregivers play a vital role in recovery and well-being of our veterans, and yet too often lack the recognition and support they deserve. I am anxious to hear what DAV thinks that VA can do to make certain that caregivers fill that essential role.

And again, I thank you all for being here and I look forward to working with you, continuing to work with you, as we care for those who served. Thank you.

Chairman TESTER. I now recognize Ranking Member Takano.

**OPENING STATEMENT OF HON. MARK TAKANO, RANKING MEMBER, U.S. REPRESENTATIVE FROM CALIFORNIA**

Mr. TAKANO. Well thank you, Chairman Tester, and thank you Ranking Member Moran and my colleague, Chairman Bost. I am happy to join all of you this morning in this hearing.

I am honored to gather this morning with members of the House and Senate Committees on Veterans' Affairs, and we look forward to hearing from the National Commander and representatives of Disabled American Veterans about your legislative priorities for the second session of the 118th Congress.

First of all, let me get an important piece of business out of the way. Are there any Californians in the room this morning? All right. Well, I would like to give a special shoutout to DAV's Junior Vice Commander, Dan Contreras, from California. Welcome, Dan, and welcome DAV-ers from California.

We convene this hearing with a deep sense of duty and commitment to the brave men and women who have served our nation. We must not waiver in our commitment to ensuring that they are able to access health care and benefits they have earned. I look forward to discussing DAV's legislative priorities this morning, and may your insights, experiences, and advocacy efforts serve as guiding lights to my colleagues and me as we fulfill our legislative and oversight responsibilities through the remainder of the 118th Congress.

After reviewing your written testimony, Commander Espinosa, it is clear that DAV's priorities align with many of my own. I share your commitment to reducing veteran suicide, increasing access to VA health care, and ensuring faithful implementation of the PACT Act.

We must also make VA more welcoming and a safer place for veterans of all backgrounds and ethnicities. Last week, DAV published a new report, "Women Veterans: The Journey to Mental Wellness." This is the third report about women veterans that DAV has published since 2014. I cannot thank you enough for the important contributions you have made through these reports, which have contained dozens of policy recommendations. We made important strides with the enactment of the Deborah Sampson Act three years ago, but more work remains to be done, and your new report will help guide further improvements.

The best way for us to honor the legacy of veterans and their survivors is to translate our words into meaningful action that uplifts and empowers those who have given so much in service to us all.

I wish we, in Congress, had more to show for ourselves in terms of legislative productivity in the 118th Congress. Unfortunately, legislation like the HOME Act and the Elizabeth Dole Home Care Act are currently being held up by those whose priorities lead the privatization of veterans' health care, enrichment of special interest groups, and the hollowing out of the VA health care system.

I remain very grateful for the overwhelming support that DAV and other VSOs provided in 2022 to pass my bill, the Honoring our PACT Act and get it signed into law. Your voices are powerful, and we look to you to guide us in our policymaking.

And as we approach the two-year anniversary of the enactment of the PACT Act, I look forward to working with DAV to continue to strengthen and protect this landmark law and ensure the more than 3.5 million veterans living with the effects of toxic exposure can receive the maximum benefits and comprehensive health care they have earned.

As part of these efforts, the Biden administration recently announced it is accelerating the timeline for veterans who were exposed to toxins to be eligible to enroll in VA health care. That means, as of this Tuesday, any veteran who was exposed to toxins or hazards has access to the effective, affordable, and quality health care that VA can offer without having to apply for disability compensation first. This is a huge deal, and I want to be very clear that it is due, in no small part, to the advocacy of the VSO community.

I look forward to continuing my work with my colleagues to make sure this transformational law is implemented effectively. This includes protecting the Toxic Exposure Fund, a mandatory funding mechanism that makes this law possible.

I have said it before and I will say it again. Toxic exposure is a cost of war. We must vigorously resist any attempts to return to the bad old days where veterans' health care was fully funded through discretionary appropriations, pitting veterans against each other and against other discretionary spending programs.

In closing, I look forward to hearing DAV's testimony today, and thank you for your advocacy and support for the veteran community, and I yield back the balance of my time.

Chairman TESTER. It is now my honor to welcome to the Joint House and Senate VA Committee my friend and colleague, Senator Mitt Romney. And I am just going to tell you, Mitt, you will never address a finer group of House and Senate members than you are about to address now.

[Laughter.]

Chairman TESTER. And he is here to introduce Commander Espinosa.

**INTRODUCTION BY THE HON. MITT ROMNEY**

Mr. ROMNEY. Thank you, Mr. Chairman, a good friend. I am not sure I agree entirely with your assessment of the entire panel, but I will take it into consideration. Thank you.

[Laughter.]

I appreciate the chance to be here with you today, and I am proud to introduce a fellow Utahan, the National Commander of the Disabled American Veterans, Nancy Espinosa. I have had the pleasure of meeting with Commander Espinosa to discuss efforts to increase our support for disabled veterans.

Since 2023, Commander Espinosa has served as National Commander for the DAV. She is a service-connected disabled veteran of the Army, and was a member of the Army Reserve from 1975 until becoming an active-duty soldier in 1985. Four years later, she joined the New Mexico Army National Guard and served there until her honorable discharge in 1990.

Commander Espinosa is currently a member of the DAV Chapter 14 in Layton, Utah, as well as the Department of Utah Adjutant. She is an active member of DAV's Commanders and Adjutants Association, and a Commissioner of the Utah Legislative Veterans and Military Affairs Commission.

DAV has more than 1 million members across the country. Commander Espinosa understands firsthand the issues that impact veterans. The work she does is vital to ensuring that veterans and

their families have access to the benefits they need to live long and full lives.

Thank you, Commander Espinosa, for your willingness to appear before the Committee today, for your service to our country, and thank you to the members of this esteemed panel.

Chairman TESTER. Thank you, Senator Romney.

[Applause.]

Chairman TESTER. We appreciate your statement very, very much. Now, Commander Espinosa, I will turn it over to you for the DAV's opening statement.

**STATEMENT OF NANCY ESPINOSA, NATIONAL COMMANDER, DISABLED AMERICAN VETERANS, ACCOMPANIED BY BARRY JESINOSKI, NATIONAL ADJUTANT; BRYAN "CODY" VANBOXEL, EXECUTIVE DIRECTOR, NATIONAL HEADQUARTERS; EDWARD R. REESE, JR., EXECUTIVE DIRECTOR, WASHINGTON HEADQUARTERS; JIM MARSZALEK, DAV NATIONAL SERVICE DIRECTOR; JOY ILEM, DAV NATIONAL LEGISLATIVE DIRECTOR; JOHN KLEINDIENST, NATIONAL DIRECTOR OF VOLUNTARY SERVICE; RYAN BURGOS, NATIONAL EMPLOYMENT DIRECTOR; AND ANNMARIE HURLEY, AUXILIARY NATIONAL COMMANDER**

Ms. ESPINOSA. Thank you very much, Chairman Tester. Thank you so much for that kind introduction, Senator Romney, and thank you for your dedication to America's veterans. I am proud to call you a fellow Utahan.

Chairman Tester, Chairman Bost, Ranking Members Moran and Takano, and members of the Committees on Veterans' Affairs, thank you for providing me the opportunity to deliver the 2024 Legislative Program of DAV, Disabled American Veterans, an organization of more than 1 million members, all of whom were injured or became ill as a result of their military service.

My written statement thoroughly details DAV's key legislative priorities for the 118th Congress and reports on our many programs and accomplishments. So today I will highlight some of our most critical policy goals.

First, I would like to start by introducing my DAV colleagues joining me today: National Adjutant, Barry Jesinoski; National Headquarters Executive Director, Cody VanBoxel; Washington Headquarters Executive Director, Randy Reese; National Service Director, Jim Marszalek; National Legislative Director, Joy Ilem; National Voluntary Services Director, John Kleindienst; National Employment Director, Ryan Burgos; and Auxiliary National Commander, AnnMarie Hurley.

I also want to recognize the DAV and Auxiliary leaders who have been vital to our organization's mission over the course of many years. Let me extend my gratitude to our National Executive Committee and the members of the National Legislative Interim Committee, as well as my Chief of Staff, Floyd Watson, Jr., for all of their support.

And finally, I want to thank my sons, Ian, who is a Navy veteran, and Eric, who served in the Air Force. While I am surrounded by countless impressive and selfless servants within

DAV's ranks, my sons hold the distinction of being my most dedicated and unwavering supporters.

[Applause.]

Ms. ESPINOSA. Messrs. Chairman, I am a service-connected disabled Army veteran of the Gulf War era, with a family legacy of military service dating back to the Civil War. My journey began when I responded to an ad for a clerk typist that said, "No experience necessary." The position turned out to be with the U.S. Army. That call to the Reserves launched my 15-year military career. But my service in the Army was marked by obstacles and loss.

While on active duty in 1989, doctors told me they found an aggressive cancer that could leave me with just six months to live. They operated, and it turned out to be a misdiagnosis. But as you can imagine, the entire ordeal was quite traumatic.

Shortly after I suffered the unexpected deaths of my sister and young stepdaughter, in rapid succession. The combined losses and health issues left me in a deep depression, so I took a hardship discharge and transitioned into the New Mexico National Guard to continue my military service.

When I separated from the Guard in 1990, I turned to VA for care. Unfortunately, VA was ill-equipped to address my needs as a woman, and was not conveniently located, so I did not start using VA for many years, and I did not even realize that VA mental health care was an option for my depression. I am happy to say that today I regularly use VA health care, and overall I am very satisfied with the quality and timeliness of my care.

But my experience of being dismissed and misunderstood by VA was not unique. Women veterans have historically been overlooked and underserved. While VA has made tremendous progress in recent decades in caring for women veterans, there is still much to be done. This is particularly critical now with the suicide rate skyrocketing among women veterans. With more women than ever serving in the military, we must ensure that VA has the resources and expertise to meet all the physical and mental health care needs of women veterans.

[Applause.]

Ms. ESPINOSA. I am pleased to announce that just last week DAV released a new report entitled "Women Veterans: The Journey to Mental Wellness." It is our third report focused on women veterans' issues in the last 10 years, this time digging deeply into the unique factors contributing to the staggering rate of suicide among women veterans. We look forward to working with you to begin implementing its 50-plus policy and legislative recommendations. Together we can save lives.

[Applause.]

Ms. ESPINOSA. Messrs. Chairmen, DAV is a fierce advocate of the VA health care system and its specialized programs. Over the past decade, there has been one consistent trend—an increasing number of veterans turning to VA. Unfortunately, there are still significant staffing shortages and an aging infrastructure that prevents and delays many veterans from receiving the care they need. Congress must ensure that VA has sufficient funding to provide timely, convenient, and high-quality care.

[Applause.]

Ms. ESPINOSA. Messrs. Chairmen, we again want to thank you and all the members here today for the historic passage of the Honoring our PACT Act in 2022. As you may remember, DAV was the first organization to bring the subject of burn pits to light in 2008, but we have been advocating about the harms of military toxic exposures dating back to World War I. We should all celebrate that millions of veterans exposed to burn pits and other toxic substances are now eligible for VA's life-changing benefits and health care.

However, many others remain ineligible because their conditions are not currently covered in the law but are linked to toxic and radiological hazard exposures. If our nation is to provide true equity for all toxic-exposed veterans, Congress must enact legislation to recognize the specific exposures and related diseases for veterans who served at K–2 in Uzbekistan, ensure parity for radiation-exposed veterans and address the exceptionally widespread PFAS water contamination. All toxic-exposed veterans deserve care now and into the future.

[Applause.]

Ms. ESPINOSA. In order to build on the success of the PACT Act, DAV and MOAA have been engaged a toxic exposure research project, and will soon release a report entitled "Ending the Wait for Toxic-Exposed Veterans," which includes detailed policy recommendations. We found, on average, it takes more than 30 years for Congress or VA to establish presumptive diseases, such as those for Agent Orange and the PACT Act. These presumptions help to ensure that all veterans receive their earned benefits. No veteran should have to wait three decades for justice.

[Applause.]

Ms. ESPINOSA. Messrs. Chairmen, DAV knows that servicemembers' families share in the sacrifices made by their loved ones. That is why we fully support the Major Richard Star Act, the Restore Veterans' Compensation Act, the Caring for Survivors Act, and the Love Lives On Act, each of which would remove barriers and correct inequities faced by wounded, ill, and injured veterans and their survivors. With your help, we can and we must get these bills enacted this year.

[Applause.]

Ms. ESPINOSA. But we know that passing new laws is not enough. We must also ensure that veterans are able to access the services and benefits they have earned. That is why one of DAV's core missions is to provide ill and injured veterans free representation with their benefits claims. With over 1 million veterans choosing DAV to represent them, I am proud to say we have the largest and best benefits advocacy initiative in the country, second to none.

[Applause.]

Ms. ESPINOSA. To help veterans access VA health care, DAV operates a national transportation network, offering veterans rides to and from VA health care facilities at no cost. Last year, DAV volunteers drove more than 575,000 hours, transporting more than 245,000 veterans to their medical appointments, saving taxpayers more than $18 million.

[Applause.]

Ms. ESPINOSA. We also help veterans achieve economic security through employment support and by empowering veteran entre-

preneurs to make the business world accessible to them and their spouses. I am proud to say that in the past decade our job fairs have resulted in over 180,000 job offers.

[Applause.]

Ms. ESPINOSA. Finally, DAV has long advocated on behalf of veterans' family caregivers. They not only share in the sacrifices made by veterans but also enhance their quality of life. That is why, in October, we launched DAV Caregivers Support, a program to provide tailored assistance and resources to those who care for veterans. Through our program, caregivers can access online resources and receive personalized care plans. They also get one-on-one support from a trained specialist. And like all of our services for veterans, DAV Caregivers Support is provided at no cost to the caregiver or the veteran.

[Applause.]

Ms. ESPINOSA. Messrs. Chairmen, in conclusion I would like to share some words from Thomas Jefferson that are inscribed on his memorial: "I am not an advocate for frequent changes in laws and constitutions, but laws and institutions must go hand in hand with the progress of the human mind. As that becomes more developed, more enlightened, as new discoveries are made, new truths discovered, and manner and opinions change, with the change of circumstances, institutions must advance also to keep pace with the times."

That statement remains true today as it did more than 200 years ago.

Our veterans need a VA that keeps up with the times, and we need you to join with us so that together we can create a better VA that our veterans deserve, today and into the future.

[Applause.]

Ms. ESPINOSA. Messrs. Chairmen, thank you for the opportunity to testify today. As always, my heart remains with DAV, the men and women who have served our great nation, and their families, caregivers, and survivors, and of course, the United States of America.

[Applause.]

Ms. ESPINOSA. Thank you. This concludes my statement.

[Applause.]

[The prepared statement of Ms. Espinosa appears on page 29 of the Appendix.]

Chairman TESTER. Thank you, Commander Espinosa. We appreciate those words. There will be three-minute rounds. I would ask the members to obey that as close as possible. I will be first.

Three years ago we passed the Deborah Sampson Act, a bill introduced by Senator Boozman. It will help eliminate barriers to care and services faced by many women veterans, and it was signed into law. This legislation also helped expand and improve access to care and benefits for survivors of military sexual trauma. The Deborah Sampson Act was a big win, but as DAV notes in a recent report on women veterans, we still have much work to do to improve care for those who have experienced MST.

So my question is this to you, Commander. Where is VA currently succeeding in providing care for veterans who have experienced MST, and where can improvements be made?

Ms. ESPINOSA. Thank you very much for that question, Senator. I would like to ask our Legislative Chairman, Joy Ilem, to respond.

Ms. ILEM. Thank you, Commander. Thank you. I think one of the key things that is positive is that DoD and VA were starting to work together to address the MST issue, and that is absolutely critical. But we know that far too many veterans, both male and female, experience military sexual trauma. We have to have a culture change, both in the DoD and VA. The positive steps have been made, moving that forward, but there is so much more to do, especially warm handoffs are so important, making sure there is care coordinators to address issues with women veterans, and male veterans who experience sexual trauma, trauma-informed care, continued resources to make sure evidence-based treatments are developed.

So there are a number of positive things, but we still have a number of issues that we still need to address, and we have to have welcoming, safe environment for all veterans using VA, no harassment, and we have to hold VA accountable for that.

Chairman TESTER. Thank you Joy, and thank you for the work that you do.

On Tuesday, DAV members and other veteran service organizations joined me at a press conference to call for swift passage of the Major Richard Star Act. This bill has overwhelming bipartisan support and would allow combat-disabled veterans to collect their full DoD retirement pay and VA disability pay, and quite frankly, this bill is a no-brainer.

So for you, Commander, what would this change mean to DAV members, and why is it so important we get this legislation passed?

Ms. ESPINOSA. That is a very important question, Senator. Thank you for asking. I would like to ask our Service Director, Jim Marszalek, to respond.

Mr. MARSZALEK. Thank you, Commander. Senator, we do support the passage, and like you said, it is a no-brainer. These are combat veterans who suffered significant injuries as a result of their service. They should be able to receive their retirement and their VA compensation separately, absolutely.

Chairman TESTER. Thank you. Chairman Bost.

Chairman BOST. Thank you, Chairman. Commander, after working with Senator Moran and Senator Tester and Speaker Johnson I was pleased to be able to get the language for H.R. 705 to protect Second Amendment rights of our veterans included in the appropriation bill and considered this week, and I am grateful for the DAV's support of this issue.

I just want to know, as things move forward, can we continue to count on that support?

Ms. ESPINOSA. Thank you very much for that question, Congressman. DAV believes that veterans must have all their rights protected, including their due process rights, and we support that legislation.

Chairman BOST. Thank you very much. Commander, also DAV's national services officers have helped other veterans navigate this

labyrinth of VA claims appeals process, and it really is a labyrinth. Can you elaborate on the meaningful claims and appeals reform that Congress should support that allows you and helps you work with them to get that done, get their claims processed?

Ms. ESPINOSA. Thank you very much for that question, Congressman. I would like to ask Service Director Jim Marszalek to respond.

Mr. MARSZALEK. Thank you. Great question. At the end of the day it starts with VA forms and how veterans are introduced to filing a claim for benefits. It is very complex. The complexity of the forms, then the letters they receive as a result of filing those forms is complex. We have to start there. There should be no wrong door at VA. It does not make any sense to us that a veteran would have to think about what claim they filed 20 years ago in order to determine what form they use.

I was just looking at forms the other day through the VBMS notification queue, and we found so many issues with them in regard to, it is confusing to veterans, for sure. So we have to fix that first. Again, no wrong door at VBA has to be the attitude going forward, so veterans are comfortable and they are not punished in any way for filing the wrong form. They are asking for help for a benefit. We need to be able to help them do that as best as we possibly can. We need to make it as easy as possible for them.

Chairman BOST. Well, let me tell you this, to the VBA, thank you for doing that. As a person who has went through this process several times, and frustration—and I am going to tell you that there are many veterans out there that give up before getting the process done, and that is wrong. Whenever I first got here we did move a bill to try to improve that process, but we have got to have your help—and thank you for your help—to allow us to continue to try to make it an easy process so that it does not drive our veterans away and that would give up.

So thank you, and with that I will yield back.

Chairman TESTER. Senator Moran.

Senator MORAN. Chairman Tester, thank you. Commander, thank you very much for your words. They are valuable and meaningful.

Let me remind the DAV that Senator Sinema and I have introduced the Veteran Caregiver Re-education, Re-employment, and Retirement Act to provide caregivers with needed support as they reenter the workforce or transition into retirement once they are no longer needed as a family caregiver. Would you be willing, would the DAV be willing to take a look at that legislation and consider supporting it?

Ms. ESPINOSA. Thank you very much for that question, Senator. It is very important to many of our members. I would like to ask our Legislative Director, Joy Ilem, to respond.

Ms. ILEM. Absolutely, Senator Moran, we would be happy to take a look at that. And you know how important caregivers are to our members, and anything we can do to support them and make sure that they have every opportunity is key. Thank you.

Senator MORAN. Thank you. I look forward to working with you, Joy, and DAV in this regard.

Commander Espinosa, the VA has been closing beds in community living centers, CLCs, due to an inability to find staff and to retain staff. My question that is written in front of me is do you have any concerns. I assume the answer to that question is yes. But do you have suggestions of how we can help the VA employ and retain staff and make sure that the needs of our veterans who are in community living centers, their needs continue to be met?

Ms. ESPINOSA. I appreciate that question, Senator. We do a lot for caregivers, as I mentioned in my remarks. I would like to ask our Legislative Director, Joy Ilem, to give detail on that.

Senator MORAN. Thank you.

Ms. ILEM. Absolutely. Long-term care, we have so many aging veterans and service-disabled veterans deserve to have options, from home-based primary care services through, we know that no one wants to have to end up in a community living center or a nursing home, but at times that is just the reality of it. They need that support. They need that help. So being able to recruit and retain the best and the brightest to care for our nation's veterans is so key, and we will do everything we can to work with you on that issue. We hope that this is an issue that will be taken up by Congress because we have an aging veteran population that is really going to be critical in the next decade.

Senator MORAN. And apparently an aging workforce.

Ms. ILEM. Yes.

Senator MORAN. Commander, thank you. You came to see me shortly after you became Commander. I appreciate that conversation and appreciate the relationship I have with you and the members of DAV. Thank you.

Ms. ESPINOSA. Thank you.

Chairman TESTER. Ranking Member Takano.

Mr. TAKANO. Thank you, Mr. Chairman. Commander, I was pleased to see in your written testimony that DAV supports enacting legislation that would require specific training protocols for community providers to ensure that these providers meet the same clinical competency and quality of care standards to which we hold VA providers.

So my question, I have a few questions here. What sort of training do you think is most critical for VA community providers to have, particularly mental health providers? And second, what would you say to those who question whether Congress should mandate training for VA's community providers at all?

Ms. ESPINOSA. I appreciate the question, Congressman. I would like to ask our Legislative Director, Joy Ilem, to respond.

Mr. TAKANO. Great.

Ms. ILEM. Thank you, Commander. It is an absolutely critical point to make sure that all providers, whether they are VA or community providers, have the proper training, especially in mental health. Suicide prevention is VA's number one clinical priority, and as such all providers in VA are trained. They are mandated and required to take training in suicide prevention efforts and lethal means safety counseling.

Unfortunately, VA's network of community providers, that is not mandated. While it is encouraged, it is not mandated. But we know so many veterans use the Community Care Network as well. We

believe they should have the same requirements and mandate. Our veterans deserve no less, and with suicide, again, on the rise we absolutely, that is a critical point.

Mr. TAKANO. Thank you. Commander, thank you for highlighting in your testimony the importance of modernizing the VA medical facilities to ensure that they can best support the delivery of health care in the 21st century. For fiscal year 2024, appropriators have provided a modest plus-up over the President's budget request, but the $2.1 billion that will be appropriated is still a far cry from the $7 billion that DAV and other independent budget VSOs are recommending for fiscal year 2025.

Why are these infrastructure investments so critical, and in the absence of sufficient funding, how should Congress and VA prioritize available resources?

Ms. ESPINOSA. Thank you very much for that question, Congressman. There are many areas in VA that need modernization—building, equipment, et cetera—but I would like to ask our Legislative Director, Joy Ilem, to add more detail.

Ms. ILEM. Thank you, Commander. With an aging infrastructure in VA, it is absolutely essential that Congress and VA work together to modernize the VA health care system. We know that, on average, buildings are 60 years old or greater, and compared to the private sector, where we are seeing more between 12 and 15 years for a facility.

Infrastructure is key in recruitment and retention of good people, modernization to have all of the IT equipment and new technologies that are available.

So the modest amount in the budget is not there. We have been advocating, as you noted, $7 billion, at least. VA's own SCIP plan, which is their Strategic Capital Infrastructure Plan, says that they need $150 billion to correct and build and modernize its system. So we have got to start making those investments. Our veterans deserve that.

Mr. TAKANO. Thank you. Thank you. I might note that this polls really high with the American public. We asked them, "Should we modernize these buildings?" and it is off the charts.

Chairman TESTER. Senator Hassan.

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

Senator HASSAN. Thank you, Mr. Chair, and to you and your co-Chair and Ranking Members, thank you all for having this hearing. Ms. Espinosa, thank you so much for being here and to all of your colleagues.

I would like to acknowledge, I was able to meet with the New Hampshire leadership of DAV back home at the end of last week, but I want to acknowledge all the Granite Staters who are here today, and as I did yesterday, a special welcome home to Vietnam vets. We are really, really glad to have you here.

Ms. Espinosa, I would also like to thank you and your family for your military service and for your work leading DAV. In your written testimony you mentioned the DAV's Caregivers Support Program, which provides support and resources to those who serve as caregivers for veterans. I know how important caregivers are to

people who experience disabilities and how difficult it can be to juggle all of the other responsibilities that we have in life with also caring for a loved one.

So Ms. Espinosa, can you please discuss the role that caregivers play in supporting disabled veterans and how Congress can continue to support them as well as the veterans that they serve?

Ms. ESPINOSA. Thank you very much for the question, Senator. I appreciate that. We have many caregivers in our DAV Auxiliary, and they work very hard to take care of their veterans and give them a good quality of life. The support that they need is a priority for them, whether it is the stipend or training to take care of the veterans. It is very important that they have that training and the backing of the VA to be able to provide care for their veteran.

Senator HASSAN. Thank you. I also wanted to follow up on another area of your testimony. Many veterans struggle with finding transportation to and from the VA. This issue affects not only disabled veterans but also veterans who live in rural areas without easy access to public transportation, and it is an issue that affects many people in New Hampshire.

In your testimony you describe the work DAV does to provide vehicles and drivers to assist veterans with getting to their VA medical appointments. I discussed how important this work was at last year's hearing, and it is even more important now as so many new veterans will be coming to VA facilities for care they are entitled to under the PACT Act. So what can the VA do to continue to support DAV's transportation network, especially as the number of veterans coming into VA facilities increases under the PACT Act?

Ms. ESPINOSA. I appreciate that question, Senator. It is very important to us. I would like to ask our Voluntary Services Director, John Kleindienst, to respond.

Senator HASSAN. Sure.

Mr. KLEINDIENST. Thank you, Commander. That is a great question. The VA would need to standardize and streamline the onboarding process for volunteers and prioritize what volunteers bring to VA as a without-compensation employee. The standardization needs to take place immediately, because if you go to one VA and another VA the priority and the standardizations are totally different. So that needs to change immediately.

We have many people willing to donate their most precious commodity, which is time, to transport veterans to and from their appointments, and lose interest when the VA drags their feet on onboarding these volunteers.

Senator HASSAN. I appreciate that, and just to my colleagues here, this is something we hear a lot about.

[Applause.]

Senator HASSAN. We lose volunteers to do this work because it takes so long, and the onboarding process is so irregular. So I hope we can work on that together. Thank you.

Chairman TESTER. Congressman Luttrell.

**HON. MORGAN LUTTRELL,**
**U.S. REPRESENTATIVE FROM TEXAS**

Mr. LUTTRELL. Thank you, sir. Thank you all for your service. I would feel remiss if I did not ask if there were any Texans in the

room. That is what I am talking about. Well, I am glad you are here too because I was going to take all of it and say there only needs to be one. Okay.

My question is, and reading over the information that you provided with us I want to talk about suicide and suicide prevention. In the VA system as a whole, in one of my subcommittees for VA I had the opportunity to discuss suicide prevention. And I am not saying I make it very uncomfortable for the VA members that are sitting in front of me when we are talking about suicide prevention because if there is anything that I would say is broken or missing in the VA it is our suicide prevention capabilities, because the number continues to grow. If you peel back the onion far enough, the one thing that continues to exponentially exceed itself is the number of veterans that are taking their lives. And I constantly get on the VA that it is their job, their job to be proactive in preventing the loss of our brothers and sisters.

But VA is a machine, a very large, capable machine, but with lots of intricacies that they also focus on, even though suicide prevention is their number one issue that they state. So Commander or—I do not know if you are going to shift this one over to Ms. Ilem—we veterans depend on our service organizations to fill the gap, whether it is retrospective, prospective information and research, to solve our veterans' problems. Veterans solve veterans' problems, plain and simple.

How are you leaning forward in this problem set? Because the 10-year plan that we have passed Congresses ago, that seemed to think that suicide prevention is a sustainable pay pipeline that we can just cookie cutter, and every single individual is different. Every single person's emotional and cognitive stability is different. You cannot treat one person like you treat the other.

So I think that we need to focus in on that and lean in on innovative ideas and modalities for our veterans to solve this suicide problem. What is DAV doing on this?

[Applause.]

Mr. LUTTRELL. Are you going to go to Ms. Ilem? I know you are.

Ms. ESPINOSA. Yea.

Mr. LUTTRELL. Okay.

Ms. ESPINOSA. Thank you very much for the question. I will ask Legislative Director, Joy Ilem, to respond. Thank you.

Ms. ILEM. Thank you for those passionate comments. We agree. This is going to take all of us together. I mean, that is one thing that we are really trying to push out there for our membership. It takes everyone to be a peer to our fellow veterans. And we need to look out for each other, and we need to take action when action is needed, and we need to make sure that crisis care is available.

Congress has done so much in terms of mental health and suicide prevention, a number of things. Everyone is looking at every type of solution. But again, it is going to require vigilance, and as you said, veterans will talk to other veterans. And we also know when somebody is in trouble and we need to take action, and we cannot be shy or worried. We need to help, right when help is needed.

Mr. LUTTRELL. And please communicate. I am talking to every veteran in this room and the brothers and sisters that are not here.

You have to communicate those innovative ideas that you stumble across in our communities and share that with this panel, so we can help move into the VA and let the VA be aware of it, as well. Because if we do not do that, we are our own worst enemy. Sir, I yield back.

Chairman TESTER. Representative Pappas.

**HON. CHRIS PAPPAS,**
**U.S. REPRESENTATIVE FROM NEW HAMPSHIRE**

Mr. PAPPAS. Thank you very much, Mr. Chairman. Commander, Thanks very much for your powerful testimony and the way that you related your own personal experiences through your service and as a veteran, and the challenges that you have faced. We are really grateful for everything that you have done and the advocacy of your team, which is terrific.

Thank you to all the veterans in the room, all the survivors and caregivers and advocates who are here, who help us get on track with respect to what we need to do together for America's veterans. And there really should be no party when it comes to this. We do not work for VA. We do not work for our party. We work all of you, so we cannot forget that. And we really appreciate the priorities you have highlighted today.

I want to commend DAV for their campaign to highlight the need to ensure long-term care options for veterans, including seriously disabled veterans with traumatic brain injuries. While efforts to research and better understand the impact TBIs have had on veterans, they have improved in recent years, but I share your concern that not enough consideration is being given to veterans with TBIs who may ultimately require specialized long-term care, ideally within their community, due to their injuries.

That is why I was pleased that language was included in the 2024 "minibus" that was just presented. It directs the Department to continue its efforts to partner with providers to ensure that veterans with TBIs are able to receive such long-term specialty care in their communities, and furthermore, it directs VA to educate case managers on the resources available to provide these veterans with the specialty care they so desperately need.

So I am wondering if you could comment on what VA is doing in terms of research into the long-term effects of TBIs and the planning and provisions of long-term specialty care, and how can Congress best advocate to support these efforts?

Ms. ESPINOSA. I appreciate the question, Congressman, thank you, and it is a very important area. I would like to ask our Legislative Director, Joy Ilem, to respond.

Ms. ILEM. Thank you, Commander, and thank you for that question. TBI, as we know, there are going to be these long-term effects that are still completely not known, but we have to be prepared. And VA is doing some critical research out there. We need to make sure that treatments are available.

And we need to make sure we are following along with these veterans to meet their unique needs. We know that could be younger veterans that require assisted living options, and we have recommended a number of proposals, to have a variety of complementary services, to make sure that veterans with TBI can live as inde-

pendent as possible but have the support that they need to be able to do that safely.

Mr. PAPPAS. Thanks very much for your response. I also want to thank DAV for being part of the coalition supporting the GUARD VA Benefits Act, which is an important piece of legislation that would reinstitute criminal penalties for folks that are violating the law, these claim sharks that are taking advantage of veterans, charging them an arm and a leg for services that we know DAV and other VSOs provide and take very seriously. We should support accredited agents, not these claim sharks that are ripping off our veterans.

I yield back, Mr. Chairman.

[Applause.]

Chairman TESTER. Senator King.

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

Senator KING. Thank you, Mr. Chairman. First I want to thank you for the work that you do generally, and that DAV does, the irreplaceable work that you do for the disabled American veterans, but specifically for the advocacy around the PACT Act. We would not have the PACT Act if it were not for you, and I want to thank you for that work. The benefits will be paying dividends for veterans for years to come.

The second thing is I want to thank you for the rides. The transportation system in my State of Maine is so important, in a rural state, and it just makes an enormous difference. I think my delegation, Steve Santos, and my delegation are over visiting on the other side of the Capitol right now, but they do fantastic work helping people to get to those appointments. Sometimes it seems like a sort of afterthought, but it is not. If you cannot get there, you cannot get the help. So thank you for the service that you provide.

A couple of issues. Joy, you mentioned long-term care is critical. That was the issue. We have got a wave coming at us. In Maine, we know about waves, and we have got a big wave heading for us right now in terms of long-term care, and it is only going to get more difficult. We have got problems with reimbursement rates, and we have got problems with staffing. So to the extent you have ideas or suggestions that can help us on the long-term care issue.

And one thing. We had a hearing up in Maine a few weeks ago on the issue of long-term care for veterans. We need navigation help. We need people that can help veterans know what the programs are, what is available, and how to navigate what is sometimes a pretty daunting system. So I hope that you can help us with that.

The other problem that we are seeing growth, unfortunately, is in mental health. We have talked about suicide. We need help with telehealth, which can be very effective in delivery of mental health. So I am asking you for help on these issues.

The final one that I am spending a lot of time on is transition. One of my first hearings over here, over 10 years ago, in the Armed Services Committee, I listened and listened about recruiting and everything, and then I said, "We should spend as much time, money, and effort on transition out as we do on recruiting in."

[Applause.]

Senator KING. There are several bills pending in this Congress. One is the Welcome Home Veterans, which would allow the notification to state veterans' offices. I think you are on record as supporting that. The Combat Veterans Pre-Enrollment Act—this is particularly important for your members—so you can enroll in the VA medical system before you leave, during the transition process, and then you can get medical care from day one. So I hope you will look at that bill. And then finally there is the TAP Promotion Act, which would allow VSO presence in the TAP program before the soon-to-be veterans leave service.

So those are all things I hope you can help us with. Those are things I think we can get done this year.

I want to, again, end where I began. Thank you for all you have done. Thank you for all you have done for veterans, in Maine and across the country.

Thank you, Mr. Chairman.

Ms. ESPINOSA. Thank you, Senator. Thank you.

Chairman BOST [presiding]. Representative Self.

**HON. KEITH SELF,**
**U.S. REPRESENTATIVE FROM TEXAS**

Mr. SELF. Thank you, Mr. Chairman. As an Army Green Beret it is always an honor to sit next to my Navy SEAL brother here, and I appreciate——

[Applause.]

Mr. SELF [continuing]. And I appreciate his setup because, Commander, in your written testimony, you highlighted the need to bolster mental health resources to prevent veteran suicide. It is a very important mission to us and the Committee as a whole, the House Committee as a whole.

As you know, the Staff Sergeant Gordon Fox Suicide Prevention Grant Program will need to be reauthorized in the next few years. We often focus on inputs—what we are doing, what the inputs are. I want to focus on the output of this program—what are the results, how are they measured—not inputs, but outputs.

So who, on this panel, can tell me how effective has the Staff Sergeant Fox Suicide Prevention Act been in preventing suicides, how is it measured, and how do you measure it? How effective is the program?

Ms. ESPINOSA. Thank you for that question, Representative. I would ask our Legislative Director, Joy Ilem, to respond.

Ms. ILEM. Thank you for that question. That is really important, and we are looking for that information as well. And I think being able to have—there have been a lot of new ideas and innovative ways to try to look for prevention, financial assistance and trying to get at points before somebody is homeless or in crisis or spiraling down.

And it is going to be key to look at the results of how those grants have been distributed, how helpful they have been in terms of the numbers of people that have been assisted, and again, how do you measure that in an effective way?

Mr. SELF. So you do not have those numbers for us yet.

Ms. ILEM. Right.

Mr. SELF. Because we will need that as we discuss, as a Committee, the reauthorization.

Ms. ILEM. Yes.

Mr. SELF. Which leads me to my next question. Well, you probably do not have an answer to this. Are there ways we can improve the application process? What other additional information do you need? So I will just leave that in your hands because we need the effects first.

In my district I have a lot of peer-to-peer counseling organizations for veteran PTSD to suicide, the whole gamut. One of them, Veterans Outpost, applied for a Fox grant last year, did not get it. And I want to ask you about what are the challenges that you are hearing on these peer-to-peer counseling, because as you know, some veterans like to go to big VA, some like to go to a community clinic, some like to go to peer-to-peer organizations.

What are the challenges faced by the peer-to-peer organizations, that you know of, for these grants?

Ms. ILEM. Well, I would note, DAV has a Charitable Service Trust where we have also provided grants to people within our different locations that can request a grant to do something special, and one that comes to mind was, I believe, in Arkansas, that was really effective.

It was a clinician who had been retired and then got a couple of folks that wanted to work with him to go out to the community and make sure that they were talking to veterans, one-on-one, and contacting everyone, letting them know that they were available there. And they felt very good about the success that they had in reaching those, and I think it is innovative ideas like that that are going to be key. And we need to continue to have that type of initiatives.

Mr. SELF. Well, I ask you to get us that information in the House Committee, certainly for the Fox Grants, the effectiveness of the program, and I look forward to working with you to see how we can, if we do need to improve it when we reauthorize it.

Mr. Chairman, I yield back.

Chairman BOST. Thank you. Representative McGarvey.

**HON. MORGAN MCGARVEY,**
**U.S. REPRESENTATIVE FROM KENTUCKY**

Mr. MCGARVEY. Thank you, Mr. Chairman. Commander Espinosa, I want to thank you for your service, both during your time in uniform and, of course, as a committed advocate for the millions of veterans and servicemembers across the country.

I also want to thank you, in particular, a report you just published last week, and I found this report really interesting. You did a lot of work, and the things that went into your research, you presented a lot of really thoughtful solutions.

In Louisville I hear about the great need for mental health clinicians who are specifically trained in issues that affect women, and for therapies that consider unique life transitions in family systems that affect women's overall health and well-being.

As women veterans in Kentucky navigate challenges related to aging, I hear about the need for better-informed VA clinicians on things like menopause. For example, when reading your report I was really surprised to read about the correlation between meno-

pause and suicide. And I agree that this warrants much more research and knowledge-sharing between both the VA and the non-VA experts.

So Commander Espinosa, I want to ask you, what are some of the specific changes that the VA can make to mental health programs and services to better meet the needs of aging women veterans right now, and what are your thoughts on how we, as a Committee, can provide the resources and support necessary to make these changes?

Ms. ESPINOSA. Thank you very much for that question, Congressman. It is very important. One thing that comes to my mind that VA could do, the formula that is used to assess risk for suicide for all veterans is based on men's experience. If that calculation could include MST or intimate partner violence, those kinds of categories should be added to that calculation. And women that have had MST are very high risk for suicide, and they should be evaluated and then reevaluated as they go along in their health care process. So that is one thing they could do.

Mr. MCGARVEY. Thank you. I appreciate that recommendation, Mr. Chairman, and I yield back.

Chairman BOST. Thank you. Representative Landsman.

**HON. GREG LANDSMAN,**
**U.S. REPRESENTATIVE FROM OHIO**

Mr. LANDSMAN. Thank you, Mr. Chair, and thank you for all of the work that you all do, and to all of the veterans and supporters here, we really do appreciate you. DAV was founded in Cincinnati. I am from Cincinnati. So over 100 years ago—yes, you can clap for that. That is exciting, yes.

[Applause.]

Mr. LANDSMAN. Cincinnati, we had the first baseball team, the first fire department, DAV. I was told once that the first fillet of fish sandwich was sold in a McDonald's restaurant in Cincinnati.

I want to join my Republican colleagues in their questions, comments, about the Fox Grants. We are talking a lot about veteran suicide, as we should be, and I think your points about making sure that we are collecting data and then developing supports for both men and women, because of the alarming rates that we are seeing women veterans take their lives. Anyways.

Getting a better understanding, and Mr. Self and Mr. Luttrell brought this up, that getting a much better sense of the data. I mean, it is really important, not just in terms of additional funding and what kind of decisions we made, but what is working and what is not working? And this is the Fox Grants, hugely important, but all of the work that we are doing to try to reduce, eliminate suicides, we have to get a much better grasp of what is actually working.

So I am curious what you would say to this question, which is, you know, we do not really have a sense right now, whether it is the Fox Grants or something else, what is working, and if we do we are not really sharing that with our partners. Is that fair? Is it unfair? I mean, this is clearly something that we are going to keep pushing on, and it is not a criticism as much as it is that we

have to get serious about understanding what works and then spreading it quickly.

Ms. ESPINOSA. I agree. Thank you very much for that, Representative. I would like to ask our Legislative Director, Joy Ilem, to add information.

Ms. ILEM. Thank you, Commander. I would just add that I think everyone wants to solve this issue and really tackle it head-on, and the grants, we need to be able to look at that data, that information, how effective they are. But we also need to know—I mean, we also look at the volume of veterans who do not use VA services. And so this is a great way, with these grants, for veterans in the community, with peers, that they may not have engaged with VA yet, but also learning about the services and resources that are available to them.

You know, because sometimes they have been out there on their own. That might be their first contact. But definitely if they may have long-term mental health issues that are serious we want to make sure they are connected with VA, from those grantees, because VA has the wraparound services and has a number of programs that are really going to be beneficial for them in the long run.

Mr. MCGARVEY. Thank you. I yield back.

Chairman BOST. Representative Budzinski.

**HON. NIKKI BUDZINSKI,**
**U.S. REPRESENTATIVE FROM ILLINOIS**

Ms. BUDZINSKI. Thank you, Mr. Chairman, and good morning, everyone. I want to first start out by thanking all the brave veterans and military members in the room for taking time to be with us here today.

The veteran service organizations like Disabled American Veterans play a crucial role in ensuring our veterans are getting the care they need, understand their benefits, and protect them from the claim sharks and bad actors that Congressman Pappas was discussing. And you all serve as the catalysts between Congress and the Veteran.

In my first year I just want to mention, I started my own Veterans Council, and in particular started a roundtable regular discussion with women veterans, in particular, in my district. And I just have to say, as a freshman serving on the House Veterans' Affairs Committee it is truly an honor to serve on this Committee and hear from you all on how we can better be serving the veterans in our communities.

It was with the help of the feedback from the VSOs that I was honored to introduce the bipartisan Edith Nourse Rogers STEM Scholarship Opportunity, H.R. 5785, with several VSOs, including DAV, having endorsed this legislation. My bill would modify requirements for the Edith Nourse Rogers STEM Scholarship to expand Post-9/11 GI Bill benefits, making it easier for our student veterans to access STEM education, and it would direct the VA to submit demographic information on denied applicants so that we can identify what gaps remain to be filled in the application process.

My question for Commander Espinosa, I appreciated your testimony and DAV's support, of course, of H.R. 5785. Can you speak to why we need more veterans in the STEM fields and how STEM expansion bills like the Edith Nourse Rogers STEM Scholarship Opportunity Act can benefit veterans, in particular women veterans who are underrepresented in STEM fields today?

Ms. ESPINOSA. Thank you very much for that question, Representative. As a previous or a past IT person I can really relate to the need for STEM in education. I would like to ask our Legislative Director, Joy Ilem, to add information.

Ms. BUDZINSKI. Great.

Ms. ILEM. Thank you, Commander. I think both of you have already made the case for why it is important. Veterans deserve to have these scholarships, and especially trying to encourage women veterans to do their graduate work and doctoral work for really careers that are essential. And we need to have women in those positions to be able to be, just like our Million Veteran Program, and others, that we want to make sure that women are represented adequately, because those are big, important fields that are going to determine our future, and we need to have women there.

Ms. BUDZINSKI. Absolutely. Thank you very much. I yield back, Chairman.

Chairman BOST. Senator Blumenthal, you are recognized for three minutes.

**HON. RICHARD BLUMENTHAL,**
**U.S. SENATOR FROM CONNECTICUT**

Senator BLUMENTHAL. Thank you, Mr. Chairman. Thank you to our House colleagues for being here, and to all of you for your service to our country and your extraordinary service, not only in uniform but afterwards. It is really exemplary and inspiring.

I have been greatly heartened and encouraged by the expansion of the PACT Act—I am sure there has been a good deal of discussion about it—to include all men and women exposed while in the military to any kind of toxic substances, whether here or abroad, whether during training or in combat. As a dad of two sons who have served—one as a Marine Corps infantry officer in Afghanistan and the other as a Navy SEAL—I am deeply concerned about the effects of exposure to toxic substances. The effects may not manifest right away. It may be only years later. And the passage of the PACT Act and now expansion is one of the ways that we are keeping faith with our men and women who serve.

But I am very concerned that many of our veterans simply do not know about it, and I would like to ask you whether there is more that we can and should do to make them aware of it, and what specifically you would recommend.

Ms. ESPINOSA. Thank you very much for that question, Senator. It is very important. I would like to ask our Service Director, Jim Marszalek, to respond.

Mr. MARSZALEK. Thank you, Commander, and great question, Senator. The outreach that VA has done as a result of the passage of the PACT Act has been pretty significant. DAV also has done significant research. We have done over 400 information seminars throughout the community just last year, informing veterans about

the PACT Act and all other VA benefits they may be entitled to. We collaborate alongside VA in a lot of those, as well, so they come to some of our outreach events.

I think not only the PACT Act outreach itself but it has also brought in a lot of veterans who maybe have filed claims many, many years ago who had a distrust in VA, come back. I was just at a recent event with Under Secretary Josh Jacobs, and he talked about a story where they were at a DAV outreach event where a Vietnam veteran heard about the PACT Act that he may be entitled to benefits and came back, but had filed a claim many, many years before and was denied, and did not think that he was entitled to benefits any longer.

So we have to continue doing that outreach, so DAV is going to continue doing our information seminars in communities throughout the country. It is one of our proudest programs to get out there and really talk to veterans and their spouses about entitlement.

Senator BLUMENTHAL. I would be very interested in any ongoing suggestions or recommendations you have that we can bring the attention or emphasize with the VA, because obviously you are in touch, on the ground. I am in Connecticut, but you are nationwide. And I think this kind of outreach is critical.

Thanks, Mr. Chairman.

Chairman BOST. Thank you. Thank you. So what we would like to say now is we want to thank the DAV for their time and efforts to bring forward their priorities. And let me say, as Chairman—and I will speak for myself as Chairman and I know the Ranking Member of both the House and the Senate—we are here for you. We want to advance the causes, to make sure our veterans are taken of. We would love to wave a magic wand and fix everything, but working together we can try to fix as much as we possibly can.

Remember, DoD, unfortunately, they have got jobs to do, and when they do that job quite often our veterans need the help that VA provides, to try to make them as whole as possible. We want to make sure that they continue to do that effort.

And with that, we will be keeping the record open for a week for any other input you might want to have on this hearing. And with that we will adjourn.

[Applause.]

[Whereupon, at 11:19 a.m., the hearing was adjourned.]

# A P P E N D I X

## Prepared Statement

KEEPING OUR PROMISE TO AMERICA'S VETERANS

National Headquarters
860 Dolwick Drive
Erlanger, KY 41018
tel 859-441-7300
toll free 877-426-2838
dav.org

Washington Headquarters
1300 I Street NW, Suite 400W
Washington, DC 20005
tel 202-554-3501

***STATEMENT OF***
***NANCY ESPINOSA***
***DAV NATIONAL COMMANDER***
***BEFORE THE***
***COMMITTEES ON VETERANS' AFFAIRS***
***U.S. SENATE AND U.S. HOUSE OF REPRESENTATIVES***
***WASHINGTON, D.C.***
***MARCH 7, 2024***

Chairman Tester, Chairman Bost, Ranking Members Moran and Takano, and Members of the Committees on Veterans' Affairs:

Thank you for providing me the opportunity to present the 2023–2024 Legislative Program of DAV—Disabled American Veterans—an organization of more than 1 million members, all of whom were injured or became ill as a result of wartime service. We are proud to have helped millions of veterans, their families, caregivers and survivors since our founding over a century ago.

I am a service-connected disabled Army, Army Reserve and National Guard veteran of the Gulf War era with a family legacy of military service.

My father, Joe Espinosa, enlisted in the Army during World War II and served four tours in Germany over his 20-year career. My Uncle Fred was a tough Marine who earned his Purple Heart after being shot during the Battle of Saipan. Uncle Benny is a 93-year-old Korean War veteran who volunteered for years at his local Department of Veterans Affairs (VA) hospital and provided military honors for service members until he was over 80-years old. My son, Ian, is a Navy veteran and my other son, Eric, served in the Air Force.

But the reason for sitting before you today can be attributed to my mother, Eleanor Espinosa. She was a tough lady who got things done in the face of adversity. She became a widow at a young age and had to raise two daughters on her own. She instilled in us the value of independence and hard work. "Have a roof, have a car, have a job," she'd always say.

So, when mom told me I needed to get a part-time job to help pay for school clothes, I responded to an ad for a clerk typist that said "no experience necessary." The position turned out to be with the Army Reserves and it launched my 15-year military career. Ten years later, I went on active duty. But my service in the Army was marked by obstacles and loss.

In 1987, I was serving on active duty when I had my son. After his birth, I was

diagnosed with endometriosis—a painful condition of the reproductive system that required me to have an emergency hysterectomy and a bowel resection. To make matters worse—doctors also told me they found an aggressive cancer that could leave me with just six months to live. Needless to say, it was a traumatic experience and I was devastated.

Fortunately, they were able to operate and successfully remove the cancerous tissues, but my months long recovery was quickly followed by the heart wrenching loss of my sister, Margaret. It was so unexpected, and even though it's been more than 30 years, I miss her more than I can put into words.

Soon after, my young stepdaughter died unexpectedly. The combined losses and health issues left me in a deep depression, so I decided, with the support of my family, to take a hardship discharge from the Army and transitioned into the New Mexico National Guard in 1989 in order to continue my military career.

When I separated from the National Guard in 1990, I turned to the VA for health care. Unfortunately, I found that my local VA medical center was ill-equipped to address my health care needs because there was very little support for women veterans at that time, especially women suffering from reproductive health issues. They simply didn't know how to deal with me, so I went outside of the VA for the gender-specific care I needed.

As far as mental health, I didn't even realize that was an option with the VA. But I figured if they couldn't handle my medical care, they weren't prepared to help treat my depression either. So, I went outside the VA health care system for that too.

The experiences of feeling dismissed and misunderstood by the very system that promised to take care of me is not unique. While every veteran will inevitably face challenges navigating an imperfect system, women veterans have historically been overlooked and underserved by the VA. That said, I am thankful for DAV's efforts to right this wrong and to see the tremendous progress that has been made in recent decades. But now is a critical time with more women than ever serving in the military and turning to VA for help with post-deployment mental health challenges following service. And particularly now—with rates of suicide skyrocketing among women veterans—lives are at stake and more must be done.

DAV has always been a champion of women veterans fighting for equity in the delivery of health care and benefits they have earned. We must continue to raise awareness about the increasing suicide rates among women veterans and focus on what we can do as a community to address this complex problem. I am pleased to inform you that just last week, DAV released a new special report entitled, *Women Veterans: The Journey to Mental Wellness. Supporting women veterans' mental health and preventing suicide through gender-tailored care.*

It is the third report focused on women veterans' issues released by DAV in

the last 10 years, and one of the most comprehensive assessments of the unique factors contributing to the staggering rate of suicide among women veterans.

According to the VA, between 2020 and 2021, the suicide rate among women veterans increased 24.1%—nearly four times higher than the 6.3% increase among male veterans and vastly higher than the 2.6% increase among nonveteran women. Women are also two times more likely than male veterans to attempt suicide and three times more likely than non-veteran women to choose a firearm as a means of suicide. These findings call for action.

We are pleased to share a copy of our new report with Committee members and hope you will take the time to read it and consider our more than 50 policy, research and legislative recommendations to help save lives.

Messers Chairman, being part of DAV is a point of extraordinary pride for me, in large part because this organization and its members understand the importance of making sure *all* of our voices are heard and *all* of our needs are represented.

Shortly after becoming President in April 1945, Harry Truman addressed our armed forces still engaged in World War II, telling them that:

*"Our debt to the heroic men and valiant women in the service of our country can never be repaid. They have earned our undying gratitude."*

Nearly 80 years later, our nation is still working to repay that sacred debt, which includes modernizing the VA so it can meet the needs of all of our nation's veterans today and in the future. Together, we have the opportunity—and the obligation—to do so. I am honored to be here today to help underscore these and other areas in further detail by presenting DAV's 2023–2024 Legislative Program.

## BOLSTER MENTAL HEALTH RESOURCES TO REDUCE VETERAN SUICIDE

One of DAV's key critical policy goals for 2024 is to ensure service-disabled veterans have timely access to the VA's specialized mental health care, services, and supports to address post-deployment readjustment issues and mental health challenges.

The *2023 National Veteran Suicide Prevention Annual Report* reflects the complexity of suicide inherent in the veteran population, and the United States as a whole, which entails numerous and complex risks and protective factors across individual, community, and societal levels. The report reflects data through 2021 and found increased rates of suicide among veterans—noting that the entire U.S. population faced health, mental health and mortality effects due to the COVID-19 pandemic.

The report confirmed that in 2021 there were 6,392 veteran suicide deaths

(approximately 18 per day)—114 more deaths than in 2020. The increase was significantly higher for women veterans, for whom there was a 24.1% increase compared to an increase of 6.3% among male veterans, and 2.6% increase among non-veteran women. According to the VA, distress increased among veterans aged 18 to 44 and among women veterans, which was associated with increasing socioeconomic concerns, greater problematic alcohol use and decreased community integration. The report also noted that suicide deaths among veterans were more likely to involve firearms than suicide deaths among non-veteran adults. Specifically, firearms were involved in 73.4% of suicide deaths among male veterans, and 51.7% of women veterans.

To address this issue, the Veterans Health Administration (VHA) created a multifaceted campaign in partnership with the National Shooting Sports Foundation (NSSF) to highlight the importance of lethal means safety counseling for veterans at risk for self-harm or suicide. While there is still more work to do to reduce the concern among veterans who believe their firearms will be confiscated if they seek mental health help from the VA, this partnership appears to be building trust among the veteran population.

Veterans access to timely, high quality, evidence-based mental health services is essential in reducing suicide. In 2023, VHA experienced net increases in overall clinical staffing, but continued to report severe shortages of mental health providers throughout most of the country. A 2023 Office of Inspector General (OIG) report (OIG-23-00659-186) notes that 91 of 139 VA facilities identified a severe shortage of psychologists, and 73 facilities identified a severe shortage of psychiatrists.

As newly established grant programs and community-based benefits to promote suicide prevention for veterans are implemented, it is vital to ensure that existing programs within VHA remain properly staffed with well-trained providers using evidence-based treatments for veterans who need specialized care. According to the 2023 suicide prevention annual report, among veterans receiving care through VHA, when comparing those solely receiving VA Community Care services versus those receiving VHA direct care services, veterans who "received Community Care services only" had higher suicide rates than those who "received VHA direct care alone." This highlights the importance of the VA being the primary provider and coordinator of veterans care and ensuring veterans have access to VA's specialized care and supportive wrap-around services even when they are receiving services through VA's community care network (VCCN).

All community care providers can assist in the national effort to reduce veteran firearm suicide by taking this critical training about how to incorporate discussions with their patients about the importance of secure firearm and medication storage, especially among at-risk veterans. Unlike VA providers, VCCN providers are not required to take available training in suicide prevention and competence in lethal means safety counseling for at-risk veterans. In fact, only a very small percentage of these community providers have completed this evidence-based, life-saving training. Understanding the

veteran experience and common mental health conditions among this population, along with training in evidenced-based treatments, is essential for delivery of quality care, preventing suicide and successful health outcomes.

We urge Congress to enact legislation that requires specific training protocols for all VCCN mental health providers to ensure they meet the same quality and access standards as VA mental health providers. Mandating training in evidence-based therapies is vital to ensuring community partners develop core competencies for addressing veterans' unique mental health and readjustment needs—particularly for conditions frequently associated with military service.

Finally, through integrated clinical and community strategies, the VHA must continue to proactively identify and improve interventions for at-risk veterans, for both veterans using VHA care and those using other care systems, to prevent suicide and overdose death. The VA must continue to increase the implementation of its Safety Planning in Emergency Departments initiative and continue its partnership and collaboration with other federal and state agencies and community partners to develop statewide plans to end veteran suicide. DAV calls on Congress to ensure the VA is provided sufficient resources for mental health and suicide prevention efforts and that the department maintains a strong suicide prevention research portfolio that includes interagency collaboration.

DAV looks forward to continuing our work with Congress on oversight of the implementation of mental health legislation already enacted and to collaborating on meaningful and innovative new legislation this year to eliminate access barriers to mental health care that can help reduce suicide among veterans.

## EXPAND THE VA'S CAPACITY TO DELIVER TIMELY, HIGH-QUALITY HEALTH CARE TO VETERANS

Over the past decade, the veterans health care system has experienced unprecedented growth and stress, while also undertaking historic reforms to ensure that veterans have timely access to comprehensive, high-quality health care. However, an increasing number of veterans have no choice but to use non-VA care due to their inability to access VA care in a timely manner.

Service-disabled veterans are prominent users of the VA health care system, a system designed to meet their unique medical, mental health and rehabilitative needs. Most indicate they want to receive care at the VA whenever possible due to its comprehensive and specialized veteran-centric care and wraparound services. But, for the VA to remain the primary provider of care, and veterans' first choice in care, the department must improve its internal capacity to deliver timely, convenient and high-quality care. Specifically, VHA must address staffing needs, aging infrastructure and challenges with its electronic health record (EHR) modernization efforts.

**Vacancies and Staffing Shortages**

The VA's workforce shortages and hiring challenges mirror those of the private sector and the country as a whole due to a lack of clinical providers. Workforce shortages are prevalent across the country and competition is high to attract the best and brightest medical professionals. According to an August 2023 OIG report, VA facilities reported 3,118 severe occupational staffing shortages across 282 occupations in fiscal year (FY) 2023; 88% of facilities reported severe occupational staffing shortages for medical officers, and 92% of facilities reported severe shortages for nurses. Every facility the OIG surveyed reported at least one severe occupational staffing shortage, with VHA vacancies reported at approximately 75,000 at the end of FY 2023. The VA must continue to accelerate its recruitment and retention efforts and expedite its hiring and onboarding processes to expand its capacity to deliver high-quality health services to our nation's veterans. At the same time, Congress must enact legislation and increase funding to address recruitment, education, expansion and retention efforts that will improve VA's workforce.

**Aging Health Care Infrastructure**

According to the VA, while private sector health facilities' median age is about 11-years old, VA facilities' median age is nearly 60-years old, which makes them difficult to renovate since they were not designed to accommodate the technological and design innovations that support modern health care delivery. For the VA to continue to be the primary health care provider and care coordinator of choice for veterans, it must improve its internal capacity by building or modernizing facilities to better meet the needs of current and future veterans. To achieve these goals, the VA needs to create a strategic plan to modernize its infrastructure and improve its project management of VA capital asset programs. We call on Congress to significantly increase construction funds for health care facilities to increase the VA's internal capacity to care for veterans.

**Information Technology and Electronic Health Record Modernization**

In June 2017, the VA initiated plans to replace its existing electronic health record system (VistA) because of its technical complexity, cost to maintain and lack of interoperability with other private health organizations. The VA's ongoing transition to a new EHR hit some stumbling blocks during its initial rollout and again in 2022 as reports of problems surfaced regarding patient safety and employee user dissatisfaction with the new system. Following a reassessment of its efforts in 2023, the VA released a revised national rollout plan to improve training and address implementation problems. The success of this new EHR system is critical to the future of the entire VA health care system, including truly seamless scheduling and clinical care coordination. Congress must provide rigorous oversight of the VA's IT modernization efforts to ensure that patient care, safety and other mission-critical work, including data collection and research, are not negatively affected. The VA must oversee contracts with vendors and hold them accountable to meet standards, expectations and timely delivery of services

while maintaining compliance with all security protocols for protection of personal identification and medical information.

**Expanding access to VA care through telehealth and virtual health services**

As the largest provider of telehealth services in the country, the VA is leading the nation in telemedicine and virtual health care advancement. In FY 2022, more than one-third of veterans who received care from the VA did so using virtual health care services, which has helped to expand access to VA care, especially in rural and remote locations. The VA must continue to leverage and build its infrastructure for virtual health services to fill gaps created by provider shortages; address long travel distances to health care facilities in certain states; and help veterans overcome limited transportation options that often keep them from obtaining timely, quality care. The VA must carefully study the efficacy of virtual health care to determine its optimal use to ensure the best health outcomes for the veterans it serves.

**VA Fourth Mission**

VA's primary mission is to care for our nation's ill and injured veterans, followed by educating and training our nation's health professionals and conducting veteran-related research to ensure veterans have access to high-quality care and specialized services. A lesser-known responsibility of the department, though critically important, is VA's fourth mission—to improve the nation's preparedness for response to war, terrorism, national emergencies and natural disasters. This support is carried out through plans and actions to support national, state and local emergency management, public health, safety and homeland security efforts. In recent years, we learned just how important a role the VA played during the global COVID pandemic, not only in continuing care for enrolled veterans but also supporting our nation's medical system. The VA must continue to maintain sufficient health care capacity to meet its fourth mission functions during national emergencies while also ensuring that veterans continue to have uninterrupted and timely access to VA health care.

## ENSURE FULL FUNDING FOR HEALTH CARE AND BENEFITS

Messers Chairmen, none of the reforms and improvements to veterans health care and benefits we are proposing can be accomplished unless the VA has full and timely funding. Unfortunately, Congress and the Administration once again failed to enact the federal budget on time this fiscal year, instead passing a series of stopgap continuing resolutions (CRs) that leave the final budget yet to be resolved. While much of VA is cushioned from the harm of government shutdowns due to advance appropriations, the use of short- or long-term CRs still has the effect of delaying new and expanded veterans programs and services from operating at full capacity. Congress must work to enact VA appropriations legislation before the start of each fiscal year.

To assure adequate funding, DAV, in partnership with Paralyzed Veterans of America (PVA) and Veterans of Foreign Wars (VFW), annually produces VA budget recommendations through publication of *The Independent Budget* (IB); with the FY 2025 budget recommendations being released last month. For more than three decades, the Independent Budget Veterans Service Organizations (IBVSOs) have provided independent, unbiased, needs-based estimates of the total resources VA requires to provide veterans with the benefits and health care services they have earned.

For FY 2025, the IBVSOs are recommending significant increases to improve VA's internal capacity to directly provide medical care. For FY 2025, we are recommending an increase for total medical care of approximately $10 billion over the projected FY 2024 level, almost a 10% increase. This level of funding would allow the VA to fill approximately 19,000 health care vacancies and expand care to more than 130,000 new unique patients. The IB recommendations would also allow the VA to expand dental care eligibility to all enrolled veterans, and to increase resources for long-term care by more than $1 billion for VA's aging veteran population. To support expanded health care delivery, the IBVSOs are recommending that the VA exponentially increase funding for VA health care infrastructure, which would include $5 billion for major construction projects, $900 million for minor construction, and $900 million for nonrecurring maintenance.

In order to improve the timeliness and accuracy of benefits claims processing, particularly with the increased workload from the PACT Act, the IBVSOs are recommending a $500 million (+9%) increase for the Veterans Benefits Administration (VBA) and a $40 million (+14%) increase for the Board of Veterans' Appeals in FY 2025. The IBVSOs are also calling for a historic $146 million (+30%) increase for the National Cemetery Administration to cover the costs of its expanded operations; to fully fund the National Shrine Initiative and Legacy Memorial programs; and to increase awareness of and utilization by eligible veterans.

Together with our IB partners, DAV will continue advocating for sufficient, timely and predictable funding for all VA programs, services, and benefits for the men and women who served.

## IMPLEMENT THE PACT ACT AND ADDRESS GAPS IN TOXIC-EXPOSURE BENEFITS

Messers Chairmen, the Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics Act, or PACT Act, signed into law on August 20, 2022, provides benefits and health care to veterans exposed to burn pits, radiation, Agent Orange and other toxins.

From August 10, 2022 through January 27, 2024, VA received over 1.3 million PACT Act-related claims and decided over 967,000 of them with an average of 159

days pending. There were some miscues along the way, which is why proper implementation by the VA and continuous oversight by Congress is key to ensuring veterans can access their benefits and key services.

It is imperative that Congress monitors the number of claims filed related to the PACT Act, how these claims affect the overall workload, and how many are approved or denied—and why. The VA should also provide data on the quality and number of exams conducted, and transparency regarding quality assurance. The PACT Act addresses a number of long-standing issues associated with environmental and toxic exposures but there are still veterans who are waiting for help.

While the PACT Act recognizes those veterans who served at Karshi-Khanabad Air Base (K2) in Uzbekistan as being exposed to burn pits, it did not address the other known and Department of Defense (DoD)-recognized toxic exposures at K2. Between 2001 and 2005, more than 15,000 service members deployed to K2 in support of military operations into northern Afghanistan following 9/11. This former Soviet air base contained residuals of chemical weapons, radioactive depleted uranium, and jet fuel, among nearly 400 other chemical compounds. The DoD knew that service members deployed there were exposed to these dangerous toxins, and a 2015 Army study found that K2 veterans have a 500% greater chance of developing certain cancers.

The PACT Act includes K2 veterans in the burn pit presumptive diseases; however, the VA has still not recognized the other toxic exposures and potential diseases unique to K2. Because of these gaps, many veterans will be denied access to life-changing health care and benefits. DAV urges Congress to enact legislation that concedes exposures to radiation, jet fuel and chemical weapons at K2; provides for studies; and recognizes presumptive diseases related to them. Additionally, K2 veterans should be provided eligibility to health care based on toxic exposures, per section 1710, title 38, United States Code.

The PACT Act also recognizes additional locations of radiation risk activities for veterans who participated in the cleanup operations in Thule, Greenland; Enewetak Atoll; and Palomares, Spain. However, there currently exists an inequity between the VA radiation-exposed presumptive process and another federal government program.

First, for VA claims where it is contended that disease developed as a result of exposure to ionizing radiation during service, service incurrence may be presumed for veterans who participated in defined radiation risk activities and have certain diseases. The second approach—to substantiate a radiation exposure-related service connection claim—requires proof of not only the veteran's on-site participation but also radiation dose estimates from the Defense Threat Reduction Agency and then a medical opinion assessing whether that dose estimate caused the claimed presumptive disease.

By comparison, the Department of Justice's Radiation Exposure Claims Act (RECA) program establishes compensation for individuals who contracted specified diseases related to atmospheric nuclear weapons development tests in the American

Southwest. The RECA program is available to uranium workers and miners, civilians exposed in downwind areas and veterans. A lump sum is payable to veterans who were on-site participants at the atmospheric nuclear weapons tests. RECA does not require claimants to prove causation of the diseases related to the radiation exposure, nor does it require dose estimates of exposures. Veterans who were exposed on-site can receive compensation from the government without dose estimates and without proving that the claimed disease is directly caused by the dose estimate of radiation exposure.

The PACT Act does recognize three new locations of radiation risk activities; however, within the first year of the PACT Act, the VA said that of the roughly 4,100 processed radiation-related claims, it denied more than 3,500 and granted about 570 from Aug. 10, 2022, to Aug. 10, 2023. That means the VA rejected 86% of those claims based on radiation exposure.

We urge Congress to enact H.R. 4655, the PRESUME Act to remove the VA dose estimate requirement for radiation exposure. This legislation will provide parity with the governmental RECA program and treat veterans' radiation exposure claims on equal footing with civilians who were not participants but only downwind from nuclear testing.

Messers Chairmen, the PACT Act originally included a requirement for a registry study on the impacts of water contamination with Perfluoroalkyl and polyfluoroalkyl substances (PFAS). Unfortunately, the provision was removed prior to final passage of the bill. We are greatly concerned about the long-term health impact of PFAS exposure as, according to DoD data, more than 700 U.S. military sites are known or likely to have discharged PFAS in the water supplies.

In 2022, the National Academies of Science, Medicine and Engineering report *Guidance on PFAS Exposure, Testing, and Clinical Follow-Up* found sufficient evidence of an association between PFAS exposure and decreased antibody response; dyslipidemia; and increased risk of kidney cancer. Additionally, it found limited or suggestive evidence of an association between PFAS exposure and increased risk of: breast cancer; liver enzyme alterations; pregnancy-induced hypertension; testicular cancer; thyroid disease and dysfunction and ulcerative colitis.

In August 2022, a large clinical study found that people with high levels of PFAS in their blood are more likely to develop hepatocellular carcinoma, the most common form of liver cancer. In October 2023, a systematic review and meta-analysis associated PFAS exposure to kidney cancer and testicular cancer.

As noted, the PACT Act originally included provisions to create a PFAS registry and authorize studies; however, those provisions were removed prior to the final passage. It is clear that the existing science has associated PFAS exposure with many lethal conditions and yet the VA does not concede PFAS exposure nor provide any presumptive diseases.

We urge Congress to enact H.R. 4249/S. 2294, the Veterans Exposed to Toxic PFAS Act (VET PFAS Act), which will add presumptive diseases for PFAS exposure and provide critical health care for veterans and their families. We need swift legislative action to address the negative long-term health impact based on exposure to these toxic chemicals.

Messers Chairmen, millions of veterans now and in the future will benefit from the monumental enactment of the PACT Act; however, Congress must provide rigorous oversight of its implementation. Further, to provide true equity to all toxic-exposed veterans, Congress must also enact legislation to recognize the specific exposures and related diseases at K2, ensure parity for radiation-exposed veterans and remove the dose estimate requirement, as well as address the exceptionally wide-spread PFAS water contamination.

In addition, the VA must become better at recognizing and granting benefits and health care to veterans exposed to toxic and environmental hazards in the future. Building on the success of the PACT Act, DAV and the Military Officers Association of America (MOAA) have been engaged in a toxic exposure research project, and will soon release a report, *Ending the Wait for Toxic Exposed Veterans,* with detailed findings and policy recommendations.

In brief, we found that, on average, it takes more than 30 years for Congress or VA to establish presumptive diseases such as those for Agent Orange and in the PACT Act. These presumptions help to ensure that all exposed veterans receive their earned benefits and get access to VA health care.

No veteran should have to wait three decades to receive care and benefits for injuries and illnesses caused by their service. We look forward to presenting this report and briefing these committees with our findings and recommendations.

**STRENGTHEN AND IMPROVE VETERANS' AND SURVIVORS' BENEFITS**

Messers Chairmen, despite significant progress and improvement over the past decade, wounded, ill and injured veterans and their survivors still face barriers and inequities in maintaining financial security due to unjust practices and failures to provide parity with similar government-provided civilian benefits.

Currently, there are two groups of veterans that are allowed to receive both their full military retirement pay and VA compensation benefits: those under the concurrent retirement plans and those longevity military retirees with at least a 50% VA disability rating. However, veterans with a 40% or lower VA disability rating and those forced to medically retire under Chapter 61 have their military retirement pay offset for every dollar of VA disability compensation received. These men and women are essentially funding their VA compensation with part of their own retirement pay. These are two separately earned benefits, and any offset between longevity military retired pay and VA compensation is completely unjust.

DAV urges Congress to enact H.R. 1283/S. 344, the Major Richard Star Act, to repeal the inequitable offset between rightfully earned military retirement pay and VA disability compensation for *all* eligible veterans, including Chapter 61 medically-retired veterans.

Similarly, veterans who were provided separation pay from the DoD are required to pay back those funds if they become eligible for VA disability compensation benefits. However, the lump-sum separation payment is not based on or due to disabilities incurred in service, and therefore withholding a veteran's VA disability compensation based on receipt of a non-related military separation benefit is unfair and must end.

DAV urges Congress to enact H.R. 3489, the Restore Veterans' Compensation Act, which would afford justice for these veterans by allowing them to keep military separation payments based on their military service, which differs from VA disability compensation.

While the VA focuses most of its attention on veterans, and rightfully so, we cannot forget those who share in the burden of sacrifice: their families, caregivers and survivors.

Created in 1993, Dependency and Indemnity Compensation (DIC) is a benefit paid to surviving spouses of service members who die in the line of duty or veterans whose death is due to a service-connected injury or disease. DIC provides surviving families with the means to maintain some semblance of economic stability after the loss of their veteran spouse. However, the current DIC benefit paid to survivors is insufficient. Today, married veterans who are receiving 100% disability compensation through the VA are being paid approximately $3,946 a month, whereas DIC payments for survivors are set at $1,613 a month. This difference is approximately 41% of the compensation paid to the service-disabled veteran who was rated at 100% with a spouse. As a result, surviving spouses have to not only deal with the heartache of losing their loved one, but also contend with the loss of approximately $28,000 a year. This particularly affects survivors who depend on that compensation as a primary source of income.

In contrast, monthly benefits for survivors of federal civil service retirees are calculated as a percentage of the civil service retiree's Federal Employees Retirement System or Civil Service Retirement System benefits, up to 55%. This is a difference between 41% and 55% and presents a significant inequity for survivors of our nation's heroes compared with survivors of federal employees.

To ensure survivors of disabled veterans receive a meaningful benefit, DAV urges Congress to enact S. 414/H.R. 1083, the Caring for Survivors Act, legislation that would index the rate of compensation for DIC payments to 55% of a 100% service-disabled veteran with a spouse, and adjust it annually for inflation. These unsung heroes need to be assured that their nation also recognizes their sacrifices, cherishes

their legacy of service, and will support them both now and in the future.

Another challenge for survivors is the financial penalty for remarrying. For decades, surviving spouses were no longer eligible for DIC benefits if they remarried prior to the age of 57. Then in 2021, the remarriage age was lowered to 55, an improvement, but there still remains a penalty for those who remarry before turning 55.

DAV urges Congress to pass H.R. 3651/S. 1266, the Love Lives On Act, legislation that would eliminate the remarriage age for survivors in receipt of DIC payments. Surviving spouses, especially those widowed at a young age, that are currently in receipt of DIC should not have to worry about losing their benefits if they remarry before the age of 55.

## PROVIDE A FULL SPECTRUM OF LONG-TERM CARE OPTIONS FOR SERVICE-DISABLED AND AGING VETERANS

Another key legislative priority for DAV is ensuring that our nation's service-disabled veterans have access to a full continuum of care, including a full spectrum of long-term care (LTC) options and supportive services to address these veterans' unique needs.

The VA's program of Geriatric and Extended Care includes a broad range of long-term supports and services for aging and disabled veterans. As part of the VA medical benefits package, enrolled veterans are eligible for homemaker and home health aide care services; skilled home health care; home based primary care; veteran-directed care; adult day health care; respite care; telehealth; and palliative and hospice care. Unfortunately, funding for home and community-based services in recent years has not kept pace with population growth, an aging veterans cohort, or inflation. For non-institutional care to work effectively, these programs must focus on prevention and engage veterans before they have a devastating health crisis that requires more intensive inpatient care. To meet the exploding demand for LTC for veterans in the years ahead, Congress must provide VA increased resources to significantly expand home and community-based LTC programming.

VA's institutional LTC services are provided through 134 VA-operated community living centers (CLCs), 162 VA-supported State Veterans Homes (SVHs), and hundreds of community-based skilled nursing facilities under contract with the VA. Through its CLCs, SVHs and contracts with community nursing homes, the VA provides care directly to around 9,000 veterans each day in VA-operated CLCs, and approximately 40,000 LTC beds in SVHs, VA domiciliaries and in community-based skilled nursing facilities, combined.

VA projects demand for LTC will continue to increase, driven by the growing numbers of aging veterans and veterans with service-connected disabilities. The VA faces three key challenges meeting the growing demand for LTC: workforce shortages,

veterans' needs for specialty LTC and access challenges due to geographic alignment of care—particularly for veterans living in rural areas.

While the overall veteran population is decreasing, the number of older veterans with the highest use of LTC services is increasing significantly. For example, the number of veterans with VA disability ratings of 70% or higher (which guarantees mandatory LTC eligibility for any reason) who are at least 85-years old is expected to grow by almost 600% by 2037. Based on this estimate, costs for LTC services and supports will need to be doubled over the same period just to maintain current services. In addition, there are tens of thousands of aging veterans with disability ratings of 50% and 60% who may need extended inpatient skilled care services but do not currently have mandatory eligibility for such services under the law.

There is also a growing population of aging women veterans who will require extended care services in the near future. It is incumbent upon the VA to ensure that institutional care settings meet appropriate environment of care standards, including those for safety and privacy to accommodate their needs. While some VA CLCs are equipped for the specialized care needs of seriously-disabled veterans with traumatic brain and spinal cord injuries, these services are not readily available in most private nursing homes in the community. Finally, placement and care of veterans with serious neurobehavioral issues or those who need intensive memory or dementia care continues to be a challenge for all LTC facilities.

We urge Congress to increase resources for expansion of home-based services and supports, as well as the modernization and expansion of VA community living centers and State Veterans Homes to meet the specialized needs of seriously-disabled veterans. We also call on Congress to enact legislation that would expand mandatory eligibility for long-term nursing home care to service-connected veterans rated 50% and 60%.

## IMPROVE THE PROGRAM PROCESS FOR CAREGIVERS

Many of our nation's veterans who suffered serious physical or psychological injuries rely on their caregivers, who are often family members or close friends. These family caregivers provide their loved ones the ability to live with dignity and have a better quality of life in their homes rather than being placed in an institution. However, this service and sacrifice often comes at a price to our nation's caregivers through lost income, limited earning potential and an impact on their own physical and emotional health.

While we appreciate that Congress has enacted thoughtful caregiver legislation and the VA has tried to improve supportive services for seriously injured and disabled veterans and their caregivers, more needs to be done to ensure veterans have access to these vital services and that ample support is provided to their caregivers.

The expansion of eligibility to caregivers of veterans from all eras made by Congress through VA's Program of Comprehensive Assistance for Family Caregivers was life-changing for many veterans. In 2020, VA adopted new eligibility regulations concurrent with the expansion of the program to veterans of all eras, which unfortunately had the adverse impact of making it dramatically harder for too many veterans and caregivers to be admitted to or remain in the program. In March 2021, VA announced that all expulsions from the department's caregiver support program would be halted until officials could review and revise existing regulations to better fulfill the program's intent.

DAV urges Congress to continue working with the VA, DAV and other veterans' organizations supporting caregivers by ensuring that the VA promulgates new regulations to create fair, consistent, transparent, and equitable eligibility criteria and reassessment rules for the program. The VA must focus on providing detailed explanations on how standards are measured and applied in each decision notification that is sent to veterans and caregivers.

## ADVANCE EQUITY IN HEALTH SERVICES AND BENEFITS

The VHA is responsible for caring for an increasingly diverse veteran population and must ensure equity in services, benefits, and health outcomes for *all* veterans whom it serves. Black, Latino and other ethnic minorities now comprise about 20% of VA's patient population—a figure projected to increase to 34% by 2040. Women veterans make up around 10% of VA patients with this number projected to increase to 18% by 2040. An estimated one million veterans identify as LGBTQ+.

Research shows that racial and ethnic minorities experience disparities in medical treatment and health outcomes. For example, Black veterans using VHA care are more likely to die of breast cancer, colorectal cancer and HIV than their white peers. Hispanic veterans are more likely to die of colorectal cancer and HIV. Women and LGBTQ+ veterans are at higher risk for suicide when compared to their nonveteran peers. The VA must work to identify common factors and biases that contribute to health inequities and disparate health outcomes for minority veterans, and develop educational tools and training protocols to ensure equitable, high-quality care for all veterans. If disparate health outcomes for these groups are identified, they must be thoroughly evaluated and resolved.

All veterans should feel welcome, safe and supported from the moment they walk into a VA facility. Certain groups of veterans, including some women and LGBTQ+ veterans, perceive VA health care environments as unwelcoming or threatening. Stranger harassment is a barrier to VA care and deters many women, LGBTQ+ and other minority veterans from seeking the medical care and specialized services they need and deserve. The VA must continue to promote its Stop Harassment and White Ribbon campaigns to eliminate sexual assault and harassment at all VA facilities. VA leadership must provide strategic, comprehensive plans to effectively address these

long-standing issues and hold medical facility directors responsible for upholding the tenants of these important campaigns to end veterans' harassment. The VA must dedicate the proper resources and staff necessary to achieve its stated anti-harassment goals and complete a successful culture change throughout the department. Ensuring safe and accommodating care environments is an essential element to providing effective health care.

The Veterans Experience Office is unique in its ability to collect information on the customer experience within the VA. Surveys to the population as a whole show gaps in meeting the unique needs of women, LGBTQ+ and minority veterans. By better understanding the needs of these veterans and increasing the use of minority peer specialists, there is an opportunity to improve cultural sensitivity and personalize veterans' care experiences within the system.

Research plays a key role in addressing gaps in programs and services for smaller subpopulations of veterans. Researchers must continue to recruit women and other minority veteran populations to ensure they are adequately reflected in research findings. DAV urges VA's Office of Research and Development to work in collaboration with the White House's new Initiative on Women's Health Research. The Million Veteran Program—VA's genomic research initiative to collect data and samples from all veterans to look at unique factors that may affect their health and personalize treatments for them—has struggled to find enough women and certain minority groups to ensure clinically significant research findings for these populations. While we are pleased the program has reached its milestone of collecting samples from one million veterans, the VA must continue outreach efforts to the underserved cohorts to ensure the data shows an accurate picture that accounts for the diversity within our veteran community.

## DAV NATIONAL SERVICE PROGRAM

### Claims Assistance

Messers Chairmen, while much of our focus in Washington, D.C., is on advocacy, DAV's core mission around the country involves providing direct services to America's ill and injured veterans and the families who care for them. DAV fulfills the mandate of service most prominently through our National Service Program by directly employing a corps of national service officers (NSOs), all of whom are wartime service-connected disabled veterans who successfully completed our 16-month formal on-the-job training program. DAV NSOs' own military, personal claims and VA health care experiences not only provide a significant knowledge base, but also help promote their passion for helping other veterans through the labyrinth of the VA system. These benefits advocates are situated in spaces provided by the VA in its regional offices, as well as in other VA facilities throughout the nation.

With our national, department, chapter and transition service officers, as well as

county veteran service officers, over 3,600 DAV benefits experts represent claimants around the country. They serve on the frontlines providing much-needed benefits advocacy to our nation's veterans, their families and their survivors. With the generous support of a grateful American public and patriotic businesses, DAV is proud to provide these services, without cost, to any veteran, dependent or survivor in need.

In 2023, DAV's service program took more than 2.8 million actions to advocate for veterans and their families, such as representing claimants in hearings and appeals for benefits, reviewing and developing records, providing professional advice and responding to inquiries, and establishing new claims for earned benefits.

I can proudly state that DAV has the largest and most well-trained service program in the country. No other organization has more impact on empowering disabled veterans to become even more productive members of society. We have over 1.1 million powers of attorney to represent veterans and their survivors before the VA. During 2023, DAV national and transition service officers interviewed over 300,000 veterans and their families, and filed more than 200,000 new claims for over 600,000 specific injuries and/or illnesses. Thanks to the great work of our service officers, claimants represented by DAV obtained more than $28 billion in earned benefits in 2023.

**Appellate Representation of Denied Claims**

In addition to our work at VA regional offices, DAV employs national appeals officers who serve appellants in the preparation and presentation of written briefs for Board of Veterans' Appeals review. These elite advocates also represent appellants in formal hearings before veterans law judges. The Board is the highest appellate level within the VA, responsible for the final decision concerning entitlement to veterans benefits. More than 80% of the claims before the Board involve disability compensation issues.

In FY 2023, DAV appeals officers provided representation in more than 16% of all appeals decided by the Board, which is a caseload of 16,323 appeals. Of appeals represented by DAV at this level, 82% of original decisions were overturned or remanded to the regional office for additional development and readjudication.

DAV also has a pro bono representation program for veterans seeking review in the United States Court of Appeals for Veterans Claims. DAV currently works with two of the most accomplished law firms in the country dealing with veterans' issues at the Court. Each of the cases acted upon by our national appeals office in calendar year 2023 was reviewed to identify claims that were improperly denied. Thanks to DAV and our relationship with private law firms and our pro bono program, 990 of these cases previously denied by the Board were appealed to the Court.

These partnerships have allowed this program to grow exponentially over the past few years, and would not have been possible without the coordinated efforts of

DAV and two top-notch law firms, Finnegan, Henderson, Farabow, Garrett & Dunner LLP of Washington, D.C., and Chisholm, Chisholm & Kilpatrick of Providence, Rhode Island. Since the inception of DAV's pro bono program, our attorney partners have made offers of free representation to more than 21,000 veterans and have provided free representation in over 16,000 cases.

**Transition Services for New Veterans**

DAV continues to provide direct, on-site assistance to ill and injured active-duty military personnel through our Transition Service Program, which provides benefits counseling and assistance to separating service members seeking to file initial claims for benefits administered through the VA. Our transition service officers (TSOs) are trained specifically to give transition presentations, review military service treatment records and initiate claims activities at nearly 100 military installations throughout the country.

DAV currently employs 26 TSOs who also provide free assistance to those in need. In 2023, DAV TSOs conducted over 680 briefing presentations to groups of separating service members, with more than 33,000 participants attending those sessions. They also counseled in excess of 45,000 people in individual interviews and electronic communications, reviewed 36,670 military service treatment records and presented over 16,000 benefits applications.

DAV remains committed to advocating for these service members to ensure that they are better informed about the benefits they have earned as a result of their military service. Through our TSO program DAV is able to advise service members of their benefits and ensure that they know about the free services we provide during every stage of the claims and appeals process.

**Information Seminar Program**

Another important outreach program for veterans is DAV's Information Seminars, which educate veterans and their families on specific veterans benefits and services. With the support of DAV's network of state-level departments and local chapters, DAV NSOs conduct these free seminars across the country.

During 2023, DAV held over 400 seminars, briefing over 17,000 veterans and their families about benefits they may be entitled to as a result of their military service. Service officers interviewed veterans and their families at these seminars and assisted in filing new claims for benefits as well.

**Disaster Relief Program**

DAV's Disaster Relief Program provides grants and supply kits to help veterans and their families secure temporary lodging, food and other necessities in the aftermath of natural disasters and emergencies in various areas around the nation. During 2023,

DAV provided over $725,000 to more than 1,000 veterans affected by natural disasters, including hurricanes, tornadoes, floods and fires throughout 21 states.

In the last 10 years, DAV disbursed 17,375 checks totaling $8,857,420 in relief.

**Caregiver Program**

In October 2023, we launched a new DAV Caregivers Support program that provides tailored support and resources to friends, family members and loved ones who provide care to those who served. Not only do caregivers share in the sacrifices veterans incurred in service, but their contributions also enhance our veterans' quality of life. DAV believes the caregivers of our country's veterans deserve their own support.

Through DAV Caregivers Support, caregivers can access online resources and risk screening to better understand their role as a caregiver; digital tools to support their caregiving responsibilities; and, receive personalized care plans with one-on-one support from a trained specialist whom has experience supporting veterans and their loved ones. All caregiver support and resources—including individual support from a trained specialist—is at no cost. They can be found at davcaregiver.org.

## VOLUNTARY SERVICES

A vital part of DAV's success is the more than 17,000 DAV and DAV Auxiliary volunteers who selflessly donate their time to assist DAV's mission of empowering veterans to lead high-quality lives with respect and dignity. By enlisting the support of volunteers, DAV helps ensure that ill and injured veterans are able to attend their medical appointments and receive care in VA medical centers, clinics and Community Living Centers. Volunteers also visit and support veterans within their communities and, in some cases, go beyond the current scope of government programs and services. Simply stated, they provide a special thanks to our nation's heroes.

If the VA had to pay federal employees for the nearly 550,000 hours of essential services to hospitalized veterans that DAV volunteers provide at no cost, the cost to taxpayers would have been more than $17.4 million last year.

**DAV Transportation Network**

The DAV Transportation Network is the largest program of its kind for veterans in the nation. This unique initiative provides free transportation to and from VA health care facilities to veterans who otherwise might not be able to obtain needed care and services. The program is operated by 149 hospital service coordinators and more than 3,200 volunteer drivers at VA medical centers across the country.

During FY 2023, DAV volunteers donated over 575,000 hours of their time transporting veterans to their VA medical appointments. With most VA medical facilities

returning to full operation, volunteers logged more than 9.2 million miles and provided more than 245,000 rides to VA health care appointments, saving taxpayers more than $18.2 million. Since our national Transportation Network began in 1987, nearly 20 million rides have been provided, with volunteers transporting veterans more than 752 million miles.

We are also very pleased to report that in 2023, DAV donated 98 new vehicles to VA facilities to use for transporting veterans, at a cost of more than $4.1 million. In 2024, we plan to donate 70 additional vehicles to the VA, at a cost of more than $3.2 million. DAV's efforts were again supported by Ford Motor Co., with the presentation of eight new vehicles to the DAV Transportation Network. To date, Ford donations have exceeded more than $6.2 million toward the purchase of 264 vehicles to support this critical transportation program. DAV is very thankful for Ford Motor Co.'s collaboration and its continued support and commitment to the men and women who have served our nation.

DAV's commitment to ensuring veterans can access the care they earned is strong and lasting. Since 1987, we have deployed DAV vehicles in every state and nearly every congressional district in order to serve our nation's ill and injured veterans, many of whom are your constituents. With a value of more than $90.7 million, DAV has donated a total of 3,763 vehicles to the VA since the program began transporting veterans to their medical appointments.

**DAV Local Veterans Assistance Program**

DAV created the Local Veterans Assistance Program (LVAP) to facilitate and recognize initiatives in which volunteers can contribute their skills, talents, professional abilities, and time in ways that benefit veterans residing within a volunteer's local community. DAV and DAV Auxiliary volunteers have answered that call in full measure. From July 1, 2022, to June 30, 2023, LVAP volunteers performed buddy checks, delivered groceries, and provided help to our nation's heroes in a variety of ways. Overall, they donated more than 1.9 million hours of service to ensure that no veteran in need of help was left behind. We see examples of this each and every day, highlighting the principal objective of our organization: keeping our promise to America's veterans.

Our LVAP volunteers contribute time and energy for various activities that include, but are not limited to:

- State department- and chapter-level volunteer benefits advocacy.
- Outreach at events such as Homeless Veterans Stand Downs and a volunteer presence at National Guard mobilization and demobilization sites.
- Direct assistance to veterans, their families and their survivors, including home repairs, maintenance and grocery shopping, among many other supportive activities.

To date, LVAP volunteers have donated more than 16.3 million volunteer hours in their local communities. We believe this important program makes a difference in the lives of all of those we serve.

**Mentorship and Rehabilitation**

Another innovative program offered by DAV is our mentorship program, which operates in collaboration with the Boulder Crest Foundation at locations in Virginia and Arizona. Boulder Crest is committed to improving the physical, emotional, spiritual, and economic well-being of our nation's military members, veterans, first responders and their family members. DAV, in partnership with the Gary Sinise Foundation, participates in annual retreats for ill and injured veterans. DAV also sponsors all-female veteran cohorts. In 2023, 40 veterans were a part of these life-changing retreats. Since 2015, 294 veterans have participated in this alternative program that offers new and holistic ways to help veterans who are struggling to overcome the challenges that often follow military service.

DAV leaders, including DAV past national commanders, national service officers, and other DAV members, have served as mentors at these retreats to the latest generation of seriously injured veterans. Spouses of many of these leaders have also served as mentors to the caregivers of participants and imparted the knowledge and understanding that comes with decades of serving as caregivers.

**Adaptive Sports**

Messers Chairmen, DAV is especially proud of our adaptive sports programs and associated events that directly improve the lives and well-being of our most profoundly injured veterans. Working in cooperation with the VA's Adaptive Sports Program, DAV is proud to co-present the annual National Disabled Veterans Winter Sports Clinic and the National Disabled Veterans Golf Clinic.

For nearly four decades, DAV and the VA have teamed up for the National Disabled Veterans Winter Sports Clinic, often referred to as "Miracles on the Mountainside." This unique clinic promotes rehabilitation and restoration by coaching and encouraging veterans with severe disabilities to conquer adaptive skiing, curling, ice hockey and other sports and adaptive recreational activities of all kinds. Often, this event offers veterans their very first experience in winter sports and gives them motivation to take their personal rehabilitation to a higher level than they may ever have imagined. Participants have included veterans with multiple amputations, traumatic brain and spinal cord injuries, severe neurological deficits and even total blindness.

After lowered participation due to the COVID pandemic, the 37th National Disabled Veterans Winter Sports Clinic was hosted in a full capacity on March 27–31, 2023. This year's event is scheduled for April 1–7, 2024 in Snowmass, Colorado.

The National Disabled Veterans Golf Clinic provides legally blind and other

eligible disabled veterans opportunities to develop new skills and strengthen their self-confidence through adaptive golf, bowling, cycling and other activities. Attending veterans participate in therapeutic adaptive sports activities that demonstrate that a visual, physical or psychological disability need not be an obstacle to an active and rewarding life. Veterans from all eras have attended our clinics, including many who were injured in Iraq and Afghanistan. DAV has proudly co-presented this event since 2017. We are happy to report that the 30th anniversary event near Iowa City, Iowa, September 10–15, 2023, was also at full capacity. This year's event is scheduled for September 8–13, 2024.

Both of these exceptional physical rehabilitation programs have transformed the lives of some of America's most severely injured and ill veterans. These unique programs help them rebuild their confidence, compensate for their injuries, and regain balance in their lives. I invite all members of these committees to come and experience these events with DAV leaders this year.

**The Next Generation of Volunteers**

Each year, DAV awards scholarships to deserving youth volunteers. These outstanding young people, who participate as DAV volunteers in the VA Voluntary Service Program and/or our Local Veterans Assistance Program, donate their time and provide compassion and support to ill and injured veterans. They represent not just our next generation of volunteerism but also the future of our nation.

We are excited to present 10 scholarships annually for a total of $110,000, with the top scholarship of $30,000. The top award will be presented at the 2024 DAV National Convention later this year.

Since the scholarship program's inception, DAV has awarded 231 individual scholarships valued at more than $1.8 million, enabling exceptional young people to pursue their goals in higher education and experience the significant rewards of volunteering. DAV is very proud of this program, and we are honored to award these scholarships to worthy student volunteers.

Messers Chairmen, DAV is extremely humbled of the service provided by our volunteers, many of whom are ill or injured veterans themselves, or family members of such veterans. These volunteers continue to selflessly serve the needs of our nation's disabled veterans on a daily basis, and we applaud their compassion and dedication.

## EMPLOYMENT AND ENTREPRENEURSHIP

The journey from injury to recovery cannot be completed until veterans are able to find meaning in life and regain purpose after injury or serious illness. For those who are able, working to care and provide for themselves and their families is a fundamental principle. Each year, thousands of men and women make the transition from military to civilian life, and DAV remains dedicated to providing our services to all who have served

and their spouses. Specifically, DAV remains fully committed to ensuring that they gain the tools, resources and opportunities they need to competitively enter the job market and secure meaningful employment, or pursue their own paths to success through entrepreneurship.

DAV's National Employment Program was established in 2014 and has firmly positioned itself at the forefront of veterans organizations in providing assistance to veterans and their spouses seeking new or better careers. One primary component of this mission was DAV forming a strategic partnership with RecruitMilitary, a veteran-operated, full-service military-to-civilian recruiting firm. In addition to hosting nearly 100 traditional and virtual career fairs with RecruitMilitary annually, DAV uses a multitude of online and offline resources to connect employers, franchisers and educational institutions with active-duty service members, Guard and Reserve personnel, veterans and their spouses.

DAV's efforts to connect veterans with careers have made a significant impact on reducing the number of unemployed and underemployed veterans, contributing to the historically low veteran unemployment rate of approximately 2.8% that our nation arrived at just before the dramatic, adverse effects of the COVID pandemic. In fact, from June 2014 through December 2023, DAV hosted almost 1,000 in-person and virtual career fairs, resulting in over 180,000 job offers extended to over 300,000 participants. During 2023 we supported both in-person and virtual job fairs across the country, with 62 in-person and 23 virtual events. In 2024, we will be hosting over 100 job fairs for active-duty service members, Guard and Reserve personnel, veterans and their spouses. We encourage you to share with your constituents our full schedule of job fairs, which can be found at davjobfairs.org. You can let them know that companies are aggressively recruiting and hiring military veterans because they know the value veterans and their spouses bring to their organization.

In addition to our sponsored veteran career fairs each year, DAV works directly with more than 380 companies seeking the many talents and skills they know only veterans possess. Moreover, DAV provides a multitude of resources that veterans can easily access within our employment resources webpage, jobs.dav.org, including a job search board offering more than 269,000 current employment opportunities around the world, direct links to companies, resources for employers and other helpful information.

Additionally, DAV expanded our efforts to recognize outstanding companies that are not only veteran-friendly but veteran-ready—companies that fully understand the value and importance of veterans in their workplace and demonstrate solid recruiting, hiring and retention efforts. DAV's Patriot Employer recognition program provides well-deserved recognition to many outstanding companies. We invite you to visit patriotemployers.org and nominate one or more companies in your respective districts and states.

Furthermore, DAV continued our partnership with "Hiring America," the foremost voice in televised programs, such as the American Forces Network (AFN), dedicated

solely to helping veterans secure meaningful employment opportunities. Each episode features companies with outstanding veteran-hiring initiatives and shares insights from business leaders, career counselors and human resource specialists. With the program's projected reach of nearly 3 million viewers, we are very excited about this addition to the growing number of tools and resources that DAV provides to veterans seeking employment and companies that want to hire them.

DAV has expanded our published resource, *The Veteran Advantage: DAV Guide to Hiring and Retaining Veterans With Disabilities*, for employers to provide companies, hiring managers or other human resources professionals with a solution-oriented, practical and strategic approach to hiring and retaining veterans with disabilities. We are pleased with the ongoing positive response to our hiring guide, and we will keep this valuable information up to date and available to companies who visit our employment resources every day. We encourage you and your staff to visit jobs.dav.org to download a copy of our hiring guide, or we would be happy to provide you with copies of the printed version.

In 2021, DAV took a dramatic leap forward in assisting entrepreneurs in the veteran- and military-connected community, including spouses, with the acquisition of DAV Patriot Boot Camp, which was formerly an independent 501(c)(3) charity. In doing so, DAV absorbed a community of thousands of entrepreneurs, supporters and mentors who participate in formal and informal training to make the business world more accessible to those who served.

DAV hosted two significant in-person training events in DAV Patriot Boot Camp's inaugural year, three events in 2022, and four events in 2023, including an accelerator program. DAV Patriot Boot Camp also provides a monthly webinar series, known as Caffeine Connect, and additional resources to empower founders to succeed. This initiative complements DAV's ongoing efforts to support and advocate on behalf of service-disabled veteran-owned small businesses (SDVOSB).

In 2024, our organization plans to host at least three in-person cohorts, a pitch competition, and launch additional education initiatives for earlier stage entrepreneurs while continuing to work with business leaders who are eager to help vetrepreneurs succeed. As founders achieve their business goals, we know they will grow and hire more of their fellow veterans and spouses as well as continue to help one another succeed in their careers and/or as entrepreneurs.

## DAV CHARITABLE SERVICE TRUST

DAV is committed to ensuring veterans and their families do not fall through the cracks. But there remain unmet needs and creative solutions that deserve our support. Organized in 1986, the DAV Charitable Service Trust is a tax-exempt, nonprofit organization serving primarily as a source of grants for qualifying organizations throughout the nation. As an affiliate of DAV, the Trust strives to meet the needs of ill

and injured veterans through financial support of programs and services that provide direct support to veterans and their families.

DAV established the Trust to advance initiatives, programs and services that may not easily fit into the scheme of what is traditionally offered through VA programs or by DAV departments and other veterans organizations in the community. Nonprofit organizations meeting the direct service needs of veterans, their dependents and their survivors, are encouraged to apply for financial support. Since the first grant was awarded in 1988, over $166 million has been invested to serve the interests of our nation's heroes.

To fulfill the Trust's mission of service, support is offered to ensure quality care and support are available for veterans with post-traumatic stress disorder, traumatic brain injuries, substance use challenges, amputations, spinal cord injuries and other combat-related injuries. It also fuels efforts to combat hunger and homelessness among veterans, and priority is given to long-term service projects that provide meaningful support to unserved and underserved veterans. Initiatives for evaluating and addressing the needs of veterans from every service era and conflict are encouraged.

Typically, grants are awarded to programs offering:

- Food, shelter and other necessities to veterans who are homeless or at-risk of homelessness.
- Mobility items or assistance specific to veterans with blindness or vision loss, hearing loss or amputations.
- Qualified therapeutic activities for veterans and/or their families.
- Physical rehabilitation, mental health and suicide prevention services.

In 2020, a $1 million grant was awarded to Save A Warrior, a nonprofit organization committed to ending the staggering suicide rate plaguing veterans, active-duty military and first responders. The grant was used to support the construction and development of Save A Warrior's National Center of Excellence for Complex Post-Traumatic Stress presented by DAV in Hillsboro, Ohio, to provide a healing outlet for ill and injured veterans combating suicide and mental health issues. In 2021, another $200,000 grant was provided for programming and the center opened in June 2022. Save A Warrior received an additional $1 million grant in November 2022 to offer trauma-focused cognitive behavioral therapy, relevant 12-step programs, cognitive processing therapy, mindfulness-based stress reduction techniques and resources to participants. The Trust continued its partnership with the organization in 2023 by awarding a $2 million grant for general operating costs and construction expenses for lodging at the S/SGT Dick Wood Warrior Village. The lodges are located in a peaceful, wooded area near the National Center of Excellence and amenities include comfortable sleeping quarters, communal areas for group interactions, dedicated meditation rooms and expansive outdoor spaces ideal for both physical activities and quiet contemplation.

DAV has also provided more than $1 million to Boulder Crest retreats, where DAV leaders and spouses serve as mentors for the latest generation of seriously-injured veterans and their caregivers.

The Trust is dedicated to making a positive difference in the lives of America's most deserving individuals and their loved ones. As long as veterans experience unemployment, homelessness, and physical and psychological illnesses, the need continues for innovative programs and services to address these challenges.

By supporting these initiatives and programs, the Trust furthers the mission of DAV. For over a century, DAV has directed its resources to the most needed and meaningful services for the nation's wounded, ill and injured veterans and their families. Significantly, the many accomplishments of both DAV and the Trust have been made possible through the continued support and generosity of corporate partners, individuals and DAV members who remain faithful to our mission.

## LEGISLATION

Messers Chairmen, DAV's stance on legislation is approved by our members in the form of adopted resolutions, calling for program, policy and legislative changes to improve health care services and benefits for wartime service-disabled veterans, their dependents and their survivors. Outlined below is a partial list of DAV's legislative resolutions approved at our 2023 national convention. On behalf of DAV, I ask members of the House and Senate Veterans' Affairs Committees to consider the merit of these proposals and use them to draft and enact legislation.

The complete text of DAV's 2023-2024 Legislative Program is available on DAV's website, to review click here.

**Disability Compensation and Other Benefits**

- Support legislation to remove the prohibition against concurrent receipt of military retired pay and veterans' disability compensation for all veterans.
- Support meaningful claims and appeals reform.
- Support legislation to increase disability compensation.
- Increase the grant and specially adaptive equipment rates for automobiles and other conveyances for eligible disabled veterans.
- Oppose reduction, taxation or elimination of veterans' benefits.
- Support legislation to provide service connection for disabling conditions resulting from toxic and environmental exposures.
- Support legislation to protect total disability based on Individual Unemployability benefits and ensure it remains available for all eligible veterans regardless of age or receipt of any other federal benefits.
- Support legislation for studies and presumptive diseases related to PFAS exposure.
- Support legislation to improve and reform Dependency and Indemnity

Compensation.
- Support legislation to improve the Department of Veterans Affairs Fiduciary Program.
- Support legislation to reform and improve Service-Disabled Veterans Life Insurance.
- Increase the Home Improvement and Structural Alterations Grant.
- Support legislation that prohibits Special Separation benefit payments from being withheld from Department of Veterans Affairs disability compensation payments.
- Support an increase in the Department of Veterans Affairs burial allowance for service-connected veterans and provide automatic annual adjustments.

**Medical and Health Care Services**
- Support program improvement and enhanced resources for VA mental health programs and suicide prevention.
- Support enhanced medical services and benefits for women veterans.
- Support equity in access to services and benefits for racial and ethnic minority service-connected disabled veterans.
- Provide comprehensive dental care to all service-connected disabled veterans within the VA health care system.
- Enhance long-term services and supports for service-connected disabled veterans.
- Strengthen and protect the VA health care system.
- Ensure a safe, secure and effective electronic health record for veterans that allows the VA to fulfill core missions of patient care, research and training.
- Support effective recruitment, retention and development of the VA health care system workforce.
- Ensure timely access to quality VA health care and medical services.
- Support legislation to provide comprehensive support services for caregivers of severely wounded, ill and injured veterans from all eras.
- Support VA research into the medical efficacy of cannabis for treatment of service-connected disabled veterans.
- Support humane, consistent pain management programs in the veterans' health care system.
- Support VA medical and prosthetic research programs.
- Support legislation to eliminate or reduce VA and Department of Defense health care copayments for service-connected disabled veterans.

**General Issues**
- Support sufficient, timely and predictable funding for all VA programs, benefits and services.
- Support elimination of employment licensure and certification barriers that impede the transfer of military occupations to the civilian labor market.
- Provide adequate funding and permanency for veterans' employment and training programs.
- Protect veterans from employment discrimination when receiving health care

for service-connected conditions.
- Account for those still missing and the repatriation of the remains of those who died while serving our nation.
- Support legislation to strengthen and protect service-disabled veteran-owned small businesses.
- Support legislation to create, improve and reform federal programs for service-disabled veteran entrepreneurship.
- Support the continued growth of Veterans Treatment Courts for justice-involved veterans.
- Support veterans' preference in public employment.
- Support fair air travel for disabled veterans.

## CONCLUSION

Messers Chairmen, DAV has been serving veterans for more than 100 years. Our organization has come before these distinguished committees for decades to highlight the challenges veterans face across the nation. We appreciate your continued efforts and commitment to these issues—and to the men and women who served—particularly since many of the challenges veterans face are not quickly or easily resolved.

Before I conclude, I'd like to share an inscription on the southeast portico of the Thomas Jefferson Memorial from a letter he wrote arguing against societal stagnation. It reads:

*"I am not an advocate for frequent changes in laws and constitutions, but laws and institutions must go hand in hand with the progress of the human mind. As that becomes more developed, more enlightened, as new discoveries are made, new truths discovered and manners and opinions change, with the change of circumstances, institutions must advance also to keep pace with the times."*

That stance remains as true today as it did more than 200 years ago.

If ever there was a need for us to focus our efforts and collaborate to create a VA for today and tomorrow, this is it. Our veterans need us. They need you. And they are worth the fight.

Messers Chairmen, thank you for the opportunity to present DAV's legislative priorities and highlight the many services we provide to America's ill and injured veterans. As always, my heart remains with DAV, the men and women who have served our great nation, their families, caregivers, and survivors—and, of course, the United States of America.

Thank you. This concludes my statement.

KEEPING OUR PROMISE TO AMERICA'S VETERANS

National Headquarters
860 Dolwick Drive
Erlanger, KY 41018
tel 859-441-7300
toll free 877-426-2838
dav.org

Washington Headquarters
1300 I St. NW, Suite 400W
Washington, DC 20005
tel 202-554-3501

## Biographical INFO

**NANCY G. ESPINOSA**
**National Commander**
**DAV (Disabled American Veterans)**

Nancy Espinosa, a service-connected disabled veteran of the Army, Reserve and National Guard, was elected as national commander for the more than 1 million-member DAV at the organization's 2023 national convention in Atlantic City, New Jersey.

Espinosa was a member of Army Reserve from 1975 until becoming an active-duty soldier in 1985. After four years of active service, she joined the New Mexico Army National Guard, serving until her honorable discharge in 1990.

Upon leaving military service, Espinosa joined DAV. Currently a member of Chapter 14 in Layton, Utah, she is the Department of Utah adjutant and also served as past department commander and chairman of the department's finance committee.

She is an active member of DAV's Commanders and Adjutants Association and a commissioner on the Utah Legislative Veterans and Military Affairs Commission.

Espinosa was awarded the Bonnie Anderson Award for Outstanding Service in 2014 by the DAV Department of Utah.

She resides in Kaysville, Utah, and is the proud mother of two grown sons.

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National Headquarters
860 Dolwick Drive
Erlanger, KY 41018
tel 859-441-7300
toll free 877-426-2838
dav.org

Washington Headquarters
1300 I Street NW, Suite 400 West
Washington, DC 20005
tel 202-554-3501

## Biographical INFO

**BARRY A. JESINOSKI**
**National Adjutant/CEO**
**DAV (Disabled American Veterans)**

Barry A. Jesinoski, a service-connected veteran of the Persian Gulf War era, was appointed national adjutant for the more than 1 million-member DAV in June 2023. As DAV's chief executive, Jesinoski leads the organization, overseeing all staff and operations for one of America's largest charitable institutions.

Before his appointment, he served as executive director of DAV National Headquarters in Erlanger, Kentucky, since August 2013. As executive director, he served as the organization's chief financial officer and chief operating officer, overseeing employment initiatives, voluntary services, communications, membership activities, fundraising, accounting, administration, human resources, information technology, outreach and logistics.

Jesinoski began his DAV career as a member of Class II at the National Service Officer Training Academy in Denver in 1995. Following graduation from the academy, he worked on the front lines of DAV's largest service initiative and represented veterans in their claims for benefits.

He rose from an apprentice in Seattle to supervise one of DAV's most prominent offices in San Diego in two years. In 2001, he was promoted to oversee benefits advocacy for an area encompassing California, Arizona, Oregon, Nevada and Hawaii. Later that same year, he was appointed to the national service staff and assigned to DAV's Washington Headquarters. The following year, he was promoted to assistant national service director.

In 2007, he was appointed deputy director of human resources and relocated to DAV National Headquarters before taking the lead as director in 2009. Then, in 2011, he returned to Washington, D.C., to lead DAV's service and legislative efforts as executive director and as DAV's principal spokesperson at the Department of Veterans Affairs, Congress and the White House. He served in that capacity until his appointment as executive director of DAV National Headquarters.

Jesinoski is focused on improving efficiencies and aligning DAV's efforts and collaboration across the organization's departments. He's initiated several DAV programs, such as the transition service program, the employment and entrepreneurship departments, service officer certification training, the case management system, the results management office and the most significant IT infrastructure project in the organization's history. He also led the site selection and construction of DAV's new national headquarters. Internally, he's championed benefit enhancements, such as a performance and retention program, flexible work schedule, accelerated PTO allotments, and bereavement and parental leave.

Through his leadership, DAV's outreach efforts have quadrupled in scope, fundraising has been diversified, and every department in his purview has taken on new initiatives aimed at achieving strategic objectives and modernizing the delivery of services.

A native of Ottertail County, Minnesota, Jesinoski was medically discharged from the Marine Corps in 1993. He earned his initial Senior Professional in Human Resources (SPHR) certification from the Human Resources Certification Institute in 2008.

He lives in Fort Mitchell, Kentucky, with his wife and two sons.

National Headquarters
860 Dolwick Drive
Erlanger, KY 41018
tel 859-441-7300
toll free 877-426-2838
dav.org

Biographical **INFO**

**B. CODY VANBOXEL**
**Executive Director/CFO, National Headquarters**
**DAV (Disabled American Veterans)**

Cody VanBoxel, a service-connected disabled veteran of the Iraq War, was appointed executive director and chief financial officer for the more than 1 million-member DAV in June 2023. He is employed at DAV National Headquarters in Erlanger, Kentucky.

As executive director and chief financial officer, VanBoxel oversees employment initiatives, voluntary services, fundraising, accounting, membership activities, administration, information technology, communications, outreach, human resources, facilities and logistics critical to DAV's mission of support for disabled veterans and their families.

Prior to this current appointment, he was appointed to assistant executive director in 2021. In this role, he worked closely with the executive director to oversee and guide numerous programs, services, and departments. VanBoxel worked as a leader and mentor to assist in guiding several important initiatives efficiently and through to completion. One of his proudest, being his assistance in the acquisition of DAV Patriot Boot Camp.

In 2017, VanBoxel was appointed to the position of national human resources director, where his responsibilities included advising the executive director and providing executive oversight for the company's human resource initiatives. He participated in strategic planning, organizational change, leadership development, talent acquisition, diversity, executive compensation, performance development and benefits. He served as chairman of the DAV National Headquarters Health and Safety Committee and provided direct oversight of all facility construction and maintenance operations. He was also instrumental in the construction and design of the new DAV National Headquarters.

Prior to directing HR, VanBoxel served as assistant national human resources director from August 2015 to October 2017.

He began his career as a national service officer apprentice at the DAV National Service Office in Washington, D.C., in 2011. He subsequently transferred to Philadelphia, an office he ultimately supervised before his first appointment to DAV National Headquarters.

A native of Hambden, Ohio, VanBoxel enlisted in the U.S. Marine Corps in June 2003 as an electronics maintenance technician. In 2005 he was accepted to the very selective Marine Security Guard program and subsequently served in West Africa, Eastern Europe and Asia. He spent nearly all of 2007 on duty in Iraq providing specialized security to Department of State and Multi-National Force - Iraq headquarters. He was honorably discharged as a sergeant in January 2009.

VanBoxel attended Western Governors University, earning a bachelor's of science degree in business management. He is also a Society of Human Resources Management Senior Certified Professional.

VanBoxel is a life member of DAV Chapter 19 in Northern Kentucky. He and his wife Giedre have three children and reside in Union, Kentucky.

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Washington Headquarters
1300 I Street NW, Suite 400 West
Washington, DC 20005
tel 202-554-3501
dav.org

## Biographical INFO

**EDWARD R. REESE JR.**
**Executive Director, Washington Headquarters**
**DAV (Disabled American Veterans)**

Edward R. "Randy" Reese, Jr., a combat veteran of the Persian Gulf War, was appointed Executive Director of DAV's National Service and Legislative Headquarters (NSLH) in Washington, D.C. in December 2018. In this capacity, he directs DAV's legislative and service programs, which provide free benefits assistance to over 200,000 veterans, survivors and family members each year. Between NSLH and 88 offices across the country, Reese manages more than 400 professional and support staff. Reese also serves as DAV's principal spokesperson before Congress, the Department of Veterans Affairs (VA) and the White House.

Reese has more than two decades of professional experience advocating for the men and women who served, having first joined DAV in 1995 as a National Service Officer and has worked in multiple locations around the country, including Kentucky, Nevada and California. He was appointed Associate National Service Director in May 1999, Assistant National Service Director in August 2000, Deputy National Service Director in August 2001, National Service Director in 2002, Deputy Director of Human Resources in July 2010, National Human Resources Director in August 2013 and Assistant Executive Director of NSLH in 2017 before his current appointment.

A nationally recognized expert on veterans benefits and services, Reese has served on a number of veteran-related federal advisory committees, including the Advisory Committee on Disability Compensation, Advisory Committee on Gulf War Veterans, and VA Vocational Rehabilitation and Employment Task Force.

A native of Bristol, Virginia, Reese enlisted in the U.S. Army in 1984. He was a rifle squad leader in the 82nd Airborne Division during the Persian Gulf War. Following the war, he served as an elite "Black-Hat" instructor in the Air Movement Operations and Jump Master Courses at Fort Bragg, North Carolina. There, he suffered a disabling back injury while conducting a night parachute jump in an airfield seizure training operation. Among his military decorations are the Combat Infantryman Badge, Master Parachutist Badge and the Meritorious Service Medal.

Reese earned his paralegal degree from Kaplan College for Professional Studies and is certified by the HR Certification Institute as a Senior Professional of Human Resources (SPHR) and Senior Certified Professional (SCP) by the Society for Human Resource Management. He is a life member of DAV Arlington/Fairfax Chapter 10. Reese and his wife Belenda currently live in Chesapeake Beach, Maryland.

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Washington Headquarters
1300 I Street NW, Suite 400 West
Washington, DC 20005
tel 202-554-3501
dav.org

## Biographical INFO

**JIM MARSZALEK**
**National Service Director**
**DAV (Disabled American Veterans)**

Jim Marszalek, a U.S. Marine Corps veteran, was appointed national service director for the more than 1 million-member DAV in August 2013. He works at DAV's National Service & Legislative Headquarters in Washington, D.C.

Marszalek manages all activities of the DAV's National Service Program, which employs approximately 255 professional national service officers, 30 transition service officers and support staff in 100 offices throughout the United States and in Puerto Rico. These service officers represent veterans and their families with claims for benefits from the Department of Veterans Affairs (VA) and the Department of Defense (DOD). DAV's direct hands-on services make up the largest item in the organization's budget for program services. DAV service officers annually interview hundreds of thousands of veterans and their families, and file over 151,000 new claims for benefits for the injured and ill veterans.

Marszalek joined the DAV professional staff in 2001 as a member of Class XI at the DAV National Service Officer Training Academy in Denver, Colorado. Following graduation in 2001, Marszalek was assigned as service officer apprentice at the DAV National Service Office in Cleveland, Ohio. He assumed supervisory roles across the country, and in 2012 was appointed as deputy national service director, where he served until his current appointment.

A native of Pittsburgh, Pennsylvania, Marszalek entered the U.S. Marine Corps in 1996 and was honorably discharged in April 2000.

Marszalek is a life member of DAV Chapter 76, Pittsburgh, Pennsylvania. He and his spouse, Jillian, reside in Ashburn, Virginia. They have two sons.

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Washington Headquarters
1300 I Street NW, Suite 400 West
Washington, DC 20005
tel 202-554-3501
dav.org

## Biographical INFO

**JOY J. ILEM**
**National Legislative Director**
**DAV (Disabled American Veterans)**

Joy J. Ilem, a service-connected disabled veteran of the U.S. Army, was appointed national legislative director for the more than 1 million-member DAV in August 2015.

Ilem is a member of the DAV's legislative team employed at DAV National Service and Legislative Headquarters in Washington, D.C. She directs the advancement of DAV's public policy objectives to promote and defend reasonable and responsible legislation to assist disabled veterans and their families nationwide, while guarding current veteran's benefits and services from legislative erosion.

Ilem began her DAV career as a member of Class III at DAV's National Service Officer Training Academy in Denver. She graduated in 1996 and was assigned as a national service officer apprentice at the DAV National Service Office in Phoenix, Arizona. In 1997, she was assigned as a DAV national appeals officer at the Board of Veterans Appeals in Washington, D.C. In 1999, she was promoted to an associate national legislative director serving with the national legislative team at DAV's National Service and Legislative Headquarters. Ilem was appointed assistant national legislative director in 2000 and deputy national legislative director in June 2009, holding that title until her current appointment.

A native of Shakopee, Minnesota, Ilem was raised in the greater Minneapolis area, and is a 1977 graduate of Totino Grace High School in Fridley, Minnesota. She earned her bachelor's degree from the University of Arizona in Tucson in 1994, majoring in archaeology, with a minor in religious studies.

Ilem enlisted in the U.S. Army in 1982. Following basic training at Ft. Jackson, South Carolina, and advanced medical training at Ft. Sam Houston, Texas, she was assigned as a medic to the 67th Evacuation Hospital in Wurzburg, Germany, where she underwent additional certification as an emergency medical technician (EMT). Ilem's military duties included assignments in the emergency room and as a non-commissioned officer in charge of surgical recovery room operations. She was honorably discharged from the Army in 1985.

A life member of DAV Chapter 10 Arlington-Fairfax, Virginia, Ilem resides in Alexandria, Virginia.

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National Headquarters
860 Dolwick Drive
Erlanger, KY 41018
tel 859-441-7300
toll free 877-426-2838
dav.org

## Biographical INFO

**JOHN KLEINDIENST**
**National Voluntary Services Director**
**DAV (Disabled American Veterans)**

John Kleindienst was appointed national voluntary services director for the more than 1 million-member DAV in August 2014. He is employed at DAV National Headquarters in Erlanger, Kentucky.

As national voluntary services director, Kleindienst is responsible for a corps of DAV volunteers who, along with DAV Auxiliary volunteers, donate nearly two million hours a year to volunteer work at Veterans Affairs (VA) medical facilities. He also directs the nationwide DAV Transportation Network, in which DAV hospital service coordinators arrange transportation for veterans who have no way to get to and from VA medical appointments. The network provides hundreds of thousands of rides for veterans across the country each year.

Kleindienst directs and coordinates activities involving the annual National Disabled Veterans Winter Sports Clinic, co-presented by DAV and the VA, which employs sports such as skiing, sled hockey and other activities to promote physical rehabilitation and therapy for veterans struggling to overcome the impact of profound disability. The clinic is the largest rehabilitation event of its kind in the world.

Additionally, Kleindienst manages DAV activities regarding the National Disabled Veterans Golf Clinic each year. As a co-presenter, DAV helps provide legally blind and eligible disabled veterans an opportunity to develop new skills and strengthen their self-esteem through adaptive golf and bowling events.

A native of Waco, Texas, Kleindienst enlisted in the U.S. Marine Corps in June 1996 and was medically discharged in October 2003 as a result of service-connected injuries. He joined DAV's professional staff as a national service officer in February 2003 at DAV's National Service Office in Waco. Following service as a service officer in multiple U.S. locations, he was appointed deputy director of human resources at DAV's National Headquarters in June 2013 and served in that position until his current appointment.

A 1996 graduate of Connally High School in Waco, he is a life member of DAV Chapter 20 in Texas. He studied criminal justice at Coastal Carolina Community College while in the Marine Corps and attended McLennan Community College in Waco after his discharge.

He and his spouse, Melanie, reside in Burlington, Kentucky and have two children, Sean and MaKenna, and two grandchildren.

National Headquarters
860 Dolwick Drive
Erlanger, KY 41018
tel 859-441-7300
toll free 877-426-2838
dav.org

## Biographical INFO

**RYAN BURGOS**
**National Employment Director**
**DAV (Disabled American Veterans)**

Ryan Burgos, a service-disabled U.S. Air Force and U.S. Army veteran of the Iraq war, was appointed national employment director of the more than 1 million-member DAV in 2023 and assigned to DAV National Headquarters in Erlanger, Kentucky.

In his role, Mr. Burgos leads the organization's job fair program to connect veterans and transitioning service members to employers, manages special employment initiatives and works with private and public sector entities to develop and build partnerships to address joblessness and underemployment.

A Texas native, Mr. Burgos enlisted in the U.S. Air Force in 2005 and transitioned into the U.S. Army 25th Infantry Division in 2007. His awards include National Defense Service Medal, Global War on Terrorism Service Medal, Iraq Campaign Medal w/ Campaign Star, Army Service Ribbon, Overseas Ribbon, Expert Marksman Badge.

Mr. Burgos, a life member of DAV Chapter 19 in Erlanger, Kentucky, joined DAV's professional ranks as a national service officer trainee in 2011. Three years later, he was promoted to national service officer supervisor and served in a supervisory role through 2022, when he was named assistant national employment director. Mr. Burgos holds a bachelor of science in business management from the University of Phoenix in Kapolei, Hawaii.

Mr. Burgos and his spouse, Bonnie-Lee, reside in Hebron, Kentucky, with their children, Mykah-Blaize, Aubrey, and Bayilee.

DAV® | Auxiliary

*Making a Difference*

## Biographical INFO

**ANNMARIE HURLEY**
**National Commander**
**Disabled American Veterans Auxiliary**

AnnMarie Hurley was elected DAV Auxiliary national commander at the 2023 DAV and Auxiliary National Convention in Atlantic City, New Jersey.

Hurley became eligible for membership through her brother, Frank, a retired major in the Marine Corps, who served four times in Vietnam, including Khe Sanh, and his sons Michael (Navy) and John Patrick (Marines). She is also eligible through her late husband, Michael (Navy), Aunt Celia (Navy), Uncle Charles (Marines), Uncle Eddie (Army), and her late grandson Michael James (Navy).

She was a caregiver for her husband Michael, who died on June 6, 2014, from airway disease attributed to his service.

Hurley was the department/executive secretary for the DAV Department of Massachusetts for more than 30 years. She is a founding member and current treasurer of Unit 3 in Braintree, Massachusetts. She has previously served as treasurer and commander for the state department.

She is the deputy representative for Veterans Affairs Voluntary Service (VAVS) at the Brockton VA Medical Center. She is chairman of the Auxiliary Department of Massachusetts POW-MIA committee.

Hurley resides in Hull, Massachusetts. She has three grown daughters from her first marriage, and a granddaughter.

## Submissions for the Record

***SUPPLEMENTAL STATEMENT OF***
***DAV (DISABLED AMERICAN VETERANS)***

During the joint hearing of the House and Senate Veterans' Affairs Committees on March 7, 2024, Representative Morgan Luttrell (TX) asked the following question:

**What is DAV doing regarding mental health and suicide prevention?**

First, I ask that the attached copy of DAVs new report—*Women Veterans: The Journey to Mental Wellness* be made part of the hearing record.

Second, I ask that the following supplemental statement, in response to Representative Luttrell's question, be included as part of the official record.

Improving suicide prevention efforts and mental health treatment for our nation's veterans is a key priority for DAV. As an organization, we look for opportunities to meet unmet needs and foster creative solutions that deserve our support. One program that helps us achieve that goal is the DAV Charitable Service Trust, a tax-exempt, nonprofit organization serving primarily as a source of grants for qualifying organizations. As an affiliate of DAV, the Trust strives to meet the needs of ill and injured veterans through financial support of programs and services that provide direct support to veterans and their families.

Since the first grant was awarded by the Trust in 1988, over $166 million has been awarded to programs offering qualified therapeutic activities for veterans suffering from post-traumatic stress, including: specialized retreats, rehabilitation programs and mental health and suicide prevention services.

One exceptional program DAV has invested in is the Save A Warrior program. In 2020, a $1 million grant was awarded to Save a Warrior, a nonprofit organization committed to ending the staggering suicide rate plaguing veterans, active-duty military and first responders. The grant was used to support the construction and development of Save A Warrior's National Center of Excellence for Complex Post-Traumatic Stress in Hillsboro, Ohio, which provides a healing outlet for ill and injured veterans combating suicide and mental health issues.

In 2021, another $200,000 grant was provided for programming and the center opened in June 2022. Save A Warrior received an additional $1 million grant in November 2022 to offer trauma-focused cognitive behavioral therapy, relevant 12-step programs, cognitive processing therapy, mindfulness-based stress reduction techniques and resources to participants. The DAV Trust continued its partnership with the organization in 2023 by awarding a $2 million grant for general operating costs and construction expenses for lodging at the S/SGT Dick Wood Warrior Village. These lodges are located in a peaceful, wooded area near the National Center of Excellence and provide comfortable sleeping quarters, communal areas for group interactions,

dedicated meditation rooms and expansive outdoor spaces ideal for both physical activities and quiet contemplation.

In its most recent grant application submitted last October, Save A Warrior offered the following highlights of the program's effectiveness and comprehensive nature:

> *Save A Warrior® (SAW) is a trailblazer in combating the military and Veteran suicide epidemic, operating out of the National Center of Excellence for Complex Post-Traumatic Stress in Hillsboro, Ohio in partnership with DAV. With an unparalleled efficacy rate of over 99.7%, our Cohort intervention program has established itself as a gold standard in suicide prevention. The intervention employs precision storytelling and deep listening techniques to accelerate the healing of intergenerational traumas and formative wounds, supported by evidence-based practices that bolster mental, emotional, and physical resilience.*
>
> *Upon completion, participants immediately join the Save A Warrior Community of Practice—a 24/7/365 accessible network that comprises over 70% of legacy graduates. This community offers a research-backed 500-Day Plan, maintained through accountable support from Cohort "Shepherds," to deepen the original healing experience and foster continuous individual recovery. Through these unique features, SAW transcends conventional approaches, ensuring that warriors emerge with a renewed sense of purpose, compassion, and dedication to their communities and loved ones. This transformative experience creates a ripple effect that positively impacts many others who might otherwise face the loss of a warrior to suicide.*
>
> *In partnership with organizations like the Disabled American Veterans (DAV), and designed to be inclusive and equitable, SAW is committed to serving warrior communities of all races, colors, religions, sexual orientations, and backgrounds. Our approach understands that the roots of suicide are multifaceted and informed by each individual's unique experience and background. By treating the whole person, our program has proven invaluable for over 2,300 Warriors, changing not only their lives but also significantly benefiting society at large.*

In 2023, DAV Charitable Service Trust awarded more than $2.7 million in total for mental health initiatives to SAW and other nonprofit organizations, as detailed in the table below:

| | | |
|---|---|---|
| A Sanctuary for Military Families, Inc. | $15,000.00 | Supports the long-term therapeutic program designed to address suicide, homelessness and unemployment for veterans and their family members. |
| Intrepid Fallen Heroes Fund | $450,000.00 | Provides treatment for traumatic brain injury, post-traumatic stress disorder and other related conditions for military personnel and veterans through upgrades and the purchase of new equipment. |
| Mental Health America of Greater Houston, Inc. | $15,000.00 | providing service-related mental and behavioral health needs to veterans involved with the justice system. |
| REBOOT Recovery | $24,000.00 | Supports veterans' participation in therapeutic and educational courses covering military-specific |
| Rush University Medical Center | $31,000.00 | Supports the Road Home Program in providing outpatient psychotherapy and treatment services to pre-9/11 veterans experiencing mental illness. |
| Rutgers University Foundation | $50,000.00 | Supports the Vets4Warriors program in providing telephonic peer counseling services to veterans and their family members. |
| Samaritan Center for Counseling and Pastoral Care, Inc. | $40,000.00 | Supports the employment costs for personnel providing mental health treatment to ill and injured veterans, service members and their families through the Hope for Heroes program. |
| Save A Warrior | $2,050,000.00 | Supports general costs and construction expenses for a facility providing a healing outlet for ill and injured veterans combatting suicide and mental health issues. |
| The Thresholds | $15,000.00 | Supports the Veterans Project in providing services to veterans experiencing mental illness. |
| TRAVIS MANION FOUNDATION | $10,000.00 | Provides personal development and leadership training to veterans through Leading with Your Strengths seminars. |
| Veterans Alternative, Inc. | $40,000.00 | Supports the employment of a therapist in providing therapeutic services for the Accelerated Wellness Program. |
| | **$2,740,000.00** | **MENTAL HEALTH** |

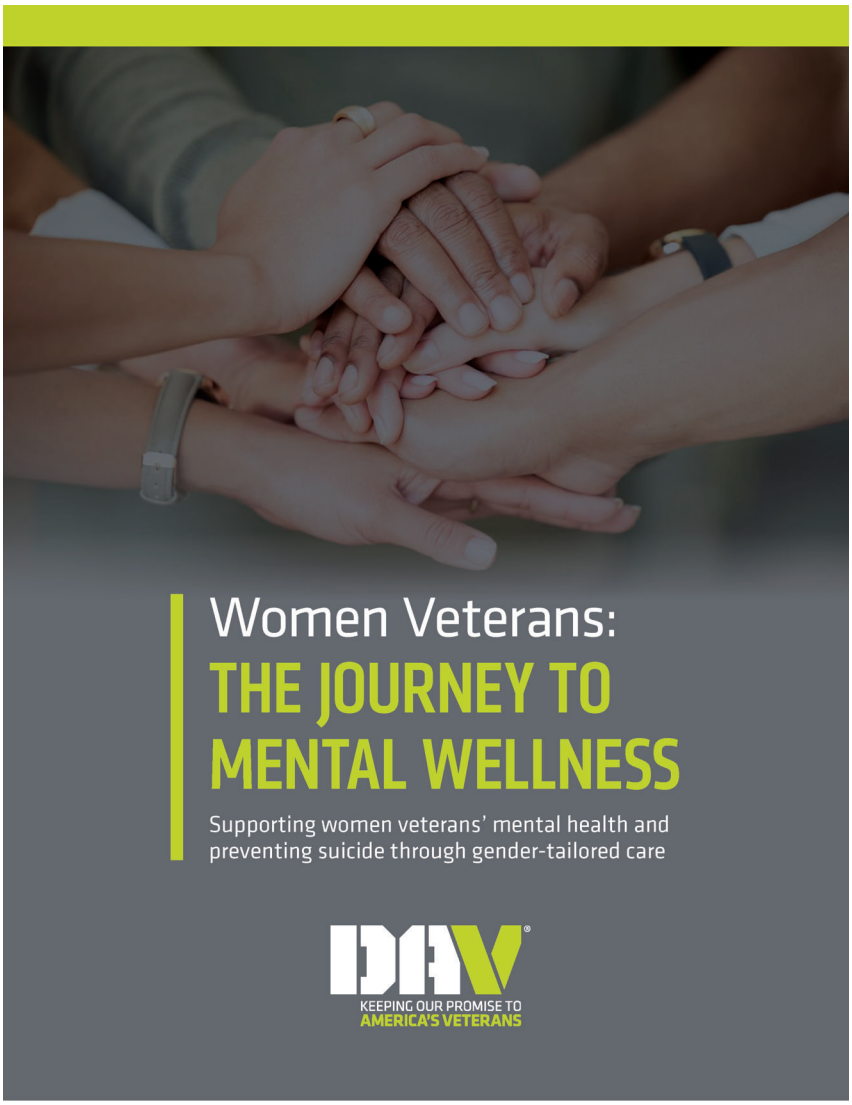
DAV has also provided more than $1 million to the Boulder Crest Foundation which hosts retreats where gender-tailored programming is offered to women veterans, with DAV leaders and spouses serving as mentors for the latest generation of seriously injured veterans and their caregivers. Boulder Crest programs use the science of posttraumatic growth to help participants and their families transform struggle and trauma into lifelong growth and strength.

DAV's National Service Foundation Columbia Trust also awarded multiple grants between 2018-2021 to a local DAV chapter in the department of Arkansas for an innovative suicide prevention program for veterans living in rural areas of the state. The program sent trained personnel into rural areas of Arkansas to locate and meet with veterans who were at high risk of suicide. A retired mental health professional led the initiative and the team made themselves available 24 hours a day, 7 days a week.

The clinician conducted face-to-face meetings with veterans, pastors and other key members within the community who helped identify and initiate direct contact with veterans. Team members and veteran peers were trained how to question a veteran

regarding suicidal intent and how to persuade them that there is help available, and make referrals to professional resources. The goal of the initiative was to help reintegrate veterans through civilian community involvement and introduce them to local veteran resources *before* a crisis occurs. These types of local programs can make a huge difference in a rural community where suicide risk among veterans is elevated and mental health services are scarce.

We strongly believe there is a need for innovative programs to address veterans' post-deployment mental health challenges. For over a century, DAV has directed its resources to the most needed and meaningful services for the nation's wounded, ill and injured veterans and their families. The many accomplishments of both DAV and the Trust have been made possible through the continued support and generosity of corporate partners, individuals and DAV members who remain faithful to our mission.


Women Veterans:
THE JOURNEY TO MENTAL WELLNESS
Supporting women veterans' mental health and preventing suicide through gender-tailored care
DAV
KEEPING OUR PROMISE TO AMERICA'S VETERANS

This report is dedicated to the women who have honorably served our nation in military service throughout history—despite often being unrecognized and underserved for their service and sacrifice.

"Women veterans are different in important ways [from male veterans] that can impact their health treatment needs and preferences." (9/14/22)

*—Jennifer L. Strauss, Ph.D., National Director, Women and Gender-Related Mental Health, Department of Veterans Affairs Veterans Health Administration*

PHOTO BY SGT. ALEXIS WASHBURN-ARMSTRONG/U.S. ARMY

## Preface

Throughout its 100-plus year history, DAV has been an unwavering champion of women veterans. This includes fighting for recognition of their military service, equity in their health care and access to their earned benefits. We understand that this population has long been underrecognized and underserved by systems historically designed primarily for men. As an organization dedicated to honoring all veterans, and the congressionally chartered voice of our nation's disabled veterans, it is DAV's duty to help correct course and ensure that our nation keeps its promise to America's women veterans.

This work is more critical than ever, as historic numbers of women serve in all branches of the military and across all occupations. Now representing more than 10% of the veteran population, a record number of women veterans are turning to the Department of Veterans Affairs for their post-service health issues and readjustment challenges. DAV previously examined those issues in two comprehensive reports in 2014 and 2018, respectively. Those reports helped increase understanding of the experiences of women veterans and made legislative and policy recommendations that ultimately led to real change through their enactment into law.

DAV is pleased to present this report, *Women Veterans: The Journey to Mental Wellness*, which is a targeted look at the growing mental health crisis among women veterans.

The stakes are staggeringly high, as shown in the VA's most recent National Veteran Suicide Prevention report. That report showed that between 2020 and 2021, the suicide rate among women veterans jumped 24.1%—nearly four times higher than the 6.3% increase among male veterans and vastly higher than the 2.6% increase among nonveteran women. *Women Veterans: The Journey to Mental Wellness* takes a close look at the unique factors putting women veterans at risk for suicide.

The findings detailed in this report make clear that we must do more and do better for women veterans. The VA has made considerable efforts to better understand the needs of and challenges faced by women veterans and to ensure equal access to quality and gender-specific care. The department must remain committed to this population and make additional efforts to fill existing gaps in care. DAV will remain a steadfast partner in this work and will continue to beat the drum until all women veterans have access to quality mental health care that fully considers their unique risk factors.

We ask that veterans, policymakers, legislators and the general public join us in this mission.

Barry A. Jesinoski
DAV National Adjutant/CEO

# Contents

# INTRODUCTION

PHOTO BY SARAYUTH PINTHONG/U.S. AIR FORCE

The Department of Veterans Affairs Veterans Health Administration (VHA) is best positioned for and charged with serving as the leader in the provision of health care for all veterans, including women. Over the past decade, the VA has significantly improved delivery of care to women veterans and evolved in commendable ways. However, despite great progress, there is much work to do to ensure women veterans are able to access the benefits and care they need and have earned.

DAV has found, and the VA recognizes, the need to invest in more research into issues affecting women veterans, make additional efforts to include women in data collection and educational materials, improve care coordination between VA providers and community partners, and make systemic culture changes to truly improve women's health services and programs within the department.

Even with known challenges and barriers to care, increasing numbers of women veterans are turning to the VA for their health care needs. The department has worked diligently to better meet the increased demand for care and specialized services and to train providers in women's health. For example, research is a hallmark of VA care, and the department has dedicated significant resources to understanding the health impacts of military service on this population and offering insight into best practices, evidence-based care and treatment options.

This is a unique population, and research indicates that women veterans using VA care have high rates of service-connected disabilities, have medically complex health histories, and use specialty care such as mental health and substance use disorder services at higher rates. The proportion of women veteran VHA users with a service-connected disability increased from 48% in fiscal year (FY) 2000 to 73% in FY 2020, and many struggle with multiple clinically complex health and mental health conditions, including trauma-related post-traumatic stress, depression and mood disorders. Additionally, the VA reports that since 2005, it has seen a 154% increase in the number of women veterans accessing VA mental health care.[1] It's also important to note that with all military occupations now open to women, more women than ever are experiencing combat-related trauma leading to visible and invisible wounds.

As a result of the impact of military service, many women veterans rely on VA health care and its specialized mental health and substance use disorder services. This report aims to raise awareness about the challenges women veterans face after service, specifically looking at mental health, substance use and VA suicide prevention efforts, and how risk factors such as sexual assault and the reproductive health cycle affect mental health. Our goal is to highlight the unique needs of women veterans and ensure care and programs are tailored to meet those needs, ultimately resulting in more effective health care and better outcomes.

Rightly so, mental wellness is a part of VHA's whole health model of comprehensive care and supportive services. The VA has a variety of mental health programs geared specifically for women veterans, including evaluation and assistance for depression, mood and anxiety disorders (including post-traumatic stress disorder); intimate partner violence; combat-related trauma; parenting and anger management; and marital, caregiver or family-related stress. Women who experienced sexual assault and harassment during military service (military sexual trauma, or MST) may also receive special services including confidential counseling and treatment for mental and physical health conditions related to MST.

And yet, too many women veterans are unaware of the resources available to them or struggle to access the timely, quality mental health services that are essential to recovery and overall well-being. DAV strongly believes that service-disabled women veterans greatly benefit from the VA's targeted research; evidence-based treatments; and comprehensive, integrated, whole-health model of care and specialized wraparound services. We urge women veterans to seek the care and support they need in their journey to mental wellness, and we call on the VA and other stakeholders to make that journey possible and accessible for all women veterans.

# VA SUICIDE PREVENTION STRATEGY

PHOTO BY SGT. JAMES R. RICHARDSON/U.S. MARINE CORPS

## Suicide Among Veterans

While we recognize that year by year, the Department of Veterans Affairs has faithfully stepped up to address this vexing issue, the rate of suicide deaths among veterans remains higher than for other Americans. The impact of suicide on women veterans in particular is more profound than ever and demands urgent attention. Between 2020 and 2021, the suicide rate among women veterans increased 24.1%—nearly 4 times higher than the 6.3% increase among male veterans and vastly higher than the 2.6% increase among non-veteran women. Women were found to be about three times as likely to die by firearm suicide than their civilian counterparts and more likely to attempt suicide than male veterans (12% versus 6%), although they have an overall age-adjusted suicide rate (17.5 per 100,000) below that of men (35.9 per 100,000).[2] **(See Figure 1.)**

According to the National Institute for Mental Health, **substance use disorder** is "a treatable mental disorder that affects a person's brain and behavior, leading to their inability to control their use of substances like legal or illegal drugs, alcohol, or medications."

Researchers have identified strong individual suicide risk factors among veterans. These include a diagnosis of a mental illness, substance use disorder, and a prior suicide attempt or suicidal ideation.[4] Some evidence points to the existence of protective factors that help bolster veterans against suicide, such as strong relationships with others; meaning in life; mindfulness; self-worth and self-compassion; and regular connection to health care, including mental health services.[4]

Women veterans have several unique risk factors for suicide. Military sexual trauma (MST) is associated with an increased risk of lifetime suicidal ideation, suicide attempts and suicide mortality in both men and women.[5-7] History of family trauma or other sexual trauma is also a risk factor for suicide.[4] Substance use disorder heightens suicide risk for both men and women. However, the risk of suicide death among women veterans with active substance use disorder is more than twice what it is for men.[8]

## A Public Health Approach to Suicide Prevention

The VA operates under a robust, multifaceted strategy to better understand and prevent suicide in all veterans, not just those enrolled in VA health care. The VA's

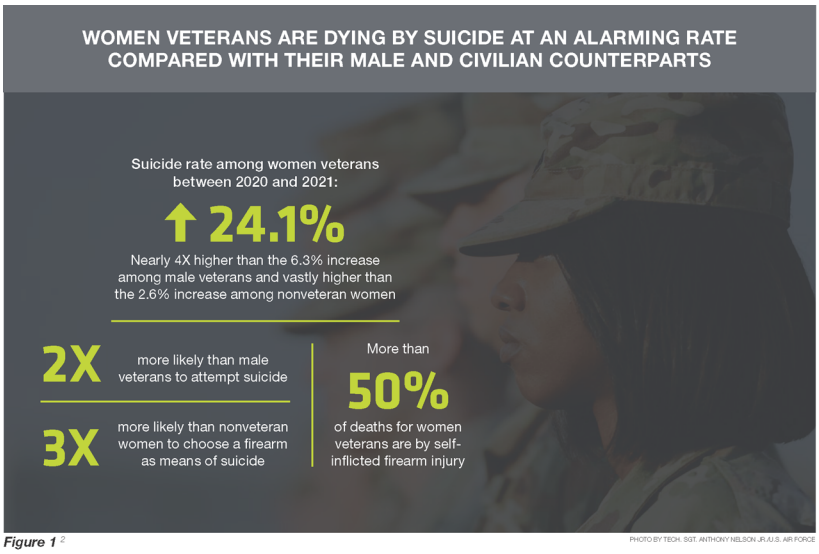



***Figure 1*** [2]

suicide prevention plan, published in 2018, is a 10-year public health strategy to reduce veteran suicides.[9] The plan is consistent with similar strategies from the White House,[10] Department of Defense[11] and Office of the Surgeon General,[12] which represents a whole-of-government approach to suicide prevention. The plans embrace a suicide prevention framework from the National Academy of Medicine[13] and an evidence-based Centers for Disease Control and Prevention (CDC) program design.[14] The VA's strategic plan has four focus areas:

- Healthy, empowered veterans, families and communities.
- Clinical and community preventive services.
- Treatment and support services.
- Surveillance, research and evaluation.

The VA classes suicide prevention as its highest clinical priority and is applying innovative suicide prevention approaches as part of its long-term strategy. First, recognizing that over 60% of veteran suicides occur among veterans **not** actively using the Veterans Health Administration (VHA),[2] the VA has adopted a public health approach to suicide prevention and extended its programming outside the walls of the VA through national, state, territorial and community partnerships. This includes public health messaging through ad campaigns such as "Don't Wait, Reach Out" and "Keep It Secure."[2] In fiscal year 2021, these efforts resulted in more than 1.9 billion engagements, video views and website visits.[2] The VA has strategically partnered with other federal agencies (the Substance Abuse and Mental Health Administration and CDC) and state and local governments on suicide prevention programming.[15] The Governor's Challenge has expanded to include all 50 states and 5 U.S. territories,[2] and 19 local mayoral programs are actively working to conduct outreach, screen for suicide risk, promote connectedness and share lethal-means safety information.[15] Finally, the VA worked collaboratively across the government to incorporate the VA crisis telephone line into the new national 988 call number for mental health emergencies. The VA expects these efforts and others captured by the suicide prevention strategy (see Appendix A 1.1) to help prevent veteran suicide both inside and outside of the VA.

While the VA includes diverse populations of veterans in all of its messaging, its campaigns are not specifically targeted at all veteran subpopulations whose needs may

Veterans Crisis Line
DIAL 988 then PRESS 1

## Ginger MacCutcheon

### 'A CHANGED PERSON'

During the 2022 DAV and Auxiliary National Convention, Ginger MacCutcheon learned about a suicide prevention program that she said changed her life.

MacCutcheon, a veteran of the Women's Army Corps and commander of DAV Chapter 116 in Parma, Ohio, had attempted suicide twice in her life. The first time was in 1980, two years after she was discharged, and again in the 1990s.

What nobody else knew at the time was that MacCutcheon had survived several violent sexual assaults while in service.

"I went back home and I didn't tell anyone anything," she said. "I always blamed myself."

MacCutcheon kept what happened to herself for decades, through abusive relationships and periods of suicidal ideation. She was completely unaware that she could receive mental health treatment or other care through the VA. Then one day during a volunteer event, something triggered post-traumatic stress symptoms for MacCutcheon, and a fellow veteran took notice.

"And he actually took me and signed me up for VA health care, and that was the first I got any help," she said, adding that the VA rallied around her and got her into counseling.

"But I think that if I had gotten treatment earlier in my life, that it wouldn't have been such a train wreck."

In 2022, she was introduced to Save A Warrior, a nonprofit organization working to end the staggering number of suicides among veterans, service members and first responders. With a grant from the DAV Charitable Service Trust, Save A Warrior opened a National Center of Excellence for Complex Post-Traumatic Stress in Hillsboro, Ohio, in June 2022. MacCutcheon attended later that fall.

"[They] dealt with me as a whole person, like my whole 65 years," MacCutcheon said. "I was a changed person when I got out of there."

At the following DAV national convention, MacCutcheon said she did something she never would have before: In a dark, crowded ballroom, she joined a friend and fellow Save A Warrior participant on the dance floor as they moved to the sounds of Gary Sinise and the Lt. Dan Band.


PHOTO BY STEVE POWELL

vary. In a recent report to Congress, the VA's Veterans Crisis Line (VCL), Be There and Lethal Means Safety campaigns were assessed through a series of focus groups. Most agreed the VA's VCL campaign was clear, but focus group members indicated that some of the messaging in the Be There and Lethal Means Safety campaigns were confusing and lacked definitive calls to action.[16]

A second innovation in the VA suicide prevention strategy is the development and use of machine learning to build a predictive model of suicidality in the veteran population, REACH VET (Recovery Engagement and Coordination for Health – Veterans Enhanced Treatment).[17] The model identifies veterans who may benefit clinically from enhanced care, outreach and assessment of suicide risk.[18] The VA and National Institute of Mental Health researchers built the model using VA clinical and administrative data. **(See Figure 2.)** The model flags veterans who, because of certain risk factors, are more likely to be at heightened risk for suicide. The veterans identified through the model are included by the VA Office of Mental Health and Suicide Prevention (OMHSP) in a monthly dashboard. Twelve months after implementation, the model had identified about 6,700 veterans each month who may have been at increased risk for suicide and about 30,000 unique veterans total in the first year.[18] Suicide prevention coordinators (SPC) at each facility have access to the dashboard and work with local clinicians to flag patient records, conduct outreach and provide at-risk veterans with enhanced services.[18,19] Over the first year of implementation, facility-level SPCs increased interactions with at-risk veterans (81.5% to 97.6%), more clinical providers were assigned to these veterans (67.2% to 89.6%), and more clinical evaluations were completed (63.6% to 86%).[18]

Initial evaluation of REACH VET has proven it to be successful for the veterans who were identified. In the first year of implementation, patients receiving the intervention completed more health care appointments overall and more mental health appointments, missed fewer appointments, completed more suicide prevention safety plans, and experienced less all-cause mortality than the control group.[19]

While DAV appreciates the VA's innovation in creating a tool to identify veterans at the greatest risk of suicide and that the model is continually refined, we understand that REACH VET uses male veterans as the normative baseline for identifying risk. This may limit its applicability to women or other minority veteran

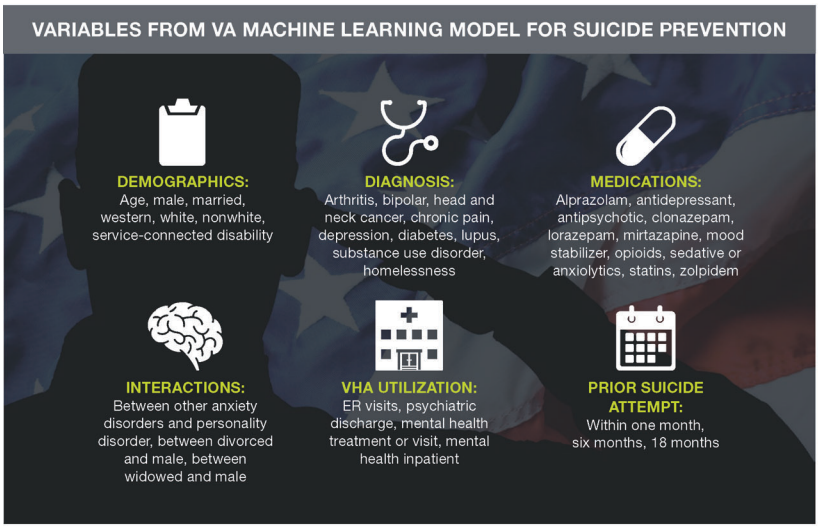



***Figure 2:*** *REACH VET suicide prevention model uses men as the baseline model for suicide prevention.*

populations at the VA.[19] For example, the model does not incorporate MST—a known risk factor for suicide for women veterans. Consideration of women-specific models to identify those at highest risk is important, because some analysis of suicide risk factors using machine learning algorithms found that correlations of suicidal ideation differed by gender.[21] For example, risk factors for suicidal ideation in men who had been deployed in the wars in Afghanistan and Iraq included one set of factors (depression and post-traumatic stress disorder [PTSD] and somatic complaints), while the model identified a different cluster of risk factors for women (MST during deployment and depression and PTSD).[21] If specific suicide risk factors for women and other subpopulations of veterans are not tested and incorporated into the REACH VET model, this successful tool for preventing veteran suicide may not identify elevated risk among some women and other diverse veterans.

Overall, the VA has taken a comprehensive and robust approach to suicide prevention. (Details of VA activities tracked to each of the four strategic objectives of the department's 2018 plan can be found in Appendix A 1.1–1.4 of this report.) As shown, about 50 programs and activities represent the implementation of the VA suicide prevention strategy. We identified two activities that primarily focused on the needs of women veterans: STAIR (Skills Training in Affective and Interpersonal Regulation) and Women's Mental Health Champions.

**STAIR** (Skills Training in Affective and Interpersonal Regulation) is a program that targets rural women veterans, especially those with military sexual trauma or other military-related trauma.

**Women's Mental Health Champions** are located at every VA facility and are clinicians with special training and interest in treating women veterans' mental health.

Robust investments have been made to support the VA's suicide prevention efforts, and Congress passed legislation to track progress. The VA was required under U.S. Code Title 38, Subsection 1709B(a)(2), to evaluate and report annually on the success of the suicide prevention program. Additionally, amendments to the Female Veteran Suicide Prevention Act (Public Law 114–188; see Appendix B 5.1) required the VA to assess and report on the impact and effectiveness of such programs for women veterans. Specifically, the law required that "The Secretary shall provide for the conduct of an evaluation of the mental health care and suicide prevention progress of the VA, using appropriate metrics, including metrics applicable specifically to women ... [and] identify the mental health care and suicide prevention programs conducted by the Secretary that are most effective for women veterans and such programs with the highest satisfaction rates among women veterans." While data is available to meet requirements within Public Law 114–188 to evaluate the effectiveness of suicide prevention for women veterans, none of the public reports do so. Without publicly reported data, the veteran community is left with an incomplete understanding of the investments, outputs and outcomes of the VA suicide prevention strategy for women. This information is critical to stakeholders and researchers, and having a public-facing database with defined metrics, including measurements for women veterans, would provide more public awareness and scrutiny of this high-priority departmental activity. Additionally, the VA should include metrics that relate specifically to women veterans in its next suicide prevention strategic plan (2028–2038).

- **Policy/Research Recommendation:** VHA should revise REACH VET to incorporate risk factors weighted for women, such as MST and intimate partner violence.
- **Policy Recommendation:** The VA should modify and improve suicide prevention messaging campaigns targeting women veterans with recommendations made by women's focus groups, including clarifying a call to action.
- **Policy Recommendation:** The VA should assess the time Women's Mental Health Champions are allotted for required duties to ensure they have ample time to pursue initiatives related to reducing women's risk for adverse mental health outcomes, including suicide.
- **Policy Recommendation:** The VA should develop a public-facing database that includes metrics that relate specifically to women veterans.
- **Policy Recommendation:** The VA should create a new position within OMHSP that is focused exclusively on overseeing the prevention of women veteran suicides in the VA and the Community Care Network.
- **Policy Recommendation:** The VA should update future suicide prevention strategies to:
  - Address suicide prevention for women veterans explicitly.
  - Evaluate and report progress against the strategy to date, including details of the impact on women veterans.

# SUICIDE PREVENTION GAPS AND VULNERABILITIES

**Rural women veterans** have higher rates of suicide by firearm than their urban women veteran peers.

In 2021, suicide was the 13th-leading cause of death among veterans overall and the second-leading cause of death among veterans under age 45.[2] We applaud the Department of Veterans Affairs on its comprehensive efforts on suicide prevention, including its research focus on women veterans. Experts agree that suicide is a complex problem that requires coordinated, evidence-based solutions that move beyond the traditional medical model of prevention. Ensuring timely access to quality mental health services for those in need is only one part of the solution. Continued reductions in veteran suicide rates will require involving veteran peers, family members and the community at large. It will also require candid conversations about secure storage of firearms and the normalization of discussions with veterans, peers, family members and health providers.

The task force report of Executive Order 13861, the President's Roadmap to Empower Veterans and End the National Tragedy of Suicide (PREVENTS; see Appendix B 6.1) was published in 2020. Though initiatives to encourage safe firearm storage for at-risk veterans had long been pioneered by the VA and major public health organizations had endorsed the usefulness of such strategies, the policy language of the road map was unprecedented. It verified the link between, and the need to address, at-risk veterans and their access to firearms.

The road map discussed the need to develop messages drawn from prior widespread, extremely successful, public-facing ad campaigns that "contributed to shifts in cultural norms or perspectives. Perhaps the most widely cited education or messaging analogy is the 'Friends don't let friends drive drunk' ad campaign, which was launched by the Ad Council. An analogous effort for suicide prevention would be encouraging friends, family members, and concerned contacts to take steps to reduce access to lethal means, such as firearms, for those at risk for suicide."

Several other PREVENTS recommendations directly involved the private sector.

- Establish a national coalition of lethal-means stakeholders to drive implementation of sustained change.
- Seek support and voluntary funding from lethal-means manufacturers to support various coalitions.
- Explore grants to public and private nonprofit entities to create or expand community coalitions focused on lethal-means safety.

## Rural Women Veterans: Reducing Barriers to Care

According to the VA, 1 in 4 women veterans who use VA health care services live in rural areas.[22] To define rurality, the VA uses a system developed by the Department of Agriculture and the Department of Health and Human Services, which is based on population density and how closely a community is linked socioeconomically to larger urban centers.

Research indicates that rural veterans report substantial physical and mental health needs, higher rates of disability and lower quality of life, and they are more likely to use VA care compared with their urban peers. Likewise, they face several unique barriers in accessing health care, such as local health provider shortages, long distances to access specialty care, lack of transportation and prohibitive travel expenses.[23]

Researchers also found that rural women veterans, like their urban peers, have a high prevalence of military sexual trauma (MST) and mental health conditions, including depression and post-traumatic stress disorder (PTSD). There is a 20% increased risk for suicide among rural veterans, and rural women veterans have higher rates of suicide by firearm than their urban women veteran peers.[24] Unfortunately, rural women veterans are less likely to receive mental health and gender-specific health care services compared with urban women peers, and those with longer drive times to access care are more likely to drop out of care.[25] Veterans living in highly rural communities, such as Guam, American Samoa, Puerto Rico, U.S. Virgin Islands and the Northern Mariana Islands, face even greater challenges due to limited or poor infrastructure.

The VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018 (Public Law 115–182; see Appendix B 7.1) allows veterans to seek health care from non-Veterans Health Administration (VHA) providers through the VA Community Care Network. However, shortages of mental health providers exist in over 50% of U.S. rural counties, thus creating disparities in access to mental health services for rural veterans.

VHA has made efforts to reduce barriers and improve access to care for rural women veterans. It specifically developed a special national initiative to train rural providers in women's health and has focused on expanding tele-mental health interventions (via videoconferencing) to provide rural women veterans effective treatments for PTSD and postpartum depression.[26,27]

Rural VA women veterans' health research and quality improvement projects are also underway looking at mitigating firearm suicide risk for high-risk rural Reserve and Guard veterans through personalized, veteran-centric firearm suicide risk reduction interventions and community engagement strategies to support community providers in delivering high-quality care to rural women veterans.[23]

- **Policy Recommendation:** The VA must develop targeted solutions to bridge gaps for the provision of mental health care services in rural communities—especially for women veterans who require specialized, evidence-based treatments for MST-related PTSD and depression.
- **Policy Recommendation:** The VA must require that community care providers who treat veterans are trained in suicide prevention, lethal-means safety counseling and evidence-based treatments for conditions common among women veterans, such as MST-related PTSD and depression.

## Lethal-Means Safety

According to the VA's 2023 National Veteran Suicide Prevention Annual Report, **firearms were used in 51.7% of women veterans' suicides**, more often than all other methods combined. The rate of women veterans dying by firearm suicide was nearly three times higher than for nonveteran women. The stark reality is that 9 out of 10 suicide attempts with a gun prove lethal.[2] These grim statistics should serve as a wakeup call for the need to as much attention to the risk of firearm suicide for women veterans as we do for men. This work requires a fuller deliberation of how ready access to firearms during dark moments correlates with deadly outcomes.

Subject matter experts understand that firearm ownership and household access to guns are risk factors for suicide.[30-34] Veterans, including women veterans, have a higher rate of gun ownership compared with the general U.S. population.[35] A recent study of women veterans found that 38% owned a firearm,[36] a rate similar to that seen in prior analysis where 30%–39% of women veterans reported owning a firearm.[37,38]

During the pandemic, women veterans, especially those with a history of PTSD and MST, expressed greater concerns about personal and family safety and demonstrated stronger beliefs and behaviors endorsing the use of firearms. Women veterans reported high levels of uncertainty brought on by the pandemic, pandemic-related threats, and social and political unrest. They expressed that these threats necessitated greater access to firearms to protect themselves, their families and their property. Between 33% and 47% of all new gun owners in 2020 and 2021 were women.[39,40] The significant changes in women veterans' beliefs and behaviors during


## Kim Hubers

### RURAL VETERANS: 'WE MATTER, TOO'

When Iraq War veteran Kim Hubers needs to go to the VA medical center in Sioux Falls, South Dakota, she has to drive nearly 25 miles. But what if she needs to see a specialist for one of the many health issues affecting nearly every system of her body?

"So, my neuromuscular neurologist, I have to go to Minneapolis to see him, and it's an eight-hour round trip," she said. "When [veterans here] need any type of specialty care, it's Minneapolis, Omaha or Fargo. And I've been sent to all of them over the years for specialty care."

The medical center closest to her is one of two in the entire state, so Hubers—the commander of DAV Chapter 1 in Sioux Falls and a volunteer benefits advocate—has heard her fair share of stories from veterans in rural areas who struggle to access VA health care.

"That's the nature of our state," she said. "But we matter, too."

Hubers, who estimates she spent over $1,000 in travel expenses to see specialists over the course of 14 months, hasn't been reimbursed for such expenses in years. She said the reimbursement system is cumbersome and has rarely worked for her.

She stopped using VA-supported community care after a series of long delays and poor communication. She stopped using the Vet Center for mental health care when she lost her counselor to turnover. On top of that, Hubers experienced years of being dismissed and misdiagnosed by VA providers, making medical appointments traumatic and detrimental to her health.

Hubers now relies mostly on private health care providers outside of the VA system and pays out of pocket for mental health counseling.

"It feels like a betrayal," she said, "and it adds a lot of frustration and a lot of emotional turmoil to something that's already hard."

Hubers said she's grateful for how DAV has highlighted the challenges of women veterans and advocated for meaningful change over the years. She's hopeful that a renewed focus on mental health will lead to even more progress.

this stressful time suggest the need for further research to ensure that the VA's lethal-means safety counseling for women veterans is trauma-informed and addresses women's concerns about family and personal safety while also ensuring veterans' safety from self-harm during mental health crises.[41]

Reducing access to lethal means during a mental health crisis, including access to firearms, is a key strategy in suicide prevention.[9,11,12] Secure storage of firearms is among the first-line interventions used in the VA with veterans at risk for suicide. Secure storage includes keeping a firearm unloaded, using a cable lock, or placing the firearm in a locked case or gun safe. Clinicians may also counsel suicidal patients to temporarily store their firearms with a trusted friend or family member. Because suicidal ideation is episodic and individuals vacillate in their intent to die,[42] interventions that place a barrier of time and space between the thought of suicide and action can be effective. Research indicates that about half of suicides take place within 10 minutes of the suicidal urge.[43] When queried about gun safety, most veterans agree they would remove access to firearms for household members who are suicidal,[35,44] or in general, they support limiting gun access for those at risk for suicide.[45] Unfortunately, the connection between suicide and lethal-means access is not always clear in the VA's universal suicide prevention campaigns. For example, focus groups assessed three major public safety campaigns, including a campaign on lethal-means safety. The report noted that focus groups found the campaign information was useful but failed to understand the connection between lethal-means safety and suicide prevention.

> The VA has many lethal-means safety interventions underway. Next steps should include identifying differences women veterans may have in their beliefs and behaviors about firearms and using trauma-informed approaches to address them.

Research indicates that about half of suicides take place within **10 minutes** of the suicidal urge.[43]

*Simple interventions that educate and encourage veterans and caregivers on safe storage practices, such as use of a gun safe or lockbox, and storing firearms unloaded and separate from ammunition, may increase the time between deciding to act and making a suicide attempt. These simple interventions may be critical in preventing suicide.* ***For more information: vaoig.gov/sites/default/files/reports/2022-11/VAOIG-21-00175-19.pdf***

The groups also found the campaign lacked a clear call to action for intended audiences.[16]

The VA has made great strides in building a strategy for limiting access to lethal means among veterans during a mental health crisis. Embedded within the VA suicide prevention strategy, clinicians counsel veterans who screen positive for risk of suicide on secure gun storage and offer free cable locks. However, researchers note that lethal-means counseling only reaches veterans with the highest risk—meaning those with lower or undetected risks may not receive the benefit of such counseling.[45] The VA also works actively to reduce the stigma associated with gun safety by working with firearm organizations to make secure gun storage a normative value among gun owners. (See programs and resource examples in Appendix A 1.2.) The VA has collaborated with veteran service organizations (VSO) and community stakeholders, as well as partnered with the National Shooting Sports Foundation and the American Foundation for Suicide Prevention to promote messaging about the importance of putting "time and space" between a veteran in crisis and a firearm. The VA also has its Reducing Firearm & Other Household Safety Risks for Veterans and Their Families brochure to provide best practices for safely storing firearms and medications—along with advice for friends and family on how to talk to the veteran in their life about the importance of safe storage. We are pleased that the VA Office of Mental Health and Suicide Prevention has worked in collaboration with researchers and clinical leaders to tailor lethal-means safety counseling for women veterans, taking into account gender-related risks and motivating factors. For example, messaging regarding safe firearm storage and proper medication disposal may resonate more strongly with mothers and encourage them to take these precautions.[46]

Given the lethality of firearms as a means for suicide and the high rate of gun ownership among veterans, including women veterans, gun safety and limited access to firearms during a crisis must be priorities in suicide prevention. Understanding women veterans' unique attitudes and beliefs about gun ownership and the reasons why some may store firearms unsafely is an important next step in addressing their receptivity to VA messaging about secure storage and its connection with suicide prevention, as well as determining whether improved gender-specific messaging and interventions are necessary to effectively address their concerns.

- **Policy Recommendation:** VHA should follow VA Office of Inspector General Report 21-00175 recommendations and require ongoing lethal-means safety training for providers rather than a one-time course at the onset of employment in VHA.[47]
- **Policy Recommendation:** The VA should conduct focus groups to determine the best secure firearm storage messages and messengers to reach women veterans.
- **Policy Recommendation:** Third-party administrators TriWest Healthcare Alliance and Optum should partner with firearm industry representatives, VSOs and suicide prevention organizations to fund a national firearm suicide prevention campaign akin to the alcohol industry's "drink responsibly" message.
- **Research Recommendation:** The Women's Health Research Network's Suicide Prevention Work Group, in collaboration with the VA Office of Women's Health and Office of Mental Health and Suicide Prevention, should investigate how suicide prevention materials and lethal-means counseling interventions are perceived and accepted by women veterans and which suicide prevention approaches are most effective.

> "Reducing access to lethal suicide methods is one of the few population level interventions that has shown to decrease suicide rates."
>
> *—Russell B. Lemle, Ph.D., Senior Policy Analyst for the Veterans Healthcare Policy Institute*

# WOMEN VETERANS HEALTH RESEARCH

PHOTO BY MASS COMMUNICATION SPECIALIST 2ND CLASS ZACHARY MELVIN/U.S. NAVY

The Department of Veterans Affairs' strength as a health care system lies in its ability to identify, research and address issues that specifically affect veterans' health. Its research program allows investigators to identify and explore genomic, biological and environmental characteristics affecting care and assess options for treatment, rehabilitation and supportive services.

Fortunately, researchers within the VA recognized the need to address challenges to fully integrating women into a health care system that has historically focused its attention on the majority male population it serves. The Women's Health Research Network (WHRN; see Appendix B 8.1) was established within the VA in 2010 to connect researchers interested in issues affecting women veterans. This initiative resulted in the most extensive volume of women veteran-specific research and made the VA, without question, a knowledge leader in women veterans health.

With growing concern about veteran suicide, in 2017, WHRN created the Women Veterans Suicide Prevention Work Group to investigate how sex and gender differences may affect women's suicidal behavior. Focus from the VA Office of Research & Development on women veterans' research (see Appendix B 8.2) has been responsible for the development of several programs that address suicidality and conditions linked to suicidal behavior including post-traumatic stress disorder (PTSD), military sexual trauma (MST), disordered eating, intimate partner violence, homelessness and substance use disorder.

Among women veterans enrolled in the VA,

**1 in 3**

report experiencing MST.[54]

We applaud the growth in research efforts focused on women veterans' unique risks and resiliencies for suicide, through the WHRN's Accelerating Research on Suicide Risk and Prevention in Women Veterans Through Research-Operations Partnerships initiative.[48] The Women Veterans Suicide Prevention Research Work Group's goal was to "target technical support for researchers, promote collaboration with national VA program offices, and ultimately increase dissemination and translation of research into clinical practice, public health strategies, and policies." The group reviewed existing research to identify research priorities and challenges and identified only 13

publications addressing suicide risk-related topics—noting that women-centered risk factors, preferences and prevention strategies were limited. However, it found some evidence that traumatic experiences such as MST, intimate partner violence, and substance abuse were important risk factors for suicide among women veterans. The work group concluded that research to inform suicide prevention tailored to meet the needs of women veterans is essential; however, many priorities and challenges remain unaddressed and require more study and continued resources and attention.[48]

Another notable research effort underway seeks to understand and develop recommendations to better address the suicide prevention needs of women veterans who use the Veterans Crisis Line (VCL). Researchers noted that "findings will inform recommendations for strengthening crisis intervention services to prevent suicide among women Veterans, and inform efforts to better tailor VCL services to, and increase engagement of, high-risk women Veterans."[49]

WHRN also aids VA recruitment of women into larger-scale or enterprisewide research endeavors, including the Million Veterans' Program (see Appendix B 8.3), which has the potential to dramatically affect research and medicine related to all veterans for years to come. We appreciate the VA's specific outreach efforts that include women veterans in this initiative and ensure adequate representation of women so that the program's findings will apply to them as well.

We also applaud the efforts of the VA Office of Mental Health and Suicide Prevention to provide new training resources on clinically relevant research findings through the development From Science to Practice series of brief evidence summaries. (See Appendix B 8.4.) Of particular relevance to suicide prevention in women veterans, the series includes evidence summaries of associations between suicide risks and women's mental and sexual health; reproductive health; and the experience of MST. Each summary focuses on specific suicide risk and protective factors and includes a concise review of relevant research in the general population and, when available, specific to veterans. These training products are also available to community providers and include community-based resources.

- **Research Recommendation:** The VA should ensure sufficient resources are provided to WHRN for continuation of its efforts to map gaps in the women veterans research agenda, especially in the area of suicide prevention, and to recruit investigators with subject matter expertise to address them.
- **Research Recommendation:** The VA should ensure all research efforts include over-sampling of underserved veteran subpopulations, including women, racial and ethnic minorities, and LGBTQ+ populations as data allows.
- **Research Recommendation:** The VA should explore more partnerships with other federal agencies, including the Department of Defense (DOD), Substance Abuse and Mental Health Services Administration, and academic partners, to ensure that women veterans' risk factors related to mental health and suicide that may be too small to measure in VA data are captured.
- **Research Recommendation:** The VA should ensure sufficient representation of women in suicide research studies to better understand unique suicide risk factors and prevention approaches and gender differences in treatment acceptability, access and effectiveness.

## Military Sexual Trauma

For decades, VA research has been at the forefront of advancing knowledge about the prevalence and impact of MST on the health and functioning of women veterans. MST is an independent risk factor for suicidality and suicide in both men and women.[4,7,50,51] This risk holds true across both age and gender, even when other confounding mental health diagnoses are considered.[52,53] Experiencing MST is also associated with mental health diagnoses linked to additional increased risks for suicidal thoughts and behavior, such as depression, substance use disorder, PTSD and intentional self-harm.[54-58]

MST encompasses sexual harassment and sexual assault that occurred during military service, which can have significant impacts on physical and mental health. The DOD notes that in 2021, 8.4% of active-duty women and 1.5% of active-duty men reported they experienced at least one incident of unwanted sexual contact in the past year.[59] Rates of sexual harassment in the same year were much higher, at 28.6% for women and 6.5% for men.[59] Among veterans enrolled in the VA, 1 in 3 women and 1 in 50 men report experiencing MST.[54]

One study found higher rates of MST among post-9/11 veterans using reproductive health care services. Among those studied, 68.7% reported experiencing MST (including 44.9% who reported experiencing assault). However, many of these veterans (30.8%) had a negative screen for MST in their clinical record. MST was found to be associated with increased suicidal ideation among these veterans, and researchers noted that underreporting of MST is highly prevalent among women veterans using Veterans Health Administration

## Penni Lo'Vette Brown

### 'HAVE TO GET BETTER'

The first time Army veteran and DAV member Penni Lo'Vette Brown learned she could get health care through the VA was by happenstance.

It was 1998, eight years after she left the military, and she had been reeling from the effects of MST and PTSD, compounded by intimate partner violence and alcohol abuse. She had become homeless and needed a shelter where she could keep herself and her children safe. The shelter she ended up at was next to a VA clinic.

Brown said her doctors put her on different medications and worked with her when she experienced adverse reactions. But she said after experiencing repeated turnover with therapists, she stopped seeking mental health treatment through the VA.

"I'm not going to keep putting a Band-Aid on this and have to rip the Band-Aid off with a new therapist every single time and start over from the beginning," she said. "We have to get better with [retaining mental health clinicians]."

Brown said she was able to get sober on her own, and she now finds healing in sharing her story and helping other veterans. A former DAV chapter commander, she's a current Benefits Protection Team leader and volunteers to assist veterans through the benefits claims process.

Brown knows how life-changing that help can be. She said when she transitioned out of the Army, nothing was done properly.

"There was no information given to me," she said, adding the MST she experienced was documented, yet nobody asked her if she needed follow-up care. Had she gotten help earlier, she said, she could have avoided alcoholism, bad relationships and low self-esteem.

"I went on not knowing that I was broken for years."

Brown isn't alone in dealing with the aftermath of MST. Among veterans enrolled in the VA, 1 in 3 women report experiencing such trauma. Experiencing MST is associated with mental health diagnoses that are linked to increased risks for suicidal thoughts and behavior, such as depression, substance use disorder, PTSD and intentional self-harm.

That's why, Brown said, it's critical the VA provide access to timely, quality and consistent mental health care and that women know what resources are available to them.


PHOTO BY STEVE POSKILL

(VHA) reproductive health care, therefore rescreening for MST within this population is essential.[60]

Another study found that veterans who identified MST as the source of their PTSD were at least three times as likely to have suicidal thoughts as those who said their PTSD was specifically related to combat or deployment. According to researchers, their results show the importance of addressing PTSD that is specifically related to MST.[61]

For over a decade, VHA has required routine screening for MST and included a clinical reminder in the electronic health record.[62] According to one expert, given that many survivors never talk about their MST experience unless asked directly, VHA's routine screening, culturally competent sensitivity and other efforts to engage veterans are crucial ways to proactively reach survivors who may not otherwise seek care.[63] With the passage of the Deborah Sampson Act (Public Law 116–315; see Appendix B 9.1), MST programs expanded training requirements for MST for clinical and nonclinical staff, strengthened the responsibilities of local MST coordinators and relaxed eligibility for MST-related care. Unfortunately, MST coordinators' responsibilities at many VA medical centers are a collateral duty. In addition, evidence of a significant number of false negative screens for MST in the study noted above suggest the need for VA providers to rescreen women veterans using a more trauma-informed approach and reach out to veterans outside of mental health settings.[60] These additional responsibilities necessitate a full-time MST coordinator at all VA medical centers.

- **Policy Recommendation:** MST should be a central pillar of suicide prevention efforts in VHA, given the exceedingly high prevalence of trauma among VHA patients.
- **Research Recommendation:** VA researchers should continue to explore ways to improve trauma-sensitive primary care for women veterans with histories of MST and expand access to new care models and evidence-based treatments that will improve their health and functioning.
- **Policy Recommendation:** VHA should ensure every VA medical center has at least one full-time MST coordinator to timely address workload; collaborate with other service lines, including reproductive health to provide trauma-informed care; provide outreach to women outside of mental health programs; and ensure veterans are effectively screened or rescreened for MST.
- **Policy Recommendation:** VHA's MST program should review suicide prevention program materials, training and the guidance given to clinicians to ensure the link between MST and heightened risk for suicidality is made explicit.

## Intimate Partner Violence Against Women Veterans

Women veterans have disproportionately high risk for intimate partner violence (IPV; see Appendix B 10.1) compared with women who didn't serve. According to the VA, nearly 1 in 5 women veterans using VHA primary care reported experiencing IPV in the past year.[64] In fact, women veterans are 1.6 times as likely to experience IPV in their lifetime compared with civilian women, and there is a strong association between a positive IPV screening and suicidal ideation and self-harm behaviors among women veterans using VHA services.[64,65] IPV includes physical or sexual violence, stalking and psychological aggression from a past or current intimate partner. Factors associated with IPV are younger age, identification as LGBTQ+, homelessness or financial hardship, and a history of MST.[66] There are also serious health risks for veterans who experience IPV, including physical injury, chronic pain, mental health conditions, reproductive health problems, housing and employment problems, and suicidal behavior.[66] As such, IPV against women veterans has been a focus of the White Ribbon VA campaign (see Appendix B 10.2)—a national call to action to eliminate sexual harassment, sexual assault and domestic violence across the department.


In response to the growing awareness of IPV among veterans and its serious consequences, the VA funded a number of IPV research projects[64] and developed the Intimate Partner Violence Assistance Program (IPVAP). VHA Directive 1198 (see Appendix B 10.3) outlines roles

## Jennifer Alvarado

### 'A VERY DARK PLACE'

For 15 years, Jennifer Alvarado lived in survival mode. She struggled to hold a job, was at risk of homelessness and relied on food banks. It was exactly the kind of life she hoped to avoid when she joined the Navy as a 19-year-old single mom.

But after years of intimate partner violence that went ignored by her peers, compounded by repeat MST, Alvarado was exactly where she didn't want to be.

"I felt lost in a lot of ways, and I had to dig myself out of a very dark place while I was trying to be an exceptional sailor and wear my uniform with pride," she said. "It was almost like I was living a double life."

According to the VA, nearly 1 in 5 women veterans using VHA primary care reported experiencing intimate partner violence in the past year.

When Alvarado turned to her leadership for help with the violence she was experiencing at home, she said she was met with sexual harassment at work.

"I felt shame to begin with, but I felt even more shame when I reached out for help," she said.

By the time she left the Navy, Alvarado said her life was chaotic and unstable. At times, she found solace in drinking, and during one phase in her life, she considered suicide. Alvarado said she's been lucky to see the same VA therapist since 2006, but other experiences have left her disappointed and further traumatized.

She said she's been sexually harassed at her local VA clinic, doctors have piled on prescriptions with adverse reactions, her benefits claim for depression was denied, and nobody even talked to her about PTSD.

With DAV's help, Alvarado eventually had a claim for PTSD approved, and for the first time in 15 years, she said, she felt truly heard. Her hope is that no veteran has to wait that long. She said the VA must regain the trust of women veterans and make sure they know what resources are available to them.

"They need to feel confident that they are going to get the care that they need and deserve."

and responsibilities for program coordinators assigned to each medical center who are responsible for ensuring compliance with the VA's strategic plan for IPV and for the education and awareness of staff within the medical center. The coordinator must ensure that all veterans are screened and identified in accordance with the national IPVAP toolkit; coordinate services; and provide interventions as appropriate for the veteran—including working with veterans and their partners to develop healthier relationships or to develop safety plans and find resources and community supports such as housing or legal aid if the veteran is ready to leave an abusive relationship.

A primary goal of the program is to use sensitive, trauma-informed screening approaches to reduce barriers to IPV disclosure (e.g., shame, stigma and privacy concerns) and identify veterans in abusive relationships. In the interest of ensuring the best help for these vulnerable veterans, trusted staff members should also routinely screen for suicide risk. Recovering From IPV Through Strengths and Empowerment (RISE; see Appendix B 10.4) is an evidence-based practice that uses a veteran-centered, nonjudgmental, trauma-informed approach to help empower veterans and increase their self-efficacy. In addition, the VA runs the Strength at Home (see Appendix B 10.5) program to assist veterans who struggle with anger in relationships and may use violence against loved ones.[66]

We applaud VHA's efforts for systemwide implementation of routine IPV screening; however, barriers to adoption of the policy remain at some sites. For example, providers reported feeling uncomfortable addressing IPV with patients, inadequate training, lack of resources or time, and competing patient care priorities and responsibilities as reasons for not conducting the screening.[67,68] Likewise, the VA must complete and report on the required IPV provisions included in Sections 5304 and 5305 of Public Law 116–315. (See Appendix B 10.6.)

- **Policy Recommendation:** VHA should ensure integration of suicide prevention and IPV services. Suicidal ideation and behaviors should be assessed among women with positive IPV screens, and identification of suicide risk should prompt an IPV assessment.[65]
- **Policy Recommendation:** VHA should continue provider training and support for routine IPV screening to ensure veterans have access to evidence-based practices such as RISE and Strength at Home.
- **Policy Recommendation:** VHA should inform VA community care partners that women veterans have higher rates of IPV and that patients who screen positive should be referred back to the VA for information, treatment, resources and safety planning if needed.
- **Policy Recommendation:** The Department of Health and Human Services should create a three-digit number (with veteran option) for the National Domestic Violence Hotline (800-799-7233) to ensure veterans can get the support and services they need to address IPV.
- **Research Recommendation:** VHA should assess the need to develop or refine machine learning algorithms to address the additional risk of any lifetime trauma, including IPV, on women veterans' suicidal behavior.
- **Research Recommendation:** VHA should determine the need for any trauma-informed refinements to the current screening process and treatment of veterans who screen positive for IPV or other lifetime trauma.

## Trauma-Informed Care

Many service-disabled veterans using the VA struggle from the residuals of combat-related post-traumatic stress. A history of trauma is associated with long-term physical and psychological effects and, while not well understood, is also believed to increase risk of suicide. These events can also affect the patient's care experience and willingness to engage in preventive care services. In addition, more veterans report MST, including about 1 of 3 women and 1 of 50 men. If those who experienced childhood trauma or interpersonal trauma as adults are included among these statistics, it is understandable why trauma-informed care practices (see Appendix B 11.1) are critical to addressing the unique needs of many ill and injured veterans using VA services.

For individuals who have high levels of trauma exposure, health care experiences can reactivate anxiety about personal safety and control. For example, during health care visits, providers performing clinical evaluations are not always able to maintain a comfortable personal space for patients, veterans may be compelled to disrobe and reveal sensitive information, and procedures are sometimes painful. These factors can be anxiety producing, even for patients without a history of trauma. Concern about medical care for this often-vulnerable population can lead to delayed or foregone preventive and routine care and greater utilization of emergency services.

Trauma-informed care is a framework that takes into account the effect that past trauma can have on current behavior and the ability to cope—and can help to minimize retraumatization during health care encounters. The medical literature describes two tiers of trauma-informed care: trauma-specific interventions

and universal trauma precautions that can be used with patients without knowing their trauma history.[69] These simple changes in communications allow patients to better understand the procedures they will be exposed to during the visit and provide them the opportunity to set priorities for the visit, ask questions and express concerns. The VA is a leader in trauma-informed care and requires training for its providers; however, it has not evaluated the value and health outcomes associated with the use of this intervention for veterans.

- **Policy Recommendation:** The VA should develop an awareness campaign to educate and engage VA community network providers in employing principles of universal precautions in trauma-informed care.
- **Policy Recommendation:** The VA should require all community network providers to be trained on trauma-informed care practices used by VHA providers to address the specific needs of veterans with known trauma histories.
- **Research Recommendation:** VA researchers should evaluate and assess the value and health outcomes associated with the use of trauma-informed care practices for veterans and, if appropriate, determine evidence-based universal practices in trauma-informed care to integrate into VA health care systemwide.

## Substance Use Disorder

Substance use disorder is among the many conditions for which gender-specific considerations have implications for care delivery. According to one study, up to 37% of women veterans misuse alcohol and 16% have substance use disorder associated with key woman veteran experiences, including combat and MST. Most women veterans with at-risk alcohol use are not in treatment—with women citing stigma and discomfort with mix-gender programs as reasons for not engaging in treatment.[70]

According to the VA Office of Women's Health, the proportion of women veteran VHA users with any mental health or substance use disorder encounters increased between fiscal year (FY) 2000 and FY 2019 (23% to 65%). The VA offers a range of services to treat veterans with substance use disorder, including short-term inpatient medication management for withdrawal, long-term medication management, individual and group behavioral health interventions, and residential rehabilitation treatment programs to manage addiction and develop critical life skills. In addition, VA substance use disorder treatment programs focus on a whole health model of care and provide complementary and alternative practices to traditional medicine, such as meditation, yoga, acupuncture and tai chi.

For women veterans, who are more likely to indicate they have poor social networks than male peers, connections to other women veterans may be critical to their recovery and long-term abstinence from substances. The VA is currently working on using innovative ways, such as the use of peer specialists and mobile apps, to reach veterans dealing with substance use disorder and to keep them engaged in treatment. Peer support specialists are often helpful in personalizing veterans' health care experiences, especially if specialists have had similar lived experiences to those they are working with and are in recovery from issues such as substance use disorder, PTSD and eating disorders.

The VA's Residential Rehabilitation Treatment Program provides a comprehensive and intensive level of care. The Mental Health Residential Rehabilitation Treatment Program mission is to provide state-of-the-art, high-quality residential treatment services for veterans with co-occurring mental health and substance use disorders, medical concerns, and/or psychosocial needs such as homelessness and unemployment. Services include 24/7 nursing coverage and support for medication compliance and administration. Researchers note that accumulating evidence within VHA suggests that creation of women-centered spaces is important for delivery of high-quality care to women veterans. However, VHA has a limited number of gender-specific residential rehabilitation treatment programs, which women veterans prefer. (See the Residential Rehabilitation section on Page 33 for more details.)

To address barriers to care for women with substance use disorder, the VA funded a pilot for a women veterans with substance use disorder patient-aligned care team (PACT) to see if this type of integrated care model could help fill a gap in programming and improve substance use disorder treatment and outcomes for women veterans. The specialized multidisciplinary team included providers with expertise in both women's health and substance use disorder, and it focused on specific issues that may put women at risk of relapse, including caregiving responsibilities, fertility challenges, MST, IPV and high rates of psychiatric comorbidities.

This specialized care team served a high-need population, with participants having a care assessment need score of 82/99 (compared with an average score of 60 for other women veterans). Most of the participants had not previously received treatment for substance use disorder nor had an ongoing relationship with a VA primary care provider. Eighty percent of the participants were maintaining evidence-based

## Jennifer Badger

### 'PEOPLE LIKE ME'

Jennifer Badger said a "whole melting pot full of different factors" led her to abuse drugs and alcohol.

At 19 years old, she enlisted in the Navy. Her father had recently died from a drug overdose, and she was looking for a way to escape the grief.

"I was … very depressed," Badger said. "I was really close with my dad."

While she loved her job as an intelligence specialist, her service came with challenges that added to the melting pot. She experienced sexual harassment and assault and struggled as one of few women in her squadron. In an attempt to fit in, she began drinking heavily.

In 2005, after four years in the Navy and as a new mom, Badger decided to reenter civilian life and found herself feeling incredibly lost. She had two more children accompanied by periods of sobriety, but she gradually began using drugs to cope. Eventually, she was deep into a methamphetamine addiction.

"One of the worst demons on the planet," Badger said of the drug.

It wasn't until 2021, when Badger had nowhere else to turn, that she sought help. Someone referred her to Welcome Home Inc., a program for veterans experiencing homelessness, funded in part by the DAV Charitable Service Trust. Before that, Badger hadn't even considered herself a veteran. Welcome Home became her connection to the VA.

During a meeting with a VA supportive housing specialist, she admitted for the first time on record that she had a drug problem. Badger was almost immediately admitted into a six-week inpatient drug rehab program at her local VA medical facility. She's been sober ever since.

Badger said what made the program phenomenal was twofold: It included off-site recreational activities that taught her how to have fun without drugs or alcohol, and it included peer specialists.

"These are people that have literally sat in the same seats that I'm sitting in … and they came out of it and here they are telling their story and helping other people," she said.

Badger is now a certified peer specialist and hopes to work with the VA in that capacity.

"I knew that I wanted to help other people like me," she said.

pharmacotherapy treatment four months after initial enrollment. Importantly, patients in this study also engaged in more routine preventive care, such as routine cancer screenings. Clinicians noted one recurring theme throughout the pilot: the desire among women veterans to have women-centered pain programs to deal with their chronic pain issues, a known risk factor for suicide.[70] Addressing chronic pain among veterans is critical due to its link with mental health conditions and suicidal behavior.

While this specialized care team treatment model is resource-intensive, serving only half the panel size of most mental health PACTs, clinicians reported using the extra time to follow up with patients, cultivate interdisciplinary relationships with related service lines and teams such as inpatient mental health and substance use disorder clinics, and coordinate care to ensure involvement across the continuum of care (e.g., inpatient-outpatient care services and programs).[70]

- **Research Recommendation:** VA researchers should conduct a nationwide analysis of the need and efficacy of women-specific programs that treat and rehabilitate women veterans with drug and alcohol dependency to determine if expanding gender-specific substance use disorder outpatient and inpatient care or the Residential Rehabilitation Treatment Program is warranted.
- **Research Recommendation:** The VA should conduct a needs assessment to determine if adding substance use disorder telehealth programming (via videoconferencing) for highly rural communities would be effective and warranted.
- **Policy Recommendation:** The VA should expand the women veterans with substance use disorder PACT integrated care model to clinics that demonstrate a high level of need and explore adding a pain expert to the team.
- **Legislative Recommendation:** Congress should provide additional funding to expand women-centered PACT programming to meet the needs of veterans with comorbid substance use disorder and chronic pain.

## Eating Disorders

Sexual trauma is a known risk factor for disordered eating, and eating disorders have been linked to an increased risk for suicide.[72] Disordered eating includes a wide range of abnormal eating behaviors versus eating disorders, which include serious conditions such as anorexia, an obsessive desire to lose weight by refusing to eat; bulimia, excess overeating, often followed by self-induced vomiting, purging or fasting; and binge eating or overeating without purging.

VHA estimates that as many as 14% of female and 4% of male patients have eating disorders. To combat the devastating physical and emotional effects of these complex conditions, the VA has created multidisciplinary clinical teams that provide both treatment and consultation within every Veterans Integrated Services Network (VISN).[72]

The VA's National Center for PTSD notes that individuals with eating disorders have high rates of comorbid PTSD and that military-specific traumas—such as MST and combat—as well as the military's strict weight and fitness requirements, may make veterans particularly vulnerable to eating disorders. (See Appendix B 12.1.)

One researcher found that women veterans reporting MST had twice the odds of developing an eating disorder compared with women who did not and suggested that it may be useful to focus on women reporting MST when implementing eating disorder screening and treatment programs. We concur with researchers that, given associations among trauma, eating disorders, obesity and mortality, such efforts could greatly improve veteran health.[72]

- **Policy Recommendation:** VHA should ensure that information about eating disorder screening, training and treatment options, along with awareness of VISN consulting teams, is available to designated women's health providers, women's mental health champions and others routinely addressing the needs of women veterans.
- **Research Recommendation:** The VA should continue to conduct women veteran-focused research on the association between multiple forms of trauma and eating disorders.

## Social Support

While the effect of social support and connectedness on suicidal behavior is not as well understood as other risks and protective factors, peer support specialists are often helpful in personalizing veterans' health care experiences, especially if they have similar experiences to those they are working with and are in recovery themselves. The VA stated it plans to use more peer support in mental health settings, including substance use disorder programming, to improve veterans' retention and engagement in more intensive evidence-based treatments.[74]

For women veterans, who are more likely to experience isolation, loneliness and poor social networks following military service than their male peers, making connections with other women veterans can

## Amber Miskovich

### 'SHAME DIES IN SAFE PLACES'

It was during her 15 years in the Ohio Air National Guard when Amber Miskovich's eating disorder really took off.

"Some of my worst times were in the military, because I was isolated," Miskovich said.

As a medic who deployed around the country to places and people in need, she was also exposed to a lot of suffering.

"And you realize that there's only so much that you could do because you're here helping and then you're going to leave," she said. "And I think that that is difficult."

Miskovich said she was introduced to a 12-step program by other nurses and medics who were also experiencing eating disorders. But what was most life-changing for Miskovich was Save A Warrior, a nonprofit organization that provides retreats and leverages the best interdisciplinary approaches to prevent suicide among veterans and first responders. With a grant from the DAV Charitable Service Trust, Save A Warrior opened a National Center of Excellence for Complex Post-Traumatic Stress in Hillsboro, Ohio, and DAV continues to support the program.

Miskovich attended a retreat after reaching what she described as a breaking point. She was experiencing issues in her marriage and grieving the death of her brother. Along with food, she turned to alcohol and shopping to numb her pain.

"I just kept feeling like … I'm not helping anyone in my family, like I'm hurting them, and it was just probably better if I wasn't here," she said.

VHA estimates that as many as 14% of female and 4% of male patients have eating disorders, numbers Miskovich believes are vastly underreported due to the shame around it. Eating disorders are also linked to an increased risk for suicide.

Miskovich said Save A Warrior retreats get to the root cause of suffering, which she noted starts well before military service for many veterans. As for the eating disorder, she said Save A Warrior allowed her to let go of the shame and guilt surrounding it.

"Shame dies in safe places," she said.


DAV has committed to reducing suicides by supporting **Save A Warrior** (see Appendix B 13.3), a nonprofit organization whose mission is ending the staggering number of veteran, active-duty service member and first responder suicides. Thanks to a grant from the DAV Charitable Service Trust, Save A Warrior opened a National Center of Excellence for Complex Post-Traumatic Stress in Hillsboro, Ohio. The DAV-sponsored center, which opened in June 2022, provides lifesaving retreats that leverage the best interdisciplinary approaches to suicide prevention.

be critical in improving mental wellness. A two-year pilot of the Women Veterans Network (WoVeN; see Appendix B 13.1) operates in local communities across the country. The eight-week program is administered through trained peer leaders. The program is open to women veterans from all eras and branches of service and explores themes including transition, balance, trust and self-esteem. While there are methodological challenges to evaluating the effectiveness of peer support groups, including WoVeN, research seems to indicate that engagement in peer support networks, along with clinical interventions, offers more protection against negative outcomes than clinical treatment alone.[74]

The VA also sponsors women-only retreats through its Vet Center Program. The VA has the authority to provide counseling in retreat settings to veterans through 2025, in accordance with Public Law 116–315, Section 5104. (See Appendix B 13.2.) These retreats are sometimes women only and open to family members, and they may provide financial, vocational and stress-reduction counseling. Women veterans attending these retreats report they are highly beneficial in helping them make peer connections and build a network of support. Some of these programs appear to show lasting beneficial effects from brief interventions, but more research is needed.

- **Research Recommendation:** VA researchers should evaluate and determine women's satisfaction with WoVeN and identify the impact and differences in mental health outcomes (symptoms and functioning) between participants and matched peers who do not participate in the program.
- **Research Recommendation:** VA researchers should determine effectiveness and mental health outcomes of VA Vet Center-sponsored women veterans retreats.
- **Policy Recommendation:** VHA should determine if current VA Vet Center retreat programming meets demand and if the number of retreats for women veterans should be increased and/or made permanent before the authority to provide them expires at the end of FY 2025.
- **Legislative Recommendation:** Congress should expand the VA's authority and resources to establish an appropriate training and oversight infrastructure to increase hiring and employment of women veteran peer support specialists in all service lines where they would be more beneficial.

## Constance Cotton

### 'YOU'RE NOT ALONE'

Toward the end of 2021, nearly two years into the COVID-19 pandemic, 17-year Army veteran and DAV life member Constance Cotton needed community. In addition to the strains of the pandemic, she had recently lost her mother and was taking care of her father.

Around that time, she discovered WoVeN, a social network of women veterans that operates in local communities across the country. Cotton said she met virtually with her local group once a week for eight weeks, with sessions led by a trained peer leader.

"It was really special. It ended up being an amazing support group for that short period of time," Cotton said, adding that the women in her group offered a safe space to share their experiences as service members and veterans.

"We were transparent about our struggle with being an invisible female veteran and feeling not appreciated [or] understood in society."

Cotton enlisted in the Army in 1988 and worked in logistics in medical units. She served around the world, including in Saudi Arabia during the Gulf War, and loved her job.

But Cotton experienced military sexual trauma various times during her military career, which she said affected her physical and mental health.

"[It] made me realize that I was not in a safe place," she said.

Her experience made it difficult to trust others or feel safe. She was also dealing with trauma related to serving in a combat zone.

"When I came home from [the Gulf War], my father picked me up and he said I had a blank stare in my eyes and I wasn't the same," Cotton said. "And from that point, I began to realize that I was in a downhill spiral."

Cotton eventually received mental health support through a VA Vet Center, where she had the same counselor for nine years. She also turned to her faith and the community of women veterans for support.

That connection can be critical in a veteran's mental wellness, particularly for women veterans, who are more likely to experience isolation, loneliness and poor social networks after service.

"It allows you to have those connections to understand that you're not alone."

# REPRODUCTIVE MENTAL HEALTH CARE

During the life cycle of women, pregnancy, birth and menopause can bring about significant hormonal shifts and changes in appearance and can change the role society imposes on a person. Researchers have asked if these physiological and life changes affect mental health and suicidality. The repercussions of failures to address reproductive mental health care issues can be devastating and even have intergenerational effects. For example, a recent study in the Department of Veterans Affairs found that women who had experienced military sexual assault were more likely to be depressed during and after pregnancy. This depression led to poorer mother-infant bonding.[75] In recognition of the significant effect of biological/reproductive phases on women's mental health, in 2020, the VA assembled a virtual reproductive mental health care team available to consult on complex mental health issues affecting women veterans and established the VA Reproductive Mental Health Consultation Program within its Office of Mental Health that is now available to all VA clinicians.[76] To date, the VA has conducted mini-residencies for providers that focus on women's reproductive mental health and has trained about 200 clinicians.[71]

- **Policy Recommendation:** Given the growing number of women veterans using VA care and their higher usage rates of mental services, the VA should increase the number of mini-residencies for providers focused on women's reproductive mental health.

## Maternity and Mental Health Care

The VA currently provides health care to approximately 650,000 (as of Dec. 29, 2023) women veterans—half of whom are childbearing age. Pregnancies among women using VA care have increased by more than 80% since 2014, from 6,950 pregnancies in 2014 to 12,524 in 2022. (See Appendix B 14.1.) Research indicates that pregnant veterans who use VA coverage have elevated rates of trauma exposure and mental health conditions that increase risk during pregnancy. For example, post-traumatic stress disorder (PTSD) during pregnancy is associated with a 35% increased risk of preterm birth, 40% increased risk of gestational diabetes and 30% increased risk of preeclampsia. Depression during pregnancy affects an estimated 28% of veterans and is associated with increased risk for postpartum depression and poor mother-infant bonding.[77]

Accumulating evidence also indicates (in the general population) that during pregnancy and up to a year after giving birth can be a time of increased risk for a mental health diagnosis and suicidality in

## Naomi Mathis

### 'NOT THE END'

Naomi Mathis joined the Air Force in 2000 as a young, single mom. She wanted to serve her country and give her children a better life—a goal she says came to fruition. And despite the turmoil she experienced during and after service, there's little she would change.

"The only thing I would change would be that we didn't lose Griff," Mathis said, referring to Staff Sgt. Patrick L. Griffin Jr.

Griffin was killed in an accidental detonation of unexploded ordnance on May 13, 2003, while operating in a convoy into Iraq. Mathis was in the same convoy.

When she left Iraq, Mathis became an instructor and slowed her life down. That's when she started experiencing what was undiagnosed severe PTSD, along with suicidal thoughts.

The most sobering wakeup call came in 2006 after the birth of her son. She doesn't know if it was hormones or the cocktail of medications she was on for PTSD, but Mathis started experiencing what seemed to be severe symptoms of postpartum depression.

"I immediately was terrified," Mathis said.

Mathis quickly saw her TRICARE doctor and demanded a change in treatment. She also started therapy.

While Mathis' care was through TRICARE, many women veterans who use the VA for maternity care are similarly at risk for negative mental health experiences. Research shows that veterans using VA maternity care are more likely than the general population to have one or more mental health diagnoses, including PTSD, which can put them at greater risk for things like suicidal ideation. VA maternity care is outsourced to community care providers, requiring a high level of coordination.

"And those providers, we need to ensure that they are trained to be able to take care of women veterans," Mathis said. "We come with a unique set of challenges mentally [and] physically."

When Mathis medically retired in 2007, she discovered DAV and became a benefits advocate, which is how she learned about the VA's specialized health care services and programs for women. She now serves at the DAV Washington Headquarters as an assistant national legislative director helping to educate Congress about the needs of women veterans and fighting for legislation to improve women's health services.

"I want people to realize that you can turn any situation around," she said. "It's not the end, no matter how hopeless it feels."

PHOTO BY JESSICA RABELLO

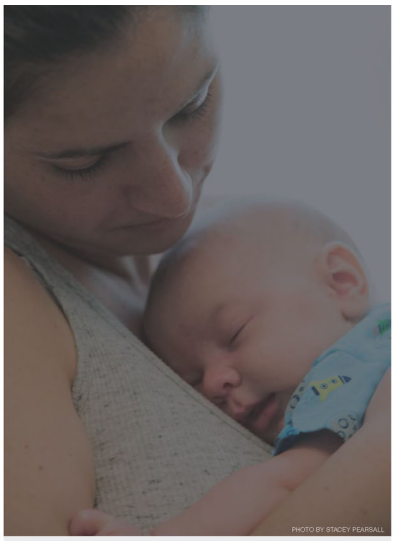


PHOTO BY STACEY PEARSALL

Having a **prior mental health diagnosis** raises the risk for suicidality in the perinatal period—indicating why suicide prevention is crucial for veterans using obstetrics services.

women patients with a prior mental health diagnosis. An analysis of postpartum suicide attempts noted a startling 27-fold increased risk of suicide among those previously hospitalized with a psychiatric diagnosis, a sixfold increase among those with prior substance use disorder, and an 11-fold increased risk for those who had a dual diagnosis of substance use disorder and mental health conditions.[78] Clinicians noted that one potential contributing factor to this increased vulnerability to adverse mental health outcomes during the perinatal period is the frequent cessation of antidepressant medications during pregnancy.[79]

Research in the veteran population points to similar findings. In a small study that followed veterans between the third trimester and six weeks postpartum, researchers identified depression and the experience of trauma, including military sexual trauma (MST), as risk factors for suicidal ideation, with 10% of the participants reporting thoughts of suicide.[80] In a larger study of veterans reporting MST, their experience was associated with an increased diagnosis of depression and suicidal ideation during the perinatal period.[81] The researchers called for safety-related mental health screenings and trauma-informed care during and after pregnancy.

Although most maternity care is provided through community partners, the VA has worked hard to create a supportive maternity experience for women veterans. Maternity programs include making maternity care coordinators available to veterans and establishing national requirements for the management of pregnant veterans.[82]

In previous reports,[83,84] DAV noted that veterans relying on VA-supported reproductive health services have a higher incidence of mental health, substance use disorder and trauma-related diagnoses than the general population. The developing evidence that a prior mental health diagnosis raises the risk for suicidality in the perinatal period means suicide prevention is crucial for veterans using obstetrics services. Since obstetrical care is provided to veterans through community partners, it is critically important that VA suicide prevention requirements for screening, referral and follow-up care be addressed within the maternity care protocols through maternity care coordinators. To improve maternal outcomes for women and to ensure they have the support they need throughout their pregnancy, the VA recently expanded veterans' access to maternity care coordinators from eight weeks to 12 months postpartum. (See Appendix B 14.1.)

Coordinating clinical handoffs and communications between an array of community partners as well as VA providers can create vulnerabilities and missed opportunities for suicide prevention. We are particularly concerned about veterans falling through the cracks between maternity services and suicide prevention programming.

- **Policy Recommendation:** The Veterans Health Administration (VHA) should ensure visibility and awareness of the reproductive mental health consultation group, earmarking time for consultants within the group to address issues arising throughout the VA health care system.
- **Policy Recommendation:** The Office of Women's Health and the Office of Mental Health and Suicide Prevention should collaborate to establish standard protocols and training for community providers treating pregnant veterans and define responsibilities for how local suicide prevention coordinators, maternity care coordinators and/or women's health clinical leaders should work together to support pregnant women veterans with elevated risk factors for suicide.

## Maria Luque

### A 'PERFECT STORM'

Several years ago, Air Force veteran Maria Luque started experiencing crippling anxiety.

"It just stopped me," Luque said.

Despite having a doctorate in health sciences and studying menopause for over a decade, Luque was taken by surprise by the symptoms associated with menopause. She eventually broached the topic with her VA doctor (whom she said is fantastic) and quickly got the care she needed.

However, Luque said a majority of the women she's talked to about menopause—including civilians who receive health care through the private sector—say they have felt dismissed by doctors.

"And when you get dismissed like that … it's very hard to kind of bounce back," said Luque, a DAV member and the founder of Fitness in Menopause, a company dedicated to improving quality of life for women in menopause through physical activity.

"We need to do better."

Usually, menopause comes with fluctuations in hormone production, beginning between ages 45 and 55, and is often accompanied by a variety of symptoms, including hot flashes, sleep disruption, body aches, weight gain, incontinence and memory problems. Menopause has also been shown to raise the risk for depression twofold in U.S. women and corresponds to the highest rates of suicide in U.S. women.

"Any woman at their healthiest, best mental state gets hit with menopause [and] can really be affected by it," Luque said. "Let's layer on the combat part of maybe a woman veteran, and let's layer on the possible sexual trauma that happened during military service as well on top of that."

She called it a "perfect storm."

Luque, who is also an alum of DAV Patriot Boot Camp for entrepreneurs, said many women lack the information needed to effectively advocate for themselves when menopause hits. Given the demographics of women using VA health care and their complex mental health histories, she said the VA needs to be more proactive in reaching women veterans and discussing menopause.

"I feel like there is a lack of information [and] there's a lack of services specifically geared towards this," she said.

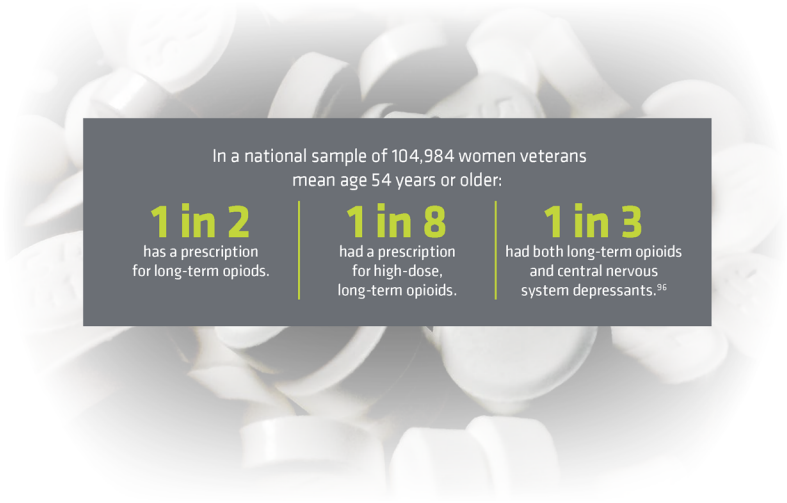
PHOTO BY WESTON GIFILS

- **Policy Recommendation:** VHA should assign responsibility for tracking and reporting suicide screening, referral and follow-up care within VHA to maternity care program coordinators. That data should be reported in the VA's annual report to Congress on suicide prevention.
- **Research Recommendation:** VA researchers should evaluate the effectiveness of assigning VA-trained peers or doulas to veterans with complex mental health conditions during the perinatal and postnatal period to better coordinate services and address adverse mental health conditions, including suicidality.
- **Policy Recommendation:** VHA should provide additional mini-residencies in women's reproductive mental health.

## Increased Suicide Risk for Women Veterans in the Life Cycle

Women with premenstrual syndrome (PMS) and premenstrual dysphoric disorder (PMDD) can experience substantial functional impairment and decreased quality of life. Results from a systematic literature review and meta-analysis suggests that PMDD is a strong risk factor for suicidality, increasing the likelihood of suicide attempt and ideation by almost sevenfold and fourfold, respectively. Researchers reported that their findings indicate that women with PMS are also at increased risk of suicidal ideation but not suicide attempt.[85] These findings support routine suicidal risk assessments for women veterans who experience moderate-to-severe premenstrual disturbance and allow for refinement of screening, diagnosis and treatment options.

Women in midlife experience perimenopause and menopause. Often starting in women's mid-40s and lasting for seven to 14 years, this life transition sees fluctuations in estrogen and progesterone production and is often accompanied by both physical and behavioral symptoms, including hot flashes and night sweats; sleep disruption; body aches; weight gain; incontinence; depression; memory problems; and changes in bone, heart and sexual health.[86] Postmenopausal women can continue to experience menopausal symptoms and are at increased risk for cardiovascular disease and osteoporosis compared with their younger selves.[87] Perimenopausal, menopausal and postmenopausal women are often prescribed antidepressants, hormone replacement therapy (HRT) and gabapentin to alleviate symptoms.[87]



This life transition and the experience of aging are also often parts of a period of life with a litany of stressors, including simultaneously raising adolescent children and caring for aging parents and other loved ones. Perimenopause, usually defined as occurring between ages 45 and 55, has been shown to raise the risk for depression in women twofold,[89] with as many as 20% of women in perimenopause reporting symptoms of depression.[90] This period of menopausal transition also corresponds to the highest rates of suicide in U.S. women[91] and mirrors increased suicide rates in midlife for women in the United Kingdom and Australia.[92]

Among perimenopausal and postmenopausal veteran women, other risks of suicide are complex and not well understood. One indicated risk for suicide in this population may be the use of HRT itself. In a cohort of over 290,000 women veterans 50 or older, 6% received a prescription from the VA for HRT.[93] These women were at increased risk for suicide attempts and suicide compared with the rest of the cohort, including a twofold increased risk for death by suicide.[93] While it is not clear that HRT drives the increased suicide risk, it may be a prognostic factor and could refine predictive suicide models such as REACH VET (Recovery Engagement and Coordination for Health – Veterans Enhanced Treatment).

Another complex factor in older women veterans is polypharmacy and suicide. Polypharmacy is frequently defined as taking five or more prescription medications at once. Older women veterans with serious mental illness and multiple prescriptions were found to have significant increased risk for both suicide and accidental overdose.[94] Long-term opioid use and benzodiazepines were particularly associated with additional suicide risk.[94] It is important to note that chronic pain in midlife women veterans can be exacerbated by menopausal symptoms[95] and prompt some women veterans to seek relief through prescription opioids.[95,96] In a national sample, 1 in 2 had a prescription for long-term opioids; 1 in 8 had a prescription for high-dose, long-term opioids; and 1 in 3 had both long-term opioids and central nervous system depressants.[96] In studies of both men and women, older age with polypharmacy that includes benzodiazepines and opioids raised suicide risk by more than seven times.[97,98] Again, these studies do not reveal if polypharmacy is causative or just prognostic of suicide risk but should be explored to refine predictive analytic models of suicide for older women veterans.

The impact of menopause on mental health and suicide risk among women veterans is understudied and not well defined. But given the suicide rate in this cohort of women and a preliminary indication of concern with depression, chronic pain and polypharmacy increasing the risk of suicide, the topic merits ongoing investment and attention both at the VA and among other stakeholders.

- **Research Recommendation:** The VA Offices of Mental Health and Suicide Prevention, Women's Health, and Research & Development should coordinate with the Women's Health Research Network in addition to VA and non-VA experts in perimenopausal women's health to explore a research agenda on the related threads of menopause, depression, polypharmacy and suicide to examine what evidence is required to help target and promote greater suicide prevention efforts both in the VA and among community providers who care for older women veterans.

# ENSURING ACCESS TO EFFECTIVE PROGRAMMING

PHOTO BY STACEY FEARSALL

## Care Coordination

The Department of Veterans Affairs' whole health approach to well-being places veterans at the center of health care and services supporting them. Care coordination is essential to ensuring quality health care delivery, particularly for women veterans who often receive care both in the VA and through the VA's network of community providers.

Some women veterans experience poor handoffs and miss opportunities for suicide prevention because they often interact with several programs and service lines at the VA and community providers. It is incumbent on the VA to ensure women veterans at risk for suicide do not fall through the cracks created by multiple services and differing coordinators overseeing various aspects of a woman's health care. The Portland VA Medical Center (VAMC) took steps to improve effective care coordination among service lines and created data to assess factors involved in effective coordination, including frequent, timely and accurate communication; mutual respect; and shared knowledge and goals. The team identified timely communication and shared knowledge as focus areas and obtained staff feedback on practices that should be used to improve outcomes in these areas. These efforts fostered understanding of problem areas in service lines and bolstered engagement in using more effective tactics by allowing staff to solve problems.[101]

**650,000**
female patients within the VA health care system are a minority population compared with
**7 million**
male veteran users.

The consequences of ineffective care transitions between the VA and community providers can be severe. In testimony before Congress, the VA Office of Inspector General (OIG) stated that it found poor patient handoffs and lack of care coordination may have led to adverse consequences, including suicides, for veterans with complex mental health needs awaiting care.[102] The OIG cited medical centers' failure to adhere to timeliness standards and refer care to community providers as appropriate and lack of assignment to a care coordinator for veterans awaiting care as key barriers to veterans receiving timely, high-quality care.

- **Policy/Research Recommendation:** The Veterans Health Administration (VHA) should encourage the use of the Portland VAMC model to identify problem areas in task integration across service lines, and it should use these experiences to inform evidence-based practices in managing task integration and standardization of operating procedures.
- **Policy Recommendation:** VHA should ensure care coordinators have adequate allocated time to track and manage veterans with complex health histories, especially as they await care in the VA or in the community.

## VA Community Care Network

### Community-Provided Mental Health Services

Women veterans are a minority population within the VA health care system, with approximately 650,000 (as of December2023) female patients compared with 7 million male veteran users. As such, the VA (by law) cannot always provide certain gender-specific services women veterans need. For example, all maternity care and in vitro fertilization services are delivered in the community, and often gynecological surgery is performed there as well. Mammography and cervical examinations are also frequently completed by community partners through the VA Community Care Network.

When the VA cannot provide mental health care in a timely or convenient manner, veterans are also referred to the private sector for care. However, care split between the VA and the community presents fragmentation of care and is rife with opportunities for gaps in care. This is true for all veterans but is especially problematic for women veterans who are at higher risk for suicide and must routinely use community services for maternity care and other gender-specific specialty services. The VA knows little about health outcomes for women using community care services through the VA Community Care Network, and these deficiencies, along with quality standards, must be addressed to ensure community providers are an effective supplement to VA care.

### Clinician Training in Suicide Prevention and Lethal-Means Safety Counseling

With women veteran suicides continuing to increase, especially with firearm use, it is vital that all clinicians who provide services be well trained in suicide prevention and lethal-means safety counseling.

VHA requires that every one of its clinical providers take a designed course in suicide risk identification and intervention. VA providers are also trained in how to counsel at-risk veterans to temporarily reduce access to firearms and other lethal means. Community care providers, by contrast, have no such requirements. The 2023 National Veteran Suicide Prevention Annual Report indicated that only 2,300 community care providers have completed a lethal-means safety course, representing less than 1% of the pool of community care providers.[2]

Numerous surveys reveal that private sector providers rarely screen or counsel any of their patients—even those at high risk—about firearm access, even though such screenings are often lifesaving.[104] It is important this critical gap be filled, since researchers found that assessing patients who report suicidal ideation about their access to firearms results in a fourfold reduction in suicide attempts and/or death in the subsequent 180 days.[105]

The VA has contracted with a pool of nearly 1.6 million community providers, yet little information is made public regarding the quality of care delivered or their knowledge about veteran-specific conditions.[106] The VA's primary clinical priority is suicide prevention, and the department prides itself on providing veterans with holistic, high-quality, evidence-based care and treatment. That tenet should stand regardless of whether care is provided in the VA or through one of its community partners. Concerns about access to care should never supersede concerns about the quality of care to which patients have access.

An independent RAND Corp. review, "The Promise and Challenges of VA Community Care,"[106] helpfully lays out the path moving forward:

> *As a payer, VHA can hold third-party administrators responsible for implementing and managing the Community Care Network and accountable for the quality and adequacy of community care providers. To do this, VHA needs to set quality standards and performance metrics and either require providers to report on their ability to meet those expectations or conduct its own evaluations.*

Competency, training and quality standards for community care clinicians should be equivalent to benchmarks expected of their VA counterparts. Training records of all community care providers are supplied to the VA but not publicly reported.

- **Policy Recommendation:** The VA should continually make publicly available the number of community care providers who have taken VA suicide prevention and lethal-means safety counseling training.
- **Policy/Legislative Recommendation:** The VA should amend its contracts with community care providers, or Congress should legislatively mandate that community care providers who treat veterans

## Nancy Espinosa

### 'THOSE SERVICES ARE THERE'

The end of DAV National Commander Nancy Espinosa's service in the Army was marked by obstacles and loss. Following the birth of her second child, she was diagnosed with endometriosis—a painful condition in which tissue grows outside of the uterus. She had to have an emergency hysterectomy to remove the organ, along with a bowel resection. Doctors also told her they found an aggressive cancer that could leave her with just six months to live. Espinosa called it a traumatic experience.

Her monthslong recovery from surgery was quickly followed by the devastating loss of her sister, Margaret.

"It was so unexpected," Espinosa said. "I still miss her, even though it's been more than 30 years."

Soon after, Espinosa's young stepdaughter unexpectedly died. She found herself in a deep depression and decided, with the support of her family, to take a hardship discharge from the Army. To continue her military career the only way she could, she transitioned into the New Mexico National Guard.

Espinosa turned to the VA for health care but felt her local medical center at the time was ill-equipped to address women's health care.

"There was very little support for women veterans, and especially female issues. They didn't know how to deal with that," she said, adding she went outside of the VA for gender-specific care.

"As far as mental health, I didn't even realize that was an option with the VA," she said. "I mean, if they couldn't handle my medical care, I didn't feel like they were prepared to help treat my depression."

So she went outside the VA for mental health care, too.

Espinosa said the VA has made notable strides in understanding and caring for women veterans since then. The VA worked hard to establish a comprehensive health and gender-specific care model for women.

"I do realize that women veterans are some of the least likely to get VA services, and I was in that same boat when I got out of the military," Espinosa said, adding that her VA care has significantly improved over the years.

"We just need to educate women veterans that those services are there, and that DAV and their fellow veterans are on their side."


PHOTO BY STEVE POSKUS

must be trained in suicide prevention and lethal-means safety counseling.

- **Policy Recommendation:** The OIG should investigate veterans' suicides in the Community Care Network with the equivalent scope to its investigations of suicides for VHA patients. A root cause analysis should be required for every veteran suicide death that occurs within 24 hours of last VHA or community care contact.

### Clinician Competence and Training in MST and PTSD

Section 133 of the VA MISSION Act (Public Law 115–182) mandated the VA to "establish standards and requirements for the provision of care by non-Department of Veterans Affairs health care providers in clinical areas for which the Department of Veterans Affairs has special expertise, including post-traumatic stress disorder [PTSD], military sexual trauma [MST]-related conditions, and traumatic brain injuries."

The MISSION Act also mandated that community care providers "fulfill training requirements established by the Secretary on how to deliver evidence-based treatments in the clinical areas for which the Department of Veterans Affairs has special expertise" before furnishing care pursuant to a contract with the VA.

These training requirements were mandated because private sector providers lack expertise in treating conditions common among veterans, such as combat and MST-related PTSD, compared with VA care that is based on rigorous evidence-based training, consultation and case review. Studies have confirmed that mental health care provided in the private sector is of lower quality than VA care. For example, over 8,500 VA providers have received comprehensive training in evidence-based cognitive processing therapy and/or prolonged exposure therapy for PTSD.[63]

Widespread MST screening and treatment programs do not exist in the community, where private mental health care providers are less likely to recognize, to cite only one example, that it is important to ask veterans about MST or use evidence-based or trauma-informed treatments when identified. By contrast, every VHA facility has a dedicated MST coordinator, mandatory MST training for all primary and mental health care providers, free MST-related treatment and MST outreach efforts. Given that many survivors never talk about their MST experience unless asked directly, all veterans enrolled in VHA are screened for experiences of MST. Providers then tailor treatment plans for survivors who need care.

Despite the MISSION Act's mandate, the VA left it up to contracted community care clinicians' discretion whether to obtain training identifying and treating these complex and unique health care conditions.

- **Policy Recommendation:** The VA should amend contracts to require community care mental health practitioners to take courses on the evaluation and management of MST-related PTSD.
- **Policy Recommendation:** The VA should enforce the MISSION Act's provisions for community care provider contracts based on demonstrated quality of care.
- **Policy Recommendation:** The VA should determine and publicly report the percentage of providers who have taken the VA-created trainings for identifying and treating veterans' PTSD based on MST.

### Residential Rehabilitation

There are three behavioral health components to the VA Mental Health Residential Rehabilitation Treatment Program: domiciliary care for veterans experiencing homelessness, residential treatment for substance abuse and residential treatment for PTSD. This program provides veterans a 24/7 transitional living environment in a safe and therapeutic community setting to address clinical and/or rehabilitation issues and optimize successful recovery.

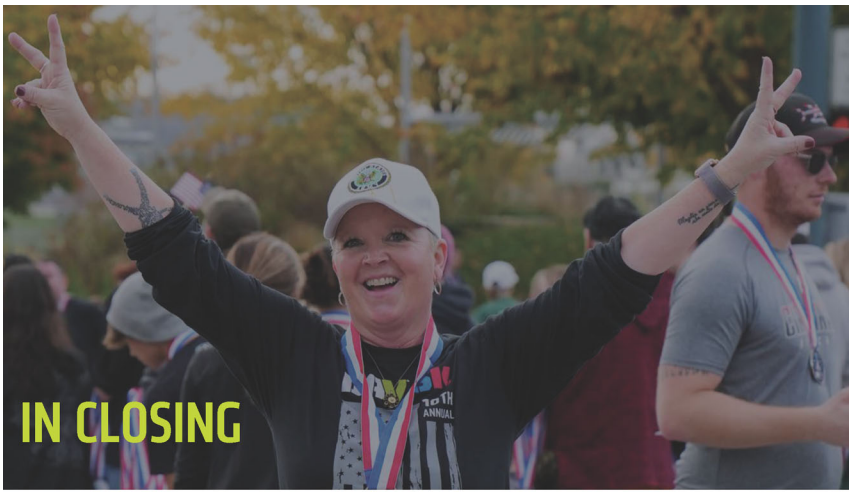
While this program is a hallmark of VHA's mental health services, women veterans who want to receive specialized, gender-exclusive care through a residential rehabilitation program may find access challenging. The VA reports that only about 13 residential rehabilitation centers provide gender-exclusive care and services, and fewer than half of all residential domiciliary facilities have separate dorm space for women veterans—accommodations that are essential to ensure the safety and comfort of women.[107] Additionally, women veterans may also experience logistical burdens in receiving such care at other VA facilities. For example, the VA will provide beneficiary travel to the closest available facility offering the care, but it must work within current authorities or coordinate other arrangements if the veteran is ineligible for beneficiary travel benefits. Providers outside of the Veterans Integrated Services Network (VISN), while ostensibly funded for all the services they provide, may prioritize the use of scarce resources for veterans within the VISN they serve. Likewise, referring providers may lack awareness of out-of-network programming availability and may be less inclined to deal with the additional administrative work that may be necessary for any out of-network consultation and referral.

While 72 hours is the VA's goal from screening to admission, fewer than 16% of women and 20% of men

are admitted within this time frame.[107] According to the VA, the average and median wait time for women's care in domiciliaries was 24 days compared with 22 days for men. Finally, child care and concern over losing custody of children because of seeking care for significant mental health conditions or substance use disorder may be barriers for women veterans who need this type of specialized care.

While we strongly believe the VA's comprehensive, integrated, whole-health model of care and specialized wraparound support services provide women veterans the type of care and support they need for recovery, some veterans may end up seeking these services in the community due to access issues. Unfortunately, there is an absence of quality standards for VA-contracted clinicians who provide residential mental health and substance use disorder care.

- **Policy Recommendation:** The VA should assess the need to add additional domiciliary beds and gender-specific programming in residential rehabilitation programs to improve access and better serve women veterans.
- **Policy/Legislative Recommendation:** Congress or the VA should mandate the following:
  - Require mental health/substance use disorder-licensed independent practitioners who want to treat veterans to take a minimum of four hours of VHA TRAIN (see Appendix B 15.1) courses corresponding to the patient population they serve, four hours on military culture (see Appendix B 15.2), and two hours of suicide prevention and lethal-means safety counseling. (See Appendix B 15.3.)
  - Require licensed independent practitioners in women's residential care facilities to take VA TRAIN courses in MST.
  - Create VA certification requirements for private facilities participating in the Mental Health Residential Rehabilitation Treatment Program. The certification standard should include:
    - Scientific evidence for a program's treatment approach.
    - A standard ratio of licensed independent practitioners per resident.
    - A semiannual peer review quality assurance system.
    - Treatment planning.
    - Accreditation by the Commission on Accreditation of Rehabilitation Facilities or an equivalent organization.
    - Requirement for forwarding treatment records to the VA within 30 days of a veteran leaving a community residential care program.
    - Recertification of residential rehabilitation programs every three years.
  - Mandate that mental/behavioral health outcome measures be administered to every VA-paid veteran participant at the point of entry, exit and six months (if reachable) following discharge from the program.
  - Require that the mental/behavioral health outcome scores of veterans be sent to VHA for data analysis and evaluation of each program.
  - Publish program outcome data on the VA's Access to Care website (see Appendix B 15.4) with health care access and quality information about VA facilities.



# IN CLOSING

The lack of recognition for women's service, isolation after separation from military service, poor social support and unique risk factors all contribute to the challenges and barriers that many ill and injured women veterans face as they transition from service members to civilians and work toward physical recovery and mental wellness after service.

Women veterans who routinely utilize the VA for primary care have significant comorbid physical and mental health conditions and trauma histories. Based on these and other findings highlighted throughout this report, it is essential that Congress, the VA, veterans advocates and other interested stakeholders work together to ensure our nation's women veterans have access to the timely, high-quality, trauma-informed and gender-specific care they need. We concur with researchers that meeting women veterans' needs across their lifespan will require continued investment in VA women-centered programs and services, including integrated mental health care and targeted suicide prevention efforts.

The VA has made appreciable gains on how it can better serve women veterans since DAV's last report in 2018, *Women Veterans: The Long Journey Home*. Many women who use VA care find it a positive experience, and the vast majority of them, across age groups, say they would recommend the VA to other women veterans.[108]

At the same time, where shortfalls exist, corrective actions must be taken. The successes and gaps in this report both highlight the importance of continuing to invest in quality improvements and ensuring the needs of women veterans are met when making policy, programmatic, clinical and infrastructure changes throughout the VA health care system.

> "It is critical that we, as the military and veteran community and all those charged with keeping our nation's sacred promise to those who served, get this right—for past, present and future generations of women veterans. **More women than ever are serving in the armed forces in all occupations, and the population of women veterans will continue to grow.** We should welcome their contributions and do everything in our power to make sure they are made whole in light of the sacrifices they make for their country."
>
> *—Joy Ilem, DAV National Legislative Director*

# APPENDIX A

## Department of Veterans Affairs Suicide Prevention Strategy Activities

| # | STRATEGIC GOAL | PROGRAM EXAMPLES | LINK |
|---|---|---|---|
| 1 | **HEALTHY AND EMPOWERED VETERANS, FAMILIES AND COMMUNITIES** | | |
| 1.1 | Integrate and coordinate across sectors and settings | **Governor's Challenge** In partnership with the Substance Abuse and Mental Health Services Administration, promotes evidence-based state or community interventions to prevent veteran suicide, including community engagement and partnership coordinators on Department of Veterans Affairs side. | samhsa.gov/smvf-ta-center/mayors-governors-challenges |
| | | **988 Suicide & Crisis Lifeline/Veterans Crisis Line** Consolidates suicide prevention and emergency mental health telephone access to one clear, memorable number nationwide. | veteranscrisisline.net |
| | | **VA suicide prevention coordinator (SPC) outreach** VA suicide prevention coordinators and case managers are present at each VA facility to connect with and support veterans and providers in times of crisis. | veteranscrisisline.net/find-resources/local-resources |
| 1.2 | Change knowledge, attitudes and behavior through communication | **Keep It Secure** Safety campaign promoting safe gun storage. | va.gov/reach/lethal-means/#firearm_storage |
| | | **Make the Connection** Curated video stories on strength and recovery, from veterans to veterans. | maketheconnection.net |
| | | **Together With Veterans** Rural veteran suicide prevention program. | mirecc.va.gov/visn19/togetherwithveterans/index.asp |
| | | **Don't Wait. Reach Out.** Ad Council campaign for veterans proactively seeking help with life stressors. | va.gov/REACH |
| 1.3 | Increase knowledge of protective factors | **STAIR (Skills Training in Affective and Interpersonal Regulation)** Targets rural women veterans, especially those with military sexual trauma and other military-related trauma. | ptsd.va.gov/professional/continuing_ed/STAIR_online_training.asp |
| | | **VA Mobile** Apps including mental health guides and prevention approaches. | mobile.va.gov/appstore/veterans |
| | | **Moving Forward** Web-based training to help veterans with mild depression or anxiety manage life challenges. | veterantraining.va.gov/movingforward |
| 1.4 | Promote responsible portrayal of veterans and suicide | **Safe messaging** Best practices for those reporting on veteran suicide events. | mentalhealth.va.gov/suicide_prevention/docs/safe_messaging_best_practices.pdf |

| 2 | CLINICAL AND COMMUNITY PREVENTIVE SERVICES | | |
|---|---|---|---|
| 2.1 | Develop, implement and monitor effective programs | **Mental health care through telehealth**<br>VA-provided video tablets for veterans to enable their participation in telehealth mental health care visits to keep them connected with care. | connectedcare.va.gov/sites/default/files/telehealth-digital-divide-fact-sheet.pdf |
| | | **VA Suicide Prevention Toolkit for Caregivers**<br>Toolkit providing guidance to veteran caregivers. | caregiver.va.gov/pdfs/PublicationsResources/VA-Suicide-Prevention-Toolkit-for-Caregivers-508.pdf |
| | | **Therapeutic Risk Management**<br>Toolkit offering risk assessment of suicidal patients and intervention tools for clinicians. | mirecc.va.gov/visn19/trm |
| | | **Veterans Self-Check Quiz**<br>Self-assessment for suicidality connected to the Veterans Crisis Line and reviewed by an online counselor. | vetselfcheck.org/welcome.cfm |
| 2.2 | Reduce access to lethal means to veterans in crisis | **Lethal-means web resources**<br>Mental health resources for talking to patients and family members regarding safe storage of guns and medications. | mentalhealth.va.gov/suicide_prevention/lethal-means/index.asp |
| | | **Gun lock distribution**<br>Free gun locks offered by SPCs at each VA facility. | news.va.gov/70891/va-offers-veterans-new-resources-safely-store-lethal-means |
| | | **Lethal-means counseling**<br>Quick guide to clinical practice, with recommendations for providers. | healthquality.va.gov/guidelines/MH/srb/LethalMeansProviders20200527508.pdf |
| | | **Safe Firearm Storage Toolkit**<br>Developed and distributed in partnership with the National Shooting Sports Foundation. | nssf.org/safety/suicide-prevention/va-afsp-nssf-partnership<br><br>mentalhealth.va.gov/suicide_prevention/docs/Toolkit_Safe_Firearm_Storage_CLEARED_508_2-24-20.pdf |
| 2.3 | Provide community training | **Community Provider Toolkit**<br>Training, resources and guidance for community providers serving veterans. | mentalhealth.va.gov/communityproviders/wellness-suicide-prevention.asp |
| | | **Social Media Safety Toolkit**<br>Guidance on how to recognize and respond to social media posts indicative of suicidality. | mentalhealth.va.gov/suicide_prevention/docs/OMH-074-Suicide-Prevention-Social-Media-Toolkit-1-8_508.pdf |

| 3 | TREATMENT AND SUPPORT SERVICES | | |
|---|---|---|---|
| 3.1 | Suicide prevention as a core health care service | **Suicide prevention coordinators**<br>Mandated in the Support for Suicide Prevention Coordinators Act (Public Law 116–96), each facility must have one SPC per 10,000 veterans. | gao.gov/assets/gao-21-326.pdf<br><br>veteranscrisisline.net/find-resources/local-resources |
| | | **Risk ID**<br>Population-based suicide risk screening requirement in ambulatory care, emergency department, and other key visits and admissions. | nationalacademies.org/event/06-22-2021/docs/D74BBFD423B45D65BBC39751BF0852566A4BACD2294B |
| | | **REACH VET (Recovery Engagement and Coordination for Health – Veterans Enhanced Treatment)**<br>Applying this predictive algorithm, the VA identifies veterans at high risk for suicide at every facility and coordinates mandated outreach and follow-up care. | hsrd.research.va.gov/for_researchers/cyber_seminars/archives/3527-notes.pdf |
| | | **High Risk for Suicide Patient Record Flag**<br>Policy requiring that at-risk veterans are flagged and provided specific services and oversight. | va.gov/vhapublications/ViewPublication.asp?pub_ID=11547 |
| 3.2 | Promote effective clinical practice | **Assessment and Management of Patients at Risk for Suicide**<br>VA and Department of Defense clinical practice guideline. | healthquality.va.gov/guidelines/mh/srb |
| | | **Skills Training for Evaluation and Management of Suicide**<br>VA mandatory training for clinicians, Talent Management System Course 39351. | va.gov/vhapublications/ViewPublication.asp?pub_ID=9789 |
| | | **Safety planning**<br>Safety plan development with at-risk veterans, initially implemented in Safety Planning in the Emergency Department but now for all clinicians. | healthquality.va.gov/guidelines/MH/srb/PHCoEPatientSafetyPlanSelfPrint3302020508.pdf |
| | | **VA S.A.V.E. Training**<br>Guide to identifying and supporting veterans at risk for suicide; mandatory for all nonclinical VA staff. | mentalhealth.va.gov/mentalhealth/suicide_prevention/docs/VA_SAVE_Training.pdf |
| | | **Women's Mental Health Champions**<br>Mental health clinicians at every VA medical center with specific training, interest and expertise in women veterans' mental health. | womenshealth.va.gov/WOMENSHEALTH/topics/depression.asp |
| | | **Suicide Risk Management Consultation Program**<br>Provides consultation, support, education and resources on therapeutic best practices for providers working with veterans at risk for suicide. | mirecc.va.gov/visn19/consult/docs/SRM-Factsheet.pdf |
| | | **MyVA Access**<br>Same-day access to mental health services. | va.gov/SAMEDAYSERVICES/Same_Day_Services_Definition.asp |

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| 3.3 | **Care for those affected by suicide, and implement community strategies for further prevention** | **Rural Veteran Outreach Toolkit & Workbook**<br>Serves as a guide with tools and activities to assist teams through the process of establishing partnerships, planning and implementing outreach events, and sustaining partnerships. | ruralhealth.va.gov/docs/RuralVeteranOutreach2023.pdf |
| | | **Guard and Reserve prevention toolkit**<br>Provides information, resources and guidance for members, loved ones and community providers. | mentalhealth.va.gov/suicide_prevention/docs/Toolkit_National_Guard_and_Reserve_Members_CLEARED_2-21-19.pdf |
| | | **How to Talk to a Child about a Suicide Attempt in Your Family**<br>Informs and guides adults when talking with children ages 2 to 5 about a suicide attempt in the family. It is not intended to replace the advice of a mental health professional. | mentalhealth.va.gov/communityproviders/assets/docs/wellness/Talking_to_a_Child_quick_reference.pdf |
| **4** | **MENTAL ILLNESS RESEARCH AND TREATMENT THROUGH MIRECC** | | |
| 4.1 | **Improve surveillance systems and data collection** | **ASCEND (Assessing Social and Community Environments with National Data) for Veteran Suicide Prevention**<br>National representative survey research study to examine incidents of suicidal thoughts and behaviors and identify risk and protective factors; sampling strategy to capture women veterans accurately. | mirecc.va.gov/visn19/ascend |
| | | **VA/DOD Mortality Data Repository**<br>Cross-agency partnership of the VA, DOD and National Center for Health Statistics to consolidate mortality data on all veterans in the U.S. | mirecc.va.gov/suicideprevention/Data/data_index.asp |
| | | **Issue Briefs**<br>Monthly reporting of compilation and analysis of leadership briefs on veteran suicide in the VA, going back to 2017. | |
| | | **Suicide Prevention Application Network**<br>Monthly reporting of suicides by VA patients recorded as standardized data in the VA Electronic Health Record. | |

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| 4.2 | **Promote research on veteran suicide prevention** | **SPRINT (Suicide Prevention Research Impact NeTwork)**<br>Health Services Research & Development-sponsored research consortium. | hsrd.research.va.gov/centers/core/sprint |
| | | **Veterans Integrated Services Network 2 Center of Excellence for Suicide Prevention**<br>Established in August 2007 with the overarching mission to reduce morbidity and mortality associated with veteran suicide and self-directed violence. | mirecc.va.gov/suicideprevention |
| | | **Rocky Mountain MIRECC (Mental Illness Research Education and Clinical Center) for Suicide Prevention**<br>Focuses on promising clinical interventions, as well as the cognitive and neurobiological underpinnings of suicidal thoughts and behaviors that may lead to innovative prevention strategies. | mirecc.va.gov/visn19 |
| | | **Behavioral Health QUERI (Quality Enhancement Research Initiative)**<br>Advances the quality of mental health care provided to veterans, especially those at highest risk for suicide. | queri.research.va.gov/centers/Behavioral-Health.pdf |
| | | **From Science to Practice**<br>Series of over 30 brief reviews for clinicians to learn about advances in suicide preventions. | mentalhealth.va.gov/healthcare-providers/suicide-prevention.asp |
| | | **Mission Daybreak**<br>Prize competition on a broad spectrum of topics to promote innovation in veteran suicide prevention. | missiondaybreak.net/about-mission-daybreak/#an-opportunity |
| 4.3 | **Evaluate prevention interventions and disseminate findings** | **Together We Can**<br>Publication series for veterans and their loved ones sharing evidence-based information about suicide prevention and postvention. | mentalhealth.va.gov/suicide_prevention/prevention/index.asp |
| | | **Short Takes on Suicide Prevention**<br>Podcast series that breaks down the science behind prevention and treatment for suicide. | denvermirecc.libsyn.com<br><br>news.va.gov/va-podcast-network/#rmm |
| 4.4 | **Refine and expand predictive analytics** | **REACH VET predictive algorithm**<br>Developed using machine learning, the algorithm examines demographic and clinical data to predict high risk for suicide among veterans. | hsrd.research.va.gov/for_researchers/cyber_seminars/archives/3527-notes.pdf |

# APPENDIX B

## Women Veterans Resources

| # | RESOURCE | DESCRIPTION | LINK |
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| 5 | **A PUBLIC HEALTH APPROACH TO SUICIDE PREVENTION** | | |
| 5.1 | **Female Veteran Suicide Prevention Act (Public Law 114–1880** | "To direct the Secretary of Veterans Affairs to identify mental health care and suicide prevention programs and metrics that are effective in treating women veterans as part of the evaluation of such programs by the Secretary, and for other purposes." | congress.gov/114/plaws/publ188/PLAW-114publ188.pdf |
| 6 | **SUICIDE PREVENTION GAPS AND VULNERABILITIES** | | |
| 6.1 | **PREVENTS: The President's Roadmap to Empower Veterans and End a National Tragedy of Suicide (Executive Order 13861)** | "On March 5, 2019, President Donald J. Trump signed Executive Order (EO) 13861: The President's Roadmap to Empower Veterans and End a National Tragedy of Suicide (PREVENTS), with a call to action to amplify and accelerate the progress in addressing Veteran suicide in the United States." | va.gov/PREVENTS/docs/PRE-007-The-PREVENTS-Roadmap-1-2_508.pdf |
| 7 | **RURAL WOMEN VETERANS: REDUCING ACCESS BARRIERS TO CARE** | | |
| 7.1 | **VA MISSION Act of 2018 (Public Law 115–182)** | Title 1 Section 101 of this bill mandates the establishment of the Veterans Community Care Program. | congress.gov/115/plaws/publ182/PLAW-115publ182.pdf |
| 8 | **WOMEN'S HEALTH RESEARCH** | | |
| 8.1 | **Women's Health Research Network** | "VA's Health Services Research & Development (HSR&D) Service … Funded since 2010, the VA Women's Health Research Network (WHRN) is among HSR&D's special initiatives to systematically transform VA's capacity to examine and reduce gender disparities in health and health care and use research to increase the delivery of evidence-based care tailored to women Veterans' needs." | hsrd.research.va.gov/centers/womens_health/WHRN-Exec-Summary.pdf |
| 8.2 | **Women's Health** | "Currently, there are 1.9 million living women Veterans, who make up 9.4 percent of the total Veteran population." | research.va.gov/topics/womens_health.cfm |
| 8.3 | **Million Veteran Program** | "VA's Million Veteran Program (MVP) is a national research program looking at how genes, lifestyle, military experiences, and exposures affect health and wellness in Veterans.<br>"Since launching in 2011, more than 950,000 Veterans have joined MVP. It's the largest research effort at VA to improve health care for Veterans and one of the largest research programs in the world studying genes and health." | research.va.gov/mvp |
| 8.4 | **From Science to Practice** | "From Science to Practice is a literature review series to help clinicians put suicide prevention research into action." | mentalhealth.va.gov/healthcare-providers/suicide-prevention.asp |

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| **9** | **MILITARY SEXUAL TRAUMA** | | |
| 9.1 | **Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020 (Public Law 116–315)** | Title V of this comprehensive law includes provisions of the Deborah Sampson Act aimed at improving health care services and programs for women veterans. | congress.gov/116/plaws/publ315/PLAW-116publ315.pdf |
| **10** | **INTIMATE PARTNER VIOLENCE AGAINST WOMEN VETERANS** | | |
| 10.1 | **Women Veterans and Intimate Partner Violence** | "IPV [intimate partner violence] occurs when a current or former intimate partner (e.g., boyfriend, girlfriend, spouse) harms, threatens to harm, or stalks their partner, and may be emotional, physical, social, or sexual in nature. " | cherp.research.va.gov/features/Women_Veterans_an_Intimate_Partner_Violence.asp |
| 10.2 | **White Ribbon VA** | "White Ribbon VA is a national call to action to eliminate sexual harassment, sexual assault, and domestic violence across the Department of Veterans Affairs." | va.gov/health/harassment-free |
| 10.3 | **Intimate Partner Violence Assistance Program (Veterans Health Administration [VHA] Directive 1198)** | "This directive sets forth roles and responsibilities for developing, maintaining and establishing an IPVAP [Intimate Partner Violence Assistance Program] to serve all VA medical facilities." | va.gov/vhapublications/ViewPublication.asp?pub_ID=8192 |
| 10.4 | **Recovering from Intimate Partner Violence Through Strengths and Empowerment (RISE)** | "The purpose of this multi-phase project is to refine and formally evaluate RISE for use with female VA patients who have experienced IPV." | hsrd.research.va.gov/research/abstracts.cfm?Project_ID=2141705767 |
| 10.5 | **Strength at Home Program** | "Strength at Home is a trauma-informed and evidence-based group program for veterans who struggle with conflict in their relationships." | socialwork.va.gov/IPV/VETERANS_PARTNERS/WhatCanIDo/Strength_Home_Program.asp |
| 10.6 | **Public Law 116–315, Sections 5304 and 5305** | Sec. 5304. Pilot program on assisting veterans who experience intimate partner violence or sexual assault.<br>Sec. 5305. Study and task force on veterans experiencing intimate partner violence or sexual assault. | congress.gov/116/plaws/publ315/PLAW-116publ315.pdf |
| **11** | **TRAUMA-INFORMED CARE** | | |
| 11.1 | **Trauma-Informed Care Practices** | "Trauma-informed care (TIC) approaches in workplace, educational or health care settings promote well-being, adaptation and resilience in those who have been exposed to prior traumatic experiences." | ptsd.va.gov/professional/treat/care/index.asp |
| | **Fact Sheet: Trauma-Informed Care for Working With Homeless Veterans** | "According to SAMHSA [Substance Abuse and Mental Health Services Administration], trauma-informed care includes having a basic understanding of how trauma affects the life of individuals seeking services." | va.gov/homeless/nchav/docs/Trauma-Informed-Care-Fact-Sheet.pdf |
| **12** | **EATING DISORDERS** | | |
| 12.1 | **VA National Center for PTSD** | "There is evidence that eating disorders are prevalent among male and female Veterans; however, they remain relatively understudied in this population." | ptsd.va.gov/professional/continuing_ed/eating_disorders_ptsd.asp |

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| **13** | **SOCIAL SUPPORT** | | |
| 13.1 | **Women Veterans Network (WoVeN)** | "WoVeN Mission: To provide a unique social network of women Veterans to foster connections and build relationships in local communities and across the nation." | wovenwomenvets.org |
| 13.2 | **Public Law 116–315, Section 5104** | "Sec. 5104. Provision of reintegration and readjustment services to veterans and family members in group retreat settings." | congress.gov/116/plaws/publ315/PLAW-116publ315.pdf |
| 13.3 | **Save A Warrior** | "Save A Warrior is dedicated to the prevention of veteran suicide and the preservation of life through the development and implementation of a groundbreaking, comprehensive program at our non-profit organization." | saveawarrior.org |
| **14** | **MATERNITY AND MENTAL HEALTH CARE** | | |
| 14.1 | **VA expands maternity care coordination for Veterans** | "All new mothers will have the support and resources they need from VA, regardless of where they give birth." | news.va.gov/press-room/va-expands-maternity-care-coordination-for-veterans |
| **15** | **RESIDENTIAL REHABILITATION** | | |
| 15.1 | **VHA TRAIN: PTSD and Eating Disorders: Enduring Recording – Jan 2022** | "There is evidence that eating disorders are prevalent among male and female veterans; however, they remain relatively understudied in this population." | train.org/vha/course/1103780/details |
| 15.2 | **Military Culture: Core Competencies for Healthcare Professionals** | "Understanding military culture can allow clinicians to tailor clinical practices for military patients who have been shown to delay care seeking, drop out of care, or receive misdiagnoses." | ptsd.va.gov/professional/continuing_ed/military_culture_competencies_hcp.asp |
| 15.3 | **VHA TRAIN: Lethal Means Safety Training – Recording** | "The training emphasizes Veteran autonomy and teaches clinicians to work collaboratively with Veterans towards solutions that align with each Veteran's values and preferences." | train.org/vha/course/1075258/details |
| 15.4 | **VA Access to Care** | "On the Access to Care site you can explore many types of health care information that are helpful for Veterans, caregivers and the public." | accesstocare.va.gov |

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## Notes

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