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Women Veterans' Perspectives on Suicide Prevention in Reproductive Health Care Settings: An Acceptable, Desired, Unmet Opportunity

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Supplementary Data

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Abstract

Background: Women veterans of reproductive age experience a suicide rate more than double their civilian peers. Developing effective suicide prevention strategies for women veterans requires identifying settings frequented by women veterans where acceptable prevention initiatives can be implemented. Reproductive healthcare (RHC) settings may provide such an opportunity.

Methods: We conducted semi-structured interviews with 21 cisgender women veterans of reproductive age using RHC services provided or paid for by the Department of Veterans Affairs (VA) to understand their beliefs, attitudes, and preferences regarding suicide risk assessment and prevention within these settings. Interview analysis was inductive and used a thematic analysis framework.

Results: Four major themes emerged from the interviews: 1) positive patient-provider relationships in RHC settings are important; 2) some women veterans prefer women providers for RHC and suicide risk screening; 3) women veterans' experiences with VA suicide risk screening and assessment vary; and 4) suicide risk screening and prevention in RHC settings is a desired and acceptable, yet unmet opportunity.

Conclusions: Findings from this novel study suggest that VA RHC settings may present a viable milieu for implementing upstream, gender-sensitive, veteran-centric suicide prevention strategies. Future research is needed with VA RHC providers to determine their needs for successfully implementing such strategies.

The suicide rate among women veterans is more than double that of civilian women (Office of Mental Health and Suicide Prevention, 2021). Particular concern has been noted for younger women veterans (i.e., 18–39 years; Office of Mental Health and Suicide Prevention, 2021). Putative reasons for this elevated risk include minority status within the military, stressors and trauma experienced across the life course, substance abuse, inadequate social support, and increased access to firearms (Hoffmire & Denneson, 2018; Monteith, Holliday, Brostow, and Hoffmire, 2019).

Acceptable, effective upstream suicide prevention strategies for women veterans that can be delivered outside of mental health care settings are crucial (Office of Mental Health and Suicide Prevention, 2018; U.S. Department of Health and Human Services et al., 2012). Implementing these programs requires identifying health care settings frequented by women veterans, where such activities could be acceptably implemented. This requires understanding their needs and preferences, which may differ from those of male veterans (Kimerling et al., 2015). Furthermore, although women veterans are increasingly using Department of Veterans Affairs (VA) health care (Frayne et al., 2018), optimizing suicide prevention strategies for this population requires consideration of how negative military experiences, like military sexual trauma (MST) and institutional betrayal (Brownstone, Holliman, Gerber, and Monteith, 2018), may decrease trust of health care providers and VA, deterring help-seeking and disclosure (Holliday & Monteith, 2019; Monteith et al., 2018). Consideration of environments in which women veterans feel safe and welcome is also key, particularly given that one in four regular VA users experiences harassment by male veterans on VA grounds (Klap et al., 2019).

Reproductive health care (RHC) settings may provide an opportunity to implement upstream suicide prevention efforts tailored to women veterans' needs and preferences. RHC addresses basic and specialized health care needs, including contraception, infertility, and gynecologic care (Katon et al., 2013). Within the VA, types of RHC provided vary by facility and are delivered across settings, including primary care (i.e., women's health clinics, general primary care) and specialty care (Katon et al., 2013). RHC is also among the top five health care needs of women veterans of reproductive age (i.e., 18–44 years), who constitute the fastest growing subgroup of veterans (National Center for Veterans Analysis and Statistics, 2017); more than 40% of women veterans using VA health care experience reproductive health conditions or seek contraceptive care through the VA (Frayne et al., 2018).

The intersection between reproductive and mental health among women veterans is well-documented. Katon et al. (2015) found that 46% of women veterans with a reproductive health diagnosis had at least one mental health diagnosis. The cooccurrence of multiple mental health conditions (e.g., comorbid posttraumatic stress disorder [PTSD] and depression) is also present across a range of reproductive health conditions, including pelvic pain, infertility, pregnancy, and menopause (Cohen et al., 2012; Katon et al., 2016; 2020; Mattocks et al., 2015; Ryan et al., 2016; Zephyrin et al., 2014). As mental health conditions are well-established important risk factors for suicide (Franklin et al., 2017), a substantial portion of women veterans using VA RHC may be at increased risk for suicide. Information is lacking, however, regarding whether women veterans would find suicide risk assessment or prevention interventions in VA RHC settings to be acceptable.

Thus, we conducted qualitative interviews with women veterans using VA RHC services to understand their experiences, beliefs, attitudes, and preferences regarding suicide risk assessment and prevention within these settings.

Materials and Methods

Study Design

This qualitative study was conducted as part of a mixed-methods study examining suicide risk among women veterans using RHC services paid for or provided by the VA (referred to as VA RHC). The quantitative components of this study included a cross-sectional survey and retrospective cohort analysis of VA administrative and clinical records (Gaeddert et al., 2020). The survey targeted women veterans who used VA RHC services in the year preceding study initiation (Fiscal Year 2018) and assessed mental and reproductive health.

Women who completed the survey ($n = 352$) were invited to participate in a qualitative interview; 270 (76.7%) expressed interest in doing so. Purposeful sampling was used to select a sample diverse in age, rurality, race, ethnicity, education, employment, income, and MST history. Thirty-seven (13.7%) women were contacted for an interview, 24 (64.9%) of those were scheduled, and 21 (87.5%) were interviewed between January and July 2019. The Colorado Multiple Institution Review Board approved this study.

Qualitative Interviews

Telephone interviews were conducted by one author (L.M.) and were audio-recorded and transcribed. Participants were compensated $25.

A semi-structured interview guide (Appendix A) was developed by the authors. Participants were oriented to the definition of VA RHC (i.e., RHC provided or paid for by the VA), then were asked questions to understand their experiences with VA RHC and comfort level discussing various topics with RHC providers. Participants were also asked about their experiences with and reactions to being asked about or provided resources for mental health and suicide risk and prevention in VA RHC and other health care settings.

Analysis

Participants' survey data were used to describe sample demographics, military service characteristics, RHC and mental health service use in the past year, and possible mental health conditions. Specifically, probable depressive disorder, provisional PTSD, drug and alcohol use, and lifetime and recent suicidal ideation and suicide attempt were assessed using validated screening tools (see Appendix B).

Analysis of interview transcripts was inductive and used thematic analysis (Braun & Clarke, 2006). Before analysis, the team engaged in bracketing, exploring their expectations, knowledge, and potential biases (Nowell, Norris, White, and Moules, 2017). For example, although coders varied in their professional backgrounds (e.g., epidemiologist, clinical psychologist, and rehabilitation psychologist), all were cisgender women without military service.

Coders reviewed transcripts independently, recording their impressions and salient quotes with analytic memos (Birks, Chapman, and Francis, 2008). Analysis was iterative, with periodic group meetings to discuss if saturation had been met and to reach consensus regarding themes. Recruitment concluded shortly after confirming that saturation had been reached for the qualitative aims. Presented quotes are de-identified and denaturalization was used to remove specific utterances (e.g., "um," "you know").

Results

Participant Characteristics

All participants were cisgender women. Table 1 summarizes demographic and military service characteristics. More than half (n = 11, 52.4%) screened positive for recent mental health conditions, and two-thirds (n = 14, 66.7%) had used past-year mental health services (Table 2). Lifetime suicidal ideation (n = 13, 61.9%) and suicide attempt (n = 5, 23.8%) were common. Most participants reported VA facilities as their usual source of VA RHC (n = 16, 76.2%; Table 3). Commonly used RHC services included pap smears, pelvic exams, pregnancy tests, and contraception (Table 3).

VA RHC Service Use and Experiences

Women veterans described using VA RHC because it was "free," convenient, and centralized; because they had earned it; and because some felt more comfortable in a veteran-focused setting. Participants received RHC services of different types, in various settings (e.g., primary care, women's health clinics, specialty clinics [obstetrics/gynecology]), from different types of providers (e.g., general practitioners, gynecologists), and at both medical centers and community-based outpatient clinics (CBOCs). Some preferred CBOCs because they felt more personal, akin to a family practitioner, whereas medical centers could feel "cold and sterile."

Most participants were generally satisfied with VA RHC. However, some mentioned long wait times to get or be seen for a scheduled appointment. A few described concerns regarding the VA's preparedness to provide RHC, pertaining to the availability of resources (e.g., exam supplies; "they had to really scrounge for them") and services (e.g., to treat menopause, for family planning).

Patient-Provider Relationships

Women veterans described how important it was to have a positive relationship with their RHC provider. Trust and rapport were considered essential to a positive health care experience—overall and for disclosing health concerns. Provider type was less important, particularly when these relational aspects were present.

Women described provider characteristics and behaviors that helped to establish trust and rapport. They appreciated providers perceived as genuine, caring, compassionate, empathic, and nonjudgmental. They also valued providers who were prompt, took the time to listen, considered their needs and preferences, explained the rationale for procedures, were responsive to their questions and concerns, and provided personalized care:

> He came in, and he was like, "I know you haven't met me before, and we're supposed to do your pap smear. But if you're uncomfortable, we can just meet today and talk and get to know each other, and we can reschedule your pap smear."

Women also described negative provider behaviors that interfered with establishing trust and rapport, such as if the provider was perceived to be judgmental (including with regard to contraceptive choices), uncaring, or unresponsive to their medical needs, as well as if they could not see the same provider regularly (e.g., when trainees were rotating through).

> "I talked to my primary care doctor [about painful cramps]… the first thing he asked me he was like, 'Are you in pain right now?' And I said, 'well no' because I wasn't on my period when I actually had the appointment…and he's like, 'okay, well we can't do anything, we can't do anything about that then.'"

A few women described instances of RHC providers limiting their options or causing them to feel uncomfortable discussing family planning.

> "I actually had to go outside the VA to get [my IUD] taken out because [the provider in the VA Women's Health Clinic] was very reluctant to take it out. And I

> told him I was having a lot of issues with it, so yeah, I went somewhere else to get it taken out."

RHC Provider Gender Preferences

Some participants expressed feeling "uncomfortable" or embarrassed talking with male providers: "Well, if it was a female, I would be okay discussing anything. Like, I know I talked to Dr. [Name], and I was super timid talking to him because it was embarrassing. It was awkward." For some, this discomfort and preference related to a belief that women providers can better understand women's health issues and bodies; for or others, their preference for women providers related to prior experiences of interpersonal violence perpetrated by men.

Importantly, some participants indicated that the provider's gender would also affect their comfort discussing suicidal thoughts and behaviors in RHC settings. One woman described why gender would affect her response to questions about suicide or mental health:

> "Because one of the experiences regarding wanting to harm myself or kill myself was male-caused. So I would prefer talking to a female…I would tell [male RHC providers] that I have had [suicidal thoughts] but I might not go into detail as much as I would with a female."

Experiences With VA Suicide Risk Assessment

Participants reported varied experiences with VA suicide risk assessment. Some discussed being asked about suicide frequently ("about every time I go to any provider") and in various VA settings, particularly mental health and primary care.

Many expressed understanding the rationale for such questions, "Oh, it's fine…I know that's part of the routine." A few even welcomed such experiences as reducing stigma and providing an opportunity to receive support:

> "I like it because, even though it may seem routine that they ask you [about suicidal thoughts and behaviors] every time you're there, that one time that maybe you are leaning that way, you're already in a safe environment that you could tell them."

Conversely, some women described these experiences as excessive: "…there's suicide stuff all the time that I just kind of block out 'cuz it's everywhere." Others described them as "awkward," uncomfortable ("he never made eye contact with me"), impersonal ("he stared at his screen the whole time"), or robotic, which often seemed to derive from provider-specific behaviors:

> "You get the nurse, and they go through this whole laundry list of questions that they have to ask you. And they just rattle it off like in a drone voice… They go through it so fast that if you were really seriously thinking about doing it, I'm not sure anybody would say, 'hey, yeah, I am.'"

Participants also discussed how disclosure of suicidality (irrespective of setting) was a vulnerable, intimate process that could be difficult: "After all these years, it's still off-putting…because there's a guilt that goes with having those feelings." Some women

described stigma regarding suicide, and concerns about the consequences of honestly disclosing being suicidal:

> "I'm thinking about what would happen afterwards…What's going to happen? I don't want to get fired. I don't want to miss work…there's still that stigma out there.But I think that would still bar me or some other people from coming forward because it's still not socially acceptable… Plus, all the other things about disappointing your family and I don't want to lose my job and everything that kinda goes along that might be a possibility."

Thus, a positive patient-provider relationship, centered on trust and rapport, was considered particularly important for discussing suicide risk. In its absence, participants indicated reluctance to disclose suicidal thoughts:

> "Personally, I'm not going to talk to anybody about mental health issues that I might have if…I don't have some type of rapport with them already…I'd have to be really, really on the edge to say to someone that I don't see hardly at all, maybe twice a year, as soon as I saw him 'hey, I've been thinking about hurting myself.'…I'd have to have some type of relationship with them."

Suicide Risk Screening and Prevention in RHC Settings

VA RHC settings appear, overall, to offer a desired, acceptable, yet unmet opportunity for suicide risk screening and prevention. Specifically, most participants said they would be comfortable with suicide risk screening and prevention (e.g., receiving resources) in these settings:

> "I think it would be great. I think that not just me, but so many females would benefit from that. I've seen so many people that need that question [about suicide] because they're maybe not seeing that they're an emotional wreck…until they're in, just close to the deep end. I just really feel that that would be a good initiative for females that [there] be a line of questioning that goes on just at like pap smears or checkups or whatever."

In fact, for some women, suicide screening in RHC settings felt less stigmatizing: "Mental health is that red flag to me, and I would feel more comfortable talking to a primary care or a reproductive health provider about that than I would being referred to like a mental health provider."

However, participants described caveats to acceptability, such as wanting these discussions to occur in the context of established patient-provider rapport:

> "You know, if he [RHC provider] felt like after our conversation that I needed those resources then I would have to sit there and go 'hmm, maybe I am not doing as well as I thought I was doing.' Because there's a trust factor there. Again, it goes back to the relationship."

Participants also wanted these discussions to occur in a dignified way:

> "If it was before when you get your vitals…that would be fine. But if it was [when] you have a gown on and they're about to do a physical exam or something, that

might be not appropriate…I would feel better if I had my clothes on and…we were just talking about my blood pressure…."

Moreover, although many women reported feeling comfortable talking with RHC providers about mental health concerns, some indicated they would feel *equally* or *more* comfortable talking with RHC providers about suicide, compared with other health care providers, because of the intimate nature of RHC:

"There are a lot of women [who] will open up more to their GYN…obviously it's a more intimate exam, so they may feel more apt to opening up about [mental health or suicide]. I think any opportunity that someone has to open about mental health issues is another opportunity to find them."

Many women endorsed RHC settings as acceptable for addressing suicide because of the perceived interrelationship between reproductive and mental health:

"I thought because I was going through menopause, 'I'm kinda depressed, this is normal.' So, I started talking to [my RHC provider] about the mental health issues because I thought it was connected to somehow, that reproductive issue."

Women veterans described how interactions between mental and reproductive health necessitated a holistic perspective that incorporated expertise from both domains. This was discussed in various reproductive health contexts, including menstruation, pregnancy, postpartum, menopause, and infertility:

"I think most mental health providers get it. But also think that reproductive doctors get more of the hormonal and chemical part of emotions. Because it's related, like when you're pregnant, you have different hormones, and when you're on your period, you get different hormones… most therapists don't have a neuropsychological background. So they're just not as in tune. Also, most therapists, unless they're a psychiatrist, they don't really understand medication as far as emotions go."

Importantly, suicide risk assessment and prevention in RHC settings was not universally desired by all participants. A few women indicated that it exceeded RHC providers' expertise:

"That's not their area of expertise. So, I wouldn't want to do that. That's just like me seeing a mental health person and talking to them about GYN stuff. That's not their area of expertise, so I wouldn't do that either."

One participant also indicated she would be cautious about disclosing suicidality to RHC providers because of potential consequences: "…they might be more apt to refer you to psychiatry quicker than [mental health providers would]." Finally, a few participants noted that they would feel "judged" if asked about suicide by their RHC provider.

Nonetheless, some who were reticent to discuss mental health concerns with RHC providers indicated this might be mitigated by receiving relevant resources (e.g., suicide prevention

information, mental healthcare referrals): “I just don’t feel like it’s their business…Maybe you would talk to them more if they offered you resources.”

Finally, despite most women welcoming suicide risk and prevention discussions in RHC settings, many had not previously been asked about, or disclosed, being suicidal to RHC providers. This was particularly true for women receiving VA RHC services from gynecologists as opposed to primary care providers:

“No, I think back [to] when I was having kids. They were very cautious, always asking because they want to make sure there’s not postpartum depression and stuff. But it seems like after there’s no child involved…I’ve never been asked those sort of questions [about suicide] when going for reproductive health.”

Discussion

Prior studies have examined veterans’ experiences and preferences regarding suicide risk assessment (Ganzini et al., 2013), and women veterans’ experiences and preferences with VA RHC broadly (Callegari et al., 2015; Mattocks et al., 2015). However, this study is the first to examine women veterans’ perceptions concerning implementation of upstream suicide prevention in VA RHC settings. Currently, suicide risk assessment for women veterans seeking VHA care typically occurs in mental health and/or integrated primary care settings. Our findings suggest that expanding such services to VA RHC settings would be acceptable to many women veterans. Although participants described suicide risk disclosure to be vulnerable and, at times, stigmatizing, they viewed RHC provider-patient relationships as inherently intimate, which often decreased their concerns around disclosing information regarding suicide.

Importantly, a few participants indicated they would feel uncomfortable discussing mental health or suicide with their RHC provider. Reasons included stigma, negative provider experiences, lack of trust and rapport, and (specific to RHC providers) perceived lack of mental health expertise. Several provider- and systems-level solutions may address these concerns. Training and education initiatives for RHC providers could address the importance of these factors on women veterans’ willingness to disclose mental health concerns and suicidal experiences. Such initiatives could emphasize the necessity of building trust and rapport, directly addressing stigma, and initiating conversations with women veteran patients regarding RHC providers’ expertise and ability to discuss mental health and suicide (including how it relates to the care they could provide, confidentiality, and the circumstances in which they would make a referral). Ensuring such information is communicated in a personalized way that conveys caring is important, considering themes gleaned in our interviews. Our findings are also consistent with prior research indicating that veterans are more likely to disclose suicidal thoughts to genuine, empathetic providers who explain their rationale for asking such questions (Ganzini et al., 2013). Women veterans in this study also demonstrated knowledge of the interrelationship between reproductive and mental health; therefore, RHC providers can discuss this relationship with patients as the rationale for asking questions about mental health and suicide.

From a systems-level perspective, public awareness initiatives focused on women veterans using VA RHC would benefit from conveying information consistent with these goals: addressing stigma, emphasizing the potential overlap between mental health and reproductive health, and encouraging help-seeking from RHC providers. This could be achieved via avenues such as posters in waiting rooms and public service announcements. Routinely providing patients with such resources may convey that VA RHC providers are prepared to discuss mental health and suicide and reduce stigma associated with doing so by normalizing such discussions in RHC settings. Notably, women in this study were more receptive to discussing suicidality with RHC providers if they were to receive resources that fit their needs, indicating that personalizing resources is also important.

Before implementing such individual- or systems-level strategies, it will be important to ensure that RHC providers have the means necessary to successfully implement such processes. This underscores a need for additional research focused on understanding RHC providers' specific needs, readiness, and willingness to conduct suicide risk assessments with women veterans.

Several limitations are worth noting. First, as with all qualitative studies, our findings may have limited generalizability beyond this sample. Most participants were highly educated and received at least some RHC at VA facilities, rather than only RHC paid for by the VA but provided in community settings, and reported using mental health services in the past year. Moreover, we solely assessed acceptability as perceived by women veterans. As noted previously, although findings suggest that VA RHC settings may present a viable milieu for implementing upstream gender-sensitive suicide prevention strategies, future work should obtain input from RHC providers to understand feasibility from their perspective. In addition, research to inform the design of optimal suicide prevention resources for VA RHC settings is recommended.

Implications for Practice And/or Policy

Our findings underscore the need for a patient-centered approach to suicide prevention with women veterans (Constand, MacDermid, Dal Bello-Haas, and Law, 2014). Establishing positive, trusting relationships with RHC providers enhanced women veterans' VA RHC experiences and may facilitate willingness to disclose concerns about mental health and suicide. Similar to other studies of women veterans that examined sensitive topics (e.g., MST, Monteith et al., 2018; family planning, Callegari et al., 2015), participants valued positive provider behaviors in line with patient-centered care (i.e., being compassionate, genuine, responsive, and personalizing care; Constand et al., 2014). Conversely, negative provider behaviors, including being dismissive or judgmental, impeded trust and rapport, reducing women veterans' comfort disclosing suicidality.

Within VA contexts, these findings have implications for refining patient-centered services for women veterans. First, it is important to increase RHC providers' awareness of how central provider behaviors are to women veterans' experiences with VA RHC and disclosure of mental health and suicidality in RHC settings. Second, findings could inform efforts under way to tailor the VA Patient Aligned Care Team (PACT) model to better meet women veterans' needs (Yano et al., 2016). The PACT model aims to achieve team-based,

integrated (colocated physical and mental health) care (Rosland et al., 2013); yet adaptation challenges (e.g., primary care mental health integration) have been noted for women veterans (Chuang et al., 2017). Finally, efforts to improve continuity of care for women veterans (VA Reproductive Mental Health Consultation Program; Strauss, Miller, and Strickland, 2021) are under way, and may offer critical opportunities to integrate training on suicide assessment and prevention in RHC settings.

These findings may also have implications beyond the VA given that (1) women frequently seek health care, including primary preventive care in RHC settings (Mazzoni et al., 2017; Hall, Harris, and Dalton, 2017); and (2) many women veterans receive some of their RHC care, even when paid for by the VA, from non-VA providers in community settings. Although we defined the latter as encompassed in our definition of VA RHC, we recognize that a comprehensive approach to upstream suicide prevention for women veterans in RHC settings must be able to be implemented in both VA and community health care settings. Such an approach is supported by recent research in the general population, which indicates that women's health providers are uniquely poised to connect women with needed behavioral health care (Crawford, Weitzen, and Schulkin, 2021).

One proposed framework for doing so is to integrate psychologists into women's health care settings, including obstetrics and gynecology settings, similar to what has been done for integrated primary care settings in recent years (Crawford et al., 2021).

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Abbreviations:

RHC	Reproductive Healthcare
VA	Department of Veterans Affairs
CBOC	community-based outpatient clinics
PTSD	Post Traumatic Stress Disorder
MST	Military Sexual Trauma
PACT	Patient Aligned Care Team

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Table 1

Demographic and Military Service Characteristics

Demographics	***n***	**(%)**
Age at survey completion (y) *		
20–29	10	(47.6)
30–39	6	(28.6)
40–49	2	(9.5)
>50	3	(14.3)
Race		
White	13	(61.9)
Black	2	(9.5)
Asian/Pacific Islander	2	(9.5)
Multiracial	2	(9.5)
Other	2	(9.5)
Ethnicity		
Hispanic	4	(19.1)
Non-Hispanic	17	(81.0)
Sexual orientation		
Heterosexual	17	(81.0)
LGBQ †	4	(19.1)
Highest level of education		
Some college, no degree	7	(33.3)
Associates or Bachelor’s degree	9	(42.9)
Master’s degree or higher	5	(23.8)
Marital status		
Married/Remarried	8	(38.1)
Divorced	7	(33.3)
Never married	6	(28.6)
Employment status		
Employed	13	(61.9)
Unemployed	6	(28.6)
Retired	2	(9.5)
Military service history		
Branch(es) ‡		
Army	11	(52.4)
Navy/Coast Guard	6	(28.6)
Air Force	3	(14.3)
Marines	2	(9.5)
Deployments		
None	8	(38.1)
Single	7	(33.3)

Demographics	*n*	(%)
Multiple	6	(28.6)
Highest Rank		
Enlisted	16	(76.2)
Non-commissioned officer	2	(9.5)
Officer	3	(14.3)
Military Service History		
Type of Discharge		
Honorable	18	(85.7)
General	3	(14.3)
Military sexual trauma (MST)[§,‖]		
None	5	(25.0)
Military sexual harassment	6	(30.0)
Military sexual assault	9	(45.0)
Years since last separation (Mean [Range])	4.3	<1 – >8

Abbreviation: LGBQ, lesbian, gay, bisexual, or queer.

[*] Median: 30; Mean: 33.9; Range: 25, 53.

[†] Transgender identity was considered a part of gender identity for these analyses and thus was not included in sexual orientation. All participants reported female birth sex and gender identity.

[‡] Total percentage exceeds 100% because participants could select multiple categories (i.e., were asked to report all branches in which they had served).

[§] Percentages computed out of total ($n = 20$) with nonmissing data on MST ($n = 20$).

[‖] MST category reflects the most severe type of MST experienced for those reporting any MST ($n = 15$).

Table 2

Mental Health, Suicidal Ideation, and Suicide Attempt History

	n	%
Mental Health Services, past year		
No	7	(33.3)
Yes	14	(66.7)
Degree of problematic drug abuse (DAST), past year		
None or low (score < 3)	19	(90.5)
Moderate (score 3–5) *	2	(9.5)
Problematic alcohol use (AUDIT-C), past year		
Negative	19	(90.5)
Positive	2	(9.5)
Provisional PTSD diagnosis (PCL-5), past month		
Negative	12	(57.1)
Positive	9	(42.9)
Major depressive disorder (PHQ-9), past 2 weeks		
Negative	15	(71.4)
Positive	6	(28.6)
Suicidal ideation (C-SSRS) †		
Lifetime	13	(61.9)
Past month	3	(14.3)
Suicide attempt (C-SSRS) †		
Lifetime	5	(23.8)

Abbreviations: AUDIT-C, Alcohol Use Disorders Identification Test-Concise (Bradley et al., 2003); C-SSRS, Columbia Suicide Severity Risk Scale (Posner et al., 2011); DAST, Drug Abuse Screening Test (Skinner, 1982); PCL-5, PTSD Checklist for DSM-5 (Weathers et al., 2013); PHQ-9, Patient Health Questionnaire-9 (Kroenke, Spitzer, and Williams, 2001); PTSD, posttraumatic stress disorder.

*DAST score of 3–5 indicates further investigation is warranted but is below the validated cutoff (>6) for identification of individuals with substance use disorders; no one in our sample screened positive.

†Complete data was available for suicidal ideation and attempt, *n* (%) reported out of $N = 21$.

Table 3

Reproductive Health Care (RHC) Use in the Past 12 Months

	n	%
Usual Source of RHC		
VA facility	16	(76.2)
Non-VA provider or facility	4	(19.1)
VA and non-VA providers used equally	1	(4.8)
Settings for obtaining RHC *		
VA primary care	16	(76.2)
VA women's health clinic	13	(61.9)
VCP provider	6	(28.2)
Non-VA women's health	6	(28.6)
Non-VA primary care	3	(14.3)
Types of RHC services used		
Pap smear	18	(85.7)
Pelvic exam	15	(71.4)
Pregnancy test	12	(57.1)
Contraception	11	(52.4)
STI test	8	(38.1)
Pre-conception	5	(23.8)
Mammogram	4	(19.1)
Prenatal	2	(9.5)
Post-pregnancy	1	(4.8)
Infertility	1	(4.8)

Abbreviations: STI, sexually transmitted infection; VA, Department of Veterans Affairs; VCP, Veterans Choice Program.

*These categories are not mutually exclusive; participants may have received RHC care in multiple settings in the past year. Specifically, $n = 9$ women reported receiving care in any of the three non-VA settings, but only $n = 1$ of those nine women reported not receiving any RHC care in a VA setting.