



WOMEN VETERANS: THE LONG JOURNEY HOME

U.S. ARMY

Foreword

DAV (Disabled American Veterans) is pleased to present this unprecedented report: *Women Veterans: The Long Journey Home*, a comprehensive study of the many challenges women face when they leave military service.

DAV commissioned and produced this report to highlight the role of women in the military, particularly over the past decade of war; to explore the issues facing women as they transition from military to civilian life; and to chronicle the unique challenges they face and sacrifices they make, which are little understood and rarely recognized. Our overarching goal is to document existing gaps in federal programs and services and spur policy changes to fill them.

The number of women in the military today and their evolving role in our national defense continue to rise. Although women in uniform have long served with honor and courage in combat environments, changes in Department of Defense (DoD) policy have now opened military occupational specialties previously closed to them, presenting a new series of challenges for women veterans.

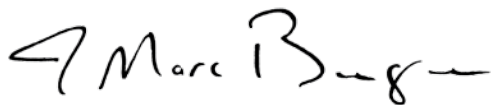
As women complete their military service and begin their transitions home, they embark on a journey. As vividly depicted in this report, the Departments of Defense, Veterans Affairs (VA) and Labor (DoL) are also on an unfinished journey themselves in terms of fostering and adapting programs and policies to support women service members returning to civilian life. These and other federal agencies must work collaboratively if women are to have timely and seamless access to high quality medical care, mental health programs and a full array of readjustment benefits. This report details programs throughout the federal government that desperately need adaptation to better assist women veterans achieve educational goals, secure employment, and achieve successful careers. We believe the recommendations in this report can help women who served make a smoother transition home to reestablish their relationships with children, spouses, extended families, friends, employers and communities.

The stories and statistics that support this report make clear that women veterans face a homecoming that is remarkably different than their male counterparts. As a nation we need to fully recognize their contributions and sacrifices—we owe them this respect and opportunity to heal and successfully transition home.

Our nation must address and change the culture that ignores or minimizes women's service and their contribution to our military mission, so that they too can fully benefit from the array of services that have been established for veterans, including for those who served in combat theaters and other hardship deployments.

Today, women represent the fastest growing group of veterans who are enrolling in VA health care. More women serving, and many more serving in the future, mean that DoD and VA programs historically focused almost exclusively toward the needs of men must change and adapt; that change must begin now and it must be pursued with urgency.

DAV pledges to be an agent for this change, and to travel the road home alongside all women who proudly volunteer and serve our nation with honor and distinction. Please join us in this journey.



J. MARC BURGESS
*National Adjutant and
Chief Executive Officer, DAV*



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Executive Summary

Women have patrolled the streets of Fallujah and Kandahar, they have driven in convoys on desert roads and mountain passes, they have deployed with Special Forces in Afghanistan on cultural support teams, they have climbed into the cockpits of fighter jets and out of the bloody rubble after IED explosions. Many have begun their long journey home. The question we ask in this report is –

“Will they walk alone?”

Women have volunteered to serve in the U.S. military since the American Revolution. Today they constitute approximately 20 percent of new recruits, 14.5 percent of the 1.4 million active duty component and 18 percent of the 850,000 reserve component. Almost 280,000 women have served Post-9/11 in Afghanistan and Iraq. While the number of male veterans is expected to decline by 2020, the number of women veterans is expected to grow dramatically, to 11 percent of the veteran population.

Because of their role in the military and society, women have unique transition challenges. They experience deployment and reintegration differently than men. Women focus more on disruption of interpersonal relationships, feeling less social support once they return home, and do not find services or commanders prepared to support a woman and her family after deployment. When compared to men, women are less likely overall to be married, more likely to be married to a fellow service member, more likely to be a single parent, more likely to be divorced, and more likely to be unemployed after

their service. Women veterans tend to be younger than men and are less likely to use VA benefits.

Women who served our country in the military are strong and heroic but their contributions have been underrecognized, even by the women themselves. The challenges of readjustment to post-military life affect women differently than men and should receive attention from their local communities and the federal government that is at least comparable to that received by men. The unique needs of women veterans are varied and complex, spanning the areas of health care, eradication of sexual assault, employment, finance, housing, and social issues. One of the most persistent problems is a military and veterans' culture that is not perceived as welcoming to women and does not afford them equal consideration. VA's Women Veterans' Task Force noted the “need for culture change across VA to reverse the enduring perception that a woman who comes to VA for services is not a veteran herself, but a male veteran's wife, mother, or daughter.” Our nation does not yet adequately recognize and celebrate the contributions of women in military service, treat them with dignity and respect, or promote their successful transition to civilian life. This is a foundational issue and will be one of the most critical but difficult to address.

We identified serious gaps in every aspect of the programs that serve women, including health care, employment, finance, housing, social issues and the eradication of sexual assault. The vast majority of these deficiencies result from a disregard for the differing needs of women veterans and a focusing on the 80 percent solution for men who dominate in both numbers and public consciousness. The recent dramatic increase in reporting of military sexual trauma is an illustration of problems and solutions that require radical change in the culture of the Armed Forces.

Many women who return from deployment are made stronger by their experiences but a significant number have difficulty with transition and need support for health care, employment, finance, housing and social issues. With the withdrawal of ground forces from Iraq and the drawdown in Afghanistan, government and the public are already turning to new issues. There is a misperception that these problems associated with war will disappear when there are no more boots on the ground. History and research tell us that this is a false hope. Women who have deployed suffer from a complex array of medical conditions that will grow over time and present long-term challenges.



Research conducted by VA shows that almost one in five women veterans has delayed or gone without needed care in the prior 12 months. VA needs to expand its delivery of gender-sensitive health care services to meet the needs of the rapidly growing number of women they serve. How can an integrated health system that serves women purport to provide comprehensive health care when a third of their medical centers do not have a gynecologist on staff? Yet that is the case in VA today. Holistic, evidence-based programs for women's health, mental health and rehabilitation must be expanded to address the full continuum of care needed by all veterans. VA should have the authority to provide lifetime eligibility for health care to every veteran who served in a combat theater; the current five-year special eligibility provided by Public Law 110-181 is not adequate.

Women have difficulty translating their military experience into civilian employment. This is clearly evident in the stubbornly high unemployment rates for some groups of women veterans. One result of our inability to reverse these unemployment trends is the disturbingly high rate of homelessness among women veterans—at least twice as high as women non-veterans. These issues must be addressed with solutions that target the special needs of women since it is clear that the traditional programs are falling short for them. Safe housing solutions for women veterans, especially women with minor children, are scarce in virtually every community.

This report provides a roadmap for urgent action to support women veterans on their long journey home. Women veterans have remained invisible for far too long to the federal, state and local programs that have a mission to support them. The need will become even more pressing as the Department of Defense (DoD) executes its downsizing plan and those who expected full military careers are suddenly thrust, with little warning, into the ill-prepared civilian community. The time has come to push for change in reintegration and readjustment support for women as they transition to post-military life. This report and the ongoing advocacy of DAV aims to trigger urgent actions from VA, DoD and other stakeholders, for an integrated approach to address the transition needs of women veterans, and an overhaul of the culture, values, and services of the federal system.

The report findings and recommendations cover the broad range of transition needs of women veterans in culture change, health care, military sexual trauma, disability compensation, justice, family and community, education, transition assistance, employment, and housing. In this executive summary we provide the 27 key recommendations in these areas to drive immediate action and change.

CROSS-CUTTING RECOMMENDATIONS

Federal and state governments and community organizations provide a wide range of programs to assist veterans with transition and readjustment. The information about these services is scattered across many federal Departments, dispersed programs, websites and print materials. The information is difficult to access and it is difficult for women to understand their eligibility.

■ Key Recommendation 1:

DoD, VA and other federal partners should collaborate to develop and maintain an up-to-date central directory and mobile apps for federal programs and services that are available to women service members and veterans who are transitioning from military to non-military life.

Women are a rapidly increasing and important component of U.S. military services. In order to understand the experience of women in the military and veterans, data needs to be routinely collected, analyzed and reported by gender and minority status. In this report, we have recommended improved data collection on women and minorities for health care, disability compensation, justice, education, transition assistance, sexual trauma, employment and housing programs. Congress, policy makers, program directors and researchers need this information in order to monitor and enhance services for women.

■ Key Recommendation 2:

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

Historically, women have not been afforded the same status as men in military service. Even today, women in the military and veterans face cultural barriers to full integration into military service, recognition as veterans and barriers to VA services and benefits. This is manifest by lack of attention to adequate protective equipment designed for women, disparities in promotion, and sexual harassment and assault within DoD. Despite recent improvement efforts at VA and DoD, women still encounter a male-dominated system that is designed to address the needs of men. Women lack consistent access to a full range of gender-sensitive benefits and services, and the federal government has not ensured that the staff in each agency are exemplifying and promoting a culture that embraces its women veterans' mission. Resources for implementation and evaluation of programs that address culture and climate are needed.

■ Key Recommendation 3:

VA and DoD should aggressively pursue culture and organizational change to ensure that women are respected and valued.

DoD, VA and other federal Departments and agencies have developed programs focused on assisting women with transition to post-military life and readjustment of women veterans and families after combat deployment. However, the federal government cannot provide all the health care, education, employment and housing support needed by women and their families. More community wide assessments, local coordination and collaboration are needed to enhance the effectiveness of health care, social supports and transition services for both men and women.

■ Key Recommendation 4:

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

■ Key Recommendation 5:

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

■ Key Recommendation 6:

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

HEALTH CARE SERVICES

A large body of historical and scientific evidence demonstrates that veterans experience a broad range of long-term health consequences after combat service. Veterans returning from combat operations are eligible to enroll in VA health care for five years from the date of their most recent discharge without having to demonstrate a service-connected disability or satisfy an income requirement. This special period of enrollment eligibility for VA health care was first established in 1998 and was expanded in 2007 by Public Law 110-181. Congress should acknowledge the health consequences of combat service and extend lifetime health benefits to all men and women who serve in a combat theater of operations.

■ Key Recommendation 7:

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

Women veterans need and want more involvement of family members in their treatment in order to improve medical, psychological and social outcomes. VA should use its current authority to improve family member involvement and request additional authority where gaps are identified.

■ Key Recommendation 8:

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

VA should be praised for its efforts to establish women's health programs and comprehensive primary care for women veterans. However, gaps still exist in some clinics and specialty services—an example is that one third of VA Medical Centers (VAMC) do not have a gynecologist on staff. VA must require VAMCs to staff and design their programs to provide a full range of primary and specialty care to women.

■ Key Recommendation 9:

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

Numerous reports have indicated that women veterans suffer from a high burden of Post Traumatic Stress Disorder (PTSD), depression and other comorbid conditions. VA has had difficulty in establishing gender-specific group counseling, residential treatment and specialty inpatient programs to serve women veterans. We recognize the difficulty in having a critical volume of women to maintain these specialized programs in every location and therefore recommend that VA and DoD work collaboratively on pilot programs to address these issues such as tele-group therapy, VA-DoD joint programs, increasing regional centers of excellence and other promising practices.

■ Key Recommendation 10:

VA and DoD should remove existing barriers and improve access to mental health programs for women. They should explore innovative programs for providing gender-sensitive mental health programs for women. An Interagency Work Group should be tasked to review options, develop a plan, fund pilots and track outcomes. VA and DoD might consider collaborations on joint group therapy, peer support networks and inpatient programs for women who served Post-9/11.

VETERANS JUSTICE INITIATIVES

Deployment has been associated with the development of behavioral issues than can contribute to veterans becoming involved with the legal system. Because Veterans Treatment Courts are supported by a multidisciplinary team, they can respond effectively to veterans who may be struggling with mental health problems, including PTSD, substance use disorders or traumatic brain injury, ensuring they receive supervised treatment rather than being incarcerated. Research and monitoring is needed to understand the key success factors and outcomes for women veterans.

■ Key Recommendation 11:

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

MILITARY SEXUAL TRAUMA (MST)

Military sexual trauma is a crime. In order to successfully eliminate rape, sexual assault and harassment, DoD must address organizational, culture and prevention solutions.

■ Key Recommendation 12:

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

■ Key Recommendation 13:

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

FAMILY AND COMMUNITY

DoD has not adequately supported or adjusted its programs to meet the needs of deployed women and their families. Husbands of deployed women service members do not receive the same level of family support services available to female spouses because programs are not designed to meet their concerns, needs and schedules or are not welcoming to men's participation. Current transition programs and treatments for relationship building, family reintegration, prevention of intimate partner violence and support for family functioning are based on civilian programs and lack evidence of effectiveness in military and veteran populations. Transition support programs that are designed for prevention, treatment and support for women and their families are needed.

■ Key Recommendation 14:

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

■ Key Recommendations 15:

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

VA's women veterans' retreat program has been a resounding success—reducing stress, improving coping skills and improving women's sense of psychological well-being. In its report to Congress, VA noted that 85 percent of participants showed improvements in psychological well-being, 81 percent also showed significant decreases in stress symptoms and 82 percent showed an improvement in positive coping skills. These are outcomes that warrant reauthorization of the program by Congress and a study of long-term outcomes in women participants.

■ Key Recommendation 16:

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

EDUCATION

The Post-9/11 GI Bill represents the largest expansion of educational support to military and veterans in our nation's history and provides excellent educational benefits. There is a paucity of information available on the education subsidies and support received by women veterans or the outcomes of the use of the Post-9/11 GI Bill benefits and services. More information is needed for program planning, policy-makers and researchers. Veteran students need targeted information to help them choose a school that works for them.

■ Key Recommendation 17:

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

■ Key Recommendation 18:

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

“Transition does not end when you first get out of the military. Veterans must have opportunities for later support as needs arise.”

*Participant from the DAV
Women Veterans Focus Group
August 11, 2014 (4)*

TRANSITION ASSISTANCE PROGRAM (TAP)

There are no comprehensive studies that evaluate the effectiveness of the TAP program. The hallmark of adult learning is that adults seek out and absorb information when they perceive that they need it, not necessarily when it is presented. Some transitioning service members may not be primed to absorb TAP training pre-separation but would be more receptive once they are actively seeking help and assistance 6-12 months later.

■ Key Recommendation 19:

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

■ Key Recommendation 20:

DoD should transfer contact information and data on all TAP participants to VA and DoL who should be responsible to provide gender sensitive follow up with all service members 6-12 months after separation to offer additional support and services, if needed.

■ Key Recommendation 21:

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

EMPLOYMENT

Department of Labor (DoL) has provided women veterans with many customized programs, communications and supports. Despite these efforts the unemployment and under-employment rates for some women are higher than men. The planned military downsizing is likely to exacerbate this problem. Additional efforts are needed to reverse these trends.

■ Key Recommendation 22 :

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

■ Key Recommendation 23:

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

HOUSING

VA's efforts to eliminate veterans' homelessness have been impressive and are showing measurable success. However, women veterans still have higher rates of homelessness than their non-veteran counterparts and housing support needs to be enhanced, particularly for women with dependent children.

■ Key Recommendation 24:

Congress should reauthorize and fully fund the Supportive Services for Veteran Families (SSVF) program to promote positive transitions for women veterans during the anticipated downsizing of the U.S. Armed Forces.

■ Key Recommendation 25:

VA and HUD should invest in additional safe transitional and supportive beds designated for women veterans.

■ Key Recommendation 26:

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

DISABILITY COMPENSATION

The burden of illness and injury in Post-9/11 veterans is high and nearly half have applied to VA for disability compensation. VA needs to do more to assure that women are receiving fair and equitable adjudication of their disability compensation claims.

■ Key Recommendation 27:

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

Introduction

Women have stepped forward to serve in the military with pride and valor since the American Revolution. Despite this reality, women were not officially recognized as permanent members of the U.S. Armed Forces until 1948. Dr. Mary Walker, a volunteer surgeon in the Civil War, is the only woman to ever be awarded the Medal of Honor.

NUMBER OF WOMEN WHO SERVED DURING WAR TIME ERAS	
Military Conflict Era	# of Women in Service
Spanish-American War	1,500
World War I	10,000+
World War II	400,000
Korean War	120,000
Vietnam War	7,000
Gulf War I	41,000
Post-9/11	280,000+

National Center for Veterans Analysis and Statistics. America's Women Veterans. Department of Veterans Affairs, Washington DC, November 2011 (1)

Until 1973, women remained a very small minority of the Armed Forces population due to legislation that imposed a two percent cap on women's participation in the military. When those gender caps were lifted, women entered military service at unprecedented rates. Today women constitute approximately 20 percent of new recruits, 14.5 percent of the 1.4 million active duty component and 18 percent of the 850,000 reserve component. Almost 280,000 women served Post-9/11 during the Global War on Terrorism (GWOT) in Operations Enduring Freedom (OEF), Iraqi Freedom (OIF) and New Dawn (OND) in Afghanistan and Iraq.

These conflicts are the longest period of continuous war in American history. This period has heralded many "firsts" for women in the military. In July 2014, Admiral Michelle Howard became the first woman in the 238-year history of the U.S. Navy to be promoted to four-star rank; Admiral Howard is also the highest ranking African American woman ever in any military service branch. Admiral Howard is a member of a group so elite that she joins just two other women who hold four-star rank, U.S. Army General Anne Dunwoody and U.S. Air Force General Janet Wolfenbarger. These outstanding women repre-

sent how very far our nation's military has come in upholding its core principles that success is judged by ability rather than gender or race.

In this war more than any other, women serving in Afghanistan and Iraq were directly exposed to combat and other violence. While women were still officially excluded from assignment to many combat roles and units, there was a critical need for their skills and therefore they were "attached" to these units to serve as combat medics, military police, explosive ordinance clearance personnel, convoy truck drivers and other dangerous occupations. These assignments, and the nature of asymmetric warfare with no front lines, put women service members into the direct line of fire and exposed them to daily threat. Even those who never traveled outside the security perimeter of a military base were constantly threatened by mortar attacks and rockets. As a result of these assignments, women were subject to visible and invisible wounds of war, including the so-called signature wounds, traumatic brain injury (TBI) and post-traumatic stress disorder (PTSD). In recognition of their irreplaceable contributions, the Pentagon announced in January of 2013 that it would open up 237,000 military occupations that were previously off-limits to women. Those previously "men-only" jobs include being assigned to roles in infantry and armor divisions and special operations. While the process is not scheduled to be completed until 2016, each Service is now developing gender-neutral standards that both men and women must pass to qualify for combat roles.

"Today, women are rising through our ranks and expanding their influence at an ever increasing rate, serving magnificently all over the world in all sorts of ways... I'd be hard pressed to say that any woman who serves in Afghanistan today or served in Iraq over the last few years did so without facing the same risks of their male counterparts."

*Admiral Mike Mullen
Chairman, Joint Chiefs of Staff
November 6, 2010*



“Everyone assumes that my husband is the veteran and he never served in the military.”

“I feel invisible.”

*Participant from the DAV Women Veterans Focus Group
August 11, 2014 (4)*

Despite the DoD leadership’s game-changing decision and public recognition of the sacrifices, heroism and critical contributions of women to the previous and current war efforts, women still question their military and veteran identity. When women talk about their military service, a large number will report that they feel invisible, that their “non-combat” role was less valued than those of the men who served and that they do not identify themselves as veterans. There remains a misperception on the part of the American public and women who serve that they are not eligible for full veterans’ benefits. VA’s Women Veterans Task Force noted the “need for culture change across VA to reverse the enduring perception that a woman who comes to VA for services is not a veteran herself, but a male veteran’s wife, mother, or daughter.”

Women have gaps in their knowledge about transition services provided by DoD, gaps in knowledge about VA eligibility, as well as false assumptions that VA does not provide the unique gender-specific health care services required by women (2). VA reports that only one in six women (15.7 percent) understand the health care benefits they earned through their service (3).

Ultimately, every woman will transition from service member to veteran. The goal of this report is to raise public awareness of the crucial role women play in the U.S. military, to gain an understanding of who women veterans are and how that affects their needs as they transition from military to civilian life, and how these needs can be better met. As the era of the long wars in Iraq and Afghanistan draws to a close, the DoD has already announced its plans to downsize its active duty force in 2015. The first “pink slips” have already been sent. This action creates an urgent imperative to address the unmet needs and gaps in transition and reintegration services for military women and veterans. DoD and VA must enhance programs that assist women on this important journey to post-military life. Unless concerted actions change the historical path to reintegration and readjustment, women face a potentially decades-long journey home.

Who are the Women Who Served in the Post-9/11 Military?

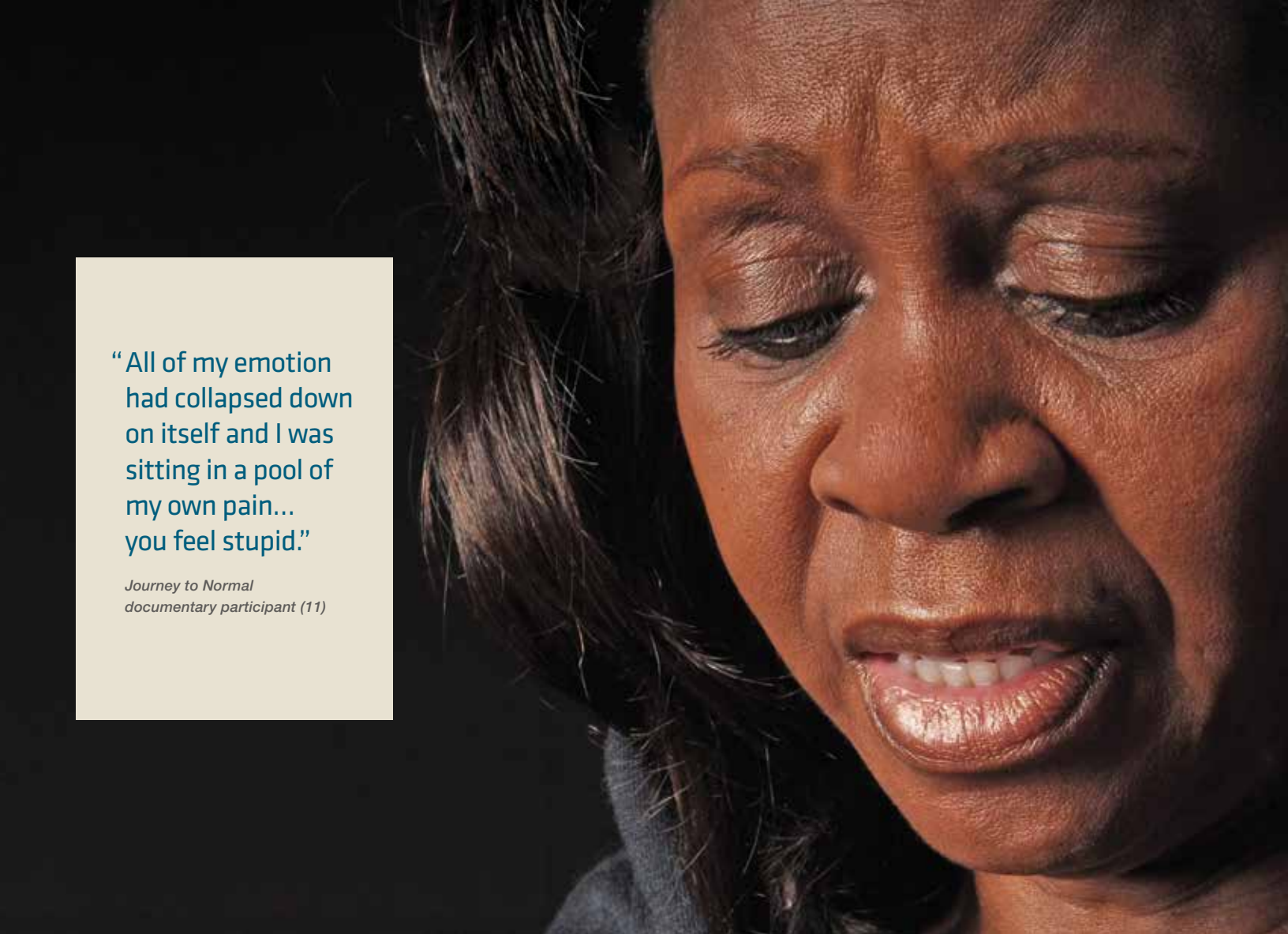
Since September 2001, approximately 2.6 million members of the active duty Army, Navy, Marines, Air Force, Coast Guard, as well as Reserve and National Guard units have been deployed to Afghanistan and Iraq. As of March 31, 2014, 1.79 million military service members, who served in the Post-9/11 era and deployed primarily in Iraq and Afghanistan, have left the military and transitioned to veteran status. Of those, 210,675 were women and 86,563 of those women served in the National Guard or Reserves (for more information go online to dav.org/women-veterans-study) (5). According to VA, in fiscal year (FY) 2012, women comprised 6.5 percent of VA's veteran patients and in FY 2013 the proportion of women increased to 6.8 percent. The number of women veterans has been growing faster than the number of men. Compared to men, women were, on average, substantially younger: 42 percent of women and 13 percent of men were less than 45 years old. In addition, women veteran patients were much more diverse with over one-third (39 percent) of women veteran patients representing a racial/ethnic minority group compared to 23 percent of men. In FY 2012, 29 percent of women veteran patients were Black/African American, six percent were Hispanic, one percent were American Indian/Alaska Native, and one percent were Asian (6).

Combat deployments impacted the physical, psychological, and social health of the men and women who served. They worked in harsh environments with possible toxic exposures (e.g., burn pits) and few amenities. In this era of all volunteer military service, a smaller number of members carried the burdens of war for this conflict, requiring longer and more frequent deployments, involuntary enlistment extensions, extended deployment rotations and reduced time at home between deployments. For example, over one-third were deployed more than once and over 400,000 service members have completed three or more deployments. The length and frequency of deployments over more than a decade have left insufficient time for reintegration and recovery (7,8). This is especially true for military women who are spouses, parents and caregivers. The stresses of war and home have often bled together in an unhealthy mix.

Many women return from wartime deployments stronger and without significant health problems, but many others suffer from unique post-war health care needs such as multi-organ systemic injuries associated with blast exposures (including mild-to-moderate TBI), as well as other physical health concerns such as chronic musculoskeletal

pain, headache, dizziness, trouble concentrating, respiratory conditions, gastrointestinal conditions, chronic multi-symptom illness and other unexplained symptoms (7). Among the most prominent health care needs reported are a variety of mental health conditions, including PTSD, generalized anxiety disorders, depression, suicide, substance abuse and sleep disorders (6). Difficulty with readjustment, combined with poor health, contributes to functional impairments and difficulty in educational and occupational performance, and in family and social relationships. Deployment may result not only in injury and immediate post-deployment symptoms and illnesses but can also have long-term impacts on health and well-being that can increase the risk for chronic diseases. Much attention has been given to the impacts of direct injuries such as burns, polytrauma, TBI and amputations of the combat wounded. However, given the complex interconnections between physical, psychological and social health, the nation must be prepared to take a more holistic, interdisciplinary bio/psycho/social/spiritual approach to providing coordinated, continuous care for veterans. We know from experience with Vietnam and the first Gulf War that veterans may not experience the consequences of their deployment immediately; illness onset may be delayed for months or years, and the prevalence of problems can be expected to increase over time. The direct and indirect injuries and illnesses that are the result of this war will be a growing veterans' health and public health burden for decades to come.





“All of my emotion
had collapsed down
on itself and I was
sitting in a pool of
my own pain...
you feel stupid.”

*Journey to Normal
documentary participant (11)*

Women veterans have unique health needs compared to the larger population of men who receive care at VA. While women in general underutilize VA health care, those who served Post-9/11 have been using VA health care in large numbers. Since October 2011, VA statistics show that more than 61 percent, or over 128,000, of Post-9/11 women veterans compared to 59 percent of men have had at least one visit to a VA health facility. The most frequent conditions diagnosed in women who seek care at VA include musculoskeletal conditions, mental health disorders, nervous system conditions, genitourinary, digestive system, endocrine and metabolic disorders and respiratory conditions. More than 8,880 Post-9/11 women veterans have been hospitalized at a VA medical center (5).

WOUNDED IN ACTION

The survival of those wounded Post-9/11 is the highest reported in modern conflicts. This is likely the result of advances in buddy care and mobile forward surgical units that bring care close to the combat, rapid medical evacuations and improved protective gear. Early on in these conflicts, the protective gear provided to women was not appropri-

ately configured to their body habitus and anatomy, which potentially impacted its effectiveness. To date, over 52,000 U.S. service members have been wounded in combat, with approximately one-third of those injuries so serious that they would not have previously survived (9).

The nature of the current conflicts and the changing role of women in the military put them at increased risk for traumatic injury and amputations. Life and limb saving procedures for massively injured individuals is now the standard of practice. We have come to recognize the usual constellation of visible war wounds, but Post-9/11 combat with its improvised explosive devices (IEDs) has become known for a different pattern of blast injury with penetrating fragment wounds, blast overpressure injury, burns and toxic inhalation. The Post-9/11 wounds often result in multiple organ damage with head, eye, ear, spinal, torso and open amputation injuries (10).

For more details visit
www.dav.org/women-veterans-study

LIMB LOSS AND AMPUTATION

While the number of women who have been wounded in action and lost a limb is small (less than 1.5 percent), women have unique needs when they lose an arm or leg. As of August 1, 2014, 23 women suffered an amputation in Iraq or Afghanistan as compared to 1,626 men. Fifteen women lost a lower extremity, three lost upper extremities, four lost both lower extremities and one woman lost both upper extremities (12).

In the Veterans Health Administration (VHA), women amputees use more health care, rehabilitation services and are seen more frequently when compared to men. Women are also more likely to be unsuccessful in fitting of their prosthesis, to experience skin problems after lower extremity amputation (13), and to have greater intensity of pain. Women with upper extremity amputation are more likely to reject their prosthesis (14,15). Women with lower extremity amputations have higher rates of hip and knee osteoarthritis (16,17). VA should support additional rehabilitation research and prosthetics development. VA, the Defense Advanced Research Projects Agency (DARPA) and the Dean Kamen organization partnered in advance prostheses and developed the DEKA Arm, a robotic arm intended to restore functionality for individuals with upper extremity amputations. Similar collaborative efforts should be applied to study women’s prosthetic needs.

Special prosthetics needs occur in women, especially during pregnancy. Pregnant women with limb loss experience increased wear on prosthetic components, need for realignment and frequent modifications depending on socket

and suspension. In addition, for women with above-the-knee amputations who need a caesarian section, a higher abdominal incision should be planned to avoid irritation by the socket brim (18).

Several additional clinical factors affect the care of women with amputations. Women, especially those with high lower extremity amputations, express a strong preference for privacy, modesty and a woman prosthetist during the sensitive evaluation and fitting process (18). Clinicians should discuss a personalized, patient centered rehabilitation plan to incorporate the woman’s rehabilitation goals. Goals are not the same for every individual and are affected by age, gender, family, employment and recreation needs.

“Only another veteran amputee can understand...so I try to help others”

*Participants from the DAV
Women Veterans Focus Group
August 11, 2014 (4)*

During rehabilitation it is important to have women peers visit to provide a source of experience and support. It is clear that women veterans with amputation use all VA services, not just prosthetics. VA should coordinate a treatment plan for each individual that provides all the integrated, interdisciplinary services that women need (18).

MILITARY SERVICE MEMBERS WHO SUFFERED AMPUTATIONS IN IRAQ AND AFGHANISTAN								
Limb Loss	Single LE	Single UE	Double LE	Double UE	Double UE & LE	Triple UE & LE	Quad UE & LE	Total
Women	15	3	4	1	—	—	—	23
Men	933	186	410	9	32	51	5	1626
Total	948	189	414	9	32	51	5	1649

Data Source: DoD-VA Extremity Trauma and Amputation Center of Excellence Registry (EACER), 01 Aug 2014, excludes finger(s), thumb(s), toe(s), LE - Lower Extremity, UE - Upper Extremity includes partial foot and hand amputations (10)

TRAUMATIC BRAIN INJURY (TBI)

Bullet wounds, IEDs and other projectiles can cause moderate to severe penetrating head injury. However, of the 300,707 individuals that DoD reports have been diagnosed with TBI, the vast majority (82.4 percent) have sustained a mild TBI or concussion (19). These invisible injuries can be subtle and difficult to diagnose but cause significant functional impairment and disability. Mild TBI symptoms can include difficulties with judgment, concentration, attention, memory, headache, dizziness and irritability.

Mild TBI or concussion is characterized by: a confused or disoriented state, which lasts less than 24 hours; loss of consciousness for up to 30 minutes; memory loss lasting less than 24 hours; and structural brain imaging (MRI or CT scan) yielding normal results (19). Patients with symptoms that persist longer than 3 months may have a triad of TBI, chronic pain and PTSD. Emerging research shows that repeated concussion can be associated with a chronic encephalopathy characterized by early dementia and Parkinsonism.

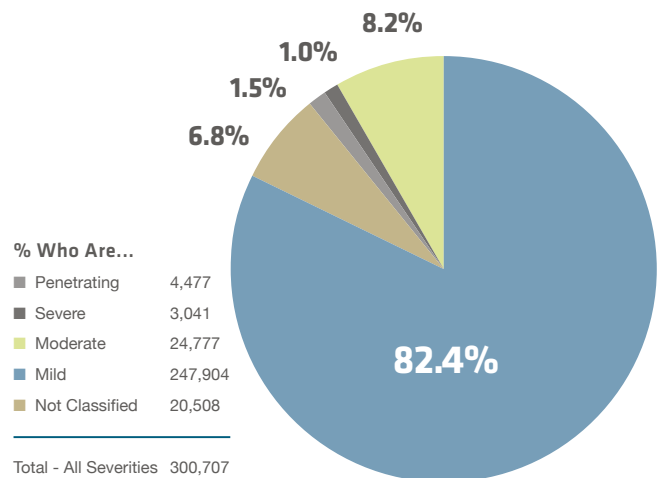
A survey of 2,348 randomly selected veterans (51 percent women) found that 10.7 percent of women and 19.7 percent of men had probable deployment-related TBI. While women respondents reported significantly lower rates of TBI, a higher percentage of women reported symptoms of physical health conditions (40.7 percent vs. 30.7 percent) and a combination of at least one probable mental health condition with symptoms of physical health conditions (34.7 percent vs. 29.2 percent). These findings are consistent with other research and underscore the importance of doing a comprehensive clinical evaluation for women with probable TBI, to include assessing and treating concurrent mental health and physical health condition (20).

MENTAL HEALTH OF WOMEN VETERANS

The other invisible wound of any combat era, and the signature injury of the Post-9/11 conflicts, is PTSD. VA health care utilization statistics show that through March 2014, over 70,300 (54.8 percent) women who served Post-9/11 have accessed mental health services in VA (6). They commonly present with adjustment disorders, depression, anxiety disorders and PTSD. Numerous early studies found that 5–15 percent of veterans experienced PTSD following deployment to combat. The review also suggested that the prevalence of depression and PTSD continues to increase with time after deployment. These studies and our historical experience after the Vietnam War indicate that in the future, women veterans will be seeking mental health services in ever increasing numbers.

DoD Numbers for Traumatic Brain Injury

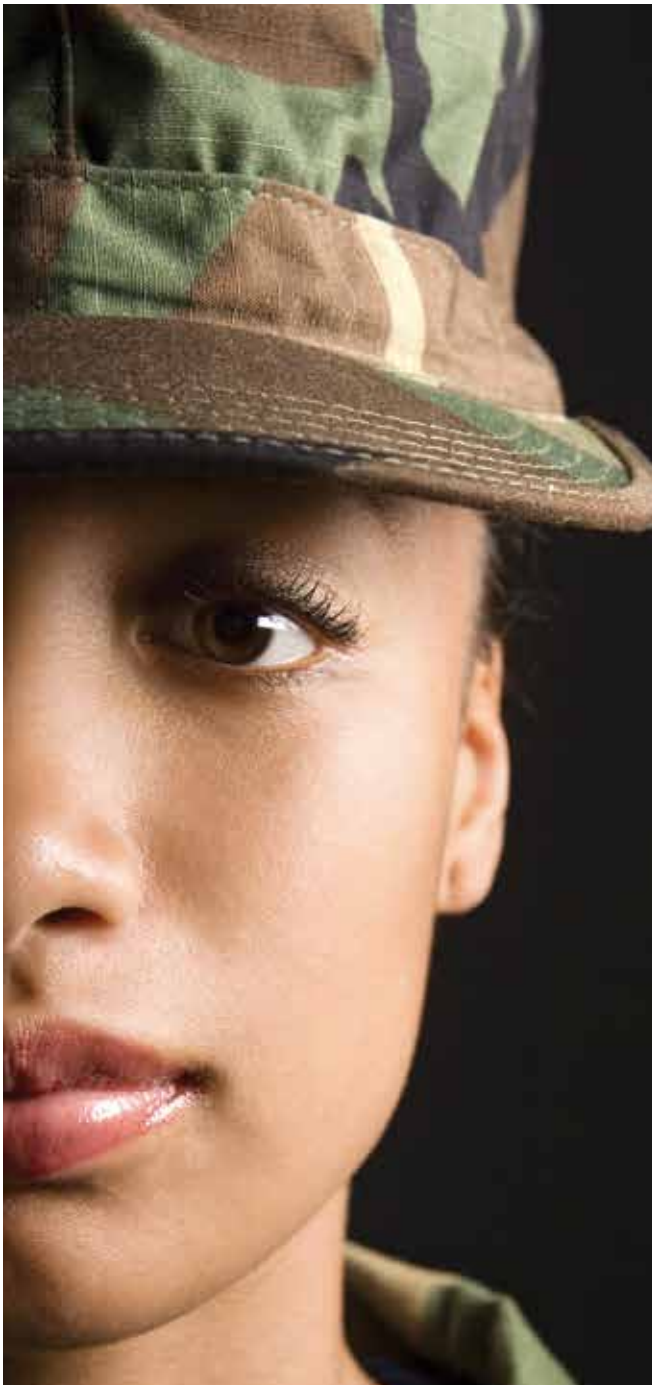
Worldwide - Totals 2000-2014 Q1



Source: Defense Medical Surveillance Systems (DMSS), Theater Medical Data Store (TMDS) provided by the Armed Forces Health Surveillance Center (AFHSC). Prepared by the Defense and Veterans Brain Injury Center (DVBIC). 2000-2014 Q1, as of May 7, 2014 (19)

A VA study of almost 290,000 Post-9/11 veterans who were new users of VA health care services, found that the two-year cumulative prevalence of mental health diagnoses increased from 6.4 percent in 2002 to 36.9 percent in 2008; PTSD diagnoses showed the greatest change, increasing from 0.2 percent to 21.8 percent (21). While these statistics are alarming, they are insignificant when weighed against the devastating impact these conditions can have on veterans' lives and those of their families and children.

PTSD can be acute or become a chronic, lifelong condition. It is often accompanied by other health problems, such as depression, TBI, chronic pain, substance use disorder and intimate partner violence. A review of medical records of 4,416 Post-9/11 veterans found that veterans who had a diagnosis of PTSD had significantly increased risk and prevalence of several diseases, including circulatory and hypertensive diseases, compared with veterans who did not have PTSD (22). Although predictors for development of PTSD were similar in men and women veterans (e.g., combat and sexual trauma), women experience higher rates of mental health disorders and medical comorbidities (7,23). Many studies find that women who served in Afghanistan and Iraq had higher rates of positive screens for PTSD symptoms than men (24). These studies demonstrate the importance of mental health screening and integration of mental health services with VA comprehensive primary care for women veterans.



DoD has been working to develop and implement programs that can increase resilience and prevent mental health conditions resulting from wartime exposures. Most of these programs are focused on individual-level interventions that address various aspects of resilience and psychological health. Despite DoD's heavy investments in prevention and resilience programs, most interventions are not evidence-based and have not been sufficiently evaluated (25). No service-specific or gender-specific information is available on whether existing programs successfully minimize PTSD after trauma or prevent the re-emergence of previous symptoms.

SUICIDE AND SUICIDE PREVENTION

Suicidal behavior is often associated with mental health problems including depression, PTSD and substance abuse. Suicidal behavior includes suicidal ideation (thoughts of harming one's self), suicide attempts or completed suicide. Historically, suicide rates in the military have been lower than in the general population; however, suicide in U.S. military personnel rose dramatically since 2005 and is of increasing concern. According to the Armed Forces Health Surveillance Center (AFHSC), suicide is now the second-leading cause of death in U.S. service members.

The number of suicides in U.S. military deployed to Iraq and Afghanistan has increased, and the estimated suicide rate in the Army almost doubled from 2004 to 2008 (from 10.8 to 20.2 per 100,000) and is now higher than in the civilian population (26). Between 1998 and 2011, there were 2,990 suicides in active-duty members. Suicide death rates were higher in men (95 percent), active duty (89 percent) who were in their 20s. Being divorced or separated was associated with a 24 percent higher risk of suicide (27). The most common method of suicide in both men and women was the use of firearms (27). Data is less accurate for veterans who are no longer on active duty but VA estimates that 22 veterans commit suicide every day. A recent study that examined suicides in veteran populations found that having served in Post-9/11 on active-duty and having a select mental health condition conveyed a higher risk of suicide than the general population (28).

To address this epidemic and prevent suicide, DoD and VA provide a number of 24/7 services to assist those in crisis and provide support.

www.veteranscrisisline.net
(800) 273-8255 Press 1
Text to 838255

Between its inception in July 2007 and August 2014, the Veterans Crisis Line received over 1.25 million calls, over 128,000 chats, as well as over 15,000 texts, and have saved more than 39,000 veterans in imminent danger (29).

Health Care

VA HEALTH CARE SYSTEM

In addressing the needs of yesterday's, today's and tomorrow's veterans, VA offers a continuum of health care services, including health promotion and disease prevention services, primary and specialized ambulatory medical, surgical and mental health care, hospital care, residential specialized mental health and substance abuse treatment programs, home care, institutional long-term care and hospice and palliative care programs. VA operates 151 medical centers, 820 community-based outpatient clinics (CBOCs), and 70 mobile clinics that serve 6.5 million veterans each year, including 1.9 million outpatient visits each week and 695,000 hospital admissions in FY 2013 (29).

VA has set improving health care for the rapidly growing population of women as a high strategic priority for its health care system. To accomplish this, VA is increasing the women's health treatment capabilities in all VA medical centers and clinics. Every VA medical center is required to have a Women Veterans Program Manager who serves as an advocate, navigator and coordinator to assist women veterans in organizing their health care services. Recent advancements include implementation of comprehensive primary care and patient centered medical home programs (Patient Aligned Care Teams/PACTs) for women. Women's PACT teams have integrated mental health services, clinical, pharmacist and social work support. The VHA has established a hotline for women veterans (1-855-VA-WOMEN or 1-855-829-6636). In 2013, 11 rural health grants were awarded to VHA facilities that enhance telehealth programs by offering care to women in rural areas (29).

Women veterans, who are a small minority of the larger predominantly male patient population, have created significant challenges for VA in assuring that it has an adequate number of women's health providers at every location. To address this need, every VAMC and CBOC is required to have a designated women's health provider on staff who completed training in women's health competencies; 92 percent of VAMCs and 82 percent of clinics meet this standard (27). Among designated women's health providers only 38 percent have panels with at least 10 percent women; this raises the question of whether there is sufficient volume to maintain clinical proficiency. Using the technique of "Scan-ECHO"—video-teleconferencing sessions for primary care providers to receive specialist consultation and patient-based education—is a promising practice to assist designated women's health providers in maintaining their skills and increasing knowledge.

GENDER-SPECIFIC CARE

On average, women are younger than men who use the VA health care system and many new veterans are of child-bearing age. As more women transition out of the military, VA is experiencing rapidly changing demographics of the women veteran population cared for in its health care facilities. This has meant that the demand for gender-specific preventative screening, breast care, gynecology specialty care, prenatal and obstetrical care, neonatal care and infertility services is increasing rapidly and will continue to grow for the foreseeable future. This changing demographic has also meant that there has been increasing demand for on-site drop-in child care for veteran parents using VA medical and social support services.

“VA needs to provide child care or at least child friendly spaces...it's taking too long and VA is not prepared for women.”

*Participant from the DAV
Women Veterans Focus Group
August 11, 2014 (4)*

These new demands for gender-specific care have required VA to restructure its clinical programs, staffing, referral network, care coordination and monitoring programs to ensure that high quality care is delivered. Despite the increase in women needing these services, a third of VA medical centers do not have a gynecologist on staff and refer all women to other VA facilities or community providers. In addition, studies have shown that primary care providers do not routinely counsel women on the potential risk of birth defects associated with their prescribed medication.

All VA facilities are required to have a health care environment that accommodates women with safety, privacy, and respect. Inpatient and residential-care facilities must provide separate and secured sleeping accommodations for women (30). The aging infrastructure in many VA facilities has made this mandate difficult to achieve and increased attention should be given to requesting and appropriating the needed minor and major construction funds to correct these identified environment-of-care deficiencies that directly impact women veterans.



VA MENTAL HEALTH CARE

The VA system offers a comprehensive array of mental health and PTSD treatment programs, including face-to-face mental health screening and assessment, counseling and psychotherapy (individual and group), pharmacotherapy, and adjunct services, such as employment counseling. Specialized outpatient, inpatient, residential treatment and women's trauma recovery programs are available at a smaller number of sites. VA has issued a number of policies, directives, guidelines, and handbooks on mental health services and programs. VA's Uniform Mental Health Services (MHS) in VA Medical Centers and Clinics Handbook defines the minimum mental health clinical services that must be provided at each VA medical center and CBOC (30). These policies state that MHS "must be provided as needed to female veterans at a level equivalent to their male counterparts at each facility"... and mental health clinicians must possess the capability and competencies to meet the unique needs of women veterans (30). Numerous reports have suggested that VA is not fully meeting this policy mandate.

VHA provides screening to every new primary care patient for depression, PTSD, MST and problem drinking. Screenings for depression and problem drinking are repeated annually, but PTSD screening is only required annually for the first five years and repeated once every five years thereafter.

VA also requires that all veterans who screen positive and are referred to mental health be contacted within 24 hours for an immediate medical needs evaluation, and then receive follow-up care within 14 days of referral if no urgent condition exists (31).

VA has integrated mental health services into primary care and many veterans receive treatment for depression, PTSD and other behavioral health needs from their PACT teams. Mental health care providers embedded in primary care teams provide general mental health services, prescribe medications and manage less complicated mental health conditions. Veterans with moderate or severe illness are referred to specialty mental health care when warranted.

In addition to mental health care in hospitals, VA provides Residential Rehabilitation and Treatment Programs (RRTPs). Mental Health RRTPs include specialized programs in Psychosocial Residential Rehabilitation Treatment Programs, PTSD Residential Rehabilitation Treatment Programs, Substance Abuse Residential Rehabilitation Treatment Programs, Domiciliary Residential Rehabilitation Treatment Programs and Domiciliary Care for Homeless Veterans. According to policy, each (Veterans Integrated Service Network (VISN) must have residential care programs designed to meet the needs of women veterans and veterans with a serious mental illness

(PTSD, MST, substance use disorder, homelessness and dual diagnoses) either through special programs or specific tracks in general residential care programs.

VA provides specialized PTSD care in outpatient, residential and inpatient settings. While 10 percent of all patients in VA's specialized outpatient PTSD treatment programs are women, VA has only three women's stress disorder treatment teams for the entire country. They are similar in structure to specialized PTSD clinical teams and provide individual and group treatment to women veterans. VA also has two women's trauma recovery programs; these are 60-day live-in rehabilitation programs that include PTSD treatment and coping skills for re-entering the community. In 2012, these two programs served only 73 women (31). Given the high rates of mental health conditions and PTSD in women, the current number of specialized programs that serve them is inadequate.

MST screening and related services are mandated to be available at every VA medical center for both women and men. One in five women enrolled in VA screen positive for MST. Each VA medical center is required to have a dedicated MST coordinator. All VA programs are strongly encouraged to assess patient preferences and to give veterans (women and men) being treated for MST the option of choosing the gender of their mental health provider (30). In 2013, VHA reported that 31 percent of VAMCs and CBOCs have problems providing adequate care for MST, often because of staffing shortages (31).

There are limited opportunities for families to be involved in veterans' mental health treatment. VA has narrow legal authority to provide support services for families of veterans who have chronic illnesses, injuries and mental health problems after deployment. Women often express an interest in having more programs available for their family members, and some also stated that they would like family members, usually a spouse or partner, to be more engaged in their treatment.

Some veterans may seek readjustment counseling in VA Readjustment Counseling Service (RCS) Vet Centers. RCS has broader authority than VAMCs to provide services to family members of combat veterans and about 36 percent of their clients don't seek care at any VAMC. For example, in 2012 and the first quarter of 2013, a total of 261,998 Post-9/11 veterans who had PTSD were seen in a VAMC, and 70,044 veterans received service for PTSD in Vet Centers. Of these, 216,090 were seen only in a VAMC, 24,136 only in a Vet Center, and 45,908 in both types of facilities (31). (RCS readjustment services are discussed further on page 24 of this report.)

PEER SUPPORT PROGRAMS

VA has recently hired over 800 peer support specialists and peer support apprentices to work at VAMCs and large CBOCs (32). The use of peer specialists and apprentices can help reduce stigma and increase the acceptability of mental health care for veterans (33, 34) and improve recovery (34). These peer staff are veterans who provide experiential, non-medical advice and insights based on their own journey to readjustment and treatment. Their ability to relate to other veterans because of their shared military experiences and mental health recovery is a key element of the program. The RCS Vet Centers have recruited a significant number of women combat veterans as peer counselors; no information was available on how many of the 800 new peer support specialists in other VA facilities are women.

POLYTRAUMA SYSTEM OF CARE

In response to the health care needs of Post-9/11 veterans, VA established the Polytrauma System of Care, consisting of five Polytrauma Rehabilitation Centers (PRCs), 22 Polytrauma Network Sites, 80 Polytrauma Support Clinical Teams, and about 50 Polytrauma Points of Contact. This "hub and spoke" system of TBI care is designed to provide the right care, at the right time, in the right place for veterans. The PRCs are component centers in the Defense and Veterans Brain Injury Consortium (DVBIC) to ensure coordination of clinical, education and research in brain injury between VA and DoD (19).

NON-HEALTH CARE SUPPORT SERVICES

In addition to its health care programs, VHA provides adjunct services that help veterans with supported employment, housing and homelessness, and caregiver support. As an example, VA provides a broad range of supports to caregivers of eligible Post-9/11 veterans including a stipend, CHAMP-VA and other special services. This integrated approach to health and support services is fundamentally different from the care available in the private sector. If properly managed, this approach could deliver substantial health benefits for women veterans in terms of better care access, continuity, coordination, effectiveness, safety and satisfaction. Combat veterans who served Post-9/11 are legally entitled to free VA health care for five years after discharge from the military, as long as their discharge was other than dishonorable.

DoD HEALTH CARE

The Department of Defense provides a comprehensive array of services to approximately 9.6 million beneficiaries (active duty military, families and retirees) through its direct care system and the Tricare Management Activity's purchased care program. The primary mission of the MHS is unique and different from VA's in that it is focused on ensuring military force readiness rather than being focused solely on the well-being of the individual patient. The MHS' direct care system is composed of 65 hospitals, 412 clinics, and 414 dental clinics at facilities across the U.S. and around the world. For TBI care, DoD has DVBIC centers and also manages the National Intrepid Centers of Excellence nationwide.

Studies consistently show that the number of service members who have mental health conditions has increased dramatically since the beginning of the Post-9/11 conflicts and the need for mental health providers and services has outstripped supply. Military service members report limited access to PTSD treatments in military treatment facilities (MTFs), in mental health clinics, and from TRICARE purchased-care providers. The Government Accountability Office (GAO) recently reported in a congressionally mandated, four-year access-to-care survey of DoD health care beneficiaries,

that 28 percent of the 24,000 surveyed TRICARE beneficiaries had problems in accessing mental health care. The survey showed that only 39 percent of civilian mental health care providers were accepting new TRICARE patients and 24 percent of beneficiaries reported that the "wait for an appointment [in mental health] was too long" (35). Stigma and concerns about effects on one's career negatively impacts the willingness of a service member to seek such care. To address stigma and increase access to care, DoD has established online and telephone non-medical resources for mental health issues for service members and their families; for example, Military OneSource is available online and by telephone 24 hours a day, seven days a week. Public service announcements and websites, such as After Deployment (afterdeployment.org), are also being used to reduce the stigma related to mental health symptoms and seeking care.

As noted previously, many women would prefer their family members be involved in their care. Some counseling and support services are available to family members on military installations, but these services are typically not integrated with mental health services, PTSD education programs or family support programs. Ironically, male spouses of women veterans are often excluded from Family Support Programs.





TRANSITION CHALLENGES AND COORDINATION OF VA AND DoD SERVICES

VA and DoD have a number of programs designed to provide seamless transition of care between their two Executive Branch Departments. Case managers in each VA medical center and benefits office coordinate with DoD discharge staff for seriously wounded veterans. For the majority of individuals; however, these systems fall far short of the goal to provide coordinated, continuous care and services as members of the military leave active duty service and transition to post-military life. In most cases, there is no warm hand-off from DoD to VA for health care, electronic records or disability benefits (31). Transitioning between systems may affect access and quality of care, for example, because of treatment interruption, the need to form new relationships with providers who are not familiar with one's history or progress, and handoff errors (7). New approaches to transitioning care from DoD to VA should be explored in order to increase access for transitioning women veterans.

Post-9/11 care management teams have been assigned to every VA medical facility to assist veterans of Iraq and Afghanistan in accessing and coordinating care. These teams maintain lists of service members who are separating from the military who reside in their catchment areas and can actively reach out to them. While VA sends letters to discharged service members, these are not customized for women and do not provide information on gender-specific benefits and services.

After more than 20 years' work and expenditure of billions of public dollars, the DoD and VA electronic health records are not interoperable and have limited communication capability. Creating a single, integrated electronic health records system, or at a minimum, systems that possess the technical ability to communicate with each other, is a requirement for seamless transition. Two successive Administrations have committed the government to implement interoperable health information systems (36,37). The two biggest federal health care systems in DoD and VA must meet this standard now and ensure that critical health care information about veterans and military members can be easily exchanged and used by both electronic health record systems.

HEALTH CARE FINDINGS AND RECOMMENDATIONS

■ Finding:

DoD and VA provide a wide range of health promotion, disease prevention and health care services for women who have served in Post-9/11. The information is scattered across many programs, websites and print materials. The information is difficult to access, eligibility for programs is difficult to understand, and it is difficult to determine whether the programs will deliver the promised outcomes.

■ Recommendation:

DoD, VA and other federal partners should collaborate to develop and maintain an up-to-date central directory and mobile apps for federal programs and services that are available to women service members and veterans who are transitioning from military to non-military life.

■ Recommendation:

The federal government should collect, analyze and publish data by gender and minority status for every program that serves veterans.

■ Finding:

Women veterans would benefit from having more programs available to their family members, and would like family members to be more engaged in their care and treatment plan.

■ Recommendation:

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

■ Finding:

Comprehensive care for women requires availability of gender-specific health treatment options, including gynecologic care.

■ Recommendation:

Every VA Medical Center must be staffed by a part-time or full-time gynecologist.

■ Recommendation:

During FY 2013, approximately one in five women veteran patients had at least one VHA emergency department (ED) visit. With the dramatic increases in the number of women veterans using VA health services, it is imperative that VA ensure that EDs have the necessary trained staff, supplies and equipment to provide high quality, round-the-clock gender-specific care. VA should ensure that EDs have specific resources for diagnosis of gynecologic and obstetrical emergencies.

■ Finding:

VA and DoD have a paucity of specialized mental health services for women. Given the high prevalence of mental health conditions, there is a need for gender-sensitive programs and environments for care delivery. Women, especially those who were sexually assaulted in the military, may be uncomfortable and avoid receiving treatment in outpatient and inpatient settings that serve virtually all men.

■ Recommendation:

VA should support innovative rehabilitation research and collaborate with DoD and the private sector to develop prosthetics that better meet women's unique needs.

■ Recommendation:

VA and DoD should remove existing barriers and improve access to mental health programs for women. They should explore innovative programs for providing gender-sensitive mental health programs for women. An Interagency Work Group should be tasked to review options, develop a plan, fund pilots and track outcomes. VA and DoD might consider collaborations on joint group therapy, peer support networks and inpatient programs for women who served Post-9/11.

■ Recommendation:

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

■ Finding:

Under current law, veterans who served Post-9/11 are legally entitled to free VA health care for five years after discharge from the military, as long as their discharge was other than dishonorable. Veterans who served in these conflicts are coming home with complex comorbid medical and psychological illnesses and injuries that are expected to worsen and increase in prevalence over the next several decades.

■ Recommendation:

Congress should pass legislation to make every veteran who serves in a combat theater of operations eligible for VA health care, for life.

Women veterans need and want more involvement of family members in their treatment in order to improve medical, psychological and social outcomes. VA should use its current authority to improve family member involvement and request additional authority where gaps are identified.

VA Disability Compensation

At the end of September 2013, a total of 714,380 Post-9/11 veterans were receiving VA disability compensation—that is some 614,348 men and 97,186 women. The average claim in this population is very complex, claiming an average 6.6 disabling conditions. For those women, the rank order of the top five disabilities (by body system) affected were the musculoskeletal, skin, neurologic, mental disorders and respiratory; whereas in men the top five were musculoskeletal, skin, audiology, neurologic and mental disorders, respectively. Women veterans were receiving, on average, an individual annual payment amount of \$12,516.56 as compared to men who received an average of \$12,841.28 (38).

During a congressionally mandated study, the VA Office of Inspector General conducted a review of VA's ability to assess combat stress in women and examined whether VBA had appropriately adjudicated women's disability claims for TBI, PTSD and other mental health conditions. The study found that a higher proportion of women generally were receiving disability benefits, but a lower proportion of women were awarded disability compensation for PTSD or TBI. The review did not identify gender-bias in VBA's adjudication of the disability claims for TBI, PTSD or other mental health conditions; the claim decision was consistent with the medical evidence on record. However, there was evidence for higher denial rates in women who claimed disability due to PTSD; while in men there were higher denial rates for mental health conditions other than PTSD. Because VBA does not retain historical data on its denial decisions, it was not possible to determine if VBA reversed its denial decisions on appeal for men more often than for women (39).

Women have perceived that the level of evidence being required by rating specialists for PTSD related to military sexual trauma is higher than when it is related to combat trauma. In December 2011, VBA issued a national training letter that provided detailed and comprehensive guidance regarding MST-related claims, including an instruction that the current regulations do not require actual documentation of the claimed stressor (e.g., sexual assault) and that a medical opinion can be considered credible evidence that the claimed stressor occurred. VBA should give special attention to ensure that these claims receive appropriate attention by raters, and that VBA follow the guidelines set forth in its training letter to ensure consistent adjudication decisions of these types of claims.

■ Finding:

VBA has the electronic capability to segregate and account for MST-related cases from other types of PTSD claims.

■ Recommendation:

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

■ Recommendation:

VBA must provide routine and comprehensive training relative to MST-related claims processing and perform routine reviews of rating decisions to ensure rule and policy compliance is being followed throughout VBA.



DAV's professional team of advocates, all veterans themselves, help veterans and their families access the full range of benefits available to them. DAV helps veterans and their families successfully file claims for VA disability compensation, rehabilitation and education programs, pensions, death benefits, employment and training programs.

Legal Problems

Veterans may require legal assistance and support for disability law, family law, employment law, housing law and criminal law during reintegration and transition. Studies of PTSD have demonstrated an association with anger, hostility, and aggression as well as behavior problems. A study of 77,998 Marines deployed to Iraq, Afghanistan or Kuwait (war-deployed Marines) with 13,944 Marines deployed elsewhere outside the United States (non-war-deployed Marines) found that war-deployed Marines who had PTSD were more likely to receive demotions, punitive discharges and drug related discharges than non-war-deployed Marines who had no psychiatric diagnosis. In addition, they were over 11 times more likely than their peers who had no psychiatric diagnosis to commit serious offenses that resulted in punitive discharges (40). An early study of Vietnam era veterans found an association between PTSD, arrest and incarceration: 45.7 percent of Vietnam veterans who had current PTSD had been arrested or jailed more than once in their lives compared with 11.6 percent of the veterans who did not exhibit PTSD, and 11.5 percent of veterans who had PTSD had been convicted of a felony (41).

In order to assist justice-involved veterans and potentially avoid unnecessary criminalization of their mental health problems, VA initiated the Veterans Justice Outreach (VJO) Program. The program ensures that eligible veterans receive access to direct outreach, assessment, and case management and access to VA health care services, as required. While VA does not provide legal services, VJO works with local courts and jails, and provides coordination and liaison with justice system partners who have set up Veterans Treatment Courts (69). Because Veterans Treatment Court judges handle numerous veterans' cases and are supported by a multidisciplinary team, they can respond more effectively by getting veterans who may be struggling with mental health problems, including PTSD, substance use disorders or TBI into a supervised treatment program rather than being incarcerated. The multidisciplinary team can link veterans with benefits and services provided by the Veterans Health Administration, Veterans Benefit Administration, State Department of Veterans Affairs, Veterans Service Organizations, and community organizations.

“Veterans Treatment Courts seek to do justice by acknowledging veterans’ service to our Nation and by empowering them to address the mental health and substance abuse issues that resulted in their entry into the criminal justice system.”

Amalea Smirniotopoulos, JD, MPP

■ Finding:

Deployment has been associated with the development of behavioral issues that can contribute to veterans becoming involved with the legal system. For criminal justice involved veterans, Veterans Treatment Courts are an alternative to incarceration that focus on getting veterans the treatments they need.

■ Recommendation:

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

“Both veterans and the community are better served by treating the veteran’s mental illness rather than incarcerating him or her.”

www.va.gov

Military Sexual Trauma

Most reports of MST are so full of polite language and euphemisms that one can be left with the impression that MST is primarily a health condition. While the aftermath of MST often involves a decades long battle with depression, PTSD, and a complex array of comorbid medical conditions, we must call MST what it is—a crime. DoD recently elevated its efforts against rape, sexual assault and sexual harassment in the military and called it one of the more serious threats to military discipline. While the proportion of service women affected by MST is higher, men are affected in large numbers as well.

Despite years of effort, sexual assault in the military remains a persistent and serious problem. Over six percent of women and one percent of men report unwanted sexual contact on DoD surveys (43). From October 1, 2012 to September 30, 2013 (FY 2013), reports of sexual assault increased in not one but in all four military services. DoD received a total of 5,061 reports of alleged sexual assault involving one or more service members as either the victim or alleged subject (suspect)—a 50 percent increase over reports received in FY12. Approximately 54 percent of the total involved service member on service member crime (44). This was a record high number of individuals who indicated that they had been sexually assaulted and asked for assistance by making a formal DoD report. DoD believes that this unprecedented increase in reporting is due to growing confidence among service members that they will be treated with dignity and that the DoD system will take appropriate action. Between 2006 and 2013, the average annual increase in sexual assault reports was about five percent. DoD has stated that they believe it is unlikely that the increase in reports in FY 2013 is due to such a dramatic increase in crime. DoD indicated it will try to confirm this impression using the 2014 Workplace and Gender Relations Survey of Active Duty Members that will study the past-year prevalence of unwanted sexual conduct. This report will be released in April 2015.

We have previously reported on the treatment and services available to military service members who are survivors of MST—while important, these are too little and too late. DoD must prevent MST by eliminating rape, assault, intimate partner violence and sexual harassment in the military. DoD must deliver on its promise to service members to take harassing sexual conduct and assault seriously, hold offenders accountable and provide dignity and care for those who are

assaulted. The DoD Sexual Assault Prevention and Response Office's (SAPRO) Sexual Assault Prevention Strategy (45) presents a five pronged, multidisciplinary approach to this problem involving prevention, investigation, accountability, advocacy/victim assistance, and assessment. In developing its approach to prevention of sexual assault, DoD and SAPRO sought the advice of federal public health agencies, universities and private sector experts. During FY 2014, DoD will carry out organization-wide, coordinated efforts to intensify its culture change and crime prevention efforts. Its new message will be that sexual assault is a crime that is not tolerated or ignored. We applaud these efforts and believe that they must be accompanied by robust evaluations to determine effectiveness (45).

■ Finding:

Military sexual assault reporting increased by 50 percent between FY 2012 and FY 2013. DoD has implemented an organization-wide, comprehensive strategic plan and prevention program to eliminate sexual harassment, sexual assault and rape.

■ Recommendation:

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

■ Recommendation:

DoD should aggressively pursue culture change to ensure that women are respected and valued service members.

■ Recommendation:

DoD should allocate the resources and staff needed to fully implement its SAPRO strategic plan.

■ Recommendation:

DoD should conduct program evaluations and prospective scientific studies to monitor the success of its plan to prevent MST, change the military culture, assess program progress and outcomes and adjust actions as needed.

Community & Family Relationships

READJUSTMENT COUNSELING

The struggle to adjust to life back home following war is nothing new. While deployed in a combat zone, service members live with physical deprivation and the daily threat of bodily harm and death. They witness horrendous injuries and experience the deaths of civilians, colleagues and friends. And on the nation's behalf, service members are asked to kill our enemies and sometimes cause the deaths of civilians.

As common as these traumatic experiences are in a war zone, they are extremely rare events here at home. The coping mechanisms developed during a combat deployment may interfere with life post-deployment, and require an adjustment. Some service members are able to make this change on their own with the support of family or friends. Others may need more formal support through peer group counseling or the help of a mental health professional.

Reintegration or adjustment to life following a combat deployment doesn't end when a service member leaves the military. In recognition that Vietnam era veterans needed formal support to successfully readjust to civilian life after exposure to combat, Congress established the Vet Centers at the VA in 1979 as reported in the Forgotten Warrior Project (46).

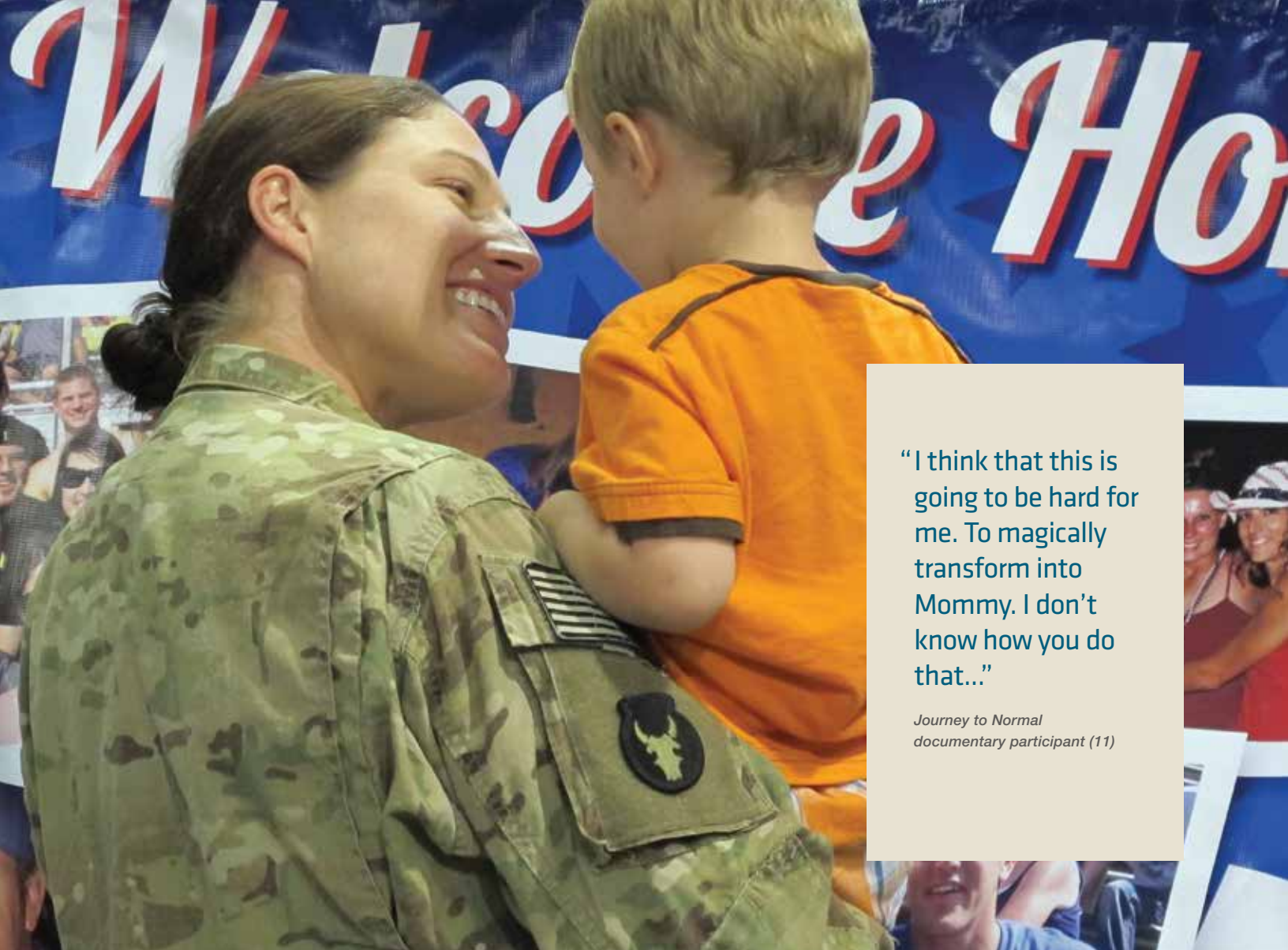
“You are supposed to behave as if nothing ever happened... [being deployed] is like being put into a food processor turned on ‘high’... that is the hardest... trying to fit in again... because you are changed forever.”

*Journey to Normal
documentary participant (11)*

Vet Centers provide counseling to veterans who served in combat theaters of operation, and their families, to assist veterans in readjusting to civilian life. Through 70 mobile vans and 300 permanent clinics, Vet Centers provided over 1.3 million visits to more than 190,000 veterans and their families (39). Services provided by the RCS include psychosocial assessment, individual counseling, group counseling, marital and family counseling related to readjustment issues, substance abuse assessment, medical referrals, employment assessment and referrals, VA benefit referrals, MST counseling and community outreach (47).

Vet Centers are based on a model of peer support with combat veterans helping one another to understand and cope with their combat experience. In line with this model, the Vet Centers are staffed predominantly with veterans (80 percent), one third of whom served Post-9/11. Sixty percent of the employees are qualified mental health professionals and 42 percent of the staff overall are women (48).

Vet Centers appear to be growing as an important place for women veterans to receive the support they need, which is no surprise as they are organized in ways consistent with the needs of women veterans. For instance, many women veterans are working mothers (49,50). This limits their ability to attend counseling appointments during the workday, an issue that is relieved somewhat by the Vet Centers' 24/7 availability by phone and expanded clinic hours that include nights and weekends. Vet Centers also have a low barrier to entry—a frequently cited reason that women veterans defer seeking mental health treatment through the traditional VA medical center (51). A request for an appointment is sufficient in the Vet Centers to get the process moving and under statute the veteran must be seen within 30 days (52). If the Vet Center can't accommodate a request under the statutory time requirement, then contracted community services must be used to meet the needs of the veteran. To establish eligibility, a veteran need only present a combat ribbon, a pay stub showing combat pay, or their discharge notice (DD214) demonstrating duty in a combat theater of operation. The requirement doesn't apply to access MST counseling (52).



“I think that this is going to be hard for me. To magically transform into Mommy. I don’t know how you do that..”

*Journey to Normal
documentary participant (11)*

Photo courtesy of Journey to Normal

VA Vet Centers have also taken a proactive approach to meet the needs of women veterans. First, Vet Center leadership established an explicit goal to have counselors trained in MST at all 300 permanent sites, they aggressively hired Post-9/11 women veterans as counselors, and offered MST sensitivity training to all Vet Center staff across the country (53). They also established a series of national calls for RCS staff to discuss women’s needs and how to best serve them.

In one very successful pilot program, championed legislatively by DAV, 134 Post-9/11 women veterans participated in six wilderness retreats. In its report to Congress on the pilot, Vet Center leaders noted such outcomes in participants as reduced stress, improved coping skills and improvement in psychological well-being. Indeed, 85 percent of participants showed improvements in psychological well-being and 75 percent maintained that improvement two months post-retreat. Eighty-one percent also showed significant decreases

in stress symptoms after two months, and 82 percent showed an improvement in positive coping skills, with average scores improving in eight of nine skills measured (54). These are remarkable outcomes that warrant reauthorization of the program by Congress. Researchers should also examine the program to determine why it succeeds and if the program’s critical success factor(s) can be replicated in other settings.

The Vet Center program has more than three decades of success in serving and treating combat veterans. The leadership of the program has taken positive thoughtful steps over the last decade to accommodate the needs of women veterans. And while we would like to see customer satisfaction data broken down by sex, we would be surprised to hear that women veterans were significantly less satisfied than the 95 percent of Vet Center clients who report satisfaction with the service and are willing to recommend it to a friend (55).

However, women veterans can only appreciate (and benefit) from RCS services if they are aware of the availability of this resource and use it. In at least one study (56) only a minority of women veterans in the population surveyed were aware of RCS.

Finding:

Women veterans are well served by Vet Centers but not all women veterans who need them may be aware of the services they offer and that they may be eligible for services. Vet Centers also need authority and funding to be able to continue their successful retreat pilot as an ongoing program.

Recommendation:

Vet Center services should be included in an up-to-date central directory for federal programs and services that are available to women service members and veterans who are transitioning from military to non-military life.

Recommendation:

Vet Centers should collect, analyze and publish user satisfaction data by sex.

Recommendation:

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

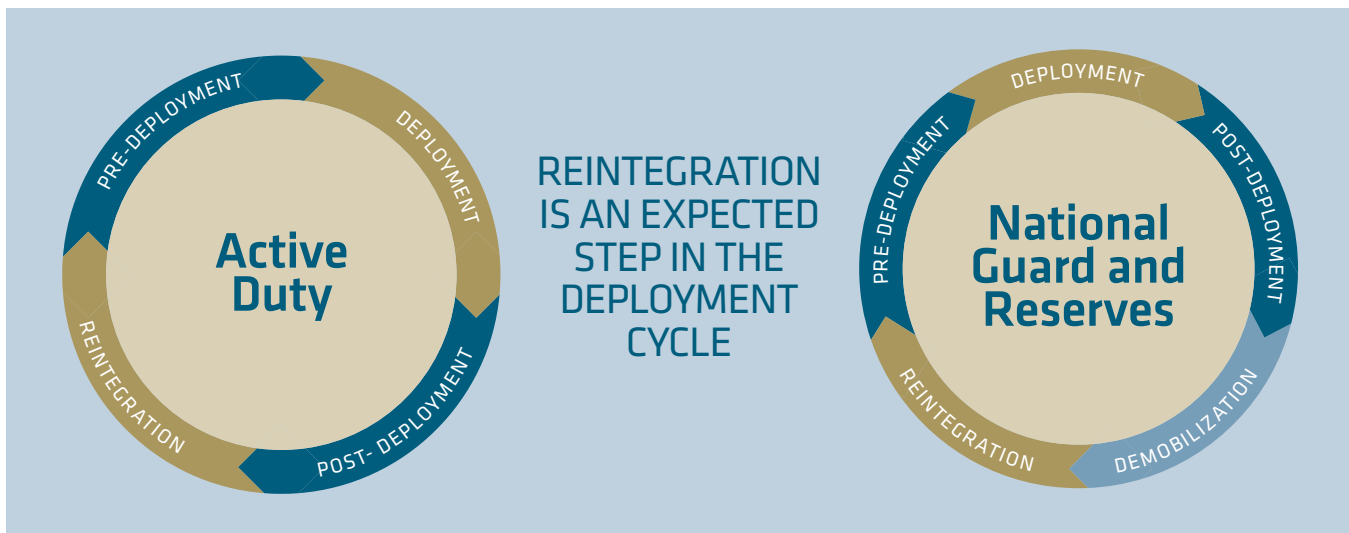
REINTEGRATION SUPPORT

Today's military clearly understands that returning from a combat zone to a home installation is a significant emotional adjustment. Unlike the experience of prior generations when troops may have had time to unwind and process their war experiences during a lengthy journey home, modern transi-

tions can be very quick. Service members today may feel that they are in a war zone one day, ready to fight in the company of their fellow personnel, and home the next day, expected to fulfill the duties and obligations of a spouse or parent.

The military has focused attention on the topic of reintegration to ensure that soldiers, airmen, Marines, and seamen return home successfully. Indeed, the return home is seen as one of the many steps in the deployment life cycle. Across the military, the focus of transition services and resources is on the whole family. Because deployment impacts both the deployed service member and their families left behind, reintegration resources address both sides of this relationship. In addition, these guides and resources also give advice to family members about what to expect during reintegration and how to best help their service member, acknowledging that most healthy adjustments require support and help from family and friends. An example of the resources available is the Military Deployment Guide (57) which is intended to be used across all services. In the guide, reintegration is described as follows:

After service members return from deployment and complete their post-deployment recovery and administrative requirements they will begin the reintegration phase of the deployment cycle. This includes reintegration into family life and the community as well as reintegration into regular military duties. Units may require service members to complete follow-up briefings, training, counseling and medical evaluations during this phase. Service members and their families may experience some stress during this phase as everyone readjusts to life together. Many support services are available for service members and their families to make this readjustment easier either through the branches of Service or through the community.



The guide enumerates and describes the myriad of counseling and support services available such as chaplains, family centers, MilitaryOneSource, Military Family Life Counselors, and more (58) and provides practical, if brief, advice to service members and families on what issues to look for and how to approach one another regarding deployment experiences.

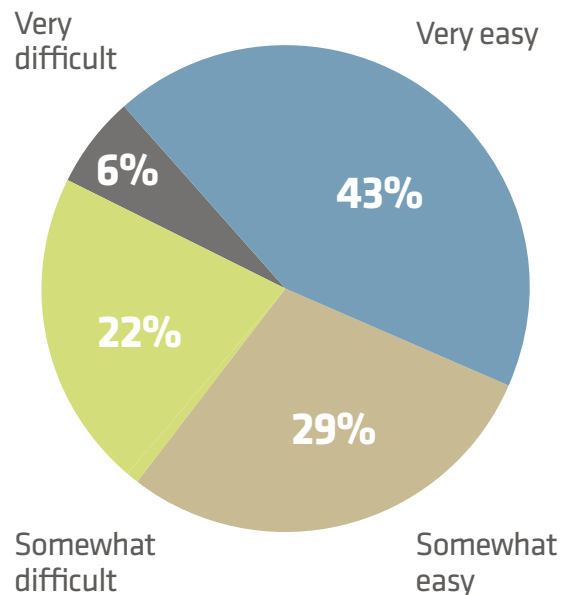
Although such national guidance and programs exist, accountability for ensuring the healthy functioning of the unit is vested in the local command structure. Guides are provided to commanders by DoD to help identify early problems and support service members through reintegration; however, within this broad mandate each local unit command or installation has latitude on what action to take, what to require, and what kind of services and programs to offer. Thus, local leaders can match resources to local needs and promote innovative services. Despite this flexibility, it is striking how few resource guides and services appear to either acknowledge the specific needs of women service members or, more specifically, to target them with supportive activities and guides. For example, see guides for the Air Force Space Command (59) and the Navy (60).

What specific support might women veterans who served in a combat theater require? To start, commanders should understand that women having a difficult reintegration experience may manifest different warning signs or symptoms than those in men. While both men and women may develop PTSD as a response to combat exposure and related events, women are more likely to manifest depression as a co-occurring condition and are less likely to display anger and resort to substance-use disorders (61). Women are also more likely than men to experience depression, an eating disorder or an anxiety disorder without a diagnosis of PTSD (62,63,64,65); yet guides for commanders don't routinely call out these conditions unique to women as red flags that require follow up (50, 51), and when these symptoms are listed in the guides, the different prevalence seen in men and women is not noted. Similarly, none of the guides reviewed in this analysis noted the different ways in which women might experience stress during and after deployment.

Studies indicate that women are much more likely to identify interpersonal issues as a significant locus of stress in this period (66) and at the same time perceive less social support than their male counterparts during the reintegration process (67). This is a particularly important finding since it is also known that social support is a key immunizing factor against the development of PTSD over the long term (68,69).

Coming Home

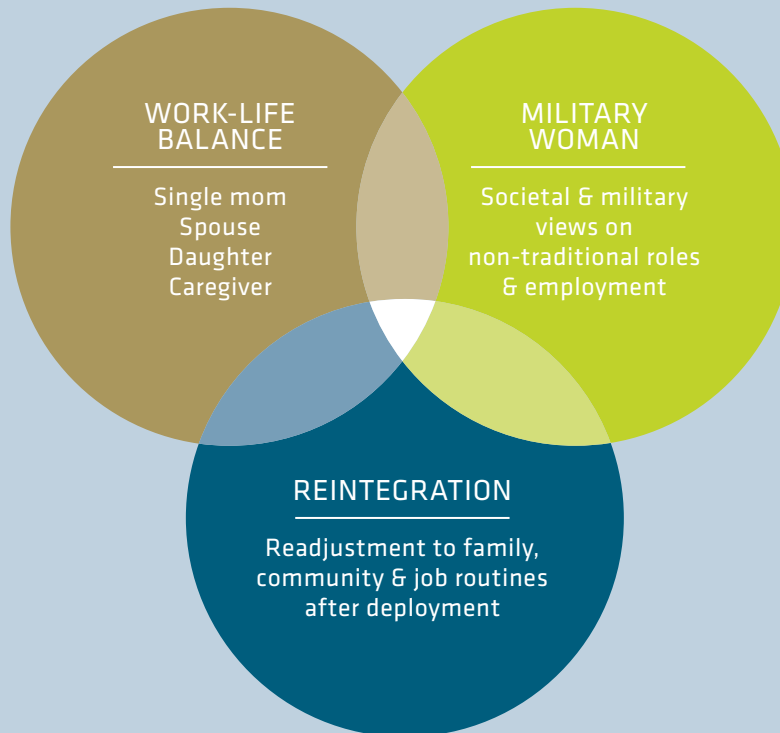
Share of all veterans who say their re-entry into civilian life was...



Notes: Based on survey of 1,853 veterans. "Don't know/Refused" responses are shown but not labeled. PEW RESEARCH CENTER

It is not at all surprising that women veterans who served in war zones feel less social support than their male peers (61,70). As noted in a 2013 study by the Institute of Medicine (IOM) (7), services and programs at military installations are geared toward supporting traditional military families where the husband is deployed and the wife remains behind. Current reintegration services fail to embrace alternative family structures. This impacts women service members preferentially because they are more likely to live as part of a nontraditional family, either as a single parent, part of a blended or step family or be part of a dual military family (49,71). Indeed, the failure of the military to adjust to the needs of deployed female service members and their families may contribute to the creation of these non-traditional households. Data from DoD show that the marriages of female service members are more vulnerable to divorce than those of male service members (72). Qualitative interviews with husbands of deployed service members report that the family support services available on base either don't serve their needs or are not welcoming because there are too few men in similar circumstances (49).

The Balancing Act of Women Veterans



When women combat veterans return to base, the camaraderie and support they experience during deployment with their male peers is often curtailed. Studies show that peer support and unit cohesion are important to successful readjustment (68,69). The men return to a support network of other male service members who can relate to their experiences. In contrast, as less than 15% of the active duty population, women have a more difficult time finding a similar network of women who can relate to their combat experience.

While there are numerous support groups for women on military bases, these programs are designed to meet the needs of, and are populated predominantly by, the civilian wives of male service members; they do not provide a peer group for women service members. Some military women may be able to maintain their relationships with their male peers, but such relationships back home can be more fraught with ambivalence and can raise suspicions of impropriety or infidelity in both wives and husbands that same-gender friendships generally avoid.

Post-9/11 women veterans not only express different concerns and stressors than their male counterparts, they desire a different way in which to process those emotions and thoughts (57). In a white paper prepared by the Army, authors note that “female service members consistently voiced that they felt that their experience of deployment was inherently

different from those of their male peers... [Women] require different pre-deployment preparation and reintegration strategies to ensure positive mental health and family outcomes... [and] communication with other women during deployment is helpful because males ‘work their issues out differently’ from the women” (73).

Transitions can be complex for women because not only are they processing what they experienced while deployed to a combat theater, they must also process societal assumptions that women are not warriors. Whenever women break traditional gender roles, they must work to create a narrative that explains their life in opposition to societal gender norms. Studies and programs on women in science, technology, engineering and mathematics (STEM) are instructive because similar to the military, women still make up less than 30 percent of all practitioners in engineering and computer science, less than 33 percent of those with advanced degrees in math and the physical sciences (74), and only 27 percent of the civilian science and technological workforce (75). In these roles women must cope with gender stereotypes and professional discrimination in these fields (76). One approach to supporting women in STEM fields is through formal mentoring and peer networking (77,78). Similarly, as a small minority in a field dominated by men, women veterans and those in the military would benefit from structured opportunities to meet with other women returning from deployments. In such a group whether



“My greatest success has been being able to give back to veterans [as a Transition Service Officer]. They don’t realize in order to work for DAV, you have to be a disabled veteran.”

DAV Transition Service Officer (TSO)

it is face-to-face or virtual, these women can help each other create a narrative about their experiences that encompasses their many roles as a wartime veteran, a woman and perhaps that of wife and mother.

One command in Fort Drum, New York has met this special need by establishing a Women Soldiers Group (79), a structured, eight-week support group that addresses issues with marriage, deployment, changing roles, child care and living as a dual military family.

■ **Finding:**

Some women in the military are actively involved in combat and must make the difficult transition home. But women have concerns that differ from those of men and process those concerns in ways that are different from them. Few programs are currently constructed to address these differences. Husbands of military women can feel isolated within the military community and feel that family support services are not intended or suitable for them.

■ **Recommendation:**

VA and DoD should develop a pilot program for structured women transition support groups to address issues with marriage, deployment, changing roles, child care and living as a dual military family.

■ **Recommendation:**

VA should evaluate the effectiveness of such transition support group pilot programs and determine whether these efforts help achieve more successful outcomes for women veterans.

■ **Recommendation:**

VA, DoD and local communities should work together to establish peer-to-peer support networks for women veterans and military members to ease transition, isolation and assist with readjustment.

■ **Recommendation:**

To ensure that women’s experiences are given value, guidance on reintegration should explicitly discuss the different ways in which men and women experience and manifest stress during and after a deployment.

■ **Recommendation:**

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

Education

Educational benefits are a major draw for recruiting military service members, and a college degree or advanced training is the key to financial independence of veterans over the long term. Educational benefits help achieve that goal, either in a college or other approved training program. Once veterans are on campus or in active training; however, education and training programs need to provide appropriate support that can help them succeed.

The original GI Bill is credited with remaking post World War II America by sending 51 percent of veterans to college (80,81). Women who served in World War II also took advantage of the GI Bill, with more than 64,000 attending college among the 2.2 million total veterans who used their education benefit (81). The original GI Bill helped soldiers who would never have been able to afford college, and promoted civic participation (81). By the early 1960s, U.S. Congress had used their GI Bill benefit (82).

THE POST-9/11 GI BILL

In more recent times, veterans continued to attain higher education with more than 30 percent obtaining some college experience compared to a little more than 25 percent of all U.S. citizens (83), but completion rates for veterans from 2000 to 2009 were surprisingly low. Among male veterans, only 16.3 percent attained a college degree compared to 18.1 percent of non-veteran males. However, women did better: in the same time period, 21 percent of women veterans had obtained a college degree, a higher rate than men overall or non-veteran women (18.2 percent) (83).

The Post-9/11 GI Bill has been extremely popular and provides for 36 months of tuition and fees equal to the most expensive in-state tuition at a public college in the state where the veteran chooses to enroll. Benefits also include a yearly \$1,000 stipend for books and supplies, and a monthly living allowance. Unlike the Montgomery GI Bill, no contribution from the service member is necessary. By 2013, the Post-9/11 GI Bill had benefited 754,529 veterans, at a cost of \$10.2 billion dollars (84).

Women often say that educational benefits were among their top motivators for joining the service. Research on women's employment outcomes suggests that a college education

is strongly correlated with long-term success. When women leaving the military have a college degree, they have a greater likelihood of finding a job sooner, finding the right job and perceiving their service as giving an advantage in civilian work (98).

However, veterans can experience barriers and encounter difficulties in every step of the education process: selecting the right school and program for their needs, navigating the benefits process, adjusting to campus life and learning how to study again. Selecting an education program or college isn't simple. Potential students need to identify a school that fits their needs and provides good educational value. Aggressive marketing to veterans by schools and, until recently, a paucity of independent information for veterans may have led to some poor choices when selecting an academic institution (86).

A recent study by Government Accountability Office (GAO) noted that information from schools does not adequately cover issues of cost, other benefits or the availability of veterans' services, and veterans reported that some information from the schools was "generally inaccurate." This prompted Congress to require that the VA itself provide this information, which has been accomplished to some degree by posting the VA GI Bill Comparison Tool (<http://department-of-veterans-affairs.github.io/gi-bill-comparson-tool/>). This tool provides estimates of the GI Bill contributions to tuition and housing for each school, rates each school on veteran indicators (Principles of Excellence, Yellow Ribbon and how many GI Bill beneficiaries already attend). The tool also lists graduation rates, loan default rates, and median borrowing for all students at the school. Each school entry also links to the National Center for Education Statistics (<http://nces.ed.gov/collegenavigator/?id=110635>) which offers comprehensive information on all schools. On August 28, 2014, VA launched the new enhanced version of the GI Bill Comparison Tool.

Most schools allow veterans to obtain credit for military training but this information is not yet incorporated into the GI Bill Comparison Tool. VA also augments the GI Bill Comparison Tool with counseling services to veterans. VA has been criticized for not providing adequate marketing of this service for use during the college selection process or appropriate staffing of this service. The process for applying for such counseling is a cumbersome paper application, many veterans are unaware of the service, and it currently takes too long to get an appointment (86).



A survey carried out by the American Council of Education in 2012 found that 62 percent of the 690 colleges and universities that responded were providing programs and services specifically for military service members and veterans, and approximately 71 percent indicated that this is a part of their long-term strategic plan. Approximately 82 percent of all institutions have an established policy regarding tuition refunds for military activations and deployments (87).

Despite this attention to student veterans, schools are unprepared, at present, to address the broad array of challenges that some veterans may bring. Service related disabilities can impact some student veteran transitions since campus disability services are largely unprepared for a rapid increase in students requiring their service (88) and may not have adequate resources to support student veterans. Veterans are often not aware of their entitlement to reasonable accommodations, or may be reluctant to identify themselves as having a problem due to stigma (89,90,91). Given the recent amendment to the Americans with Disabilities Act, which

includes difficulty with attention and concentration, and the prevalence of combat stress, PTSD and TBI among veterans, this is an important issue for schools to address (92).

A large survey of veteran students indicated that 51.7 percent of participants had completed their college degrees by 2013. Many GI Bill veterans went on to earn higher degrees: 31 percent who initially earned a vocational certificate, almost 36 percent who initially earned an associate degree, and 21 percent who initially earned a bachelor's degree went on to earn higher degrees (93). While the completion rates may be lower than non-veteran students, this may be due to the non-traditional nature of student veterans who tend to be older, have families, juggle employment and school, and may interrupt their progress in higher education due to military obligations (83,93,94). There are critical research gaps related to the success and supports for student veterans. These issues should be studied and addressed so that every veteran can maximize his or her education and training experience.



■ Finding

The Post-9/11 GI Bill represents the largest expansion of educational support to military and veterans in our nation's history and provides excellent educational benefits. There is a paucity of information available on the education subsidies and support received by women veterans or the outcomes of the use of the Post-9/11 GI Bill benefits and services. More information is needed for program planning, policy-makers and researchers. Veteran students need targeted information to help them choose a school that works for them.

■ Recommendation

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

■ Recommendation

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

“It’s hard to go from doing something significant to being a nobody.”

*Journey to Normal
documentary participant (11)*

Financial Security

EMPLOYMENT / EMPLOYMENT SERVICES

For men and women alike, a key requirement for a successful transition away from military service is the ability to establish satisfying, stable employment as a civilian. Most military members make this transition successfully, but some struggle. With the United States facing a significant draw-down of about a million service members by 2020 (95), it is critically important that employment programs and services are effective at helping men and women in the military make this transition smoothly.

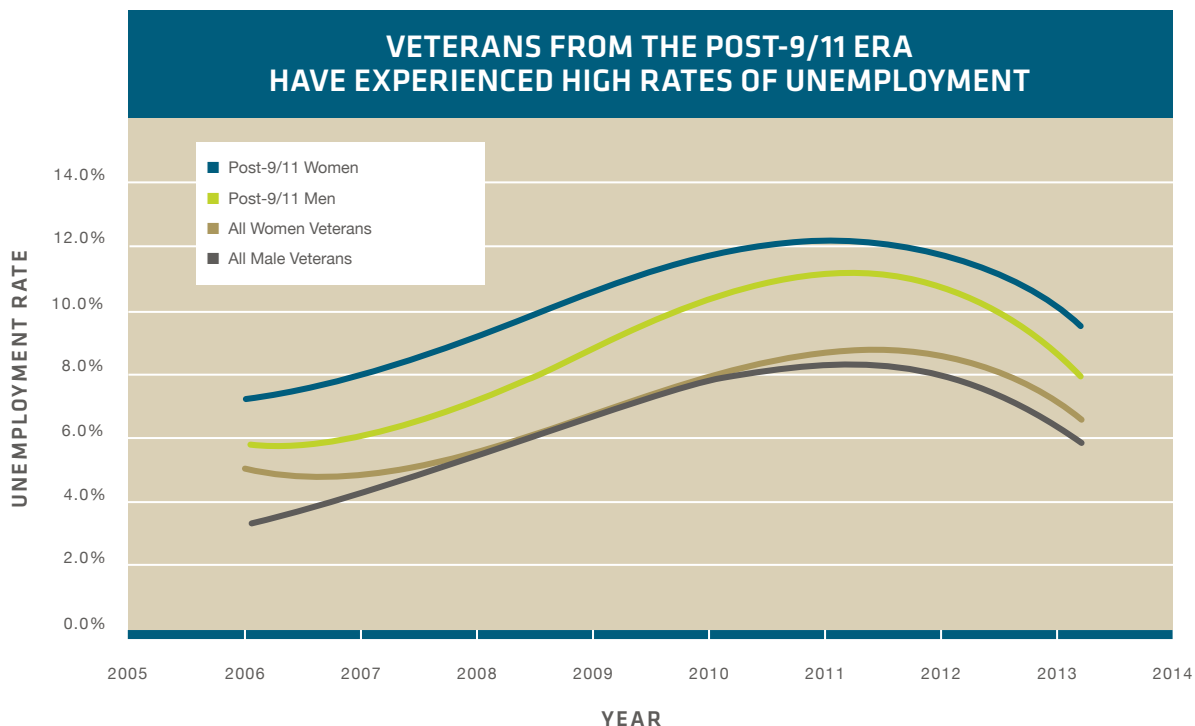
Employment data makes it clear that recent veterans have struggled to make the transition from military to civilian life. While the unemployment rate for all veterans throughout the economic downturn was better than that for the civilian labor force as a whole (96), Post-9/11 veterans had persistently higher rates of unemployment than other veterans and it took longer for that trend to peak at 12.1 percent and start to decline after 2011. This trend was even more pronounced among women veterans, with unemployment among Post-9/11 women climbing to 12.5 percent through 2012 (96). The latest data show gains for Post-9/11 women veterans, with an unemployment rate declining to 9.3 percent in 2013 (97). However, this rate is only slightly below peak unemployment reached by the country overall in the depth of the recession in

October 2009 (98). Indeed, as a whole, women veterans have struggled with unemployment following the recent recession, lagging behind all men and non-veteran women (96). With almost 200,000 or so women ready to leave the military over the next four to five years, it is imperative that we improve our support for women veterans' employment.

The reasons underlying this persistently higher rate of unemployment are not definitively known. However, characteristics such as a younger age, being unmarried or divorced, lower educational attainment and having children at home are associated with a higher rate of unemployment and are also prevalent among women veterans.

Age

Younger workers have a higher rate of unemployment than older workers (99) with 18-24 year olds experiencing the highest level of unemployment among adults. Both male and female Post-9/11 veterans in this age cohort have a higher rate of unemployment than their civilian peers and the highest rate among veterans overall (97).



Bureau of Labor Statistics • www.bls.gov/opub/ted/2014/ted_20140325.htm (96)

Marital Status

Marital status correlates with employment. Married women have lower rates of unemployment than divorced, separated, widowed or never-married women (100,101). After age 35, women veterans are less likely to be married than their civilian counterparts due to more separation and divorce in this population. Indeed, in all age cohorts, women veterans are more likely to experience divorce (71).

Educational Attainment

Younger women veterans, 17-24 years old, have a lower level of attainment of a bachelor's degree (5.2 percent) than non-veteran women (9.7 percent) of the same age. This difference persists among 25-34 year olds, with only 29 percent of veteran women attaining a bachelor's degree compared to 36 percent of non-veteran women of the same age (71). Analysis of veteran data show that poverty and educational attainment are linked. Only 3.2 percent of veterans with a bachelor's degree live in poverty compared to the 6.9 percent of veterans without a bachelor's degree who live in poverty (102,103).

Motherhood

Single mothers have higher rates of unemployment than married mothers (12 percent vs 4.8 percent, respectively) (104). Eleven percent of women service members are single parents compared with four percent of men. Women veterans are slightly more likely to have children than non-veteran women (58 percent compared to 52 percent) (103). Among younger veterans this difference is pronounced with 29 percent of women veterans 17-24 years of age having children while only 13 percent of age-matched civilian women have children. Women veterans are more likely to have children under the age of 18 at home which correlates with poorer employment outcomes (105).

Medical and Mental Health Concerns

According to the VA, women veterans have higher rates of medical and mental health concerns than do male veterans, and one in five women veterans who use VA health care have experienced MST (106). Overall, women veterans have a higher rate of trauma exposure than their civilian counterparts when pre-enlistment, during-service and following-service experiences are taken into account (107). One recent survey of veterans (108) indicates a significant difference in women veterans' perception of the impact of war on their emotional and mental health with 43 percent of them stating they are worse now than before serving in Iraq or Afghanistan, which is higher than the 30 percent of men who feel the same way. Mental health needs and diagnosis of PTSD, TBI and the effects of MST as well as physical health concerns have all been noted as risk factors for poor employment outcomes in veterans (85,109,110,111).

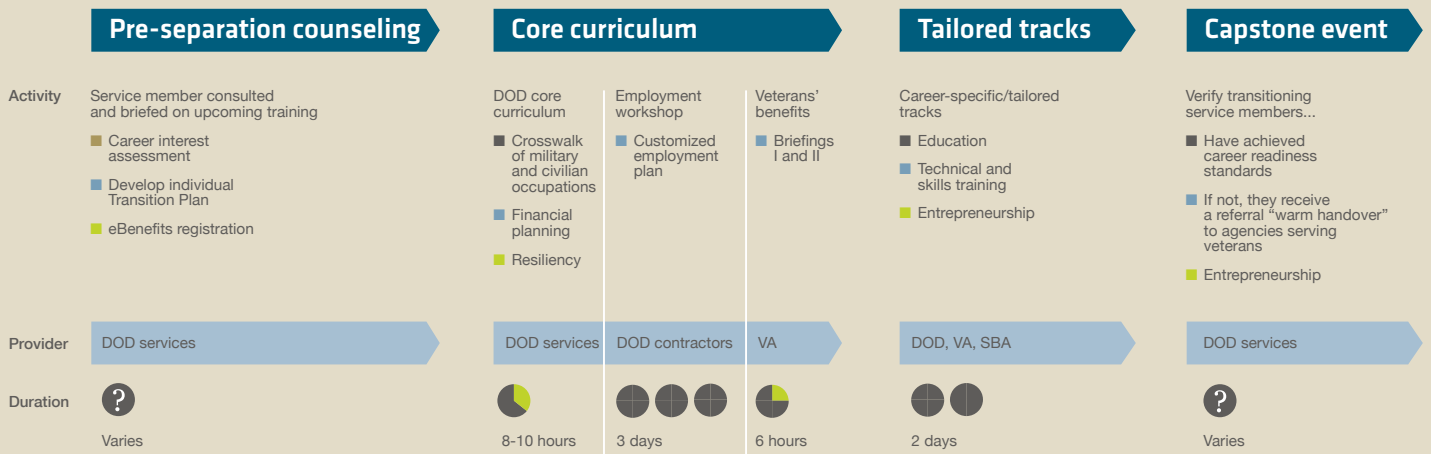
Even when these factors are controlled, Post-9/11 women veterans and National Guard women veterans have higher rates of unemployment than other groups (117). Given this constellation of factors working against employment success for some women veterans and their demonstrated higher rates of unemployment, it is important for all of the partners working on veteran transition challenges to identify the specific needs of women and institute specialized programs and outreach for them.

TRANSITION ASSISTANCE

The challenge of making the transition from military service to civilian employment has been widely discussed (113). For many in the military, seeking civilian employment may be the first time they have developed a resumé or interviewed for a job. For most, it can be a challenge to translate the skills, knowledge, and experience gained in military assignments into language accessible to a civilian hiring audience. In particular, specialized training and certificates gained during service do not generally translate into certification or licensure requirements for an equivalent position in the civilian sector. Finally, military members who move frequently or have been absent on deployments may not have a robust local network of civilian contacts who can help identify employment opportunities where they live.

There is no direct evidence that this transition is any different for women than it is for men. Yet, women veterans' unemployment rate remains stubbornly high and women have voiced frustration with the transition process. For instance, women veterans were less likely than men (32 percent compared to 47 percent) to believe the military was doing enough to ease transitions to civilian life, and more women (18 percent) than men (7 percent) doubt their military skills will be useful in the civilian job market (108). Other studies found that women felt they had been led to believe that military training would be more valuable than it is in their search for employment (114,115).

Employment sector data appears consistent with the idea that women veterans find their military experience to be of less value in the job market. The data indicates that women veterans' employment patterns appear much more like that of civilian women than male veterans. Although women are filling technical positions in the military, they don't appear to be able to capitalize on that experience in the private sector in the same way as men (97,101).



Source: GAO analysis of implementing agencies' documentation

In recognition of the need to help service members to transition effectively to civilian life, Congress established the original Transition Assistance Program (TAP) in 1991 (116). The new DoD program, called Transition GPS (Goals, Plans, Success) covers all service members and incorporates career readiness and transition preparation into the entire span of a military member's career. The revised program covers all departing service members¹. It is intended to help service members identify their post-separation education, financial and employment goals. After participating in the structured program, service members are expected to have clear goals for employment or education and will know where and how to access the services that can help them achieve those goals.

According to a recent review of the program by GAO (95), comprehensive data on participation rates and information on the effectiveness of the training is not readily available and post-transition outcome data is limited. The data that is gathered has not been publicly released with an analysis of outcomes and satisfaction by gender.

Finally, as noted in the chapter on reintegration, commanders are the lynchpin of the program. They must ensure that transitioning service members attend the various trainings and they are responsible for ensuring an appropriate review of the service member's employment plan and directing any needed follow up as part of the program "capstone." GAO recognized that without uniform data gathering and accountability to ensure all commanders fulfill this responsibility, the impact of the program may be limited.

Finding:

The effectiveness of the TAP program cannot be assessed in the case of women.

Recommendation:

Data on participation, satisfaction, effectiveness and outcomes for TAP should be collected and analyzed by gender and race and returned in real time to commanders for their assessment and corrective actions.

Finding:

TAP does not offer elements targeted at women or their needs.

Recommendation:

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

Finding:

While the warm handoff for transitioning service members who have not completed an acceptable transition plan is laudable, the proof of success is whether every plan has been successfully implemented six months to a year out from separation. The hallmark of adult learning is that adults seek out and absorb information when they perceive that they need it, not necessarily when it is presented. Some transitioning service members may not be primed to absorb TAP training pre-separation but would be more receptive once they are actively seeking employment six months later.

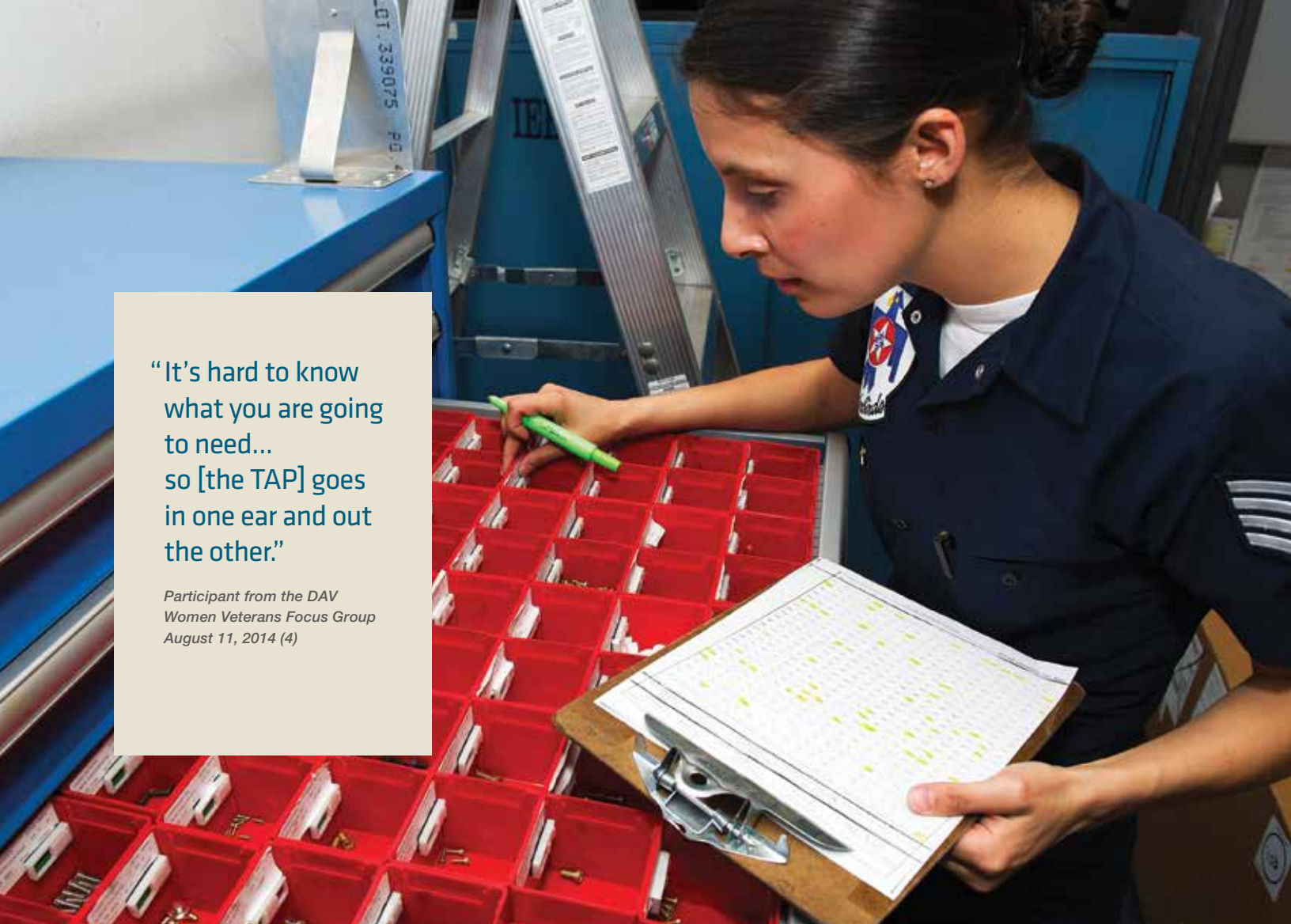
Recommendation:

DoD should transfer contact information and data on all TAP participants to VA and DoL who should be responsible to provide gender sensitive follow up with all service members 6-12 months after separation to offer additional support and services, if needed.

Recommendation:

To judge the success of TAP, employment outcomes and educational attainment should be tracked and reported on a rolling basis, analyzed by gender and race, for all separated service members.

¹TAP participant requirements are defined as "all service members who have been on active duty for at least 180 days are eligible for TAP services, but those separating because of a disability are eligible regardless of the length of their active duty service. Eligible service members must be provided TAP while they are on active duty, either as soon as possible within the 2 years prior to their anticipated retirement date or in the 1 year prior to their anticipated separation date. In either case, TAP services must generally commence no later than 90 days prior to their discharge or release. The exceptions to this rule occur when retirements or separations are not anticipated until 90 or fewer days of active duty remain, or a member of the reserve is being demobilized under circumstances in which the 90 day requirement is unfeasible. In such cases, TAP services must be provided as soon as possible within the remaining period of service." (2014). *Transitioning Veterans: Improved Oversight Needed to Enhance Implementation of Transition Assistance Program*. U.S.G.A. Office. Washington, DC.



“It’s hard to know what you are going to need... so [the TAP] goes in one ear and out the other.”

*Participant from the DAV Women Veterans Focus Group
August 11, 2014 (4)*

DEPARTMENT OF LABOR

Department of Labor (DoL) is responsible for providing the employment workshop during the TAP program and they run a variety of programs and services that help support veterans in their search for employment. This includes the Veterans Employment and Training Service (VETS) that provides employment resources and expertise, and the Gold Card which can be used by unemployed Post-9/11 era veterans to receive enhanced intensive services at DoL American Job Centers and the associated website, Career One Stop (www.careeronestop.org) (118). This support is individualized to the needs of the veteran and includes six months of follow-up with a case manager. In addition, DoL sponsors My Next Move for veterans, a job search portal that allows them to use their military occupation code to browse jobs and career information and to take an assessment to find out about careers compatible with their interests. A similar portal from DoD, Hero 2 Hired (119), targets National Guard and Reserve members.

Importantly, DoL has a visible and strong focus on women veterans and their needs (120) and uses specific messages and images of women veterans that provide an inviting entry portal. However, the employment resources offered are the same for women as for men and one limited study indicates that women are unlikely to use these veteran related services (121).

JOINING FORCES

Launched by the White House in 2011, Joining Forces is a government initiative to promote employment for military members and their families (122). The effort brings together federal agencies, state government, educational institutions and the private sector to promote and support employment and training for military families and veterans. Through the initiative (and supported by tax credits for veteran hiring), private businesses and non-profit organizations have pledged to hire or train more than 800,000 veterans and their spouses.

Working with state licensure and certification processes, the initiative has also made progress in bringing attention to the need to streamline the translation of military training and certification to private sector equivalents (113,123). While all of these efforts are tremendously positive and have raised national awareness of the skills and talent of former military members, the initiative is broad based without specific outreach to women veterans. In some instances, the private sector has done well to appeal to and welcome women veterans, using images and messages that include women veterans, while others have focused only on telling the stories of military men, giving the appearance that these occupations are closed to women. In addition, the Work Opportunity Tax Credit to encourage industry and non-profits to hire veterans expired December 31, 2013. With unemployment among Post-9/11 women veterans still high, and given the anticipated drawdown of strength at DoD, this tax credit should be made permanent.

VA EMPLOYMENT PROGRAMS

VA provides vocational rehabilitation and employment support for service-connected disabled veterans and current military service members who have been injured and are anticipated to receive a service-connected rating upon separation from the military². Participants meet with trained counselors who work with them to create a rehabilitation plan. If the veteran enters a long-term employment services track which includes training, education support and vocational training support, VA reimburses employers for up to 50 percent of a veteran's salary while in training. A Congressionally mandated longitudinal study of program outcomes is being conducted with final outcome data available as early as 2015. An interim assessment from 2007 concluded that women were slightly more likely to successfully complete the program than men (124).

VA recently wound down the Veterans Retraining Assistance Program which had been given temporary authority from Congress. It targeted older veterans (35-60 years of age) who were unemployed and not otherwise eligible for other VA education or training benefits. Training was focused on occupations in high demand by businesses. To date, more than 126,000 applicants have been approved and \$866 million in benefit payments have been made (125). After completion of their training, veterans files are transferred to DoL job centers that have responsibility for providing job placement support and tracking employment outcomes. The program closed in March 2014 and no information on the success of women veterans in using the program has been published to date. A report on the program was due to Congress in July 2014.

■ Finding:

With the exception of those who served in peacetime, women veterans continue to experience significant levels of unemployment. Post-9/11 women veterans transitioning from active service are struggling to find employment quickly.

■ Recommendation:

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

■ Recommendation:

The DoL should work closely with state certification organizations to translate military training and certification to private sector equivalents. VA and DoD should establish a grant program to accelerate these efforts.

■ Recommendation:

Congress should make the Work Opportunity Tax Credit, as it applies to veterans, permanent.



**“Nobody wanted to hire a vet.
It took me 10 months to find
the same job I had before
military service.”**

*Participant from the DAV
Women Veterans Focus Group
August 11, 2014 (4)*

²VA service-connected disability rated at least 20 percent with an employment handicap, or rated 10 percent with a serious employment handicap, and be discharged or released from military service under other than dishonorable conditions.

Shelter

RISK FACTORS FOR HOMELESSNESS IN VETERANS

- Psychiatric Diagnosis
- Substance Use Disorder
- Trauma (including sexual trauma, before, during or after military service)
- Single Parent
- Unmarried
- Unemployed
- Deployment
- Low Levels of Social Support

(61, 62, 70, 108, 126, 127)

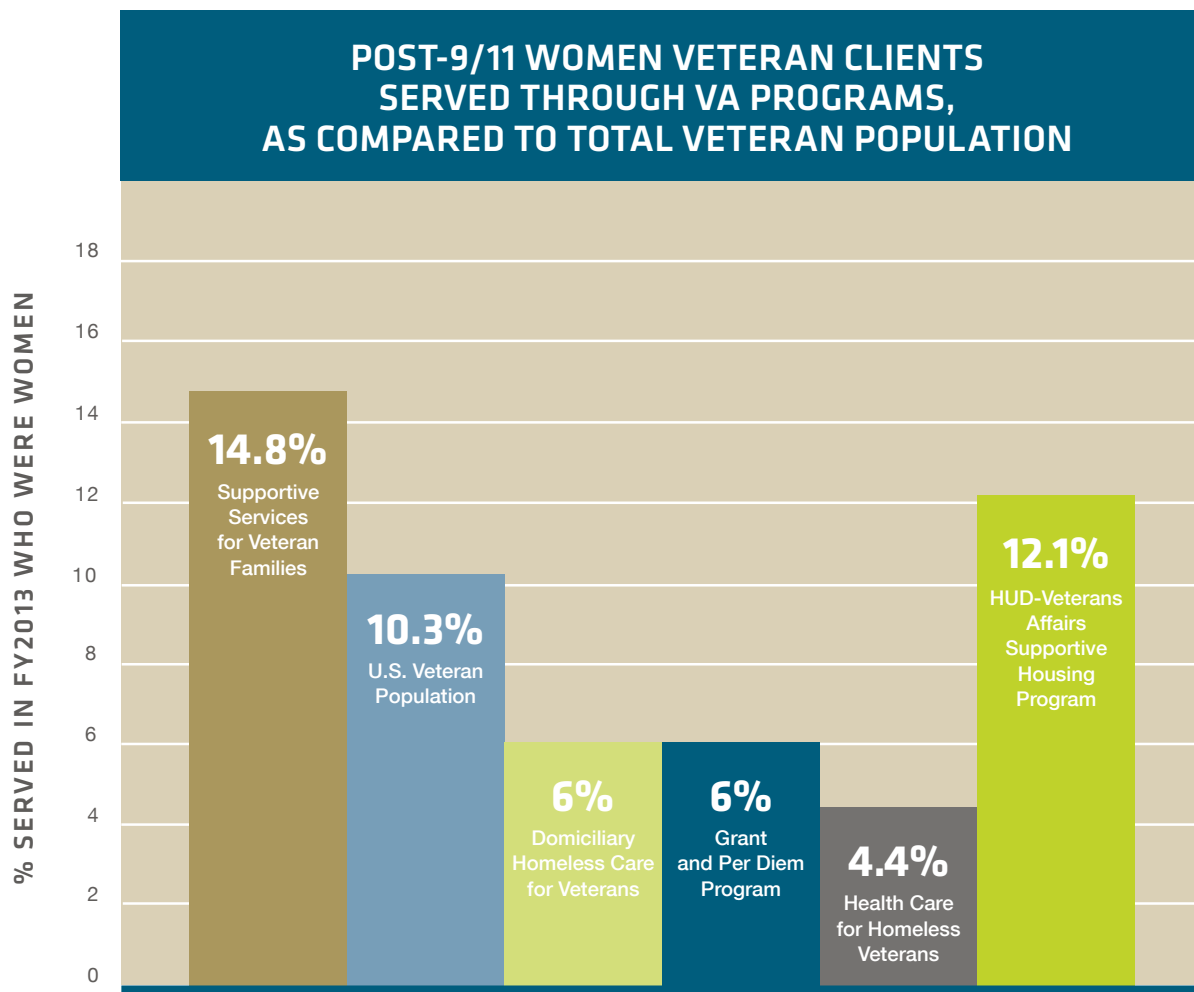
Help for Homeless Veterans
877-4AID-VET
va.gov/homeless | (877) 424-3838

PREVENTING HOMELESSNESS

The over-representation of veterans in the U.S. homeless population has long been recognized (128). However, the recognition that women veterans are at significant risk for homelessness is a more recent development (133,134). In 2013, there were 4,456 women veterans estimated in the annual point-in-time survey of the homeless (131) representing eight percent of homeless veterans in shelters on survey day. This is a startling number if one considers that women overall only represent 0.9 percent of homeless adults. Women veterans are two to four times more likely to be homeless than non-veteran women (107,127,130,132,133). In one study, African American women veterans, ages 18-29, who live in poverty, were shown to be particularly susceptible to becoming homeless, with 36.3 percent experiencing homelessness compared to 11.9 percent of all other women veterans in poverty. At all ages, poor African American women veterans experience a high degree of homelessness at 29.7 percent (132).

The risk factors for homelessness among men and women veterans are similar, although the distribution of the risks may vary. Of note among the known risk factors, are history of trauma, being a single parent, being unemployed, and having low levels of social support following separation from the military. These may be characteristics that are found more often among today's women veterans. For instance in 2010, nearly 40 percent of women veterans served by HUD-VASH entered the program with their dependent children (133).

Eliminating veteran homelessness was established as a goal for the Federal Government in 2009 and has had strong support from all of the Federal partners; in particular VA (128). The leadership focus, coordination and additional resources have made a real difference in veteran homelessness and especially for the long-term homeless population. However, this focus on veteran homelessness brought attention to the fact that the programs in place at the beginning of the effort in 2009 did not adequately serve women veterans and indeed could contribute to re-traumatizing them (134,135). For instance, audits found that adequate safety measures were not in place to protect women residents of VA housing—buildings lacked separate sleeping spaces, locks on bathrooms, adequate lighting in stairwells and monitoring by staff. The evaluations also criticized VA for not having enough transitional and supportive beds designated for women veterans. As the factors that contribute to women veterans homelessness became better understood, it was



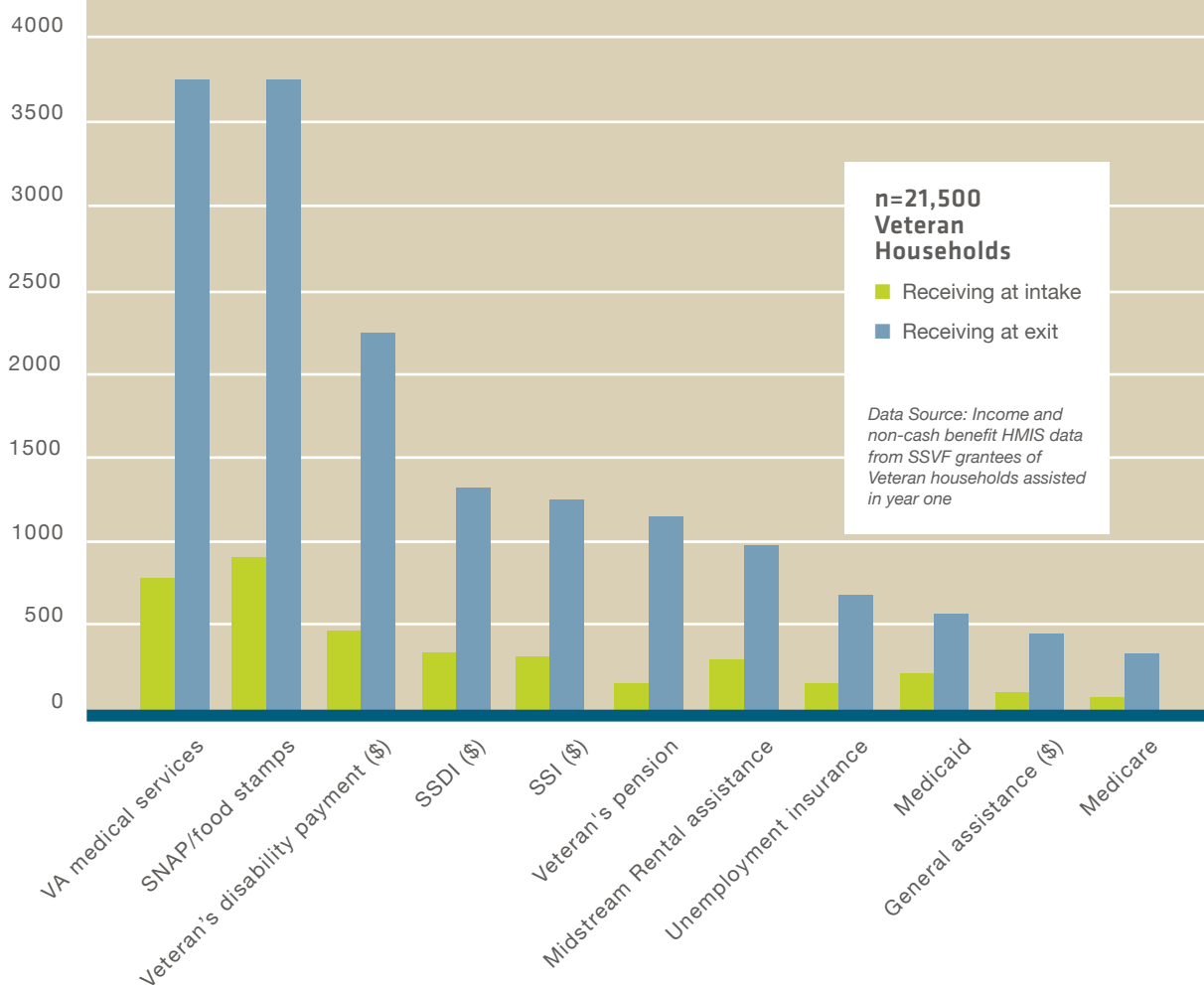
also recognized that existing programs needed to be able to accommodate families (not just the veteran) and should offer culturally competent intake procedures and ongoing support in recognition of women’s experience of trauma, distrust and failure to recognize themselves in the label “veteran” (117). With the support of Congress and with contributions from all the Federal partners, the programs today appear to address some of these earlier criticisms, although outcome data by gender needs to be collected and reported to ensure programs are now meeting the needs of women veterans.

Because existing temporary housing facilities could not be easily modified to address safety concerns, the VA has converted some Grant and Per Diem opportunities to support “transition-in-place” (TIP) housing subsidies. Service providers were allowed to use the per diem toward rental subsidies with the goal to have the veteran take over the lease at the end

of the supported period. In 2012, 31 of 38 programs funded applied the TIP model (136). This is an important resource for women veterans because it both provides a safer place for them to reside and also permits children to stay in subsidized housing units. Importantly, TIP also emphasizes an exit to permanent housing further promoting housing stability for the veteran (136,137).

The reinvigoration of HUD-VASH has provided an important housing resource for women veterans. Again, like the TIP model, children are able to live with their parents in the subsidized rental units and women can feel relatively safe and secure in their own housing. HUD-VASH is intended to be longer-term and is packaged with supportive services from VA and thus is intended for veterans who have long-term chronic impediments to stable housing.

RECEIPT OF BENEFITS AND SERVICES FROM SSVF PROGRAM (Supportive Services for Veteran Families)



Across all of the programs serving significant numbers of women veterans, the federal government through the women's bureau of the DoL has introduced the concept of "trauma informed care" to the provider community. Training and guidance helps service providers understand the experience of women veterans and provides approaches and suggested language to use with these veterans so they may feel safe and more open to accepting support (107). However, one important gap that remains to be filled is to ensure that women veterans escaping domestic violence are eligible for homeless services at VA. While the definition of homelessness under Title 42 was updated by Congress to include flight from domestic violence and abuse as an eligibility criteria for services (42 USC 11302 (b)), the appropriate cross reference has not been made to homeless programs authorized under Title 38 at the VA (38 USC 2002).

As indicated by the rates of women veterans' participation in each program, the newest program for veterans, Supportive Services for Veteran Families (SSVF), initiated in 2012, has been a successful intervention, serving both a large number of veterans and a high percentage of women. Importantly, 45 percent of those served were part of a family unit with children. The program is intended to be short term: the median length of service was 90 days in 2013 and the cost of the interventions is modest, between \$2,400 and \$2,800 per household. Finally, the outcomes for the program look promising with 60 percent of households exiting to rental or permanent housing that is not subsidized, while most of the remainder went to other subsidized housing (138). One of the key interventions emphasized in SSVF is to stabilize income for these veterans, which often means ensuring they are enrolled for all of the benefits and subsidy programs appropriate for their circumstances.

This combination of housing and income stabilization has been successful. Over the short life of the program, more than 90 percent of households with children continue to be housed and more than 85 percent of households without children avoid homelessness (136,138). This demonstrates that rapid re-housing of those who become homeless and prevention services for those at imminent risk of losing housing is a cost-effective intervention for at-risk veterans. As this program is only authorized through 2015, Congress should be encouraged to make the program permanent and fund it at adequate levels to meet the needs of existing veterans and the many more who will be making the transition from military service in the upcoming DoD draw down. A modest investment over the next five years could do much to prevent long-term chronic homelessness from developing among the Post-9/11 cohort.

HOME LOANS

The VA Home Loan Guaranty program is an important benefit earned through military service. Veterans can use the program to purchase a home, refinance a home or make home improvements. VA home loans have an advantage over conventional loans because no down payment is required, no private mortgage insurance is needed, closing costs are limited and standards for the borrower are generally lower (to allow more veterans into home ownership). Down the road, if the veteran runs into trouble with the loan, VA will intervene with the lender to negotiate a resolution that will hopefully permit the veteran to remain in her home (139,140,141).

Veteran home ownership has historically been higher than that of the general population—at about 80 percent compared to about 68 percent of the general population (142). This advantage in home ownership is attributed at least in part to the VA home loan program. In FY 2012, about 1.4 million veterans used the VA Home Loan Guaranty program. This amounted to \$1.588 billion dollars in expenditures. Data on utilization of the program from 2004 indicates that women veterans represent about six percent of home loan beneficiaries (139). More recent comprehensive data is not available, although it was noted that in the first half of FY 2013, VBA witnessed an increase of 28 percent in the number of loans going to women veterans (143).

A survey conducted by VA of veterans and active duty military and Reserves, indicates that women veterans are aware of the Loan Guaranty Program and have a higher knowledge of it than the total veteran sample (74.1 percent of women were knowledgeable vs. 68.2 percent of all veterans who said they were knowledgeable of the program) (144). As a tool in the VA armament to assist women veterans to have a stable, productive life after separation from the military, women's participation and knowledge of the program should continue to be tracked and published. Home loan literature and advertising should be sure to feature women veterans.

■ Finding:

VA's efforts to eliminate veterans' homelessness have been impressive and are showing measurable success. Women veterans still have higher rates of homelessness than their non-veteran counterparts and housing support needs to be enhanced particularly for women with dependent children.

■ Recommendation:

VA and HUD should invest in additional safe transitional and supportive beds designated for homeless women veterans, especially those with children.

■ Recommendation:

Congress should reauthorize and fully fund the SSVF program to promote positive transitions for women veterans during the anticipated downsizing of the U.S. Armed Forces.

■ Recommendation:

Congress should pass legislation to ensure that veterans escaping domestic violence are eligible for homeless programs under Title 38 of the US Code equivalent to eligibility definitions under Title 42.

■ Recommendation:

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

■ Recommendation:

VA should track and publish data on women veterans' utilization of home loans and supported housing benefits.

“I needed help and I was unemployed and bouncing from couch to couch for quite some time. And it was really tough for me to look at my best friend and say ‘hey dude can I come live with you for six months? I need a place to stay.’”

*NY Veterans History Series: Women Warriors
December 7, 2013 (145)*

<http://www.nypl.org/events/programs/2013/12/07/new-york-veteran-history-series-women-warriors>

Conclusion

The cost of military and combat service is unique to each woman. For some, the greatest sacrifice is leaving home, family and friends; for others it is the barren living conditions and constant stress of war; for others it is the burden of visible and invisible wounds; and some women are asked to pay the ultimate cost. Because of their role in the military and society, women live with unique challenges. They are strong and heroic, but because of the magnitude of the challenges faced, they may well need support during post-military readjustment periods.

Throughout U.S. history, women have volunteered to serve in the military, but their contributions have been under-recognized, even by the women themselves. The challenges of transition to post-military life affect women differently than men and, accordingly, women should receive special attention from the federal government and the communities they live in. These needs are varied and complex, spanning the areas of health care, reduction and ultimately eradicating sexual assault, employment, finance, housing and aid with a variety of social issues. Throughout the report, specific gaps in current resources are highlighted and recommendations are laid out to address these needs. Through our collective efforts, women won't be left to make the long journey home alone.

“I think when you talk about men in the military, it's easy to deal with it in isolation...men doing men stuff...running around with their guns... it's hard core and cool. When you talk about women in the military you have to look at how the military touches our society...it speaks to us as a culture, a society and a Nation.”

Journey to Normal
documentary participant



Photo courtesy of Devyn Reyes



Photo courtesy of Journey to Normal



Photo courtesy of Journey to Normal



Photo courtesy of Journey to Normal



Acknowledgements

DAV is deeply grateful for the outstanding contributions of the many staff, women veteran members and collaborators who contributed to this unprecedented report on women veterans.

Sigma Health Consulting, LLC (Sigma) provided assistance and did extraordinary work to assemble this report highlighting the challenges that confront the women who serve our nation in uniform and the assistance needed for their long journey home. The report summarizes DAV's policy, oversight and legislative recommendations that will ensure that our nation meets its obligation to provide equitable services and support for women veterans. Frances Murphy, M.D, M.P.H. is an Air Force veteran, President and Chief Executive Officer of Sigma and a former VA Deputy Under Secretary for Health in the Department of Veterans Affairs. She was joined by Sherrie L. Hans, Ph.D. and Bradley J. Reina, Ph.D. candidate in carrying out the review.

DAV is also deeply appreciative for the contributions of its women veteran members who participated in DAV Women Veterans Focus Groups on August 11, 2014. Their service, patriotism and heroism enrich and inspire us as an organization. Without their insights, this report would not have been possible.

This DAV report was developed in collaboration with filmmakers JulieHera DeStefano and Andrew Swensen. Their documentary film, *Journey to Normal: Women of War Come Home*, vividly recounts the experiences of women soldiers who served in Iraq and Afghanistan, and follows their reintegration after they returned home. We give special thanks to Ms. DeStefano and the entire *Journey to Normal* (JTN) team for allowing us to have access to the many hours of film interviews of women veterans conducted in Afghanistan and here in the United States. The JTN collaboration provided DAV with a very personal view and understanding of the experience of Post 9/11 women service members, the challenges they face at war and at home and helped shape our report. The film documents the compelling stories of these women veterans and their unfinished journeys home.

We would also like to extend our sincere gratitude to the DAV Charitable Service Trust and its Board of Directors for the grant that made this report possible.



Photo courtesy of U.S. Army Alaska



Photo by Staff Sgt. Jason Epperson, 3rd MEB PAO

*We honor all of those who have made the ultimate sacrifice while serving our nation; with a special remembrance of Army PFC Amy Bullock Sinkler, who was killed in action in Afghanistan on January 20, 2011 while serving with the Rough Riders from the 17th Combat Sustainment Support Battalion, 3rd Maneuver Enhancement Brigade based out of Fort Richardson, Alaska. Amy's journey is shared in the documentary *Journey to Normal: Women of War Come Home*.*

Bibliography

1. U.S. Department of Veterans Affairs National Center for Veterans Analysis and Statistics (2011). *America's Women Veterans: Military Service History and VA Benefits Utilization Statistics*. Department of Veterans Affairs, Washington, DC.
2. Washington, D.L., Kleimann, S., Michelini, A.N., Kleimann, K.M., Canning, M. (2007). Women veterans' perceptions and decision-making about Veterans Affairs health care. *Military Medicine*, 172(8): 812-817.
3. U.S. Department of Veterans Affairs (2010). *National Survey of Veterans, Active Duty Service Members, Demobilized National Guard and Reserve Members, Family Members, and Surviving Spouses Final Report*, Page 85, Department of Veterans Affairs, Washington, DC.
4. Murphy, F.M. (2014). *Women Veterans Focus Group. Disabled American Veterans Convention, Las Vegas NV. August 11, 2014.*
5. U.S. Department of Veterans Affairs Veterans Health Administration Office of Public Health Post-Deployment Health Group (2014). *Analysis of VA Health Care Utilization among 210,675 Female and 1,580,745 Male Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND) Veterans. Cumulative from October 1, 2001 - March 31, 2014*, Department of Veterans Affairs, Washington, DC.
6. Frayne, S.M., Phibbs, C.S., Saechao, F., Maisel, N.C., Friedman, S.A., Finlay, A., Berg, E., Balasubramanian, V., Dally, S.K., Ananth, L., Romodan, Y., Lee, J., Iqbal, S., Hayes, P.M., Zephyrin, L., Whitehead, A., Torgal, A., Katon, J.G., Haskell, S. (2014). *Sourcebook: Women Veterans in the Veterans Health Administration. Volume 3. Sociodemographics, Utilization, Costs of Care, and Health Profile. Women's Health Evaluation Initiative, Women's Health Services, Veterans Health Administration, Department of Veterans Affairs, Washington, DC.*
7. Institute of Medicine (2013). *Returning home from Iraq and Afghanistan: Assessment of readjustment needs of veterans, service members, and their families*. The National Academies Press. Washington, DC.
8. Baiocchi, D. (2013). *Measuring Army Deployments to Iraq and Afghanistan*. ISBN 978-0-8330-7868-1. RAND Corporation
9. Defense Casualty Analysis System, U.S. Military Casualties—GWOT Casualty Summary by Casualty Type, <https://www.dmdc.osd.mil/dcas/>, accessed August 10, 2014.
10. Institute of Medicine (2014). *Gulf War and Health, Volume 9: Long-Term Effects of Blast Exposures*. The National Academies Press. Washington, DC.
11. DeStefano, J. (2014). *Journey to Normal: Women of War Come Home*. Journey to Normal, Inc., Pittsburgh, PA. Interviews conducted 2011-2013, unreleased and reproduced by permission.
12. DoD-VA Extremity Trauma and Amputation Center of Excellence Registry (EACE-R), excludes finger(s), thumb(s), toe(s), includes partial foot and hand amputations, as of August 1, 2014
13. Meulenbelt, H., Geertzen, J., Jonkman, M., Dijkstra, P. (2009). Determinants of Skin Problems of the Stump in Lower Limb Amputees. *Arch Phys Med Rehabil* 90:74-81
14. Biddiss, E., Chau, T. (2007). Upper limb prosthetics: critical factors in device abandonment. *Am J Phys Med Rehabil* 86:977-987.
15. Ostlie, K., Lesjo, I., Franklin, R., Garfelt, B., Skjeldal, O., Magnus, P. (2012). Prosthesis rejection in acquired major upper limb amputees: a population based survey. *Disab and Rehab Assis Tech* 7(4):294-303.
16. Smith, E., Comiskey, C., and Carroll, A. (2011). A study of bone mineral density in lower limb amputees and a national prosthetics center. *J Prosthet Orthot* 23(1):14-20.
17. Struyf, P., Van Heugten, C., Hitters, M., Smeets, R. (2009). The prevalence of osteoarthritis of the intact hip and knee among traumatic leg amputees. *Arch Phys Med Rehabil* 90:440-446.
18. Randolph, B.J. (2014). *Personal Communication. August 14, 2014*
19. Defense Veterans Brain Injury Centers, DMSS/TMDA provided by Armed Forces Surveillance Center as of May 7, 2014. Accessed at www.dvbic.dcooe.mil, August 1, 2014.
20. Nillni, Y.I., GradU.S., J.L., Gutner, C.A., Luciano, M.T., Shipherd, J.C., Street, A.E. (2014). *Deployment Stressors and Physical Health Among OEF/OIF Veterans: The Role of PTSD*. *Health Psychol*. 2014 Jul 14 [Epub ahead of print].
21. Seal, K.H., Metzler, K.S., Gima, D., et al. (2009). Trends and risk factors for mental health diagnoses among Iraq and Afghanistan veterans Using Department of Veterans Affairs health care, 2002-2008. *American Journal of Public Health* 99(9):714-720.
22. Andersen, J.M., Wade, K., Possemato, K., and Ouimette, P. (2010). Association between post-traumatic stress disorder and primary care provider-diagnosed disease among Iraq and Afghanistan veterans. *Psychosomatic Medicine* 72(5):498-504.
23. Maguen, S., Cohen, B., Ren, L., et al. (2012). Gender differences in military sexual trauma and mental health diagnoses among Iraq and Afghanistan Veterans with post-traumatic stress disorder. *Womens Health Issues* 22(1):e61-66.
24. Bean-Mayberry, B., Yano, E.M., Washington, D.L., et al. (2011). Systematic Review of Women Veterans' Health: Update on Successes and Gaps. *Women's Health Issues* 21(4): S84-91.
25. Institute of Medicine (2014). *Preventing Psychological Disorders in Service Members and Their Families: An Assessment of Programs*. The National Academies Press., Washington, DC.
26. Kuehn, B.M. (2009). Soldier suicide rates continue to rise: military scientist work to stem the tide. *JAMA*. 301(11):1111-1113
27. Trofimovich, L., Skopp, N.A., Luxton, D., Reger, M.A. Health care experiences prior to suicide and self-inflicted injury, active component, U.S. Armed Forces, 2001-2010. *MSMR* 19(2):2-6.
28. Kang, H.K., & Bullman, T.A. (2008). Risk of suicide among U.S. veterans after returning from the Iraq or Afghanistan war zones. *Journal of the American Medical Association* 300, 652-653.
29. *Veterans Health Care Overview 2014 PowerPoint (personal communication)*
30. U.S. Department of Veterans Affairs Veterans Health Administration (2008). *VHA Handbook* 1160.01
31. Institute of Medicine (2014). *Treatment of Post-traumatic Stress disorder in Military and Veterans Populations: Final Assessment*. The National Academies Press Washington, DC.
32. U.S. Department of Veterans Affairs, *More than 800 Veterans Hired as Mental Health Peer Specialists and Peer Apprentices*, Press Release, November 5, 2013, accessed at <http://www.va.gov/opa/pressrel/pressrelease.cfm?id=2487>, August 14, 2014.
33. *The President's New Freedom Commission on Mental Health (2003). Achieving the Promise: Transforming Mental Health Care in America*, Washington DC.
34. Barber, J.A., Rosenheck, R.A., Armstrong, M., Resnick, S.G. (2008). Monitoring the Dissemination of Peer Support in the VA Healthcare System. *Community Mental Health J* 44:433-441.

35. U.S. Government Accountability Office (2013). *TRICARE Multiyear Surveys Indicate Problems with Access to Care for Nonenrolled Beneficiaries*. Washington, DC. GAO-13-364
36. Bush, G. W. (2004). *Executive Order: Incentives for the Use of health information technology and establishing the position of the national health information technology coordinator*. White House. Washington, DC. Executive Order 13335.
37. *Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009*. (PL 110-185 122 Stat 619) 42 U.S.C. §300jj et seq.; §17901 et seq.
38. U.S. Department of Veterans Affairs Veterans Benefits Administration (2014). *Annual Benefits Report FY2013*. Washington DC. July 17, 2014
39. U.S. Department of Veterans Affairs Office of Inspector General (2010). *Review of Combat Stress in women Veterans Receiving VA Health Care and Disability Benefits*, Washington, DC. Report 10-01640-45
40. Highfill-McRoy, R., Larson, G.E., Booth-Kewley, S., Garla, C.F. (2010). *Psychiatric diagnoses and punishment for misconduct: the effects of PTSD in combat-deployed Marines*. *BMC Psychiatry* 10:88-93.
41. Kulka, R. A. (1990). *Trauma and the Vietnam War generation: Report of findings from the National Vietnam Veterans Readjustment Study*. New York: Brunner/Mazel
42. *Veterans Justice Outreach*. www.va.gov/vjo.asp, accessed August 14, 2014
43. U.S. Department of Defense (2013). *2012 Workplace and Gender Relations Survey of Active Duty Members*.
44. U.S. Department of Defense (2014). *Annual Report on Sexual Assault in the Military Fiscal Year 2013*. Washington, DC. May 1, 2014.
45. U.S. Department of Defense Sexual Assault Prevention and Response Office (2014). *2014-2016 Sexual Assault Prevention Strategy*. Washington, DC.
46. *Veterans Health Care Amendment of 1979*. (P.L. 96-22) Title 38 United States Code 17 S 103(a)(1)11612a.
47. U.S. Department of Veterans Affairs Office of the Inspector General (2011). *Post-Traumatic Stress Disorder Counseling Services at Vet Centers*. Washington, DC. VAOIG-10-00628-17
48. *AMVETS, Disabled American Veterans, Paralyzed Veterans of America, Veterans of Foreign Wars of the United States* (2014). *The Independent Budget: For the Department of Veterans Affairs: A Comprehensive Budget & Policy Document Created by Veterans for Veterans FY2015*. Washington, DC.
49. MacDermid-Wadsworth, S. (2014). *Women in Combat*. Presented at *Psychological & Social Aspects of Health & Wellbeing*. (personal communication)
50. Lange, G. (2008). *Pilot Study of Reintegration and Service Needs for Women Veteran Mothers*. U.S. Department of Veterans Affairs Health Services Research and Development. Washington, DC. SHP 08-186.
51. Owens, G.P., Herrera, C.J., Whitesell, A.A. (2009) *A preliminary investigation of mental health needs and barriers to mental health care for female veterans to Iraq and Afghanistan*. *Traumatology* 15(2): 31-37
52. *Eligibility for Readjustment Counseling and Related Mental Health Services*. Title 38 United States Code Section 1712A.
53. U.S. Department of Veterans Affairs Center for Women Veterans Advisory Committee on Women Veterans (2012). *Advisory Committee on Women Veterans Meeting Minutes*. Accessed 14-08-22. <http://www.va.gov/WOM-ENVET/ACWVreports.asp>
54. U.S. Department of Veterans Affairs Veterans Health Administration *Readjustment Counseling Service* (2014). *Report to the Committee on Veterans Affairs U.S. senate and House of representatives on the pilot program to provide reintegration and readjustment counseling services through a group retreat setting*. Washington, DC.
55. *Partnership for Public Service Samuel J. Heyman Service to America Medals*. (2011) 2011 Career Achievement Medal Recipient: Alfonso Batres. Accessed 14-08-22. http://servicetoamericamedals.org/SAM/recipients/profiles/cam11_batres.shtml.
56. California Research Bureau (2012). *California's Women Veterans: Responses to the 2011 Survey*. Sacramento, CA.
57. U.S. Department of Defense (2011). *Military Deployment Guide: Preparing You and Your Family for the Road Ahead*
58. U.S. Department of Defense. Accessed 14-08-22. <http://www.militaryonesource.mil/>
59. U.S. Department of Defense United States Air Force Space Command. *Commander's Reintegration Toolkit*.
60. U.S. Department of Defense Naval Health Research Center. San Diego, CA. Accessed 14-08-22. <http://www.med.navy.mil/sites/nmcscd/nccosc/postdeploymentUserGuide/navy.ht>
61. Yano, E. M., Hayes, P., Wright, S., Schnurr, P.P., Lipson, L., Bean-Mayberry, B., Washington, D.L. (2010). *Integration of women veterans into VA quality improvement research efforts: what researchers need to know*. *J Gen Intern Med* 25 Suppl 1: 56-61.
62. Street A.E., Vogt, D., Dutra, L. (2009). *A new generation of women veterans: Stressors faced by women deployed to Iraq and Afghanistan*. *Clinical Psychology Review* 29: 685-694. Blank
63. Seal KH. *Testimony before the House Veterans Affairs Committee. Hearing on "Mental Health: Bridging the Gap Between Care and Compensation for Veterans"*; 6/14/2011.
64. Iverson, K.M., Hendricks, A.M., Kimerling, R., Kregel, M., Meterko, M., Stolzmann, K.L., Baker, E., Pogoda, T.K., Vasterling, J. J., Lew, H.L. (2011). *Psychiatric diagnosis and neurobehavioral symptom severity among OEF/OIF VA patients with deployment-related Traumatic Brain Injury: A gender comparison*. *Women's Health Issues* 21(4, Supplement): S210-S217.
65. Maguen, S., Luxton, D.D., Skopp, N.A., Madden, E. (2012). *Gender differences in traumatic experiences and mental health in active duty soldiers redeployed from Iraq and Afghanistan*. *J Psychiatr Res*, 46(3): 311-6 .
66. Morin, R. (2011). *The difficult transition from military to civilian life*, Pew Research Center, The Pew Charitable Trusts.
67. Demers, A. (2011). *When veterans return: The role of community in reintegration*. *Journal of Loss and Trauma* 16(2): 160-179
68. Boscarino, J. A. (1995). *Post-traumatic stress and associated disorders among Vietnam veterans: The significance of combat exposure and social support*. *Journal of Traumatic Stress* 8(2): 317-336.
69. Pietrzak, R. H., Johnson, D.C., Goldstein, M.B., Malley, J.C., Rivers, A.J., Morgan, C.A., Southwick, S.M. (2010). *Psychosocial buffers of traumatic stress, depressive symptoms, and psychosocial difficulties in veterans of Operations Enduring Freedom and Iraqi Freedom: The role of resilience, unit support, and post-deployment social support*. *Journal of Affective Disorders* 120(1-3): 188-192.
70. Vogt, D., Vaughn, R., Glickman, M.E., Schultz, M., Drainoni, M., Elwy, R., Eisen, S. (2011). *Gender differences in combat-related stressors and their association with post-deployment mental health in a nationally representative sample of U.S. OEF/OIF veterans*. *Journal of Abnormal Psychology* 120: 797-806.
71. U.S. Department of Veterans Affairs National Center for Veterans Analysis and Statistics (2013). *Women Veteran Profile*. Washington, DC.
72. Negrusa, S., et al. (2014). *Gone to war: have deployments increased divorces?* *Journal of Population Economics* 27(2): 473-496.
73. Naclerio, A., et al. (2011). *The Concerns of women currently serving in the Afghanistan theater of operations*, White Paper. Washington, DC. Health Service Support Assessment Team, ISAF Joint Command. Retrieved from <http://dacowits.defense.gov/Reports/2012/Documents>

74. National Science Foundation (2014). *Low Participation Fields for Women: Computer Science and Engineering, 1991-2010*. Washington, DC.
75. National Girls Collaborative Project (2013). *The State of Girls and Women in STEM*. http://www.ngcproject.org/sites/default/files/documents/ngcpstemstats_web.pdf
76. Marder, J. (2012). *Why engineering, science gender gap persists*. PBS Newshour. Accessed: 14-08-22. <http://www.pbs.org/newshour/rundown/science-engineering-and-the-gender-gap>
77. Association for Women in Science. *Mentoring*. Accessed 14-08-22. <http://www.awis.org/?Mentoring>
78. Jencks, F., Zacharias, M. (2014). *Mentoring tomorrow's STEM innovators*. White House ONLINE, accessed 2014-07-09: <http://www.whitehouse.gov/blog/2014/02/06/mentoring-tomorrow-s-stem-innovators>
79. U.S. Department of Defense U.S. Army Medical Department. *Eight-week women soldier's support group begins Feb. 8 at behavioral health. Fort Drum, NY*. Accessed 14-08-22. http://www.drum.amedd.army.mil/news/2011/0211/020711_04.htm.
80. Haydock MD. "The GI Bill," *American History Magazine*, Sept/Oct 1999, Web Published on "The History Net," <http://www.historynet.com/the-gi-bill-cover-page-october-99-american-history-feature>, viewed August 6, 2014.
81. Mettler S. *Bringing the State Back in Civic Engagement: Policy Feedback Effects of the G.I. Bill for World War II Veterans*. *American Political Science Review*. 96(2)/June 2002. 351-365
82. Shinseki E. Department of Veterans Affairs, "Business Steps Up: Hiring our Heroes", Remarks at U.S. Chamber of Commerce U.S. Chamber of Commerce, Washington, DC, November 12, 2009
83. Holder, K.A. (2007). *The Educational Attainment of Veterans*. Housing and Household Economic Statistics Division, Industry and Occupation Branch, U.S. Census Bureau.
84. Gibson S. Department of Veterans Affairs. Remarks at Joining Forces Pledge Launch, Washington, DC, April 30, 2014.
85. Horton, J. L., Jacobson, I.G., Wong, C.A., Wells, T.S., Boyko, E.K., Smith, B., Smith, T.C. (2013). *The impact of prior deployment experience on civilian employment after military service*. *Occupational and Environmental Medicine* 70(6): 408-417.
86. U.S. Government Accountability Office (2014). *VA Education Benefits: VA Should Strengthen Its Efforts to Help Veterans Make Informed Choices*. Washington, DC. GAO 14-324
87. American Council on Education (2012). *From Soldier to Student II: Assessing Campus Programs for Veterans and Service Members* <http://www.acenet.edu>
88. Diramio DiRamio, D., Ackerman, R., and Mitchell, R. (2008). *From Combat to Campus: Voices of Student-Veterans*. *NASPA Journal* 45(1), 73-102.
89. Madaus From the Editor. *Special JPED Issue Journal of Post Secondary Education and Disability* 22(1);2009
90. Shackelford, AL. *Documenting the Needs of Student Veterans with Disabilities: Intersection Roadblocks, Solutions and Legal Realities*.
91. Burnett, S. (2009) *Collaboration for Military Transition Students from Combat to College: It Takes a community*. *Journal of Postsecondary Education and Disability* 22(1):10-17.
92. Grossman Special JPED Issue *Journal of Post Secondary Education and Disability JPED Forward* 22(1);2009.
93. Cate, C.A. (2014). *Million Records Project: Research from Student Veterans of America*. Student Veterans of America, Washington, DC.
94. Vacchi, D.T. (2012). *Considering Student Veterans on the Twenty-First-Century College Campus*. *About Campus* 17(2): 18.
95. U.S. Government Accountability Office (2014). *Transitioning Veterans: Improved Oversight Needed to Enhance Implementation of Transition Assistance Program*. Washington, DC. GAO-14-144
96. U.S. Department of Labor Bureau of Labor Statistics (2013). *Unemployment among veterans of the U.S. Armed Forces declines in 2012*. TED: The Editors Desk. Washington, DC. Accessed 14-08-22 www.bls.gov/opub/ted/2013/ted_20130322.htm
97. U.S. Department of Labor Bureau of Labor Statistics (2014). *Economic News Release: April 04, 2014, p. o. s. Employment Status of the Civilian Population 18 years and over by veterans status, sex, not seasonally adjusted*. Washington, DC.
98. U.S. Department of Labor Bureau of Labor Statistics (2014). *Labor force statistics from the current population survey*. Washington, DC. Accessed 14-08-22 http://data.bls.gov/pdq/SurveyOutputServlet?request_action=wh&graph_name=LN_cpsbref3
99. U.S. Department of Labor Bureau of Labor Statistics (2013). *Employment Situation of Veterans 2012*. Washington, DC.
100. Hartmann, H., Hayes, J. (2011). *Women and men living on the edge: Economic insecurity after the great recession*. Institute for Women's Policy Research. Washington, DC. C386
101. U.S. Department of Labor Bureau of Labor Statistics (2014). *Employment Characteristics of Families 2013*. Washington, DC.
102. U.S. Congress, Joint Economic Committee Chairman's Staff. (2011). *Broken Promises: The need to improve economic security for veterans*. Washington, DC
103. U.S. Congress, Joint Economic Committee Democratic Staff. (2013). *Building job opportunities for returning veterans*.
104. U.S. Department of Labor Bureau of Labor Statistics (2014). *Employment Characteristics of Families Summary*. Economic News Release, Washington, DC. Accessed 14-08-22. <http://www.bls.gov/news.release/famee.nr0.htm>
105. Cooney, R.T., Segal, M.W., Segal, D.R., Falk, W.W. (2003). *Racial differences in the impact of military service on the socioeconomic status of women veterans*. *Armed Forces & Society* 30(1): 53-85.
106. U.S. Department of Veterans Affairs Task Force on Women Veterans (2012). *Strategies for Serving Our Women Veterans*. Washington DC.
107. U.S. Department of Labor Women's Bureau (2011). *Trauma-Informed Care for women veterans experiencing homelessness: a Guide for Service Providers*. Washington, DC.
108. DiJulio, B., Deane, C., Firth, J., Craighill, P., Clement, S., Brodie, M. (2014) *After the Wars: Survey of Iraq & Afghanistan active duty soldiers and veterans*. Kaiser Family Foundation. Personal communications DiJulio, B.
109. Ostovary, F. D., J (2011). *Challenges and opportunities of Operation Enduring Freedom/Operation Iraqi Freedom veterans with disabilities transitioning into learning and workplace environments*. *New directions for Adult and Continuing Education* 132: 63-73.
110. Humensky, J. L., Jordon, N., Stroupe, K.T., Hynes, D.M. (2013). *Employment status of veterans receiving substance abuse treatment from the U.S. Department of Veterans Affairs*. *Psychiatric Services* 64(2): 177-180.
111. U.S. Government Accountability Office. (2014). *VA Vocational Rehabilitation and Employment*. GAO. Washington, DC.
112. Kleykamp, M. (2013). *Unemployment, earnings, and enrollment among post 9/11 veterans*. *Social Science Research* 42: 836-851.
113. U.S. Department of Defense, Defense Business Board (2013). *Employing our Veterans Part II: Service Member Transition*. Washington, DC.
114. Business and Professional Womens Foundation.(2007). *Women Veterans in Transition*. Washington, DC.
115. Thom, K. B., E (2011). *Chicagoland female veterans; a qualitative study of attachment to the labor force*. American Institute for Research National Center on Family Homelessness.
116. Transition Assistance Program 1991 (P. L. 101-510) S 502 (a)(1)
117. Vow to Hire Heroes Act of 2011 (VOW) (P.L. 112-56 Title II 125 S 711, 712.

118. Careeronestop: Pathways to success. Accessed 14-08-22. <http://www.careeronestop.org/>
119. U.S. Department of Defense. Hero2Hired. Accessed 14-08-22. <https://h2h.jobs/>
120. U.S. Department of Labor Veterans Employment & Training Service. Women Veterans. Accessed 14-08-22. <http://www.dol.gov/vets/women/veterans/>
121. Boraas, S., Roemer, G., Bodenlos, K. (2013). Assessment of the work-force system's implementation of the veterans' priority of service provision of the Jobs for Veterans Act of 2002. *Mathematica*. Washington, DC
122. White House. *Joining Forces*. Washington, DC. Accessed 14-08-22. <http://www.whitehouse.gov/joiningforces>
123. Executive Office of the President (2013). *The fast track to civilian employment: Streamlining credentialing and licensing for service members, veterans and their spouses*. White House. Washington, DC.
124. Abt Associates Inc (2008). *2007 Veterans Employability Research Survey*. U.S. Department of Veterans Affairs. Washington
125. U.S. Department of Veterans Affairs, Veterans Benefits Administration, Veterans Retraining Assistance Program. Washington, DC. Accessed 14-08-22: benefits.va.gov/vow/education.asp
126. Hamilton, A.B., Poza, I., Washington, D.L. (2011). Homelessness and trauma go hand-in-hand: Pathways to homelessness among women veterans. *PowerPlay: A Journal of Educational Justice* 3(2): 66-94.
127. Mettraux, S. (2013). Homelessness and risk factors for homelessness among veterans from the era of the Afghanistan (OEF) and Iraq (OIF/OND) conflicts. U.S. Department of Veterans Affairs, Washington, DC.
128. U.S. Interagency Council on Homelessness (2013). *Opening Doors: Federal Strategic Plan to Prevent and End Homelessness Update 2013*. Washington, DC.
129. Gamache, G., Rosenheck, R., Tessler, R. (2003). Over representation of women veterans among homeless women. *American Journal of Public Health* 93(7): 1132-1136.
130. Syracuse University Institute for Veterans and Military Families. (2013). *A National Summit on Women Veteran Homelessness: A Leadership Dialogue*. Syracuse, NY.
131. U.S. Department of Housing and Urban Development Office of Community Planning and Development (2013). *The 2013 Annual Homeless Assessment Report (AHAR) to Congress: Point-in-time estimates of homelessness*. Washington, DC.
132. Fargo, J. M., Mettraux, S., Byrn, T., Munley, E., Montgomery, A.E., Jones, H., Culhane, D. (2012). Prevalence and risk of homelessness among U.S. veterans. *Preventing Chronic Disease* 9: 110-112.
133. Syracuse University Institute for Veterans and Military Families National Veterans Technical Assistance Center (2013). *Lessons learned from the U.S. Department of Labor grantees: Homeless female veterans and homeless veterans with families*. Syracuse, NY.
134. U.S. Department of Veterans Affairs Office of the Inspector General (2012). *Veterans Health Administration: Audit of the Homeless Providers Grant and Per Diem Program*. Washington, DC. 11-00334-115
135. U.S. Government Accountability Office. (2012). *Homeless Women Veterans: Actions Needed to Ensure Safe and Appropriate Housing*. Washington, DC.
136. U.S. Interagency Council on Homelessness (2013). *Ending homelessness among veterans*. Washington, DC.
137. U.S. Department of Veterans Affairs (2012). *Effectiveness of Permanent Housing Program FY2012 Report*. Washington, DC.
138. U.S. Department of Veterans Affairs National Center on Homelessness Among Veterans (2014). *Impact and Performance of the Supportive Services for Veteran Families (SSVF) Program: Results from the FY2013 Program Year*. Washington, DC.
139. Economic Systems, Inc, ORC Macro, The Hay Group (2004). *Evaluation of VA's Home Loan Guaranty Program*. United States Department of Veterans Affairs Veterans Benefits Administration. Washington, DC.
140. Perl, L. (2012). *VA Housing: Guaranteed Loans, Direct Loans, and Specially Adapted Housing Grants*. Congressional Research Service. Washington, DC.
141. U.S. Department of Veterans Affairs Veterans Benefits Administration. *Home Loans*. Washington, DC. Accessed 14-08-22. <http://www.benefits.va.gov/homeloans/>
142. U.S. Department of Veterans Affairs National Center for Veterans Analysis and Statistics (2013). *Profile of Veterans: 2011*. Washington, DC.
143. U.S. Department of Veterans Affairs Advisory Committee on Women Veterans (2013). *VA Advisory Committee on Women Veterans Meeting Minutes April 9-11*. Washington, DC.
144. U.S. Department of Veterans Affairs National Center for Veterans Analysis and Statistics (2011). *2010 National Survey of Veterans: Understanding and Knowledge of VA Benefits and Services*. Washington, DC.
145. New York Veterans History Project (2013). *NY Veterans History Series: Women Warriors, Dec 7, 2013*. New York Public Library, New York, NY. <http://www.nypl.org/events/programs/2013/12/07/new-york-veteran-history-series-women-warriors>

Appendices

The following tables provide additional information about Post-9/11 women veterans.

DISTRIBUTION OF SEPARATED PERSONNEL IDENTIFIED ON THE DOD ROSTER ¹ OF OPERATION ENDURING FREEDOM (OEF), OPERATION IRAQI FREEDOM (OIF), AND OPERATION NEW DAWN (OND) ² PARTICIPANTS, BY COMPONENT TYPE			
Service Component Type	Active Duty	Reserve/Guard	Total ^{3,4}
Total OEF/OIF/OND Veterans	1,061,063	730,357	1,791,420
Men	936,561	643,773	1,580,334
Women	124,112	86,563	210,675
Unknown	390	21	411

¹ Based on DMDC deployment rosters received through April 9, 2014. Roster only includes separated OEF/OIF/OND Veterans with out-of-theater dates through February 2014.

² Effective September 1, 2010, the name of Operation Iraqi Freedom was changed to Operation New Dawn (Secretary of Defense memorandum, February 17, 2010). Because this is a cumulative report, Veterans who have served in any or all of these conflicts are included in the frequencies presented.

³ Beginning with the 3rd Qtr FY 2009 report, Veterans who received health care but subsequently died in-theater have been included in the quarterly analysis.

⁴ The number of individuals who died in-theater through 2nd Qtr FY 2014 is 5,851.

DEMOGRAPHIC AND MILITARY CHARACTERISTICS OF SEPARATED FEMALE AND MALE VETERANS WHO SERVED IN OEF/OIF/OND ^{1, 2, 3}				
Characteristics	WOMEN (n=210,675)		MEN (n=1,580,745) ^a	
	Number	Percent	Number	Percent
RACE/ETHNICITY				
White	104,081	49.4	987,875	62.5
Black	45,055	21.4	177,129	11.2
Hispanic	22,376	10.6	150,834	9.5
Others	16,827	8.0	97,473	6.2
Unknown	22,336	10.6	167,434	10.6
BIRTH YEAR COHORT^b				
1990 or Later	6,952	3.3	51,305	3.2
1980 – 1989	109,274	51.9	765,048	48.4
1970 – 1979	55,366	26.3	390,434	24.7
1960 – 1969	30,250	14.4	287,383	18.2
1950 – 1959	8,196	3.9	74,119	4.7
1926 – 1949	613	0.3	11,714	0.7
Unknown	24	0.0	742	0.0
BRANCH				
Air Force	49,640	23.6	257,765	16.3
Army	111,276	52.8	831,710	52.6
Coast Guard	318	0.2	3,680	0.2
Marine	8,649	4.1	231,493	14.6
Navy	40,792	19.4	256,097	16.2
UNIT TYPE				
Active Duty	124,112	58.9	936,951	59.3
Reserve/Guard	86,563	41.1	643,794	40.7
RANK				
Enlisted	184,281	87.5	1,410,354	89.2
Officer	26,394	12.5	170,391	10.8

¹ Based on DMDC deployment rosters received through April 9, 2014. Roster only includes separated OEF/OIF/OND Veterans with out-of-theater dates through February 2014.

² Beginning with the 3rd Qtr FY 2009 report, Veterans who received health care but subsequently died in-theater have been included in the quarterly analysis.

³ The number of individuals who died in-theater through 2nd Qtr FY 2014 is 5,851.

^a Includes 411 individuals with unknown sex.

^b In 2nd Qtr FY12, the birth year category "1990 or later" was added, and the earlier 1980 group redefined as ending in 1989. This adjustment was made to better equalize the number of years represented in each range. Birth year ranges were introduced 3rd Qtr FY 2009 in order to account for younger Veterans.

**VA HOSPITALIZATIONS AND OUTPATIENT VISITS² FOR 210,675 FEMALE
AND 1,580,745 MALE OEF/OIF/OND VETERANS IDENTIFIED ON THE COMBINED DoD LIST¹**

Treatment Category		WOMEN (n=210,675)		MEN (n=1,580,745)	
		Number	Percent	Number	Percent
Evaluated by VA during FY 2002-2014	Yes	128,380	60.9	929,380	58.8
	No	82,295	39.1	651,365	41.2
Inpatient stays ^a <i>Hospitalized at least once at a VAMC during FY 2002-2014</i>	Yes	8,882	4.2 ^b	70,607	4.5 ^c
	No	201,793	95.8 ^b	1,510,138	95.5 ^c
Number of times hospitalized at a VAMC <i>during FY 2002-2014</i>	1	6,056	68.2 ^d	46,133	65.3 ^e
	2	1,518	17.1 ^d	12,067	17.1 ^e
	3+	1,308	14.7 ^d	12,407	17.6 ^e
Outpatient visits ^a <i>Seen as an outpatient at VA at least once during FY 2002-2014</i>	Yes	128,372	60.9 ^b	929,289	58.8 ^c
	No	82,303	39.1 ^b	651,456	41.2 ^c
Number of days seen as an outpatient <i>during FY 2002-2014</i>	1	11,704	9.1 ^f	96,719	10.4 ^g
	2-10	41,832	32.6 ^f	351,179	37.8 ^g
	11+	74,836	58.3 ^f	481,391	51.8 ^g

¹ Data presented are from inpatient and outpatient health records. Internal inconsistencies may exist for a small number of individuals who had multiple values for sex on different health care visits.

² Hospitalization and outpatient visits recorded as of March 31, 2014.

^a A total of 8,874 female and 70,516 male Veterans received care as both inpatients and outpatients.

^b Percent based on total number of eligible female Veterans (210,675).

^c Percent based on total number of eligible male Veterans (1,580,745).

**DEMOGRAPHIC AND MILITARY CHARACTERISTICS OF SEPARATED FEMALE AND MALE
OEF/OIF/OND VETERANS UTILIZING VA HEALTH CARE¹**

Characteristics	WOMEN (n=128,380)		MEN (n=929,380)	
	Number	Percent	Number	Percent
RACE/ETHNICITY				
White	59,816	46.6	565,179	60.8
Black	30,564	23.8	111,601	12.0
Hispanic	14,086	11.0	95,799	10.3
Others	8,931	7.0	49,732	5.4
Unknown	14,983	11.7	107,069	11.5
BIRTH YEAR COHORT ^a				
1990 or Later	2,985	2.3	20,574	2.2
1980 – 1989	65,549	51.1	446,650	48.1
1970 – 1979	33,761	26.3	226,811	24.4
1960 – 1969	20,071	15.6	179,061	19.3
1950 – 1959	5,602	4.4	48,708	5.2
1926 – 1949	409	0.3	7,552	0.8
Unknown	*	0.0	24	0.0
BRANCH				
Air Force	24,150	18.8	112,709	12.1
Army	75,811	59.1	548,921	59.9
Coast Guard	125	0.1	1,358	0.1
Marine	5,603	4.4	142,832	15.4
Navy	22,691	17.7	123,560	13.3
UNIT TYPE				
Active Duty	77,657	60.5	556,268	59.9
Reserve/Guard	50,723	39.5	373,112	40.1
RANK				
Enlisted	115,001	89.6	847,927	91.2
Officer	13,379	10.4	81,453	8.8

¹ Hospitalization and outpatient visits recorded as of March 31, 2014.

^a In 2nd Qtr FY12, the birth year category "1990 or later" was added, and the earlier 1980 group redefined as ending in 1989. This adjustment was made to better equalize the number of years represented in each range. Birth year ranges were introduced 3rd Qtr FY 2009 in order to account for younger Veterans.

* To protect the privacy of Veterans, frequencies of fewer than 10 individuals are not reported.

NUMBER OF DIAGNOSES BY BROAD ICD-9-CM CATEGORIES FOR THE 128,380 FEMALE AND 929,380 MALE OEF/OIF/OND VETERANS EVALUATED AT VA HEALTH CARE FACILITIES¹

Diagnosis (ICD-9-CM Categories)	WOMEN (n=128,380)		MEN (n=929,380)	
	Number ^a	Percent	Number ^a	Percent
Infectious and Parasitic Diseases (001-139)	27,592	21.5	151,348	16.3
Malignant Neoplasms (140-209)	2,492	1.9	13,999	1.5
Benign Neoplasms (210-239)	15,726	12.2	69,272	7.5
Diseases of Endocrine/Nutritional/ Metabolic Systems (240-279)	47,138	36.7	336,927	36.3
Diseases of Blood and Blood Forming Organs (280-289)	12,781	10.0	35,891	3.9
Mental Disorders (290-319)	70,312	54.8	523,271	56.3
Diseases of Nervous System/Sense Organs (320-389)	61,640	48.0	453,946	48.8
Diseases of Circulatory System (390-459)	25,219	19.6	221,287	23.8
Disease of Respiratory System (460-519)	46,574	36.3	252,498	27.2
Disease of Digestive System (520-579)	50,668	39.5	341,683	36.8
Disease of the Genitourinary System (580-629)	56,121	43.7	125,016	13.5
Diseases of Skin (680-709)	38,001	29.6	212,068	22.8
Diseases of Musculoskeletal System Connective System (710-739)	76,385	59.5	558,184	60.1
Symptoms, Signs and Ill Defined Conditions (780-799)	76,425	59.5	514,021	55.3
Injury/Poisonings (800-999)	37,577	29.3	293,681	31.6

¹ Hospitalizations and outpatient visits recorded as of March 31, 2014.

^a The total may be higher than the 128,380 female and 929,380 male Veterans because a Veteran can have more than one diagnosis and each is entered separately in this table.

Fulfilling our Promises to the Men and Women who Served.

DAV empowers veterans to lead high-quality lives with respect and dignity. It is dedicated to a single purpose: fulfilling our promises to the men and women who served. DAV does this by ensuring that veterans and their families can access the full range of benefits available to them; assisting them with employment; fighting for the interests of America's injured heroes on Capitol Hill; and educating the public about the great sacrifices and needs of veterans transitioning back to civilian life. DAV, a non-profit organization with 1.2 million members, was founded in 1920 and chartered by the U.S. Congress in 1932.

- Providing free, professional assistance to veterans and their families in obtaining benefits and services earned through military service and provided by the VA and other agencies of government.
- Providing outreach concerning its program services to the American people generally, and to disabled veterans and their families specifically.
- Representing the interests of disabled veterans, their families, their widowed spouses and their survivors before Congress, the White House and the Judicial Branch as well as state and local government.
- Extending DAV's mission of hope into the communities where these veterans and their families live through a network of state-level Departments and local chapters.
- Providing a structure through which disabled veterans can express their compassion for their fellow veterans through a variety of volunteer programs.

If you're a veteran who needs free help, or you'd like to help us keep the promise, visit DAV.org.





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