

WOMEN VETERANS: THE JOURNEY AHEAD



HONORING THE SERVICE OF WOMEN VETERANS



FULFILLING OUR PROMISES
TO THE MEN AND WOMEN WHO SERVED



Foreword

The U.S. military, as studies have shown, is a fairly accurate cross-section of America. It is a diverse blend of race, region, education, creed and—increasingly—gender.

Women, now eligible to compete for assignment in all military occupational specialties and positions, are the fastest-growing subpopulation of the military and veteran communities. They comprise almost 20 percent of the active-duty armed forces, Reserve and National Guard and 10 percent of the total veteran population.

But the population of women in these communities is growing more rapidly than the systems we have in place to support them. This has created an environment in which—whether intentional or not—women’s service to the nation is often less recognized, less respected and less valued than their male counterparts.

It has led to a culture that, in many ways, continues to tell women they don’t quite belong.

In the last decade alone, we’ve borne witness to some of the most significant milestones for women in military service, and it is understandable that with such rapid evolution there will be growing pains as the nation’s infrastructure adapts to accommodate gender-specific needs. But the cultural lag has hindered the progress necessary to effectively serve this population, and that must change.

DAV’s *Women Veterans: The Journey Ahead* follows our 2014 report *Women Veterans: The Long Journey Home*, giving credit for the work done and successes achieved while also spotlighting remaining needs and making recommendations for a road map forward.

The journey ahead is not just for women veterans. The Department of Veterans Affairs, among other institutions, has a responsibility to provide and administer effective programs, services and benefits these women have earned. Specifically, VA has an opportunity to utilize what we’ve learned about this population to transform the department with women veterans central to planning and decision-making during this period of significant reform.

Mahatma Gandhi said, “No culture can live if it attempts to be exclusive.” Yet every day, in ways both large and small, women veterans go overlooked because we are attempting to wrap them into an existing, at times ill-fitting, system rather than creating a system that wraps around them.

We challenge VA to take the findings of this report to adapt their culture into one of inclusivity and to further refine their “whole veteran” care model, which evidence shows women veterans in particular benefit from. We believe the department can recognize the trends among women veterans—in a way that no other health care system is poised to do—and use that information to best support this population’s unique and interconnected needs.

Women do belong. They are carving out larger, more prominent places in our military and veteran spaces each day. But we can’t just tell them they belong; we have to show them. And DAV resolves to ensure that the federal programs in place to serve women veterans are effective to meet their needs and fully honor their military service and sacrifice.



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Women have a larger presence in the military today than ever before. With more than 200,000 women serving in the active-duty military, VA predicts that by 2020 women veterans will comprise nearly 11 percent of the total veteran population. (Photo by Cpl. Garrett White/U.S. Marine Corps)

Women have served in the United States military with distinction for generations—from Women’s Army Corps, Women Accepted for Volunteer Services and Women Airforce Service Pilots (better known as the WACs, WAVEs and WASPs) of World War II to combat nurses in Korea and Vietnam to Female Engagement Teams in Afghanistan. Women’s equitable capabilities were recognized in 2013 with the lifting of the ban on women in combat and fully realized in December 2015 when all combat positions were opened to women. Since then, two women have graduated from U.S. Army Ranger School, the U.S. Army Infantry Basic Officers Leader Course, and the U.S. Marine Corps Infantry Officer Course. As of 2015, women make up 15.5 percent of active-duty military and 19 percent of the Guard and Reserve.¹ Currently, women are 10 percent of all veterans,² a number expected to increase to 16.3 percent within the next 25 years.³ As recruits, both men and women were promised that a grateful nation would care for those “who shall have borne the battle,” providing them with benefits and health care services for a lifetime to address both the visible and invisible wounds of military service. Today, as we continue our efforts to support women veterans, we ask the nation to uphold this promise

and ensure women can take full advantage of the unique, holistic benefits and services offered by the Department of Veterans Affairs and other federal agencies.

In September 2014, DAV published *Women Veterans: The Long Journey Home*. In that report, we focused on the unique challenges experienced by women veterans transitioning from military service in the post-9/11 era and making a successful adjustment to civilian life. We reviewed reports and interviewed experts across the government to examine the adequacy and effectiveness of services and programs for women transitioning from the military. In that first report, we found many opportunities to strengthen government efforts and made 27 key recommendations to catalyze improvements in such programs as transition assistance, employment, justice initiatives, family services, housing and health care. We shared the results of our findings in more than 50 interviews with radio, TV and print media, and testified before Congress in three separate hearings focused on the needs of women veterans and women service members transitioning from the military and wartime service to civilian life. Finally, we met with government leaders and program managers and participated in panel discussions and on committees

where we recommended ideas for improving government services for women veterans.

We are pleased to report that significant progress has been made on many of the issues we raised in our 2014 report. Congress enacted comprehensive legislation that focused exclusively on women veterans and subsequently passed six other laws that included provisions specific to issues and recommendations for changes DAV suggested. Additional legislation introduced during the 114th and 115th Congresses focused on key priorities discussed in the report: promoting gender-specific health care for women veterans; improved training for clinical providers; ensuring the privacy, dignity and security of women by improving the environment of care in VA medical facilities; enhancing and coordinating maternity care services; developing a women's peer support program; expanding access to child care; and increasing outreach to women veterans to ensure awareness of the services and benefits they have earned. Further progress has been made on a majority of recommendations by the agencies themselves. For example, VA has expanded access to information for women veterans through the Women Veterans Call Center, 1-855-VA-Women (1-855-829-6636); promoted culture change and awareness campaigns; instituted strong maternity care coordination policies and directives; initiated transition assistance sessions exclusively for women; enhanced veterans' access to child care; and focused on expanding eligibility and services in the programs for homeless and unstably housed women veterans. In all, Congress and the agencies have addressed in whole or in part all but six of the recommendations made in the last report. (A full summary of progress is in **Appendix A.**)

This progress is a testament to the combined effort of the veterans service community and military support groups, Congress and federal agencies working collaboratively to ensure the needs of women veterans are understood and being met. However, there is more work to be done. For the current report, *Women Veterans: The Journey Ahead*, we reviewed progress made since 2014, analyzed new reports, interviewed experts, and identified where additional efforts need to be made and where new efforts are warranted to meet the unique needs of women veterans. We also wished to expand the focus of this report to encompass those needs across a lifespan, in recognition that our commitment to women veterans is lifelong and ongoing. However, we found that research and studies examining the needs of older women veterans are sparse, despite findings that older women veterans experience a higher all-cause mortality than nonveteran women^{4,5} and

express significantly lower perceived health, physical function, life satisfaction, social support, quality of life and purpose in life compared to nonveteran women over 80 years of age.⁶ Although currently, only 13.6 percent of women who use VA benefits and services are 65 or older (compared to 50.2 percent of men), this is a lifelong journey; VA will need to anticipate and plan for an aging female population just as they have for men.

The report findings and recommendations cover the broad range of women veterans' needs across a lifespan, including health care, mental health, community care, shelter, legal concerns, education, disability benefits and financial security. In this executive summary, we provide 45 key recommendations to drive immediate action that ensures women veterans benefit from a holistic approach to transition, recovery and long-term support offered by VA and its partner agencies.

HEALTH CARE

Comprehensive Primary Care for Women Veterans

VA has developed and deployed a successful model of comprehensive primary care for women veterans. However, administrative, organizational and leadership shortcomings that impact all care at VA have also undermined the Veterans Health Administration's ability to consistently meet the needs of women veterans. At the local level, women veterans program managers play a critical role by ensuring the needs and preferences of women veterans are understood and addressed. Similarly, the VA Office of Women's Health Services plays the same role nationally and establishes the forward-looking research, training and planning agenda for women veterans health care in VHA.

- **Recommendation:** The VA undersecretary for health must hold VA facility leaders and directors accountable for meeting women veterans' standards of care for quality, privacy, safety and dignity, which includes ensuring these standards are applied in all primary care and specialty care clinics (for example, prosthetic clinics where women fit and adjust their prostheses). Leaders who do not meet these standards must not be eligible to receive an outstanding performance rating.
- **Recommendation:** Specific-purpose funding for the Office of Women's Health Services must be maintained to ensure that women's health training, culture change, leadership coordination, standard setting, information technology development, and identification and prioritization of research needs related to women veterans continues without interruption.

Community Care

To meet growing demand and expand geographic access, VA must continue to incorporate community providers into its health care system, including services for women veterans. However, the unique needs of women veterans are best met within a strong system of comprehensive and gender-sensitive primary care that helps ensure that all of the physical, mental and social needs of women veterans are identified and appropriate referrals are made. At present, the private sector is not prepared to take on this role. As VA expands community care, it will need to take actions to build competencies in community providers, ensure coordination and intensive case management (when needed), and structure contracts to support network adequacy for women's health services.

- **Recommendation:** Women veterans primary care services and gender-sensitive mental health care must be designated as essential, foundational services that VA maintains at every facility.
- **Recommendation:** Clarify roles and responsibilities for verifying that all designated women's health providers who treat small numbers of women have documented proficiencies in women's health as required by VHA.
- **Recommendation:** VA must ensure that community care contractors meet VA-established standards for adequacy of women's health services by both number and geographic location. They must also meet reasonable timeliness standards for wait times that are comparable with those of VA for routine and urgent care. Contractors who do not maintain adequate service access could potentially incur penalties.
- **Recommendation:** In drafting regulations to implement the VA MISSION Act of 2018, VA must ensure that challenges identified by women regarding their experience with the Veterans Choice Program are addressed. Regulations must include clear explanations of eligibility and identify requisite activities to develop veterans' awareness of the new community care program in addition to steps they must take to receive a referral and ultimately schedule appointments for community care. VA must establish a reasonable time line for results of diagnostic work or care to be communicated with VA and the veteran, and safeguards must be established to ensure veterans' credit is not harmed when VA is the responsible payer for care and fails to pay bills in a timely manner.
- **Recommendation:** Training offered to community care providers must include modules specific to the needs and experiences of women veterans.

- **Recommendation:** VA should ensure that all VA and community care clinicians who provide services for women veterans adhere to VA's evidence-based clinical practice guidelines recommendations.
- **Recommendation:** Congress should extend the number of days it authorizes VA to reimburse care for women veterans' newborns.
- **Recommendation:** Performance measures should be developed to support delivery of high-quality, safe and coordinated maternity care.
- **Recommendation:** VA needs to continuously monitor the demand for maternity care services and ensure that the need for quality maternity care services, maternity care coordinator staffing and maternity care prosthetic needs are met.
- **Recommendation:** Women veterans program managers at each facility must play an integral role in leadership assessments and decision-making about community care and services for veterans to ensure the needs and preferences of women veterans are addressed. This includes Veterans Integrated Service Networks and facility leadership utilizing women veterans program managers' expertise when working with Community Veterans Engagement Boards, academic affiliates, Vet Centers, community care, and other community health and social service providers to establish local networks.

Rehabilitation and Prosthetic Services

VA Rehabilitation and Prosthetic Services provides a lifetime of valuable support including gender-specific items for pregnancy, postpartum and following breast removal. The needs of women veterans have been included in recent clinical practice guidelines, and the service has focused attention on women veterans in training materials, publications and speaking engagements. But research advances for women with limb loss have been hampered by a limited number of women veterans who require these prostheses who could participate in research studies.

- **Recommendation:** VA Rehabilitation and Prosthetic Services should continue to highlight the needs of women amputees in research, presentations and training activities.
- **Recommendation:** VA Rehabilitation and Prosthetic Services should continue to explore advances in 3D printing technology to provide better fitting prostheses and a wider range of customizable options for women veterans, and promote 3D printing as a treatment choice to meet the specialized prosthetic needs of women veterans.

■ **Recommendation:** Congress should clarify VA research authority to ensure that VA researchers can lead and fund cooperative research studies. Partners may include academic affiliates, other federal agencies and for-profit industry in order to advance understanding and application of prostheses for women. Civilian, military and veteran women should be used as research participants to provide an adequate research base to advance innovations.

VA MENTAL HEALTH CARE

From 2003 through 2012, women's use of VA health care services increased 80 percent, with women veterans proportionately using mental health services more intensively than men. Forty percent of younger women veterans seen in VHA facilities used mental health services, as did 31 percent of older women veterans, a fivefold increase in women's use of these services. VA provides comprehensive mental health and post-traumatic stress disorder treatment programs, such as integrated care models that colocate primary care and mental health providers, or the Behavioral Health Interdisciplinary Program that provides an integrated treatment plan and services to individual veterans. VA has consistently been shown to provide superior mental health services when compared to the private sector. Yet men and women still experience barriers to seeking mental health care, and variability in the quality of services continues to exist across VA.

■ **Recommendation:** VA should develop a comprehensive five-year strategic plan for mental health services, as suggested by the National Academy of Sciences Committee. The plan should address becoming a high-reliability organization that provides accessible, high-quality, integrated mental health care services. The unique needs of women veterans should receive explicit attention in the Mental Health Strategic Plan.

Peer Support Counseling

VA has a robust peer support program of more than 1,000 specialists nationwide, 18 percent of whom are women. Peer support is an important component of care for women veterans and an important need expressed by women. VA is testing various models to provide this service to women veterans; however, little rigorous model development and testing has been done.

■ **Recommendation:** VA should define specific outcome measures for the Women Veterans Peer Specialist program, including if veterans

successfully connect with mental health services, whether those services include evidence-based therapies, and whether participants had greater adherence to treatment and were more satisfied with their care. VA should continue to evaluate a variety of models to meet needs expressed by women veterans, including the integration of peer counselors in women veterans comprehensive primary care teams.

Veterans Suicide and VA Suicide Prevention Efforts

Women veterans are twice as likely to commit suicide as civilian women, and younger women veterans' relative risk is even higher. Access to and familiarity with firearms is one prominent risk factor that younger men and women veterans share. The best protections against suicide are prompt identification of mental health concerns, the development of a safety plan for access to lethal methods of suicide and engagement in an evidence-based treatment program. Specific analysis of gender differences for risk, protective factors, harm reduction strategies and treatments are yet to be done.

■ **Recommendation:** As VA develops its update of the Clinical Practice Guidelines for Assessment and Management of Patients at Risk for Suicide, the guidelines work group should assess the scientific basis and publish recommendations on gender-based differences in risk, protective factors and treatment efficacy for suicide prevention.

■ **Recommendation:** As part of a comprehensive suicide prevention strategy, VA should aggressively promote routine screening for mental health conditions and suicide risk; improve access for women veterans to evidence-based treatments; and promote harm reduction strategies, including education of providers and family on how to talk to a veteran in crisis or at risk for suicide about safe storage of firearms.

Eating Disorders

VA has just begun training teams in recognition and treatment of eating disorders among veterans. Women veterans with trauma in their backgrounds, including military sexual trauma, intimate partner violence or post-traumatic stress disorder, are at risk for developing eating disorders, which have significant clinical implications.

■ **Recommendation:** Ensure that women veterans and their clinicians are aware of available VA resources for eating disorders, and continue training clinicians about the clinical implications of eating disorders.

Substance Use Disorders

Rates of substance use disorders are significant among women veterans who use VHA services. Such disorders contribute to suicides, can make women vulnerable to intimate partner violence, and co-occur with other mental health conditions that can complicate diagnosis and treatment. And they make women veterans vulnerable to a spiral of decline: job loss, homelessness, criminal activity and family dissolution. To combat this downward trajectory, women veterans require full access to the wraparound services offered by VHA.

- **Recommendation:** VA should ensure women veterans have timely access to a full spectrum of integrated substance abuse treatment services, from detoxification to rehabilitation.
- **Recommendation:** VA should increase the availability of gender-exclusive substance use disorder programming and ensure all programming venues comply with environment of care standards for women's privacy and safety.

Military Sexual Trauma

The impact of military sexual trauma, or MST, has both immediate and lifetime impacts. It has an economic cost—\$3.6 billion a year by one estimate—as well as high personal costs. Sexual misconduct and assault don't occur in a vacuum. These crimes flourish in an environment where sexual innuendo, gender-based bullying, unfair treatment, low expectations and fundamental disrespect for women are allowed to flourish. Fixing this culture problem at the Department of Defense is the job of its leaders at all levels.

- **Recommendation:** DOD should work with other federal agencies and outside experts to evaluate and disseminate effective approaches to creating gender equity within a male-dominated workplace. Additionally, DOD should take an aggressive stand against sexual harassment and assault in the military by holding commanders accountable for creating a positive culture of inclusion and respect and sponsoring women's empowerment.
- **Recommendation:** All service branches should aim to prosecute 100 percent of nonrestricted claims of sexual assault, as the Air Force does.

Readjustment Counseling Services

Readjustment counseling in VA continues to be an important resource for women veterans, with 12 percent of current visits made by women. Vet Centers

explicitly create outreach and access plans each year that take into account the local population of veterans, including minority populations such as women, and create specific strategies to reach them.

- **Recommendation:** Local Vet Center leadership must be included in any local planning to establish high-performing community care networks to ensure their knowledge and understanding of veterans' needs and existing community resources are included in plans. VA should also establish clear protocols for transferring veterans to and from Vet Center care and community care providers when needed.
- **Recommendation:** Permanently extend beneficiary travel, with appropriate oversight mechanisms, for eligible veterans using Vet Center programs.

Retreats

Nature-assisted therapies, including retreats, have been shown to have a clear and consistent positive impact on readjustment for women veterans. The Vet Center pilot retreat program has had great success with the more than 300 women veterans who have attended.

- **Recommendation:** The Vet Center women's retreats have shown consistent positive outcomes and should be permanently authorized and expanded by Congress and available to women veterans who need them.

VA Women Veterans Health Research

The VA Office of Research and Development continues to play an important role in identifying factors that affect veterans' care and improving the treatment and programs that serve them. Women must be included in all research to ensure that results of projects are representative of the entire veteran population.

- **Recommendation:** VA must redouble efforts to ensure significant representation of women in the Million Veteran Program and all broad-based research endeavors—not just those projects that specifically address them.
- **Recommendation:** To the extent possible, ensure adequate representation of women in all biomedical research. All VA clinical trials must report differences in sex and gender, as National Institutes of Health studies do.
- **Recommendation:** VA should continue prioritizing research areas for women veterans by mapping knowledge gaps.

SHELTER

VA and its partners at the departments of Housing and Urban Development and Labor have made tremendous progress in addressing the needs of homeless veterans, including the needs of homeless and precariously housed women veterans. Women veterans are less likely to be literally homeless than men, remaining in dangerous relationships or living transiently with friends and family rather than sleeping on the street. VA has made adjustments to its services to try to capture these veterans into their programs. However, gaps still exist between what these women need and what VA provides to ensure they successfully transition to stable housing.

■ **Recommendation:** To address unmet needs, Congress should hold hearings to examine the needs of women veterans who are precariously housed or homeless, identifying any gaps in eligibility that could be addressed to prevent chronic homelessness. Congress should also consider expanding authority under VA's existing grant programs that serve homeless veterans to allow funds to address some of the remaining priorities held by women veterans, such as short-term vouchers for child care expenses, to remove short-term impediments to long-term employment and housing stability.

Financial Security

Overall, women veterans are adequately employed and have higher incomes than comparable civilian women at all ages. However, they continue to make less than their male peers, a gap which generally increases over time. Some subpopulations of women veterans struggle with employment. Younger women still lag behind their older peers, although they are doing much better now than during the financial crisis, and disabled women veterans and those in school still struggle with employment. State efforts to help military service members transfer experience, training and certificates to the private sector have helped all veterans find meaningful employment after service.

■ **Recommendation:** DOL should partner with VA and veterans service organizations to understand barriers to full employment for women veterans, particularly those in school and those with disabilities, and adjust their employment programs based on these findings.

■ **Recommendation:** Veterans service organizations should continue to work with VA and their state and community partners to expand best practices for certification and education credits for military experience and training.

LEGAL ISSUES

Some women veterans have unmet civil legal needs that impede their ability to obtain and maintain stable housing and employment. VA's promotion of access to free and low-cost legal services is a tremendous help to this group of women veterans. Women veterans also benefit, as do men, from the ability to access Veterans Treatment Courts and gain treatment and services instead of being incarcerated. But access to these programs is highly variable across the country and outcomes for program participants are unclear.

■ **Recommendation:** VA should set clear program goals and metrics for the Veterans Justice Outreach Program that can be applied in differing local conditions across the country to particularly ensure that minority populations of veterans, such as women, are being effectively served.

■ **Recommendation:** VA should continue to research and report on the legal and health care needs of justice-involved women veterans and on outcomes of programs like Medical Legal Partnerships, Veterans Justice Outreach and Veterans Treatment Courts. VA could ask the National Academy of Sciences to study these programs or bring together an interdisciplinary group from VA, the Bureau of Prisons and the Department of Justice to examine best practices and establish clear national program metrics, goals and outcome measures.

■ **Recommendation:** As in other VA programs, women in linked services for Veterans Justice Outreach and the Health Care for Re-entry Veterans Program should be assigned to women peer mentors and specialists. VA should study the need for and effectiveness of peer mentors and specialists to support women veterans who have cases in family court. Women veterans program managers should be tapped to help coordinate these and other services these women require.

■ **Recommendation:** VA and DOJ should work cooperatively to establish uniform program guidelines for Veterans Treatment Courts that favor the broadest inclusion criteria to allow veterans to avoid incarceration, enter into treatment and work toward recovery. Congress should require the departments to report on their progress in this endeavor.

TRANSITION

VA and DOD have both invested in transition assistance and outreach to veterans once they have left active duty. While some studies of reintegration and the needs of military families have been done, the studies have not included explicit methods to assess the needs of women military members or determine how well current programs support their transitions. VA and DOD are implementing a new pilot program to include a women-specific day in the existing Transition Assistance Program.

- **Recommendation:** The VA and DOD Joint Incentive Fund should be applied to needed research into women's experiences with reintegration and family and community re-engagement.
- **Recommendation:** As part of ongoing assessment efforts, DOD must ensure that it collects data and study the effects of deployment on the families, and in particular the spouses, of women service members and on dual military families. Special attention should be given to any differences in support and services these families may need.
- **Recommendation:** The Transition Assistance Program should collect and publicize outcome and satisfaction data broken down by gender and race.
- **Recommendation:** DOD should study women's experience with post-deployment combat stress, reintegration, and family post-deployment and community re-engagement. DOD should also develop materials and programs that address the special post-deployment challenges of women in the military.

VA Disability Compensation

The Veterans Benefits Administration has successfully conducted outreach to women veterans transitioning from the military, resulting in women's utilization of benefits and services that is approaching comparability with men. VBA created equitable reviews for claims related to military sexual trauma through a series of interventions that corrected past inequities. However, the OIG identified processing failures again in August 2018 that led to denial of these claims. Recent data publications have included data specific to women veterans, but not all VBA programs reported data this way. Some of the information may indicate ongoing inequities that require VBA follow-up.

- **Recommendation:** VBA should continue to conduct and publish analysis of women veterans' use, experience and success in pursuing veterans benefits and should ensure all VBA programs are examining their data to identify any gender inequities in the services provided.

- **Recommendation:** We concur with recommendations made by OIG and urge VBA to reinstitute training and refresher training for VBA employees handling MST-related claims; update the checklist for such claims, to include detailed steps claims processors must take in evaluating these special claims in accordance with applicable regulations; require claims processors to certify that they completed all required development action for each claim; and establish routine quality review measures to ensure consistency and accuracy of these claims.

Vocational Rehabilitation and Employment

Vocational Rehabilitation and Employment is an important program for women veterans, who currently make up a little more than 20 percent of users. While the program studies and publishes outcomes and participant satisfaction, it has not published this data analyzed for female participants.

- **Recommendation:** VA should analyze race and gender outcomes in longitudinal studies of Vocational Rehabilitation and Employment participants and make the data and analysis publicly available.

Education

VBA educational benefits are being used by women veterans in large numbers, comparable to those of men, and women are successfully obtaining college degrees. Like their male counterparts, women veterans can benefit from clear, complete information on the services and culture offered by educational institutions as they decide where to pursue their degree and spend their government-funded educational benefits. Although the VA GI Bill Comparison Tool is a step forward in collecting and organizing information that veterans may wish to know about a school, it suffers from both too much information and too little. While many military-friendly best practices are included in the tool, many schools do not consistently report the information that would allow outcomes or demographic information about utilization to be analyzed.

- **Recommendation:** VA and veterans service organizations that evaluate and publish information about veterans' use of educational benefits or their outcomes should include consistent breakdowns by gender, race and age.



Historically, the Air Force has had the highest percentage of enlisted and officer women; however, by 2016, the Navy had nearly caught up. In both services, approximately 1 in 5 enlisted members and officers are women. (Photo by Petty Officer 1st Class Chad J. McNeeley/U.S. Department of Defense)

DAV's *Women Veterans: The Long Journey Home* highlighted the different needs of women compared to their male counterparts as they returned from military service to their families and communities. We found that women had a different readjustment experience than men and that, while many types of federal services and benefits were available, women veterans were often not aware of them. We also looked at how effective those services were in meeting the unique readjustment needs of women veterans and made recommendations to improve the services provided to women to ensure a successful transition.

In this follow-up report, DAV focuses on what progress has been made over the past four years, how services have been tailored or improved to meet the needs of this growing population, and what challenges still exist for women seeking care in a changing health care environment. First and foremost, women aren't just small men; women's body proportions are different, their hormones are dissimilar, and the roles society and their families expect them to play are unique. And certainly when

it comes to military service, the experience women have and their perception of it differs from most men. Taken together, these perceived and actual differences mean that women veterans have different needs and expectations related to the health care services and benefits they have earned.

Women veterans are more racially and ethnically diverse than men, with the post-9/11 cohort made up of 31 percent non-white, non-Hispanic women (compared to the 81 percent of male veterans who are white).⁷ They are more likely to be divorced⁸ than their male counterparts or civilian women,^{9,10} less likely to be married and five times more likely to be in a dual-service-member marriage than men.¹¹ Overall, this means women veterans are less likely to have the family support system that married military men generally enjoy. In addition, compared to men who served, women veterans are younger, have a lower median income (or no income), and are more likely to live in poverty and qualify for food stamps.^{12,13} In addition, among homeless or unstably housed veterans, women are more likely to have custody of minor children compared to men.¹⁴ Taken



Approximately 1 out of 5 women who visits VA facilities tells their VA health care provider they experienced sexual trauma while in the military. Every VA facility has a designated MST Coordinator who serves as a contact person for MST-related issues.

together, these circumstances mean women veterans have more economic stress than men and are more financially precarious.

Finally, women veterans are more likely to have lived through physical or sexual trauma before entering the military than male recruits¹⁵ and much more likely to experience sexual harassment, sexual assault or both than men while in military service.¹⁶ Women must work harder to feel comfortable and accepted within a male-dominated, sometimes hostile work environment defined by archetypal masculinity,¹⁷ and are less likely to feel supported by commanders, peers and civilians alike. Civilian women don't identify with their military experience, and male service members may not either. Male veterans are more likely to have communities of support during and after service when they are more likely to return to military bases and families. Peer support and a sense of belonging

are an important antidote to adverse readjustment reactions—a protective factor that may be hard for women veterans to find. Add this lack of belonging to the stress of deployment, combat and military service, and these experiences can have a lasting impact on women. When polled, 60 percent of women who served thought their time in the military had negatively impacted both their physical and mental health.¹⁸ This is reflected in the increasing number of women veterans who are seeking care from the Department of Veterans Affairs: Women veterans now make up 9 percent of VA users, up from 6.6 percent in 2007, which represents almost 47 percent of the total women veterans population (comparable to men at 48 percent).¹⁹ Between 2000 and 2015, the percentage of women veterans using Veterans Health Administration services increased from 10 to 23 percent, or just under 440,000 women.²⁰ By 2017, this number was above a half-million.²¹

Researchers have also found that women veterans who use VA services have unique vulnerabilities. For instance, women veterans who use VA maternity care benefits are about three and a half times more likely to have active post-traumatic stress disorder, five and half times more likely to have current symptoms of depression, and four times more likely to have a service-connected disability rated at 50 percent or above compared to pregnant women veterans who elect not to use the VA maternity benefit.²² These characteristics make this population high risk for pregnancy complications. Women veterans with active PTSD experience a higher rate of pre-term birth (9.2 percent) than those with no history of PTSD (7.4 percent), and this complication leads to longer hospital stays and more antenatal complications.²³

Women veterans with active PTSD also experience a higher rate of pre-eclampsia and gestational diabetes compared to the expected rate in the general population.²⁴ These conditions can be life-threatening for both mother and child. Having knowledgeable maternity coordinators who understand these risks and can educate community obstetricians is crucial to ensuring women veterans have healthy babies and a positive birth experience.

Women who have served also report more mental illness and more chronic diseases than their civilian counterparts. Compared to civilians, women veterans report more suicidal thoughts (4 versus 8 percent), mental illness (22 versus 33 percent), cancers (11 versus 13 percent) and arthritis (26 versus 33 percent).²⁵ Women veterans' risk for suicide (like men) exceeds that of civilian women by two and half times,²⁶ and older women veterans are more likely to die of all-cause mortality than their civilian counterparts.²⁷ They also report significantly lower perceived health, physical function, life satisfaction, social support, quality of life and purpose.²⁸ Offering integrated mental health and primary care services with designated women's health providers is key to meeting the specialized needs of this population. Women veterans who did not use VA care report more unmet health care needs than users of Veteran Health Administration services,²⁹ and women veterans who used designated women's health providers had the best health outcomes and highest level of satisfaction with the administration.^{30, 31}

On June 6, 2018, President Donald Trump signed the John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Networks Act of 2018

(Public Law 115-182), commonly referred to as the VA MISSION Act of 2018.³² This legislation enacts several important changes to VA health care.

Specifically, its provisions:

- Eliminate the VA Choice Program and streamline seven community care programs into a single integrated network, the Veterans Community Care Program.
- Allow veterans and their doctors to choose the best option on where to get health care, whether in VA or VA's outside community care network.
- Streamline eligibility standards for community care by eliminating the former distance and wait-time restrictions.
- Establish a walk-in care benefit in the community for veterans in need of urgent but non-emergency care.
- Invest in VA's clinical workforce to recruit and retain high-quality health care providers.
- Enhance access to care by expanding telehealth and changing provider certification standards.
- Establish mobile deployment teams to provide surge support and fill gaps in care to VA facilities with the highest need.
- Expand VA's comprehensive caregiver support program to pre-9/11 veterans, providing eligible caregivers additional support services and a monthly stipend.

Many of the provisions in the VA MISSION Act of 2018 can help address the needs of women veterans. However, we urge VA to examine complaints, concerns and satisfaction rates of women veterans using the Choice Program or community services before they draft regulations to implement the new network. Leaders in the women veteran stakeholder community must remain vigilant and steadfast in ensuring VA applies these changes to address unique challenges women veterans face and their gender-specific needs.

VA and its federal partners across the government have work left to do to ensure that our nation's women veterans receive quality care tailored to their unique needs and that VA and other government programs are effective and result in positive health and readjustment outcomes for this population. The remainder of this report assesses current government programs intended to serve women veterans, highlights opportunities for improvement, and recommends immediate actions to enhance the scope and quality of services supporting women veterans in their lifelong journey to achieve health and well-being.



At each VA medical center nationwide, a Women Veterans Program Manager is designated to advise and advocate for women veterans. She can help coordinate all services, from primary care to specialized care for chronic conditions or reproductive health.

VA HEALTH CARE SERVICES

In addressing the needs of veterans today and in the future, the Department of Veterans Affairs takes a “whole health” approach and offers a continuum of patient-centered health care services. These include health promotion and disease prevention services; primary and specialized ambulatory medical, surgical and mental health care; complementary and integrative health treatments; inpatient hospital care; residential specialized mental health and substance abuse treatment programs; Home Based Primary Care and home health services; institutional long-term care; and hospice and palliative care programs. These services encompass women’s reproductive health services such as preventive screenings, contraceptives, specialty gynecological care, maternity care and fertility care. VA has trained over 5,500 primary care providers in comprehensive women’s health care, has 196 gynecologists on staff and provides on-site mammography at 50 locations.³³ In addition, VA provides comprehensive care for military sexual trauma, including trauma coordinators at all facilities; screenings of all veterans; treatment for mental and physical conditions related to MST; and outpatient, inpatient and residential care including

all indicated medications. VA operates 145 medical centers, 25 ambulatory care centers, 1,008 clinics and 300 Vet Centers.^{34, 35} In fiscal year 2016, VA served 6.26 million veterans.

For more than a decade, VA has experienced a rapid increase in the population of women veterans who use VA benefits, from 10 percent of all women veterans in 2000 to 23 percent in 2015.³⁶ By 2017, the number of women veterans using Veterans Health Administration services reached 484,317.³⁷ To meet this growing demand, VA has made substantial investments in comprehensive primary care for women and in enhanced women’s health treatment capabilities at VA medical facilities. Every VA medical center is required to have a women veterans program manager who serves as an advocate, navigator and coordinator to connect women veterans to care and assist them in organizing their health care services.³⁸ VA’s success in outreach to women about VA services contributes to market penetration rates for Veterans Integrated Service Networks that vary from 56 to 83 percent of women who eventually use VHA services. Outreach is a critical component to promote utilization since women veterans who don’t use VA are much less likely to receive information about VA women’s health services (only 21 percent).³⁹

Women veterans program managers play a critical role within each facility's management team by ensuring engagement and coordination with community providers that serve women veterans and advocating within the facility for the resources required to serve women veterans. As VA continues its journey to modernize services, standardize administrative functions and expand community care,⁴⁰ it will be critically important that the program managers remain strong advocates for the needs of women, continue to coordinate services inside and outside VA and between VA and Vet Centers, and apply their women's health policy and program expertise at the facility level.

VHA has been a leader in lesbian, gay, bisexual and transgender care since 2012, when it took actions to expand health equity and participate successfully in the Human Rights Campaign's Health Equality Index. VHA prepared to participate by launching 570 initiatives at 145 facilities, to promote a welcoming and inclusive environment for LGBT veterans. Then, 120 facilities participated in the 2013 Health Equality Index survey and 91 were awarded equality leader status (75 percent), a higher percentage of leaders than for survey participants as a whole. VHA achieved leader status by publicizing its policies giving equal visitation to members of the LGBT community, prohibiting discrimination against patients and staff who identify as such, and providing training in LGBT-centered care for key staff.⁴¹ A small online survey in 2014 validated these findings, as 79 percent of transgender veterans who used VHA

Infertility Treatment

VA finalized regulations in February 2017 to support in vitro fertilization services for both male and female veterans who qualify by virtue of a service-connected disability that results in their inability to procreate without the use of fertility treatment. (Public Law 114-223)

These services have been added to the suite of infertility evaluation and treatment services covered by VA, including testing, hormone therapies, corrective surgeries, ultrasound evaluations, intrauterine insemination, cryopreservation and storage of embryos and gametes. (Public Law 115-141)

Veterans with questions about these services are advised to visit VA's website for **in vitro fertilization services** or contact the Women Veterans Call Center at 1-855-VA-WOMEN.



COURTESY OF THE U.S. CONGRESS

SEN. TAMMY DUCKWORTH

On Nov. 12, 2004, I came within inches of losing my life while piloting a Black Hawk helicopter over Iraq. Out of nowhere, a rocket-propelled grenade tore through my aircraft, costing me both my legs, my career as a military pilot and, I assumed, any hope I had of starting a family.

I was wrong. Ten years later—to the week—I gave birth to my first daughter, Abigail.

To me and my husband, her birth was a miracle. After years of trial and error, of getting our hopes up and then dashed, we conceived Abigail through IVF treatments.

But even as a congresswoman (at the time), the process of getting—not to mention paying for—IVF was about 100 times more complicated than it should've been.

Like so many other women early in their careers, I waited to have kids. Then I got deployed. And then I got shot down.

By the time I got out of Walter Reed and was eager to start a family, my injuries made it next to impossible to conceive. So I went to my local VA and asked for help, only to be sent right back out the door, told that the VA wouldn't give me the treatment I needed, that they didn't provide those services.

I'm thankful that my husband and I ended up being able to scrape together enough money to pay out of pocket for IVF, and I'm glad that in the years since the VA has started covering IVF.

Now I'm using my own experiences—my own frustrations and my own two miracles, Abigail and Maile—as inspiration. Inspiration to keep pushing for better legislation, for rallying my colleagues and for doing whatever it takes to ensure that red tape doesn't prevent or delay even a single other veteran from having her own little miracle, too.

care were satisfied with it (compared to 70 percent in fairly scant research of transgender civilians). But the survey still found areas for improvement, with ethnic minorities and lower-income veterans more likely to be dissatisfied, and high delay rates for mental health and medical care (though not statistically significant due to the small sample size of the study).⁴² VA still scores highly in the most recent survey, with 97 participating facilities (the most of any public, private, for-profit or nonprofit health care network), with 59 of these facilities rating as equality leaders (60 percent), but the drop in participation suggests that VHA may need to re-emphasize health care equity for LGBT veterans.⁴³ Some studies have shown that LGBT veterans are at twice the risk of suicidal ideation compared to heterosexual peers and are more likely to screen positive for post-traumatic stress disorder, alcohol misuse and depression. Those compelled to hide their sexual orientation during military service were also more likely to screen positive for depression and PTSD.



JAMIE FOX | Navy veteran

COMPREHENSIVE PRIMARY CARE FOR WOMEN VETERANS

VHA has advanced women's care by including women's needs in comprehensive primary care and patient-centered medical home programs (called Patient Aligned Care Teams). Such teams are designated women's health providers and have integrated mental health services and clinical, pharmacist and social work support. VA has established mini-residencies to train additional designated women's health providers. Some clinics are organized as specialty women-only services with separate waiting rooms and even separate entrances to the facilities. However, most primary care or Patient Aligned Care Teams see both men and women, which often results in smaller numbers of women on a provider panel. In a 2017 report, the VA inspector general found that most designated women's health providers (53.9 percent) had fewer than 10 percent of women comprising their panels. In addition, many such providers (55.7 percent) did not document how they met VHA criteria for proficiency in providing gender-specific care.⁴⁴ These numbers indicate VA should reconsider how to ensure designated women's health providers have the requisite skill set to provide care to women in locations where few receive care.

Women may be given a choice about the model of primary care that suits their individual needs and preferences. Women veterans seen by a designated women's health provider reported a higher overall positive experience with VHA health care, as judged by patient satisfaction metrics (including Survey of Healthcare Experiences of Patients, Consumer Assessment of Healthcare Providers and Systems, and Patient Centered Medical Home measures).⁴⁵ Women veterans thought these providers spent more time with them and therefore the women were more satisfied with their care.⁴⁶ Gender-specific cancer screening occurred more consistently for women seeing a designated women's health provider—94.4 percent received mammograms and 91.9 percent completed cervical cancer screening, compared to 86.3 and 83.3 percent, respectively, for other VA providers.⁴⁷ Women veterans value the communication and coordination of care and the innovative delivery models offered to them, including the personalized context of military-sensitive and gender-specific care.⁴⁸ This coordination extends to phone support. Of women VA users, 63 percent indicated they got the support they needed over the phone, which correlated with a higher overall perception of access and care coordination among these veterans.⁴⁹ Users of women-only clinics also



reported a higher satisfaction with the respect they received from not only clinicians but also clerical and support staff. Women veterans who were satisfied with their VA primary care used VA more frequently.⁵⁰

Although VA has had success in establishing a network of effective gender-sensitive care, there is still room for improvement. This system of care for women is embedded in a larger system that is struggling with fundamental organizational and clinical support deficiencies that impact the ability of first-line providers to deliver the care patients need, as has been widely reported.⁵¹ VA has an antiquated scheduling system that makes it difficult to organize care for patients; suffers from inadequate ancillary staffing to support physicians in providing efficient care; has issues with customer service, particularly among clerical staff; and sometimes lacks adequate space and equipment to support clinical delivery. Women veterans and their providers experience these same deficiencies. For instance, in VA's own study of barriers to care for women veterans, 60 percent were satisfied with access to primary care appointments, 71 percent with access to women's health services and 70 percent with access to mental health. However, the largest number of spontaneous written comments focused on the archaic scheduling and appointment confirmation processes and interactions with clerks around these functions.⁵²

Interviews with women's health primary care providers reveal layers of organizational constraints that impact care delivery.⁵³ Providers report that the push for 30-minute clinic appointments was inadequate to meet all of the needs, including pap smears and breast exams, of the women patients they see. (VA women's health policy permits longer appointments and smaller panel sizes for women veterans, but this allowance doesn't appear to have penetrated into practice at all VA facilities.) Importantly, providers also criticized the failure to have adequate and fully trained clinical support teams to ensure equipment, processes and clinic flow worked effectively and efficiently to meet the needs of women veterans during their appointments. They also noted the perennial issue of poor scheduling and organizational systems to ensure women veterans were seen when needed and that clinical providers knew in advance what services these veterans required at the scheduled visit. For instance, VA requires that a woman observer be present in the exam room when a pelvic examination is performed; however, clinicians rarely knew that one was required until a clinical reminder appeared on the screen, thus requiring them to leave the exam room and find a woman who could observe the exam.⁵⁴ A comprehensive electronic women's health package with flexible, integrated scheduling and panel management could



BELINDA HILL

DAV National Service Officer Belinda Hill spent 30 years in the Army. When she retired from the service in 2009, she began to use VA services in New Orleans.

“We didn’t have a VA hospital; we had a VA clinic,” she said. “We now have a hospital, and there’s a big difference.”

Hill said while she was a patient at the clinic, they would give her a new primary care doctor every six months. She said she never felt comfortable because every time she’d go see the doctor, it was like starting over with her care. However, she said the VA hospital has given her the positive experience she’d originally expected.

“It’s very patient friendly,” said Hill. “When you walk in, there’s always someone with a friendly face helping you find where to go.”

Even though Hill said she gets most of her care through the VA hospital in New Orleans, it doesn’t seem like they considered the needs of women veterans when they built the new facility.

“They need to look more into the needs of women veterans and the specific things women need,” she said. “They send us out [to community care] to deal with a lot of female issues, and that’s a bad thing.”

help overcome some of these deficiencies and should be a top requirement for VA’s new electronic records system. It is also important that the women’s health package VA selected be fully compatible with that used by the Department of Defense to ensure a seamless transfer of health information between the department and VA. Experts in women veterans’ health must be fully engaged in developing requirements for and selecting information technology products so that the needs of this population are included in such decisions. One example of such a need is the alert installed by VA in 2012 to caution physicians prescribing drugs to pregnant women or those who may become pregnant about drugs that may have a deleterious impact on the developing embryo or fetus. In the future, these gender-specific functionalities need to be included in VA health care systemwide.

Finally, some VA primary care providers indicated that, despite the specialized training and women’s health mini-residency programs, they still didn’t feel adequately prepared to care for women veterans and particularly felt uncomfortable with their competency to work with women who had experienced sexual trauma.⁵⁵

VHA can also improve its organizational oversight to consistently ensure the privacy, safety and dignity of all women patients. In 2016, the Government Accountability Office found inconsistent adherence to VA policy on the environment of care for women veterans. In all six VA medical centers inspected during the study, adherence ranged from 61 percent of the requirements met to 85 percent.⁵⁶ Outpatient clinics consistently had the lowest level of compliance, meeting on average only 74 percent of the standards examined. The most frequent deficiencies included a lack of auditory privacy in check-in stations and in procedure and testing rooms, and a lack of privacy curtains in exam rooms or curtains not situated to provide privacy during an exam—especially during pelvic exams. Sanitary products and trash bins were also not found in the restrooms used by women patients. A 2017 VA inspector general study found that women who were inpatients most frequently complained that their rooms could not be locked from the inside.⁵⁷ Finally, facilities also failed to restrict access to the clinic areas to allow only patients, their loved ones and staff to enter the area.⁵⁸ These findings are disturbing since the 2016 report was a follow-up to a GAO evaluation completed in 2010 that found a number of similar weaknesses in environment of care measures for women. Making some of the changes is relatively simple and therefore may suggest that medical centers have not prioritized even these basic needs of women



A woman veteran is fitted for a wheelchair at the VA Sierra Nevada Health Care System in Reno, Nev. Enrolled patients at VA medical centers can now schedule appointments directly with amputation care and wheelchair clinics, without having to first see a primary care provider.

veterans.⁵⁹ For example, changing the position of exam tables to promote privacy, adding curtains, and stocking bathrooms with trash cans and feminine hygiene products does not require significant dollars or time. The Veterans Canteen Service or Voluntary Service, no doubt, could provide the necessary feminine hygiene products and lidded trash cans as a donation to women veterans' clinics if funding is an issue. The failure of so many outpatient clinics to address these simple needs is discouraging.

At a time of rapid and significant change within the VA system to improve administrative functions and integrate care with community providers, it is critical VA keeps the needs and interests of women veterans central to planning and decision-making. As women veterans are a minority population within a larger male-dominated system, their needs can inadvertently be overlooked if vocal and knowledgeable advocates are not present and involved at all levels of organizational decision-making. For this reason, it is imperative VA continues providing specific-purpose funds for women's health activities directed by the Office of Women Veterans Health Services. Without adequate funding, this national program office will be unable

to continue efforts to target underperforming facilities and Veterans Integrated Service Networks for additional education and quality improvement interventions or conduct analysis and training development to target emerging and overlooked needs for women veterans.

- **Recommendation:** The VA undersecretary for health must hold VA facility leaders and directors accountable for meeting women veterans' standards of care for quality, privacy, safety and dignity, which includes ensuring these standards are applied in all primary care and specialty care clinics (for example, prosthetic clinics where women fit and adjust their prostheses). Leaders who do not meet these standards must not be eligible to receive an outstanding performance rating.
- **Recommendation:** Specific-purpose funding for the Office of Women's Health Services must be maintained to ensure that women's health training, culture change, leadership coordination, standard setting, information technology development, and identification and prioritization of research needs related to women veterans continues without interruption.

COMMUNITY CARE

The Veterans Access, Choice and Accountability Act of 2014 (also known as Choice) mandated a new program of purchased care to expand access to care for veterans into the community, alleviating an internal lack of capacity in some VHA facilities.⁶⁰ The deficiencies in Choice are well documented.⁶¹ VA has learned valuable lessons from its efforts to continuously improve the Choice Program over the past few years and has proposed important changes to the program to try to address administrative, capacity and quality deficiencies.⁶² As VA implements these reforms, DAV maintains the primary focus should always be on the best possible health outcomes for ill and injured veterans. An integrated health care system with VA as a primary provider and

coordinator of care, including community care as a supplement offers all veterans the best opportunity to achieve their maximum health potential.⁶³ The future shape of veterans care in the community will now be underway with the passage of the VA MISSION Act of 2018, signed as Public Law 115-182 on June 6, 2018. We focus here on the particular needs of women veterans and highlight potential vulnerabilities they face in this shift toward providing more care for veterans in the community.

The model for community care put forward by VA⁶⁴ includes a number of key elements that are important to understand as we discuss women veterans:

- VA aims to create local high-performing networks in regional markets around the country. Discussions about what services to purchase and which to keep in-house with VA providers will occur locally under the direction of medical center leadership as they assess how best to meet the needs of their service population in the local market. A key requirement of that network is to ensure veterans have timely access to the services they earned under the uniform benefits package.⁶⁵
- VA has defined a set of foundational services they should retain and continue to build internal capacity and competency to deliver. These currently include primary care such as women's health,⁶⁶ mental health care; urgent care; geriatrics and extended care; rehabilitation services; care coordination; post-deployment health services; and pain management.⁶⁷ All other services offered in the medical benefits package would be assessed on a market basis to determine whether they should be purchased in the community or delivered by VA clinicians.
- The program for community care envisions that each facility will establish a robust care coordination function to support and manage veterans care when it is purchased. The vision is to establish a stepped care function from basic coordination of appointments and records transfers for simple authorizations to complex clinical care management. This would include clinical assessment and support in addition to coordination of records and communication. Care management would be targeted to those veterans who require complex care, such as those with a cancer diagnosis, kidney failure or traumatic brain injury.
- Providers offering services through care in the community are to be assessed and prioritized for ongoing inclusion in the VA network based on quality measures for both administrative



JOANN MARTINEZ | Air Force veteran

(e.g., timeliness) and clinical quality. This component of community care is still being developed by VA. As part of the process, VA envisions maintaining simplified referral and approval processes such as care bundles that are consistent with best-practice standards.

As we examine the needs of women veterans against this model for community care, there are a number of concerns to highlight. First, as noted earlier in this report, most women veterans who use VA care have complex needs. For instance, they have higher levels of musculoskeletal issues, mental health requirements and substance use than their male counterparts. Further, 1 in 4 have experienced military sexual trauma. Of care recipients ages 18 to 44, 73 percent have a service-connected disability; more than half of these veterans complete 12 or more visits with VA providers each year.⁶⁸ Women veterans also die younger than their civilian counterparts and rate themselves lower on assessments physical and mental health.⁶⁹

With such complex needs and vulnerabilities, women veterans can benefit greatly from VA's integrated approach to care, benefits and services, (which include primary care) comprehensive mental health care, women's health services, peer counseling and transition services, as well as supportive housing and employment services. Indeed, VA primary care, including the model of primary care and mental health integration, is used as the hub around which services are organized and where patients who need

additional services are identified and guided to other programs. Approaches to improving access that increase reliance on providers outside VA may prove counterproductive if they compromise the team's ability to coordinate care or diminish the team's role as a primary point of contact for patients.⁷⁰ The social workers and mental health providers embedded in VA Patient Aligned Care Teams ensure the full range of services are offered to veterans. This approach to care for veterans has been demonstrated to improve access and engagement with mental health services.⁷¹ At present, outside providers are not prepared to take on the complex challenges of caring for and coordinating care for women veterans. In a recent RAND study of New York state, only about 2 percent of private-sector providers had the knowledge and skills to provide high-quality care to veterans.⁷² Quality was defined as applying clinical practice guidelines; routinely screening for common conditions in veterans; accommodating patients with disabilities; familiarizing with military culture and screening for military service and deployment health concerns. Given how unprepared the private sector is to provide integrated primary and mental health care services, it is imperative that women's primary care and women's mental health care are clearly defined by VA leadership as foundational services that every VA medical center provides in-house.

The VA MISSION Act of 2018 requires VA to establish competency standards for non-VA providers

Maternity Care Coordination

VA does not provide obstetric care for women veterans at VA medical centers. Rather, VA purchases care in the community for women veterans who need it. However, **VA patients frequently have diagnoses that create challenges during pregnancy.** These include anxiety (21 percent), depression (28 percent), post-traumatic stress disorder (19 percent), musculoskeletal problems (17 percent), neurological issues (10 percent) and endocrine dysfunction (10 percent). PTSD, for instance, has been associated with a higher risk of spontaneous pre-term births, more antenatal complications and extended length of stay in the hospital postpartum. Overall, women who receive VA-sponsored maternity care have a higher-than-expected incidence of pre-eclampsia, fetal growth restriction and placental abruption.

To address these complexities and support the **44 percent increase in authorizations for maternity care** in VA between 2011 and 2016, the department has created a robust model of maternity care coordination.

Each VA medical center has a maternity care coordinator who is responsible for:

- Facilitating communication between VA clinicians and community providers of maternity care.
- Ensuring record transfer both to the community and back to VA.
- Providing support and education to pregnant women veterans.
- Screening for postpartum needs.
- Confirming follow-up care in VA is re-established.

in treating veterans for injuries and illnesses that the department has a special expertise in, such as post-traumatic stress disorder, traumatic brain injury and military sexual trauma. VA is also directed that all outside providers, to the extent practicable, meet these standards before furnishing care. VA should ensure that a program is established to provide continuing medical education to non-VA providers so they are competent to provide care for the common mental and physical conditions of women veterans. Prior to the passage of this legislation the VHA Office of

In a recent RAND study, only about **2 percent** of private-sector providers had the knowledge and skills to provide high-quality care to veterans.

Community Care attempted to prepare community providers to see VA patients by offering training online for these clinicians.⁷³ These training resources include examples of women veterans and discussion of military sexual trauma and its impact. However, none of the training resources or reference materials were readily identifiable as specific for the care of women veterans. In particular, there was no training that highlighted risk factors and health impacts common among the VA female patient population. The Office of Women's Health Services has many such resources available on their internal resource page that, if made available to community providers, could help support their work with women veterans. The VA MISSION Act of 2018 requires that VA offer training to community providers. The department should ensure that this training clearly includes robust resources on the diagnosis and treatment of conditions associated with women veterans.

During a time of radical change at VA, it is critically important that leadership clearly articulate the importance of maintaining access and services for women veterans. As local medical center directors make decisions about what services to keep in-house and what should be purchased in the community, essential services that are important to

a small minority of their service population—like women veterans—may easily be overlooked. DAV is concerned that medical center leadership has not understood and aligned all of the requirements and expectations for women's health services found in policy,⁷⁴ nor set up a systematic approach to ensure that these requirements are adhered to as the delivery system is redesigned. It is the responsibility of VA leadership to ensure that women veterans' images and needs are included in all aspects of the department, from brochures and educational information to policy and all clinical guidance. The fact that the newly published VA strategic plan⁷⁵ fails to use the words "woman" and "women" anywhere in the main body of the plan indicates that the needs of women veterans have not been articulated as a high priority for the department as it moves forward with major improvements. Women seem to be literally an afterthought in the plan, appearing only in the appendix.⁷⁶

A recent study of the Veterans Choice Program may serve to inform implementation of community care under the VA MISSION Act of 2018. Because their need for gender-specific care is not always offered by VA, women on average use almost twice as much contract care as men under VA's community care program. Women veterans indicated they had significant problems in understanding eligibility for the program, scheduling care and learning the results of diagnostic testing from providers in the program. In addition, some women veterans complained that VA's tardiness in paying bills for their care affected their credit.⁷⁷ In drafting regulations for implementing the VA MISSION Act of 2018, VA must identify and address the issues that women identified as problems with the Choice Program.

The Government Accountability Office also recently published findings of wait time studies for the Choice Program. The office, working with the VHA, identified lag times both within VA in making referrals and sharing patient information and with the third-party administrators in scheduling appointments and contacting veterans to confirm appointments. These lag times lengthened wait times for contract care well beyond the 30 days required by law.⁷⁸

As part of communicating the importance of maintaining women's access to needed services, VHA leadership should also ensure that clear standards define "network adequacy" for women's services within contracts for community care. For instance, if mammography is being purchased in the community, as part of a contract, VA must establish a standard quantity and geographic distribution that

is adequate to serve women veterans in the region. If contractors are unable to meet these adequacy standards or maintain them over the life of the contract, VA should identify specific consequences for the contractor. Particularly in markets with few women veterans or for services that are rarely used, like in vitro fertilization, there may not be sufficient market incentives through reimbursement alone to ensure network adequacy without considering penalties for the contractor.

To ensure high-quality network providers, VA plans to use clinical quality measures, working with Medicare to determine this measure set. For women's health services, where the needs of the population changes over their life, VA will need to work with additional stakeholders like the National Quality Forum, American Cancer Society and Medicaid to identify appropriate measures. For instance, the forum has endorsed standard measures for cervical cancer screening, osteoporosis and C-sections.⁷⁹ In the case of mammography, Congress has dictated that VA use American Cancer Society screening guidelines⁸⁰ and has specifically prohibited VA from obligating or expending funds that would contravene use of these guidelines.⁸¹

Finally, the inclusion of care coordination and complex care management in the community care model is critically important for all veterans, most especially women. VA women's health offers a robust model of care coordination for maternity care that can be used as a model of how to structure and deliver care coordination for extended episodes of community health care. As a basis for this care coordination model, VA published in 2018 an updated evidence-based pregnancy care clinical practice guideline at www.healthquality.va.gov. All providers serving women veterans should be required to adhere to these patient-centered, evidence-based clinical practice guidelines.

VA currently reimburses care for newborns for seven days, unless there is a specific service-connected disability that qualifies the child under VA's Civilian Health and Medical Program.⁸² In the private sector, newborns are covered for up to 30 days under the mother's insurance.⁸³ Congress has shown interest in extending the number of days VA reimburses for newborn care and to pay for transportation of a newborn to another facility when the current facility cannot provide an appropriate level of care, or in the case of an emergency. Because of women veterans' risk for adverse health or pregnancy outcomes due to service-connected or other disabilities, extending coverage for women veterans' newborns would result in a more robust and equitable benefit.



SONYA NUNEZ

When Air Force veteran Sonya Nunez learned the Department of Veterans Affairs would begin assisting veterans with in vitro fertilization reproductive help, she was elated.

Under the Continuing Appropriations and Military Construction, Veterans Affairs and Related Agencies Appropriations Act of 2017, veterans who have sustained injuries that leave them unable to have children can receive assisted reproductive technologies help, including in vitro fertilization treatment.

But Nunez soon discovered that even though she was fully qualified to receive the benefit, VA was not prepared for her to take advantage.

Nunez lives in Arkansas, where the only fertility treatment center available couldn't accept the payment from VA because the offer amount was too low. As a solution, Nunez and her husband were sent to Dallas—a five-hour drive from their home—to undergo the lab work and testing needed.

"I think people don't understand that IVF isn't a simple procedure," said Nunez. "The lab work is very time sensitive. For me to go to Dallas to have it done, I had to take two weeks of unpaid leave, because I had to stay during the duration."

If Nunez could have gone to a local facility, she said she could have taken labs as needed and been ready to undergo the procedure when her body was ready, and not be stuck in another city hoping for the best.

"I just don't understand how [VA was] willing to pay for me to go back and forth to Dallas, and yet they couldn't negotiate a contract with my local facility," added Nunez. "I don't think anybody thought about how much time veterans would need to take off work to travel for this kind of procedure. I think this is a great program. I would have loved to benefit from it, but I couldn't keep driving all the way to Dallas."

After three attempts at in vitro fertilization in the Dallas facility, Nunez said she has given up on trying to utilize the program.



BRENDA REED

When Brenda Reed was a young Army private stationed in Germany, she was issued combat boots made for men. Reed served from 1978-1984, when women were relatively new in the regular Army, and it was fairly common to be issued men's gear.

Not long after, she broke her foot in four places while running on cobblestone streets in the ill-fitting boots, which eventually led to the amputation of her leg.

"Through the years that followed, I would get stress fractures in the same areas over and over and I developed osteoporosis in that foot and ankle and in May 2009, I stepped down off the bottom step of a step stool and my leg shattered a third of the way up, severing my leg in half," recalled Reed.

After several major surgeries, Reed's leg was amputated. However, Reed quickly learned that VA was not as prepared to help a woman veteran amputee as they should have been.

"I got my first prosthetic six weeks after the amputation and I didn't have any problems learning to walk on it," said Reed. "But it was getting the fit, which still isn't good. I was under the impression I would be able to get a foot my size that looked similar and it was just the opposite."

Reed was given a prosthetic foot designed for a male. As a solution to the poor fit, the VA opted to shave off parts of the prosthetic rather than providing her with one created for women.

"I was told [by the VA tech] I was the only woman that he had seen and he wasn't exactly sure what to do because he had never done prosthetics for women," Reed said. "I told him it shouldn't be any different than doing it for a man. A fit is a fit. If it doesn't fit, it isn't right."

VA has a number of coordination functions and associated positions important to women veterans: maternity care coordinators, military sexual trauma coordinators, homeless coordinators, telehealth coordinators, Veterans Justice Outreach coordinators, transition care management teams and women veterans program managers. As has been recommended elsewhere for other aspects of VA administrative and clinical operations,⁸⁴ rather than merely layering on a new function, VA leadership should clearly define the roles and responsibilities of all coordination functions in the field relevant to the care of women veterans, remove role conflicts, clarify reporting responsibility and accountability, define models for how the remaining coordinators will operate, and work together to maximize function and health outcomes for all veterans. To ensure quality care, the VA Women's Health Service at the national and local level must be a member of any teams established to define these future working models for coordinating care.

- **Recommendation:** Women veterans' primary care services and gender-sensitive mental health care must be designated as essential, foundational services that VA maintains at every facility.
- **Recommendation:** Clarify roles and responsibilities for verifying that all designated women's health providers who treat small numbers of women have documented proficiencies in women's health as required by VHA.
- **Recommendation:** VA must ensure that community care contractors meet VA-established standards for adequacy of women's health services by both number and geographic location. They must also meet reasonable timeliness standards for wait times that are comparable with those of VA for routine and urgent care. Contractors who do not maintain adequate service access could potentially incur penalties.
- **Recommendation:** In drafting regulations to implement the VA MISSION Act of 2018, VA must ensure that challenges identified by women regarding their experience with the Veterans Choice Program are addressed. Regulations must include clear explanations of eligibility and identify requisite activities to develop veterans' awareness of the new community care program in addition to steps they must take to receive a referral and ultimately schedule appointments for community care. VA must establish a reasonable time line for results of diagnostic work or care to be communicated with VA and the veteran, and safeguards must be established to ensure veterans' credit is not harmed when VA is the responsible payer for care and fails to pay bills in a timely manner.

- **Recommendation:** Training offered to community care providers must include modules specific to the needs and experiences of women veterans.
- **Recommendation:** VA should ensure that all VA and community care clinicians who provide services for women veterans adhere to VA's evidence-based clinical practice guidelines and recommendations.
- **Recommendation:** Congress should extend the number of days it authorizes VA to reimburse care for women veterans' newborns.
- **Recommendation:** Performance measures should be developed to support delivery of high-quality, safe and coordinated maternity care to women veterans.
- **Recommendation:** VA needs to continuously monitor the demand for maternity care services and ensure that the need for quality maternity care services, maternity care coordinator staffing and maternity care prosthetic needs are met.
- **Recommendation:** Women veterans program managers at each facility must play an integral role in leadership assessments and decision-making about community care and services for veterans to ensure the needs and preferences of women veterans are addressed. This includes Veterans Integrated Service Networks and facility leadership utilizing women veterans program managers' expertise when working with Community Veterans Engagement Boards, academic affiliates, Vet Centers, community care and other community health and social service providers to establish local networks.

REHABILITATION AND PROSTHETIC SERVICES

While the number of women who have been wounded in action and lost limbs is small (about 2 percent in VA and the Department of Defense⁸⁵), women have unique needs when they lose an arm or a leg. In VHA, women amputees use more health care and rehabilitation services and are seen more frequently compared to men. Women are also more likely to be unsuccessful in fitting their prosthesis, experience skin problems after lower-extremity amputation⁸⁶ and have greater intensity of pain. Women with upper-extremity amputation are more likely to reject their prosthesis.⁸⁷ Women with lower-extremity amputations have higher rates of hip and knee osteoarthritis.⁸⁸ Special prosthetic needs also occur in pregnancy. Pregnant women with limb loss experience increased wear on prosthetic components and need realignment and frequent modifications as their bodies change rapidly during pregnancy. For women with above-the-knee amputations who need a caesarian section, a higher abdominal incision should be planned to avoid

irritation by the socket brim. Women also express a strong preference for privacy, modesty and a woman prosthetist during evaluation and fitting.⁸⁹

Although the number of women with limb amputations who use VA is small, across the lifespan, more than half of women (and men) in VHA care rely on VA prosthetic and sensory aids services for important devices and services.⁹⁰ In fiscal year 2016, this encompassed 233,005 women veterans.⁹¹ VA provides a wide variety of medical devices to support or replace a body part or function, from hearing aids and glasses to walkers, wheelchairs, home oxygen and other durable medical equipment. Services also cover specialized needs for women, like maternity items such as maternity support belts, breast pumps and nursing bras (four annually); post-mastectomy items such as a breast prosthesis, swimsuits and bras; and devices like an intrauterine device or pelvic floor strengthener.⁹²

VA has one of the leading prosthetic service and research communities in the world. It has been focused over the last few years on ensuring VA understands and serves the needs and preferences of women veterans appropriately. Within the VA and DOD Clinical Practice Guideline for Rehabilitation of Lower Limb Amputation, the work group of experts adopted a recommendation to incorporate gender preferences and concerns into individualized treatment plans. This was preceded by a publication from the Extremity Trauma and Amputation Center of Excellence, "A Review of Unique Considerations for Female Veterans with Amputations."⁹³

Despite this progress, VA is still having difficulty sourcing prostheses that fit women due to a lack of prosthetic options for women in the wider marketplace.⁹⁴ One avenue for alleviating this issue, 3D printing, is something both VA and DOD are actively researching through an interagency work group and ongoing collaboration with the Food and Drug Administration, and DOD at the Walter Reed National Medical Center Printing Lab.^{95,96} Walter Reed's 3D Medical Application Center uses computer-aided design and manufacturing technologies to fabricate custom medical models, implants, prostheses and prosthetic parts.⁹⁷ They have helped print custom prostheses for holding a fishing rod, wearing ice skates or getting around without strapping on full prosthetic legs.⁹⁸ The technology and lab has obvious applications for women, who often have issues with prosthetic fit, function and appearance. At a VA Innovation Creation Challenge in 2015, a team worked on an idea from veterans advocate Sgt. LisaMarie Wiley for a socket that would allow veterans to use a single lower-leg prosthesis while swapping attachments for different uses.⁹⁹ VA funding has also been received for a 2018 research

VA Prosthetic and Sensory Aids Services for Women Veterans

Woman-specific prosthetic and sensory aids service items include but are not limited to:

- Breast pumps.
- Nursing bras.
- Post-mastectomy items.
- Wigs for alopecia.
- Long-acting, reversible contraceptive devices (e.g., intrauterine devices).
- Maternity support belts.
- Vaginal dilators.

Other prosthetic and sensory aids service items:

- Orthotic and prosthetic services, including custom-fabricated and fitted limbs and supports for spine or limbs.
- Mobility aids such as walkers and wheelchairs.
- Hearing aids and eye glasses.
- Communication and assistive devices.
- Home respiratory therapy, such as home oxygen services.
- Recreational and rehabilitative equipment.
- Surgical implants.
- Durable medical equipment.

project to develop a new system to 3D print custom energy-absorbing feet to fit any shoe size that would incorporate a quick disconnect system to change foot and shoe combinations.¹⁰⁰ Until 3D printers are more widely available, women veterans with prosthetic needs should note that the 3D Medical Application Center accepts referrals for custom prostheses or attachments from any VA or DOD provider.

VA also has plans to collect data on women users of prostheses, including funding prosthetic research that will help optimize women's upper-limb prostheses.¹⁰¹ However, because VA has a very small population of women prosthetic users, VA and DOD research communities would benefit from collaborating with industry and academia to expand the number of women in the eligible research population who can be recruited to participate in comprehensive research studies to advance prosthetic science for women. VHA established the Amputee Veterans Registry to help target care and has plans for a second phase to add outcome measures to help researchers identify best practices. In 2017, VA established the Prosthetic Women Emphasis Group to also determine best practices and appropriate prosthetic needs of women veterans. Additionally, VA's Rehabilitation and Research Development Service was selected for and received funding for three studies of the needs of women veterans with limb loss.¹⁰²

■ **Recommendation:** VA Rehabilitation and Prosthetic Services should continue to highlight the needs of women amputees in research, presentations and training activities.

■ **Recommendation:** VA Rehabilitation and Prosthetic Services should continue to explore advances in 3D printing technology to provide better fitting prostheses and a wider range of customizable options for women veterans, and promote 3D printing as a treatment choice to meet the specialized prosthetic needs of women veterans.

■ **Recommendation:** Congress should clarify VA research authority to ensure that VA researchers can lead and fund cooperative research studies. Partners may include academic affiliates, other federal agencies and for-profit industry in order to advance understanding and application of prostheses for women. Civilian, military and veteran women should be used as research participants to provide an adequate research base to advance innovations.



VA provides a full continuum of mental health services to women veterans through VA medical centers, Vet Centers, community-based outreach clinics, and partnerships with other local treatment providers across the country. They also have specialty care for women with post-traumatic stress disorder and support programs for treating the effects of military sexual trauma.

The post-9/11 veteran population has a larger proportion of women than any previous era. Of post-9/11 veterans, 21 percent are women, versus 10 percent of the overall veteran population. These demographics are driving rapid change in the population the Department of Veterans Affairs serves, due in part to the fact that women use VA health care at higher rates. From fiscal years 2003 to 2012, there was an 80 percent increase in women users of VA health services, nearly 1 in 5 of whom served after 9/11. Women tend to use the full range of outpatient services and use the services more intensively than men. This includes higher use of VA mental health and substance use disorder services (37 versus 24 percent for least one service) and more intensive use of services overall (14 versus 8 percent for at least six visits).¹⁰³ Combat exposure and cumulative deployment time are among the strongest predictors of mental health need.

Effective mental health services are particularly important for women veterans using VA care. Utilization of Veterans Health Administration care correlates with women veterans who have symptoms of post-traumatic stress disorder and major depression with low incomes.^{104, 105} Between 2000 and 2015, the

proportion of women veterans seen in VHA facilities who had a mental health encounter increased from 23 to 40 percent of the population served.¹⁰⁶ In this same time period, the percentage of women veterans using mental health and substance use disorder services increased fivefold. Utilization by men in the same time period increased only twofold.¹⁰⁷ Older women veterans using VHA services also rely on them heavily, although at a lower rate than younger veterans. Among women veterans 65 and older, mental health and substance use disorder diagnoses increased from 19 to 31 percent between 2000 and 2015, propelled by diagnosis of depression, PTSD and anxiety disorder. Vietnam-era women veterans are aging into this mature population of VHA users. They have a lifetime prevalence of PTSD of about 20 percent¹⁰⁸ and, 40 years after that conflict, have a prevalence rate of active PTSD of 6 percent; one-third currently have major depression.¹⁰⁹

Among veterans, traumatic brain injury, or TBI, frequently co-occurs with PTSD. TBI is a brain insult that causes a change in consciousness and can lead to an onset of immediate physical (e.g., headache, nausea, fatigue, sleep difficulty, dizziness) and cognitive (e.g., difficulty with attention, concentration and memory)



DELPHINE METCALF-FOSTER

In 1990, U.S. Army 1st Sgt. Delphine Metcalf-Foster deployed to Saudi Arabia with a grave registration company in support of Desert Storm/Desert Shield. Their mission was to send the remains of fallen U.S. troops back to America for repatriation.

“When we first got over to Saudi Arabia, we had no blankets for the first two weeks so we had to sleep in body bags,” recalled Metcalf-Foster. “There were many times where we would wonder if we would have to go home in this blue, red or green body bag. It was very devastating, to say the least.”

Upon returning home, Metcalf-Foster said she suffered from invisible wounds that prevented her from living her life how she wanted.

She sought mental health care from her local VA in San Francisco, but was added to a mental health group of all males.

“That did not work, because a lot of their issues were not my issues,” she said.

So, VA found her a woman veteran mental health group to try. The problem there, she said, was the group was aimed at military sexual trauma (MST) survivors, and she didn’t fit there, either.

“I didn’t have MST, but I was in combat, I saw the worst of the wars,” Metcalf-Foster said. “I got together with the director at the San Francisco VA and decided to get together groups for women who were in combat to help with our specific issues and it really helped. To this day, I still go for treatment.”

Metcalf-Foster—who was elected as the first woman veteran national commander of DAV in 2017—said serving other veterans has helped her heal.

“Whether it was on women’s issues, access for women, or just in general helping veterans, being able to give back helped me overcome a lot, especially when I think about what I went through when I first came home,” she added.

symptoms. PTSD, whether co-occurring with TBI or not, can also lead sufferers to drink alcohol excessively to self-medicate.¹¹⁰ In a retrospective study of almost 1,300 Iraq and Afghanistan War veterans who sought care at a large urban VA medical center, screening for PTSD, TBI and alcohol use disorder showed that veterans with mild TBI had a higher risk of PTSD and more severe subthreshold PTSD symptoms, including more re-experiencing, avoidance and hyperarousal symptoms than veterans without.¹¹¹ In this cohort, men were more likely to be diagnosed with alcohol use disorder than women (20 versus 6 percent). They also differed in that PTSD predicted alcohol use diagnosis in men but mild TBI did not; in women, neither mild TBI nor PTSD predicted alcohol use diagnosis. In another study of Iraq and Afghanistan veterans, alcohol misuse was higher among men (20.3 versus 16.4 percent) and women (6.8 versus 5.6 percent) with TBI than without; patients under 30 with TBI had the highest rates.¹¹² Until research can better identify risk factors of alcohol use disorder for women combat veterans, providers must be vigilant and assess women veterans for alcohol use disorder, minor TBI and other mental health disorders.

Intimate partner violence is a significant health problem for women veterans. One in three women veterans experience lifetime physical and/or sexual intimate partner violence compared with 1 in 4 civilian women.¹¹³ In a web-based survey on a national sample of U.S. women veterans, more than half of the survey participants reported intimate partner violence during their lives. Of these women, 28 percent met criteria for related TBI history and 12.5 percent met criteria for related TBI with current symptoms. When adjusting for race, income and past-year intimate partner violence, women with related TBI with current symptoms were almost six times more likely to have probable related PTSD than those with no related TBI history. These findings suggest that women veterans who experience intimate partner violence should be screened for both TBI and PTSD symptoms in order to ensure proper diagnostic work-up and treatment planning.¹¹⁴ These findings also have implications for VA planning, policy and practice. VA provides routine screening of women patients for intimate partner violence using a brief validated screening tool.¹¹⁵ It is important that VA providers and social workers receive adequate training and are sensitive to the needs of women who screen positive. In one study, women veterans expressed preferences for programs that addressed physical safety and emotional health, and improved coping skills, but were not as interested in learning about

community resources. They also preferred meeting with a counselor immediately after disclosing intimate partner violence.¹¹⁶ Women veterans need support and information regarding treatment options in VA, as well as referral to community services when appropriate. VA plans to have intimate partner violence coordinators available at all VA medical centers.

VA provides initial and periodic screening to every primary care patient for depression, PTSD, military sexual violence and problem drinking. Veterans who screen positive for any of these conditions are referred to a mental health practitioner for further evaluation. The goal is to have same-day, integrated primary care and mental health practices that allow a mental health practitioner to meet with patients who screen positive before they leave the clinic. At minimum, these patients must be contacted within 24 hours for a medical-needs evaluation and receive follow-up care within 30 days if no urgent condition is identified.¹¹⁷ Integration of mental health into primary care is supported by evidence of superior outcomes for veterans requiring mental health services. Primary care mental health integration reduces wait times for mental health services;¹¹⁸ reduces the no-show rate for follow-up appointments;¹¹⁹ and improves the identification of psychiatric co-morbidities, substance use disorder and depression among primary care patients.¹²⁰ Integration also engages patients more effectively in their mental health care treatment plan. Patients seen in primary care by mental health specialists are more likely to attend future mental health appointments and participate in treatment.¹²¹ Those with depression are more likely to accept antidepressant medication treatment,¹²² and veterans with positive PTSD screenings are more likely to initiate long-term treatment when seen the same day by a mental health specialist in primary care.¹²³ VA's primary care mental health integration is an innovative, team-based approach that ensures veterans receive high-quality, coordinated, patient-centered and responsive mental health care.

VA has partnered with the Department of Defense to produce evidence-based clinical practice guidelines for major depressive disorders, substance use disorders, PTSD, management of suicide risk and opioid treatment of chronic pain. As of 2018, a new guideline is being developed for sleep disorders, including insomnia.

In an effort to improve coordination of mental health specialty care services, VHA has also recently implemented the Behavioral Health Interdisciplinary Program in its general mental health clinics. The program model assigns patients to interdisciplinary teams who collaborate to deliver a comprehensive plan for each individual's general mental health care needs. The program goal is to provide a patient-centered model of mental health care that delivers better integration of outpatient services, improved access, coordination and continuity of care. We applaud this effort and encourage VHA to incorporate this into all women veterans' specialty mental health care clinics.

The National Academy of Sciences Committee to Evaluate VA Mental Health Services conducted a survey of post-9/11 veterans, published in the 2017 Evaluation of the Department of Veterans Affairs Mental Health Services. That survey found that a majority of veterans using VA services reported satisfaction and positive experiences with VA mental

“There was a turning point in my military career at Fort Knox when I was the victim of a sexual assault. It really changed my perspective. I did not really find much support in my unit; I didn't really find much support anywhere. It was a very lonely time for me. I came back out of it, and now I'm ready to help other women who were in the same situation as I was.”

—Callie Rios, Army veteran

health care. Furthermore, the committee reported that the quality of mental health services was as good as, or better than, that available from providers in the private sector. However, while evidence-based mental health services are available to veterans and mostly comply with clinical practice guidelines and policy mandates, there remains an unacceptable amount of variability and persistent gaps in mental health service delivery across the VA system. DAV believes VA should take action to ensure evidence-based mental health services are accessible and consistently delivered to every veteran.



Data from the National Academy committee's survey of post-9/11 veterans were analyzed to compare the reasons men and women who had mental health needs reported that they did not use VA mental health care services. In general, the female and male veterans were similar in their awareness of VA mental health benefits and how to apply for them, in their trust of VA and in feeling welcome in VA facilities. One major difference was that the women were significantly more likely to report that they believed they were not entitled to or eligible for VA mental health care (52 percent of women versus 34 percent of men). The committee also found that women face unique barriers to mental health care at VA, largely related to challenges associated with being a woman in a traditionally male-dominated system, as well as issues that are specific to military sexual trauma. During interviews conducted at VA medical centers, women veterans reported frustration at having to prove they are veterans (it is often assumed that a female at VA is a wife accompanying her husband) and not being acknowledged as a combat veteran. Furthermore, women reported feeling uncomfortable in VA health facility waiting rooms, where they are outnumbered by men. Many women also reported

receiving unwanted sexual attention while in VA facilities, which can be particularly upsetting for women who have sustained military sexual trauma. In 2018, VA launched a targeted program to address this issue and ensure all women (patients and staff) are treated with respect in VA facilities. The End Harassment program was established to address sexual harassment that women veterans experience when they receive care at VA facilities. About a quarter of women report experiencing such harassment, as do about half of female staff in VHA. The intervention includes a campaign, training, reporting and feedback on program implementation reported up through the Veterans Integrated Service Networks.¹²⁴

VA policy states that "mental health services need to be provided ... in a manner that recognizes that gender-specific issues can be an important component of care." For instance, women veterans using mental health services report that their symptoms intensified during life events where hormone levels are known to fluctuate, including premenstrual (42.6 percent), during pregnancy (33.3 percent), postpartum (33.3 percent) and during menopause (18.2 percent).¹²⁵ Women veterans appreciate having gender-specialized mental health services, rating the availability of such

services as extremely important.¹²⁶ In a similar survey of women veterans in VA care, while just fewer than half reported that mental health care services met their needs, those that had received gender-sensitive care had a twofold higher perception of the adequacy of the care they received.¹²⁷

However, even with VA's policy position of providing equivalent mental health services to women veterans, they are likely not receiving all of the mental health services they require. The suicide rate for women veterans is more than two times higher than for civilian, adult women and has increased more than twice as much as the suicide rate for male veterans.¹²⁸ As determined in the recent study of post-9/11 veterans, both men and women experience an overall unmet need for mental health services.¹²⁹ The barriers that keep these veterans from seeking the care they need are well known: lack of knowledge about services and how to apply for them, poor scheduling practices and poor customer service in VHA, lack of convenience in available times and distance to care, and mental health stigma.¹³⁰ Specific studies of recent women veterans found similar results; only about two-thirds of women veterans who indicated they needed mental health care had sought it at VA,¹³¹ and the reasons for avoiding care at VA included stigma as well as past trauma.¹³² In one survey, women veterans have been critical of VA mental health services, with 48 percent indicating they didn't believe VA provided quality mental health services.¹³³

■ **Recommendation:** VA should develop a comprehensive five-year strategic plan for mental health services, as suggested by the National Academy of Sciences Committee. The plan should address becoming a high-reliability organization that provides accessible, high-quality, integrated mental health care services. The unique needs of women veterans should receive explicit attention in the VA Mental Health Strategic Plan.

PEER SUPPORT COUNSELING

VA has a robust peer support program, with more than 1,000 peer support specialists or apprentices around the country. As of May 2017, 18 percent (or 191 of them) were women. However, the distribution of women peer counselors is not actively managed by VA. Some facilities may have several women and others none.¹³⁴ The VA MISSION Act of 2018 requires VA to place peer specialists within Patient Aligned Care Teams in certain settings “to promote the use and integration of services for mental health, [substance use disorder] and behavioral health in a primary care setting.”¹³⁵ Women's comprehensive

primary care teams should be included in these placements as another opportunity to test peer support models to aid women veterans.

The use of peer counselors can help reduce stigma, increase the mental health care available to veterans¹³⁶ and improve recovery.¹³⁷ These peer staff are veterans who provide experiential, nonmedical advice and insights based on their own readjustment and recovery. Peer counselors can be especially important in the peri-injury and post-amputation surgery and limb-loss amputation period. Their ability to relate to other veterans because of shared military experiences and recovery is a key element of the program. However, in at least one survey, women veterans thought the level of services was inadequate; 86 percent thought VA did not offer enough peer mentor support, even though 50 percent would have liked to take advantage of such a program.¹³⁸

In response to a recommendation from the Advisory Committee on Women Veterans, VA Mental Health Service and Women's Health Service partnered to test the use of women peer counselors in women's health clinics at five facilities.¹³⁹ Assessment results of utilization and satisfaction are due in 2018. When publicizing the result of the pilot, VHA should clearly articulate the goals this model was intended to achieve. Women veterans want respectful, gender-specific mental health care.^{140, 141} However, it isn't clear if this pilot was intended to address these needs or had alternative goals. VA has an opportunity to add to the literature on peer support generally and on how peer counselors might contribute to improving mental health outcomes for women specifically. To date, evidence for the efficacy of peer support for recovery and improved mental health outcomes is promising but sparse.^{142, 143}

The VA MISSION Act of 2018 requires VA to carry out a program to place at least two peer specialists within Patient Aligned Care Teams in certain VA medical centers to promote the use and integration of services for mental health, substance use disorder and behavioral health in a primary care setting. Likewise, it will be necessary to ensure peers placed in these settings receive a higher level of training and certification. If the peer counselor pilots are successful, VA should include women's comprehensive primary care teams in the implementation of this new mandate.

■ **Recommendation:** VA should define specific outcome measures for the Women Veterans Peer Specialist program, including if veterans successfully connect with mental health services, whether those services include evidence-based

therapies, and whether participants had greater adherence to treatment and were more satisfied with their care. VA should also continue to evaluate a variety of models to meet needs expressed by women veterans, including the integration of peer counselors in women veterans comprehensive primary care teams.

VETERANS SUICIDE AND VA SUICIDE PREVENTION EFFORTS

Suicide is a national tragedy and a complex issue that requires a public-private approach to improve evidence-based prevention and intervention efforts. In its 2018–2022 strategic plan, VA stated that suicide prevention is its highest strategic clinical priority. In fact, VA has worked diligently with other government partners to gain a greater understanding of the epidemiology of veteran suicide and for the first time can more reliably track suicide among veterans and explore differences between veterans and civilians. This required an interagency collaborative effort with DOD and the Centers for Disease Control and Prevention, as well as state governments, to ensure that veteran status was accurately and consistently captured in national statistics. As a result of this work, VA learned that approximately 22 veterans die every day by suicide, with about six of those 22 under active

users.¹⁴⁵ Together these studies suggest that connecting veterans with VHA care may result in lower suicide rates, making improvements to mental health care access even more imperative.

The newest VA report based upon data from 2005 to 2015 found that suicide rates among veterans and service members were relatively unchanged from earlier estimates (about 20 a day). Further, it indicated that in 2015 women veterans were twice as likely to commit suicide than their nonveteran peers.¹⁴⁶ Addressing women with gender-sensitive interventions may be necessary to combat this growing epidemic.

Among Iraq and Afghanistan War-era veterans, suicide risk was significantly higher (41 percent), while the overall risk of death was significantly lower (25 percent) when compared to the general U.S. population. While women veterans have a 33 percent lower risk of suicide than men, they are still a 2.5 times higher risk of suicide than nonveteran women in the U.S. general population.¹⁴⁷ The same study found that “in both male and female veteran groups, the suicide risk was higher among younger, white, unmarried, enlisted and Army/Marine veterans”¹⁴⁸ and that neither deployment nor the number of deployments was a contributing factor to suicide risk. Having a history of traumatic brain injury has been

shown to contribute to an increased risk of suicide.^{149, 150 151}

Research shows that, nationally, 90 percent of individuals who commit suicide have mental health conditions and more than 80 percent had not received treatment at the time of death.¹⁵²

In 2013, VA and DOD produced the Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide, found at www.healthquality.va.gov. The main treatments discussed in the guideline are psychotherapy,

pharmacotherapy and electroconvulsive therapy. Thus, a primary component of suicide prevention is prompt identification of risk and entry into evidence-based treatment for the relevant psychiatric illness. Future iterations of clinical practice guidelines should also address women’s increased use of firearms in self-directed violence. Clinicians should understand that at-risk women veterans, like their male peers, should also be educated about safe storage of firearms. VA is currently studying an improved system for identifying at-risk veterans through the REACH VET program (Recovery Engagement and Coordination for Health

“Limiting immediate access to firearms for veterans in crisis can save lives. Safe gun storage is one of the most important ways to prevent suicide.”

—Russell Lemle, Ph.D.,

Chief Psychologist at San Francisco VA Health Care System

VA care.¹⁴⁴ Based on reporting from 23 states between 1999 and 2010, researchers learned that suicide rates among veterans who used VHA care decreased by 31 percent while suicide increased by 61 percent for veterans who do not use VA health care services. Suicide rates among all women veterans increased 62.4 percent between 2001 and 2014, a bigger increase than seen among male veterans (29.7 percent). Among women veterans not using VA services, the increase was 82 percent, while those using VA services did not experience an increase in suicide rate during the same period despite having more risk factors than non-VA

– Veterans Enhanced Treatment), which analyzes VA health records data to locate veterans with a statistically elevated risk of suicide and then notifies those veterans’ providers, allowing them to re-evaluate and enhance each veteran’s care.¹⁵³ As of 2018, VA is also updating the suicide prevention guideline and should make it a priority to explore the evidence and publish guideline recommendations on gender-based differences in risk, protective factors and treatment efficacy for suicide prevention.

The Veterans Crisis Line, originally called the National Veterans Suicide Prevention Hotline, is administered jointly between VA and DOD. Initiated in 2007, the crisis line can be accessed via the toll-free telephone number 1-800-273-TALK (1-800-273-8255), online chat (added in 2009) and text messaging (added in 2011). Since the crisis line was established, almost 3 million calls, 363,000 chats and 81,000 texts have been received, leading to 478,000 referrals to VA suicide prevention coordinators and 78,000 dispatches of emergency services.¹⁵⁴ For veterans and service members in crisis, it provides immediate access to support services and an urgent connection to VHA mental health services. Trained crisis line staff members address mental health concerns directly with service members and veterans, or give advice to their family or friends.

A new VA program for veterans with an other than honorable discharge was recently established. Individuals requiring emergency mental health care can receive full access to comprehensive mental health services, including inpatient mental health care and follow-up outpatient, residential and substance use disorder service for up to 90 days. If long-term treatment is needed, VA will coordinate a transition to community-based care, but it does not have the legal authority to provide ongoing care to veterans with other than honorable discharges at VA’s expense.¹⁵⁵ VA should evaluate the impact of these programs in terms of suicide prevention and mental health outcomes and inform Congress of its findings.

VA has taken a multipronged approach to research on suicide and suicide prevention. It funds investigator-initiated projects through the Office of Research and Development as well as supports a Center of Excellence in Suicide Prevention and Veterans Integrated Service Network 19’s Mental Illness Research Education and Clinical Center on suicide prevention. Peer-reviewed research on suicide interventions has conclusively demonstrated that restriction of access to lethal means is one of the few effective suicide interventions. A systematic review on suicide prevention concluded that of the methods used for reducing suicide risk (mass



MARY DEVER

In May 2012, Air Force Staff Sgt Mary Dever found herself struggling to adjust following her recent deployment to Afghanistan. Dealing with the residual effects of a military sexual trauma and combat trauma, Dever felt overwhelmed by thoughts and feelings uncharacteristic to her nature.

“I confided in my supervisor that I had a hard time sleeping and couldn’t get certain images out of my head,” said Dever. “My rational mind knew they weren’t real, but something inside me would startle as though they were happening at any given moment.”

Her supervisor intervened and called for help. Dever was taken by ambulance to Walter Reed National Military Medical Center where she was involuntarily committed to the inpatient psychiatric unit for a five-day observation.

“They tell you to seek help, so I did, but in a way, being taken away like that was traumatic in itself,” she said. “I felt angry and betrayed, even though I see now it was for my own safety.”

Dever separated from the military in 2015 and started receiving mental health treatment from VA. It wasn’t until she met her current care team that she truly started to feel like she was healing.

“I didn’t trust anyone anymore after that initial experience,” Dever said. “Who was to say it wouldn’t happen again? It took a while for me to trust that my therapist wasn’t going to have me committed for anything I told her. Once I started trusting her, I was finally able to get the help I desperately needed.”

media, community, family education, provider education, lethal-means restriction and screening programs), restricting access to lethal methods and the education of physicians in depression recognition and treatment were effective means to prevent suicide.¹⁵⁶ Consistent with these findings, VA has distributed over 3 million gunlocks nationwide since 2010 and disseminates a safety video and brochure on safe gun storage, found at veteranscrisisline.net/support/shareable-materials.

■ **Recommendation:** As VA develops its update of the Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide, the work group should assess the scientific basis and publish guideline recommendations on gender-based differences in risk, protective factors and treatment efficacy for suicide prevention.

■ **Recommendation:** As part of a comprehensive suicide prevention strategy, VA should aggressively promote routine screening for mental health conditions and suicide risk; improve access for women veterans to evidence-based treatments; and promote harm reduction strategies, including education of providers and family on how to talk to a veteran in crisis or at risk for suicide about safe storage of firearms.

EATING DISORDERS

Studies indicate a significant prevalence of eating disorders among veterans and military men and women.¹⁵⁷ Women and girls who experience sexual trauma are prone to developing eating disorders that may manifest many years after the assault.^{158, 159} Survivors of military sexual trauma similarly develop eating disorders in response to assault.¹⁶⁰ Eating disorders have significant physical and psychological consequences, and if not successfully treated, prolonged disrupted eating can result in a wide variety of dangerous health conditions, including gastrointestinal disorders, stomach and esophageal ruptures, seizures, sleep disturbances, insulin resistance, irregular heartbeat, heart failure and death.¹⁶¹ In recognition of the importance of identifying and treating veterans with eating disorders, VA mental health leadership has developed 10-week, multidisciplinary, outpatient treatment team training, delivered remotely by video conference. The curriculum covers the problem of eating disorders in veterans, teaches Enhanced Cognitive Behavioral Therapy, reviews screening approaches and psychological assessment and approaches to psychotherapy, introduces dietitians' role and treatment techniques, covers medical complications and therapy, and examines relapse prevention and

follow-up.¹⁶² Three teams were trained on a pilot version of the curriculum in 2016 and 10 in 2017, with more trainings and analysis of the pilot curriculum planned for 2018.^{163, 164}

■ **Recommendation:** Ensure women veterans and their clinicians are aware of available VHA resources for treating eating disorders and continue training clinicians about the clinical implications of eating disorders.

SUBSTANCE USE DISORDERS

Substance use disorders are considered to be a significant problem among military veterans and associated with a number of issues that negatively impact health, mental health, relationships, employment and housing. About 15.3 percent of men and 7.2 percent of women using VA health care services have a substance use disorder.¹⁶⁵ Substance use disorders among recent war veterans are often co-occurring with other mental health conditions such as post-traumatic stress disorder, anxiety and depression. Cumulative deployment time, combat exposure and post-deployment reintegration challenges are all predictive of an increased risk for developing a substance use disorder. Substance use often contributes to suicide or suicidal ideation, with 30 percent of completed suicides preceded by alcohol or drug use.¹⁶⁶

In recent years, rates of problematic substance use among female veterans have been increasing.¹⁶⁷ While men have greater rates of addiction than women, many women veterans have characteristics that make them more prone to substance use disorders than men, including past trauma (physical and sexual).¹⁶⁸ Women veterans using VHA services are known to have a greater need for mental health services (37 percent of women versus 24 percent of men having at least one mental health need) and to use mental health and substance use disorder services more intensively than male peers. Women, in general, also have a higher prevalence of chronic pain than men. Military prescriptions for pain relievers quadrupled during recent deployments, and long-term use of opioids is associated with addiction or misuse of the drug.¹⁶⁹ Women are also more likely to misuse substances when life circumstances such as divorce, death of a partner or employment status change.

These complex problems are ideally addressed by a system, like VA, that provides comprehensive services including health care, mental health and peer support services, specialized rehabilitation programs, housing assistance and vocational rehabilitation. VA uses a range of interventions to reduce substance use among this population, including preventative screening; motivational interviewing techniques;

web-based interventions; evidence-based behavior and pharmacological treatments including Naloxone, a prescribed medication used in emergencies to reverse opioid poisoning, as well as substitution and withdrawal medications. Veterans also have access to residential treatment programs; however, environment of care standards, including safety issues, still exist for women patients at some facilities. A recent VA inspector general report found that women inpatients' most frequent complaint is that the door to their rooms did not lock.¹⁷⁰ It is unclear the extent to which VA makes restrooms and shower facilities available exclusively to women within these programs.

While research indicates 7.2 percent of women using VA health care services have a substance use disorder, little is known about the capacity of VA to meet the needs of women with substance use disorders. In a comparative study looking at the percentage of VA facilities offering special programs or groups exclusively for women versus other facilities offering such treatment, VA had the lowest proportion of programs for women, at 19.1 percent (compared to 31 percent). However, VA offered an average of five key supportive services for women, including child care, domestic violence counseling and transportation assistance, which was significantly higher than the averages for other federal, local and for-profit facilities.¹⁷¹ Current VA guidance for substance use services states, "Programs are strongly encouraged to make available gender-specific services when clinically needed for veterans with [substance use disorder] including services for those with consequences of Military Sexual Trauma."¹⁷²

VA providers with expertise in women's health are more likely to be conscious of and sensitive to women's minority status within the military and VA. Likewise, VA's ability to offer more gender-tailored substance use disorder treatment services could help to decrease stigma and increase treatment utilization, attendance, and the overall satisfaction rates and feeling of comfort among women veterans who need this care.¹⁷³ Researchers found that women receiving care at VA medical centers that offered specialized services for women were more likely to engage in treatment and were more receptive to substance use disorder treatment when gender-specific care options were accessible.¹⁷⁴ However, one recent study indicated that primary care clinicians identified insufficient resources and knowledge about care options and referrals as barriers to helping women connect with necessary care.¹⁷⁵ VA must improve training for primary care providers to ensure they are comfortable talking about these sensitive issues and are knowledgeable about services and referral options.



CALI MULLINS

Cali Mullins spent her 20-year career in the Navy solving problems—fixing airplanes, executing emergency management plans and resolving logistical issues. After the military, she went on to work helping homeless veterans struggling with addictions and mental health issues.

"I feel like substance abuse is a big issue for women veterans, and it doesn't get the same amount of traction," said Mullins. "It's much easier for men to come in and say they have an addictive issue and receive treatment and it's OK."

Mullins, who herself struggled with addiction for years, noted that of the dozens of clients her organization helped, only a handful were women and many of them conveyed a sense of feeling alone. She said those clients were very happy to interact with her as a woman and as someone who personally understood mental health challenges.

"It's very hard for a woman to go into a room full of men and say, 'I have an issue and I need help,'" said Mullins. "Women—especially military women—are expected to do so much and fill so many roles and be as strong as men. You almost can't put yourself in a position where you're vulnerable, because vulnerability equals weakness."

Being able to trust those around you and fostering a culture where women don't feel isolated are two areas Mullins noted are critical for veterans to get—and stay—better.

"Women veterans feel terribly isolated," said Mullins. "But I can fight to make sure that the women who come after me have it easier and feel more welcome and have that sense of community that we had in the military."

Likewise, VA must use innovative approaches to increase same-sex programming for women veterans.

- **Recommendation:** VA should ensure women veterans have timely access to a full spectrum of integrated substance abuse treatment services, from detoxification to rehabilitation.
- **Recommendation:** VA should increase the availability of gender-exclusive substance use disorder programming and ensure all programming venues comply with environment of care standards for women's privacy and safety.

MILITARY SEXUAL TRAUMA

In this #MeToo moment in history, it shouldn't be necessary to state that sexual harassment and assault are intolerable crimes and the antithesis of the military values of honor and respect. Yet in 2016, 1 in 23 military women survived sexual assault,¹⁷⁶ 1 in 5 active-duty women reported they experienced sexual harassment or a sexually hostile work environment,¹⁷⁷ and 1 in 4 women veterans reported they suffered sexual trauma while serving in the military. In fiscal year 2017, the military recorded a total 6,769 reports of sexual assault, an increase of nearly 10 percent compared to the 6,172 reports made in 2016.¹⁷⁸ The impact of military sexual trauma, or MST, is both immediate and lasting—many continue to fight to overcome the mental and physical impacts of these crimes every day.¹⁷⁹

Military women who experience sexual assault, battery or harassment may respond by requesting a change in duty station or a change to assigned duties to distance themselves from the perpetrator or the memory of the attack, even if the request is disadvantageous to their career advancement. Work performance may deteriorate suddenly without explanation, behavior may change, and they may become depressed or self-medicate with drugs or alcohol. Any of these reactions can harm a service member's career or, indeed, end it.¹⁸⁰ Survivors of MST are at increased risk for depression, alcohol abuse and PTSD, and report more chronic health problems and a greater degree of impaired health than other women veterans.¹⁸¹ This impact isn't confined to the survivor alone but can affect interpersonal relationships as well, affecting marriages and impeding trust, socialization and healthy sexual relationships.^{182, 183}

MST has an economic cost in addition to an emotional one. RAND estimates the total cost to the U.S. economy of disclosed and undisclosed cases in a single year to be \$3.6 billion.¹⁸⁴ Costs to the U.S. taxpayer include the health care costs associated with MST, as well as payments made as veterans benefits to survivors. Veterans can also feel an economic cost as a result of diminished function, depression or PTSD that impede their ability to contribute to their fullest economic potential.

Service Branch Response to MST



ARMY SHARPE (Sexual Harassment/Assault Response and Prevention) includes the I. A.M. Strong campaign to “Intervene, Act and Motivate,” with messages such as “not in my Army” and “not in my squad.” The Army has also developed SHARPE training with three hours of facilitated discussion and online learning for every soldier.

sexualassault.army.mil/index.aspx



NAVY has created Live Our Values: Step Up to Stop Sexual Assault campaign and the SAPR fleetwide training, as well as training and tools targeting leadership and their role in prevention.

www.public.navy.mil/bupers-npc/support/21st_Century_Sailor/sapr/Pages/default.aspx



AIR FORCE focuses on victim support with trained staff and prosecutors, expedited transfers and periods of nonrating, as well as prosecuting 100 percent of nonrestricted reports filed.

www.af.mil/SAPR.aspx



MARINE CORPS follows the model of training, victim support and prosecution and the creation of a positive command climate.

usmc-mccs.org/index.cfm/services/support/sexual-assault-prevention



COAST GUARD

allhands.coastguard.dodlive.mil/2018/08/23/

coast-guard-releases-updated-sexual-assault-strategic-plan

With critical input from Congress and advocacy groups, DOD has acknowledged the grave problem of MST and has taken steps to stem its occurrence. In the last few years, through the Sexual Assault Prevention and Response Office at the departmental level, DOD has instituted more prevention activities, including integrating Sexual Assault Prevention and Response into military service academy training and promoting installation-level innovation and sharing of effective interventions through the Installation Prevention Project.^{185, 186} Each branch of the military has established programs to combat sexual assault and harassment involving training, culture change campaigns, victim support and accountability for perpetrators (see Page 34). In another step to help women engage in culture change, learn and support one another, DOD has fully endorsed Lean In circles for military women, requiring commanders to provide “unconditional support” including “space and time for service members and civilians to participate in the circles”¹⁸⁷ for the purposes of peer-to-peer mentoring. This support has resulted in 128 Lean In military circles with over 2,000 members.¹⁸⁸

An aggressive command posture is vital to changing the status quo. Sexual misconduct and assault don't occur in a vacuum. These crimes flourish in an environment where sexual innuendo, gender-based bullying, unfair treatment, low expectations and a fundamental disrespect for women are allowed to flourish.¹⁸⁹ Fixing this problem is about fixing the culture, and fixing the culture is the job of leaders. Military commanders must be central to creating a new culture in the military. Sexism and misogyny are observed more frequently in workplace or social situations infused by and intertwined with male identity.^{190, 191} Sexism, misogyny and sexual assault are about the dominant culture defending its position and retaining dominance and power.¹⁹² To break that cultural frame, the male leaders within it must show the way and set a positive example of inclusion and respect at all command levels. Secretary of Defense Jim Mattis, referring to sexual assault as a “cancer” within the ranks, established this expectation, stating, “We will accept no casualties due to sexual assault in our military family.”^{193, 194}

DOD commissioned the RAND Corporation to conduct a nonpartisan study in July 2016. In 1996, DOD was required by P.L. 104-201 to survey its “gender relations climate.”¹⁹⁵ It has periodically surveyed troops and published findings since that time. RAND's most recent study is the first effort to estimate the risk of sexual assault at individual military installations. RAND used the results of surveys as well as data collected at the installation



LEEIA ISABELLE

Navy veteran Leeia Isabelle survived sexual trauma during her time in the military but, like many other men and women, did not report the assault.

“I wanted to bury it, make it go away,” said Isabelle. “It was over, so I wanted to leave it in the past. But it didn't go away, and it affected my relationships with the people around me.”

Her road to recovery has been long, with periods of isolation before finally finding healing through group therapy with fellow women veterans, cognitive behavioral therapy and, ultimately, involvement with other veterans in her local area.

“When I joined DAV, I was pretty much checked out mentally; I was just going through the motions, and I wasn't really fully engaged in my life,” said Isabelle. “They helped pull me out of that shell of isolation.”

Veterans, she explained, share an unspoken understanding.

“I haven't shared too many of my experiences with other members, but I feel like they understand, and that made me comfortable and feel like I was in a safe place.”

Isabelle said her local DAV chapter commander fostered a culture of welcoming and belonging within the organization, encouraging her to reach out to other women veterans, acknowledging the importance of building a diverse network of perspectives and experiences.

“DAV is very focused on the underrepresented demographics within the veteran community,” said Isabelle. “That's what sets this organization apart from other groups for me.”

level on sexual assault and harassment to assess this risk. Although complete, the release of the report has been delayed by DOD over concerns about the study methodology. RAND said its researchers stand by the report and its conclusions, which they assert have cleared a rigorous, independent review process.¹⁹⁶ Prior to releasing the report, now scheduled for September,¹⁹⁷ DOD said it is working with RAND

“All women, particularly our women in uniform, deserve to work and live without the fear of sexual assault and harassment.”

—Lydia Watt, CEO
Service Women’s Action Network

to “better understand and validate its statistical methods used.”¹⁹⁸ We are hopeful release of the RAND report will help DOD identify solutions to ensure service members’ safety and develop an effective plan to eliminate sexual assault in the military services.

DOD has the opportunity to once again lead the country in creating workplace equity, as it did more than 50 years ago with the integration of the services and the development and advancement of people of color. It is now time to do the same for women. The military knows how to establish expectations for behavior and instill values to support them by holding leaders at all levels accountable for living, teaching and reinforcing those expectations. Top military commanders understand this and are speaking forcefully about the need to live military values.¹⁹⁹

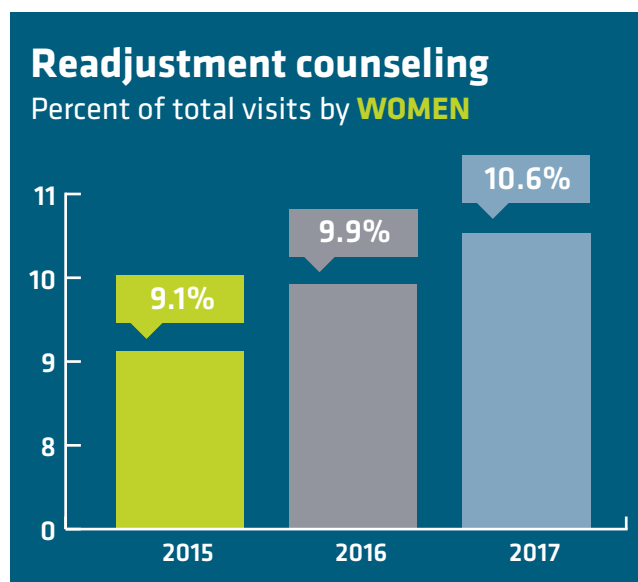
To ensure new efforts are effective at stopping sexual assault, harassment and a hostile work environment, the military should continue to draw on existing literature and best practices.²⁰⁰ However, the literature on proven interventions is thin and focused largely on college and school-aged populations as opposed to a workplace setting where leaders can either perpetuate the culture or change it. The #MeToo movement demonstrates that many industries are struggling with how to combat sexual harassment and assault and how to create an inclusive workforce that takes full advantage of everyone’s talents. DOD can lead the way by partnering with other federal agencies such as VA, the Equal Employment Opportunity Commission,

and Centers for Disease Control and Prevention as well as private-sector firms to evaluate interventions and disseminate them across the services, within government and to the private sector. Veterans and active-duty military alike are proud of their service and want to recommend a military career to their daughters as well as their sons, without reservation.

- **Recommendation:** DOD should work with other federal agencies and outside experts to evaluate and disseminate effective approaches to creating gender equity within a male-dominated workplace. Additionally, DOD should take an aggressive stand against sexual harassment and assault in the military by holding commanders accountable for creating a positive culture of inclusion and respect and sponsoring women’s empowerment.
- **Recommendation:** All service branches should aim to prosecute 100 percent of nonrestricted claims of sexual assault, as the Air Force does.

READJUSTMENT COUNSELING SERVICE

VA Vet Centers provide an important service for active-duty and transitioning warriors who may be struggling with transition or experienced MST. In fiscal year 2015, Vet Centers provided readjustment counseling to 226,000 veterans, service members and family members.²⁰¹ Of those Vet Center users, 10.8 percent were women, and that number grew to 11.3 percent by September 2016,²⁰² and 12 percent by 2017.²⁰³ Visits by women are 10.6 percent of all visits, up from 9.9 percent in 2016 and 9.1 percent in 2015. Vet Centers may provide an attractive option for women veterans because of the low barrier to entry (readjustment counseling is free with no enrollment process) but also because veterans, many of whom are women, staff the clinics. As of 2016, a full



25 percent of Vet Center staff was women who had served in combat zones,²⁰⁴ and by 2017, 42 percent of Vet Center counselors were women. Vet Centers have made feeling comfortable an integral part of the experience, both by making sure that male, female and combat veteran counselors are available and by piloting separate waiting rooms in some facilities. This program seeks out veterans where they are, with mobile Vet Centers to publicize services and community access points where veterans can see counselors outside the clinic setting. As of February 2018, 980 of these community access points were in operation around the country. The Readjustment Counseling Service provides an excellent model for how to give local leaders flexibility to address regional needs and serve the local population of veterans while making sure not to ignore minority populations like women veterans. This kind of flexibility can be key to serving women veterans at the local level.

Each Vet Center is required to create an outreach plan for the year, to show how they will address challenges and barriers to care for not only women but also other cohorts of veterans distinguished by age, race and service era.²⁰⁵

Vet Centers collect data on satisfaction with readjustment counseling services, last year collecting 12,000 customer feedback forms and showing that 97 percent of respondents would recommend Vet Centers to another veteran. While these results are impressive, the forms are anonymous and do not collect demographic information, making it impossible to assess whether satisfaction differs based on gender, race, age or era of service.

While the Vet Center is an important place for women to receive mental health and MST care, authorization for VA's Beneficiary Travel program, which supports travel for eligible veterans receiving examinations, treatment and care, is not permanent. Without this benefit, women who are using Vet Centers in increasing numbers for critical MST and transition care may lack the ability to access it. So far, VA has been hesitant to make it permanent because of cost and the need to share records that aren't usually shared between VA and Vet Centers.²⁰⁶ There are also issues with oversight and project management in beneficiary travel that have been noted by the GAO²⁰⁷ and VA inspector general reports²⁰⁸ that should be addressed. However, in order to ensure access, VA should establish the appropriate oversight responsibilities and Congress should permanently extend beneficiary travel benefits to Vet Center care for veterans who meet the eligibility requirements.

■ **Recommendation:** Local Vet Center leadership must be included in any local planning to establish

Women's Retreats Sponsored by Veterans Service Organizations and VA

Focus Forward Fellowship A four-day student retreat focused on mentorship, community, and academic and career success.

After Her Service A weekend resiliency-building retreat combined with six months of follow-up professional coaching.

Women Veterans Rock leadership retreats

Two-day retreats focused on building the networks and skills needed to successfully build post-military lives and careers.

Boulder Crest's Warrior PATHH (Progressive and Alternative Training for Healing Heroes)

A seven-day nonclinical retreat in nature staffed by combat veterans and civilians focused on "post-traumatic growth" and currently being studied in an 18-month longitudinal survey.

Center Point Recovery retreats Open to women currently in counseling at a Vet Center, set in nature and focused on building communities of women veterans, while also developing self-regulation and recovery skills.

Northport VA Medical Center (New York)

Healing in Nature retreats were held in 2016 and 2017, focusing on wellness, personal growth and community-building through outdoor activities and self-care. The retreat is paid for through donations rather than regular VA funding.

VA Black Hills (South Dakota) Semiannual women's retreats held for 20 years (through fall 2013) to educate women about PTSD and strategies for coping, with a special emphasis on family relationships.

VA Salt Lake City Organizes retreats for men, women and mixed-gender groups through partnerships in their mountain community. In 2014, they held a women's retreat in Park City to connect women veterans with each other and work on moving forward.



From left, women veterans Seymone Spence, Diana Fritz, Stephanie Driessel, DAV Assistant National Legislative Director Shurhonda Love, Luz Helena and Valerie McIntosh spent seven days together at the Boulder Crest PATTH (Progressive and Alternative Training for Healing Heroes) retreat in northern Virginia, funded by a DAV Charitable Service Trust grant.

high-performing community care networks to ensure their knowledge and understanding of veterans' needs and existing community resources are included in plans. VA should also establish clear protocols for transferring veterans to and from Vet Center care and community care providers when needed.

- **Recommendation:** Permanently extend beneficiary travel, with appropriate oversight mechanisms, for eligible veterans using Vet Center programs.

RETREATS

Retreats that place veterans together, often in nature or focusing on problem-solving situations, offer a way for transitioning veterans to interact, solve problems and engage with a larger community that has shared similar experiences. A review of the available literature on nature-assisted therapies found uniformly positive outcomes for veterans who participated in some kind of retreat or course (from gardening to backcountry navigation), without any negative effects. Although many of the cited studies were relatively small and qualitative, veterans reported outcomes such as improved mental and physical well-being, a path back to work and improved ability to deal with PTSD symptoms in everyday life.²⁰⁹

Women may especially benefit from the retreat model; they are less likely to be members of a veterans service organization and often have trouble locating communities of other women veterans.²¹⁰ Women veterans also report feeling out of place among civilian women, and if they experienced MST, women veterans may feel uncomfortable around male veterans. After the Readjustment Counseling Service began a successful pilot of women's wilderness retreats in 2013, they have become a more common part of the readjustment process. The pilot has been reauthorized every year since then, and 15 retreats have now been held with 337 women veterans participating. This weeklong retreat is led by Vet Center counselors and focused on reducing symptoms and developing positive coping mechanisms. These retreats have been analyzed via surveys given before, immediately following and two months after the retreat, and they show continued reduction in all symptoms. Legislation is in Congress to grant full, ongoing authority for women-veteran-focused retreats, which will allow the Vet Center to provide travel funds for staff and veterans²¹¹ and offer the program to more women veterans who need it.

- **Recommendation:** The Vet Center women's retreats have shown consistent positive outcomes and should be permanently authorized and

expanded by Congress and available to women veterans who need them.

VA WOMEN VETERANS' HEALTH RESEARCH INITIATIVE

Research has always played an important role in veterans health care, from the development of the first artificial heart to the recent and ongoing Million Veterans Project, a genomic study looking at military exposures, lifestyles and health information for the purpose of finding new ways to prevent and treat illnesses in the veteran population. VA has used research to assure it is providing high-quality, effective care and to make adjustments to critical health care programs. Until as recently as the 1990s, women were routinely excluded from biomedical research, including clinical trials conducted within and outside VA because most researchers believed they were too chemically complex to understand changes between baseline and post-intervention measures. Finally, Dr. Bernadine Healy, the first woman director of the National Institutes of Health, effectively ended the practice of systemically excluding more than half of the world's population from general biomedical research, thus ensuring biomedical interventions are safer and more effective for all.

While women are now routinely included in research, VA often struggles to identify and recruit a sufficient number of women participants. Women are currently underrepresented in the landmark Million Veteran Program research effort, which will serve as a key reference point for longitudinal genetic research through the next decades. Genes determine individual traits in addition to some risk factors for developing diseases such as heart disease or certain cancers. Some of these risks are also affected by lifestyle choices and environmental exposures. Genes may explain why, despite similar exposures and lifestyles, some individuals seem “protected” from developing certain diseases or conditions while others are more prone to developing them. It may also help researchers understand why some interventions are more effective for some people but ineffective, or even harmful, for others.

For VA to recognize health trends among veterans, the important Million Veteran Program database must reflect key demographic characteristics within the veteran population, such as age, race, ethnicity, sex and era of military service. This ensures that the study population is representative of the veteran population and any findings in the study population are also likely to be found in the veteran population. Women are underrepresented

in the project, currently making up just 8 percent of participants. VA's goal is to increase that percentage to at least 11 percent to ensure statistical validity. Underrepresentation of women would pose challenges to making any broad-based findings from the program. VA must redouble efforts to ensure significant representation of women in the program and all broad-based research endeavors—not just those projects that specifically address them.

In a health care system that has historically served men and in which women still comprise a small but growing subpopulation (about 11 percent of the veteran population and 9 percent of VA health care users), research that identifies unique sexual and gender differences in exposures, health care utilization patterns, program effectiveness and outcomes is critical in ensuring the specific needs of women veterans are met. VA researchers also urge that published results for all clinical trials report differences in sex and gender.²¹²

To VA's credit, its researchers have developed important programs and networks, including the VA Women's Health Research Network, through the department's Health Services Research and Development Service to share information about the health and health care of women veterans. Through the network, researchers mapped knowledge gaps in evidence-based practices in managing the health and health care of women veterans. VA's Evidence-Based Synthesis Program created a “map” of VA's research focused on women, recommending prioritization of some areas, including mental health, primary care and prevention, reproductive health, complex chronic conditions, aging and long-term care, access to care and rural health, and post-deployment health.²¹³ Given the comparatively small number of women veterans, it is unlikely research efforts focused on the impact of military service outside VA will be undertaken. For these reasons, it is essential that there is continued support for research focused on this population.

- **Recommendation:** VA must redouble efforts to ensure significant representation of women in the Million Veteran Program and all broad-based research endeavors—not just those projects that specifically address them.
- **Recommendation:** To the extent possible, ensure adequate representation of women in all biomedical research. All VA clinical trials must report differences in sex and gender, as National Institutes of Health studies do.
- **Recommendation:** VA should continue prioritizing research areas for women veterans by mapping knowledge gaps.



Women veterans in need of assistance often isolate themselves, decreasing their access to critical interventions to prevent homelessness. For any veteran with dependent children, being identified as homeless creates a threat and fear of youth protective services assessing the situation as dangerous and removing the children from their parent.

PREVENTING HOMELESSNESS

In 2009, the U.S. government established a goal to eliminate veteran homelessness.²¹⁴ After nearly a decade of work, significant progress has been made toward that goal. The 2016 point-in-time census count identified 39,955 homeless male veterans, 3,328 homeless women veterans and 188 homeless transgender veterans.²¹⁵ Based on this data, 9.2 percent of the adult homeless population are veterans, with women veterans representing only 0.8 percent of that total.²¹⁶ Overall, the 2016 count represents a 46 percent decline in veteran homelessness since 2009. This compares favorably to the overall decline in homeless adults, which has only seen a reduction of 14 percent since 2007. This success in reducing veteran homelessness is a testament to the hard work and dedication of the Department of Veterans Affairs and its federal partners, including the departments of Housing and Urban Development and Labor.

Yet even with these reductions, both male and female veterans remain overrepresented in the homeless population compared to the general

population and those living in poverty.²¹⁷ The risk factors for homelessness among men and women veterans are similar, although the distribution of risk varies. Among the risk factors are a history of trauma or sexual abuse, single parenthood, substance use and mental health issues, unemployment, and low levels of social support following separation from the military.^{218, 219} Among homeless women veterans, 30 percent had children living with them; and among women veterans who were unstably housed, 45 percent had children under their custody.²²⁰ As a result of these risk factors, women who served are twice as likely as other women to become homeless and three times as likely as other women living in poverty to lose their housing.²²¹

The Federal Strategic Plan to Prevent and End Homelessness states, “VA is committed to using a Housing First approach to connect veterans to appropriate services and housing assistance.”²²² Applying universal screening to patients at VA medical facilities to identify homeless veterans and those at risk of becoming homeless is a key strategy to finding veterans who need support. Indeed, as VA

undergoes its current transformation and looks at changing its offered services maintaining primary care as a foundational service embedded within a strong web of coordinated services will be important for VA's continued progress toward ending veteran homelessness.

This is particularly true for women veterans, who are less likely to frequent shelters due to safety concerns. Choosing to “couch surf” with family and friends instead, they may not be identified through other means of outreach to homeless veterans.²²³ Indeed, while the point-in-time homeless census counted 3,328 women veterans as homeless in 2016, 10 times as many women veterans used VA specialized housing programs or identified as homeless. In 2009, the McKinney-Vento Homeless Assistance Act, which defines homelessness, was revised to count individuals escaping domestic violence, but those in unstable living environments such as “couch surfers” are no longer counted as homeless and therefore are not eligible for many federal homeless programs. VA does have some prevention programs, such as Supportive Services for Veterans Families, that may be used for impoverished veterans to keep them in permanent housing.²²⁴ It is difficult to obtain estimates of both men and women who are unstably housed. In various small studies, as many as 1 in 4 women veterans report being homeless at some point over their lifetime; 1 in 10 in any given year.²²⁵ Importantly, women veterans report “couch surfing” (50 percent) and remaining in a violent relationship (43 percent) much more often as a means to maintain a roof over their heads than the alternative of sleeping in their car (30 percent) or on the street (15 percent).²²⁶ For this reason, it was an important step forward for Congress to expand the definition of homelessness for VA programs to include “any individual or family who is fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions”²²⁷ and without means to obtain housing.²²⁸

Due to concerns about the safety and psychological comfort of women veterans and their children in traditional homeless shelters and programs, VA relies heavily on three programs to serve women veterans: HUD-VA Supportive Housing, Supportive Services for Veteran Families and modified Homeless Providers Grant and Per Diem Program.²²⁹ Overall, 11 percent of veterans served by the VA homeless program in 2016 were women,²³⁰ two-thirds of whom were between 40 and 60 years of age.²³¹ Women comprised 12 percent of the HUD-VA Supportive Housing

recipients and 13 percent of the Supportive Services for Veteran Families participants.²³² HUD-VA Supportive Housing subsidizes veterans in private rental properties, permitting families to stay together and women to maintain a safe space while also receiving coordinated VA treatment services. Similarly, Supportive Services for Veteran Families helps stabilize veterans at imminent risk of losing housing to maintain their living situation, or rapidly rehuses veterans and works to stabilize their income by connecting them with services for which they are eligible. VA also made important changes to the Grant and Per Diem Program to allow funds to be used to support transition-in-place services and subsidies to stabilize veterans' living circumstances. Of veterans the Grant and Per Diem Program now



KASSANDRA BENSON | Air Force veteran



Once homeless, Army Staff Sgt. Sharalis Canales often shares her story with young soldiers at Natick Soldier Systems Center in Natick, Mass. (Photo by David Kamm/U.S. Army)

serves, 7 percent are women, compared to 6 percent in 2013. VA reports that more than 200 program grantees served women veterans in 2014, with 40 providing services specifically for women and another 38 with the capacity to serve women with dependent children.²³³

VA, HUD, the Department of Labor and Congress deserve great credit for persevering in their focus to end veteran homelessness, and we applaud the Trump administration for the continuity at the U.S. Interagency Council on Homelessness to maintain this important work. Given the hard-fought victories in addressing veteran homelessness, now is not the time to lessen support or pull back on the options available to support women veterans who need it. Indeed, projections provided to the VA homeless program show a 9 percent increase in anticipated demand for homeless services by women veterans between 2015 and 2025 due to their increasing numbers in the overall veteran population.²³⁴

VA's commitment to assessing the needs of homeless veterans through CHALENG (Community Homeless Assessment, Local Education and Networking Groups) offers insight on additional gaps in services homeless women veterans face. Women respondents to the last survey identified their highest unmet needs as follows: child care, credit counseling, dental

care, family reconciliation, housing for registered sex offenders, legal assistance to restore a driver's license, child support issues, settling outstanding warrants and fines, and eviction or foreclosure prevention.²³⁵ The success of Supportive Services for Veteran Families, at an affordable price, relied on housing and income stabilization. Among the unmet needs highlighted in CHALENG are opportunities to further extend these twin pillars of stability. A lack of child care or a driver's license makes it difficult to get to work reliably and maintain an income. Eviction and foreclosure destabilize housing, while bad credit makes it difficult to secure. Recouping owed child care payments helps stabilize family finances. VA and Congress should work together to continue to create flexibility in the Grant and Per Diem Program to address these unmet needs.

■ **Recommendation:** To address unmet needs, Congress should hold hearings to examine the needs of women veterans who are precariously housed or homeless, identifying any gaps in eligibility that could be addressed to prevent chronic homelessness. Congress should also consider expanding authority under VA's existing grant programs that serve homeless veterans in order to allow the programs to use funds to address some of the remaining priorities held by women

veterans, including short-term vouchers for child care expenses, to remove short-term impediments to long-term employment and housing stability.

HOME LOANS

The VA Home Loan Guaranty program is an important benefit earned through military service. Veterans can use the program to purchase a home, refinance a home or make home improvements. VA home loans have an advantage over conventional loans in that no down payment is required, no private mortgage insurance is needed, closing costs are limited, and standards for borrowers are generally lower to promote greater veteran home ownership.²³⁶ In fiscal year 2016, nearly 66,000 women veterans, or about 10 percent of veterans served, used \$16 billion in guaranteed loans—an increase of 6 percent since 2004. Women veterans appear to be aware and are taking advantage of their loan guaranty benefit²³⁷ in large numbers.

FINANCIAL SECURITY

In general, women veterans are favorably positioned in terms of financial security compared to nonveteran women. Fewer women veterans live in poverty than nonveteran women (10 versus 15 percent in 2015). And though poverty rates were highest for women veterans ages 17 to 24 (17.5 percent), the rate was still lower than their nonveteran counterparts (25.4 percent). Median household income is also higher for women veterans, averaging \$55,000 per year, compared to \$47,000 for nonveteran women. The gap was closest for women ages 25 to 34, but again, women veterans had higher household income across all ages compared to their civilian counterparts.²³⁸ However, women veterans in all age cohorts make significantly less than male veterans, a gap that generally increases with age,²³⁹ which is particularly disturbing given their overall higher levels of educational attainment.

During the financial crisis of 2008 and 2009, young women veterans faced large unemployment rates, and these rates took longer to peak than nonveterans and male veterans. However, since the financial crisis, numbers have returned to below 6 percent, with no statistically significant difference between veterans of either gender or all nonveterans, although post-9/11 women veterans still had the highest rates of unemployment.^{240, 241}

Homeless veteran numbers continue to worry advocates and policymakers, and research into specific questions paints a more worrying picture for women veterans. The University of Southern

California's State of the American Veteran surveys (2013–2016) found evidence of financial hardships for men and women veterans, though such numbers varied a great deal based on the location of the survey and the age cohort of the veteran; 60 to 80 percent of all veterans had no job prospects when they left the military, and 16 to 46 percent encountered significant financial trouble.

Studies of women veterans, both in peer-reviewed research and government analysis, have not come to clear conclusions about the financial status of women veterans, or veterans in general. Only five peer-reviewed studies examined the employment and earnings outcomes for women veterans. The first three found that women veterans, on the whole,

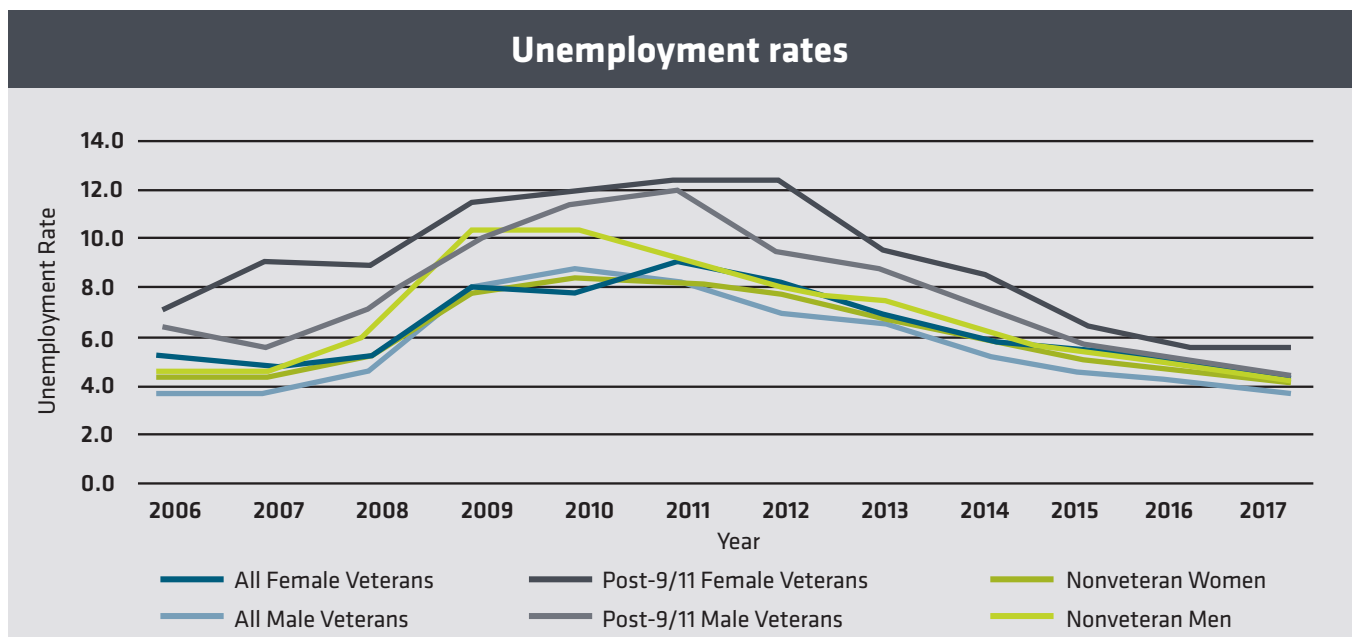
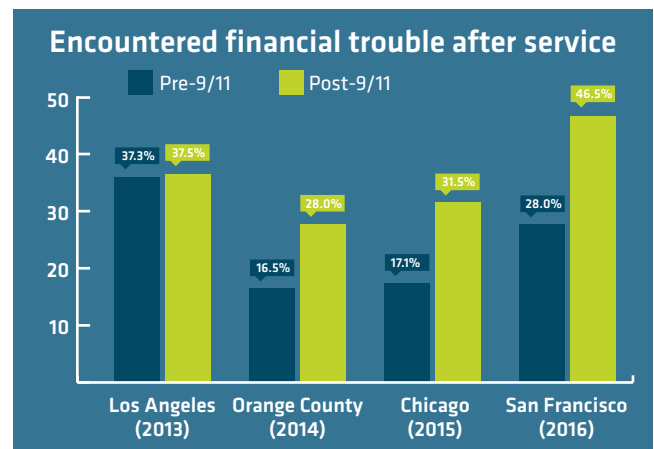
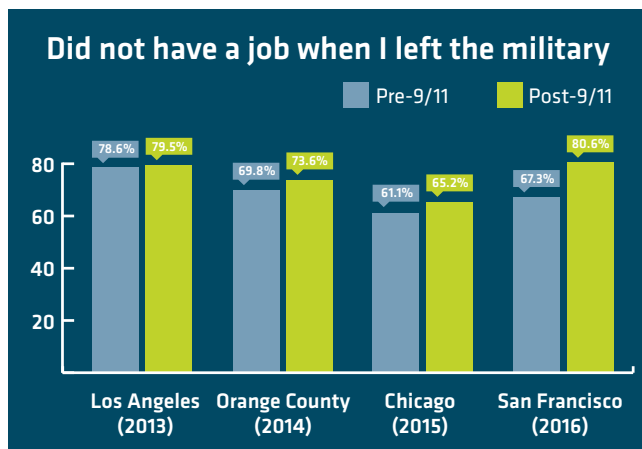


NANCY ESPINOSA | Army, Guard and Reserve veteran

earned less than nonveteran women, once factors such as demographics and selectivity were controlled for. For black women veterans and pre-all-volunteer-force women veterans, this gap was smaller or nonexistent, suggesting that veteran status may have offered a kind of “credential” for black women veterans and pre-all-volunteer-force women that is less valuable today than it was in the past.^{242, 243} A fourth study concluded that earnings for women veterans were broadly similar, but that women veterans experienced higher unemployment.²⁴⁴ This conclusion has also been borne out by Department of Labor numbers in past years, though as the unemployment rate chart below shows, the gap has nearly been eliminated since 2015. A peer-reviewed study focusing on the effect of disability on women veterans’ employment found no statistically significant difference in employment rates between women veterans and nonveterans. However, the study did find that women veterans reporting a disability (service-connected or not) are

more likely to be unemployed than nonveterans and had greater odds of being out of the labor force.²⁴⁵ This final study suggests that disability status needs to be considered when discussing the employment and earnings possibilities for women veterans. Roughly 277,000 women have been deployed in 563,000 deployments between 2001 and 2015, exposing many women to combat experiences²⁴⁶ and suggesting that disability may become an increasing problem for women veterans. Indeed, women made up 8.5 percent of disability claims submitted to the Veterans Benefit Administration in 2013,²⁴⁷ rising to 10.7 percent in 2016.²⁴⁸ Meanwhile, DOL has noticed a four-year trend showing the highest rates of unemployment for women veterans are for 18- to 54-year-old women currently enrolled in school. In 2016, this group had an 8 percent unemployment rate, higher than both male veterans and women nonveterans.²⁴⁹

U.S. Bureau of Labor Statistics data and DOL efforts do show some bright spots on the



employment front. Women veterans are over-represented in the labor force—they make up 10 percent of veterans and 12 percent of the overall labor force (though much of this may be attributed to the younger age of female veterans compared to male veterans). Thirteen percent of the veterans served by DOL's Jobs for Veterans State Grant program are women. Additionally, women comprise 13 percent of the veterans referred to jobs and 13 percent of those who retain referred jobs after six months. This does not suggest that all women who use Jobs for Veterans State Grant services are referred to jobs, or retain them, but that women are making use of and succeeding with available job-seeking and training services at an equitable rate compared to men.²⁵⁰ The success of these grant services may account for some of the improvement in women veteran unemployment rates since the financial crisis.

Another bright spot for veteran employment is the push to improve the portability of military training certifications into the civilian world and to make it easier to move certifications from state to state. Unlike many issues affecting veterans, licensed occupations are governed mainly by state law, making national change difficult. Movement on this issue has come from state groups like the National Conference of State Legislatures, National Governors Association Center for Best Practices and the Council of State Governments, who together launched a three-year project in 2017 to improve the portability and clarity of state licensing requirements.²⁵¹ DOL also contracted the National

Governors Association Center for Best Practices, as a result of the Veterans Opportunity to Work to Hire Heroes Act of 2011 (or VOW Act), to run a two-year demonstration and research project focused on easing veterans' credentialing and licensing. The project had success in moving veteran licensing forward in all six demonstration states. (See table.)

The project also identified common barriers and strategies to address them, as well a set of lessons learned for governors.²⁵² The Defense-State Liaison Office reports on this process as well, finding that 39 of 50 states have made some progress toward best practices. These practices related to licensure and academic credits include giving academic and licensing credit for military education and training, continuing licenses in good stead for National Guard and Reserve members on active duty, and supporting service members with active licenses who are moving from state to state.²⁵³

- **Recommendation:** DOL should partner with VA and veterans service organizations to understand the barriers to full employment for women veterans, particularly those in school and those with disabilities, and adjust their employment programs based on these findings.
- **Recommendation:** Veterans service organizations should continue to work with VA and their state and community partners at the local level to expand best practices for certification and education credits for military experience and training.

National Governors Association Center for Best Practices Demonstration and Research Project



TOPIC	DEMONSTRATION STATES
Policies allowing veterans to apply for licensure reciprocity	Illinois, Iowa, Minnesota, Nevada, Virginia
Policies allowing for veterans to achieve licensure by exam	Illinois, Minnesota, Wisconsin
Development of Education Bridge programs	Illinois, Iowa, Minnesota, Nevada, Wisconsin, Virginia
Strategies to grant veterans advanced standing in training programs	Illinois, Iowa, Minnesota, Nevada, Wisconsin
Strategies to streamline administrative rules and processes	Minnesota, Virginia, Wisconsin



Air Force Capt. Catherine Santiago, Air Force Legal Operations Special Victims' Counsel attorney at Malmstrom Air Force Base, Mont., helps victims of sexual assault through the military justice program. (Photo by Senior Airman Jaeda Tookes/U.S. Air Force)

Some veterans may have a wide variety of legal needs during and after transition from military to civilian life. Veterans may need legal assistance with disability, family, employment and housing issues, as well as criminal matters if they experience post-deployment mental health challenges during reintegration and transition. Since the mid-2000s, specialized Veterans Treatment Courts have begun trying to improve veteran outcomes in the field of criminal law and the Department of Veterans Affairs' Veterans Justice Outreach program has worked with courts and veterans to link justice-involved veterans with needed services, helping to reduce recidivism and homelessness. Health Care for Re-entry Veterans aids incarcerated veterans as they transition out of prison, to promote a successful transition and prevent homelessness. A recent partnership between the VA Center for Women Veterans and the National Center for Medical-Legal Partnerships has begun to address other noncriminal legal issues like housing and family law.²⁵⁴

CIVIL LAW

Four of the top 10 unmet needs for homeless women veterans in the 2016 VA CHALENG survey required civil legal assistance to resolve.²⁵⁵ Threatened eviction, wrongful denial of VA benefits and pursuit of child support are common examples of civil legal needs expressed by women veterans. These legal issues can impact income and access to housing, leaving veterans at risk of falling into poverty and homelessness.²⁵⁶ The medical-legal partnership model places pro bono nonprofit civil lawyers in health care settings where they can aid patients with their civil legal needs. Medical-legal partnership attorneys are now on-site in 11 VA medical centers, helping to resolve legal issues such as a discharge upgrade or a threatened eviction. In a two-year study of medical-legal partnerships at four Veterans Health Administration facilities in New York and Connecticut, lawyers provided civil legal services to 791 veterans and addressed 1,187 issues, 98 percent of which required an attorney. While VA itself does not have the authorization to pay for

veterans' legal services, partnerships with outside organizations like LegalHealth in New York and the Connecticut Veterans Legal Center, offer a way to address legal issues that may impact veterans' health and quality of life.²⁵⁷

CRIMINAL LAW

Today's veterans are especially at risk for involvement with the criminal justice system. Post-traumatic stress disorder has been estimated to affect nearly 20 percent of Iraq and Afghanistan War veterans, and the prevalence of combat experience, in both men and women, leads to higher rates of PTSD and of increased severity. PTSD, especially untreated, has shown a "strong positive association" with increased rates of arrest and convictions for veterans.²⁵⁸

Since the mid to late 2000s, Veterans Treatment Courts or Dockets have been established in a growing number of jurisdictions as a way to improve outcomes for justice-involved veterans. Veterans Treatment Courts are an adaptation of the drug court or mental health court model, wherein veterans are diverted from incarceration into a treatment program composed of linked services for substance use disorders or mental health treatment. Veterans courts may also link veterans to VA services, if eligible, as well as other services such as housing, transportation, peer mentoring, trauma treatment and medical care.²⁵⁹ Though there is little research on veterans courts, a preliminary study indicated positive outcomes from a Midwestern veterans court, particularly when veterans were "provided a combination of trauma-specific treatment, peer mentor services and medication."²⁶⁰ It is important to note, however, that veterans courts have no accepted best practices, and services can vary significantly from court to court. Of 461 veterans courts surveyed by VA:

- 68.8 percent had a mentor component, and 9.5 percent had a mentor program under development.
- 20 percent only accepted veterans with related mental health conditions; 5.6 percent only combat veterans; and 2.2 percent only Iraq and Afghanistan War veterans.
- 20 percent accepted only misdemeanor charges, 13.7 percent only felony charges, and 65.7 percent both misdemeanor and felony.
- 17.9 percent only accepted violent offenses if they were domestic violence, 3.9 percent excluded domestic violence charges, and 61.9 percent accepted all violent offense charges.²⁶¹

In 2009, VA initiated the Veterans Justice Outreach Program with the goal of reducing and preventing "recidivism and homelessness among veterans by

linking justice-involved veterans with appropriate supports and services."²⁶² Veterans Justice Outreach specialists are tasked by VA policy to identify veterans in criminal justice settings and "engage them in treatment and rehabilitation programs or community support services that will assist to: (1) Prevent their homelessness; (2) Facilitate recovery and readjustment to community life; and (3) Desist from commission of new crimes or parole or probation violations."²⁶³ Each VA medical center is required to have at least one Veterans Justice Outreach specialist on staff to serve veterans in criminal and treatment courts, in contact with law enforcement and during incarceration in local jails.²⁶⁴ As a 2016 Government Accountability Office report noted, the choice of how to address these issues and where to concentrate efforts (e.g, jail, treatment court, or probation) is largely up to the local facility and Veterans Justice Outreach specialist.²⁶⁵ Both the Veterans Justice Outreach Program and the number of Veteran Treatment Courts and Dockets have grown considerably in recent years. The program has grown from serving 27,000 veterans in 2012 to about 46,500 in 2015. The number of Veterans Treatment Courts likewise increased from 65 in fiscal year 2010²⁶⁶ to 461 by June 2016, an increase of 609 percent over only six years.²⁶⁷ With the time-consuming nature of working with veterans in specialized treatment courts, VA is having difficulty keeping up with the demand for the Veterans Justice Outreach services.²⁶⁸

Women form a small percentage of justice-involved veterans—only 4 in 86 veterans in a small study of a large Midwestern criminal justice system and 5 percent nationally, according to VA data.²⁶⁹ Women veterans involved in the criminal justice system face different challenges than male veterans. In comparison to male justice-involved veterans, women veterans served by the Veterans Justice Outreach Program were younger, more likely to have a service-connected disability rating, more likely to be diagnosed with a mental health disorder and less likely to be diagnosed with substance use disorder. Justice-involved women veterans were also found to have medical, substance use and especially psychiatric treatment needs, and may be homeless or at risk of becoming so.²⁷⁰ Women veterans are also far more likely to have experienced sexual harassment and military sexual trauma (1 in 5 women, compared to 1 in 100 men), and may display a number of co-morbid conditions (PTSD, anxiety, depression and eating disorders). Such trauma and associated conditions mean that treatment options that work for men, such as mixed-gender support groups, may not succeed for women.²⁷¹

While VA tracks a good deal of demographic data about Veterans Justice Outreach participants, at present, the program does not track data by gender or compare outcomes by gender against clear goals. Likewise, the Government Accountability Office found that the program did not have clear performance goals or metrics to measure progress toward those goals.²⁷² This is doubly important for women veterans. In the absence of clear performance measures, and as women are a minority of justice-involved veterans, it would be easy for women's specific needs to be overlooked. The Veterans Justice Outreach Program is oversubscribed, with requests for new specialists far outstripping supply. (For example, 54 facilities submitted requests for at least one specialist in fiscal year 2015 when VA announced funding for 13 available positions.)²⁷³ Funding for these positions comes from VA central office, but the program has no current congressional authorization or appropriation.²⁷⁴ In 2018, Congress introduced legislation that would require VA to hire 50 additional Veterans Justice Outreach specialists to work with Veterans Treatment Courts.²⁷⁵

- **Recommendation:** VA should set clear program goals and metrics for the Veterans Justice Outreach Program that can be applied in differing local conditions across the country to particularly ensure that minority populations of veterans, such as women, are being effectively served.
- **Recommendation:** VA should continue to research and report on the legal and health care needs of justice-involved women veterans, and on outcomes

of programs like Medical Legal Partnerships, Veterans Justice Outreach and Veterans Treatment Courts. VA could consider asking the National Academy of Sciences to study these programs, or bring together an interdisciplinary group from VA, the Bureau of Prisons and the Department of Justice to examine best practices and establish clear national program metrics, goals and outcome measures.

- **Recommendation:** As in other VA programs, women in linked services for Veterans Justice Outreach and the Health Care for Re-entry Veterans programs should be assigned to women peer mentors and specialists. VA should study the need for and effectiveness of peer mentors and specialists to support women veterans who have cases in family court. Women veterans program managers should be tapped to help coordinate these and other services these women require.
- **Recommendation:** VA and DOJ should work cooperatively to establish uniform program guidelines for Veterans Treatment Courts that favor the broadest inclusion criteria to allow veterans to avoid incarceration, enter into treatment and work toward recovery. Congress should require the departments to report on their progress in this endeavor.

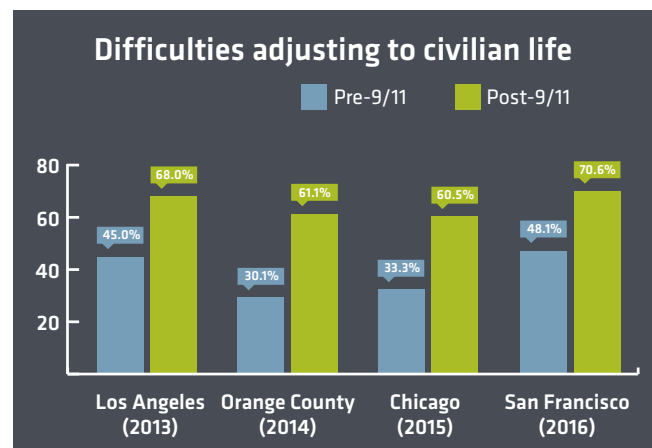


A sailor assigned to the amphibious assault ship USS Bonhomme Richard (LHD-6) is greeted by family members during a homecoming celebration. (U.S. Navy photo/Released)

Transitioning away from the military and back to family life is difficult for any veteran. In a study of veterans in four large metropolitan areas, at least 60 percent of post-9/11 veterans and at least 30 percent of pre-9/11 veterans reported difficulties adjusting to civilian life.²⁷⁶

Women and men face similar challenges reintegrating into community and family life after deployments or military service, but women may experience that transition differently than men. Women are transitioning from a male-defined culture of war fighting to a civilian world where cultural expectations cast them as mothers, wives and family caretakers.²⁷⁷ Civilians often don't recognize them as veterans or active-duty military, for instance leaving disparaging notes when women park in spots reserved for military and veterans. Women veterans in dual-military relationships report that they are mistaken for the civilian partner, something that can be extremely painful following the difficulties of service and deployment.

There is little research on women's specific transition experiences, and the Department of Defense, military service branches or Department of Veterans Affairs have not been investing the



resources needed to track women's social, economic, community or work-related outcomes as they transition from deployment back to a garrison and into their community roles, proceeding through the reintegration process. The underrepresentation of women veterans in studies has so far hindered investigators' ability to answer questions about women's reintegration.²⁷⁸

VA recently established the Social and Community Reintegration Research program to evaluate methods of sustaining and recovering

full community involvement by veterans with psychiatric disorders. The program is designed to improve the understanding of how mental health conditions affect community involvement factors such as education, work, and family and social relationships. The goal is to then apply the research findings to clinical practices to assist veterans with their reintegration in the community. This area of investigation has not received enough attention in the past, and VA should ensure adequate investment is made in the development of this research. Special attention should also be paid to ensuring that women veterans are included and that the sample size is adequate to accurately assess their unique needs and outcomes.

DOD does not distinguish between men and women in their post-deployment educational materials.²⁷⁹ Likewise, it appears that neither VA nor DOD are tracking and publishing reintegration and post-deployment issues by gender so that differences can be identified and better understood. In the Military Family Life Project Study, DOD made sampling decisions that resulted in a drastic and unacknowledged underrepresentation of women. Male spouses made up only 3.6 percent of the study's respondents, though other DOD materials make clear that 45 percent of active-duty women are married. Leaving out dual-military families, for unclear reasons, may have contributed to such undersampling, as 20 percent of all active-duty women were in dual-military marriages.^{280, 281} With the small number of male spouses included in the

study, none of the information in the resulting study was broken out by gender. And despite the significant number of women now in the military and veteran community, this lack of analysis by gender is common in much of the data reported in large studies. As more and more women transition out of the military, and at different stages of their military careers, both VA and DOD stand to fall behind in understanding the needs of women veterans.

- **Recommendation:** The VA and DOD Joint Incentive Fund should be applied to needed research into women's experiences with reintegration and family and community re-engagement.
- **Recommendation:** As part of ongoing assessment efforts, DOD must ensure it collects data and studies the effects of deployment on the families, and in particular the spouses, of women service members and on dual military families. Special attention should be given to any differences in support and services that these families may need.

TRANSITION ASSISTANCE PROGRAM

Prior to 2018, DOD did not feature any women-specific information in the Transition Assistance Program and did not publish data on women's satisfaction or outcomes from the program. A Government Accountability Office report focused on other issues with the program, mainly on DOD's progress moving all disengaging service members through the program by DOD-stated deadlines.²⁸² This lack of data makes it hard to see whether DOD and VA are adequately preparing women service members for the particular challenges that they may face returning to civilian life. However, VA is currently partnering with DOD on a pilot program to introduce an additional day of women-specific training in the Transition Assistance Program. The pilot is being rolled out first with the Air Force, but other branches of the armed services have voiced interest. Assessing satisfaction and outcomes of these programs will be important to understand if changes are needed and if the effort should be expanded.²⁸³

- **Recommendation:** The Transition Assistance Program should collect and publicize outcome and satisfaction data broken down by gender and race.
- **Recommendation:** DOD should study women's experiences with post-deployment combat stress, reintegration, and family post-deployment and community re-engagement. DOD should also develop materials and programs that address the specific post-deployment challenges of women in the military.



Someone left this note on the car of Rebecca Landis Hayes, a former Navy doctor. (Source: www.blogs.va.gov/VAntage/28724/women-vets-see-hear-thank/)

VA DISABILITY COMPENSATION

The Veterans Benefits Administration has worked hard over the past several years to ensure women veterans are aware of the benefits they have earned and understand how to apply for them. According to a report VBA gave to the Advisory Committee on Women Veterans,²⁸⁴ as of February 2017, the Women Veterans Call Center fielded 47,000 incoming calls and made 395,000 successful outbound calls to inform women veterans about how to access services for which they may be eligible. More than 120,000 of those interactions occurred in fiscal year 2017.²⁸⁵ Through a network of women veterans' coordinators at each regional office, VBA has conducted local outreach and briefings across the country, interacting with nearly 115,000 women veterans in these face-to-face sessions. According to VBA, women veterans make up almost a quarter of all online eBenefits users, representing nearly 1 million women, and VBA engages women veterans through social media, including a Twitter Town Hall event convened just for them.

As of September 2016, more than 4.3 million veterans were receiving VA disability compensation,²⁸⁶ and 10.7 percent of these were women.²⁸⁷ In fiscal year 2017, more than 450,000 women received compensation or pension benefits from VBA.²⁸⁸ As women veterans currently make up 9.8 percent of all veterans,²⁸⁹ this level of representation in compensation indicates active pursuit of benefits by women veterans at levels comparable to men and speaks to the success of VBA outreach to women veterans. The top five claimed conditions by women veterans were lumbosacral or cervical strain, scars, tinnitus, post-traumatic stress disorder and hearing loss.²⁹⁰

VBA reports that "performance metrics identify and reduce or eliminate any disparities in the timely provision of equitable and respectful benefits to women veterans in terms of satisfaction, proportionality in use, equity of compensation on the same conditions and equality in length of time to issue decisions."²⁹¹ This internal analysis of data to identify and correct inequities is an important step to ensure women veterans are able to receive all the benefits they have earned. It is notable that VBA is tracking these metrics and that the Annual Benefits Report includes data on benefits provided to women veterans;²⁹² however, every chapter of the report should include specific data on women. The education, loan guaranty and insurance chapters for fiscal year 2016 did not break out data by gender.

VBA is also working to ensure women are treated equitably once they apply for benefits. In 2010, the VA Office of the Inspector

General conducted a review of the disability claims review process for stress disorders to determine if gender-based inequities existed.²⁹³ The review found that VBA denied women veterans' PTSD claims more often than they did men's. In follow-up, VBA found that the success rate for PTSD claims associated with military sexual trauma were lower than other claims for PTSD. VBA leadership reminded staff of the existing internal evidentiary guidance for MST-related claims and instituted new training with VBA personnel and medical examiners to address this discrepancy. Since fiscal year 2011, following additional training, VBA saw the rate for MST-related claims climb, reducing the observed discrepancy by almost 24 percentage points.²⁹⁴



BRIGITTE MARKER | Coast Guard veteran

Unfortunately, the process VBA put into place to ensure consistency and accuracy in processing PTSD claims associated with sexual trauma was short lived. The OIG released a new report²⁹⁵ in August 2018 that highlighted findings of a review of veterans' MST-related claims to determine whether VBA staff correctly processed these claims in accordance with established VBA policy prior to denial.

VBA reported it processed approximately 12,000 claims per year over the last three years for PTSD related to MST and denied about 5,500 of those claims (46 percent) in fiscal year 2017. The OIG review team assessed a sample of 169 denied MST-related claims adjudicated from April 2017 through September 2017 and found that VBA staff did not properly process 82 of the 169 cases reviewed. As a result, OIG estimated that VBA staff incorrectly processed approximately 1,300, or 49 percent, of the 2,700 MST-related claims denied during the review period.

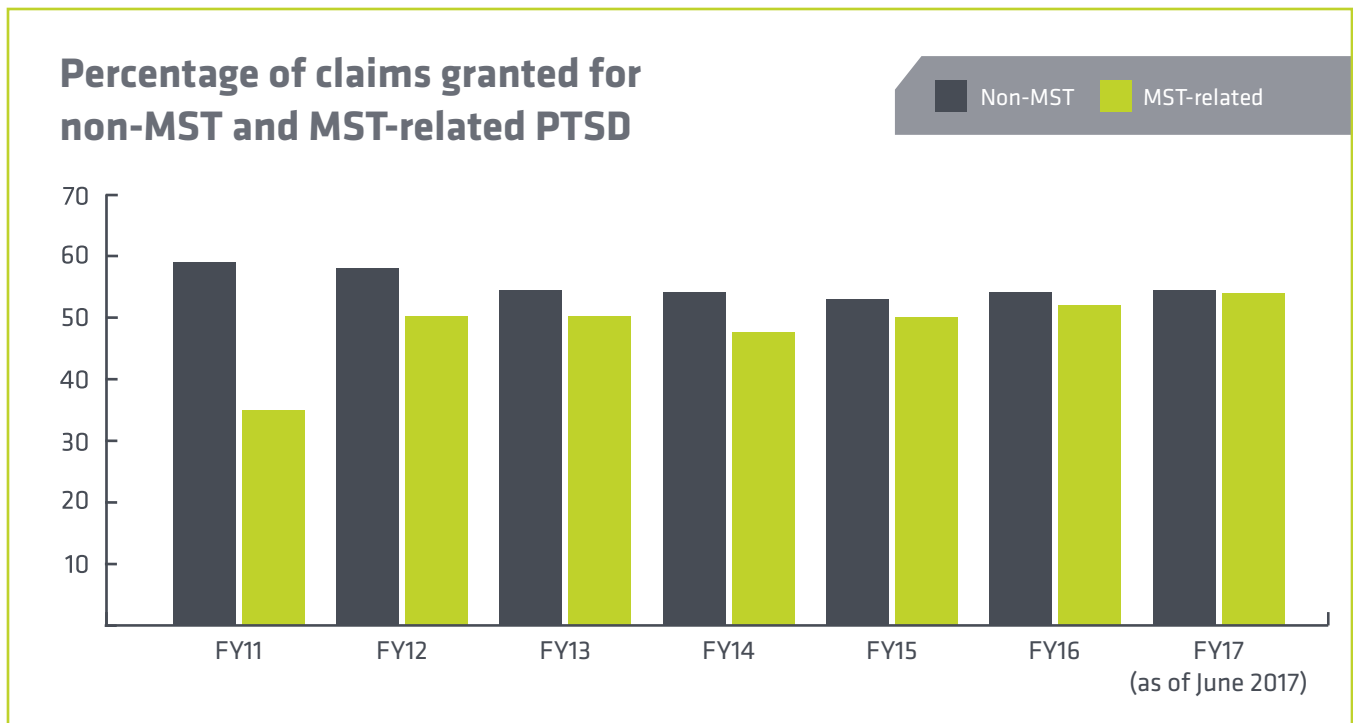
The review team found that staff did not follow the required claims processing procedures related to evidence gathering, medical examination requests, veteran contact and insufficient medical opinions.

VBA had previously established a Segmented Lanes model to process highly complex cases as well as sensitive issues such as MST-related claims. These cases required processing by special operations teams made up of veterans service representatives and rating veterans service representatives. The OIG review team concluded that special operations teams staff developed subject matter expertise on these highly sensitive claims as a result of focused training

and repetition. However, under the subsequently established National Work Queue model, VBA no longer maintained special teams to process these claims. Under the new model, claims were distributed daily to each VA regional office, which then determined the distribution of MST-related claims. OIG determined, due to these changes, most VBA staff at regional offices lacked familiarity and overall became less proficient at processing MST-related claims.

The national Systematic Technical Accuracy Review team for Compensation Service and the quality review teams at each VA regional office execute VBA's quality assurance programs. Systematic Technical Accuracy Review staff completed special, focused quality improvement reviews of MST-related claims beginning in 2011. Staff performed the reviews on MST-related claims twice a year and identified errors similar to those identified by the OIG review team, such as missed evidence or behavioral markers and failure to request necessary medical examinations. However, VBA reported the review office stopped completing the reviews in December 2015 because it had met the requirements outlined by GAO,²⁹⁶ and because VBA reallocated resources toward other areas as a result in the decline of the error rate for MST-related claims between 2011 and 2015.

Additionally, OIG reviewed VBA's training modules, which had not been updated since 2014, despite a number of changes to the Adjudication Procedures Manual and found the procedure checklist for MST-related claims was outdated and inaccurate, contained



erroneous development procedures, misstated the MST coordinator's role and responsibilities, lacked information on how to rate claims where a diagnosis other than PTSD was given, and contained incomplete information on what constitutes an insufficient or inadequate examination.

VBA acknowledged the need for updated and annual training and stated it was in the process of creating a new training program. OIG suggested VBA review all denied MST-related claims since the beginning of fiscal year 2017, determine whether all mandated procedures were followed, take corrective action on claims not properly processed and render a new decision as appropriate, and report the results back to OIG. Additional recommendations were made related to re-establishing appropriate training and quality reviews, as well as establishing accountability and accuracy measures for processing these claims.

- **Recommendation:** VBA should continue to conduct and publish analyses of women veterans' use, experience and success in pursuing veterans benefits and should ensure all VBA programs are examining their data to identify any gender inequities in the services provided.
- **Recommendation:** We concur with recommendations made by OIG and urge VBA to reinstitute training and refresher training for VBA employees handling MST-related claims; update the checklist for such claims to include detailed steps claims processors must take in evaluating these special claims in accordance with applicable regulations; require claims processors to certify that they completed all required development action for each claim; and establish routine quality review measures to ensure consistency and accuracy of these claims.

VOCATIONAL REHABILITATION AND EMPLOYMENT

VA's Vocational Rehabilitation and Employment program provides vocational assessment, rehabilitation and job training for veterans with service-connected disabilities who have an employment barrier. For those veterans with service-connected disabilities that are so severe as to prevent them from immediately considering work, the program provides services to help them live as independently as possible. Currently, women make up 21.2 percent of the 137,097 veterans receiving Vocational Rehabilitation and Employment benefits, much more than their percentage in the veteran population overall but consistent with women's representation among all post-9/11 veterans (18 percent). A congressionally mandated longitudinal study of the program requires VA to report on 16 data points annually, especially the outcome measures of



DR. LISA KIRK

As a doctor of public health, Air Force Lt. Col. Lisa Kirk spent decades practicing military and preventative medicine. When she was forced to medically retire due to her multiple sclerosis, she wondered how she could continue to do what she loved.

When she came to DAV, she was told about Vocational Rehabilitation and Employment and the services they provided to help her with job placement. She said she didn't know she would need that sort of assistance at the time, but it proved essential in the following months.

"Vocational Rehabilitation stepped in and actually worked with me to determine what I wanted to do with the rest of my life," said Kirk. "At the time, I didn't really know if I wanted to go back to work full time, but my Voc Rehab counselor helped me determine what my goals were and what I wanted to accomplish."

Kirk's counselor called her a few months later and told her he'd found a job for her at the Naval Hospital Oak Harbor on Whidbey Island, Wash.

"It was such a great transition for me, that my boss was aware of my condition. And it was a wonderful way to transition back to work after what some people would say was a devastating thing to happen, not being able to move my right foot, my hand was getting weaker, I wasn't sure I could work again full time," Kirk said. "But I did, and the whole process was a great thing."

employment, income, home ownership and use of other services (e.g., Social Security disability insurance, Supplemental Security Income or unemployment benefits).²⁹⁷ The study reveals mainly positive outcomes for the program, with around 90 percent of veterans reporting moderate to high satisfaction. The study has also shown high levels of employment (all cohorts above 75 percent for currently employed at time of survey) and home ownership (all cohorts above 60 percent at time of survey) for rehabilitated veterans.²⁹⁸ However, the Government Accountability Office still notes problems with program management, workload and staff allocation as of 2015.²⁹⁹ And much like many other VA programs, while VA reports the number of women veterans in the Vocational Rehabilitation and Employment program, it does not make easily available a breakdown of other data by gender or race, such as employment, housing or satisfaction. An appendix in the longitudinal study report promises a regression analysis of satisfaction that would yield such data, but no appendices are included in the publicly available report.³⁰⁰ Of note, one study of 11,603 veteran outcomes in state vocational rehabilitation agencies showed inequities for veterans of color compared to white veterans in terms of the odds of successfully returning to work, which highlights the importance of VA breaking down data by race and gender in analysis of the Vocational Rehabilitation and Employment program.³⁰¹

■ Recommendation: VA should analyze race and gender outcomes in longitudinal studies of Vocational Rehabilitation and Employment participants and make the data and analysis publicly available.

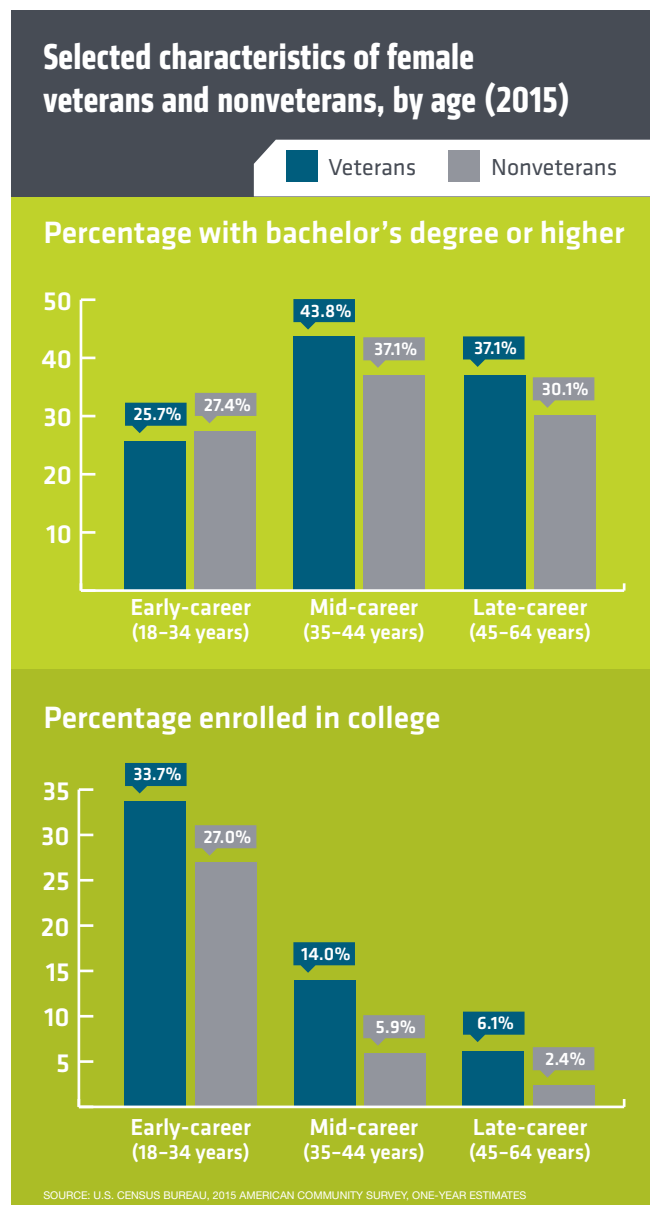
EDUCATION

Educational benefits are a major draw for potential service members, especially for women. The Post-9/11 GI Bill provides funding for 36 months of tuition and fees, equal to the most expensive in-state tuition at a public college in the state where the veteran chooses to enroll. The bill also provides a yearly \$1,000 stipend for books and supplies and a monthly living allowance. Over 80 percent of both men and women in a 2011 Pew Research study said education benefits were the main reason they joined the military.³⁰² The GI Bill is often credited with remaking postwar America by sending 51 percent of veterans on to higher education, including more than 64,000 women.^{303, 304} The original GI Bill was used proportionally by fewer women than men.³⁰⁵ Since then, women have gained more educational benefits from their military service—today’s post-9/11 women veterans have higher educational attainment than nonveteran women and veteran men.³⁰⁶ In 2015,

149,375 women veterans used VA education benefits. Most of these veterans were ages 25 to 34 (61 percent), with 16 percent ages 35 to 44, 14 percent ages 17 to 24, and 8 percent ages 45 to 54. Only 1.7 percent of beneficiaries were older than 54.

Women veterans are overrepresented in higher education compared to their numbers in the military and broader veteran population. Degree attainment and educational enrollment by women veterans varies by age cohort. The highest rate of bachelor’s degree attainment in women occurs for those ages 35 to 44, with lower numbers for women over 45 and under 35. (See graph below.)³⁰⁷

Women veterans fare exceptionally well in terms of educational attainment in relation to both nonveteran women and male veterans. (See graph on Page 55.)³⁰⁸ Yet veterans as a whole face a large number of challenges in postsecondary education.



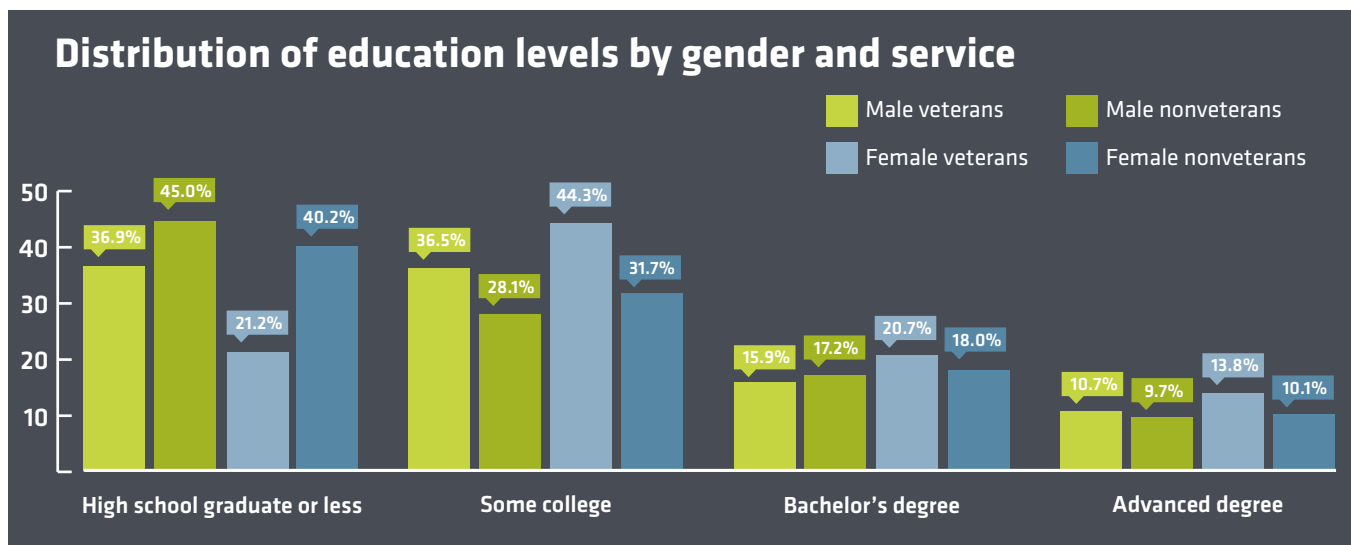
Social challenges may arise from significant differences between veterans and traditional students in terms of knowledge, experience and lifestyle. Mental health issues may pose particular problems for student veterans, leading to alcohol problems, fights and isolation. Traumatic brain injury may pose issues for both physical tasks (sitting at computers) and cognitive tasks (learning, attending, time management, organization and self-regulation).

The transition to the unstructured and inconsistent world of the university can be difficult for student veterans accustomed to military discipline and a command structure.³⁰⁹ Veterans may experience difficulties receiving benefits, delays in payment and lack of credit for military training at some institutions.³¹⁰ Like male veterans, but unlike female college students, women veterans are often hesitant to seek out help when they have a problem, whether it concerns mental health or academics. Too many veteran coordinators on campus simply expect veterans to come to them when they need help. Instead, early research suggests they should be designing effective communication plans that reach women veterans before problems start and demonstrate understanding of women veterans' needs and experiences.³¹¹ Other than the general success of women veterans in education and their surprising hesitance to seek help, we know little about what currently affects educational outcomes and success for women veterans.

A study jointly run by the Student Veterans of America, National Student Clearinghouse and VBA found strong returns for the 853,000 veterans who had used the Post-9/11 GI Bill and suggestions of a strong return on investment for the U.S. government. Seven out of 10 users of the bill either earned or were continuing to work toward a degree at the time of

the study.³¹² Women have especially benefited from the Post-9/11 GI Bill. They make up 20 percent of bill beneficiaries and have earned 23 percent of the degrees conferred, though they only make up 16.5 percent of the military today.³¹³ By late 2016, more than 247,000 women veterans had used more than \$4.8 billion in benefits under the Post-9/11 GI Bill.³¹⁴ This compares favorably to the 284,000 women who had used the Montgomery GI Bill from its introduction in 1984 through 2009, the year that the Post-9/11 GI Bill was introduced.³¹⁵ Women veterans' high usage rates of the Post-9/11 GI Bill reinforce the importance of the educational benefit for women who join the military and the need to make sure we understand what factors affect women veterans' experiences in higher education.

Though hundreds of thousands of veterans have used VA benefits to attend colleges and universities, the experience has not been universally positive for all veterans. Some schools employed aggressive or deceptive recruiting efforts, encouraged students to take out pricey private loans rather than federal loans, failed to disclose veteran graduation data, or intensively recruited veterans with traumatic brain injury or emotional vulnerabilities that the schools were not equipped to support.³¹⁶ VA has tried to address some of these issues with the GI Bill Comparison Tool, updated in August 2014, and by establishing the Principles of Excellence.³¹⁷ The comparison tool builds off available data about schools and student veteran complaints to offer a one-stop shop for information on school quality. While it does not specifically address outcomes for women veterans, the tool does offer a great deal of information about schools, what they have to offer veterans and what they do not. Many schools conform to at least one best practice that enables veterans' success on



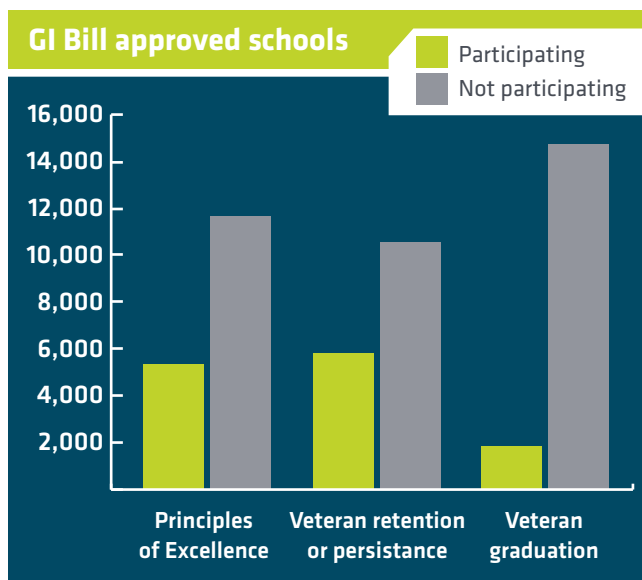
campus, such as Principles of Excellence, Yellow Ribbon or Veteran Success on Campus programs. (See **Appendix B**.) The tool also offers cautionary information, including student complaints submitted through the GI Bill Feedback System and accreditation risks. There is evidence that the tool and executive order are working: According to current comparison tool data, 82 percent of GI Bill students are studying at programs covered by the Principles of Excellence, even as only 32 percent of approved schools participate in the program.

Educational institutions are not required to provide information to VBA. While the categories of graduation rate, average salaries of graduates, loan repayment and retention rate are all included in the tool, with space for numbers on both veterans and nonveterans, it is fairly normal to observe “no data” in these fields. Schools without data can still enroll large numbers of veterans, as can schools with numerous student complaints. In a worrisome statistic, proprietary or for-profit schools have enrolled 27 percent of GI Bill students, used 40 percent of the funds and only produced 19 percent of the degrees from the Post-9/11 GI Bill.³¹⁸ However, Executive Order 13607 states that institutions receiving veterans and military benefits should be required to comply with the Principles of Excellence.³¹⁹ While the order has not been used to enforce this compliance by withholding funds (and there may be good reason for not doing so), VA and DOD could choose not to display information on the GI Bill Comparison Tool for schools that don’t report data or don’t comply with the Principles of Excellence. Alternatively, VA could display a stronger warning within the tool when schools fail to comply with

these requirements. It is concerning that a majority of schools approved to receive federal money do not participate in the Principles of Excellence and don’t report veteran retention, persistence or graduation rates. (See graph below.)

Since the GI Bill Comparison Tool was released, new research has been completed about what veterans and service members want from a “military-friendly” institution. Unsurprisingly, student service members and veterans primarily want schools to be accredited and approved to accept educational benefits.³²⁰ VA could do more to meet their other expressed needs. In particular, VA could require schools to make clearer what military credits they accept, perhaps including this information in the educational plan. VA should also establish a feedback tool to collect input from recruits on what additional information they need and how to improve the comparison tool.

■ **Recommendation:** VA and veterans service organizations that evaluate and publish information about veterans’ use of educational benefits or their outcomes should include consistent breakdowns by gender, race and age.



Principles of Excellence

Educational institutions participating in Principles of Excellence agree to the following guidelines:

- Provide students with a personalized form covering the total cost of an education program.
- Provide educational plans for all military and veteran education beneficiaries.
- End fraudulent and aggressive recruiting techniques and misrepresentations.
- Accommodate service members and reservists absent due to service requirements.
- Designate a point of contact to provide academic and financial advice.
- Ensure accreditation of all new programs prior to enrolling students.
- Align institutional refund policies with those under Title IV, which governs the administration of federal student financial aid programs.³²³



When the draft ended in 1973, women represented just 2 percent of the enlisted forces and 8 percent of the officer corps. Today, those numbers have increased to 16 percent and 18 percent respectively. (Photo by Staff Sgt. Joe W. McFadden/U.S. Air Force)

When women raised their right hands and swore to support and defend the Constitution of the United States, they understood it could mean sacrificing their lives, if need be, and would require placing this duty above their personal well-being. As a result of this oath and their service on our behalf, women veterans—like all veterans—want to establish successful careers and relationships after service and

have their service to our nation acknowledged. The sacrifices they make are not always recognized or acknowledged, and women work hard to reconcile their societal roles as caregivers, mothers and wives with the warriors they are. DAV recognizes these sacrifices and struggles, honors the service of women and will continue our support to empower veterans to lead high-quality lives with respect and dignity.

Progress since 2014 DAV report *Women Veterans: The Long Journey Home*

■ KEY RECOMMENDATION 1: IN PROGRESS

The Department of Defense, Department of Veterans Affairs and other federal partners should collaborate to develop and maintain an up-to-date **central directory** and mobile apps for federal programs and services available to women service members and veterans who are transitioning from military to nonmilitary life.

Outcome: A central directory, available to veterans, has not been published. However, the Women Veterans Call Center (1-855-VA-WOMEN) and chat line have become the go-to resources for information about services for women veterans and transitioning military members, similar to DOD Military OneSource. Veterans Benefits Administration women veteran coordinators have also increased their outreach to provide information on VA benefits, reaching more than 100,000 women veterans each of the past several years.

References

- Women Veterans Call Center
- May 2018 update provided by Margarita Devlin, executive director, Benefits Assistance Service, VBA

■ KEY RECOMMENDATION 2: IN PROGRESS

The federal government should collect, analyze and publish **data by gender** and minority status for every program that serves veterans, to improve understanding, monitoring and oversight of programs that serve women veterans.

Outcome: VBA has implemented this recommendation for women veterans, including analysis and statistics on women in a majority of the chapters included in their last annual benefits report. VBA stated in May 2018 that they plan to include statistics on women veterans in all of the chapters in their next publication. The Veterans Health Administration has been much less consistent in publishing data that includes analysis of women veterans' experience and outcomes with health care services. While the women veterans sourcebook is an excellent resource, analysis and reporting on women veterans should be a routine component of program oversight and accountability in VHA and will be particularly important going forward with VHA expansion to engage more community providers.

References

- VBA Annual Benefits Report FY 2016 for previous reporting
- Margarita Devlin's 2018 statements to the Women Veterans Advisory Committee
- The last women veterans sourcebook was published in February 2014; a new version is currently under review in the department and expected to be released by the end of fiscal year 2018

■ KEY RECOMMENDATION 3: IN PROGRESS

VA and DOD should aggressively pursue **culture and organizational change** to ensure women are respected and valued.

Outcome: Women's Health Services is leading a VA-wide communication initiative to enhance the language, practice and culture of VA to be more inclusive of women veterans. The VHA Office of Women's Health Services developed and released information, posters and public service announcements to raise the visibility of women veterans and acknowledge their contributions to America's military as part of the She Wore These campaign. In addition, the same office recently developed similar materials to combat sexual harassment and gender-based bullying by male veterans toward female veterans and female VA staff, a significant issue reported in research studies. DAV is eager to see this campaign fully implemented and the results it produces.

References

- She Wore These campaign materials
- End Harassment program materials on the internal Women's Health Services website and promoted through local VA facilities

■ KEY RECOMMENDATION 4: IN PROGRESS

DOD, VA and local communities should work together to establish **peer support networks** for women veterans to ease transition and isolation and to assist with readjustment problems.

Outcome: DOD leadership has issued instructions for commanders to fully support Lean In circles for women military members. Women veterans have established Lean In opportunities with sponsorship from the VA Center for Women Veterans. Public Law

114-2, the Clay Hunt Suicide Prevention for American Veterans Act, required VA to develop community networks. VA has never implemented this provision.

References

- Lean In website at leanin.org

■ KEY RECOMMENDATION 5: IN PROGRESS

VA should establish **child care services** as a permanent program to support health care, vocational rehabilitation, education and supported employment services.

Outcome: Congress enacted extensions to child care services for veterans attending appointments and has introduced legislation numerous times in the 114th and 115th Congresses, but the authority is not yet permanent.

References

- Extensions: Public Law 114-223, Public Law 114-228
- Bills to achieve permanence: S. 469 and H.R. 3365, H.R. 1496, H.R. 1948 (114th Congress); H.R. 95, S. 2565 and H.R. 5486 (115th Congress)

■ KEY RECOMMENDATION 6: IN PROGRESS

VA should build upon the local community partnerships and outreach established for other programs, such as homeless veteran programs, to establish **support networks for women veterans** in accessing health care, employment, financial counseling and housing.

Outcome: The VA Center for Women Veterans has made strides in building partnerships with external groups at the national and local level to connect and expand networks of support for women veterans. VHA women veterans program managers also have this mandate in their position descriptions, although uniform expectations for outreach would help achieve more uniform engagement with community providers across the country. Finally, the Vet Centers conduct local planning each year with outreach to groups who support veterans, including those working with women veterans.

References

- 2017 National Women Veterans Summit and examples therein

■ KEY RECOMMENDATION 7: NO PROGRESS

Congress should pass legislation to make all individuals who served in a combat theater of operations **eligible for VA health care for life**.

Outcome: Legislation has been introduced, but committees have not taken action.

References

- H.R. 1685 and S. 699 (115th Congress), to provide eligibility to combat veterans for mental or behavioral health problems; no further action taken

■ KEY RECOMMENDATION 8: IN PROGRESS

DOD and VA should increase **engagement and treatment of family members** in post-deployment health care and the transition programs for service members and veterans.

Outcome: VA has authority to treat family members if care is in the best interest of the veteran; Vet Centers offer care to combat veterans and their spouses when in the best interest of the veteran. Warrior to Soul Mate retreats are offered at several VA medical centers. Legislation introduced in Congress provides for the reintegration and readjustment services to veterans and family members in group retreat settings. Post-9/11 family caregivers receive mental health care and health care insurance under VA's Program for Comprehensive Services for Family Caregivers; other eras will become eligible under the VA MISSION Act of 2018.

References

- S. 681 and H.R. 2452 (115th Congress), with a provision to include spouses in group retreat

■ KEY RECOMMENDATION 9: IN PROGRESS

VA needs to improve access to **gender-specific health care for women veterans** by requiring every VAMC to hire a part-time or full-time gynecologist.

Outcome: In 2018, VHA has 196 gynecologists on staff (distribution across sites not available). Congress has introduced legislation to make these services required at all VAMCs.

References

- Dr. Patty Hayes' May 2018 presentation before the Women Veterans Advisory Committee
- S. 804, H.R. 93, and S. 681 and H.R. 2452 (115th Congress)

■ KEY RECOMMENDATION 10: PARTIAL COMPLETION WITH OTHER ELEMENTS IN PROGRESS

VA and DOD should **remove existing barriers and improve access** to mental health programs for women. They should explore **innovative programs** for providing gender-sensitive mental health programs for women. An interagency work group should be

tasked to review options, develop a plan, fund pilots and track outcomes. VA and DOD might consider **collaborations** on joint group therapy, peer support networks and inpatient programs for women who served after 9/11.

Outcome: Congress included some provisions in law to extend and evaluate mental health services for women veterans, but there is more to be done. An August 2018 VA and DOD miniresidency conference will ensure attending providers have clinical knowledge and skills to provide gender-sensitive foundational mental health services, including postpartum depression screening; a miniresidency mental health program; development of psycho-education; and skills groups for women veterans on topics such as pain, parenting and relationships.

References

- Expansion of counseling for other than honorable discharges for military sexual trauma (Public Law 115-141)
- Expansion of evaluation of mental health and suicide prevention programs for women (Public Law 114-188)

■ KEY RECOMMENDATION 11: NO PROGRESS

VA and the Department of Justice should track and report on the experience of **women in Veterans Treatment Courts**. VA and DOD should sponsor research to determine the key success factors for the Veterans Treatment Court model, including the need for fidelity to the full model and the optimal training, staffing, structure and processes needed to maximize their outcomes and effectiveness. Outcomes such as rearrest, reconviction, employment, family relations, quality of life and health outcomes should be studied.

■ KEY RECOMMENDATION 12: IN PROGRESS

DOD should eliminate **rape, sexual assault and sexual harassment in every part of its organization and take action to establish a culture** that does not tolerate sexual assault and sexual harassment.

Outcome: DOD has appropriately framed the problem as one rooted in the culture of the organization and is tracking appropriate statistics to identify problems; culture change efforts are underway, to which leadership engagement at all command levels will be the key to success.

References

- Sexual Assault Prevention and Response Office
- Individual plans of each service branch (Page 34)
- Safe Helpline website at safehelpline.org

■ KEY RECOMMENDATION 13: PARTIAL COMPLETION WITH OTHER ELEMENTS IN PROGRESS

DOD should allocate the resources needed to fully implement its Sexual Assault Prevention and Response Office's strategic plan. DOD should conduct program evaluations and scientific studies to monitor the success of its plan to prevent MST, change the military culture, assess program progress and outcomes, and adjust actions as needed.

Outcome: DOD has established a robust Sexual Assault Prevention and Response Office function, including offices within each service branch and outreach officers across the country. The department has a robust plan and appears to be following up on their intent.

References

- Statements by Secretary Jim Mattis
- Contents of Sexual Assault Prevention and Response Office plans for each service branch

■ KEY RECOMMENDATION 14: NO PROGRESS

DOD should improve policies and programs that provide family support to the spouses and children of women veterans.

Outcome: DOD has neither adequately studied the needs of the spouses of women veterans nor has shown evidence that this population has received special attention or support. Family cohesion during and after service helps protect service members from mental health and transition problems. DOD should collaborate with VA in providing STAIR (skills training in affect and interpersonal regulation) protocol on parenting for veterans who have experienced trauma.

■ KEY RECOMMENDATION 15: IN PROGRESS

VA and DOD should develop a pilot program for structured women transition support groups to addresses issues with marriage, deployment, changing roles, child care and living as a dual-military family. VA should evaluate effectiveness of transition support groups and determine whether these efforts help achieve more successful outcomes for women.

Outcome: Congress has sponsored legislation to support such efforts, and DOD has supported Lean In circles for women, although not as a pilot for evaluation. VA also has temporary authority for retreats that may include family members, and Vet Centers have limited authority to offer family members care if it is deemed to also serve the health interest of the veteran.

References

- S. 681 and H.R. 2452, and H.R. 91 (115th Congress)
-

■ KEY RECOMMENDATION 16: IN PROGRESS

Congress should reauthorize the VA Readjustment Counseling Service's women veterans retreat program. VA researchers should study the program to determine its key success factor(s) and whether it can be replicated in other settings.

Outcome: Authorization for the retreats has been extended by Congress, but permanent authorization has not been provided.

References

- Public Law 114-228 and Public Law 115-62
 - H.R. 1575 (114th Congress), supported permanent status for the retreats, but it was not enacted
-

■ KEY RECOMMENDATION 17: NO PROGRESS

VA should address the needs of women veterans in education by piloting programs such as education and career counseling, virtual peer support for women students and child care services. VA should establish comprehensive guidelines that schools can use to assess and improve their services and programs for student veterans. Special attention should be given to the needs of women veterans on campus. Schools that adopt these guidelines should be rated as such on the GI Bill Comparison Tool. VA should market its education counseling services on the VBA website and emphasize them during the Transition Assistance Program. Alternative options such as live chat and email should also be made available and marketed.

■ KEY RECOMMENDATION 18: NO PROGRESS

VA should enhance its monitoring and reporting on educational institutions to include consistent standards for granting credit for military training and education credit transfer, support for veteran students with identified disabilities, educational outcomes and barriers, availability of career counseling, and job placement success.

Outcome: Both VA and DOD provide information on which programs offer veteran-friendly services. VA has also established Principles of Excellence and has asked for voluntary adherence by schools. However, the information and ratings as described in our analysis remain too overwhelming to be helpful. If anything, the information has become more confusing as more details are added. Veterans are more likely to follow national news magazine rankings than the

information from either department, because such news rankings are simple and easy to understand.

■ KEY RECOMMENDATION 19: IN PROGRESS

Transition Assistance Program partners should conduct an assessment to determine needs of women veterans and incorporate specific breakout sessions during the employment workshop or add a specific track for women in the three-day session to address those needs.

Outcome: VA worked with DOD to develop and implement a pilot Transition Assistance Program module for women transitioning out of the military, called the Women's Health Workshop for Active Duty Servicewomen. The pilot is being implemented first at five sites in the Air Force in 2018, with plans to extend it to other services if successful.

References

- Initiative sponsored by the Women's Health Work Group of the Health Executive Committee of the Joint Executive Committee, which includes the secretaries of both VA and DOD.
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■ KEY RECOMMENDATION 20: COMPLETE

DOD should transfer contact information and data on all Transition Assistance Program participants to VA and the Department of Labor, which should be responsible to provide gender-sensitive follow-up with all service members six to 12 months after separation, to offer additional support and services if needed.

Outcome: VBA women veterans coordinators are using lists of transitioning service members to conduct outreach and help women veterans understand and take advantage of the resources available to them.

References

- May 2018 update provided by Margarita Devlin, executive director, Benefits Assistance Service, VBA
-

■ KEY RECOMMENDATION 21: NO PROGRESS

Data on participation, satisfaction, effectiveness and outcomes for the Transition Assistance Program should be collected and analyzed by gender and race and returned in real time to commanders for their assessment and corrective actions. To judge the success of the program, employment outcomes and educational attainment should be tracked and reported on a rolling basis, analyzed by gender and race, for all separated service members

Outcome: No information has been found on this recommendation. The Women's Health Work Group did hold one focus group with women veterans and

found that they were not satisfied with the current Transition Assistance Program, but additional feedback and accountability to commanders is needed.

■ **KEY RECOMMENDATION 22: IN PROGRESS**

DOL and VA should develop structured pilot programs that build on the promising practices from DOL CareerOneStop service centers but that target unemployed women veterans, to assist them with job placement and retention.

Outcome: Action on this specific suggestion has not been taken, but on their own, DOL has focused on collecting data on women veteran unemployment, to the degree that they understand which subpopulations of women veterans continue to struggle with employment and are able to target activities to them.

References

- Current report
-

■ **KEY RECOMMENDATION 23: PARTIAL COMPLETION WITH OTHER ELEMENTS IN PROGRESS**

DOL should work more closely with state certification organizations to translate military training and certification to private-sector equivalents. VA and DOD should establish a grant program to accelerate these efforts.

Outcome: DOL provided funding for pilot activities that governors and state legislators have continued forward successfully to help provide credit and certification for military experience and training. This work continues.

References

- National Conference of State Legislatures, National Governors Association Center for Best Practices, and The Council of State Governments (2018)
 - Occupational Licensing: Assessing State Policy and Practice
-

■ **KEY RECOMMENDATION 24: IN PROGRESS**

Congress should reauthorize and fully fund the Supportive Services for Veteran Families program to promote positive transitions for women veterans during the anticipated downsizing of the U.S. armed forces.

Outcome: Congress reauthorized Supportive Services for Veteran Families for an additional five years, starting in 2015. Legislation to make the program permanent has been introduced but not enacted.

References

- H.R. 3680 for permanent authorization (115th Congress)
-

■ **KEY RECOMMENDATION 25: COMPLETE, BUT AT RISK**

VA and the Department of Housing and Urban Development should invest in additional safe, permanent housing with support for women veterans.

Outcome: While HUD-VA Supportive Housing was reauthorized for five more years in 2015 and Congress has continued to increase the number of vouchers available to veterans, VA has considered releasing funds designated for case management from centralized funding.

References

- April 2018 news release
-

■ **KEY RECOMMENDATION 26: COMPLETE**

VA should work with community partners to provide housing programs to accommodate women veterans with families.

Outcome: VA reframed the Grant and Per Diem program to allow more flexibility in how the funding was used, significantly increasing the number of programs funded that either target women or are able to include services for them.

References

- National Coalition for Homeless Veterans
-

■ **KEY RECOMMENDATION 27: IN PROGRESS**

VBA should continue to track, analyze and report all of its rating decisions by gender to ensure accurate, timely and equitable decisions by its rating specialists.

Outcome: VBA indicated that they conduct such analysis but should ensure the details are made publicly available.

References

- VBA Annual Benefits Report

VETERAN EDUCATION INITIATIVES

Yellow Ribbon Program

Degree-granting institutions of higher learning participating in the Post-9/11 GI Bill Yellow Ribbon Program agree to make additional funds available without an additional charge to GI Bill entitlement. These institutions voluntarily enter into a Yellow Ribbon Agreement with the Department of Veterans Affairs and choose the amount of tuition and fees that will be contributed. VA matches that amount and issues payments directly to the institution.

Only veterans entitled to the maximum benefit rate, as determined by service requirements, or their designated transferees, may receive this funding. Active-duty service members and their spouses are not eligible for this program.³²¹

Eight Keys to Veteran Success

- Create a culture of trust and connectedness across the campus community to promote well-being and success for veterans.
- Ensure consistent and sustained support from campus leadership.
- Implement an early alert system to ensure all veterans receive academic, career and financial advice before challenges become overwhelming.
- Coordinate and centralize campus efforts for all veterans, together with the creation of a designated space for them (even if limited in size).
- Collaborate with local communities and organizations, including government agencies, to align and coordinate various services for veterans.
- Utilize a uniform set of data tools to collect and track information on veterans, including demographics, retention and degree completion.
- Provide comprehensive professional development for faculty and staff on issues and challenges unique to veterans.
- Develop systems that ensure sustainability of effective practices for veterans.³²²

Veteran Success on Campus

VA provides a vocational rehabilitation counselor to each school, along with a VA Vet Center outreach coordinator, to provide peer-to-peer counseling and referral services.

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Dr. Murphy, an Air Force veteran and president and CEO of Sigma Health Consulting, is a former VA deputy undersecretary for health. She was the highest career official in VHA, and the first woman—and first woman veteran—to hold this key position. Dr. Murphy also served on the President's New Freedom Commission on Mental Health and is the recipient of numerous awards for her work in transforming VA's mental health care system.

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DAV is deeply grateful for the work of Dr. Murphy and her team in support of this follow-up report on women veterans, which details the health impact of military service and sacrifices made by the women who serve. The team's guidance, combined with thoughtful recommendations for needed changes in federal programs, particularly VA policies, programs and health services, contribute to DAV's ultimate goal of improving the lives of women veterans as they complete their journey at home.

DAV is also grateful for our collaboration with renowned military and veteran photographer Stacy Pearsall. During three combat tours, she earned the Bronze

Star Medal and Air Force Commendation with Valor for combat actions in Iraq. Though disabled and retired from military service, Pearsall continues to work worldwide as an independent photographer and is an author, educator, military consultant, public speaker and founder of the famed Veterans Portrait Project. A Nikon Ambassador, Pearsall was named a White House Champion of Change, and her work has been exhibited at numerous galleries, including the Pentagon, the Smithsonian National Portrait Gallery and the National Veterans Memorial and Museum. She holds an honorary doctorate from the Citadel and was one of only two women to win the National Press Photographers Association Military Photographer of the Year competition—the only woman to have earned it twice.

Both Dr. Murphy and Pearsall are life members of DAV and established a highly successful veteran-owned small business and service-disabled veteran-owned small business, respectively. This report is testimony to their profound commitment to ensuring women veterans' voices are heard and acknowledged. This unprecedented and unique collaboration allowed for a more informed report and for us to see through the stories of the women themselves what the transition experience is like for those who served.

We also extend our thanks and sincere gratitude to the Department of Veterans Affairs for their cooperation and assistance as we gathered information reflected in this report, and for their continued efforts to highlight women veterans in their policies, programs and materials across the organization. In addition, we are grateful to the women veterans who so graciously shared their own stories and experiences for this publication. In a way that a report alone cannot do, their personal accounts help to communicate the challenges women veterans face and show the profound impact the right programs and services can have on the lives of those who served.

Finally, the publication of this report would not be possible without the exceptional financial contributions from individuals and corporate partners of DAV. We give special thanks to the following friends for their generous contributions that made this report possible:

- Todd and Heather Allen, Texas
- Carolyn Grimm, Washington
- Virginia Hajeian, New York
- USAA
- Sara Young, Illinois

STACY L. PEARSALL

Stacy L. Pearsall got her start as an Air Force photographer at the age of 17. As an Aerial Combat Photojournalist, she traveled across the globe documenting the military story. During three combat tours, she earned the Bronze Star Medal and Air Force Commendation with Valor for combat actions in Iraq.

“Uniquely, military photographers are artists and combatants at the same time,” said Pearsall. “I carried a gun, but I always felt my camera was my greatest weapon.”

Injuries from an improvised explosive device sustained in combat precluded her from deploying any further. She was faced with a conundrum—either take an administrative role, or retire. Pearsall chose the latter.

“It was a devastating blow to my moral, not to mention caused a major identity crisis,” Pearsall said. “I’d forgotten how to be anything but Staff Sgt. Stacy Pearsall. Not only did I have to begin the physical healing process, but also address the emotional trauma that had taken place simultaneously. In the subsequent years after my medical retirement, I realized the emotional rehabilitation presented the biggest challenge.”

Pearsall has not let her disabilities hold her back. With her service animal America’s VetDogs Charlie by her side, she continues to work worldwide as an independent photographer represented by Aurora Photos, and is an author, educator, military consultant, BRAVO748 public speaker and founder of the Veterans Portrait Project. Her work has been exhibited at The Woodruff Arts Center, The Pentagon, the Smithsonian National Portrait Gallery, the National Veterans Memorial and Museum among numerous other galleries and venues. Pearsall is a Nikon and Manfrotto Ambassador and Ilford Master.

Pearsall was one of only two women to win National Press Photographers Association (NPPA) Military Photographer of the Year competition, and the only woman to have earned it twice. She’s been awarded the Hill Vets 100, honored with the Daughters of the American Revolution Margaret Cochran Corbin Award, lauded by the White House as a Champion of Change, and holds an honorary doctoral degree from The Citadel. Pearsall has served as a nominating juror for the Pulitzer Prize and held a presidential-appointed board member position for the NPPA.



“I realize now that I will never be cured of PTSD. However, I am better equipped to live my life with this burden. Charlie has brought a sense of calm to my world. My stress levels are greatly reduced, thus my seizures are non-existent. With Charlie’s support, I have taken back control.”



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