



Women Veterans: **THE JOURNEY TO MENTAL WELLNESS**

Supporting women veterans' mental health and preventing suicide through gender-tailored care



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-JASINSKI/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	1
VA Suicide Prevention Strategy	2
Suicide Among Veterans	2
A Public Health Approach to Suicide Prevention	2
Suicide Prevention Gaps and Vulnerabilities	7
Rural Women Veterans: Reducing Barriers to Care	8
Lethal-Means Safety	8
Women Veterans Health Research	12
Military Sexual Trauma	13
Intimate Partner Violence Against Women Veterans	15
Trauma-Informed Care	17
Substance Use Disorder	18
Eating Disorders	20
Social Support	20
Reproductive Mental Health Care	24
Maternity and Mental Health Care	24
Increased Suicide Risk for Women Veterans in the Life Cycle	28
Ensuring Access to Effective Programming	30
Care Coordination	30
VA Community Care Network	31
In Closing	35
Appendix A	36
Appendix B	41
References	44



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

WOMEN VETERANS ARE DYING BY SUICIDE AT AN ALARMING RATE COMPARED WITH THEIR MALE AND CIVILIAN COUNTERPARTS

Suicide rate among women veterans
between 2020 and 2021:

↑ 24.1%

Nearly 4X higher than the 6.3% increase
among male veterans and vastly higher than
the 2.6% increase among nonveteran women

2X more likely than male
veterans to attempt suicide

3X more likely than nonveteran
women to choose a firearm
as means of suicide

More than
50%
of deaths for women
veterans are by self-
inflicted firearm injury

Figure 1 ²

PHOTO BY TECH. SGT. ANTHONY NELSON JR./U.S. AIR FORCE

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 Defense¹¹ 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 Medicine¹³ 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 POISALL

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

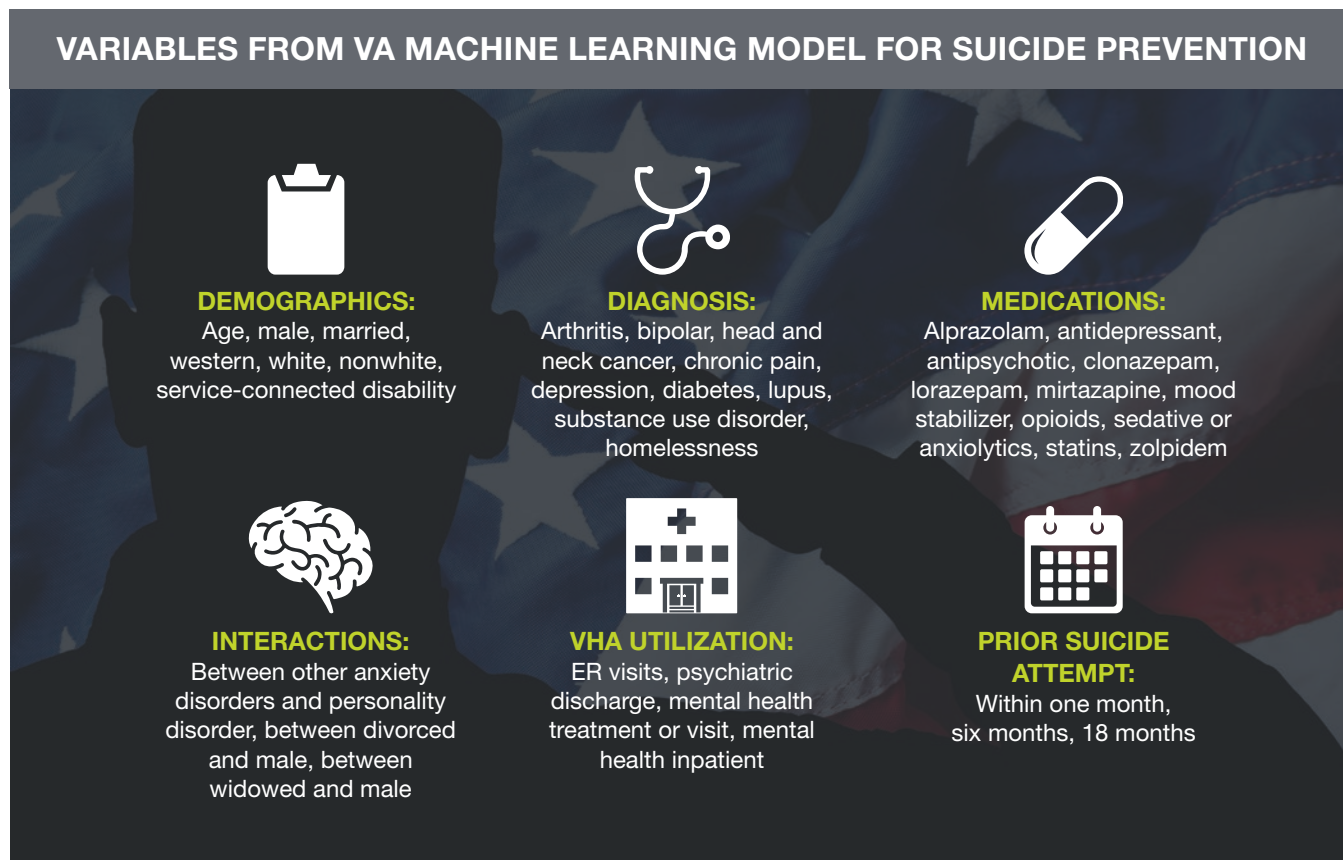


Figure 2: REACH VET suicide prevention model uses men as the baseline model for suicide prevention.

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

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

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

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

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.

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.



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:** vaioig.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.⁴³ 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.

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

Among women veterans enrolled in the VA,
1 in 3
report experiencing MST.⁵⁴

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 POISALL

(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 projects⁶⁴ 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.”



PHOTO BY WILLIAM HENDRA

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



PHOTO BY B. WISE PHOTOGRAPHY

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.



PHOTO BY SHANG ONG

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 pre-term 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 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.



PHOTO BY WESTON CARLS

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.

- **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

In a national sample of 104,984 women veterans mean age 54 years or older:

1 in 2

has a prescription for long-term opioids.

1 in 8

had a prescription for high-dose, long-term opioids.

1 in 3

had both long-term opioids and central nervous system depressants.⁹⁶



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. women⁹¹ 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 symptoms⁹⁵ 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.



PHOTO BY STACEY PEARSALL

ENSURING ACCESS TO EFFECTIVE PROGRAMMING

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

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.

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

■ **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 December 2023) 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 POSSALL

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/vsn19/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 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 Toolkit providing guidance to veteran caregivers.	caregiver.va.gov/pdfs/PublicationsResources/VA-Suicide-Prevention-Toolkit-for-Caregivers-508.pdf
		Therapeutic Risk Management Toolkit offering risk assessment of suicidal patients and intervention tools for clinicians.	mirecc.va.gov/visn19/trm
		Veterans Self-Check Quiz 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 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 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 Quick guide to clinical practice, with recommendations for providers.	healthquality.va.gov/guidelines/MH/srb/LethalMeansProviders20200527508.pdf
		Safe Firearm Storage Toolkit Developed and distributed in partnership with the National Shooting Sports Foundation.	nssf.org/safety/suicide-prevention/va-afsp-nssf-partnership mentalhealth.va.gov/suicide_prevention/docs/Toolkit_Safe_Firearm_Storage_CLEARED_508_2-24-20.pdf
2.3	Provide community training	Community Provider Toolkit Training, resources and guidance for community providers serving veterans.	mentalhealth.va.gov/communityproviders/wellness-suicide-prevention.asp
		Social Media Safety Toolkit 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 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 veteranscrisisline.net/find-resources/local-resources
		Risk ID 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) 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 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 VA and Department of Defense clinical practice guideline.	healthquality.va.gov/guidelines/mh/srb
		Skills Training for Evaluation and Management of Suicide VA mandatory training for clinicians, Talent Management System Course 39351.	va.gov/vhapublications/ViewPublication.asp?pub_ID=9789
		Safety planning 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 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 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 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 Same-day access to mental health services.	va.gov/SAMEDAYSERVICES/Same_Day_Services_Definition.asp

3.3	Care for those affected by suicide, and implement community strategies for further prevention	Rural Veteran Outreach Toolkit & Workbook 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 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 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 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 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 Monthly reporting of compilation and analysis of leadership briefs on veteran suicide in the VA, going back to 2017.	
		Suicide Prevention Application Network Monthly reporting of suicides by VA patients recorded as standardized data in the VA Electronic Health Record.	

4.2	Promote research on veteran suicide prevention	SPRINT (Suicide Prevention Research Impact NeTwork) 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 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 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) 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 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 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 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 Podcast series that breaks down the science behind prevention and treatment for suicide.	denvermirecc.libsyn.com news.va.gov/va-podcast-network/#mmm
4.4	Refine and expand predictive analytics	REACH VET predictive algorithm 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
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. “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

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. 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

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

REFERENCES

1. Office of Mental Health and Suicide Prevention. (2018). *Suicide Among Women Veterans: Facts, Prevention, Strategy, and Resources*. U.S. Department of Veterans Affairs. [mentalhealth.va.gov/docs/OMHSP_Suicide_Prevention_Fact_Sheet_Updated_June_2018_508.pdf](https://www.mentalhealth.va.gov/docs/OMHSP_Suicide_Prevention_Fact_Sheet_Updated_June_2018_508.pdf)
2. Office of Mental Health and Suicide Prevention. (2023). *National Veteran Suicide Prevention Annual Report*. U.S. Department of Veterans Affairs. [mentalhealth.va.gov/docs/data-sheets/2023/2023-National-Veteran-Suicide-Prevention-Annual-Report-FINAL-508.pdf](https://www.mentalhealth.va.gov/docs/data-sheets/2023/2023-National-Veteran-Suicide-Prevention-Annual-Report-FINAL-508.pdf)
3. Hoffmire, C.A., Monteith, L.L., Forster, J.E., Bernhard, P.A., Blois, J.R., Vogt, D., Maguen, S., Smith, A.A., & Schneidman, A.I. (2021). Gender Differences in Lifetime Prevalence and Onset Timing of Suicidal Ideation and Suicide Attempt Among Post-9/11 Veterans and Nonveterans. *Med Care*, 59, S84–S91. doi.org/10.1097/mlr.0000000000001431
4. Ullman, K., Landsteiner, A., Linskens, E., MacDonald, R., McKenzie, L., Murdoch, M., Sayer, N., Stroebel, B., Sultan, S., Venables, N., & Wilt, T.J. (2021). *Risk and Protective Factors Across Socioecological Levels of Risk for Suicide: An Evidence Map*. U.S. Department of Veterans Affairs. hsrd.research.va.gov/publications/esp/risk-factors-suicide.cfm
5. Decker, S.E., Ramsey, C.M., Ronzitti, S., Kerns, R.D., Driscoll, M.A., Dziura, J., Skanderson, M., Bathulapalli, H., Brandt, C.A., Haskell, S.G., & Goulet, J.L. (2021). Military sexual trauma and suicidal ideation in VHA-care-seeking OEF/OIF/OND veterans without mental health diagnosis or treatment. *Psychiatry Res*, 303, 114089. doi.org/10.1016/j.psychres.2021.114089
6. Wilson, L.C., Newins, A.R., Wilson, S.M., Elbogen, E.B., Dedert, E.A., Calhoun, P.S., Beckham, J.C.; VA Mid-Atlantic MIRECC Workgroup; & Kimbrel, N.A. (2020). Self- and Other-Directed Violence as Outcomes of Deployment-Based Military Sexual Assault in Iraq/Afghanistan-era Veteran Men and Women. *J Aggress Maltreat Trauma*, 29(6), 714–724. doi.org/10.1080/10926771.2020.1725213
7. Kimerling, R., Makin-Byrd, K., Louzon, S., Ignacio, R.V., & McCarthy, J.F. (2016). Military Sexual Trauma and Suicide Mortality. *Am J Prev Med*, 50(6), 684–691. doi.org/10.1016/j.amepre.2015.10.019
8. Bohnert, K.M., Ilgen, M.A., Louzon, S., McCarthy, J.F., & Katz, I.R. (2017). Substance use disorders and the risk of suicide mortality among men and women in the US Veterans Health Administration. *Addiction*, 112(7), 1193–1201. doi.org/10.1111/add.13774
9. Office of Mental Health and Suicide Prevention. (2018). *National Strategy for Preventing Veterans Suicide*. Department of Veterans Affairs. [mentalhealth.va.gov/suicide_prevention/docs/Office-of-Mental-Health-and-Suicide-Prevention-National-Strategy-for-Preventing-Veterans-Suicide.pdf](https://www.mentalhealth.va.gov/suicide_prevention/docs/Office-of-Mental-Health-and-Suicide-Prevention-National-Strategy-for-Preventing-Veterans-Suicide.pdf)
10. The White House. (2021). *Reducing Military and Veteran Suicide: Advancing a Comprehensive, Cross-Sector, Evidence-Informed Public Health Strategy*. The White House. [whitehouse.gov/wp-content/uploads/2021/11/Military-and-Veteran-Suicide-Prevention-Strategy.pdf](https://www.whitehouse.gov/wp-content/uploads/2021/11/Military-and-Veteran-Suicide-Prevention-Strategy.pdf)
11. Suicide Prevention Office. (2015). *Department of Defense Strategy for Suicide Prevention*. U.S. Department of Defense. [dspo.mil/Portals/113/Documents/TAB%20B%20-%20DSSP_FINAL%20USD%20PR%20SIGNED.PDF](https://www.dspo.mil/Portals/113/Documents/TAB%20B%20-%20DSSP_FINAL%20USD%20PR%20SIGNED.PDF)
12. Office of the Surgeon General. (2021). *The Surgeon General's Call to Action to Implement the National Strategy for Suicide Prevention*. Department of Health and Human Services. [hhs.gov/sites/default/files/sprc-call-to-action.pdf](https://www.hhs.gov/sites/default/files/sprc-call-to-action.pdf)
13. Mrazek, P.J. and R.J. Haggerty, eds. (1994). *Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention Research*. Committee on Prevention of Mental Disorders, ed. Institute of Medicine. National Academies Press. [ncbi.nlm.nih.gov/books/NBK236319](https://www.ncbi.nlm.nih.gov/books/NBK236319)
14. Division of Violence Prevention National Center for Injury Prevention and Control. (2010). *Suicide Prevention: A Public Health Issue*. Centers for Disease Control and Prevention. [cdc.gov/violenceprevention/pdf/asap_suicide_issue2-a.pdf](https://www.cdc.gov/violenceprevention/pdf/asap_suicide_issue2-a.pdf)
15. Substance Abuse and Mental Health Services Administration. (2022). *Governor's and Mayor's Challenges to Prevent Suicide Among Service Members, Veterans, and their Families*. SAMHSA. [samhsa.gov/smvf-ta-center/mayors-governors-challenges](https://www.samhsa.gov/smvf-ta-center/mayors-governors-challenges)
16. Department of Veterans Affairs, RB Management Consultants Pursuant To A Contract (36c10x20d0004, 36c10x21n0065) under the direction of the Office of Mental Health and Suicide Prevention, Veterans Affairs Central Office, Department Of Veterans Affairs. (2022). Final Report: *Study On Effectiveness Of Suicide Prevention And Mental Health Outreach Programs Of Department Of Veterans Affairs For The Hannon Veterans Mental Health Care Improvement Act Of 2019*, Section 401s.
17. McCarthy, J.F., Bossarte, R.M., Katz, I.R., Thompson, C., Kemp, J., Hannemann, C.M., Nielson, C., & Schoenbaum, M. (2015). Predictive Modeling and Concentration of the Risk of Suicide: Implications for Preventive Interventions in the US Department of Veterans Affairs. *Am J Public Health*, 105(9), 1935–1942. doi.org/10.2105/ajph.2015.302737
18. Matarazzo, B.B. (2018). *REACH VET: Recovery Engagement and Coordination for Health – Veterans Enhanced Treatment Predictive Analytics for Suicide Prevention*. U.S. Department of Veterans Affairs, Health Services Research & Development. hsrd.research.va.gov/for_researchers/cyber_seminars/archives/3527-notes.pdf
19. McCarthy, J.F., Cooper, S.A., Dent, K.R., Eagan, A.E., Matarazzo, B.B., Hannemann, C.M., Reger, M.A., Landes, S.J., Trafton, J.A., Schoenbaum, M., & Katz, I.R. (2021). Evaluation of the Recovery Engagement and Coordination for Health–Veterans Enhanced Treatment Suicide Risk Modeling Clinical Program in the Veterans Health Administration. *JAMA Netw Open*, 4(10), e2129900–e2129900. doi.org/10.1001/jamanetworkopen.2021.29900
20. Fenwick, K.M., Lehavot, K., Goulet, J.L., Shipherd, J.C., & Kauth, M.R. (2022). *LGBTQ+ Veteran Research: Emerging Evidence for Reducing Health Disparities*. VA Women's Health Research Network (VA HSR&D SDR 10-012). hsrd.research.va.gov/centers/womens_health/LGBTQ-Veteran-Research-Snapshot2022.pdf
21. Gradus, J.L., King, M.W., Galatzer, L.I., & Street, A.E. (2017). Gender Differences in Machine Learning Models of Trauma and Suicidal Ideation in Veterans of the Iraq and Afghanistan Wars. *J Trauma Stress*, 30(4), p. 362–371. doi.org/10.1002/jts.22210
22. Veterans Health Administration. (2018). *Sourcebook Volume 4: Women Veterans in the Veterans Health Administration*. U.S. Department of Veterans Affairs. [womenshealth.va.gov/materials-and-resources/publications-and-reports.asp#sourcebook-v4](https://www.womenshealth.va.gov/materials-and-resources/publications-and-reports.asp#sourcebook-v4)
23. Mengeling, M., Sadler, A., & Fenwick, K. (2023). *Rural Women Veterans' Healthcare Research: Reducing Access Disparities*. U.S. Department of Veterans Affairs, Women's Health Research Network (VA HSR&D SDR 10-012). hsrd.research.va.gov/centers/womens_health/Rural-Health-Research-Snapshot2023.pdf
24. McCarthy, J.F., Blow, F.C., Ignacio, R.V., Ilgen, M.A., Austin, K.L., & Valenstein, M. (2012). Suicide among patients in the Veterans Affairs health system: Rural-urban differences in rates, risks, and methods. *Am J Public Health*, 102(S1), S111–7. doi.org/10.2105/ajph.2011.300463
25. Friedman, S.A., Frayne, S.M., Berg, E., Hamilton, A.B., Washington, D.L., Saechao, F., Maisel, N.C., Lin, J.Y., Hoggatt, K.J., & Phibbs, C.S. (2015). Travel time and attrition from VHA care among women Veterans: how far is too far? *Med Care*, 53, S15–22. doi.org/10.1097/mlr.0000000000000296
26. Sanders, A.M., Golden, R.E., Kolehmainen, C., Brenton, J.K., & Frayne, S.M. (2022). Implementation experience and initial assessment of a rural women's health training program in support of the U.S. Department of Veterans Affairs as a learning health system. *Learn Health Syst*, 6(4), e10334. doi.org/10.1002/lrh2.10334
27. Weiss, B.J., Azevedo, K., Webb, K., Gimeno, J., & Cloitre, M. (2018). Telemental Health Delivery of Skills Training in Affective and Interpersonal Regulation for Rural Women Veterans Who Have Experienced Military Sexual Trauma. *J Trauma Stress*, 31(4), 620–625. doi.org/10.1002/jts.22305
28. Office of Mental Health and Suicide Prevention. (2021). *National Veterans Suicide Prevention Annual Report*. U.S. Department of Veterans Affairs. [mentalhealth.va.gov/docs/data-sheets/2021/2021-National-Veteran-Suicide-Prevention-Annual-Report-FINAL-9-8-21.pdf](https://www.mentalhealth.va.gov/docs/data-sheets/2021/2021-National-Veteran-Suicide-Prevention-Annual-Report-FINAL-9-8-21.pdf)

29. Miller, M., Azrael, D., & Hemenway, D. (2004). The epidemiology of case fatality rates for suicide in the northeast. *Ann Emerg Med*, 43(6), 723–730. doi.org/10.1016/s0196064404000691
30. Anglemeyer, A., Horvath, T., & Rutherford, G. (2014). The accessibility of firearms and risk for suicide and homicide victimization among household members: a systematic review and meta-analysis. *Ann Intern Med*, 160(2), 101–110. doi.org/10.7326/m13-1301
31. Brent, D.A. (2001). Firearms and suicide. *Ann N Y Acad Sci*, 932, 225–39; discussion 239–40. doi.org/10.1111/j.1749-6632.2001.tb05808.x
32. Miller, M., Lippmann, S.J., Azrael, D., & Hemenway, D. (2007). Household firearm ownership and rates of suicide across the 50 United States. *J Trauma*, 62(4), 1029–34; discussion 1034–5. doi.org/10.1097/01.ta.0000198214.24056.40
33. Studdert, D.M., Zhang, Y., Swanson, S.A., Prince, L., Rodden, J.A., Holsinger, E.E., Spittal, M.J., Wintemute, G.J., & Miller, M. (2020). Handgun Ownership and Suicide in California. *N Engl J Med*, 382(23), 2220–2229. doi.org/10.1056/nejmsa1916744
34. Miller, M., Barber, C., White, R.A., & Azrael, D. (2013). Firearms and suicide in the United States: is risk independent of underlying suicidal behavior? *Am J Epidemiol*, 178(6), 946–55. doi.org/10.1093/aje/kwt197
35. Theis, J., Hoops, K., Booty, M., Nestadt, P., & Crifasi, C. (2021). Firearm Suicide Among Veterans of the US Military: A Systematic Review. *Mil Med*, 186(5–6), e525–e536. doi.org/10.1093/milmed/usaa495
36. Monteith, L.L., Holliday, R., Miller, C.N., Schneider, A.L., Brenner, L.A., & Hoffmire, C.A. (2022). Prevalence and Correlates of Firearm Access Among Post-9/11 US Women Veterans Using Reproductive Healthcare: A Cross-Sectional Survey. *J Gen Intern Med*, 37, 714–723. doi.org/10.1007/s11606-022-07587-1
37. Simonetti, J.A., Azrael, D., Rowhani-Rahbar, A., & Miller, M. (2018). Firearm Storage Practices Among American Veterans. *Am J Prev Med*, 55(4), 445–454. doi.org/10.1016/j.amepre.2018.04.014
38. Valenstein, M., Walters, H., Pfeiffer, P.N., Ganoczy, D., Ilgen, M.A., Miller, M.J., Fiorillo, M., & Bossarte, R.M. (2020). Possession of Household Firearms and Firearm-Related Discussions with Clinicians Among Veterans Receiving VA Mental Health Care. *Arch Suicide Res*, 24(sup1), 260–279. doi.org/10.1080/13811118.2019.1572555
39. Miller, M., Zhang, W., & Azrael, D. (2022). Firearm Purchasing During the COVID-19 Pandemic: Results From the 2021 National Firearms Survey. *Ann Intern Med*, 175(2), 219–225. doi.org/10.7326/M21-3423
40. National Shooting Sports Foundation. (2022). *NSSF Retailer Surveys Indicate 5.4 Million First-Time Gun Buyers In 2021*. NSSF. nssf.org/articles/nssf-retailer-surveys-indicate-5-4-million-first-time-gun-buyers-in-2021/
41. Monteith, L.L., Miller, C.N., Polzer, E., Holliday, R., Hoffmire, C.A., Iglesias, C.D., Schneider, A.L., Brenner, L.A., & Simonetti, J.A. (2023). “Feel the need to prepare for Armageddon even though I do not believe it will happen”: Women Veterans’ Firearm Beliefs and Behaviors during the COVID-19 Pandemic, Associations with Military Sexual Assault and Posttraumatic Stress Disorder Symptoms. *PLoS ONE*, 18(2), e0280431. doi.org/10.1371/journal.pone.0280431
42. Bryan, C.J., Rudd, M.D., Peterson, A.L., Young-McCaughan, S., & Wertenberger, E.G. (2016). The ebb and flow of the wish to live and the wish to die among suicidal military personnel. *J Affect Disord*, 202, 58–66. doi.org/10.1016/j.jad.2016.05.049
43. Aunon, F. (2023). “Keep It Short And Simple,” *The Development of a Brief, Motivational Interviewing-Based Firearm Storage Intervention for Primary Care*. U.S. Department of Veterans Affairs. hsrp.research.va.gov/for_researchers/cyber_seminars/archives/video_archive.cfm?SessionID=6312
44. Simonetti, J.A., Rowhani-Rahbar, A., King, C., Bennett, E., & Rivara, F.P. (2018). Evaluation of a community-based safe firearm and ammunition storage intervention. *Inj Prev*, 24(3), 218–223. doi.org/10.1136/injuryprev-2016-042292
45. Valenstein, M., Walters, H., Pfeiffer, P.N., Ganoczy, D., Miller, M., Fiorillo, M., & Bossarte, R.M. (2018). Acceptability of potential interventions to increase firearm safety among patients in VA mental health treatment. *Gen Hosp Psychiatry*, 55, 77–83. doi.org/10.1016/j.genhosppsych.2018.10.010
46. Strauss, J. L., Miller, L. J., & Strickland, S. (2021). Applying Research to Advance Suicide Prevention in Women Veterans. *Med Care*, 59, S6–S8. doi.org/10.1097/MLR.0000000000001434
47. Office of the Inspector General. (2022). Deficiencies in Lethal Means Safety Training, Firearms Access Assessment, and Safety Planning for Patients with Suicidal Behaviors by Firearm. *Evaluation of the LMS training compliance*. Department of Veterans Affairs. oversight.gov/sites/default/files/oig-reports/VA/VAOIG-21-00175-19-Final-Report.pdf
48. Hoffmire, C.A., Denneson, L.M., Monteith, L.L., Dichter, M.E., Gradus, J.L., Cappelletti, M.M., Brenner, L.A., & Yano, E.M. (2021). Accelerating Research on Suicide Risk and Prevention in Women Veterans through Research-Operations Partnerships. *Med Care*, 59, S11–S16. doi.org/10.1097/MLR.0000000000001432
49. Dichter, M. (2022) *Strengthening Suicide Prevention Efforts for Women Veterans through the Veterans Crisis Line*. U.S. Department of Veterans Affairs, Health Services Research & Development. hsrp.research.va.gov/publications/inprogress/sept22/default.cfm?InProgressMenu=sept22-5
50. Office of Mental Health and Suicide Prevention. (2021). *Military Sexual Trauma – A Risk Factor for Suicide*. U.S. Department of Veterans Affairs. mentalhealth.va.gov/suicide_prevention/docs/FSTP-Military-Sexual-Trauma-A-Risk-Factor-for-Suicide.pdf
51. Livingston, W.S., Tannahill, H.S., Meter, D.J., Fargo, J.D., & Blais, R.K. (2023). The Association of Military Sexual Harassment/Assault with Suicide Ideation, Plans, Attempts, and Mortality Among US Service Members/Veterans: A Meta-Analysis. *Trauma Violence Abuse*, 24(4), 2616–2629. doi.org/10.1177/15248380221109790
52. Gross, G.M., Ronzitti, S., Combellick, J.L., Decker, S.E., Mattocks, K.M., Hoff, R.A., Haskell, S.G., Brandt, C.A., & Goulet, J.L. (2020). Sex Differences in Military Sexual Trauma and Severe Self-Directed Violence. *Am J Prev Med*, 58(5), 675–682. doi.org/10.1016/j.amepre.2019.12.006
53. Gibson, C.J., Maguen, S., Xia, F., Barnes, D.E., Peltz, C.B., & Yaffe, K. (2020). Military Sexual Trauma in Older Women Veterans: Prevalence and Comorbidities. *J Gen Intern Med*, 35(1), 207–213. doi.org/10.1007/s11606-019-05342-7
54. Gradus, J.L., Street, A.E., Kelly, K., & Stafford, J. (2008). Sexual harassment experiences and harmful alcohol use in a military sample: differences in gender and the mediating role of depression. *J Stud Alcohol Drugs*, 69(3), 348–351. doi.org/10.15288/jsad.2008.69.348
55. Seelig, A.D., Rivera, A.C., Powell, T.M., Williams, E.C., Peterson, A.V., Littman, A.J., Maynard, C., Street, A.E., Bricker, J.B., & Boyko, E.J. (2017). Patterns of Smoking and Unhealthy Alcohol Use Following Sexual Trauma Among US Service Members. *J Trauma Stress*, 30(5), 502–511. doi.org/10.1002/jts.22214
56. Holliday, R., Smith, N.B., & Monteith, L.L. (2018). An initial investigation of non-suicidal self-injury among male and female survivors of military sexual trauma. *Psychiatry Res*, 268, 335–339. doi.org/10.1016/j.psychres.2018.07.033
57. Goldberg, S.B., Livingston, W.S., Blais, R.K., Brignone, E., Suo, Y., Lehavot, K., Simpson, T.L., Fargo, J., & Gundlapalli, A.V. (2019). A positive screen for military sexual trauma is associated with greater risk for substance use disorders in women veterans. *Psychol Addict Behav*, 33(5), 477–483. doi.org/10.1037/adb0000486
58. Bryan, C. & Bryan, A. (2014). Non-suicidal self-injury among a sample of United States military personnel and veterans enrolled in college classes. *J Clin Psychol*, 70(9), 874–85. doi.org/10.1002/jclp.22075
59. Sexual Assault Prevention and Response. (2022). *Department of Defense Annual Report on Sexual Assault in the Military, Fiscal Year 2021*. U.S. Department of Defense. sapr.mil/sites/default/files/public/docs/reports/AR/FY22/DOD_Annual_Report_on_Sexual_Assault_in_the_Military_FY2022.pdf
60. Monteith L.L., Kittel, J.A., Schneider, A.L., Miller, C.N., Holliday, R., Katon, J.G., Brenner, L.A., & Hoffmire, C.A. (2023). Military Sexual Trauma Among Women Veterans Using Veterans Health Administration Reproductive Health Care: Screening Challenges and Associations with Post-Military Suicidal Ideation and Suicide Attempts. *J Interpers Violence*, 38(11-12), 7578–7601. doi.org/10.1177/08862605221145725

61. Blais, R.K., & Monteith, L.L. (2019). Suicide Ideation in Female Survivors of Military Sexual Trauma: The Trauma Source Matters. *Suicide Life Threat Behav*, 49(3), 643–652. doi.org/10.1111/sltb.12464
62. Veterans Health Administration. (2018). *VHA Directive 1115(1). Military Sexual Trauma (MST) Program*. U.S. Department of Veterans Affairs. va.gov/vhapublications/viewpublication.asp?pub_ID=6402
63. Lemle R. B. (2018). Choice Program Expansion Jeopardizes High-Quality VHA Mental Health Services. *Fed Pract*, 35(3), 18–24. ncbi.nlm.nih.gov/pmc/articles/PMC6368051
64. Iverson K.M., Dichter M.E., Portnoy G.A., Fenwick K.M. *Women Veterans' Intimate Partner Violence Research: Improving screening and treatment in VHA care*. VA Women's Health Research Network (VA HSR&D SDR 10-012). 2023. hsr.d.research.va.gov/centers/womens_health/IPV-Research-Snapshot2023.pdf
65. Brignone, E., Sorrentino, A. E., Roberts, C. B., & Dichter, M. E. (2018). Suicidal ideation and behaviors among women veterans with recent exposure to intimate partner violence. *Gen Hosp Psychiatry*, 55, 60–64. doi.org/10.1016/j.genhosppsych.2018.10.006
66. Iverson, K., & Yano, E. (2023 March 15). *Intimate Partner Violence: A Research Overview and Implications for Care* (Slide Presentation). U.S. Department of Veterans Affairs.
67. Iverson, K.M., Adjonon, O., Grillo, A.R., Dichter, M.E., Gutner, C.A., Hamilton, A.B., Stirman, S.W., & Gerber, M.R. (2019). Intimate Partner Violence Screening Programs in the Veterans Health Administration: Informing Scale-up of Successful Practices. *Gen Intern Med*, 34(11), 2435–2442. doi.org/10.1007/s11606-019-05240-y
68. Portnoy, G. A., Iverson, K.M., Haskell, S.G., Czarnogorski, M., & Gerber, M.R. (2012). A Multisite Quality Improvement Initiative to Enhance the Adoption of Screening Practices for Intimate Partner Violence into Routine Primary Care for Women Veterans. *Public Health Rep*. 136(1), 52–60. doi.org/10.1177/0033354920966022
69. Raja, S., Hasnain, M., Hoersch, M., Gove-Yin, S., & Rajagopalan, C. (2015). Trauma Informed Care in Medicine: Current Knowledge and Future Research Directions. *Family & community health*, 38, 216–226. dx.doi.org/10.1097/FCH.0000000000000071
70. Spinella, S., McCune, N., McCarthy, R., El-Tahch, M., George, J., Dorritie, M., Ford, A., Posteraro, K., & DiNardo, D. (2022). WVSUD-PACT: a Primary-Care-Based Substance Use Disorder Team for Women Veterans. *J Gen Intern Med*, 37(Suppl 3), 837–841. doi.org/10.1007/s11606-022-07577-3
71. Strauss, J. (2022 September 14). *VA is Ready to Meet the Challenge of Addressing Women Veterans' Mental Health Care Needs* (National Lead and Women's Mental Health Program Manager Partnerships Stakeholder Meeting). U.S. Department of Veterans Affairs, Office of Mental Health and Suicide Prevention.
72. Breland, J. Y., Donalson, R., Li, Y., Hebenstreit, C. L., Goldstein, L. A., & Maguen, S. (2018). Military sexual trauma is associated with eating disorders, while combat exposure is not. *Psychol Trauma*, 10(3), 276–281. doi.org/10.1037/tra0000276
73. Liberto, J., (2023 February 1). *Substance Use Disorder (SUD): An Integrated, Collaborative, and Stepped Care Approach* (Slide 47, National Mental Health Director, Substance Use Disorder (SUD) VSO Briefing). U.S. Department of Veterans Affairs, Office of Mental Health and Suicide Prevention.
74. Galovski, T., & Vogt, D. (2022.) *The Role of Peer Support in Reducing Risk of Negative Outcomes for Women Veterans* (Spotlight on Women's Health Seminar). U.S. Department of Veterans Affairs, Health Services Research & Development.
75. Creech, S.K., Kroll-Desrosiers, A., Benzer, J.K., Pulverman, C.S., & Mattocks, K. (2022). The impact of military sexual trauma on parent-infant bonding in a sample of perinatal women veterans. *Depress Anxiety*, 39(3), 201–210. doi.org/10.1002/da.23218
76. Strauss, J.L., Miller, L.J., & Strickland, S. (2021). Applying Research to Advance Suicide Prevention in Women Veterans. *Med Care*, 59, S6–S8. doi.org/10.1097/mlr.0000000000001434
77. Fenwick, K., Katon, J., & Patton, E. (2023). *VA pregnancy and maternity care research*. U.S. Department of Veterans Affairs, Women's Health Research Network (VA HSR&D SDR 10-012). hsr.d.research.va.gov/centers/womens_health/Pregnancy-Maternity-Care-Research-Snapshot2023.pdf
78. Comtois, K.A., Schiff, M.A., & Grossman, D.C. (2008). Psychiatric risk factors associated with postpartum suicide attempt in Washington State, 1992-2001. *Am J Obstet Gynecol*, 199(2), 120.e1-5. doi.org/10.1016/j.ajog.2008.02.011
79. Petersen, I., Gilbert, R.E., Evans, S.J., Man, S.L., & Nazareth, I. (2011). Pregnancy as a major determinant for discontinuation of antidepressants: an analysis of data from The Health Improvement Network. *J Clin Psychiatry*, 72(7), 979–85. doi.org/10.4088/jcp.10m06090blu
80. Szpunar, M.J., Crawford, J.N., Baca, S.A., & Lang, A.J. (2020). Suicidal Ideation in Pregnant and Postpartum Women Veterans: An Initial Clinical Needs Assessment. *Mil Med*, 185(1-2), e105–e111. doi.org/10.1093/milmed/usz171
81. Gross, G. M., Kroll-Desrosiers, A., & Mattocks, K. (2020). A longitudinal investigation of military sexual trauma and perinatal depression. *J Womens Health (Larchmt)*, 29(1). 38–45. doi.org/10.1089/jwh.2018.7628
82. Veterans Health Administration. (2020). *VHA Directive 1330.03: Maternity Health Care and Coordination*. U.S. Department of Veterans Affairs. va.gov/vhapublications/ViewPublication.asp?pub_ID=9095
83. Disabled American Veterans. (2014). *Women Veterans: The Long Journey Home*. Disabled American Veterans.
84. Disabled American Veterans. (2018). *Women Veterans: The Journey Ahead, in Honoring the Service of Women Veterans*. Disabled American Veterans.
85. Prasad, D., Wollenhaupt-Aguiar, B., Kidd, K. N., de Azevedo Cardoso, T., & Frey, B. N. (2021). Suicidal Risk in Women with Premenstrual Syndrome and Premenstrual Dysphoric Disorder: A Systematic Review and Meta-Analysis. *J Womens Health (Larchmt)*, 30(12), 1693–1707. doi.org/10.1089/jwh.2021.0185
86. National Institute on Aging. (2021 September 30). *What is Menopause?* National Institutes of Health. nia.nih.gov/health/what-menopause
87. Cleveland Clinic. (2021 October 5). *Postmenopause*. my.clevelandclinic.org/health/diseases/21837-postmenopause
88. Crouch, M. (2022 June 22). *Nearly 2 Out of 3 Women Age 50-Plus Regularly Face Discrimination*. AARP. aarp.org/health/conditions-treatments/info-2022/women-discrimination-and-mental-health.html#:~:text=Age%2Drelated%20discrimination%20persists,against%20because%20of%20their%20age
89. Freeman, E.W., Sammel, M.D., Liu, L., Gracia, C.R., Nelson, D.B., & Hollander, L. (2004). Hormones and menopausal status as predictors of depression in women in transition to menopause. *Arch Gen Psychiatry*, 61(1), 62–70. doi.org/10.1001/archpsyc.61.1.62
90. Cohen, L.S., Soares, C.N., Vitonis, A.F., Otto, M.W., & Harlow, B.L. (2006). Risk for new onset of depression during the menopausal transition: the Harvard study of moods and cycles. *Arch Gen Psychiatry*, 63(4), 385–90. doi.org/10.1001/archpsyc.63.4.385
91. Garnett, M.F., Curtin, S.C., & Stone, D.M. (2022). Suicide Mortality in the United States, 2000–2020. *NCHS Data Brief*, (433), 1-8. cdc.gov/nchs/data/databriefs/db433.pdf
92. Yeager, S. (2022). *Suicidal Thoughts and Menopause*. In *Feisty Menopause*. feistymenopause.com/blog/mentalhealthandmenopause
93. Gibson, C.J., Li, Y., Jasuja, G.K., Self, K.J., Seal, K.H., & Byers, A.L. (2021). Menopausal Hormone Therapy and Suicide in a National Sample of Midlife and Older Women Veterans. *Med Care*, 59, S70–S76. doi.org/10.1097/mlr.0000000000001433
94. Gibson, C.G., Li, Y., Jasuja, G.K., Keyhani, S., & Byers, A.L. (2022). Long-term Psychoactive Medications, Polypharmacy, and Risk of Suicide and Unintended Overdose Death Among Midlife and Older Women Veterans. *J Gen Intern Med*, 37, S770–S777. doi.org/10.1007/s11606-022-07592-4
95. Gibson, C.J., Li, Y., Bertenthal, D., Huang, A.J., & Seal, K.H. (2019). Menopause symptoms and chronic pain in a national sample of midlife women veterans. *Menopause*, 26(7), 708–713. doi.org/10.1097/gme.0000000000001312

96. Gibson, C.J., Li, Y., Huang, A.J., Rife, T., & Seal, K.H. (2019). Menopausal Symptoms and Higher Risk Opioid Prescribing in a National Sample of Women Veterans with Chronic Pain. *J Gen Intern Med*, 34(10), 2159–2166. doi.org/10.1007/s11606-019-05242-w
97. Byers, A., Maust, D., Morin, R., & Barry, L. (2020). Adverse Outcomes, Polysubstance Use, and Polypharmacy in Older Veterans. *Am J Geriatr Psychiatry*, 28(4, Suppl), S10–S11. doi.org/10.1016/j.jagp.2020.01.027
98. Morin, R., Li, Y., Steinman, M., Wiechers, I., & Byers, A. (2020). High-Risk Medication Use and Polypharmacy in Older Veterans Who Attempt Suicide. *Innov Aging*, 4(Suppl 1), 747–747. doi.org/10.1093%2Fgeron%2Fgaa057.2690
99. Kulkarni, J. (2022). Why depression in women is so misunderstood. *Nature*, 608(7924), S54. doi.org/10.1038/d41586-022-02213-w
100. Monteith, L.L., Holliday, R., Dichter, M.E., & Hoffmire, C.A. (2022). Preventing Suicide Among Women Veterans: Gender-Sensitive, Trauma-Informed Conceptualization. *Curr Treat Options Psychiatry*, 9(3), 186–201. doi.org/10.1007/s40501-022-00266-2
101. Ali, H., Edwards, S., Gerrity, M., & Gittel, J. (2023 April). *Understanding Relational Coordination Within and Across Service Lines in a Vertically Integrated* (Cyber Seminar). U.S. Department of Veterans Affairs, Health Services Research & Development. hsrd.research.va.gov/for_researchers/cyber_seminars/archives/video_archive.cfm?SessionID=6330&Seriesid=54
102. *Combatting a crisis: Providing veterans access to life-saving substance abuse disorder treatment*, U.S. House of Representatives Committee on Veterans' Affairs Subcommittee on Health, 118th Cong. (2023). (testimony of Julie Kroviak, MD). veterans.house.gov/calendar/eventsingle.aspx?EventID=6151
103. *Letter to Secretary McDonough*, U.S. House of Representatives Committee on Veterans' Affairs, 117th Cong. (2022). (signed by Rep. Lauren Underwood). underwood.house.gov/sites/evo-subsites/underwood-evo.house.gov/files/Rep.%20Underwood%20Letter%20to%20Sec.%20McDonough%20-%20Lethal%20Means%20Safety_April%202022.pdf
104. Roszko, P.J.D., Ameli, J., Carter, P.M., Cunningham, R.M., & Ranney, M.L. (2016). Clinician attitudes, screening practices, and interventions to reduce firearm-related injury. *Epidemiol Rev*, 38(1), 87–110. doi.org/10.1093/epirev/mxv005
105. Boggs, J. M., Beck, A., Ritzwoller, D. P., Battaglia, C., Anderson, H. D., & Lindrooth, R. C. (2020). A Quasi-Experimental Analysis of Lethal Means Assessment and Risk for Subsequent Suicide Attempts and Deaths. *J Gen Intern Med*, 35(6), 1709–1714. doi.org/10.1007/s11606-020-05641-4
106. Rasmussen, P.W., & Farmer, C.M. The Promise and Challenges of VA Community Care: Veterans' Issues in Focus. *Rand Health Q*, 10(3), 9. rand.org/pubs/perspectives/PEA1363-5.html
107. Jennifer Burden, Ph.D, National Mental Health Director, Mental Health Residential Rehabilitation Treatment Program, February 01, 2023. MHRRT P VSO Stakeholders Briefing.
108. Sheahan, K.L., Goldstein, K.M., Than, C.T., Bean-Mayberry, B., Chanfreau, C.C., Gerber, M.R., Rose, D.E., Brunner, J., Canelo, I.A., Darling Mshs, J.E., Haskell, S., Hamilton, A.B., & Yano, E.M. (2022). Women Veterans' Healthcare Needs, Utilization, and Preferences in Veterans Affairs Primary Care Settings. *J Gen Intern Med*, 37(Suppl 3), 791–798. doi.org/10.1007/s11606-022-07585-3

SPECIAL THANKS:

SIGMA Consulting/Fran Murphy, M.D./Sherrie Han, M.D.

Russell B. Lemle, Ph.D., Senior Policy Analyst for the Veterans Healthcare Policy Institute

Joy Ilem, National Legislative Director

Jon Retzer, Assistant National Legislative Director

Naomi Mathis, Assistant National Legislative Director

M. Todd Hunter, Deputy National Communications Director

Elizabeth DePompei, Communications Associate

Marissa Coffenberry, Senior Graphic Designer

Doreen Briones, Production Manager

Susan Edgerton

Notes

Notes



Stay informed. Follow along with updates to legislation affecting veterans and their families by joining DAV CAN (Commander's Action Network) at daviccan.org.



NATIONAL HEADQUARTERS

860 Dolwick Drive
Erlanger, KY 41018
859-441-7300
Toll-Free 877-426-2838

WASHINGTON HEADQUARTERS

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

dav.org

This report is available online at
womenveterans.org.



give.org