KEEPING OUR PROMISE TO AMERICA'S VETERANS

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STATEMENT OF
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FOR THE SENATE COMMITTEE ON VETERANS' AFFAIRS
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Chairman Tester, Ranking Member Moran, and Members of the Committee:

On behalf of DAV's (Disabled American Veterans) more than 1 million members, thank you for inviting us to provide testimony for the Senate Veterans' Affairs Committee hearing titled, *"Caring for All Who Have Borne the Battle: Ensuring Equity for Women Veterans at VA."*

DAV members, all of whom are war-time disabled veterans who were wounded, injured, or made ill during their service, utilize the Department of Veterans Affairs (VA) benefits and the Veterans Health Administration (VHA) services at extremely high rates—in fact many depend on VA as their sole source of health care.

Throughout its 100-plus year history, DAV has been an unwavering champion of women veterans and made a concerted effort to highlight and recognize their contributions to the defense of our country. The integration of women into every career path in the armed services has resulted in a rise in the number of women who serve and subsequently increasing numbers of women have applied for disability benefits and enrolled in VA health care following military service. Women are in fact the fastest-growing demographic of veterans—with over 650,000 now using VA health care services. Women veterans using VA care have high rates of service-connected disabilities, many have medically complex health histories and use specialty care—such as mental health and substance use disorder services at higher rates. Unfortunately, for too many women veterans untreated mental health issues have led to a rising suicide rate among this population in recent years.

About two years ago, DAV began work to review all available medical research literature concerning mental health among the women veterans' population, particularly focused on gaps in care and solutions to prevent suicide. In February of this year, DAV released our new report *Women Veterans: The Journey to Mental Wellness* with our findings and recommendations for change. This report is the third in a series of reports on women veterans DAV has released over the past decade, but the first one that is dedicated to mental health. Our report is a comprehensive look at the unique risk factors contributing to the staggering rate of suicide among women veterans and how the VA can and must do better. In addition to identifying gaps in gender-tailored mental

health care and suicide prevention initiatives, DAV offers more than fifty legislative and policy recommendations that have the potential to save the lives of women veterans.

Our report comes on the heels of VA's most recent Annual Veterans Suicide Prevention Report published in November 2023, which is based on the most recent data and analysis from 2021. Despite a public health approach and concerted efforts to reduce suicide among veterans, VA's report showed increased rates of suicide for veterans. However, the most alarming finding was that the suicide rate among women veterans jumped 24.1% in 2021; nearly four times higher than the 6.3% increase among male veterans and vastly higher than the 2.6% increase among non-veteran women. While there has been significantly more attention and resources provided in recent years to reduce veteran suicide, these statistics demonstrate there is a need to focus more on the unique challenges and obstacles women veterans face on their journeys to mental wellness.

VA Women's Health Research

As we conducted an exhaustive review of the most recent and available VA research on women veteran's mental health care, the most consistent finding, regardless of the issue, was that there simply is not sufficient research or data specifically focused on women veterans. We found, and the VA recognizes, the need to invest in more research on issues impacting women veterans, and to ensure that data on this group of veterans is included in all VA research and data collection efforts.

Researchers within the VA have long recognized the need to address challenges to fully integrate women into a health care system that has historically focused on the majority male population it serves. For those reasons, the Women's Health Research Network (WHRN) was established within the VA in 2010 to connect researchers interested in issues affecting women veterans. This initiative has resulted in the most extensive volume of women veterans-specific research anywhere and has made the VA a knowledge leader in women veterans health. While this effort has resulted in real progress, it is clear there is still more work to be done to ensure this growing population has access to effective health care services and programs tailored to meet their needs.

DAV recommends that Congress ensure the Women's Health Research Network has sufficient resources to continue its efforts to map gaps in the women veterans' research agenda, especially in the area of suicide prevention, and to recruit investigators with subject matter expertise to address them. The VA must ensure all research efforts include over-sampling of all underserved veteran subpopulations, including women who have been too often left out of research until the last few decades. In particular, DAV recommends that VA expand its research on mental health issues that are associated with elevated risk of suicide, specifically those discussed in the testimony below.

Lethal Means Safety

The issue of lethal means safety is particularly important when it comes to suicide prevention for our nation's veterans and a growing concern among women

veterans who are at significantly higher risk compared to their civilian counterparts. According to VA's 2023 Annual Veterans Suicide Prevention Report, firearms were used in 51.7% of women veterans' suicides, more often than all other methods combined. The rate of women veterans dying by firearm suicide was nearly three times higher than for non-veteran women dying from firearm suicide.

Developing an effective lethal means safety initiative begins by understanding the many reasons why women veterans choose to own firearms. Perhaps the most common reason cited is to protect themselves—which requires that the firearm is easily accessible. This coincides with the fact that many women veterans have experienced military sexual trauma (MST) or interpersonal violence (IPV). However, we know that suicidal ideation is episodic and when individuals are in crisis they often vacillate in their intent to die, which is why interventions that can create a barrier of time and space between the thought of suicide and the action are considered most effective. VA needs to promote lethal means solutions that are designed specifically for women veterans, and that are communicated in an effective manner to women veterans.

In an effort to raise awareness about suicide prevention, VA included women veterans in its lethal means safety campaigns. Unfortunately, these efforts have not been as successful as hoped. Women veterans who were part of a focus group looking at VA's public awareness campaign expressed that the ads fell short and it was not clear why it is so important to keep their firearms at a safe distance in a time of crisis. Women indicated they understood the message about the need for safe storage of firearms in general, but that there was lack of clarity about suicide prevention and crisis intervention messaging. As such, VA will need to refocus its efforts and develop clear, concise messaging for women veterans.

DAV recommends the Women's Health Research Network's Suicide Prevention Work Group, in collaboration with the VA Offices of Women's Health and Mental Health and Suicide Prevention, investigate how suicide prevention materials and lethal-means counseling interventions are perceived and accepted by women veterans in order to help determine which suicide prevention approaches are most effective. The VA should continue to conduct focus groups with women veterans to determine the most effective secure firearm storage messages and messengers for this population.

Another way to improve lethal means safety awareness is by requiring training for VA's community care network (CCN) providers. Women veterans are high users of community care, particularly since the many gaps in gender-tailored care and specialized care regularly require women veterans to be referred out to the community. Suicide prevention is the Veterans Health Administrations (VHA) number one clinical priority and it is required that all VA clinical providers take a specially designed course on suicide risk identification and intervention. VA providers are also trained in how to counsel at-risk veterans to temporarily reduce access to firearms and other lethal means. However, the CCN third-party administrators do not require their providers to take suicide prevention or lethal means safety counseling. It has been reported that only 2,300 of VA's community care providers have completed a lethal-means safety course,

representing less than 1% of the pool of the nearly 1.6 million community care providers.

DAV recommends that the VA amend its contracts with community care providers, or Congress must legislatively mandate, that all community care providers who treat veterans must be trained in suicide prevention and lethal-means safety counseling on at least an annual basis, the same as VA providers. To ensure this training is being completed, the VA should regularly publish the number of community care providers who have taken VA suicide prevention and lethal-means safety counseling training.

Rural Women Veterans

For many women veterans who live in rural areas, mental health issues and suicidality are magnified. The number of transitioning service members that choose to live in rural areas has risen, and according to the VA, 1 in 4 women veterans who use VA health care services live in rural areas. Research shows that there is a 20% increased risk for suicide among rural veterans, and rural women veterans have higher rates of suicide by firearm than their urban women veteran peers.

Rural veterans already face unique challenges, including access to basic healthcare, lack of transportation, long distances to health care facilities, and a lack of digital communication services. Veterans living in highly rural and remote communities, such as Guam, American Samoa, Puerto Rico, U.S. Virgin Islands and the Northern Mariana Islands, face even greater challenges due to limited or poor infrastructure.

Accessing mental health services can be especially difficult in rural communities, where even the most basic medical care can be a challenge to access. In addition, the isolation that comes from living in these areas has been identified as a high-risk factor for suicide and intimate partner violence, yet another layer of obstacles facing rural women veterans.

Researchers also found that rural women veterans, like their urban peers, have a high prevalence of MST and mental health conditions, including depression and PTSD. Unfortunately, rural women veterans are less likely to receive mental health and gender-specific health care services compared with urban women peers, and those with longer drive times to access care are more likely to drop out of care.

DAV recommends the VA develop targeted solutions to bridge gaps for the provision of mental health care services in rural communities—especially for women veterans who require specialized, evidence-based treatments for MST-related PTSD, depression, and other mental health issues linked with higher suicide rates.

Military Sexual Trauma and Intimate Partner Violence

All too frequently military sexual trauma (MST) and/or intimate partner violence (IPV) goes unreported or unrecognized. Jennifer Alvarado, who was profiled in our report, is a Navy veteran who suffered in silence for 15 years reeling from the effects of repeated MST and IPV that she experienced during her time in service. When Alvarado

reported the abuse she was experiencing at home to her leadership, rather than help, she was met with sexual harassment. Subsequently, she battled with homelessness, depression, as well as PTSD and turned to drugs and alcohol to cope until one day, she considered suicide. Fortunately, Alvarado is one of the lucky ones, because eventually she was able to receive the help she needed. She found a VA therapist that listened and helped her get through this crisis. She also credits DAV benefits assistance with helping her get beyond survival mode and working with her to get her claim for MST-related PTSD approved.

It is important to note, that women veterans are not the only ones who may experience sexual trauma. Among veterans enrolled in the VA, 1 in 3 women and 1 in 50 men report experiencing MST. Also, despite the increased focus by the Department of Defense on eliminating MST in recent years, we found that the number of service members who report having experienced sexual harassment and sexual assault has steadily increased. Research continues to show that MST is a major risk factor for suicide among veterans regardless of gender.

DAV strongly recommends that MST be a central pillar of suicide prevention efforts in VHA, given the exceedingly high prevalence of MST-related trauma among VHA patients.

Women veterans are also at higher risk for intimate partner violence than those who did not serve. In fact, according to one study 1 in 5 women veterans using VHA primary care reported experiencing IPV or domestic assault. There is also a strong association between a positive IPV screen and suicidal ideation and self-harm behaviors among women veterans. Women veterans who seek help for intimate partner violence not only need mental health support, but also benefits claims assistance and the kind of wrap-around social services offered by VA.

DAV recommends that VHA educate community care partners that women veterans have higher rates of IPV and require that patients who screen positive be referred back to the VA for information, treatment, resources, and safety planning if needed.

Having a safety plan can play a critical role in helping to save the life of a woman who might be experiencing intimate partner violence. While there are options to get help such as the National Domestic Violence Hotline, we believe it could be made easier for a veteran in crisis to reach this life saving line.

DAV recommends the Department of Health and Human Services to create a three-digit number, similar to the "988" Suicide Crisis Line (with a veteran option) for the National Domestic Violence Hotline (800-799-7233) to ensure veterans can get the support and services they need to address IPV.

REACH VET—Suicide Predictive Modeling

One of the main tools in VA's suicide prevention strategy is a predictive model of suicidality in the veteran population called REACH VET (Recovery Engagement and Coordination for Health – Veterans Enhanced Treatment), that identifies veterans at higher risk for suicide and who may benefit clinically from outreach, additional risk assessment and enhanced care. The REACH VET model flags veterans who, because of certain risk factors, are more likely to be at heightened risk for suicide. Veterans identified through the model are included in a monthly dashboard by the VA Office of Mental Health and Suicide Prevention and passed on to local suicide prevention coordinators and VA mental health providers for assessment and care.

Initial evaluation of REACH VET has proven it to be successful for the veterans who were identified. In the first year of implementation, patients receiving the intervention completed more mental health appointments and health care appointments overall, missed fewer appointments, completed more suicide prevention safety plans, and experienced less all-cause mortality. We appreciate VA's effort to leverage technology to reduce the number of veteran suicides, however we found that the original REACH VET predictive model did not include MST or IPV as a risk factor in its algorithm. We are pleased to learn that revisions to the model are now being made and that REACH VET 2.0 is underway.

DAV strongly recommends that VHA revise its REACH VET model to incorporate all risk factors that significantly impact women, such as MST and intimate partner violence.

Substance Use Disorder and Eating Disorders

Within the veteran population, there is a high risk of substance use disorders (SUD), too often originating as an attempt to control pain or to cope with trauma and post deployment mental health issues. The risk of suicide death among women veterans with active substance use disorder is more than 2 times the rate of male veterans. Research shows there is a direct link between trauma and substance use disorder as well as eating disorders. According to one study, 16% of women veterans have substance use disorder associated with traumatic experiences, including combat and MST. Furthermore, most women veterans with at-risk alcohol use are not in treatment—citing stigma and discomfort with mix-gender programs as reasons for not engaging in treatment.

One important way VA treats substance use disorder and mental health issues, such as PTSD is through inpatient treatment. VA's Mental Health Residential Rehabilitation Treatment Program (MHRRTP) provides residential treatment for substance abuse, as well as domiciliary care for veterans experiencing homelessness, and residential treatment for veterans with PTSD. This program provides veterans a 24/7 transitional living environment in a safe and therapeutic community setting to address clinical and rehabilitation issues that can help optimize successful recovery.

DAV recommends the VA should assess the need to add additional domiciliary beds and gender-specific programming in residential rehabilitation programs to improve access and better serve women veterans.

Women veterans are often the sole provider and caregiver of their families which can limit the amount of time they are able to be away from their family to receive treatment or care. For women in these roles, residential treatment is often not a viable option. In order to address this gap, VA has integrated mental health care with primary care in their Patient Aligned Care Team (PACT) system to better support women veterans who have comorbid mental and physical health issues. PACTs that specialize in caring for women veterans who have substance use disorder and chronic pain issues could be a very effective treatment option that would not require them to sacrifice time away from their families or jobs.

DAV recommends that Congress provide additional funding to expand women-centered PACT programming to meet the needs of veterans with comorbid substance use disorder and chronic pain.

Another area of concern among the women veteran's population which can have an impact on suicide rates is eating disorders. The VA's National Center for PTSD notes that individuals with eating disorders have high rates of comorbid PTSD and that military-specific traumas—such as MST and combat—as well as the military's strict weight and fitness requirements, may make veterans particularly vulnerable to eating disorders. DAV found that eating disorders are not as well researched within the veteran community as other types of mental health issues, despite the fact that VHA estimates as many as 14% of female and 4% of male veteran patients have eating disorders. One study found that women veterans reporting MST were twice as likely to develop an eating disorder and suggested that it may be useful to focus on women reporting MST when implementing eating disorder screening and treatment programs.

DAV recommends that VA continue to conduct women veteran-focused research on the association between multiple forms of trauma and eating disorders in order to develop more effective interventions, treatments, and therapies.

Trauma Informed Care and Social Support

Trauma-Informed Care (TIC) is an approach that can be used by health care providers and assumes that an individual is more likely than not to have a history of trauma. TIC principles help providers recognize the presence of trauma symptoms in patients and to better understand the role trauma may play in an individual's life. We know that women veterans are more likely to have been exposed to trauma such as combat, MST and IPV compared to civilian counterparts. VHA has been a leader in this type of care approach, and has trained its providers to ensure a patient is not retraumatized when they are being treated. We are concerned that when women veterans go to VA community care providers they will not receive the same quality of trauma informed care. It is essential that Congress, the VA, veterans advocates and

other interested stakeholders work together to ensure our nation's women veterans have access to the timely, high-quality, trauma-informed and gender-specific care they need.

DAV recommends that VA develop an awareness campaign to educate and engage VA community care network providers in employing principles of universal precautions in trauma informed care.

Social support is well-established as a major protective factor following traumatic events that can lower suicide risk. One exceptional non-governmental program DAV has strongly invested in is the Save A Warrior program, a nonprofit organization committed to ending the staggering suicide rate plaguing veterans, active-duty military and first responders. We are proud to have provided a major grant to support the construction and development of Save A Warrior's National Center of Excellence for Complex Post-Traumatic Stress in Hillsboro, Ohio, which provides a healing outlet for ill and injured veterans combating suicide and mental health issues. We have also provided significant support to the Boulder Crest Foundation which hosts retreats with gender-tailored programming for women veterans, with DAV leaders and spouses serving as mentors for the latest generation of seriously injured veterans and their caregivers. Boulder Crest programs use the science of post-traumatic growth to help participants and their families transform struggle and trauma into lifelong growth and strength.

The VA also sponsors women-only retreats through its Vet Center Program. The VA has the authority to provide counseling in retreat settings to veterans through 2025, in accordance with Public Law 116–315, which are sometimes women-only, and may provide financial, vocational, and stress-reduction counseling. Women veterans attending these retreats report they are highly beneficial in helping them make peer connections and build a network of peer support.

DAV recommends VHA assess whether its current Vet Center retreat programming meets demand and whether it would be beneficial to increase the number of retreats for women veterans. We also recommend that the current statutory authority for these retreats that expires at the end of FY 2025 be made permanent.

Another form of social support comes through VA's peer specialists who provide support services to help other veterans by sharing common experiences and working towards their recovery and wellness goals. The VA has stated it plans to use more peer support in mental health settings, including substance use disorder programming, to improve veterans' retention and engagement in more intensive evidence-based treatments.

DAV recommends that Congress expand the VA's authority and resources to establish an appropriate training and oversight infrastructure to increase hiring and employment of women veteran peer support specialists in all service lines where they would be most beneficial.

Reproductive Mental Health Care

Perhaps the most underappreciated aspect of women veterans mental health care is the relationship to reproductive care. During the life cycle of women—pregnancy, birth and menopause can bring about significant hormonal shifts and increase the possibility for mental health challenges.

Research indicates that pregnant veterans who come to VA are likely to have elevated rates of trauma exposure and mental health conditions that can increase risks during pregnancy. For example, PTSD during pregnancy is associated with a 35% increased risk of pre-term birth, a 40% increased risk of gestational diabetes, and a 30% increased risk of preeclampsia. It is also associated with increased risk for postpartum depression and poor mother-infant bonding.

I know first-hand how dramatically pregnancy can impact a person's mental health. During my service in Iraq, I experienced a number of traumatic combat experiences that eventually led to a diagnosis of PTSD, and a course of treatment that included a number of medications. Later, while on active duty as an instructor at Keesler Air Force Base, I became pregnant and medical complications forced me to have an emergency C-section, giving birth to my son two months early. Subsequently, I began experiencing postpartum depression. One day, while my baby boy was sleeping on the bed, I started having terrible, intrusive thoughts that threatened to harm both of us. This served as a wake-up call for me, and I quickly got the mental health care I required to get through this crisis.

While I was fortunate to get the right help to get through my crisis, many women veterans are not even aware of the powerful impact hormonal changes can have on their mental health. Although most maternity care is provided through community partners, the VA has worked hard to create a supportive maternity experience for women veterans, which includes making maternity care coordinators available to veterans and establishing national requirements for the management of pregnant veterans.

DAV recommends that VHA assign responsibility for tracking and reporting suicide screening, referral and follow-up care within VHA to maternity care program coordinators, and that the data they collect be reported in the VA's annual report to Congress on suicide prevention.

Another issue that affects many women veterans' mental health, but often does not get as much attention is menopause. Usually, menopause comes with fluctuations in hormone production, beginning between ages 45 and 55, and is frequently accompanied by a variety of symptoms, including hot flashes, sleep disruption, body aches, weight gain, incontinence and memory problems. Menopause has also been shown to double the risk for depression. However, the impact of menopause on mental health and suicide risk among women veterans is understudied and not yet well-defined. Given the rising suicide rate for women veterans, including older women, and a

preliminary indication of concern with depression, chronic pain and polypharmacy increasing the risk of suicide, further research into menopause and mental health is clearly warranted.

DAV recommends that VA's Offices of Mental Health and Suicide Prevention, Women's Health, and Research & Development coordinate with the Women's Health Research Network – in addition to VA and non-VA experts in perimenopausal women's health – to explore a research agenda on the related threads of menopause, depression, polypharmacy and suicide. They should also work together to target and promote greater suicide prevention efforts both in the VA and among community care network providers who care for older women veterans.

VA's Community Care Network (CCN) and Care Coordination

Women veterans are referred to the community for all maternity care, and at times for many other gender-specific services; in fact, some VA health care facilities don't provide any specialty gender-specific care, instead using its CCN providers. It is critical that the VA's CCN providers transmit all of their medical records back to VHA so that they can incorporate them into the veteran's electronic health record to ensure safe and high-quality care for veterans receiving care at both VA and in the community. Unfortunately, the transfer of medical records back to VA continues to be a problem. VA has community care coordinators to help ensure veterans' records are complete and that referrals to its CCN providers result in veterans receiving the care they need. VHA uses one-on-one maternity care coordinators as a resource for pregnant veterans because of pregnancy-related risks and the potential for developing post-traumatic stress, suicidal thoughts, or associated postpartum depression.

DAV recommends that VHA ensure maternity care coordinators have adequate allocated time to track and manage veterans with complex health histories, especially those utilizing community care services.

Mr. Chairman, first and foremost we appreciate the continued focus by this Committee on addressing the needs of our nation's women veterans. DAV's report, *Women Veterans: The Journey to Mental Wellness* includes dozens of recommendations to improve the mental health and lives of women who have served. A finding highlighted throughout the report and this testimony is that many women veterans who utilize the VA have significant comorbid physical and mental health conditions and trauma histories. And for too long, women veterans have been made to fit inside of a health care system designed for men. Given the significantly increased rates of suicide among this population we can and must do better.

While VA has made progress and important changes to improve care and services for women veterans, gaps still exist—especially in mental health programs and services. VA must continue and expand its women's health research efforts, improve community care provider training and address the limited access to gender-specific mental health programming. Based on the findings we have highlighted, it is essential

that Congress, the VA, and veterans advocates work together to ensure our nation's women veterans have access to the timely, high-quality, trauma-informed and gender-specific care they need. When we work together, we can not only improve the lives of our nation's women veterans, we can save them.

This concludes my testimony on behalf of DAV. Again, we appreciate the opportunity to testify and I am happy to address any questions members of the Committee may have.