Mental Health Service Preferences and Utilization Among Women Veterans in Crisis: Perspectives of Veterans Crisis Line Responders

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Abstract

Women military veterans are at increased risk of suicide compared to non-veterans, but little is known about the mental health service preferences and needs of women veterans in crisis. This study used qualitative, secondary source key informant interviews to ascertain the experiences of women veterans in crisis from 54 responders working at the Veterans Crisis Line. Responders indicated that women veterans reported different experiences with Veterans Administration (VA) and non-VA care, though drivers of satisfaction or dissatisfaction were similar. Availability of specialty care, sensitivity to veterans' issues or Military Sexual Trauma, strong provider

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relationships, and continuity of care contributed to satisfaction; lengthy appointment wait times, limited service options, and insensitivity to veterans' issues contributed to dissatisfaction. Responders suggested that barriers limiting VA access for women veterans are perceived as similar to non-VA care. Findings suggest that caller experiences with providers drive satisfaction with VA and non-VA mental health services.

Background

The rate of suicide among women veterans of military service is significantly higher than among non-veteran women, a magnitude of difference far surpassing that between male veterans versus non-veterans.[1–3] Partially in response to these alarming trends, recent policy proposals, and the Department of Veterans Affairs (VAs) strategic plans indicate an increased interest in learning more about women veterans, factors that influence their access to care, and best practices for effective health interventions.[2, 4, 5] Research on women veterans, who represent a growing share of all veterans but who currently account for less than 10% of veterans nationwide, is thus needed. Women veterans in crisis or at risk of suicide are an even smaller subset of all women veterans, and the small numbers make research focused on this group inherently challenging and requires creative research approaches.[2]

Specific mental health treatments have been proven to reduce suicide risk among persons at risk.[6–9] Thus, identifying at-risk women veterans and facilitating their access to mental health care is a promising suicide prevention strategy.[10, 11] For those eligible to receive care within the VA, such care may be effective at reducing suicide risk: between 2001 and 2014, the VA reported that "the rate of suicide among female veterans who use VA services increased 4.6 percent while the rate of suicide increased 98 percent among female veterans who do not use VA services."[2, 12] Additionally, many studies indicate that the quality of VA mental health care compares favorably to private sector care.[13–15]

Unfortunately, women veterans may not always reap the benefits of VA care. A recent review looking specifically at mental health care for women veterans found that access may be limited due to economic (e.g., cost), geographic (e.g., transportation to distant providers), organizational (e.g., clinical hours), and patient-related (e.g., poor health status) barriers to care.[16] Of note, a national survey of women veterans found that women who experienced Military Sexual Trauma (MST) and perceived a lack of gender-sensitive care were more likely to forgo or delay necessary services.[17] As a result of these challenges, women veterans who use the VA tend to report lower access to care, satisfaction with services, and treatment compliance than their male counterparts.[16, 18–25]

A critical research question is therefore to determine the extent to which these challenges and experiences affect mental healthcare service preferences and utilization among women veterans and their willingness to engage in services, especially when in crisis. Call responders at the Veterans Crisis Line (VCL) speak to women veterans who are suicidal or otherwise in crisis. These responders are, therefore, uniquely positioned to provide information that can help identify women veterans' mental health treatment needs and preferences.

Operating 24 hours a day and 365 days a year, the VCL is a VA call center located in upstate New York that provides support to veterans, as well as veterans' friends, caregivers, and families. All VCL call responders are VA employees with prior experience in mental health, social services, or operating call lines; all receive training prior to serving the VCL call lines or text message center and are instructed to respond to caller concerns and facilitate their access to VA or other appropriate care. To the extent possible, responders provide callers with one or more referrals to a list of pre-approved resources; similarly, all contacts to the VCL conclude with a referral to the local VA Suicide Prevention Coordinator (SPC), who is trained to reach out to veterans in crisis and help direct them into local services and supports. The goal of these efforts is to provide a

continuous chain of support to veterans in crisis and to help to address their concerns through the utilization of appropriate programs and services. In this qualitative study, the study team leveraged the expertise and experience of VCL call responders to gain insights into existing strengths of the VCL-facilitated pathways to crisis-related services and to inform efforts to better meet the needs of women veterans at risk of suicide.

Methods

Study aim

Research exploring the causes of suicide is beset with challenges due to the nature of the condition: individuals who have completed a suicide cannot be interviewed. In its place, studies use either proxy data sources (e.g., psychological autopsies) or proxy outcomes (e.g., interviews with individuals who have survived a suicide attempt or who have had thoughts of suicide). Though all methods entail inherent biases, they can both independently and collectively provide insight into pathways to suicide and elucidate potential avenues for prevention.[26] The aim of this study was to interview proxy informants (i.e., VCL responders) to identify the barriers and facilitators to mental health service utilization described by women veterans at risk of suicide and explore pathways for improving access and use of these services.

Recruitment and sample description

In the summer of 2015, over 300 call responders worked at the VCL, with approximately 100 responders assigned to each of the day, evening, and night shifts. All call responders working at the VCL during the study fieldwork period were invited via email to participate in interviews, and a web-based scheduling system was created to facilitate anonymous sign-ups when study staff was on site. A total of 54 VCL responders participated in the study: 13 from the night shift (11:30 P.M. to 8:00 A.M.), 23 from the day shift (7 A.M. to 4:00 P.M.), and 18 from the evening shift (3:30 P.M. to 12:00 A.M.). Forty-three of the responders (80%) were women, and 12 of the responders were veterans (22%). Forty-eight interviewees (89%) had worked at the VCL for at least 1 year, and 43 (80%) had been with the VCL for three or more years. Credentials as a mental health counselor or medical professional are not necessary to qualify for employment with the VCL, though 18 (33%) of the respondents included in this study reported prior experience on a suicide or crisis line, in the social work field, or in mental health services.

Interview procedures

In May and June of 2015, the RAND interview team conducted in-person, one-on-one semi-structured interviews with 54 VCL responders in a secure room located at the VCL facilities. After obtaining written informed consent, each one-hour interview was audio recorded. Only one responder did not consent to audio recording; for this interview, the interviewer transcribed the interview in real time. All procedures were approved by RAND's Institutional Review Board.

To understand why women veterans engage in mental health services, the study team asked responders about three distinct women caller populations: those receiving VA mental health services, those receiving non-VA mental health services, and those who are not engaged in care. The study team also asked responders about the challenges they faced when providing a referral, what callers who were in care said they liked or disliked about the care they received, and the reasons why some callers reported that they were not engaged in care. Responders were asked to consider all female veteran calls they had received during their tenure and to differentiate responses

by age, season (e.g., more or fewer calls during spring or winter), or other call variables as appropriate.

Data preparation

All audio-recorded interviews were transcribed verbatim with the exception of personal identifiers. The transcripts were then uploaded to a qualitative analysis software program (Dedoose™) where a two-stage coding process was undertaken. The first stage was theory-driven coding: the team developed a preliminary codebook of 18 parent codes that corresponded to specific questions and themes in the interview guide; these codes were applied to blocks of text by a preliminary coder and reviewed by a second coder to resolve unclear applications and discrepancies via discussion (see Table 1 for a description of parent codes). The second stage was a data-driven approach in which the team developed sub-codes for each parent code after a review of

Table 1
Parent codes (and associated definitions) assigned to transcript text

Parent code	Definition
1. Era differences	Differences between Veterans of different war eras
2. Call differences	Differences between Veterans who contact VCL via phone, chat, text
3. Category codes	Frequency of several call characteristics or concerns
4. Concerns	Concerns expressed by any caller; male, female, third-party caller
5. Caller presentation/ characteristics	Characteristics or presentation of caller
6. Narrative	Narrative/story associated with a call
7. Methods/means	Perceptions associated with caller risk of suicide, methods and means of suicide, etc.
8. Protective factors	Reasons that the person has not followed through on suicide
9. Feelings/reasons for suicide	Reasons the person is considering suicide
10. Mental health at VHA	Experiences in the Veteran's Health Administration (VHA)
11. Mental health outside of VHA	General experiences with mental health services outside of the VA
12. Mental health-no services	Experiences of women not receiving any MH care
13. Resources offered	Types of resources/referrals offered by the VCL
14. Resources needed	Concerns/needs not addressed by referrals
15. Outcomes/reactions	Caller reactions to referrals
16. Challenges connecting to services	Barriers to connecting callers to services
17. Engagement strategies	Responder strategies used to engage callers in services or in talking about their issues
18. Suggestions	Suggestions to improve services or processes to meet caller needs

a subset of ten transcripts; these sub-codes were then applied to the remaining transcripts by preliminary coder and reviewed by the second coder with discrepancies resolved via discussion.

Analysis

The study team performed three theme-centered analyses to examine patterns or themes emerging from the qualitative data.[27] First, responses to each interview question were reviewed for frequent or dominant themes and topics, responses that were diverse and wide-ranging, and relevant examples or quotations. These analyses resulted in two primary lines of findings relating to suicide risk (parent codes 1–9) and mental health service utilization (parent codes 10–18), which were then developed separately and resulted in separate reports of findings, the latter of which is reflected here.[28] Within each line of findings, the study team reviewed each code again to identify mixed or contradictory viewpoints. Finally, the study team compared the dominant themes and topics to minority, mixed, and contradictory viewpoints to fully elucidate potential relationships between competing responder views.

Results

The results below include themes from VCL responder interviews in three areas: callers' experiences with VA mental health services, callers' experiences with non-VA mental health services, and experiences of those not receiving mental health care. Responses across all areas are summarized in Table 2. Overall, responders reported that between 10 and 25% of callers to the VCL are women veterans; 45 of the 54 responders that were interviewed by the RAND team reported that between half and almost all women callers they spoke with were receiving mental health treatment of some kind, either within the VA or from a private provider.

Women caller experiences with VA mental health services

Forty-two of the 54 call responders reported that between half and almost all women callers receiving mental health services indicated they were receiving treatment at their local VA hospital or campus. In response to the question, "How do callers say they feel about the mental health services they are getting at the VA?" Fifty-seven percent of responders reported that callers seem satisfied with their care and their experiences are much more positive than negative.

VA mental health services: drivers of satisfaction

Three themes emerged reflecting what responders believed generally increased women veterans' satisfaction with VA mental health care. The first was women veterans' level of engagement in care, which respondents attributed to a close relationship with a trusted therapist who could meet the individual needs of the woman in crisis. As explained by one respondent, "With women, it's more about being able to develop a therapeutic relationship with the same person on a consistent basis." Several respondents reported that patient-provider engagement was often related to whether the VA facility nearest to them provides ongoing services for women, especially if offered by women clinicians. Similar impressions were also reported about women-only support groups, with one responder stating that "if the women are in female-specific care, they seem to be more satisfied with the treatment than if it happens to be a mixed-gender group or program."

The second theme was providers' sensitivity to women's experiences as veterans. A common sentiment was that "[civilian providers] can't relate to the veteran aspect" of mental health issues, whereas callers "feel as if [VA doctors] are more attuned to veteran needs" which better enabled providers to address mental health issues stemming from military experiences.

Table 2

Results summary table: drivers of satisfaction with mental health services and barriers to seeking care

	VA mental health services	Non-VA mental health services	Women not receiving care
Proportion of VCL female caller pop	42/54 (78%) VCL responders reported that between half and almost all women receive treatment at VA	12/54 (22%) VCL responders reported that between half and almost all women receive treatment outside of the VA	Responders reported that only a small proportion of women veterans are not receiving services at the time of the call
Experience	31/54 (57%) VCL responders reported that women veterans are satisfied with VA mental health services	37/54 (69%) VCL responders reported that women veterans are satisfied with non-VA mental health services	N/A
Drivers of Satisfaction	• High level of engagement in care, often linked to: o Relationship with trusted clinician o Availability of women clinicians o Women-only services or support groups • Sensitivity to Veteran experience • Integrated, streamlined records and services	• Women-only services or support groups • Relationship with trusted physician • Choice of providers and services • Access to specialists • Access to MST services • Confidentiality	N/A
Barriers to Care	• Structural barriers to care: difficulty obtaining appointments, unwelcoming clerical staff, transportation, limited business hours • Coverage issues o Eligibility concerns o Limited service connection o Unaffordable copays • "Male-oriented" VA culture unreceptive to women veteran needs o Lack of women-specific services or support groups o MST discomfort around male Veterans • Lack of confidentiality	• Not sensitive/understand Veteran issues or military culture • High cost of care	• Structural barriers to care: difficulty obtaining appointments, unwelcoming clerical staff, transportation, limited business hours • Poor prior experience with VA care, as personally experienced or reported by others • "Male-oriented" VA culture unreceptive to women veteran needs o MST survivor discomfort around male Veterans o MST experience ignored or challenged o Culture of mistrust of VA • Lack of awareness of need for help

Table 2
(continued)

VA mental health services	Non-VA mental health services	Women not receiving care
		• Feeling overwhelmed o Fear of stigma o Fear of undergoing treatment • Alternative coping strategies that displace formal avenues of health care

N/A not available

The third theme was the VA's provision of streamlined services. Several responders noted that, for some callers, the integrated VA record platform that enabled providers to link veterans to other services (financial, legal, etc.) was an attractive feature of VA care. As summarized by one responder, "some of them would rather be in the VA because they want to have a consistency of care" and the ability to access a variety of social supports within a centralized system.

VA mental health services: women's concerns

Responders also suggested that they heard complaints about certain aspects of VA mental health care. The most frequently reported caller complaint, according to responders, was related to structural or logistical barriers to accessing mental health services. For example, the majority of responders reported that women callers complained of difficulties obtaining appointments at the VA, with lengthy delays between an initial call and the first appointment. As described by one responder, "It's taking six months to get in and then they finally get an appointment and the provider cancels it." In the event that a caller was able to attend an appointment, responders report that clerical staff may be unwelcoming, with some callers reporting that they "feel like they're getting disrespected a lot, especially by clerical staff. I've heard a number of times where their baby sitter was late getting there, they were maybe five minutes late and their appointment was cancelled. The person was really pretty rude about it." This inflexibility on the part of clerical staff creates logistical challenges for patients who may encounter significant difficulties obtaining or attending a subsequent appointment while the unwelcoming approach discourages women veterans from maintaining a consistent treatment regimen.

Responders reported that women also faced challenges managing the logistics of attending appointments and are often disappointed to find that scheduled sessions are brief or infrequent. One responder told us: "A lot of times, veterans don't have transportation to the VA because they live miles away, and if they don't own a vehicle, how do they get there? [And] many veterans feel like when they're seeing a doctor, that they're being rushed—the [appointments are] 30 minutes or less. Because of the over-abundance of veterans needing care, there's many delays."

Responders noted that the lengthy travel times and limited business hours of most VA clinics created problems for women who worked or attended school during these hours, who were primary caregivers for young children or parents, or who had transportation or financial limitations. As

stated by one respondent, "They're so busy between working and taking care of their families and a lot of them are going to school…. It seems like that's something that's going to be an issue to get them the services they need, especially if they're living, you know, 30 miles from the VA. They've got to drive to the VA, sit in a waiting room, have their appointment and then drive back."

Only a few responders reported that eligibility concerns, limited service connection, or unaffordable copays were identified by callers as barriers to mental health services in the VA, though they noted that there were also some resources available to overcome these challenges.

The other frequently reported barrier concerned the lack of available specific services for women, and how this might particularly hinder victims of MST from accessing mental health care at the VA. Responders suggested that for survivors of MST, the limited access to women medical providers, OB/GYN specialists, counselors, or women-only support groups exacerbated discomfort or triggered traumatic memories experienced around males. One responder stated, "I talked to a couple of females that have been enrolled in group therapy sessions and were surrounded primarily by men—and they have MST… From what they've told me, it's all that could be offered to them at the time."

Related to this point, the culture of the VA was cited by several responders as an ongoing challenge to linking women callers to services. Responders suggested that the "male-oriented" programming and décor of many VAs signaled to women that they were not welcome or did not belong. As stated by one respondent, "The female veterans that I've talked to say that they have different needs than the male veterans because their experiences were different within the military…sometimes the VA doesn't necessarily recognize that."

Women caller experiences with non-VA mental health services

Twelve of the 54 responders reported that between half and almost all women callers they spoke with indicated that they are receiving mental health services outside of the VA. Almost all responders reported that the limited hours of operation, challenges with scheduling, transportation, and the predominantly male environment were all identified as factors contributing to women callers seeking care outside of the VA. One respondent stated, "Most of them have tried the VA, but for one reason or another, have become discouraged, and then they start looking elsewhere."

Of the 37 responders who discussed women caller satisfaction with non-VA mental health services, 25 (68%) reported that women were generally satisfied with their care.

Non-VA mental health services: drivers of satisfaction

Responders reported that access to women-only support groups or women-focused services, convenience (e.g., a range of appointment times, close proximity to the provider), a choice of providers and services, and greater access to specialist services were often identified as factors contributing to women caller satisfaction with non-VA care. These factors were especially important for women recovering from MST, with one call responder saying: "A lot of the women that are going for mental health services outside the VA, they feel they have options. They can shop around and, this one has a women's clinic, or this one has a rape crisis center, and it's all women, and everything about it is women. And that is a really big deal for them… The surroundings didn't look as sterile, they looked comfortable to them, and a little more feminine… They would say that [providers] really knew what they were talking about. They were very open talking about rape, flashbacks, sexual assault, whatever. And it just felt more comfortable."

Another theme raised by responders was patient confidentiality and its implications for employment and benefits, whether perceived or actual, of non-VA care. According to responders, callers expressed concerns about a mental health or other issue being recorded in their VA record because "if you have something on your record, you can't get a security clearance," a factor they fear might limit post-military career options. Responders reported that callers felt these fears were

alleviated in a private setting, where medical records were not automatically linked to the VA system.

Non-VA mental health services: women's concerns

Respondents reported that callers' attitudes with respect to non-VA mental health services were more positive than negative, but call responders mentioned some criticisms of non-VA mental health care. Some responders noted that women callers said private providers do not adequately understand veteran issues or military culture, thereby limiting their ability to empathize and treat mental health issues stemming from military service. Other responders reported that mental health services outside of the VA can be costly, especially for those who are underinsured.

Women who are not currently receiving mental health services

Responders reported that a small but important segment of women callers are not currently receiving mental health services at the time of their call. Although specific reasons for avoiding care may vary by individual, five key themes emerged from discussions with responders reflecting factors that they believed prevented this small group of women veteran callers from accessing mental health care.

First, several responders noted that the same structural issues that made the VA challenging for existing women patients (e.g., difficulty obtaining appointments, unwelcoming clerical staff, transportation, limited business hours) were often mentioned by callers as reasons that they were not in care at all. Although responders reported that some callers felt that the VA reputation is sometimes deterrent enough to avoid care, they suggested that most callers avoiding care had previous poor experiences with the VA. One responder summarized the deterrence feedback loop as follows: "Well, a big thing … would be difficulty trusting others and the VA in general. Social media comes in a big play with this, too. Because veterans are talking to each other. Or they're in a closed Facebook group, which it sounds like, very often, is a [complaining] session about the VA." In this way, one patient's negative experience is reinforced by their experiences on social media, further eroding trust in the VA and deterring those in the social media group from seeking care.

Second, call responders noted that women often viewed the male-dominated culture of the VA as a deterrent to seeking VA services, especially women recovering from MST. In addition to avoiding areas that are predominantly populated by men, respondents reported that women callers considered VA facilities as potentially hostile environments for MST survivors. As reported by one responder, "I hear this from women: 'I don't want people to tell me…that if I didn't wear makeup and if I didn't dress in the outfit I did' [they wouldn't have been assaulted]." Similarly, responders reported that women callers felt their concerns about sexual assault were often brushed aside even in non-VA clinical settings, with providers sometimes perceived as challenging the legitimacy of assault claims. Finally, responders also reported that women callers expressed concerns about being considered "vulnerable" or "weak" for seeking help where "everybody is the soldier [at the VA]. You can't be weak."

Third, several responders noted that "lack of awareness" was an issue among the unengaged population, which takes two general forms: a caller may be unaware or "in denial" about their need for mental health services or may be unaware of the availability of specific mental health services, both of which can complicate the mental health referral process. Several responders attributed these issues to the "information overload" provided at military discharge, when veterans often "tune out" information that may not seem immediately relevant to their needs. As summarized by one responder, "they get so much [information] at discharge from the military that I don't think it all sinks in."

Among the women callers who are aware of their need for services but not yet engaged, the majority of responders reported that callers were "overwhelmed," had a "fear of the unknown" and a "fear of being labeled," or stigmatized, the fourth theme explaining why women veterans at risk for suicide may not access mental health services. Some call responders characterized this orientation toward mental health treatment as a burden for busy or overwhelmed veterans, stating, "[T]hey're already feeling too overwhelmed to think about…counseling or doctor appointments [that] are a burden on top of everything else." Four respondents used the term "Pandora's box" to describe the callers' fears about undergoing treatment, reflecting the sentiment that "[G]oing into counseling is going to make them talk about their experience. And they're afraid that… [doing so] will cause them more trauma."

Finally, responders noted that some women callers avoid mental healthcare services in favor of alternate coping strategies. Responders expressed support for some of these strategies, such as "religion, yoga, other support—online groups" or religious counseling. However, responders mentioned that other callers appeared to complicate their problems by self-medicating with alcohol or other substances.

Discussion

The purpose of this study was to use key informants at the VCL to identify whether women veterans in crisis were accessing VA care, and if they were, what kept them engaged in care. Conversely, if women veterans in crisis were not in care, the study team sought to identify reasons why and whether they were accessing care elsewhere. Because women veterans in crisis represent a relatively small population of military veterans, interviews with responders at the VCL provide some insight into this small but at-risk group.

A key finding of this study is the extent to which responders report that caller experiences with providers and clinic staff appear to drive satisfaction with mental health services, both within and outside of the VA healthcare system. This observation echoes previous studies showing that positive experiences with attentive providers can have positive effects on women's willingness to seek or maintain treatment, disclose important health information, or comply with a treatment regimen.[22–24] Specifically, call responders told us of women veterans' preference to see providers who understand military culture and Veteran's issues, which the VA is uniquely suited to provide. Additionally, responders reported caller satisfaction with services provided by women clinicians, more specific mental health programming for women, and emphasis on "safe environments" for women survivors of MST.[29, 30] Given evidence in a corresponding study that MST is the most frequently discussed concern among women callers to the VCL, providing gender-appropriate or gender-specific care may be especially important for meeting the needs of women veterans in crisis.[28] Though such care is offered at a growing number of VA medical centers, it must be balanced with actual demand and limited resources, especially given the relatively low proportion of Veterans who are women.

Consistent with previous findings in both the general civilian and veteran populations, responders reported that structural, cultural, and psychosocial barriers to care are a disincentive for callers seeking care and reduce the frequency with which they access services.[31–36] Responders suggest that the experience or reputation of these barriers may deter women veterans from accessing the full range of services they need, pushes some callers to seek private care, and fosters resistance to VA referrals among some caller groups.[17, 19, 35] Studies in other healthcare settings indicate that the deterrence effect of barriers to access can be mitigated if patients are informed about inconveniences ahead of time.[37] Therefore, while reforms are being implemented, VA and VCL messaging about delays or barriers may improve caller follow-through.[38] Furthermore, expansion of innovative care delivery models, such as telehealth, may help alleviate transportation, geographic, or financial barriers and improve the frequency or duration of mental health treatment.

Preliminary work in this area suggests that mental health services provided by the VA may be especially suitable to telehealth models of care and can alleviate scheduling or travel concerns due to the "anytime, anywhere" nature of service availability that allows patients to remain at work or home, step away briefly for the duration of their appointment, and resume normal activity following the conclusion of the call.[39–42]

As structural barriers are addressed, the VA also has an opportunity to change or refine its cultural and communication practices to better engage women veterans in care. For example, studies indicate that stigma deters patients from seeking care in both VA and non-VA contexts but that sensitive messaging can overcome initial patient hesitation.[43–45] Formally rebranding suicide prevention coordinators (the primary source of referral for most callers to the VCL) as "crisis coordinators," as most responders already refer to them, may alleviate callers' negative reactions to the term "suicide prevention coordinator" and reduce stigma that might otherwise deter women from seeking care.[46] Finally, these findings suggest that the issue of culturally appropriate care is a double-edged sword for the VA, whereby VA clinicians' sensitivity to military culture is an attractive feature of care for veterans that is not otherwise available in private practices, yet the male-dominated nature of the environment may deter engagement.[17, 47–50] By refocusing mental health communications around a shared military culture and developing more gender-specific programs, the VA could shift the conversation about cultural practices and provide nuanced care to women veterans that is unique to those familiar with military culture.[48]

Overall, these interviews with VCL call responders reinforce the findings from previous studies regarding barriers and facilitators of mental health care and shed new light on how they impact women veterans in crisis. Continuing improvements to the VA mental health service infrastructure and associated messaging may enhance the experiences and perceptions of women VCL callers and ultimately improve the ability of the system to meet the needs of women veterans at risk of suicide.

Limitations

The qualitative key informant interview method used in this study sheds light on the service preferences of women veterans who are suicidal or in crisis, but some limitations should be considered. First and foremost, the study team asked call responders about their impressions of women veteran caller views instead of talking to women veterans themselves. This provides a useful lens, especially because obtaining the views of individuals in acute psychiatric crisis for interviews presents many logistical and ethical challenges.[26] Even so, studies of healthcare providers serving as proxy respondents for their patients suggest potential biases.[51] Second, though all call responders across all shifts were eligible to participate in the study, the study team only interviewed the 54 who volunteered out of the more than 300 total responders. The group of volunteers interviewed may not represent the views of all call responders, and the study team has no way of knowing whether those who participated in the study have different perspectives than those who did not. In spite of these limitations, a range of plausible and potentially important research hypotheses was generated and mental health policy directions for women veterans were identified. Future quantitative survey methods based on these findings may further assess the pervasiveness of these views and the potential benefits from suggested policy directions.

Implications for behavioral health

Call responders at the VCL are on the front lines of working to prevent suicide among veterans. Their work provides unique access to women veterans in mental health crisis, a group at elevated risk of suicide, and unusual insight into related healthcare needs and preferences. Through qualitative methods, this study systematically assessed call responders' perspectives about barriers and facilitators to mental health service use among women veterans, and identified potential ways

of enhancing utilization of mental health services and preventing women veteran suicide. Call responders identified women-focused services, choice of provider, service availability and access, sensitivity to veteran experience, convenience, and confidentiality as features that drive women veteran satisfaction with mental health services and facilitate their utilization. In contrast, these responders identified structural barriers to care, services or environments insensitive to the needs of MST survivors, financial limitations, confidentiality concerns, and cultural issues as core barriers that discourage the initiation or utilization of mental health service treatment for women veterans. By addressing these barriers and enhancing existing facilitators of mental health service utilization, behavioral health practitioners serving women veterans can improve mental health service utilization among those at risk of suicide and improve health outcomes.

Additional avenues of research may explore models for shifting VA culture to be more receptive of women veteran needs or the ways in which social media encourages or discourages mental health utilization among women veterans. As more women enter military service and online interactions comprise a larger component of post-service socialization, there are several opportunities to explore culture change, the intersection of social media and mental health, and the impact upon mental health services and utilization.

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Compliance with Ethical Standards

All procedures were approved by RAND's Institutional Review Board.

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