



Depression and Bipolar
Support Alliance

March 17, 2021

The Honorable Julia Brownley
Chair
Veterans' Affairs Subcommittee on Health
2262 Rayburn House Office Building
Washington, DC 20515

The Honorable Jack Bergman
Ranking Member
Veterans' Affairs Subcommittee on Health
566 Cannon Office Building
Washington, DC 20515

RE: Hearing: Beyond Deborah Sampson: Improving Healthcare for America's Women Veterans
in the 117th Congress

Dear Chair Brownley and Ranking Member Berman,

As the leading peer-directed organization for people living with depression and bipolar disorder, the Depression and Bipolar Support Alliance (DBSA) is proud of our work advocating for quality mental health care for our nation's veterans—especially our women veterans. DBSA lent its expertise to supporting language that resulted in the Veteran Partners' Efforts to Enhance Reintegration Act (Veteran PEER Act), which was enacted as part of the MISSION Act and will help further integrate behavioral health into the primary care setting through the use of veteran peer specialists.

DBSA has created support groups devoted solely to the needs of woman veterans as part of our portfolio of national online support groups. Additionally, over 100 women veterans have completed the DBSA Veteran Peer Specialist course, including 88 who were either working or volunteering as veteran peer apprentices at U.S. Department of Veterans Affairs (VA) behavioral health facilities. It is from this first-hand experience that we respectfully provide our comments to the House Veterans' Affairs Subcommittee on Health as part of your congressional hearing: Improving Health Care for Women Veterans.

According to the Department of Veterans Affairs, there are currently 1.9 million living women veterans, which represents 9.4 percent of the total veteran population. The mental health needs of these women are great.

The journal *Social Psychiatry and Psychiatric Epidemiology* report that 37% of women veterans have ever had an alcohol or drug use disorder. Further 68 percent of women veterans report some childhood adversity, and they have the highest rates of childhood sexual abuse. The paper's author suggested that "one of the implications of this study is the need to assess for

childhood adversity, to help people recognize its relationship with substance use and cope with its health impacts.” The author further went on to state that “when people join the military or when veterans access healthcare at the VA or in the community would be good times to assess and treat childhood adversity, and we’re often missing those opportunities now.”¹

Female veterans with PTSD as a result of military sexual trauma are twice as likely to have suicidal thoughts as those with PTSD from any other cause, according to a 2018 study led by researchers from the VA Eastern Colorado Health Care System. In addition, those who identified military sexual trauma as the source of their PTSD were at least three times as likely to have suicidal thoughts as those who said their PTSD was specifically related to combat or deployment.²

We applaud the VA’s efforts toward mental health programs geared specifically for women. These programs include evaluation and assistance for challenges including depression, mood, and anxiety disorders (including posttraumatic stress disorder); intimate partner and domestic violence; sexual trauma; parenting and anger management; and marital, caregiver, or family-related stress. These programs have met with success. According to a paper published from a 2015 VA survey, half of all women veterans using VA primary care service reported perceived mental health needs. The good news is that 84.3% of these women received care with nearly all of them (90.9%) receiving their care at a VA facility. Yet only about half (48.8%) reported that their mental health care met their needs completely or very well.(Kimerling et al.)³

In a more recent 2018 study, women veterans with multiple positive screenings for mental health conditions were less likely to rate communication with their providers as high, compared with women without mental health conditions. Women with mental health conditions were significantly less likely to have high trust in their providers than women without a mental health condition (Chanfreau-Coffinier et al).⁴ Kimerling et al. did provide a solution, however. The author’s findings stated that gender related experiences were associated with two-fold increased odds of perceived access. Additionally, Chanfreau-Coffinier et al. shared the need to build trust among the women veterans seeking mental health services. The paper went on to state that women who were more engaged with their health care rated their mental health care as higher quality than those who were younger, nonwhite, Hispanic, and without a usual source of primary care, according to another 2015 paper. The more-engaged group was also more likely to receive care in accordance with their preferences with respect to the availability of female providers, women-only treatment settings, and women-only treatment groups.⁴

Given these findings, DBSA respectfully recommends increased employment of women veteran peer specialists at the primary VA medical facilities in addition to those who are already employed at the VA behavioral health facilities. Peer support services are a proven protocol of care. Those receiving peer support services are better engaged with their mental health and are at less risk for hospitalization for a mental health issue.⁵

We applaud the VA's stated objective to help women veterans who are interested in education and training, employment assistance, and vocational rehabilitation. Providing funding to women veterans to enroll in approved Veteran Peer Specialist training courses not only enables increased access to peer support services at VA facilities, it also provides a career path for women veterans.

Respectfully,



Michael Pollock
Chief Executive Officer

¹Evans EA, Upchurch DM, Simpson T, Hamilton AB, Hoggatt KJ. Differences by Veteran/civilian status and gender in associations between childhood adversity and alcohol and drug use disorders. *Soc Psychiatry Psychiatr Epidemiol.* 2018 Apr;53(4):421-435. doi: 10.1007/s00127-017-1463-0. Epub 2017 Nov 29. PubMed PMID: 29188311

²Blais RK, Monteith LL. Suicide Ideation in Female Survivors of Military Sexual Trauma: The Trauma Source Matters. *Suicide Life Threat Behav.* 2019 Jun;49(3):643-652. doi: 10.1111/sltb.12464. Epub 2018 Apr 20. PMID: 29676496.

³Kimerling R, Pavao J, Greene L, Karpenko J, Rodriguez A, Saweikis M, Washington DL. Access to mental health care among women Veterans: is VA meeting women's needs? *Med Care.* 2015 Apr;53(4 Suppl 1):S97-S104. doi: 10.1097/MLR.0000000000000272. PMID: 25767985; PMCID: PMC7529478.

⁴Chanfreau-Coffinier C, Gordon HS, Schweizer CA, Bean-Mayberry BA, Darling JE, Canelo I, Yano EM. Mental Health Screening Results Associated with Women Veterans' Ratings of Provider Communication, Trust, and Care Quality. *Womens Health Issues.* 2018 Sep-Oct;28(5):430-438. doi: 10.1016/j.whi.2018.05.004. Epub 2018 Jul 14. PMID: 30017475.

⁵Solomon P, Draine J, Delaney M. The working alliance and consumer case management. *J Ment Health Admin.* 1995;22:126-134.

Wexler B, Davidson L, Styron T. Severe and persistent mental illness. In: Jacobs S, Griffith EEH, editors. 40 years of academic public psychiatry. London: Wiley; 2008. pp. 1-20.

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