



DEFINING A NEW AGE OF
WOMEN VETERAN CARE:
*FINDINGS FROM CALIFORNIA
COMMUNITY PROVIDERS*



INSTITUTE FOR VETERAN POLICY @
SWORDS TO PLOWSHARES
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VETS HELPING VETS SINCE 1974



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INTRODUCTION



Women veterans are the fastest growing veteran cohort and their numbers will continue to grow as more choose to serve in the U.S. military. While there are many commonalities between men and women veterans, there are important differences in experience, physical and mental health challenges and access to resources which must be addressed.

The term “military-civilian divide” is often used to point out the isolation of a small sector of our population who have served. This is doubly true for women veterans who have also been under-served or excluded from veteran status, services, and culture.

Just one in four women veterans access care through the Department of Veterans Affairs. While we hope to encourage more women to access VA counseling, medical and disability compensation and pension resources, we also recognize that the VA cannot adequately meet all the needs of women veterans. A large majority of women veterans are seeking care and support in the community which is ill-equipped to understand the specific issues they face or the resources available to them. Women veterans risk falling through the cracks as they face both the military-civilian divide and also systems which are not gender appropriate. Pointing out no malice, the largely fraternal veteran organizations and systems have naturally developed over generations serving men; now we have a special duty to address underserved cohorts left out of those systems. Those seeking services in the civilian system-of-care are unlikely to self-identify as veterans and the providers are unlikely to ask about veteran status or be able to provide culturally competent care.

The systems are changing, however it is vital that we make an intentional effort to improve health indicators for women who have served and guarantee culturally competent, equitable and high quality services and supports.

Mental Health Needs:

- Although women and men are both prone to experience post-traumatic stress disorder (PTSD), women who have been physically injured are more likely to have PTSD.¹
- Women are at higher risk stemming from combat stress or military sexual trauma than veteran men.²
- Higher proportions of women veterans are diagnosed with mental health conditions by the VA, but lower proportions are diagnosed with PTSD and traumatic brain injury (TBI). The Veterans Benefits Administration (VBA) denies women veteran’s disability claims for PTSD more often than veteran men.³ This is believed to be in part due to the struggle for recognition of combat service.
- Social support is a very important predictor of one’s likelihood to develop mental health issues.⁴
- Sexual assault has a larger impact on PTSD symptomatology than any other trauma, including combat exposure.⁵
- Women with combat exposure have increased odds of behavioral problems (PTSD, depression, substance abuse). As combat exposure increased, the odds of each behavioral problem increased. The risk was most striking for PTSD.⁶
- Women fare far worse than men in terms of psychiatric symptoms as a result of traumatic brain injury (TBI).⁷ Women with TBI are more than two times more likely than men with TBI to be diagnosed with depression, as well as 1.3 times more likely to suffer from non-post-traumatic stress disorder anxiety disorders and 1.5 times more likely to suffer from PTSD and depression.⁸

- Depression is exceedingly prevalent among women veterans. Women are more likely than men to have mild depression, major depression, and adjustment disorders.⁹ Depression is twice as common in women as in men, and causes increased risk for osteoporosis, cardiovascular disease, metabolic syndrome, and dementia.¹⁰

Substance Abuse:

- Men are twice as likely as women to have substance use disorders. In contrast, women are 70 percent more likely to have serious psychological distress.¹¹
- Substance abuse is four times more common among women with TBI than men.¹²

Suicide:

- A study by the VA compiling 11 years of data found that women veterans complete suicide at nearly six times the rate of other women.¹³
- More severe forms of sexual trauma (e.g., sexual assault but not sexual harassment) are significantly and positively associated with suicidal ideation.¹⁴

Domestic/Intimate Partner Violence:

- Thirty-nine percent of women veterans and 30—44 percent of active duty women report having experienced intimate partner violence.¹⁵

Economic Challenges/Homelessness:

- Six percent of women veterans are unemployed.¹⁶
- Women with TBI are 2.7 times more likely than men with TBI to be unemployed after deployment and are almost seven times more likely to be homeless.¹⁷
- Women veterans are three to four times more likely to experience homelessness than their civilian counterparts.¹⁸
- A disproportionately high number of homeless women veterans have a history of MST: significantly higher than stably housed women veterans.¹⁹ Homeless women veterans who reported military sexual assault report greater severity of PTSD and other psychiatric symptoms.²⁰

Physical Health:

- Most common physical health problems in women veterans:²¹
 - Back trouble, arthritis and muscular alignments from carrying equipment and loads.
 - Digestive illnesses and urinary problems from deployment-related sanitary conditions.
 - Loss of sight, shrapnel injuries, amputations, traumatic brain injury, and paralysis; especially among those who served in Iraq and Afghanistan.

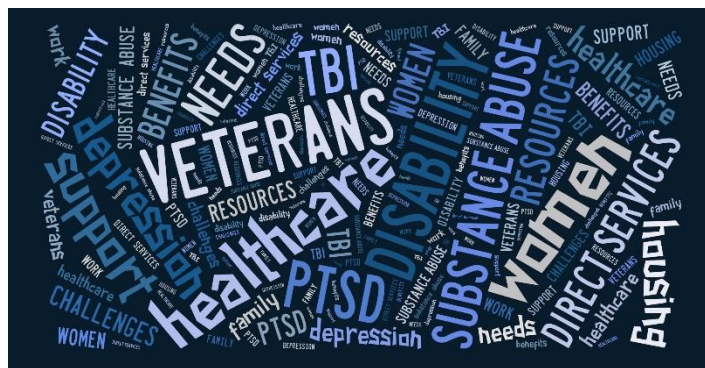
BACKGROUND

With the support from The California Wellness Foundation (TCWF), Swords to Plowshares established the California Women Veterans Project (CWVP) and re-granted \$700,000 in competitive grant funds to 22 organizations with the goal of improving health indicators of women veterans in California, and improving the overall system-of-care in the state. CWVP project partners have provided 1,837 women veterans with direct health and wellness services, and engaged in outreach and community education to 3,965 women veterans.

The CWVP began with an intensive research phase to determine the regional needs of California women veterans, their access to culturally competent services to address those needs, as well as best practices for serving women veterans. Our work led us to focus on four major regions within California: Central Valley, Los Angeles Area, San Diego Area, and San Francisco Bay Area. Some of the identified needs of women veterans within these regions included:

- Excessively long distances to access veteran services—over 90 miles for some in the Central Valley, and/or lack of services that meet women veteran’s needs;
- Rapid increase of homelessness among women veterans, including a 51 percent increase in the population of homeless women veterans in Los Angeles since 2009 while the general homeless population decreased by three percent during the same period; and
- High populations of trauma and mental illness among the women veteran population: 17,641 women veterans treated for PTSD in San Francisco Bay Area, and 30 percent of the homeless veteran population in San Diego suffer from severe mental illness.

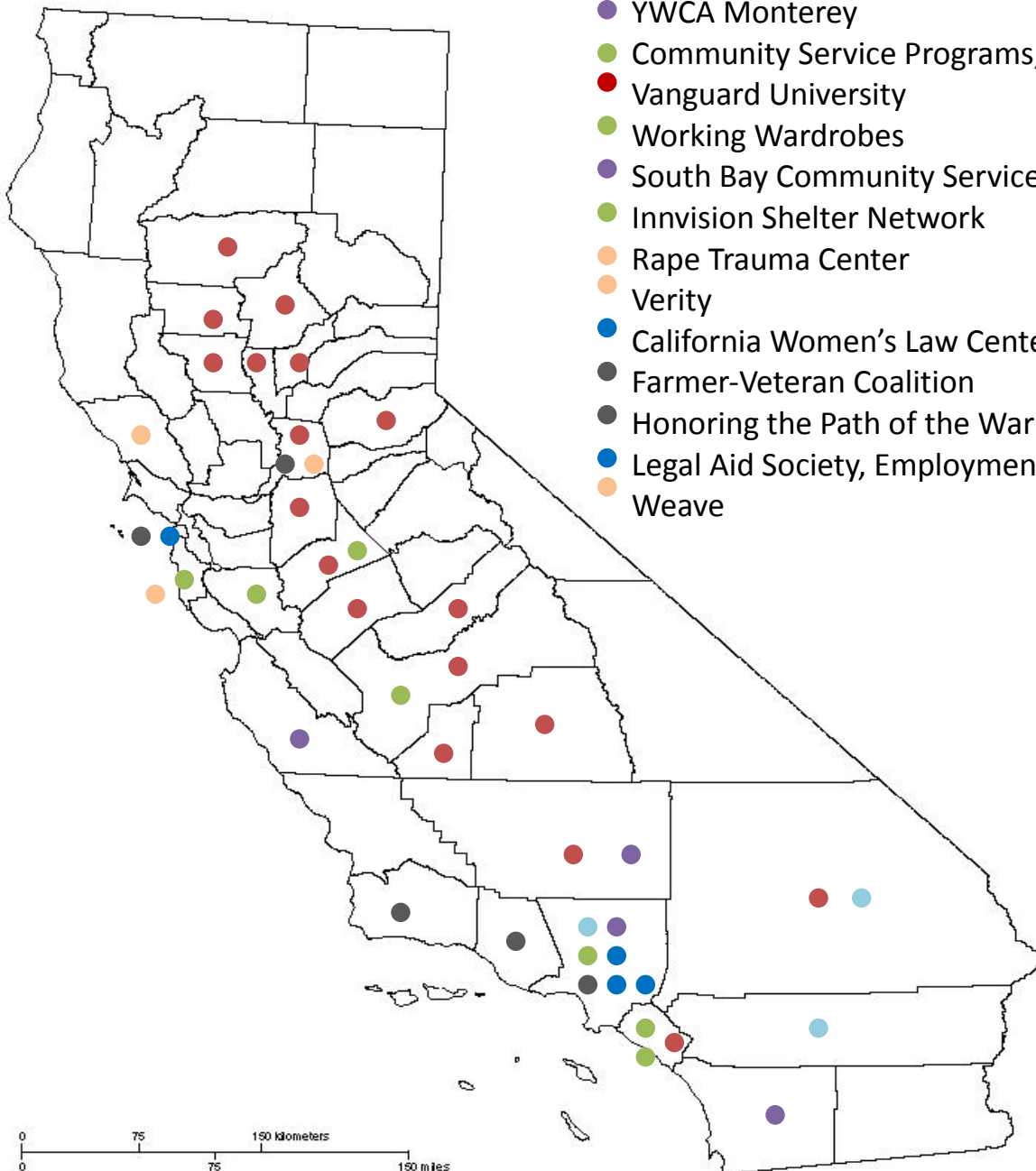
Recognizing that women veterans often do not self-identify or seek services from veteran-specific providers, the request for proposals was disseminated through veteran and non-veteran-specific health and social services networks. Grantees were selected from a broad array of organizations delivering health, mental health, housing, rape crisis, family, employment, and other services in an effort to address women veterans' well-being through a broad-based public health approach.

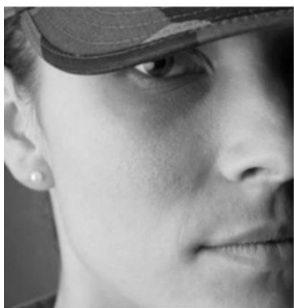


GRANTEE MAP

- Healthcare
- Legal Services
- Direct Services
- Outreach
- Crisis Counseling/
Domestic Violence
- Housing Services
- Networking/ Retreats

- Central Valley Health Network
- CSU Stanislaus
- California Veterans Assistance Foundation
- Harriet Buhai Center for Family Law
- Holman Community Development Corp.
- Inner City Law Center
- Jewish Vocational Services
- Reins of H.O.P.E
- US VETS
- YWCA Monterey
- Community Service Programs, Inc.
- Vanguard University
- Working Wardrobes
- South Bay Community Services
- Innvision Shelter Network
- Rape Trauma Center
- Verity
- California Women's Law Center
- Farmer-Veteran Coalition
- Honoring the Path of the Warrior
- Legal Aid Society, Employment Law Center
- Weave





Five of the partner organizations selected were veteran-specific agencies which had identified a need to develop or improve services for women within the client base. The remaining 17 partners provided services to women and families in a non-veteran-specific context but had recognized, anecdotally or otherwise, that they were serving women veterans and sought to refine that service or develop new programs specifically for women veterans.

During the grant year, Swords to Plowshares provided women veteran cultural competency training and technical assistance through webinars. Staff provided our cultural competency training on the needs of women veterans, *Combat to Community: Women Veterans—Unique Experiences, Obstacles to Care and Resources*, and a series of technical assistance webinars which may be accessed at youtube.com/vetshelpingvets.

The following materials review lessons learned and recommendations for improving health and wellness among women veterans in California and throughout the nation.

UPFRONT CHALLENGES

STAFF CULTURAL COMPETENCY

Finding: Significant training needed to provide culturally competent and trauma-informed care

Many partners, including veteran-specific providers expressed the need for training specifically addressing women veterans. In addition to the training provided by Swords to Plowshares several partners took it upon themselves to engage in research and staff training to ensure deeper level of expertise. Those who did not engage in cultural competency trainings realized in retrospect after the program had been developed that they should have done “*more training around military culture, and the general psyche of women who have served. Our learning has been exponential and we are still surprised at just how naïve we were.*”

Examples of Training:

- Community Services Programs’ Project H.E.R. (Heal. Engage. Respond.) which provides sexual assault services, provided a series of five training opportunities for all staff involved in the project and require volunteers to engage in at least two trainings.
- Rape Trauma Services (Marin) expanded their 65-hour state certified Sexual Assault Counselor Training to include military trauma, military rape, military PTSD, and information regarding referral services.

Nursing professionals stated there are no trainings or resources available on the needs of veterans in their workplace. None of the focus group participants identified any tangible resources available for their use on the job.—Vanguard University, Nursing Professionals in Orange County Focus Group

Veteran services organizations also need to engage in cultural competency training in order to attract and retain women clients. Having expertise in veteran issues and services does not necessarily mean that staff or leadership are aware of the needs, resources and culture of serving women or the rapidly changing landscape of care. Engaging

women veteran staff, volunteers, advisory board members, or others is extremely helpful in breaking down cultural obstacles; however, veteran staff and particularly volunteers should also be trained on the issues and resources available to their peers. Understaffed and overworked social service agency staff rarely have the time or resources to address cultural shifts without a commitment from leadership.

Finding: More resources needed upfront to launch programs than anticipated

Strengthening the system-of-care grants under this program ranged in size from \$10,000 to \$35,000, and were not intended to start up entirely new programs without leveraging existing programs and resources. That said, many projects found that they needed more resources than anticipated, including staff, training, and time to develop community connections. Organizations initially had difficulty attracting women to their services, establishing connections to veteran service organizations, and project planning. In addition, organizations expressed a need to assign full time staff to their women veteran projects but could not attract sufficient grants or other funding to do so.

Partners in the non-veteran service arena may have been marginally or anecdotally aware that they were serving women veterans but had not established screening protocols or evaluation methods. In addition, some project launches were delayed until the agencies felt that they had an adequate understanding of the overwhelming amount of information required to be confident in outreach and service provision.

In addition to funding, many partners found they had to shift priorities and strategies based on the obstacles outlined in this paper. In this instance, because this was the first time that a statewide project sought to address the complex needs of women veterans, the need to tailor programs mid-stream was unavoidable. Our hope is that the lessons learned presented here this report will assist other providers in starting up effective programs with sufficient planning.

INSULAR VETERAN ORGANIZATIONS

Finding: Civilian organizations not easily trusted

Staff spent countless hours making personal connections and fostering relationships in efforts to be recognized as a trusted and valued resource.—Community Service Programs, Inc.

A significant number of partners expressed difficulty engaging with veteran federal, state and community-based veteran-specific organizations. Working on the assumption that they would simply introduce themselves to these organizations in order to establish referral networks and support proved difficult as the veteran field is small and insular. This is a natural outgrowth of the military-civilian divide. It is also a natural tendency of organizations to be protective of their clients and of scarce resources. Indeed, in the Post-9/11 service environment, while government and philanthropy increased the focus on funding military and veteran programs, there has been a perception that non-veteran providers have been seen as jumping on the band wagon and competing for funds without the proper commitment and knowledge base.

This distrust can be well-founded in that poor service provisions can lead to extremely bad outcomes for veterans. On the practical level, direct services staff and leadership do not have time to responsibly review the bonafides of every organization which shows a 'new' interest in veteran care. This phenomenon is not unique to veteran service providers, all cohort specific providers tend to be very protective of their clients, particularly those who have been marginalized. They tend to have an affinity and passion to serve their client base, whether based on protected

immutable factors such as gender, sexual preference, minority status, or on shared experience, prior service, trauma, or specific physical or mental health status and feel that because they have the best understanding of their cohort.

This insular nature, while understandable, leads to lost opportunities in developing a community system-of-care, particularly with regard to women veterans who may find themselves lacking services which address their needs as veterans and as women.

Finding: Difficult to navigate resources and share/receive information

The veteran service delivery system is complex and difficult to navigate, with a myriad of eligibility criteria and great variance in the quality of services. Cultural competency training helps to introduce resources and concepts but this remains a problem for the veteran service field as a whole. There are no comprehensive guides to all of the federal, state, local, community and government based resources. In addition, once one delves down into the availability of specific resources, eligibility is complex and ever-changing. No single entity can or should be able to absorb this web of resources. The best strategy is to develop strong regional and issue-based networks and share responsibility and expertise.

OPINIONS AMONG SYSTEM-OF-CARE AND PUBLIC ABOUT WOMEN IN SERVICE

Finding: Prevailing attitudes regarding women in service and combat

There is so much emphasis placed on veterans as a whole that most people automatically think of veterans as male, or do not consider the significant struggles that women veterans face. —Central Valley Health Network

CWVP grantee organizations strongly noted prevailing attitudes among their constituency, those tied to their programs such as board members, clergy, and even staff, of women in service. While women have always served combat roles, this experience is still not universally recognized; even in the military and veteran communities. Because of this, the nature of their injuries are often pre-conceived by providers to be unrelated to combat. Providers may not believe the extent to which women have served on the frontlines, carried and fired weapons, been wounded, and experienced and witnessed violence and trauma.

When dealing with military sexual trauma (MST), one partner reported that *"the program's focus on sexual violence and veterans was on occasion ill-received by other veteran-serving agencies. And that they 'had to work diligently to dispel common myths about military sexual trauma and to overcome barriers to accessing the veteran community, given the wider societal attitude to sexual violence and silence surrounding the issue..."* Both the veteran and civilian communities need to understand that attention to MST is not intended to portray military men as perpetrators and that veteran men also experience sexual trauma; even higher numbers than women veterans. Also, disturbingly, attitudes of rape culture including ideas that women should or would not be in the military or that they bear responsibility for sexual violence still exist. Rape was trivialized because women were entrenched in the forces and a minority among men, and to be in mostly male units is not "a woman's place." In other cases, survivors were blamed as putting themselves in a situation to become raped because they joined the military in the first place.

While the grantees' focus may have been on direct services, they often found themselves working to educate the public and potential community partners that a woman's place is to serve her country and that the threat of military sexual trauma, harassment or assault is never justified because she is a minority among men.

Finding: Assumptions of eligibility for and availability of VA care

I didn't know that many women see an MD outside of VA hospitals/medical facilities.—Nursing professional, Vanguard University Focus Group

There is little understanding among community-based women's health and social service sectors of VA resources, and providers are unaware of how to help their patients navigate VA services. Many community providers are under the impression that veterans do not need their services because they have the VA. However, not all veterans are eligible for VA medical services and many veterans may prefer to seek treatment outside of the VA because of the patient populations or the cultural reminders of military service. MST survivors who are in the Guard or Reserve may also fear an impact on their career if they seek VA care. In fact, 76 percent of women and 72 percent of veteran men seek services outside of the VA.²² Further, veterans may have good practical or personal reasons for choosing community-based resources, and they should not be discouraged or turned away simply because prior service might make them eligible for VA care. Grantees had to dispel their own assumptions of VA care availability, since many first thought directing women to the VA would be a clear-cut undertaking, or it was presumed the VA could provide more services than they actually perform.

Finding: The civilian healthcare community is not aware of some of the specific needs of the returning generation of Afghanistan and Iraq veterans

It has been determined that women veterans are distrustful of providers who do not possess first-hand understanding of the nature of their service and possible trauma.

The worldview, the mindset, and the historical perspective of life in the military must be understood so providers can make a significant contribution to health and welfare of veterans and their families. And unless it is understood how the unique characteristics of the military impact service members and their families, providers cannot work effectively with them.²³

REACHING WOMEN VETERANS

Finding: Challenges in outreach and attrition

Grantees had to consider how military cultural values, still held by veterans even long after service, interact with their perceptions of trauma and affect their help seeking behaviors. Data shows that service personnel are reluctant to seek out mental health services and if they do engage in treatment, they prematurely drop out of services.²⁴ This is especially true for women veterans who engage less with the VA and have competing priorities such as family and work.

Finding women veterans that self-identify has been the greatest challenge. CVHN has learned many veterans didn't know they would qualify for so many services and programs that would pay or reduce costs related to their healthcare. A lot of women veterans are not affiliated with the VA and their services, but are more familiar with civilian programs and organizations.—Central Valley Health Network

Outreach, therefore, has been a challenge. Women with children, for example, are less apt to go to a medical facility that does not provide childcare, allow children in the facility, or have flexible hours for scheduling appointments. Women veterans who live far from VA or other facilities don't wish to drive the long distance with their children, and would need to find childcare for long hours of commuting to medical facilities. Because they are not engaged in the military veteran community, they may miss (or be missed by) public health messaging regarding military-specific health needs.

One of CWLC's focus group participants was a single parent of two children and has been trying to prioritize her physical and mental health needs that include dental reconstruction, PTSD due to MST and other mental health issues. But, as the sole provider for herself and her young children, she decided she could no longer afford to take care of herself and despite not feeling "job-ready" has pushed herself into the job market after being laid off and is now struggling to maintain her mental health without assistance. She also states that she must focus on the more immediate needs of her young son, who has substantial medical and educational needs.

Data suggests that among women veterans, there is a 30 percent attrition rate within three years of initial VA use, despite recent advances in VA women veteran care.²⁵ Attrition is a heavy concern among providers, both VA and civilian. Among grantees, we learned reaching women veterans is also difficult for civilian organizations not connected to veteran care. Even organizations that were completing all the appropriate procedures to target women veterans for their programs were met with recruiting difficulties.

While outreach to schools seems like a good option to reach younger veterans, many found women veterans may struggle with their veteran identity at school. While many colleges offer veteran-specific resources, women who don't self-identify may not take full advantage and are thus difficult to find.

CASE VIGNETTE

California Women's Law Center (CWLC)

One of CWLC's focus group participants was a single parent of two children and has been trying to prioritize her physical and mental health needs that include dental reconstruction, PTSD due to MST and other mental health issues. But, as the sole provider for herself and her young children, she decided she could no longer afford to take care of herself and despite not feeling "job-ready" has pushed herself into the job market after being laid off and is now struggling to maintain her mental health without assistance. She also states that she must focus on the more immediate needs of her young son, who has substantial medical and educational needs.

It has been difficult to recruit and coordinate focus groups despite the fact that they are offered during evenings and weekends, transportation and childcare services are provided, and all participants are compensated for their time. For example, one of our contacts in Tulare tried valiantly (but ultimately failed) to put together a focus group with women veterans in the area, even though she placed announcements regarding the focus group discussions in community calendars, local television spots, newspapers and numerous online forums, including Facebook. She also posted flyers at various organizations, including veteran and health focused organizations, but was still not able to encourage participation from women veterans.—California Women's Law Center

Because of their dueling responsibilities to family, work, etc. women veterans often sought services from organizations but then didn't return. While women tended to seek services when they were in dire need, transportation issues, long distances to medical facilities, family priorities, childcare challenges, work and other responsibilities hindered their return and presented obstacles to care. These challenges are consistent with previous findings among civilian organizations,²⁶ and while not surprising, we presumed civilian agencies not tied to veteran care and would be thus able to meet the needs of those resistant to veteran-specific care. Some organizations created specialized programs such as peer support groups for women veterans, and would find that after expressing interest in attending, women veterans either wouldn't show up or would stop coming for services. Some organizations found the women they served fell into homelessness or had other service-related trauma/issues that inhibited them from seeking additional care.²⁷

Throughout this program, we've encountered numerous women veterans who were interested in the workshops. After the initial intake, some of the women did not return. Childcare and transportation were major barriers for women. Those who owned their own car were limited with funds to fuel it. Working Wardrobes offered supportive services in the form of gas cards, bus passes, and shuttle services.
—Working Wardrobes

Unfortunately, some of the women veterans who come through our shelter doors are there for a very limited amount of time; some, one or two days, and we would not have wanted them to slip away without the knowledge of this program. One of the challenges we faced included working with some women who we would meet with once and would immediately lose contact with the program. This left us no chance for intensive case management or mentoring involvement. These clients were only able to obtain minimal info and referrals to community resources. We understand that this happens from time to time with this population, and if we were able to provide these clients some source of support and or referral to achieve their goal, we feel we have served our purpose.—Innvision Shelter Network

Many women veterans, particularly those who are homeless or nearly homeless and in most need of legal and other services, often do not have the capacity to engage in lengthy legal actions. A number of women veterans with interesting, viable legal actions simply did not return multiple follow-up attempts or disappear after the initial meeting and in some cases, after pro bono legal counsel was acquired.—Legal Aid Society, Employment Law Center

Isolation, distrust of institutions and high attrition rates make establishing relationships swiftly paramount. To overcome these obstacles, grantees had to move quickly to ensure that clinical, as well as intake and other staff, engaged in cultural competency training, ensured knowledge of eligibility criteria and access to referral resources, and were able to provide warm hand-offs to referrals. “Meeting veterans where they are” is thus essential in both an existential and geographical sense.²⁸

Women may live in rural areas, far from VA medical centers and other veteran-specific programs. From the end of the first Gulf War to the present, the percentage of rural veterans who are women has more than doubled. Grantee agencies in rural areas are in a unique position to respond to the needs of rural women veterans, but are challenged to link women to additional resources in the area, as they tend to be few. These organizations were faced with being the end-all, be-all for women veterans seeking care, and were stressed to respond with more services than they are typically able to provide.

Services identified as needed in the Central Valley for women veterans include primary healthcare services, mental and behavioral health, women’s health and family planning, dental and vision, pediatrics and assistance with understanding public benefit programs that may be available to them.—Central Valley Health Network

Finding: Women veterans are not easily identifiable

Women may not self-identify as a veteran for many reasons, perhaps because they didn’t see combat, they may be a National Guardsman or in the Reserves; they may have traumas which are too closely related to their military service and which are triggering; or they may have less than an honorable discharge. Lack of self-identification makes screening for veteran status a challenge, and is often confusing by the wording of the intake questions or even by the provider’s understanding of veteran culture.

Women often need to juggle both service member and family member roles. She is often a wife, mother, or daughter, with responsibilities to her family that often conflict with her role and responsibilities as a service member. As such, they often put the role of spouse/partner/mother before their identity as a veteran.

Most women did not identify themselves as veterans and those who did were either already working or were single parents trying to keep their families afloat.— Working Wardrobes

Possible trauma may leave women veterans confused about their veteran identity and inhibit them from self-reporting veteran status. They may be prideful of their service even if that service placed them in a traumatic situation, but angry at the nature of the events. Sexual trauma survivors may be angry that they were perhaps forced out of the military because of sexual harassment or assault and subsequently further victimized. These experiences may inhibit them from self-reporting for fear of triggering trauma symptoms.

Women with less than an honorable discharge, commonly referred to as veterans with *bad paper*, may also feel a similar sentiment. They may feel degraded by their discharge status which may not represent their service, which for the most part may have been served honorably. They may not self-identify as a veteran because they may not qualify for federal programs and because their discharge status labels them as such. They may have expressed behavioral

changes as a result of an undiagnosed trauma which was treated with an infraction of unit discipline rather than as symptoms of mental health risk.

SPECIALIZED CARE

Finding: Some women didn't want tailored services

Interestingly, some women veterans didn't want tailored services specific to women but wanted to receive the same standard of care as veteran men.

An example of such, university grantees sought to enhance on-site veteran clubs, which seek to provide an educationally and emotionally supportive environment for veterans, to be more welcoming to women. Some of the grantees noted that while clubs which were predominately veteran men hindered women from joining, women wanted to become more integrated with veteran men in the veteran clubs rather than providing specific space or programs for women which may segregate them.

Finding: Challenge to create specialized services for women with small grants

As predicted, it was difficult to establish stand up services for women veterans with very little funds. While the state of philanthropic efforts is mostly focused on economic opportunity, programs which focus on health and wellness of veterans are largely underfunded. However, many were able to leverage funding from current programming to create special projects for devoted to women veterans.

DEFINING THE NEW AGE OF WOMEN VETERAN CARE

COMMUNITY SYSTEMS-OF-CARE

Recommendation: Provide support where needed rather than where we presume women should go for care

This challenge demands a focused shift on the part of caregivers. While we may hope and aspire to meet all of our clients' needs, that is not be possible or wise. If we are to relieve gaps in services and support for women veterans we must meet them where they are and share resources and knowledge to ensure that they receive care that is sensitive and responsive to their military history as well as specific service provision. We encourage all community-based providers to screen for veteran status and assist women in accessing veteran-specific resources but not to simply refer women out to the VA or veteran service organizations. Women may have very good reasons for preferring the civilian system-of-care; moreover, they should not forfeit access to culturally competent care in the civilian system because of their service.

In addition, because women may not self-identify, and are isolated from one another and both the civilian and veteran systems-of-care, it is important to embed health and wellness in other social services. We intentionally partnered with several groups who provided employment, housing, retreats, faith-based and legal services in order to reach women who may avoid 'traditional' health services.

Recommendation: Learn VA services eligibility and access points



As noted above, women veterans do not necessarily identify as veterans or seek out veteran-specific services, notably VA benefits and care. Partners noted that many didn't know they would qualify for so many services and programs that would pay or reduce costs related to healthcare. Many women veterans are not affiliated with the VA and their services but are more familiar with civilian programs and services.

The VA provides multiple quality services to women veterans, including physical and mental healthcare, trauma counseling, and disability benefits. In addition, the VA funds community-based programs which provide transitional supportive housing (Grant Per Diem), permanent supportive housing (HUD/VASH), employment services (Homeless Veteran Reintegration Program/Veteran Employment Assistance Program) and eviction prevention and rapid rehousing (Supportive Services for Veteran Families). Providers need to be familiar with the types of resources available as well as eligibility requirements and procedures for securing care which can be complex and in some cases trigger stress. While providers may refer out or partner with others in assisting clients, it is important to have a working understanding of processes to support women veteran clients.

Each VA medical center now has a women veteran coordinator and an MST coordinator to assist in navigating care. OB/GYN services are available either on-site or through partnerships with local hospitals and providers. The VA also has residential treatment for women with PTSD or other mental health need, however, gender-specific and veteran-specific residential treatment is extremely limited. Partners also reported the "Change of care providers at the VA, particularly among those that provide mental healthcare and therapy. This includes mental health doctoral interns or fellows who provide care for a few months and then leave—after completing required clinical hours for their degrees. This frequent flux of therapists, interns and assistants made it very difficult to develop the necessary trust required for a therapeutic relationship. The lack of a stable staff also required women veterans to recount painful memories again and again without gaining headway in healing."

In addition, many VA facilities do not offer prenatal care, obstetrics, or mammography. This has often led to disintegrated healthcare as women seek these critical services from community systems. This does them a disservice if they have service-related issues related to these services but can't get care at the VA.

Not all veterans are eligible for VA healthcare, disability or pension benefits. Generally they must be service-connected, meaning they have an injury or illness that occurred or was exacerbated during the time of service. That said, veterans have a general presumption of eligibility for five years after separation from the military and eligibility may be available based on a means test. In order to receive disability or pension benefits, veterans must file a claim with the VA benefits administration which can be very complex, however, if successful, women veterans can secure a higher level of benefits than SSDI or other government programs. Vet Centers provide free counseling to veterans who have experienced military sexual assault and/or are combat veterans and veterans who have experience MST can receive healthcare associated with that trauma from VA medical centers regardless of discharge type.

Women's community-based providers do well by establishing relationships with VA women coordinators in the first instance. Beyond that, familiarity with the claims process, particularly for PTS and MST is essential in shepherding clients through what can be a long and painful adjudication process. For additional resources, visit Inner City Law Center, Swords to Plowshares, and California Women's Law Center websites.

It is often difficult for MST survivors to file for and obtain VA compensation benefits. Not only do they have to relive traumatic experiences in telling their stories, they must also meet certain legal standards and evidentiary demands. Our work helps women veterans to better navigate the disability compensation adjudication process. We ensure that our clients submit fully developed claims that meet the VA's legal requirements.—Inner City Law Center

Recommendation: Defining VA service gaps and advocate for increased access to VA care

While the VA does provide quality services, gaps exist and there are cultural, practical and bureaucratic obstacles to VA care. Going to the VA can be an unpleasant experience for women at best, and trigger PTS in the worst case scenario. Community providers should also be aware of the instance of women who have received ‘bad paper’ or a less than honorable discharge and are denied access to care. These bad discharges can be unwarranted and be related to trauma, gender and sexual orientation. There are a significant number of women service members who were raped and/or sexually assaulted in service who subsequently were separated from the military on the basis of ‘personality disorder’ diagnosis, or for ‘misconduct’ stemming from PTSD. These obstacles can be overcome through a change in character of service determination which is a difficult but not insurmountable process. Women who are turned away on this basis, however, may simply give up without the help of advocates. In addition, the amount of time it takes for legal processes related to VA claims, coupled with competing obligations and practical barriers results in too many women dropping out of the process and thus forfeiting earned benefits and care. Similarly, those who were removed from service for homosexuality prior to the repeal of ‘Don’t Ask Don’t Tell’ may have received an other than honorable discharge status. There is no blanket fix for these discharges; each case must be adjudicated on its own. Women with bad discharges can, however, receive counseling for MST and issues related to combat stress at Vet Centers and in some cases receive limited VA medical care.

Women reported difficulty getting to VA facilities because of transportation issues, lack of childcare and the inability to seek care during work/business hours. In addition, while many VA facilities have established women’s clinics, the VA caters to a predominantly male clientele. Women express discomfort in the VA environment which can range from being identified as a spouse of a veteran, rather than as the veteran themselves, to harassment from other VA clients and in the most serious circumstances triggering past trauma.

While the majority of the women veterans who participated in the focus group project could access therapy for PTSD due to MST from VA facilities, some women who suffered this trauma found the VA and other facilities that required close interactions with male veterans as “triggers” preventing them from accessing treatment from these facilities. Even Women Health Clinics at VA facilities were not sufficiently protective, particularly if they were not separate stand-alone facilities and did not have separate entrances limited to women veterans.—California Women’s Law Center

BECOMING A TRAUMA-INFORMED COMMUNITY

Recommendation: Define the evolving needs of women veterans

The needs of women veterans will continue to increase as their numbers grow in the coming years. More women will take on traditional combat roles which will likely result in consequent trauma. As the VA creates more effective programs to support women veterans, and outreach strategies encourage them to self-identify, women may seek

federal support more regularly. But organizations on the ground and in the community must prepare themselves for the influx of women transitioning from service who may need long-term care. These organizations throughout California have proven to meet the ever changing needs of women veterans.



In our community, so many organizations offer services centered on employment, education and housing. As we wrapped up our program, we've realized that there are no services for health education and stress management. This was a great opportunity for us to provide effective health and wellness workshops tailored to the specific needs of women veterans.—Working Wardrobes

Equine therapy has given me a different perspective on my current issue. I have been in talk therapy, but it seems that I was able to connect with the horses more than an actual person (therapist). With the horses I was able to let my guard down and totally trust what the horses were communicating to me.—Reins of HOPE



Recommendation: Increase access to care and support for women veterans throughout the state

No one entity can shoulder the burden of care that veterans have and will continue to need. The changing landscape of veteran care will likely impact women greatly in the coming years as they are the largest growing cohort of veterans. As we have long advocated, resources should be provided where women need them, not where we believe women should seek them.

PARTNER HIGHLIGHT

Legal Aid Society, Employment Law Center and California Women's Law Center

Currently, women veterans with PTSD from MST are often forced to live surrounded by male veterans if they want to avoid homelessness and access the significant benefits and services available in veteran-only supportive housing facilities. LAS-ELC and CWLC are working on both a legal and policy level to ensure that veteran-only housing facilities provide appropriate accommodations to women veterans disabled by PTSD from MST and ensure that these facilities are safe for this specific population.

Recommendation: Create linkages among community providers to increase referral system and share best practices

Once a relationship is established among a provider and client, the provider may be less apt to send their client to another provider unless they know that a relationship can also be formed. Creating meaningful relationships between providers is always a challenge. A warm hand-off can be difficult when there is distrust or confidentiality concerns.

Women veterans have unique needs that require a unique response. For this reason, civilian providers must begin a dialogue around specialty care, to share information and coordinate a treatment response that takes into account the whole veteran and her complex needs. Best practices for services and support should be shared throughout referrals so organizations can learn from one another and continue to define an effective system-of-care.

Making partnerships with veteran serving organizations and collaboratives (a group of organizations and individuals dedicated to serving and improving the system-of-care for military, veterans, and their families) is an important step in the outreach process. While women veterans may not always access care from veteran serving organizations, they may have additional veteran-specific needs that may be met by veteran serving organizations. You may serve a crucial role in increasing access to care by directing women to these services when appropriate.

UNIQUE TREATMENT CONSIDERATIONS

Recommendation: Implement appropriate screening methods to identify women veterans

If providers do not ask the initial intake questions, 'Have you ever served in the military?' they will likely miss connections when a patient discusses health issues such as depression, anxiety, and pain associated from an injury during their service. Without context of service, civilian providers do a disservice for veterans by not acknowledging that symptoms may be related to their service.—Vanguard University

Many providers don't ask if their clients served in the military, and are unaware that many women seek medical care from civilian healthcare facilities. Others who do implement screenings may not be familiar with the appropriate terminology to ask in order to receive the correct information. For example, asking, "Are you a veteran?" will likely exclude many women veterans from self-reporting. Alternatively, asking, "Have you served in the U.S. military?" will encourage them to identify. See our publication *Women Veteran Screening Guide*, available on our website for more information on screening tools.

Recommendation: Separate the trauma from the veteran and dispel assumptions among providers of the woman veteran's experience

It is important as a treatment provider and advocate to distinguish the woman veteran from the trauma she has experienced. Often to be a "victim" is counter-intuitive to being a "warrior." Women may struggle with this and it may impact the way they seek and receive treatment. As mentioned previously, providers should recognize that bravery and courage to endure such a trauma and serve her country honorably is part of her identity, even if she is unable to confront the memories proudly.

Recommendation: Apply a culturally-informed practice and approach

Military culture has been recognized as a distinct subculture of American civilian society. Thus, in order to effectively reach veterans, practitioners need to explore the culturally-based constructs of the warrior mentality or worldview. Mental health workers need to consider how military cultural values held by veterans interact with perceptions of trauma and affect their help seeking behaviors in general.²⁹ Providers must develop workable, gender-appropriate and responsive solutions that will enable women veterans to receive much needed health and wellness services.

It is imperative for providers to establish trust with their clients, which can be especially difficult with women veterans since there are very real differences in the experiences of civilian and military women who have spent years living and working in a male dominated culture by which they are a scrutinized minority, to say nothing of exposure to trauma. Women veterans have been trained in the military to be hyper-vigilant, aware of their surroundings and to defend themselves. They may maintain a highly alert and possibly a nervous emotional state, and may find it difficult to feel relaxed and safe with a new provider. The provider's role is to help them feel safe and be able to turn off the hyper-vigilance they've learned to maintain.

I believe the impact of this grant will have longer reaching effects than initially anticipated. The impact of cultural competency trainings and technical assistance we received will ripple into our programs for many years to come. The ability to put a human face to the complexities of women veterans has been invaluable as we continue our work in the community, and interact with these families.—South Bay Community Services

As women veterans tend to be more isolated and less connected to the veteran system-of-care, they are alienated from their women veteran peers as well. As Reins of HOPE stated, “We realized right away how disconnected most participants feel and the importance of providing them ways such as this to connect not only with other women who have served but to resources available to them in the community.” In many instances, peer groups were the first time for many women veterans since leaving the military that they were in the company of fellow women veterans. This allowed them to associate their experiences and trauma in new ways, and to disclose more information and seek treatment in ways they otherwise would not have done.

From our observations, we were blown away at how open these women were with sharing their story. They had suffered from so much pain that having this sense of camaraderie made it a safe place for them to share their experiences.—Working Wardrobes

Women veterans often seek advice from their peers: Women veteran advocates may have knowledge or ties to community needs of women veterans. Advocates may be women veteran coordinators at veteran service organizations or the VA; they may be public advocates for women veteran care; or they may be peer mentors that have previously received services.

We have been able to reach women by word of mouth: women veterans are eager to recommend Honoring the Path of the Warrior as an organization women veterans trust and feel supported by; word seems to travel quickly around the country. Women veterans bring their friends and acquaintances to events.—Honoring the Path of the Warrior



Ways to become culturally and trauma informed:

- Isolation, distrust of institutions and high attrition rates make establishing relationships quickly paramount. To overcome these obstacles, ensure that clinical as well as intake and other staff engage in cultural competency training. Ensure knowledge of eligibility criteria and access to referral resources. Whenever possible, provide warm hand-offs to referrals.
- Consider creating a veteran working group or steering committee to empower veteran clients. Ask “alumni” of your program for their feedback, about safety, cultural competency, and treatment considerations. Have a veteran lead the project if possible.
- Identify or seek out veterans within behavioral health organizations to act as coordinators and counselors for veteran clients. Establish a veteran peer group or group therapy cohort. Engage in alternative therapies within your organization or community such as equine therapy.
- Providers are also strongly encouraged to work with staff at local VA medical centers, Vet Centers and/or community-based out-patient clinics (CBOCs). While there are still barriers to VA, they have expertise with service-connected injuries and illnesses and can provide comprehensive medical care. Note that Vet Centers are specifically tasked with counseling combat veterans and survivors of MST, regardless of discharge. Securing medical care may present more challenges.

Treatment considerations for clients who've experienced military sexual trauma:

- It is important to make sure that the veteran seeking care is made to feel safe, and it is important for you as the provider to explore what feeling safe may mean case-by-case. Be sure to discuss confidentiality and resources you can offer, and try to understand their experiences as unique compared to civilian clients.
- Consider the impact that veteran's trauma history might be having on his/her behavior.³⁰
- Use your relationship as a tool.
 - Model power-sharing and positive regard in relationships.

Organization Highlight: Honoring the Path of the Warrior creates a safe space for healing

“During our five-day retreat, we work intensively with the women veterans, allotting time for them to speak for ten minutes, sharing any challenges or traumas they no longer want to carry alone. The group listens deeply and witnesses the veteran as she speaks. We create rituals that hold a safe and secure space for women to share what they are ready to share. So many women are left isolated with traumas they have lived through. This safe space helps them step beyond that isolation, and offers a profound way for them to support each other. As trust builds, women are able to share more of their own experiences and find new tools to meet them. This is a meaningful and significant component of HPW women veterans’ retreats. It is difficult to share and witness so much pain AND women veterans return year after year to the retreat. Each summer, between one half and two thirds of the women return.”

Recommendation: Create a movement for women veteran care in California

There has been a heightened interest in women veterans in recent years which we hope will continue and accelerate. Generations of fraternal supports and services have excluded women from the resources and benefits associated with of past service. This project was intended to have lasting impact and jump start a movement to improve women veteran health in California and throughout the nation. Service providers, academics and researchers, philanthropists and government have all recognized the need for improvement but struggle to develop strategies and secure funds.

In addition, there has been some pushback in the veteran community that women do not need specialized care and an assumption in the civilian world that they are taken care of by the VA and government entities.

We applaud the California Wellness Foundation’s funding of a focused, intentional look at women veteran wellness.

Our intention is to help government and private funders identify needs and promising practices and to recognize that some experimentation and risk is required to improve service provisions in the veteran women space. Partnerships highlight the importance of alleviating service gaps and should be strengthened to guarantee the highest quality of subject-based and identity-based support.

We collaborated with a partner agency U.S. VETS who had a population of women undergoing treatment for substance abuse. While we are centered more on training and employment, we were out of our element of when we attempted to take on PTSD and MST. Luckily, we partnered with other organizations who offer proper treatment.—Working Wardrobes

Recommendation: Advocate for increased care and support for women veterans in California

The project has created a movement of support for women veterans. Swords to Plowshares efforts and CWVP partners collaborations will continue well beyond this grant to further impact the availability of cultural competent supportive services for women veterans. Many grantee organizations were motivated to change programs significantly or expand and/or add additional programs to improve services for women veterans based on knowledge gained through this work.

NEXT STEPS IN THE NEW AGE OF WOMEN VETERAN CARE

While the CWVP partners achieved tremendous results with modest grants. This is the first and only funding project of this kind in California and the country, and we have only scratched the surface of dialogue among providers and advocates.

As the veteran care landscape evolves, funding should be targeted to meet the needs of women veterans. Grants which equip community organizations like those in the *California Women Veteran Project*, who can leverage dollars and increase their capacity, would continue this movement to meet women veterans at every corner of the California map.

We strongly encourage government and the philanthropic community to leverage the investment of the California Wellness Foundation to replicate and expand this model in California and beyond. We are now in a better position to advocate for increased support for women veterans and to devote much needed time and resources to ensure that they receive culturally competent and comprehensive services.

SOURCES

- ¹ Maguen, et al, “Gender differences in traumatic experiences and mental health in active duty soldiers redeployed from Iraq and Afghanistan.” 2012; OIG, & “Review of Combat Stress in Women Veterans Receiving VA Healthcare and Disability Benefits.” December 2010.
- ² Kimerling, R., Weitlauf, J. C., Iverson, K. M., Karpenko, J. A., & Jain, S. Gender issues in PTSD. In M. J. Friedman, T. M. Keane, & P. A. Resick (Eds.), *Handbook of PTSD: Science and Practice*. New York: Guilford Press, 2013.
- ³ Department of Veterans Affairs, Office of Inspector General. Review of Combat Stress in Women Veterans Receiving VA Healthcare and Disability Benefits. Accessed December 16, 2010: va.gov/oig/52/reports/2011/VAOIG-10-01640-45.pdf.
- ⁴ Ozbay, Fatih, et al. “Social Support and Resilience to Stress.” *Psychiatry (Edgemont)*; 4(5): 35-40, May 2007.
- ⁵ Wolfe, Jessica et al. “Sexual Harassment and Assault as Predictors of PTSD Symptomatology among U.S. Female Persian Gulf War Military Personnel.” DOI: 10.1177/088626098013001003 *J. Interpers Violence*. Vol. 13 No. 1 40-5.7. February 1998.
- ⁶ Adams et al. “The association of combat exposure and injuries with behavioral health problems among enlisted female Army members returning from Iraq or Afghanistan.” *Addiction Science & Clinical Practice*, 10 (Supplement 1):A1. <http://www.ascpjournal.org/content/10/S1/A1>, 2015.
- ⁷ Fann, J.R., et al. (2009). Treatment for depression after traumatic brain injury: A systematic review. *Journal of Neuro-Trauma*, 26(12): 2383-2402; Iverson, K.M. et al. Psychiatric diagnoses and neurobehavioral symptom severity among OEF/OIF VA patients with deployment-related traumatic brain injury: A gender comparison. *Women’s Health Issues*. 21(4): S210-S217, 2011.
- ⁸ Iverson, K.M., et al. Psychiatric diagnoses and neurobehavioral symptom severity among OIF/OEF VA patients with deployment-related traumatic brain injury: A gender comparison. *Women’s Health Issues*. 21(4): S210-S217, 2011.
- ⁹ Haskell, S.G. et al. The burden of illness in the first year home: Do male and female VA users differ in health conditions and healthcare utilization. *Women’s Health Issues*. 21(1): 92-97, 2010.
- ¹⁰ Eileen M. Resnick, Monica Mallampalli, and Christine L. Carter. Current Challenges in Female Veteran’s Health. *Journal of Women's Health*. 21(9): 895-900. Doi:10.1089/jwh.2012.3644, September 2012.
- ¹¹ Golub, Andrew, Bennett, Alexander. “Introduction to the Special Issue: Drugs, Wars, Military Personnel, and Veterans. Substance Use Misuse. 48(10): 10.3109/10826084.2013.816859, July 2013.
- ¹² Stanford University. The Clayman Institute for Gender Research. “To treat traumatic brain injury in soldiers, take gender into account.” Accessed July 12, 2015: <http://gender.stanford.edu/news/2013/treat-traumatic-brain-injury-soldiers-take-gender-account#sthash.w8w5er7y.arwj6rsp.dpuf>.
- ¹³ Los Angeles Times. “Suicide rate of female military veterans is called 'staggering'.” Accessed June 26, 2015: <http://www.latimes.com/nation/la-na-female-veteran-suicide-20150608-story.html#page=1>.
- ¹⁴ Monteith, L. L., Menefee, D. S., Forster, J. E. And Bahraini, N. H. A Closer Examination of Sexual Trauma during Deployment: not all sexual traumas are associated with suicidal ideation. *Suicide and Life-Threat Behavior*. DOI: 10.1111/sltb.12171, 2015.
- ¹⁵ Department of Veterans Affairs, “Overview of IPV.” Information accessed on March 15, 2015: ptsd.va.gov/public/pages/domestic-violence.
- ¹⁶ U.S. Department of Labor, Bureau of Labor Statistics, “Employment Situation of Veterans Summary.” March 18, 2015; and U.S. Census Bureau, American Community Survey PUMS, 2015.
- ¹⁷ Stanford University. The Clayman Institute for Gender Research. “To treat traumatic brain injury in soldiers, take gender into account.” Accessed July 12, 2015: <http://gender.stanford.edu/news/2013/treat-traumatic-brain-injury-soldiers-take-gender-account#sthash.w8w5er7y.arwj6rsp.dpuf>.
- ¹⁸ VA HSR & D Center for the Study of Healthcare Provider Behavior presentation at National Forum on Homelessness among Veterans. “Women Veterans Who are Homeless,” 2010.
- ¹⁹ Government Accountability Office, “Homeless Women Veterans: Actions Needed to Ensure Safe and Appropriate Housing,” GAO-12-182, Page 1, December 2011.

-
- ²⁰ Decker, et al. "Military Sexual Assault and Homeless Women Veterans: Clinical correlates and treatment preferences." *Women's Health Issues*, Volume 23, Issue 6, e373-e380.
- ²¹ Department of Veterans Affairs, Veterans Health Administration, "Analysis of VA Health Care Utilization among OIF/OEF/OND Veterans, Cumulative from 1st Quarter. FY 2002-4th Quarter. FY 2014." Released January 2015.
- Ozbay, Faith et al. "Social Support and Resilience to Stress." *Psychiatry* (Edgemont). 4(5): 35-40, May 2007.
- ²² Department of Veterans Affairs. Profile of Women Veterans, 2012.
- ²³ Hall, L. K. The importance of understanding military culture. *Social Work in Healthcare*, 50(1), 4-18, 2011.
- ²⁴ Weiss, E., Coll, J. E., & Metal, M. The influence of military culture and veteran worldviews on mental health treatment: Practice implications for combat veteran help-seeking and wellness. *International Journal of Health, Wellness & Society* 1(2), 2011.
- ²⁵ Hamilton et al. Factors related to attrition from VA healthcare use: Findings from the National Survey of Women Veterans. *J. General Intern Medicine*. Supplement 2:S510-6. DOI: 10.1007/s11606-013-2347-y, July 28, 2013.
- ²⁶ Friedman, et al. Travel time and attrition from VHA care among women veterans: how far is too far? *Med Care*. 53(4 Supplement 1):S15-22. DOI: 10.1097/MLR.0000000000000296; Hamilton, et al. Factors related to attrition from VA healthcare use: Findings from the National Survey of Women Veterans. *J. General Intern Medical Supplement* 2:S510-6.DOI: 10.1007/s11606-013-2347-y, April, 2015.
- ²⁷ Swords to Plowshares created a re-grant program for agencies, both veteran and non-veteran to serve women veterans in California. Reports as of September 2014 show significant challenges in outreach and attrition, July 28, 2013.
- ²⁸ Hoge, CW. Interventions for war-related post-traumatic stress disorder: meeting veterans where they are. *JAMA*. 306(5):549-551, 2011.
- ²⁹ Weiss, E., Coll, J. E., & Metal, M. The influence of military culture and veteran worldviews on mental health treatment: Practice implications for combat veteran help-seeking and wellness. *International Journal of Health, Wellness & Society* 1(2), 2011.
- ³⁰ Bell, Margret. "Homelessness and Military Sexual Trauma." Presentation to the Department of Veterans Affairs. Accessed:
https://www.google.com/url?Sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0CB8QFjAAahUKEwj1bPQs7HHAhWRmYgKHTWkAVs&url=http%3A%2F%2Fwww.va.gov%2FHOMELESS%2Fdocs%2FGPD%2Ftrainings%2fgpdtrn_MST_6_14_12_Krinsley_part_3.pptx&ei=b4dsvzu2cjgzogs1yibyq&usg=afqjcnde-g1ayjonhy6qehnlbekdjy5kg&bvm=bv.99804247,d.cgu&cad=rja.

