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Literature Review on "Military-to-Civilian Transition: The Importance of GBA+ for the Canadian Armed Forces"

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Literature Review on "Military-to-Civilian Transition: The Importance of GBA+ for the Canadian Armed Forces"

A REPORT SUBMITTED TO THE CANADIAN ARMED FORCES TRANSITION GROUP
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Table with Acronyms

CAF	Canadian Armed Forces
DND	Department of National Defence (Canada)
DoD	Department of National Defense (United States)
GBA+	Gender-Based Analysis Plus
GBV	Gender-Based Violence
IPV	Intimate Partner Violence
LGBT+	Lesbian, Gay, Bisexual, Transgender plus, such as Queer, Intersex, Two-Spirit
LGBTQ2S	Lesbian, Gay, Bisexual, Transgender, Queer, Two-Spirit
MCT	Military-to-Civilian Transition
MST	Military Sexual Trauma
NATO	North Atlantic Treaty Organization
PTSD	Posttraumatic Stress Disorder
SGBA	Sex- and Gender-Based Analysis
TBI	Traumatic Brain Injury
TG	Transition Group
VA	Veterans Affairs (United States)
VAC	Veterans Affairs Canada
VHA	Veterans Health Administration (United States)

Executive Summary

The findings of this scoping review unequivocally establish the importance of applying a GBA+ lens to military-to-civilian transition research and policies, programs, and services. While there is a dearth of Canadian research on the topic, the extensive international studies and government sources we collected provide valuable insight into the potential challenges encountered by women, LGBT+, Black, People of Colour, and Indigenous members who are medically or voluntarily releasing or facing retirement. These potential challenges include increased vulnerabilities and risks across the various domains of well-being—in health outcomes, complex trauma histories, employment and housing insecurities, lack of tailored services, social disconnection, and more. While the vulnerabilities and risks are experienced at the individual (and sometimes familial) level, they are often caused by systemic and structural issues such as histories of discrimination and marginalization, sexual and gender-based violence, lack of adequate equipment and services, and more. These vulnerabilities and risks are further exacerbated by societal inequalities and civilian lack of knowledge about non-traditional veterans. Thus, setting the strategic goal of achieving equitable transition outcomes for historically marginalized service members and veterans requires both individually targeted solutions and broader structural change. Measures that can help prevent or ameliorate the vulnerabilities and risks of women, LGBT+, Black, People of Colour, and Indigenous releasing/retiring members are important. Likewise, we recommend tailored and separate programing as well as education/training for DND/CAF staff (and knowledge transfer to VAC, civilian service and health care providers, and Canadian society at large) that reflect the lived experiences and needs of these releasing/retiring members. Considering the large amount of health research uncovered in this scoping review, it would seem prudent to develop an additional stand-alone health research program that focuses on the needs of these members, especially women veterans. In fact, our findings stress the importance of collaboration with the Canadian Forces Health Services and civilian health care providers to prevent and reduce vulnerabilities and risks well before release/retirement in order to set members up for a successful transition. The importance of including lived experience voices at all levels of research and program development also emerged as a key factor for success. The implementation of our recommendations should include consultation with the respective subpopulations of concern, for example through outreach, advisory committees, and community engagement boards that include upstream knowledge and experience from serving members as well as downstream input from released/retired members. Redesigning transition services to meet all releasing/retiring members' needs is not an easy task and buy-in by leaders and accountability mechanisms are important factors that will affect its success. Considering the lack of research and programing in Canada or internationally that directly and explicitly applies a GBA+ lens to MCT, the CAF TG has the unique opportunity to advance this important work. However, conventional conceptualizations of both MCT and GBA+ emerged as too

limiting to address the problem of inequitable transition outcomes, calling for a broader intersectional sex and gender lens that can capture multiple transitions across time/life.

Introduction

This study examines the intersectionally shaped sex- and gender-specific problems faced by women, men, and non-binary people preparing for and/or undergoing military-to-civilian transition (MCT). We provide a comprehensive overview and analysis of Canadian and international research as well as of government initiatives related to MCT and sex, gender, and intersectionality. We identify gaps in knowledge regarding the experiences of diverse Canadian veterans with MCT and identify programs, training, and research that could be developed to address the transition needs of diverse Canadian serving and releasing/retiring members. Based on our findings, we also provide recommendations for the Canadian Armed Forces (CAF) and its Transition Group (TG). Our research is guided by three main questions:

Research Question #1: Through a GBA+ lens, what challenges do non-traditional, historically marginalized military service members face when preparing for and/or undergoing MCT?

Research Question #2: What MCT policies and programs that address GBA+ considerations have been developed so far by Australia, Canada, New Zealand, the United Kingdom, and the United States—the five partner countries comprising the intelligence alliance knows as the Five Eyes?

Research Question #3: How can the CAF, and the TG more specifically, better integrate a GBA+ lens into its work on MCT?

This study was conducted by a multidisciplinary research team that includes former military members as well as members of gendered, racialized, sexual, and Indigenous minority groups. The bulk of the research was carried out by the principal investigator and the three co-investigators. The other four team members provided feedback on the full report and advice in the development of the recommendations based on their areas of expertise.

Part I: Transition and GBA+

Background and Context

This research is motivated by two current policy concerns of the Government of Canada:

1) Military-to-Civilian Transition (MCT): The Transition Group of the Canadian Armed Forces (CAF TG) was set up in 2018 to replace the former regional Joint Personnel Support Units (JPSU) and Integrated Personnel Support Centres (IPSC)—now called Canadian Armed Forces Transition Units (CAF TU) and Transition Centres (CAF TC). The CAF TG "has a mandate to support all members with professional services as they transition from active duty to post-military life" (Government of Canada, 2019a). Its goals are "to support all CAF members and their family to prepare for and, at the appropriate time, complete a seamless and successful transition" and "provide fully professional, personalized, and standardized transition services aligned across the CAF, VAC and other supporting agencies to all CAF members, Veterans, and their families, with special care and attention provided to those who are ill or injured" (Government of Canada, 2019a).

2) Gender-Based Analysis Plus (GBA+): The Government of Canada defines GBA+ as "an analytical process used to assess how diverse groups of women, men and non-binary people may experience policies, programs and initiatives." It further explains: "The 'plus' in GBA+ acknowledges that GBA goes beyond biological (sex) and socio-cultural (gender) differences. We all have multiple identity factors that intersect to make us who we are; GBA+ also considers many other identity factors, like race, ethnicity, religion, age, and mental or physical disability" (Government of Canada, 2018a).

The origins of GBA+ go back to the 1995 Beijing Declaration and Platform for Action, which committed to "mainstreaming a gender perspective in all policies and programmes, so that, before decisions are taken, an analysis is made of the effects for women and men, respectively" (United Nations, 1995, p. 38). The Government of Canada signed on to the Beijing Declaration and Platform for Action and followed suit by creating an approach called gender-based-analysis (GBA) to be implemented across departments and agencies. DND/CAF adopted GBA in response to the United National Security Council Resolution 1325 of 2000, which acknowledges the need for gender perspectives in conflict, post-conflict, and peace building processes, and women's participation in decision making (Johnstone & Momani, 2019a). GBA was later amended to GBA+ to include other identities that intersect with sex and gender (e.g., race, ethnicity, sexuality). GBA+ training, through the Status of Women online course, is mandated for most DND/CAF employees (Johnstone & Momani, 2019b). In parallel, gender mainstreaming was incorporated into health policy, research, and practice in Canada through the approved Training

Manual on Gender Mainstreaming in Health used in medical schools since 2002 and the adoption of Sex and Gender-Based Analysis (SGBA) by the Canadian Institutes of Health Research (CIHR) in 2006 (Government of Canada, 2018b; Medical Women's International Association, 2013).

Drawing in GBA+ while also recognizing the importance of SGBA, this report inquires into the importance and implications of an intersectional sex and gender lens for MCT policy, programming, and research in Canada.

Research Approach

The research team works from a broad multidisciplinary understanding of MCT, which is important to capture as much of the relevant literature as possible. We conceptualize MCT as a complex, and not necessarily linear, process of leaving military employment and becoming successfully re-established as a civilian, involving multiple personal, familial, policy, and societal factors across many determinants of well-being. First, the process of transition includes **multiple determinants of well-being** that can be captured through the seven domains outlined in the CAF/VAC Well-being Framework (Government of Canada, 2019b). Determinants include employment or other meaningful activity, finances, health, life skills and preparedness, social integration, housing and physical environment, and cultural and social environment. Second, across these domains the **factors impacting transition are located at multiple levels** including individual factors (e.g., type of release, length of service, sex), familial factors (e.g., marital status, presence of a supportive spouse, caregiving responsibilities), community factors (e.g., services, peer support), policy factors (e.g., health policy, veterans policy, equity legislation), and societal factors (e.g., labour market conditions, gender norms). Third, transition scholars have theorized that MCT involves multiple phases, including, for example, approaching the military transition, managing the transition, and assessing the transition . Our research team understands that the **phases of transition are not mutually exclusive**, but rather can overlap and play out differently in each case, depending on individual, interpersonal, community, military organizational, and broader societal factors. Thus, while the concept of a 'transition' from military to civilian life may imply a clean break when moving between military and civilian spheres, it is important to be attentive to the **continuities and discontinuities in veterans' experiences** (Higate, 2001).

The research team treats sex and gender as distinct. **Sex** refers to biological classification on the basis of anatomical, hormonal, and chromosomal distinctions that are used to assign people to male, female, and intersex categories. **Gender** is a social construct that is attributed to individuals on the basis of perceived sex. Gender refers to socio-cultural norms, expectations, and roles associated with masculinity and femininity, and is a primary way of organizing relationships of power in societies (Scott 1986). Sex and gender are often assumed to be binary

constructs—male/ female and men/women—but our research team recognizes the problematic nature of such an assumption and the need to capture experiences that go beyond the binary to include those who identify as intersex, transgender, Two-Spirit, nonbinary, genderfluid, genderqueer, agender, and more (Bryski, 2020).

Distinguishing sex and gender allows for a more comprehensive employment of GBA+, one that does not conflate sex with gender, while recognizing intersections that exist between sex and gender. GBA+ has its roots in an intersectional feminist approach, with the *plus* highlighting that gender-based analysis ought to go beyond sex/gender, to include the examination of a range of other intersecting identities. Intersectionality, a framework originally developed by Black feminist scholar Kimberlé Crenshaw (1989), reveals how gendered insecurity, oppression, and marginalization intersect with and are compounded by other forms of marginalization rooted in colonialism, racism, ableism, ageism, heteronormativity, and more. In addition, our research team is keen to avoid the common conflation of sex/gender with females/women, and recognizes the importance of making men and masculinities—both privileged and marginalized—visible as part of the analysis of sex, gender, and intersectionality (Whitehead & Barrett, 2001).

As the research we present next shows, sex, gender, as well as other factors such as ethnicity, race, sexuality, Indigeneity, ability, family and support structure, military and deployment experience, rank, age, and more—and their intersections with each other—powerfully influence the experiences and outcomes of MCT.

Part II: Literature Review

Methodology

We used a scoping review methodology to undertake a literature review on the importance of GBA+ for MCT. Scoping reviews provide a clear, organized approach for determining the breadth and nature of a literature, identifying gaps in existing research, summarizing and disseminating research findings, and guiding future research (Arksey & O'Malley, 2005; Pham et al., 2014). Arksey and O'Malley (2005)'s scoping review framework informs the collection, review, and summarization of literature over five stages: 1) identifying the research question; 2) identifying relevant literature; 3) selecting literature; 4) charting the data; and 5) collating, summarizing, and reporting the results. The current literature review was organized in a similar way, and the search strategy following this section provides details pertinent to each of our stages described below.

In the first stage, we identified key concepts and research questions that align with our conceptualization of GBA+ and MCT (outlined above) and in consultation with the Scientific Authority. Search terms were subsequently delineated from these key concepts and research questions, as well as from our familiarity with the literature. In the second stage, the principal investigator and three co-investigators identified potentially relevant literature by inputting the search terms into various electronic databases available through several Canadian universities and Google search engine. Hand searching reference lists for sources that did not surface in the electronic searches was also completed. This included scanning reference lists of key sources identified through the electronic searches, searching relevant website databases such as that of the Consortium on Gender, Security & Human Rights (Consortium on Gender, Security & Human Rights, 2020), and reviewing reference lists provided by other team members based on their respective areas of expertise. Potentially relevant literature was compiled in a centralized EndNote library (Clarivate, 2020) for further evaluation. In the third stage, we reviewed abstracts of the identified literature to screen for eligibility according to established selection criteria. Accepted references were organized into several categories within EndNote based on emergent themes in the literature, and refined in accordance with the GBA+ framework. The principal investigator and three co-investigators were each assigned several categories to review independently. Final decisions of eligibility (i.e., literature inclusion/exclusion) were made as literature was reviewed in more depth. In the fourth stage, we charted the data by reviewing, extracting, and synthesizing details related to GBA+ and MCT from literature abstracts. We reviewed full articles, as needed, for clarification or elaboration. In the fifth stage, we collated the summarized literature for each category into the results section of our report. We analyzed and discussed findings through the lenses of GBA+ and MCT theory; analyses were

also informed by the seven domains of the CAF/VAC Well-being Framework (Government of Canada, 2019b). Finally, based on the literature review and in consultation with all team members, we developed a set of recommendations on the subject of GBA+ and MCT, including areas for future research and potential program development.

Search Strategy

Item/Task	Description
Team members performing searches	Maya, Leigh, Linna, Kimberley
Electronic database searches (university libraries[1]; Google search engine) Hand searching key reference lists Google Scholar final sweep	Maya – grey literature; government programs/policies (Google) Leigh – peer reviewed literature; grey literature (NEOS – 14 Albertan university and college libraries; and Government of Alberta Libraries) Linna – peer reviewed literature; grey literature (OMNI – 13 Ontario university library databases; Google Scholar) Kimberley – peer reviewed literature; grey literature (MSVU/Dalhousie libraries)
Research questions	RQ #1: Through a GBA+ lens, what challenges do non-traditional, historically marginalized military service members face when preparing for and/or undergoing MCT? RQ #2: What MCT policies and programs that address GBA+ considerations have been developed so far by the Five Eyes countries? RQ#3: How can the CAF, and the TG more specifically, better integrate a GBA+ lens into its work on MCT?
Academic database search terms (*for scholarly and grey literature*) Boolean search: **OR** - search terms within same cluster; **AND** - between each cluster	Releasing member/veteran-related terms: Military veteran, veteran, retired military, ex-military, military personnel, military member, military service member, ex-army, ex-navy, ex-air force, armed forces personnel GBA+-related terms: gender*, female*,

[1] University libraries were searched based on those available to team members through academic affiliation.

Item/Task	Description
Used quotations marks to enclose search strings as needed to focus search (e.g., "retired military")	women*, masculin*, feminin*, sex*, LGBT*, lesbian, gay, bisexual, queer, transgender, two-spirit*, Indigen*, Aboriginal, American Indian, Native American, First Nation, Inuit, Métis, visible minorit*, rac*, ethnic*, African American, Maori Transition-related terms: releas*, pre-release, peri-release, post-release, transition*, reintegrat*, adjust*, post-military, after-service, post-service, separat*, retir*, military transition, military transition to civilian life, military to civilian transition, military-civilian transition, military career transition, military to civilian life
Google search terms (*for policies and programs*)	Releasing member/veteran-related terms: veteran, ex-military GBA+-related terms: gender, female, women, LGBT, transgender, Indigenous, Aboriginal, American Indian, Native American, First Nation, Inuit, Métis, African American, Maori, minority, race/racial, intersectionality, of color Transition-related terms: release, transition, separate/separation Organization- and country-related terms: Department of Defence/ Defense, Defence/Defense Department, Veterans Department, Department of Veterans, Department of Veterans Affairs, NATO, United States, Canada, New Zealand, United Kingdom, Australia (+ program, policy, resource, support)
Inclusion/exclusion criteria (*applies to both scholarly/grey literature searches and program/policy searches*)	Inclusion: • Peer-reviewed publications including research, perspective, and synthesis

Item/Task	Description
	articles; • Publications/reports by governments and/or governmental organizations; • Current MCT programs and policies provided by government with GBA+ considerations; • Studies that employ quantitative, qualitative, or mixed methodologies; • Studies that examine releasing military service members and veterans; • Studies that examine historically marginalized military members/veterans (i.e., women, visible minority, Indigenous, LGBT military members/veterans); • Studies that examine sex- and gender-related health issues before, during or since military release; • Studies that focus on other transition-related issues (e.g., socio-economic issues) • Studies that examine military service members'/veterans' first hand experiences or perspectives surrounding MCT, or the viewpoint of service providers for whom a sex, gender or intersectional inquiry is the focus. <u>Exclusion</u>: • Studies, reports, programs or policies provided by non-government organizations; • Studies, reports, programs or policies that are published before 2010; • Studies, reports, programs or policies that examine military service

Item/Task	Description
	members/veterans before 2001; • Studies, reports, programs or policies with sex, gender, women, sexuality, race, Indigeneity mentioned only in passing, without inquiry; • Studies, reports, programs or policies focusing on family members of releasing military service members/veterans rather than the releasing member/Veteran; • Studies that test inventories or other measures within a military/veteran population, but do not focus on releasing military service members'/veterans' MCT experience • Books/book chapters; • Theses/dissertations; • Newspaper/magazine articles.
Search timeframe	10 year span: literature published between Jan. 1, 2010 to Feb. 15, 2020[2]
Geographic search parameters	The Five Eyes: Canada, US, AUS, UK, NZ Justification: In the planning stages of this study, we did a preliminary scan of a broader set of countries such as the Nordic countries, but found that even though they were leaders on gender issues, this had not translated into specific MCT initiatives. We therefore chose to focus on the Five Eyes, as this group includes some of the most advanced GBA+ related MCT initiatives and Canada's key partners.

[2] Several literature sources published between February 16, 2020 to June 30, 2020 were also included beyond the established search timeframe. These additions beyond the set date parameters were newly published sources of particular relevance to the study that emerged through "Google alert" or were identified by team members.

Search Results of the Scoping Review

The study identified 1,077 research articles and government sources related to GBA+ and MCT since 2010 that met our inclusion criteria. Overwhelmingly, the research collected here is based on the United States (*n*=1,023), with much less literature found for Canada (*n*=26), the United Kingdom (*n*=12), Australia (*n*=11), and New Zealand (*n*=1). In addition, four sources included multiple countries: the United States and Canada (*n*=1), Canada and the United Kingdom (*n*=1), the United States and Israel (*n*=1), and the United States, the United Kingdom, and Denmark (*n*=1). The research distribution based on year of publication[3] is as follows: 2010 (*n*=22), 2011 (*n*=47), 2012 (*n*=41), 2013 (*n*=78), 2014 (*n*=86), 2015 (*n*=118), 2016 (*n*=115), 2017 (*n*=131), 2018 (*n*=126), 2019 (*n*=145), and 2020 (*n*=54). A consensus approach was taken in the directed content analysis of the data. This approach is guided by the processes described by Hsieh and Shannon (2005). We organized articles and other sources into categories according to their focus on a particular aspect relevant to MCT and/or a particular subpopulation relevant for a GBA+ lens, specifically (1) Transition; (2) Mental health, physical health, and multi-factor health; health care access & utilization; and health research; (3) Sexual violence/military sexual trauma; (4) Family; (5) Socioeconomic issues; (6) Homelessness; (7) GBA+ considerations; and (8) Government resources, programs, and initiatives.

There is a very small amount of research focused specifically on *transition* that takes GBA+ considerations into account (*n*=16)—and it primarily focuses on *women* veterans' experiences with transition. Therefore, we cast a wide net to capture the range of concerns that must be taken into account when looking at the MCT process and transition outcomes for veterans. The vast majority of research looks at health issues of women veterans, focusing on sex and sex differences. The health literature includes, most prominently, research on health care provision and utilization (*n*=175), followed by mental health (*n*=130), physical health (*n*=103), multifactor health considerations (*n*=58), and considerations for veteran health research (*n*=24). Sexual violence, in particular military sexual trauma (MST) and its potential health sequelae, is a prominent concern in the GBA+ relevant transition literature (*n*=151). Family issues are also a key theme (*n*=50), underscoring the fact that MCT does not happen just for an individual but within their family system. Articles on socioeconomic issues include discussion of MCT and veteran issues in relation to employment, education, and the criminal justice system (*n*=33). Relatedly, homelessness is the focus of a growing body of research on veteran transition that is beginning to pay attention to sex, gender, and intersectionality (*n*=33). There is a small but significant body of veteran research that examines other GBA+ considerations such as LGBT+ issues and experiences (*n*=76), race and Indigeneity (*n*=80), intersectionality (*n*=22), and

[3]Publication years for government resources are not included as not all were identifiable.

masculinities (*n*=12). Finally, our review also identified government resources, including policies, programs, and initiatives targeting releasing/retiring members and veterans from historically marginalized groups (*n*=114).

It should be noted here that sources discussed in this scoping review for the most part do not define their use of 'male', 'female', 'women', and 'men' or reflect on their use of terminology. Therefore, the discussed literature often seems to conflate sex and gender, e.g., by using the term gender differences to discuss health-related sex differences or referring to female or male veterans when discussing gender issues experienced by women and men veterans. While we recognize that sex and gender overlap and are not always straightforward to distinguish, we have chosen to change the author's language at times to be both more specific and inclusive. Thus, we use, for example, 'female' or 'male' when the literature discusses sex-specific health issues and 'women veterans' and 'men veterans' in the broader context. The same problem extends to other relevant areas, such as to discussions of race and ethnicity which are not always distinguished and often lumped together under the term 'minority'.

Transition

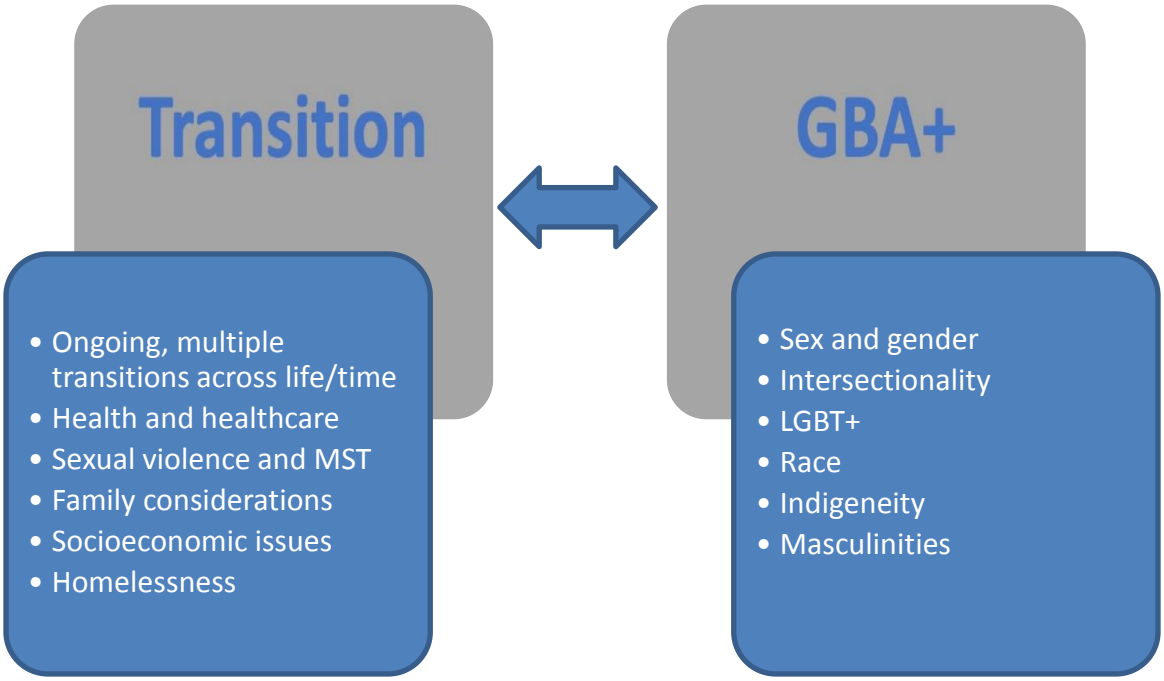
Only a small number of articles (*n*=16) in our scoping review deal specifically with the issue of transition and adjustment to civilian life. These articles focus mostly on experiences based out of the United States (*n*=12), but also include research from Canada (Eichler & Smith-Evans, 2018; Hachey et al., 2016; MacLean et al., 2014b) and Canada/United Kingdom (Bulmer & Eichler, 2017). A majority of the research that specifically focuses on transition relies on qualitative research methods, which reflects an interest in the *experiences* of service members and veterans who are transitioning. None of these articles take an explicit intersectional lens. Instead, most focus on the experiences and needs of women veterans (e.g., Burkhart & Hogan, 2015; Hawkins & Crowe, 2018b; Thomas, McDaniel, Haring, Albright, & Fletcher, 2018), while others have a more general focus but provide some cursory comments on the unique experiences and challenges of women and other minority veterans (e.g., Ahern et al., 2015; Albright et al., 2018). Three of the articles were based on scoping reviews, two focusing on the international gender and transition literature (Eichler, 2017; Eichler & Smith-Evans, 2018) and the other on the literature on women veterans' lived experiences in the United States (Dodds & Kiernan, 2019). These scoping reviews show that gender and veteran issues is a small but quickly growing area of research interest. While Eichler (2017) and Eichler and Smith-Evans (2018) focus on post-release research, Dodds and Kiernan (2019) cover the literature on women joining, serving, and releasing, offering an important longitudinal lens. Both sets of authors emphasize the need to explore issues that go beyond a focus on health issues, and instead look at the interconnected nature of health, socio-economic, social, housing, and other issues.

One of the key questions this segment of the literature addresses is how to understand and conceptualize transition. This research shows that there are multiple meanings to transition and, indeed, multiple transitions that service members go through over time. The US literature in particular examines transition as **post-deployment and community reintegration** issues. For women, reintegration to civilian life after a deployment presents specific challenges, including sex- and gender-specific mental and physical health problems, "higher personal negative and family negative reintegration experiences" (Strong, Crowe, & Lawson, 2018, p. 522) compared to men (Beder, Coe, & Sommer, 2011), and more disrupted social connections (Ahern et al., 2015; Ashley, Tapia, Brown, & Block, 2017). Post-deployment may lead to feelings of ambivalence, a changed sense of self, and disconnection. Transition outcomes are determined by a combination of biological, psychological, and social factors at the individual, family, and community level (Maiocco & Smith, 2016; Strong et al., 2018). Transition also needs to be considered in relation to **premature release** due to minority stress and discrimination experienced by veterans who are part of a stigmatized minority group. As Dichter and True (2015, p. 196) found in their research on women veterans, "multiple forms of oppression within and outside military service ... often contributed to individual decisions to enter and leave the military including poverty, abuse, violence, addiction, racism, classism, heterosexism, and other social conditions that impact women's lives." Bulmer & Eichler (2017) examine transition as the process of **unmaking military identities**, and point to the lack of explicit attention within militaries to 'untraining' or 'deprogramming' service members. Furthermore, rather than assume a linear transition, they suggest, understanding transition as fraught, complex, and difficult because it relies on not only renegotiating one's own identity but negotiating military-civilian boundaries and norms—including gender norms (Bulmer & Eichler, 2017). Burkhart and Hogan (2015) offer an interestingly broad conception of transition *in the plural*, as **transitions emerged as a key recurring experience** from their interviews with women veterans. These transitions included choosing a military career, adapting to the military, being in the military, being a woman in the military, departing from the military, experiencing the stressors of civilian life, and making sense of being a veteran-civilian (Burkhart & Hogan, 2015). As the research shows, transition is a concept that applies more broadly and the experiences of service members and veterans include many life-long transitions.

The literature stresses the unique needs of particular subpopulations, with an overwhelming focus on women veterans. In the Canadian context, while earlier research conducted by Veterans Affairs Canada had not indicated that sex was a significant factor in the adjustment to civilian life (MacLean et al., 2014b), more recent analysis of VAC data shows that women veterans in Canada are "less likely to report an easy adjustment to civilian life" (Hachey et al., 2016, p. 8). US research confirms that women experience different transition outcomes, and that their specific transition needs are linked to their unique pre-military and military experiences (Beder et al., 2011; Burkhart & Hogan, 2015). Top concerns reported in a needs

assessment conducted in partnership with the Service Women's Action Network (SWAN) in the United States, include gender bias, issues with recognition, and harassment/assault for serving military women, while women veterans noted poor mental health, difficulty connecting with fellow women veterans, and financial problems (Thomas et al., 2018). Importantly, the authors found a link between the concerns reported by serving women and the poorer transition outcomes experienced by women veterans (Thomas et al., 2018). Other research shows that key factors that negatively impact transition outcomes for service women include a lack of gender-specific policies and services, education and employment opportunities, and mental health and MST supports as well as gender role expectations and social stigma regarding women veterans (Hawkins & Crowe, 2018b; Strong et al., 2018). One study noted that minority veterans—such as women, ethnic, racial, and sexual minority veterans—in particular feel that they lack preparedness for their MCT, which underscores the need to remove barriers and create resources targeting these more vulnerable veteran populations (Albright et al., 2018). Peer support is also found to be less available to veterans who do not fit the male norm—specifically women veterans, veterans recovering from substance abuse, non-combat veterans, and injured veterans feel more isolated and less able to connect to peers, resources, or services (Ahern et al., 2015; Ashley et al., 2017). As the research shows, those who face vulnerabilities and heightened risks are unfortunately less well positioned to access the transition supports they require and often encounter supports that are not tailored to their needs.

Figure 1. Overview of topics emerging from scoping review on the importance of GBA+ for military-to-civilian transition.



Mental Health

Overview

A total of 130 peer-reviewed articles were identified on topics related to mental health. This body of literature focuses on women veterans (*n*=65), sex/gender differences (*n*=64), and men veterans (*n*=1) in the United States (*n*=126), the United Kingdom (*n*=2), Australia (*n*=1), and Canada (*n*=1). Research designs include primary research using quantitative (*n*=101), qualitative (*n*=11), or mixed (*n*=6) methodologies, as well as systematic reviews (*n*=7), literature reviews (*n*=3), a meta-analysis (*n* =1) and a perspective piece (*n*=1). Civilian comparisons are also included in these analyses. Two overarching themes encompass the literature on mental health: **mental health risks and outcomes** (*n*=91), and **mental health treatments and interventions** (*n*=39).

Research examining **mental health risks and outcomes** focuses on **comorbid mental health issues** (Arditte Hall, Davison, Galovski, Vasterling, & Pineles, 2019; Banducci, McCaughey, Gradus, & Street, 2019; Creech & Borsari, 2014; Cucciare, Mengeling, Han, Torner, & Sadler, 2020; Curry et al., 2014; Evans, Glover, Washington, & Hamilton, 2018b; Fetzner, Abrams, & Asmundson, 2013; Freedy et al., 2010; Gobin, Green, & Iverson, 2015; Gross, Bastian, Smith, Harpaz-Rotem, & Hoff, 2020a; Hassija, Jakupcak, Maguen, & Shipherd, 2012; Hughes, Jouldjian, Washington, Alessi, & Martin, 2012; Huston, Grillo, Iverson, Mitchell, & System, 2019; Japuntich et al., 2016; Litwack, Mitchell, Sloan, Reardon, & Miller, 2014; Luxton, Skopp, & Maguen, 2010; Mitchell, Rasmusson, Bartlett, & Gerber, 2014a; Mitchell, Wolf, Reardon, & Miller, 2014b; Nunnink et al., 2010; Schweizer et al., 2019; Smith et al., 2017; Welsh, Olson, & Perkins, 2019; Wilson et al., 2018b), as well as research focused primarily on **posttraumatic stress disorder (PTSD)** (Bannister, Lopez, Menefee, Norton, & Wanner, 2018; Conard & Sauls, 2014; Crum-Cianflone & Jacobson, 2014; Hall, Elhai, Grubaugh, Tuerk, & Magruder, 2012; Haun, Duffy, Lind, Kisala, & Luther, 2016; Jakob, Lamp, Rauch, Smith, & Buchholz, 2017; King, Street, Gradus, Vogt, & Resick, 2013; Lehavot et al., 2018a; Lehavot, Katon, Chen, Fortney, & Simpson, 2018b; Levine & Land, 2014; Lunney, Schnurr, & Cook, 2014; Meyer et al., 2018; Middleton & Craig, 2012; Schnurr & Lunney, 2011; Stricker, Keller, Castillo, & Haaland, 2015; Vogt et al., 2011a; Vogt et al., 2017; Xue et al., 2015), **suicide (including suicidal ideation, suicide attempts, and non-suicidal self-harm)** (Aslan et al., 2020; Bergman, Mackay, Smith, & Pell, 2019b; Bryan & Bryan, 2014; Bullman, Hoffmire, Schneiderman, & Bossarte, 2015; Gradus, King, Galatzer-Levy, & Street, 2017a; Gradus et al., 2017b; Gutierrez et al., 2013; Hoffmire et al., 2019; Horwitz, Smith, Held, & Zalta, 2019; Kaplan et al., 2013; Khan et al., 2019; Lee et al., 2018; McCarten, Hoffmire, & Bossarte, 2015; Monteith et al., 2020; Ronzitti et al., 2019), **substance use and addictions** (Cucciare et al., 2015; Golden, Thakurta, Slatore, Woo, & Sullivan, 2018; Hoggatt et al., 2015a; Hoggatt, Williams, Der-Martirosian, Yano, & Washington, 2015b; Kalpakci, Sofuoglu, Petrakis, & Rosenheck, 2018; Kelley et al., 2015; Kelley et al., 2013; Scott et al., 2013; Simpson et al., 2016;

Vest, Homish, Fillo, & Homish, 2018; Wilson et al., 2019a), **general mental/psychological health (broadly speaking, without focus on a specific condition or treatment)** (Demers, 2013; Feldman & Hanlon, 2012; Ganzer, 2016; Hoglund & Schwartz, 2014; Jones & Hanley, 2017; Lacks & Lamson, 2018; Runnals et al., 2014; Scoglio et al., 2017; Vogt et al., 2011b; Weissman et al., 2019), **depression** (Curry et al., 2019; Liu, Collins, Wang, Xie, & Bie, 2019; Packnett, Elmasry, Toolin, Cowan, & Boivin, 2017; Sairsingh, Solomon, Helstrom, & Treglia, 2018; Thomas et al., 2016; Thomas et al., 2019), **eating disorders** (Arditte Hall, Bartlett, Iverson, & Mitchell, 2018; Bartlett & Mitchell, 2015; Buchholz, King, & Wray, 2018; Rosenbaum et al., 2016; Slane et al., 2016), and **sleep disorders/insomnia** (Babson, Wong, Morabito, & Kimerling, 2018; Foster, Hansen, Capener, Matsangas, & Mysliwiec, 2017; Martin et al., 2017).

Most research on **mental health treatments and interventions** focuses on **treatment efficacy** for a range of mental health disorders such as PTSD, depression, insomnia, and substance use disorder (Castillo, Lacefield, C'De Baca, Blankenship, & Qualls, 2014; Cucciare, Simpson, Hoggatt, Gifford, & Timko, 2013; Dick, Niles, Street, DiMartino, & Mitchell, 2014; Dunlop et al., 2017; Haaland, Sadek, Keller, & Castillo, 2016; Jackson, Weiss, & Cloitre, 2019; Kelly, Robbins, & Martin, 2019; Krupnick, Melnikoff, & Reinhard, 2016; Kumpula et al., 2019; Lawrence, Matthieu, & Robertson-Blackmore, 2019; Mouilso, Tuerk, Schnurr, & Rauch, 2016; Najavits, Enggasser, Brief, & Federman, 2018; Reddy, Dick, Gerber, & Mitchell, 2014; Schnurr & Lunney, 2012; Schnurr & Lunney, 2015, 2019; Shivakumar, Anderson, Suris, & North, 2017; Stefanovics & Rosenheck, 2019; Wolf, Lunney, & Schnurr, 2016). Other topics include **treatment preferences** (Abraham, Wright, White, Booth, & Cucciare, 2017c; Bernardy et al., 2013; Breland, Donalson, Dinh, Nevedal, & Maguen, 2016; Charlotte et al., 2015; Culver et al., 2016; Currier, Deiss, & McDermott, 2017; Giannitrapani, Huynh, Schweizer, Hamilton, & Hoggatt, 2018; Hebenstreit, Madden, Koo, & Maguen, 2015; Hourani, Williams, Bray, Wilk, & Hoge, 2016; Jones, Greenberg, Phillips, Simms, & Wessely, 2019; Kreyenbuhl, Lucksted, Despeaux, & Sykes, 2019; Oliva et al., 2012; Schwartz et al., 2015; Seng et al., 2013; Stevenson, 2020; Sullivan-Baca, Naylon, Zartman, Ardolf, & Westhafer, 2020) and **therapy models and/or programs** (Castillo, C' de Baca, Qualls, & Bornovalova, 2012; Kip & Diamond, 2018; Lehavot et al., 2017b; Martin, Badr, & Zeineddine, 2018).

Mental Health Risks and Outcomes

Most research investigating the mental health of women veterans and sex/gender differences focuses on correlates between different mental health conditions or comorbid mental health issues (*n*=23). After this, PTSD (*n*=18) is the most heavily researched topic, followed by suicide (*n*=15), substance use/addictions (*n*=11), general mental/psychological health (*n*=10), depression (*n*=6), eating disorders (*n*=5), and sleep disorders/insomnia (*n*=3), respectively. As the 2016 National Health Interview Survey demonstrates, women veterans are at greater risk for serious psychological distress than men veterans, and this risk is increased among women

veterans who are Hispanic or White, middle aged, less educated, and not living with a spouse (Weissman et al., 2019).

In general, women veterans are at greater risk for eating disorders and insomnia than their men counterparts; comorbid depression, PTSD, and anxiety is common among both women and men, but the risk for depression appears to be higher for women veterans (Buchholz et al., 2018; Curry et al., 2014; Foster et al., 2017; Hughes et al., 2012; Litwack et al., 2014; Mitchell et al., 2014a; Mitchell et al., 2014b). Conversely, a higher prevalence of substance use, particularly alcohol abuse, is seen in men veterans (Conard & Sauls, 2014; Curry et al., 2014; Hoggatt et al., 2015a; Kalpakci et al., 2018; Scott et al., 2013; Vest et al., 2018), with suggestion that this risk is greater for men who have retired from military service and have comorbid depression (Fetzner et al., 2013; Vest et al., 2018). Women veterans with a substance use disorder are more likely to be younger, have experienced trauma, and they often have comorbid mental health issues, such as PTSD (Cucciare et al., 2013; Evans et al., 2018b; Gobin et al., 2015; Hoggatt et al., 2015b; Kalpakci et al., 2018; Scott et al., 2013). Insomnia is common in women veterans (Babson et al., 2018; Martin et al., 2017), and Schweizer et al. (2019) find that women veterans with comorbid insomnia and PTSD are at increased risk of using alcohol as a sleep aid, increasing their risk for substance abuse.

Much of the research on veterans' mental health is examined in the context of military service. For example, Bartlett and Mitchell (2015) highlight aspects of military service that increase risk for mental illness, such as MST, strict physical fitness requirements, and deployment (both with and without combat exposure). Notably, veterans' mental health is frequently examined through the lenses of deployment and trauma, and there are consistent links between deployments involving combat exposure or sexual assault and subsequent PTSD diagnoses for both women and men veterans (Conard & Sauls, 2014; Ganzer, 2016; Hassija et al., 2012; Hoglund & Schwartz, 2014). Indeed, trauma from combat exposure and sexual assault are more associated with PTSD than other types of trauma in military populations, with the most severe cases linked to sexual trauma (Jakob et al., 2017). Specific to women veterans, literature shows that MST poses a risk for PTSD, comorbid mental health conditions, and poor health habits (e.g., smoking) (Banducci et al., 2019; Freedy et al., 2010; Japuntich et al., 2016; Middleton & Craig, 2012; Wilson et al., 2019a).

Research highlights a potential for negative psychosocial outcomes for women veterans with PTSD, such as impaired global and neurocognitive functioning and reduced health- and work-related quality of life (Haun et al., 2016; Meyer et al., 2018; Schnurr & Lunney, 2011; Stricker et al., 2015; Vogt et al., 2017). PTSD researched in the context of deployment and trauma frequently conceptualizes it in relation to other mental health issues, including a propensity for comorbid substance use and depression among women veterans (Gross et al., 2020a; Hassija et al., 2012; Nunnink et al., 2010). For example, Gross et al. (2020a) find that tobacco use

following deployment is more likely among women veterans living with PTSD than their men counterparts. Moreover, Xue et al. (2015)'s meta-analysis highlights predictors of PTSD for women and men veterans, making connections to factors both before and after trauma. They find that risk factors for PTSD which occur *outside* of trauma include "female gender, ethnic minority status, low education, non-officer ranks, army service, combat specialization, high numbers of deployments, longer cumulative length of deployments, more adverse life events, prior trauma exposure, and prior psychological problems" (p. 1); factors associated *with* trauma include "increased combat exposure, discharging a weapon, witnessing someone being wounded or killed, severe trauma, and deployment-related stressors" (p. 1).

Rates of post-deployment PTSD may vary by type of trauma between women and men veterans. For example, Freedy et al. (2010) demonstrate stronger correlations between PTSD and sexual victimization in women veterans and stronger links to PTSD and war zone exposure in men veterans. Despite this, women veterans can also experience PTSD, depression, and substance abuse, often together, following combat exposure (Hassija et al., 2012; Welsh et al., 2019). However, when women veterans have competing home life disruptions, they experience more severe PTSD symptoms and comorbid substance use issues following both combat exposure and MST (Banducci et al., 2019). Specific to women veterans, it is unclear whether military-related trauma differentially impacts the mental health of women veterans compared to trauma that occurs outside of military service, in both childhood and adulthood. For example, Arditte Hall et al. (2018) show that military-related trauma has a stronger link to eating disorders for women veterans than either adult physical or sexual assault that is not military-related, despite finding all three are associated with severe eating disorder symptoms. Conversely, Huston et al. (2019) find a significant correlation between a history of intimate partner violence (IPV) and eating disorders, depression, and PTSD. Further, Kelley et al. (2015) note that depressive symptoms mediate the effects of nonmilitary-related trauma on substance use for both women and men veterans.

Mental health screening rates increase for women veterans with multiple deployment tours (Conard & Sauls, 2014), and certain expectations and conditions of deployment can impact women veterans' mental health. For example, in a qualitative study of Australian women veterans, Feldman and Hanlon (2012) show that women's emotional well-being can be negatively impacted post-deployment if they experience disparity between *anticipated* professional benefits of deployment and their *actual* experiences. Reserve/guard women veterans deployed on temporary unit status (individual-augmentees) are at greater risk for depression, PTSD, and hazardous drinking than their women peers who deploy with their home unit (Cucciare et al., 2020). In addition, women veterans that perceive low levels of unit cohesion and self-efficacy during deployment are at greater risk for PTSD and depression (Welsh et al., 2019). Conversely, Sairsingh et al. (2018) demonstrate that higher levels of social support and financial comfort help protect women veterans from developing depression.

Research suggests that post-deployment depression is higher among women veterans (Conard & Sauls, 2014; Curry et al., 2019; Packnett et al., 2017; Runnals et al., 2014) while post-deployment substance use is higher among men veterans (Scott et al., 2013; Vest et al., 2018). Notably, women veterans with alcohol use disorder often experience psychiatric comorbidity (Kalpakci et al., 2018). Moreover, women veterans of lower military rank have been found to be at higher risk for binge drinking following deployment than officers (Cucciare et al., 2015).

A national cross-sectional study by Monteith et al. (2020) reveals that women veterans have high rates of lifetime suicidal ideation (48%), suicide attempts (18%), and non-suicidal self-harm (13%). Further, Aslan et al. (2020) find that women veterans with severe mental illness, particularly young women veterans, surpass both their civilian counterparts and men veterans in their risk for self-harm. Factors related to military service such as shorter lengths of time served and higher amounts of trauma exposure, augment women veterans' risk for suicide and non-suicidal self-harm (Bergman et al., 2019b; Bryan & Bryan, 2014; Monteith et al., 2020). Suicide by firearm is more salient among veteran populations than civilian populations for both women and men (Horwitz et al., 2019), yet this risk appears to be higher for men veterans (McCarten et al., 2015). Khan et al. (2019) find a greater risk of suicidal ideation among women veterans who experienced life threat and sexual harassment in the line of duty. Gradus et al. (2017a) echo this, finding that women veterans who develop PTSD as a result of sexual harassment experienced during deployment are especially susceptible to suicidal ideation.

Women veterans can face considerable psychological distress while coming to terms with their military experiences during civilian reintegration due to a sense of loss, questions of identity and/or belongingness, and "bringing the war home" (Demers, 2013; Jones & Hanley, 2017, p. 1). These changes put women veterans at increased risk for diminished post-military quality of life, including reduced work and/or family functioning and satisfaction (Smith et al., 2017; Vogt et al., 2011a). Moreover, socio-economic stressors (e.g., low income), shifting social roles, poor social support, and lost identity after military service impact the likelihood of substance abuse for women veterans (Evans et al., 2018b; Xue et al., 2015). The transition from military service to civilian life may be a peak time for suicidal ideation in veterans, especially during the initial period of transition for men veterans (Bullman et al., 2015; Monteith et al., 2020), and mental health issues or previous suicide attempts exacerbate risk for suicide in cases of administrative military discharge (Hoffmire et al., 2019). In addition, recent research shows that women veterans are at greater risk of suicidal ideation and attempts after military service than during or before, despite a higher likelihood of onset before military service (Monteith et al., 2020).

Mental Health Treatment and Interventions

All identified therapy models and interventions focus on the US context. Veterans Affairs (VA) and the Department of Defense (DoD) in the United States recommend applying clinical

treatment modalities for PTSD that are "individual, manualized trauma-focused psychotherapies that have a primary component of exposure and/or cognitive restructuring" (Kip & Diamond, 2018, p. 314). Indeed, exposure therapies, cognitive therapies (e.g., cognitive processing therapy; CPT, cognitive behavioral therapy; CBT) and eye movement desensitization and reprocessing (EMDR) appear to be cornerstones for treating PTSD (Kelly et al., 2019; Kip & Diamond, 2018; Martin et al., 2018; Mouilso et al., 2016; Schnurr & Lunney, 2012; Schnurr & Lunney, 2015, 2019; Wolf et al., 2016). Accelerated Resolution Therapy (ART), an intervention derived from EMDR that adheres to VA/DoD's clinical guidelines, may be ideal for treating trauma of an especially sensitive nature (e.g., trauma related to classified combat operations, sexual assault) due to its brevity (Kip & Diamond, 2018).

Beyond the pillars of exposure- and cognitive-based therapies for PTSD, other clinical interventions demonstrate efficacy for women veterans. For example, interventions for women veterans with PTSD that target psychosocial health, such as interpersonal psychotherapy (IPT), are also efficacious in focusing more on increasing social support and improving interpersonal functioning, and focusing less on the traumatic event itself (Krupnick et al., 2016). Similarly, civic service interventions (i.e., community-based, high-frequency volunteering including activities such as leadership and goal-setting) show promise for supporting women veterans' psychosocial health concurrently with treatment for PTSD and depression (Lawrence et al., 2019). Interventions that target psychosocial factors (e.g., interpersonal psychotherapy) are also valuable in treating other mental health issues such as suicidal ideation associated with depression (Kumpula et al., 2019). Acceptance and commitment therapy also shows promise for depression, particularly depression with suicidal ideation (Kumpula et al., 2019). Further, there is a growing trend toward integrating alternative approaches to PTSD interventions, such as yoga, mindfulness, and aerobic exercise, into more traditional approaches (Dick et al., 2014; Reddy et al., 2014; Shivakumar et al., 2017). Of note, Reddy et al. (2014) demonstrate that women veterans who participate in specialized yoga therapy not only experience reduced PTSD symptoms, but are also open to subsequently engaging in psychotherapy.

In addition to demonstrated merit for individualized PTSD interventions, research also shows efficacy for group treatment modalities for PTSD and eating disorders, often based on the traditional exposure and/or cognitive therapies (Breland et al., 2016; Castillo et al., 2012; Castillo et al., 2014). Stefanovics and Rosenheck (2019) compare the effectiveness of women-only and mixed-gender intensive treatment programs for PTSD and find no difference in overall symptom reduction between the two. However, they find the women-only group to have higher levels of commitment to therapy, stay in treatment longer, and are more likely to participate in post-treatment follow-up sessions. Web-based treatments have the potential to enhance accessibility for women veterans. For example, a qualitative study by Lehavot et al. (2017b) shows that the Delivery of Self Training and Education for Stressful Situations (DESTRESSS) model, an online cognitive-behavioral intervention designed specifically for

women veterans with PTSD, provides women veterans with an evidence-based treatment that is gender-sensitive, cost-effective, and easily accessed. Telephone-based treatment modalities may also be of value from an accessibility standpoint, yet some women veterans perceive this mode of treatment delivery as too impersonal (Abraham et al., 2017c).

Research shows various patterns among veterans for mental health treatments involving medication. In general, women veterans prefer non-medication treatments to medication treatments for insomnia and PTSD and this preference may especially be the case for younger women veterans (Culver et al., 2016; Hughes et al., 2012). However, women veterans are more likely to take prescription medication for headaches than men veterans, particularly when they perceive a lower quality of mental health or experience symptoms of PTSD (Seng et al., 2013). Women veterans may be prescribed medication for PTSD more frequently than men veterans, especially psychotropic medications and benzodiazepines (Bernardy et al., 2013). However, as awareness increases about adverse medication side effects for women, such as weight gain, health professionals are becoming more likely to prescribe antipsychotic and mood stabilizing medications with a low risk of metabolic side effects to women veterans (Charlotte et al., 2015; Kreyenbuhl et al., 2019; Schwartz et al., 2015).

Women veterans voice various preferences for substance use disorder and eating disorder treatments. For example, in the case of substance use disorder treatment, Giannitrapani et al. (2018) find in their qualitative study that women veterans prefer treatment perceived as safe (e.g., harassment-free, women-only groups, physical spaces sensitive to women's needs), flexible, accommodating, supportive rather than punitive, and delivered by well-informed providers. In the case of managing eating disorders, Breland et al. (2016) find that women veterans prefer treatment in a group format that includes the development of concrete skills, addresses the relationship between eating and mental health, incorporates interactive learning and mindfulness with cognitive-behavioral therapy, and has flexible access.

Women and men veterans may differ in help-seeking patterns for mental health issues. A UK study finds that women military personnel are more likely to seek help from formal medical sources than informal support from friends, family or their military unit, and they are more likely than men to seek formal support for problem recognition upon advice from others (Jones et al., 2019). In the case of US student veterans, women veterans are more likely than men veterans to seek both formal and informal mental health support (Currier et al., 2017).

Physical Health

Overview

A total of 103 articles were identified as peer-reviewed articles that address physical health issues experienced by women veterans and sexual/gender differences between women and men. The types of research studies included in this section were: ethnography; rapid reviews; meta-analysis; cross-sectional surveys; secondary analysis; retrospective designs; statistical analysis; cohort studies; secondary analysis; and quasi-experimental designs.

The majority of the papers (*n*=100) were completed in the United States, with the exception of one from the United Kingdom (Bergman et al., 2015) and two which are multi-country submissions including the United States, the United Kingdom, and Denmark (Maynard et al., 2020) and the United States and Israel (Rissling et al., 2016).

A range of physical health related issues were discussed across the articles reviewed, including: **cancer** (Bastian et al., 2016; Bergman, Mackay, & Pell, 2015b; Buechel & Connelly, 2018; Colonna, Halwani, Ying, Buys, & Sweeney, 2015; Daly, Hansen, Kwon, & Roberts, 2018; Luther et al., 2013; Lynch, Viernes, Khader, DuVall, & Schroeck, 2019); **cardiovascular conditions** (Bielawski et al., 2014; Chen, Ramanan, Tsai, & Jeon-Slaughter, 2020; Davis et al., 2015; Farmer et al., 2017; Goldstein et al., 2014a; Goldstein et al., 2014b; Goldstein et al., 2018; Gonsoulin et al., 2017; Haskell et al., 2017; Higgins et al., 2017; Sambamoorthi, Mitra, Findley, & Pogach, 2012; Vimalananda et al., 2013a; Vimalananda et al., 2013b; Virani et al., 2015; Whitehead et al., 2019); **chronic conditions** (Bielawski et al., 2014; Gawron et al., 2017b; Gray et al., 2016; Kramer et al., 2017; Lehavot, Hoerster, Nelson, Jakupcak, & Simpson, 2012; McCabe et al., 2018; Mohanty et al., 2015; Prescot et al., 2018; Reed et al., 2018; Rivera, Hylden, & Johnson, 2015a; Schauer et al., 2019); **diabetes** (Gray et al., 2016; Katon et al., 2014b; Rissling et al., 2016; Rouen, Krein, & Reame, 2015; Vimalananda et al., 2013b); **eating related issues** (Breland, Donalson, Nevedal, Dinh, & Maguen, 2017); **efficacy of vitamin use** (Alazzeh et al., 2015); **fibromyalgia** (D'Aoust et al., 2017; Higgins et al., 2017; Mancuso et al., 2020; Mohanty et al., 2015)**; headaches** (Carlson et al., 2013); **irritable bowel syndrome** (Graham et al., 2010; Mohanty et al., 2015); **menopause** (Dietz et al., 2018; Gerber et al., 2015; Gibson, Li, Bertenthal, Huang, & Seal, 2019a; Gibson, Li, Huang, Rife, & Seal, 2019b; Katon et al., 2018b; Rouen et al., 2015); **musculoskeletal related issues** (Corcoran, Dunn, Formolo, & Beehler, 2017; D'Aoust et al., 2017; Gonsoulin et al., 2017; Haskell et al., 2012; Higgins et al., 2017; Randolph, Nelson, & Highsmith, 2016; Resnik, Borgia, & Clark, 2020; Washington et al., 2016); **pain** (Corcoran et al., 2017; Denke & Barnes, 2013; Gibson et al., 2019a; Gibson et al., 2019b; Groessl, Weingart, Johnson, & Baxi, 2012; Kroll-Desrosiers et al., 2016; Oliva et al., 2015; Rivera et al., 2015a); **reproductive health** (American College of Obstetricians Gynecologists Committee on Health Care for Underserved Women, 2012; Arora et al., 2020; Beaulieu et al., 2015; Borrero et al., 2017; Britton et al., 2019; Callegari et al., 2015a; Combellick et al., 2020; Gawron,

Mohanty, Kaiser, & Gundlapalli, 2018b; Gawron et al., 2017b; Judge, Zhao, Sileanu, Mor, & Borrero, 2018; Katon et al., 2014a; Katon et al., 2015a; Katon et al., 2018b; Kroll-Desrosiers et al., 2016; Mattocks et al., 2015a; Mattocks et al., 2011; Schwarz et al., 2010; Schwarz et al., 2013; Schwarz et al., 2018); **sexual health behaviour** (Albright et al., 2019b; Beaulieu et al., 2015; Gawron et al., 2018b; Lehavot et al., 2014b); **sleeping related issues** (Ninivaggio et al., 2018; Rissling et al., 2016); **smoking** (Bastian et al., 2016; Berg, Gruber, & Jorenby, 2020; Berg, Smith, Cook, Fiore, & Jorenby, 2016); **traumatic brain injuries** (Amara, Iverson, Krengel, Pogoda, & Hendricks, 2014a; Amoroso & Iverson, 2017; Cogan, McCaughey, & Scholten, 2020; Gray et al., 2020; Kim et al., 2018; McGlade, Rogowska, & Yurgelun-Todd, 2015); and **vaccinations** (Albright et al., 2019b; Buechel & Connelly, 2018; Daly et al., 2018; Hall et al., 2020).

Many of the papers were exploratory in nature. Authors note that there are many 'unknowns' in prevalence rates, treatment, and experiences of women veterans living with various conditions. For example, in order to better understand the reproductive needs of women veterans receiving care through the Veterans Affairs (VA) health care system, Borrero et al. (2017) set out to determine the rates of contraceptive use, unmet need for prescription contraception, and unintended pregnancies. Acknowledging that maternal morbidity and mortality are important health and wellness indicators for women, Combellick et al. (2020) also identify that the rates of these indicators are unknown in the population of women veterans and seek to fill in this knowledge gap.

Qualitative research in this area examines the experience of women veterans living with various physical health difficulties. Denke and Barnes (2013) set out to better understand women veterans' chronic pain experiences and found that US military culture has a significant role in whether or not these women decided to seek help due to fear of stigmatization and not being believed by health care providers. The preference of women veterans for peer support intervention to promote behaviours as part of cardiac rehabilitation is explored by Goldstein et al. (2018). The study determines that individual preferences should be accounted for in peer matching and programs should be encouraged to provide opportunities for women veterans to develop in-person relationships through trust-building activities (Goldstein et al., 2018).

Specific Health Conditions: Reproductive/Sexual Health

Although all previously indicated articles described physical health conditions experienced by female veterans as a sex comparison with men, a significant number of papers (*n*=40) explore reproductive or sexual health issues specific to female veterans. A range of reproductive or sexual health issues are the subject of these papers including: **sexual behaviours** (Albright et al., 2019b); **sterilization** (Arora et al., 2020); **general sexual health** (Beaulieu et al., 2015; Lehavot et al., 2014b); **general reproductive health** (Gawron et al., 2018b; Katon et al., 2015a; Katon et

al., 2018b; Mattocks et al., 2011; Schwarz et al., 2010); **contraception use** (Borrero et al., 2017; Gawron et al., 2017b; Gerber et al., 2015; Harrington, Shaw, & Shaw, 2017; Jackson, 2017; Judge et al., 2018; Kazerooni, Blake, & Thai, 2015; Kazerooni, Takizawa, & Vu, 2014; Koenig et al., 2019); **pregnancy** (Britton et al., 2019; Callegari et al., 2015a; Hall et al., 2020; Katon et al., 2017a; Katon et al., 2014b; Kroll-Desrosiers et al., 2016); **human papillomavirus vaccination and prevalence** (Buechel & Connelly, 2018; Daly et al., 2018); **maternal morbidity** (Combellick et al., 2020); **menopause** (Dietz et al., 2018; Gibson et al., 2019a; Gibson et al., 2019b); **post-menopause** (Katon et al., 2016; LaFleur et al., 2016; Rouen et al., 2015); **infertility** (Katon et al., 2014a; Mancuso et al., 2020; Mattocks et al., 2015a); **hysterectomy rates** (Katon et al., 2017b); **post-natal issues** (Keddem, Solomon, Marcus, Schapira, & Mattocks, 2019; Schwarz et al., 2013); and **abortions** (Schwarz et al., 2018). Of note is a paper from the American College of Obstetrics and Gynecologists Committee on Health Care for Underserved Women, which provides an overview of reproductive health care for women in the military and among women veterans (American College of Obstetricians Gynecologists Committee on Health Care for Underserved Women, 2012). The report highlights the importance of obstetrician-gynecologists to ask about women's military service and be aware of health conditions commonly experienced by women veterans (e.g., PTSD, MST). Recommendations are also made in the report for additional research on the effect of military service on reproductive health and ongoing efforts for collaboration to ensure comprehensive care.

Unique to the women veteran population are the potential impacts that their military-related tasks have on their reproductive health. Katon led several studies to determine the prevalence of reproductive related issues in women veterans including adverse pregnancy outcomes (Katon et al., 2017a), hysterectomies compared to civilian population (Katon et al., 2017b), pregnancy-related disorders (Katon et al., 2014b), and comorbid medical and mental health conditions among women veterans with reproductive health diagnoses (Katon et al., 2015a).

Complexities

Several research studies set out to better understand the nature and experiences of specific physical health issues in women veterans, which reveal the interconnected nature of physical and mental well-being. For example, in identifying characteristics and outcomes of women veterans undergoing cardiac catheterization, Davis and colleagues (2015) conclude that this population tends to be younger and more likely to be living with obesity, depression, and posttraumatic stress disorder (PTSD). Similarly, in a study examining quality of life in women veterans with a diagnosis of fibromyalgia, D'Aoust and colleagues (2017) find a significant relationship between fibromyalgia and psychological symptoms of depression and PTSD. The co-existence of mental health difficulties in veteran women living with physical health conditions, more specifically with diverse reproductive health diagnoses, is also echoed in a study by Katon and colleagues (2015a). All of these papers conclude by highlighting the

significance of their findings on the importance of integrated health expertise and the need to better inform the development and implement of various interventions, programs, and policies aimed at supporting women veterans.

For women veterans living with musculoskeletal pain, authors are exploring the effectiveness of possible treatments such as chiropractic (Corcoran et al., 2017; Corcoran, Dunn, Green, Formolo, & Beehler, 2018) and yoga (Groessl et al., 2012).

Role of Military Service on Physical Health

The relationship between military events such as deployment and combat exposure on various aspects of physical health in women veterans was another sub-theme identified in the physical health literature. Haskell and colleagues (2012) conducted an observational study using VA administrative data to understand the prevalence of rates of musculoskeletal conditions of women and men veterans in the seven years after their deployment to Afghanistan and Iraq. With the same cohort, Haskell and colleagues (2017) explore cardiovascular risks. Wang, Lee, and Spiro (2015) investigated the relationship between warfare exposure and general health and determine that exposure to combat causalities may be a better predictive factor in health for men than women, in comparison to deployment to a war zone. However, Wang and colleagues (2015) highlight that "given the expansion of women's military roles […] in direct combat, their degree and scope of warfare exposure is likely to increase" (p. 35) and might alter this gender difference.

Given the unique work-related experiences of women veterans, research also explores their physical health experiences in comparison to their civilian counterparts. For example, when comparing self-assessment of health and access to health care services between civilians and military-connected women (e.g., veterans, active duty members, and National Guard or Reserves), civilian women, active duty women, and National Guard or Reserves women are found to rate their health and health access similarly (Lehavot et al., 2012). Women veterans in this study were found to consistently report poorer health (Lehavot et al., 2012). In their work on hormone therapy use in women veterans, Gerber and colleagues (2015) find that women veterans with a mental health diagnosis (i.e. mood disorder, anxiety disorder) are more than twice as likely than the general population to use hormone therapy during menopause. A study examining the active and passive smoking exposure and lung cancer incidence by Bastian and colleagues (2016) shows that although women veterans have higher rates of tobacco use and exposure to passive smoking compared to women civilians, they do not have a higher risk of lung cancer. A study aimed at determining cardiovascular disease (CVD) risk factors concludes that the prevalence and conditions of CVD among veterans accessing Veterans Affairs health care services is similar to that seen in the civilian population but veterans are more likely to have non-traditional CVD risk factor (e.g., depression) (Whitehead et al., 2019). Understanding

the increasing number of women veterans of childbearing age, McCabe and colleagues (2018) identify preconception risks of this population by comparing women with a service history and those without. They find that women veterans demonstrate a preconception health profile that presents as markedly different from their civilian counterparts, particularly in the areas of insufficient sleep and diagnosed depression (McCabe et al., 2018). Although this study did not go so far as to identify factors contributing to this difference, it adds to the growing body of knowledge of the impact that military work has on the health of women veterans. Research that compares the physical health experiences between civilian and women veteran populations increasingly highlights the health differences between them, and informs the quality of care provided to women veterans in both the military and civilian health systems.

Much of this segment of the research compares the physical health experiences between women veterans and men veterans including: **sexual behaviour** (Albright et al., 2019b); **obesity** (Breland et al., 2019); **pain and combat exposure** (Buttner et al., 2017); **cardiovascular disease** (Goldstein et al., 2014a; Haskell et al., 2017; Sambamoorthi et al., 2012; Virani et al., 2015; Whitehead et al., 2019; Wilmoth, London, & Parker, 2011); **medication use** (Inslicht & Neylan, 2018); **infertility** (Katon et al., 2014a); **rheumatoid arthritis** (Maynard et al., 2020); **disability after deployment injury** (Rivera et al., 2015a); **pulmonary hypertension** (Ventetuolo et al., 2017); and **diabetes** (Vimalananda et al., 2013a; Vimalananda et al., 2013b).

Findings of research examining sex differences in physical health conditions include: for traumatic limb loss resulting in amputation and prosthesis use, women and men report similarly high prevalence of physical and health conditions (Katon & Reiber, 2013) while women veterans report higher rates of prosthesis rejection and lower rates of prosthesis replacement (Katon & Reiber, 2013; Randolph et al., 2016; Resnik et al., 2020). The other area of physical health with a marked body of research was traumatic head injuries (Carlson et al., 2013; Cogan et al., 2020; Gray et al., 2020; Kim et al., 2018; McGlade et al., 2015). Neurobehavioral symptoms (e.g., headaches, cognitive skills) and the greater use of outpatient services are found to be more common among women veterans compared to their male counterparts (Carlson et al., 2013; Cogan et al., 2020; Gray et al., 2020).

Use of Medication

Studies exploring the impacts of prescription medication, particularly opioids, on the physical health of women veterans were also reviewed. Olvia and colleagues (2015) aim to better understand the sex differences in chronic pain management for individuals receiving care through the Veterans Health Administration (VHA) in the United States and find that women veterans are more likely than their male counterparts to receive an assortment of management strategies, including contraindicated and recommended polypharmacy. Another study examines opioid prescription and use among a sample of midlife women veterans living with

chronic pain (Gibson et al., 2019b). In this national sample of 104,984 women veterans, it was determined that evidence of menopausal symptoms is closely associated with potentially risky long-term opioid prescription patterns. Finally, a study that looks at the prescription of opioids with the VHA for women during pregnancy finds that a substantial proportion of these women are being prescribed opioids (Kroll-Desrosiers et al., 2016).

Multi-Factor Health

Overview

A total of 58 peer-reviewed articles in this collection relate to the relationship between mental health and physical health. This body of literature focuses on women veterans (*n*=33) and sex/gender differences (*n*=25) in the United States (*n*=54), Canada (*n*=2), and the United Kingdom (*n*=2). Research designs include primary research using quantitative (*n*=48), qualitative (*n*=2), or mixed (*n*=4) methodologies, as well as perspective pieces (*n*=2), a systematic review (*n*=1), and a literature review (*n*=1). Civilian comparisons are included in these analyses.

Research discussing multi-factor health issues shows clinical complexity (e.g., co-occurring or interacting mental health and physical health issues) between a range of mental health and physical health conditions including **posttraumatic stress disorder (PTSD)** (Beckie, Duffy, & Groer, 2016; Bradley et al., 2012a; Bradley, Nygaard, Hillis, Torner, & Sadler, 2017; Breyer et al., 2016; Cohen et al., 2012; Creech et al., 2019; Epstein, Martindale, Workgroup, & Miskey, 2019; Gibson, Li, Inslicht, Seal, & Byers, 2018; Gould et al., 2019; Hieda et al., 2019; Iverson et al., 2011; Iverson, Pogoda, Gradus, & Street, 2013c; Johnson, 2013; Kibler et al., 2018; Kuffer et al., 2019; Lee et al., 2019; Lippa et al., 2018; Mattocks et al., 2010; Maynard, Nelson, & Fihn, 2019; Nillni et al., 2020; Rivera & Johnson, 2014; Rivera, Krueger, & Johnson, 2015b; Runnals et al., 2013; Shivakumar, Anderson, & Suris, 2015; Stevelink & Fear, 2016; Szpunar, Crawford, Baca, & Lang, 2020; Turban, Potenza, Hoff, Martino, & Kraus, 2017; van Den Berk Clark, Chang, Servey, & Quinlan, 2018; Wachen et al., 2013; White et al., 2010; Wolf et al., 2013; Yaffe et al., 2019; Zhang et al., 2019; Ziobrowski, Sartor, Tsai, & Pietrzak, 2017), **depression** (Beckie et al., 2016; Bradley et al., 2012a; Bradley et al., 2017; Cheney et al., 2014a; Cohen et al., 2012; Creech et al., 2019; Driscoll et al., 2015; Duffy et al., 2015; Epstein et al., 2019; Gerber, King, Iverson, Pineles, & Haskell, 2018b; Kroll-Desrosiers et al., 2019a; Mattocks et al., 2010; Maynard et al., 2019; Nillni et al., 2020; Patel et al., 2016; Rivera & Johnson, 2014; Runnals et al., 2013; Shen, Findley, Banerjea, & Sambamoorthi, 2010; Shivakumar et al., 2015; Stevelink & Fear, 2016; Szpunar et al., 2020; Turban et al., 2017; White et al., 2010; Wilson, Nassar, Ottomanelli, Barnett, & Njoh, 2018a; Wolf et al., 2013; Yaffe et al., 2019; Ziobrowski et al., 2017), **reproductive and/or sexual health** (Beckie et al., 2016; Breyer et al., 2016; Callegari, Zhao, Nelson, & Borrero, 2015b; Callegari et al., 2014; Cohen et al., 2012; Judge-Golden, Borrero, Zhao, Mor, & Callegari, 2018; Kroll-Desrosiers et al., 2019a; Mattocks et al., 2010; Miller &

Ghadiali, 2018; Nillni et al., 2020; Patel et al., 2016; Rivera & Johnson, 2014; Shivakumar et al., 2015; Szpunar et al., 2020; Turban et al., 2017; van Den Berk Clark et al., 2018), **pain** (Beckie et al., 2016; Cohen et al., 2012; Creech et al., 2019; Driscoll et al., 2015; Epstein et al., 2019; Fenton, Goulet, Bair, Cowley, & Kerns, 2018; Haun, Paykel, Alman, Patel, & Melillo, 2020; Lee et al., 2019; Patel et al., 2016; Runnals et al., 2013; Thompson et al., 2015; Wilson et al., 2018a), **traumatic brain injury (TBI)** (Epstein et al., 2019; Iverson et al., 2011; Iverson et al., 2013c; Johnson, 2013; Lippa et al., 2018; Maynard et al., 2019; Yaffe et al., 2019), **cardiovascular issues** (Bradley et al., 2012b; Gibson et al., 2018; Hieda et al., 2019; Kibler et al., 2018; Shen et al., 2010; Wachen et al., 2013; Ziobrowski et al., 2017), **substance use** (Bradley et al., 2012b; Callegari et al., 2015b; Callegari et al., 2014; Gerber et al., 2018b; Stevelink & Fear, 2016; Ziobrowski et al., 2017), **cognitive impairment or neurological issues** (Gould et al., 2019; Iverson et al., 2011; Lwi et al., 2019; Wachen et al., 2013; Yaffe et al., 2019), **musculoskeletal issues** (Fenton et al., 2018; Serré, 2019; Thompson et al., 2015; Wachen et al., 2013; Ziobrowski et al., 2017), **anxiety** (Bradley et al., 2017; Creech et al., 2019; Mattocks et al., 2010; Nillni et al., 2020; Wolf et al., 2013), **bodily injury and/or disability** (Lippa et al., 2018; Rivera et al., 2015b; Thompson et al., 2015; Wilson et al., 2018a), **suicidal ideation or behaviour** (Duffy et al., 2015; Szpunar et al., 2020; Turban et al., 2017; Zhang et al., 2019), **overactive bladder or urinary incontinence** (Bradley et al., 2012a; Bradley et al., 2017; Creech et al., 2019; Wachen et al., 2013), **diabetes** (Creech et al., 2019; Gibson et al., 2018; Shen et al., 2010; Ziobrowski et al., 2017), **sleep issues** (Kuffer et al., 2019; Patel et al., 2016; Turban et al., 2017), **hormones or genes** (Kuffer et al., 2019; Wolf et al., 2013; Zhang et al., 2019), **hypertension** (Creech et al., 2019; Shen et al., 2010; Ziobrowski et al., 2017), **gastrointestinal issues** (Creech et al., 2019; Wachen et al., 2013; White et al., 2010), **health-related quality of life** (Der-Martirosian, Cordasco, & Washington, 2013; Vogt et al., 2020), **schizophrenia** (Duffy et al., 2015; Mattocks et al., 2010), **bipolar disorder** (Duffy et al., 2015; Mattocks et al., 2010), **headache** (Maynard et al., 2019; Ziobrowski et al., 2017), **body mass index** (**BMI)/weight** (Cheney et al., 2014a; Kibler et al., 2018), **irritable bowel syndrome (IBS)** (White et al., 2010), **borderline personality disorder** (Cheney et al., 2014a), **visual impairment** (Stevelink & Fear, 2016), **pulmonary issues** (Wachen et al., 2013), **coronary artery disease** (Gerber et al., 2018b), **fatigue** (Patel et al., 2016), and **parasitic infection** (Duffy et al., 2015).

Research often examines mental and physical health complexities among women and men veterans within the context of military-related experiences, such as **deployment stress and/or combat exposure** (Afari et al., 2015; Breyer et al., 2016; Cater & Koch, 2010; Conard & Scott-Tilley, 2015; Driscoll et al., 2015; Epstein et al., 2019; Iverson et al., 2011; Iverson et al., 2013c; Lee et al., 2019; Mattocks et al., 2010; Maynard et al., 2019; Rivera & Johnson, 2014; Rivera et al., 2015b; Runnals et al., 2013; Shivakumar et al., 2015; Turban et al., 2017; van Den Berk Clark et al., 2018; Vogt et al., 2020; Wachen et al., 2013; Zhang et al., 2019), **sexual assault** (Beckie et al., 2016; Bradley et al., 2017; Cheney et al., 2014a; Driscoll et al., 2015; Miller & Ghadiali, 2018;

van Den Berk Clark et al., 2018; White et al., 2010), and **polytrauma** (Cater & Koch, 2010; Kibler et al., 2018; Raggio, Sexton, Authier, & Rauch, 2016; Wolf et al., 2013; Ziobrowski et al., 2017). Sociodemographic factors such as **age** (Beckie et al., 2016; Der-Martirosian et al., 2013; Kibler et al., 2018; Lwi et al., 2019; Maynard et al., 2019; Patel et al., 2016; Shen et al., 2010; Thompson et al., 2015; Yaffe et al., 2019) and **social support** (Driscoll et al., 2015; Hawkins & Crowe, 2018a; Kroll-Desrosiers et al., 2019a; Stevelink & Fear, 2016; Thompson et al., 2015) also emerge in this research, but are emphasized to a lesser extent.

Social support and age interact with mental health and physical health complexities. One Canadian study shows greater odds of physical and mental health disability for women veterans than men veterans—a risk which may be augmented by low social support (Thompson et al., 2015). Similarly, the impact of visual impairment on women veterans' psychosocial well-being increases as social support decreases (Stevelink & Fear, 2016). The first year after military service appears to be particularly precarious for veterans' mental and physical health, and both women and men veterans may be less satisfied with their health-related quality of life than work or family relationships (Vogt et al., 2020). Despite a risk for post-service difficulties, social support facilitates community reintegration for women veterans with physical and psychological injuries (Hawkins & Crowe, 2018a).

Older women veterans (e.g., ages 65 and over) with MST have poorer physical and mental health than those who have not experienced MST (Der-Martirosian et al., 2013). Bradley et al. (2012a) find that women veterans with urgency urinary incontinence (leakage with urge or pressure to urinate immediately) or both urgency and stress urinary incontinence (urinary leakage while participating in an activity) smoke more, exercise less, and are more likely to have a history of head injury. They also show a relationship between post-deployment depression and stress urinary incontinence for women veterans with a history of sexual assault that can persist over time. Other research shows a risk for women veterans with lifetime sexual assault to have a BMI qualifying as obesity alongside depression and borderline personality disorder; this association may be stronger for older, less educated women (Cheney et al., 2014a) with comorbid PTSD, depression, IBS and/or pain (Beckie et al., 2016; White et al., 2010).

Drawing on data from the National Health and Resilience in Veterans Study, Ziobrowski et al. (2017) demonstrate key sex/gender differences in comorbid mental health and physical health outcomes when trauma is involved, showing a differential impact on women and men veterans by trauma type. Results of this study show that physical assault is associated with a greater risk for PTSD in women veterans and a greater risk for suicidal ideation, heart attack, and high blood pressure in men veterans. Moreover, this study finds that this relationship is stronger for men veterans, despite an established risk for depression in women veterans who have experienced sexual assault.

Medical releases due to mental health or physical health issues may have different patterning between women and men veterans. For example, a Canadian study by Serré (2019) reveals a higher proportion of medical releases due to musculoskeletal issues for women veterans than their men peers, despite no sex/gender differences in the proportion of medical releases related to mental health issues. They also demonstrate that medical releases due to mental health issues are higher among both women and men veterans that are 45 years of age and younger. Yet, this same study shows that under the age of 35, men veterans have higher odds of medical release due to mental health issues and women veterans have higher odds of medical release due to musculoskeletal issues. Moreover, this pattern is mirrored for women and men veterans releasing from the CAF with less than 10 years of service.

Despite many combinations of mental health and physical health complexities shown in this body of literature, on the one hand, PTSD and depression emerge as two of the most common mental health conditions studied alongside physical health conditions; one the other hand, reproductive and/or sexual health issues and pain are the top physical health conditions investigated in conjunction with mental health. Moreover, PTSD, depression, reproductive/sexual health, and pain are often examined together in a single study (Breyer et al., 2016; Cohen et al., 2012; Kroll-Desrosiers et al., 2019a; Nillni et al., 2020; Shivakumar et al., 2015; Szpunar et al., 2020; van Den Berk Clark et al., 2018). Due to the many different combinations of mental health and physical health complexities presented in this literature, the remaining discussion of multi-factor health research is structured within the four leading topics studied of PTSD, depression, reproductive and/or sexual health, and pain. As such, not every health issue previously outlined above is detailed below.

PTSD Complexities

The nature of military service can put women veterans at increased risk for trauma exposure, possibly more so than their peers in the general population, which renders them vulnerable to negative health sequelae from PTSD and physical health issues (Shivakumar et al., 2015; van Den Berk Clark et al., 2018). A consistent relationship is seen between PTSD and deployment-related TBI for both women and men veterans (Iverson et al., 2011; Iverson et al., 2013c). Research suggests that men veterans have a higher risk for PTSD and TBI (Maynard et al., 2019); yet women veterans with PTSD are more likely to have moderate-severe TBI, depression, and migraine headaches related to service injuries than men veterans (Epstein et al., 2019; Maynard et al., 2019). Women veterans also have a greater risk for concurrent depression, anxiety, and neurobehavioral issues alongside TBI and PTSD than their men counterparts (Iverson et al., 2011). Yaffe et al. (2019) find in their cohort study that women veterans, ages 55 and over, with TBI, PTSD, and depression related to military service are 50-80% more likely to develop dementia, and this risk doubles for women living with more than one of these health issues. Further, the relationship between PTSD and TBI puts women veterans at risk for

neurobehavioral symptoms (affective, e.g., irritability; somatosensory, e.g., nausea; cognitive, e.g., poor concentration; vestibular, e.g., loss of balance) (Iverson et al., 2011; Lwi et al., 2019), and women veterans with cognitive impairment are at increased risk for comorbid medical and psychiatric disorders (Lwi et al., 2019). Women veterans with comorbid PTSD and TBI can also experience challenges as they transition to the civilian workforce due to the resulting levels of disability from this comorbidity (Johnson, 2013). For example, post-concussion somatosensory symptoms (e.g., headaches, nausea, light sensitivity, hearing difficulties, numbness, changes in taste, smell or appetite) appear to increase for women veterans who are also diagnosed with PTSD, which impacts functionality (Lippa et al., 2018).

Research indicates PTSD may be predictive of cardiovascular disease among women veterans (Gibson et al., 2018; Hieda et al., 2019; Kibler et al., 2018), and this relationship is stronger with comorbid PTSD and diabetes (Gibson et al., 2018). A study by Wachen et al. (2013) shows an association between combat-related posttraumatic stress and poor post-deployment physical health outcomes, including cardiovascular issues, among others (e.g., dermatological, gastrointestinal, genitourinary, musculoskeletal, neurological, and pulmonary issues), that holds equally for women and men veterans. Higher blood pressure levels and BMI are also seen in women veterans with PTSD (Kibler et al., 2018).

Depression Complexities

Much of the research on depression is examined together with PTSD (Beckie et al., 2016; Bradley et al., 2012a; Bradley et al., 2017; Cohen et al., 2012; Creech et al., 2019; Epstein et al., 2019; Maynard et al., 2019; Nillni et al., 2020; Rivera & Johnson, 2014; Runnals et al., 2013; Shivakumar et al., 2015; Stevelink & Fear, 2016; Szpunar et al., 2020; Turban et al., 2017; White et al., 2010; Wolf et al., 2013; Yaffe et al., 2019; Ziobrowski et al., 2017). For example, Creech et al. (2019) identify key mental health and physical health comorbidities through a systematic review of clinical complexity in women veterans. They find that PTSD, depression, and anxiety commonly present alongside diabetes, hypertension, chronic pain, gastrointestinal disorders, and urogenital issues (Creech et al., 2019). PTSD and depression are also linked to comorbid irritable bowel syndrome (IBS) in women veterans who have experienced sexual assault (White et al., 2010).

Women veterans living with depression are at risk for comorbid diabetes, heart disease, and hypertension (Shen et al., 2010). Similarly, the odds of women veterans developing coronary artery disease increases by 60% with comorbid depression, especially among those who smoke and are over the age of 45 (Gerber et al., 2018b). Concomitant depression and spinal cord injury is common for veterans and can negatively impact women veterans' life satisfaction (Wilson et al., 2018a).

Reproductive and Sexual Health Complexities

Research by Rivera and Johnson (2014) suggests women veterans have higher rates of reproductive health issues than the general population. Women veterans living with mental health issues, such as PTSD and depression, show increased risk for reproductive health complications including infertility, pain-related conditions (e.g., dysmenorrhea), polycystic ovarian syndrome, sexually transmitted illness, and increased risk of hysterectomy, both during and after military service (Cohen et al., 2012; Shivakumar et al., 2015; van Den Berk Clark et al., 2018). In addition, women veterans are at risk for developing mental health issues during pregnancy, and women veterans with a history of suicidal ideation are at increased risk for depression in their postpartum period (Szpunar et al., 2020). Turban et al. (2017) demonstrate a correlation between hypersexuality, sexually transmitted infections (STIs), suicidal ideation, PTSD, insomnia, and depression, particularly among men veterans, that is linked to their higher propensity toward using digital social media to find sexual partners than women veterans. Likewise, a cohort study of US war veterans reveals a higher risk for sexual dysfunction diagnoses among men veterans with PTSD than their women veteran counterparts (Breyer et al., 2016).

A history of mental illness is associated with a greater number of unintended pregnancies in women veterans, especially among those women with comorbid mental health disorders (Judge-Golden et al., 2018; Miller & Ghadiali, 2018). For example, women veterans with a substance use disorder are less likely than those without to use and adhere to prescription contraception, increasing their risk for unintended pregnancy (Callegari et al., 2015b; Callegari et al., 2014). Pregnant women veterans may be at greater risk for having depression than the general population, and this risk is augmented for women with active duty service and past anxiety (Kroll-Desrosiers et al., 2019a). PTSD and moral injury are highlighted as predictors for adverse pregnancy outcomes (e.g., preterm birth, gestational diabetes) as well as postpartum depression and anxiety (Nillni et al., 2020). Both unintended pregnancy and pregnancy loss are key perinatal stressors that put women veterans at risk for developing mental health issues (Miller & Ghadiali, 2018). Moreover, women veterans can face comorbid mental health issues with pregnancy following deployment. For example, Mattocks et al. (2010) find pregnant women veterans are twice as likely to be diagnosed with depression, anxiety, PTSD, bipolar disorder, or schizophrenia following deployment than their non-pregnant counterparts. Additionally, military sexual harassment is associated with mental health issues (e.g., emotional disturbances) for women veterans both during and after pregnancy (Miller & Ghadiali, 2018).

Pain Complexities

Chronic pain is commonly recognized among US veterans in their first year after military service (Vogt et al., 2020). Chronic pain increases the likelihood of disability for both women and men veterans, and can place significant limitations on their activity levels; specific to women

veterans, this may especially be the case among women ages 50 to 79 years with comorbid mental health issues (Patel et al., 2016; Thompson et al., 2015). For example, post-menopausal women veterans with moderate to extreme pain have less physical function and more symptoms related to depression, fatigue, and insomnia than those with lower levels of pain (Patel et al., 2016).

Different patterns between women and men veterans with pain and comorbid mental health issues may depend on the source of injuries leading to pain. For instance, pain is linked to a higher likelihood of PTSD for both women and men injured during deployment, and this association is stronger among men veterans with combat exposure (Lee et al., 2019). Conversely, a complex relationship between pain, PTSD, and depression is stronger for women veterans with deployment-related back pain and migraine headaches (Runnals et al., 2013). Despite a higher propensity for women veterans than men veterans to have temporomandibular disorders (TMDs), a painful musculoskeletal condition, little differences are seen between women and men veterans with comorbid TMDs and mental health issues (Fenton et al., 2018). Research shows an increased risk for men veterans to experience depression with spinal cord injuries when pain is present; women veterans experiencing depression alongside spinal cord injuries are at risk for reduced life satisfaction (Wilson et al., 2018a). Women veterans with chronic pain report more childhood interpersonal trauma and MST, but less combat exposure, than men veterans (Driscoll et al., 2015). Both women and men veterans with multiple, concurrent injuries (polytrauma) are at risk for comorbid mental and physical health sequelae (Cater & Koch, 2010).

Health Care Access & Utilization

Overview

A total of 175 articles were identified as peer-reviewed articles in this section addressing the access, evaluation, and utilization of health care programs, supports, and services aimed at supporting women veterans. Most of the papers reviewed on this topic are research studies, however, a few commentary or 'call-to action' papers are included (Lloyed-Hazlett, 2016; Yano & Hamilton, 2017). Among the research papers, there is a mix of quantitative (Amara et al., 2014b; Weimer et al., 2013), qualitative (e.g., Lehavot, Der-Martirosian, Simpson, Shipherd, & Washington, 2013; Macdonald et al., 2020), and mixed method (Cordasco et al., 2015b; Miller & Ghadiali, 2015) approaches represented.

Most of the articles were completed in the United States, with the exception of one paper from Australia (Warner, Neuhaus, Avery, & Davies, 2019), one from the United Kingdom (Bergman, Frankel, Hamilton, & Yano, 2015a), and one which was a dual country submission that included the United States and Canada (Sedlander et al., 2018).

Women Veterans' Access and Utilization Patterns

Research related to health care access and utilization is organized as realities and experiences of women veteran service users, health care providers, and the systems in which these interactions occur.

Geographical Factors

There are ten papers that explicitly address program and service access facilitators and barriers as related to geography. Papers, by Brooks, Dailey, Bair, and Shore (2014; 2016), Ingelse and Messecar (2016), and Mengeling, Sadler, Torner, and Booth (2011) describe the population demographics and health utilization patterns of rural women veterans enrolled in VA programs to inform service improvement initiatives. Addressing the well-known health disparities that exist between rural and urban-dwelling Americans, Cardasco and colleagues (2016) conducted a national survey to address the specific issues among these women. The relationship between travel time to VA services and attrition was the subject of the study by Friedman et al. (2015), which determined that these two phenomenon were directly related.

Socioeconomic Factors

Although more thoroughly developed in another section of this report, socioeconomic factors are identified as having a role in women veterans' access to health care services. For example, food insecurity is associated with delaying seeking access to health care services among women veterans (Narain et al., 2018a; Narain et al., 2018b; Shen & Sambamoorthi, 2012) as was unstable housing (Copeland, Finley, Vogt, Perkins, & Nillni, 2020; Shen & Sambamoorthi, 2012). Specific to mental health care services within the VA, low income is found to predict nonuse among women veterans (Lahavot et al., 2015; Washington, Davis, Der-Martirosian, & Yano, 2013b).

Role of Technology

Technology is viewed as a possible solution or alternative to challenges of accessing veterans' health services due to factors such as geography (Brooks et al., 2014), treatment seeking stigma (Williston, Bramande, Vogt, Iverson, & Fox, 2020), and limited program access (Morland et al., 2015). Several different terms are used in the papers speaking to technology-based service solutions including: **mobile** (Armstrong, Ortigo, Avery-Leaf, & Hoyt, 2019); **telehealth** (Azevedo, Weiss, Webb, Gimeno, & Cloitre, 2016; Goode et al., 2020; Jaconis, Santa Ana, Killeen, Badour, & Back, 2017; Kotzias et al., 2019); **virtual consultation** (Cordasco et al., 2015b); **web-based** (Moin et al., 2015); **telemental** (Moreau et al., 2018); **telemedicine** (Morland et al., 2015; Morland et al., 2019; Tan et al., 2013); **mobile application** (Riordan, Alexander, & Montgomery, 2019); **remote management** (Sedlander et al., 2018); **portal intervention** (Dang et al., 2019); and **telephone-based** (Mattocks et al., 2017b).

Technology-based care is a relatively new method of delivering health services and as expected there are a number of papers introducing or piloting these new approaches (Azevedo et al., 2016; Cordasco et al., 2015b). These innovations are discussed in a variety of contexts including utilization to provide **patient education** (Cordasco et al., 2015b; Dang et al., 2019), **reducing health disparities** (Azevedo et al., 2016; Moreau et al., 2018), **provide programming and treatment for physical health conditions** (Dang et al., 2019; Goode et al., 2020; Moin et al., 2015; Riordan et al., 2019; Tan et al., 2013), **provide programing and treatment for mental health conditions** (Azevedo et al., 2016; Jaconis et al., 2017; Kotzias et al., 2019; Morland et al., 2015), and **program coordination** (Mattocks et al., 2017b). There are also papers that describe studies identifying preferences of women veterans and the use of technology as well as other considerations aimed at care providers (Armstrong et al., 2019; Morland et al., 2019; Sedlander et al., 2018).

Utilization & Attrition

The utilization of health services aimed at supporting women veterans are all conducted within the context of the Veterans Health Administration (VHA). There are a number of studies examining the utilization patterns and differences between women and men in various situations including: **spinal cord injury care** (Curtin, Suarez, Di Ponio, & Frayne, 2012); **mild traumatic brain injury** (Amara et al., 2014b; Rogers et al., 2014); **time since returning from deployment** (Duggal et al., 2010; Haskell et al., 2011); **management of chronic pain** (Bade et al., 2019; Evans et al., 2018c; Murphy, Phillips, & Rafie, 2016; Weimer et al., 2013); and **access to supports for mental health issues** (Ahlin & Douds, 2018; Bachrach, Blosnich, & Williams, 2019; Breland, Greenbaum, Zulman, & Rosen, 2015b; Gallegos et al., 2015; Stefanovics & Rosenheck, 2020; Valenstein-Mah et al., 2019).

Many of the papers conclude that women veterans are more likely to access VHA services compared to men (Curtin et al., 2012; Duggal et al., 2010; Evans et al., 2018c; Finlay et al., 2015; Valenstein-Mah et al., 2019). In fact, one of the papers states that over the five-year period of the study, the use of VHA maternity benefits increased by 44% (Mattocks et al., 2014a) supporting another study indicating that gender-specific care (e.g., pregnancy) saw an 133% increase resulting in nearly $1500 cost of care per woman between 2000 and 2008 (Yoon, Scott, Phibbs, & Frayne, 2012). This is partially attributed to an increase in the number of women enlisted in the military (Mattocks et al., 2014a; Yoon et al., 2012). The other area where there is notable difference in utilization patterns is in mental health services, where women veterans appear to have both elevated risk for mental health difficulties and increased use for VHA supports compared to men (Finlay et al., 2015; Fontana, Rosenheck, & Desai, 2010; Hoffmire, Kemp, & Bossarte, 2015; Maguen et al., 2012a).

However, it is important to note that socioeconomic changes in a women veterans' situation, such as unstable housing at marital separation, have been found to be associated with a decrease in accessing health care including through VHA (Copeland et al., 2020; Delcher, Wang, & Maldonado-Molina, 2013). This is echoed by another study that finds lower income to be a predictor to accessing VA mental health care for women (Di Leone et al., 2013). Utilization rates were also lower for women veterans in a study that examined VHA service access the year after service in Iraq and Afghanistan for US troops (Leslie et al., 2011).

The counterbalance to the literature examining *utilization* of VHA services by women veterans is the research exploring issues connected to *attrition* or barriers impacting ongoing utilization. Cited in a paper by Hamilton, Frayne, Cordasco, and Washington (2013a), for women veterans there is a 30% attrition rate within 3 years of initially accessing the VHA. Hamilton and colleagues (2015a) identify that having alternate insurance coverage and greater distance to VA sites of care are the most common reasons that women veterans decide to stop using VHA services. The relationship between longer time spent driving to health services and the lower likelihood of accessing services are also identified in a paper by Friedman and colleagues (2015). Another study reveals that women becoming pregnant is a significant reason for attrition (Katon et al., 2015c).

Two significant factors that increase the likelihood of attrition of women veterans from VHA services are perceptions of gender bias (Mattocks et al., 2020; Newins et al., 2019) and experiences of harassment at VA health care settings (Di Leone et al., 2013; Dyer et al., 2019a; Klap et al., 2019; Moreau et al., 2020).

Women Veterans' and Health Care Providers' Experiences

Women Veterans' Experiences

There is a large volume of papers exploring women veterans' experiences of health care programs and services that are important for program evaluation and needs identification. Typically, these same papers also explored the preferences of women veteran health care users.

There are papers that aim to enhance knowledge on **women veterans' experiences** with the entire VA health system, providing important information on how the system is meeting the overall needs of women veterans (Aronson et al., 2019; Bidassie et al., 2020; Chanfreau-Coffinier et al., 2019; Davis et al., 2016; Friedman et al., 2011; Hamilton et al., 2017; Mattocks et al., 2018; Washington, Farmer, Mor, Canning, & Yano, 2015). Poor continuity of care between military and veteran health care systems, the need for information about VA services, gender bias, negative interactions with health care providers, and feelings of being unsafe are

some of the reported experiences of women veterans in the VHA (Chanfreau-Coffinier et al., 2018; Evans, Washington, Tennenbaum, & Hamilton, 2019; Mattocks et al., 2020; Wagner, Dichter, & Mattocks, 2015). Positive experiences such as feeling respected, being provided with comprehensive health information (Callegari et al., 2019b; Wagner et al., 2015), and general positive perception of VA services are also identified (Mattocks et al., 2020; Mengeling et al., 2011; Washington et al., 2015).

Other studies are interested in understanding women veterans' experiences within specific programs. For example, women veterans describe negative experiences with family planning counseling throughout their interactions with the VA that included perceptions of gender-based discrimination, perceived judgment around their reproductive choices and lack of continuity of care by providers (Callegari et al., 2019b; Gray et al., 2015; Katon et al., 2013; West & Lee, 2013). Another study of women veterans with the VA Department of Maternal Care finds that first-time mothers welcomed the availability of pre- and post-natal classes and that coordinators are helpful in navigating the system (Katon et al., 2018a). Women veterans going through menopause feel that not all of their VHA providers are knowledgeable about menopause (Dietz et al., 2018).

Stigma is commonly identified as a factor influencing women veterans' willingness to seek out health supports through VA or to continue to access them (Cheney, Dunn, Booth, Frith, & Curran, 2014b). There are two distinct 'types' of stigma cited in the literature: stigma related to mental health (Harding, 2017) and stigma related to being a woman (Grindlay et al., 2017).

Stigma as a barrier is identified through many articles exploring experiences of women veterans in mental health care (Katon et al., 2017c; Kimerling et al., 2015b; Kimerling et al., 2016b; Newins et al., 2019; Tsai, Mota, & Pietrzak, 2015; Williston et al., 2020). In a study exploring the nature of health care discussions regarding alcohol consumption, researchers find that stigma, shame, and discomfort in addition to co-occurring mental health difficulties are barriers (Abraham, Lewis, & Cucciare, 2017a; Abraham et al., 2017b). In a paper by Ingelse and Messecar (2016), feelings of stigmatization are also described as a significant barrier for women veterans living in rural communities in their experience of accessing mental health care.

Gender bias is described as contributing to stigma related to being a woman and appears to influence help-seeking behaviours as it related to pain management (Giannitrapani et al., 2018; Driscoll et al., 2018) and reproductive issues (Edmonds et al., 2019; Grindlay et al., 2017).

Experiences of **harassment** at VA health care settings features prominently in a number of papers (Di Leone et al., 2013; Dyer et al., 2019a; Klap et al., 2019; Moreau et al., 2020). Descriptions of these incidents include catcalls, sexual and/or derogatory comments, propositions, stalking, and disparagement of veteran status (Klap et al., 2019). Sexual

harassment within the properties of the VA is a unique predictor for discontinuing services by women veterans (Di Leone et al., 2013) and is confirmed to be a substantive gender difference among service users (Dyer et al., 2019b). Women veterans reporting sexual harassment at VA medical centres are more likely to have a history of MST or exposure to other trauma and thus, are thus less likely to feel welcomed (Klap et al., 2019).

Health Care Providers' Experiences

Health care service provision is a bi-directional relationship. Therefore, research conducted to understand the experiences of health care providers working with women veterans as well as research to support their work is an important group of literature requiring careful consideration. Care providers identify that they struggle with how to offer services to women veterans, and suggest that a tailored, gender-sensitive approach is important (Fox et al., 2016; Hamilton et al., 2020; Than et al., 2020; Zuchowski et al., 2017). The need for women-specific service provision is the subject of the work by Brunner, Cain, Yano, and Hamilton (2019) that explores perspectives of health care providers within the context of their work to identify specific needs for the women veteran population with whom they work. When describing ideal care, participants highlight, among many others, the need for separate primary care services from men, expanded reproductive health services, fostering active interest in women's health across the program, and prioritizing women's health in the VHA (Brunner et al., 2019). From the perspective of women veterans, the overall experience of outpatient care appears to be better than women receiving care from non-designated health care providers (Bastian et al., 2014) including increased health screenings (Bean-Mayberry et al., 2015; Weitlauf et al., 2013). The evidence appears to support a gender-sensitive approach to care; however, it is important to note that this shift in service delivery is not without its challenges (Bergman et al., 2015a).

Successful efforts have been made to provide staff training aimed at eliminating barriers to quality care and enhance positive attitude toward women veterans, as described by Meredith and colleagues (2017b). Reviews of current, relevant, and gender-sensitive tools available is the subject of service provider studies with nurse practitioners (Fitzgerald, 2010), emergency room staff (Cordasco et al., 2015a; Cordasco et al., 2013), and mental health professionals (Kroll-Desrosiers, Crawford, Moore Simas, Clark, & Mattocks, 2019b; Ramchand et al., 2016; Pomernacki et al., 2015).

The Patient Aligned Care Team (PACT) is an initiative aimed to safeguard that patients receiving services from the VHA receive care that is consistent with medical home principles. The PACT was the subject of a program evaluation paper by Chuang et al. (2017) that identifies barriers and facilitators from primary care providers and staff.

Women Veterans' Preferences

Many of the papers explore women veterans' preferences for their health care services. The importance of seeking out women veterans' voices and actively integrating these voices into research was emphasized by these authors (Brunner et al., 2019; Callegari et al., 2019b; Dekleijn, Lagro-Janssen, Canelo, & Yano, 2015; Dietz et al., 2018; Dyer et al., 2020; Evans et al., 2019; Goldstein et al., 2017a; Katon et al., 2018a; Kotzias et al., 2019; Mengeling et al., 2011; Morland et al., 2019; Newins et al., 2019; Rohrer et al., 2011; Sedlander et al., 2018; Shamaskin-Garroway et al., 2018; Thomas et al., 2017; Trentalange et al., 2016; Wagner et al., 2015; Washington, Bean-Mayberry, Mitchell, Riopelle, & Yano., 2011; Washington, Bean-Mayberry, Hamilton, Cordasco, & Yano, 2013; Washington & Yano, 2013; Washington et al., 2015). For some women veterans there were preferences for technology-based treatment solutions (Dyer et al., 2020; Mengeling et al., 2011; Morland et al., 2019). There is a strong preference for women-centred programs and services (Brunner et al., 2018; Dietz et al., 2018; Goldstein et al., 2017a; Katon et al., 2018a; Sedlander et al., 2018) particularly when there are efforts towards military culturally-competent care (Dyer et al., 2020; Kotzias et al., 2019). Other preferences indicated in this group of literature include: non-primary care physical health services (Newins et al., 2019); expanded mental health services (Newins et al., 2019); use of technology to support periods of time between visits (Sedlander et al., 2018); and creating social networks as a resource (Evans et al., 2019; Lahavot et al., 2013b; Wagner et al., 2015).

Military Cultural Competency and Gender Sensitivity

The need for health care services to be sex- and gender-sensitive as well as culturally competent is identified throughout much of the literature on health care access and utilization. Cultural competency pertains to the military culture to which women veterans belong and how this may play a role in the access and use of health programs and services. Sex and gender sensitivity speaks to recognition of the unique qualities of a veteran given their sex and gender and how this may inform the access and use of health programs and services. Throughout the examined literature, there is acknowledgement that there are different health care needs between women veterans and men veterans, therefore, informing exploratory work done by many researchers. Identifying the specific health need differences between women and men is one of the first steps informing gender-sensitive programs and services. For example, there are differences in service access (Bade et al., 2019; Driscoll et al., 2018; Goldstein et al., 2019a; Harrington et al., 2019; Moore, Gao, & Shulan, 2015; Vance, Alhussain, & Sambamoorthi, 2019; Washington, Bean-Mayberry, Riopelle, & Yano, 2011), access to prevention programs (Cavanagh et al., 2020; Danan et al., 2019; Gunter-Hunt et al., 2013; Lairson et al., 2011; Lilienthal et al., 2017; MacGregor et al., 2011; Mattocks et al., 2019a; Mattocks et al., 2019; Washington et al., 2019), demographic differences for specific conditions (Curtin et al., 2012; Grossbard et al., 2013; Rinne et al., 2017), predictors to accessing mental health care (Di Leone

et al., 2013; Elnitsky et al., 2013; Fox, Meyer, & Vogt, 2015; Lam et al., 2017), and program and service utilization patterns (Duggal et al., 2010; Ersek et al., 2013; Etingen et al., 2020; Heslin et al., 2013).

Military Cultural Competency

Simply inquiring about a women's military service has been found to be an important first step in establishing rapport as well as highlighting potential health issues for which women veterans may be at increased risk (Chuang et al., 2017; Conard & Armstrong, 2017; Conard, Armstrong, Young, & Hogan, 2015; DeLeone et al., 2015; Harding, 2017; Levander & Overland, 2015; National Library of Medicine, 2012). In addition, it is also important to understand the role of specific military related activities such as deployment (Koblinsky, Schroeder, & Leslie, 2017; Lloyed-Hazlett, 2016; Ryan et al. 2015; Weitlauf et al., 2020) and how this may have an impact on the type of services provided (Kotzias et al., 2019; Hack, Deforge, & Lucksted, 2017; Zephyrin, 2016). Interestingly, only one paper identifies the need to address cultural shifts experienced by women when becoming a civilian once again (Villagran, Ledford, & Canzona, 2015).

Sex and Gender Sensitivity

Sex- and gender-sensitive providers and services are discussed a great deal in this group of articles, emphasizing the importance of not only recognizing the differences in the manifestation of health issues between women and men but also the importance of adequately addressing them in the effort to create targeted prevention and treatment strategies (Huang & Ramoni, 2019; Hughes, 2011; Lapham et al., 2013; Maguen, Ren, Bosch, Marmar, & Seal, 2010; Whitehead et al., 2014). One study finds that gender sensitivity varies, specifically in mental health care (Oishi et al., 2011).

The degree to which health care personnel such as nurses, medical assistants, and clerks are sensitive to the role of gender on the care of women veterans is investigated by Tan and colleagues (2013). They find that prior work with women in addition to working in rural locations is associated with greater gender sensitivity compared to those with more years of VA service (Abraham et al., 2017a). The willingness to create a gender-sensitive health environment as a result of prior experience working with women is echoed in a paper by Reddy, Rose, Burgess Jr., Charns, and Yano (2016). The study finds that VA facilities with greater capacity (e.g., academic affiliation, knowledge of women's health) to support a women's health clinic are more likely to adapt one (Reddy et al., 2016). For some professions within the VA, they identify the need for a women-specific model of care to inform their services (Roberts, Kovacich, & Rivers, 2018; Yano, Haskell, & Hayes, 2014; Yano et al., 2016).

The call for increased gender sensitivity is also highlighted for women veterans living with specific health issues such as smoking cessation (Farmer, Rose, Riopelle, Lanto, & Yano, 2011),

chronic pain (Driscoll et al., 2018), posttraumatic stress disorder (Fontana et al., 2010), substance use disorders (Heslin, Gable, & Dobalian, 2015; Hoggatt, Simpson, Schweizer, Drexler, & Yano, 2018; Lewis et al., 2016), eating disorders (Huston, Iverson, & Mitchell, 2018), contraceptive care (Wolgemuth et al., 2020) and general mental health (Miller & Ghadiali, 2015; Kroll-Desrosier et al., 2020; Sayer et al., 2014; Williams et al., 2018; Yee et al., 2011).

From a systems perspective, a modified Delphi study was conducted to ensure that women veterans have access to comprehensive care in a space that is sensitive to their needs (Dekleijn et al., 2015). The 14 priority recommendations fall into three broad themes: design and provision of services sensitive to trauma histories; integrating preferences and information needs identified by women; and sex awareness and cultural transformation in every aspect of VA process (Dekleijn et al., 2015).

From a user's perspective, as described in the reviewed literature, women veterans generally felt welcomed to VA but acknowledged that there should be more opportunities to make women feel more welcomed when the issue was examined in a study by Moreau et al. (2020). It is also noteworthy that another study, completed by Macdonald et al. (2020) concludes that one-third of women veteran participants perceive gender-based care discrimination in the VA.

Health Research

A total of 24 sources were identified relating to health research. The majority of this research was based in the United States (*n*=21), with the exception of two sources from Australia and one from Canada. The importance of expanding research efforts in the area of women veterans' health and transition outcomes is a common theme in this group of literature (Eichler, 2016; Goldstein et al., 2019b; Yano et al., 2010; Yano, 2015). In fact, the article by Eichler (2016) poses specific questions (e.g., "how does a sexualized and gendered military culture impact the health and well-being of Canadian military members and Veterans?", p. 7) that researchers should ask themselves when engaging in gendered military and veteran health research. In the article by (Frayne et al., 2013), the authors share that "while women have served in the US military conflict since the American Revolution, the Veterans Health Administration (VHA) [has] paid little heed to the specific needs of women Veterans for much of its early history" (p. S.504). Acknowledging women's increasing role in the armed forces as well as their unique health experiences, there is a call within the VA for work to be done to support women veterans. The paper by (Frayne et al., 2013) provides an overview of the Veteran Affairs Women's Health Practice-Based Research Network (WH-PBRN), an organization created in support of women veterans' health research through a network of VHA partnered facilities. To address the expanding participation of women in the US military, the Society for Women's Health Research (SWHR) convened a one-day conference to share research focused on the

needs of this specific population as described in a paper by Resnick, Mallampalli, and Carter (2012).

Bastian, Bosworth, Washington, and Yano (2013) wrote an introduction to the supplement of the Journal of General Internal Medicine aimed at disseminating new research findings on the health and health care of military and veteran women in the United States. The editors of this special edition organize the research into six main topic areas which have been previously identified as important areas for the VHA: access to care and rural health; primary care and prevention; mental health; health concerns associated with military deployment; complex chronic conditions/aging and long-term care; and reproductive health (Bastian et al., 2013).

Polomano and Stringer (2012) completed the introduction to a special "In Focus" series in an issue of *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, showcasing nursing research on the health of servicewomen and women veterans. The featured articles include topics such as: experiences of nurses in combat support hospitals; pregnancy and contraceptives; sexual transmitted diseases among deployed women; living with deployment related trauma and PTSD; and combat-related fatalities and injuries (Polomano & Stringer, 2012)

The state of women veterans' health research is the subject of systematic reviews (Bean-Mayberry et al., 2011a; Bean-Mayberry et al., 2011b). The authors note that although research methods are mostly observational in nature there is movement towards more analysis. As well, the reviews conclude that there is growth in the breadth and depth of the literature, however, there remain gaps in research on post-deployment adjustment for veterans and their families and quality of care outcomes of interventions for health conditions (Bean-Mayberry et al., 2011a; Bean-Mayberry et al., 2011b).

More recently, a 2017 literature review was conducted to help inform policy development and research planning (Danan et al., 2017). Consistent with the findings published by Bean-Mayberry et al. (2011a), Bean-Mayberry et al. (2011b), and Danan et al. (2017) conclude that observational studies, focused on data collection, for example, through interviews and focus groups, make up the bulk of the existing literature, adding that this body of research also focuses on mental health. Research gaps identified in this paper include a lack of sex-specific results in studies that compare differences between women and men, particularly when discussing chronic conditions, as well as the need for randomized trials in intervention studies (Danan et al., 2017).

A scoping review by Englert and Yablonsky (2019) identifies gaps in knowledge related to the health of women in the US military, concluding that the majority of the papers are in the areas of obstetric-gynecologic health and mental health. Englert and Yablonsky (2019) also state that there are minimal research papers reporting experimental or quasi-experimental designs.

Some reviews look at specific health-related issues in military-connected women. For example, Lacks, Lamson, Rappleyea, Russoniello, and Littleton (2017) conducted a systematic review of the current research around biopsychosocial-spiritual health of active duty women. The authors conclude that there is notably more information about the biological health issues compared to psychological and social health of these women. In addition, the study indicates that there is very little published literature on the interconnectedness of biological, social, psychological, and spiritual health, thus recommending additional research. Interestingly, a rapid review by Oster, Morello, Venning, Redpath, and Lawn (2017) comes to a different conclusion, finding that there is quite a bit of interconnectedness in the literature of the mental, physical, and social health of veterans. Another example of specific-health related systematic reviews can be found in work by Lawrence-Wood et al. (2016) that examines the effects of military service on the sexual and reproductive outcomes in servicewomen and women veterans. Women's health issues, such as menopause and post-menopause health, fertility, and breastfeeding, are inadequately addressed in the literature (Lawrence-Wood et al., 2016). Other areas which authors examine in the existing literature include: servicewomen, veterans, and their families (Mankowski & Everett, 2016; Sahlstein Parcell & Baker, 2018); and veteran women and suicidality (Hoffmire & Denneson, 2018).

There is evidence of knowledge translation in the area of military and veteran women's health research (Yano et al., 2011; Yano & Frayne, 2011). An article by Eagan (2019) provides an overview of the research literature while highlighting the knowledge gaps and barriers to care as related to menstrual regulation or suppression for active-duty women and provided clinical recommendations to enhance obstetric and gynecological care. Similar efforts can be seen in a paper by Ghahramanlou-Holloway, Cox, Fritz, and George (2011) that functions as an evidence-informed guide for psychologists providing assessment and treatment for military-connected women. Muirhead et al. (2017) reviewed select literature, VA resources, and spoke to subject matter experts to identify critical questions for nursing professionals when working with women veterans. For health professionals working with Australian servicewomen and female veterans, Neuhaus and Crompvoets (2013) summarize research findings addressing: gender-specific health effects of service; physical standards and training; sexual and reproductive health; mental health and well-being, and maternal relationships; and health service equity.

Sexual Violence/Military Sexual Trauma (MST)

Military sexual trauma as defined by the US Department of Veterans Affairs refers to "sexual assault or repeated, threatening sexual harassment" experienced during military service (United States Department of Veterans Affairs, 2015). MST is a central topic in the reviewed literature, and is discussed primarily in relation to its potential health sequelae, especially mental health sequelae, and the provision and utilization of care for serving member and

veterans who are MST survivors. The literature examines these questions as they pertain to women with MST specifically, and MST survivors as a whole—sometimes, but not always, with attention to sex and/or gender differences. A total of 151 sources were identified relating to sexual violence or MST in relation to MCT writ large, and all of this research is based out of the United States. Most of the research was conducted by the VA/VHA itself and based on the population of VA/VHA users. Our review does not include the full scope of existing literature on MST, but rather only the MST literature that is pertinent to MCT outcomes. We therefore do not capture literature pertaining to other MST-related issues, for example, on MST incidents themselves, reporting/non reporting/reporting by a 3rd party, or institutional responses and peer responses to the reporting.

The reviewed literature includes four review articles, including one systematic review (Pulverman, Christy, & Kelly, 2019a), one comprehensive review (Pulverman & Creech, 2019), one literature review (Romaniuk & Loue, 2017), and one meta-analysis (Wilson, 2018). The vast majority of articles rely on quantitative methods such as self-report questionnaires, surveys, statistical analysis of health and sociodemographic data, retrospective cohort studies, and more. There is a small but notable number of articles that draw on qualitative research methods, such as phenomenology (Brownstone, Gerber, Holliman, & Monteith, 2018; Freysteinson et al., 2018; Monteith et al., 2018; Monteith, Gerber, Brownstone, Soberay, & Bahraini, 2019a), narrative approaches (Dichter, Wagner, & True, 2018), ethnography (Hannagan, 2017), grounded theory (Zaleski & Katz, 2014), or findings from semi-structured qualitative interviews (Katz, Huffman, & Cojucar, 2016a; Mattocks et al., 2012; Turchik, Bucossi, & Kimerling, 2014a; Turchik et al., 2013). While the quantitative research is important to document the prevalence and health sequelae of MST, the qualitative research is key to understanding how survivors perceive the effects of MST on their lives and health, what their experiences mean to them (Hannagan, 2017), and what institutional actions are necessary for healing (Brownstone et al., 2018).

A few articles try to assess **prevalence** (Barth et al., 2016; Wilson, 2018), while there is recognition that non-disclosure makes it difficult to assess the full scope of the problem of MST (Blais, Brignone, Fargo, Galbreath, & Gundlapalli, 2018). Wilson's meta-analysis finds that MST is pervasive among women and men in the US military, with 15.7% of military personnel and veterans reporting having experienced MST (3.9% of men, 38.4% of women) (Wilson, 2018). Prevalence rates are found to be significantly higher among women, especially younger women, though some researchers are finding that women in midlife (aged 45 to 54) report MST at higher rates and with greater negative impact on their health compared to other age cohorts (Gibson, Gray, Katon, Simpson, & Lehavot, 2016). The need to look at particular subpopulations of MST survivors emerges from the literature in regards to: older women with MST (Gibson et al., 2020); transgender veterans who have a significantly heightened risk of experiencing military sexual assault, especially transgender men (Beckman, Shipherd, Simpson, & Lehavot,

2018); the experiences and needs of male MST survivors (Monteith et al., 2019a; Morris, Smith, Farooqui, & Suris, 2014; Reddy & Murdoch, 2016; Romaniuk & Loue, 2017; Schry et al., 2015); homeless women veterans who have high rates of MST (Brignone et al., 2016; Freysteinson et al., 2018); women veteran sex workers who report higher rates of MST history (Strauss et al., 2011); and veterans living with Hepatitis C and with a history of MST (White et al., 2013).

Research is inconsistent in its **focus and scope** as articles examine MST, military sexual assault itself, physical victimization, or stalking specifically (Lucas, Cederbaum, & Kintzle, 2019), and more. Thus, at least one researcher calls for clearer, consistent, and agreed-upon definitions of the problem to be studied which would allow for comparability of research findings (Shale, 2014). The question of definition is tricky though, as MST exists within a continuum of sexual violence and many of the reviewed articles highlight the complexity of, often cumulative, sexual trauma experiences among the military and veteran population. Some of the research focuses on MST and its impacts, but a significant number of articles look at MST within the context of lifetime sexual assault (Goyal et al., 2017; Sadler, Mengeling, Syrop, Torner, & Booth, 2011). This is important as previous sexual abuse/assault is associated with increased likelihood of later sexual assault for both women and men veterans (Schry, Beckham, The Va Mid-Atlantic Mirecc, & Calhoun, 2016; Wolfe-Clark et al., 2017). Furthermore, the literature on MST is paying increased attention to the relationship between MST and IPV, including IPV-related MST, for both women and men (Mercado, Ming Foynes, Carpenter, & Iverson, 2015; Relyea, Portnoy, Combellick, Brandt, & Haskell, 2019). There is an urgent need to better understand the interaction between sexual traumas across the lifespan—from childhood sexual and physical abuse and adult assault in and outside, during and after, the military—to understand the impacts of cumulative trauma on this particular population (Dichter et al., 2018; Scoglio et al., 2019). The literature also underscores the need to understand how women cope with multiple stressful military deployment experiences such as the increased risk for MST alongside combat and separation from family (Mattocks et al., 2012). Other research examines gender differences in combat exposure, MST, and mental health outcomes among deployed military personnel, showing that women are more likely than men to experience MST while also increasingly being exposed to combat (Maguen, Luxton, Skopp, & Madden, 2012c).

Research on MST and its short- and long-term consequences is far from straightforward, as it involves understanding MST in relation to a spectrum of trauma experiences and stressors experienced by military members and veterans, especially women and other vulnerable subpopulations (e.g., transgender individuals). MST is associated with negative health and occupational outcomes for service women, leading to greater odds of mental health treatment, posttraumatic stress disorder treatment, suicide attempt, career demotion, and attrition (Millegan et al., 2015; Rosellini et al., 2017). As Dichter et al. (2018, p. 843) argue, IPV and non-partner sexual assault are exacerbated by military employment for women, as their qualitative

research with women highlights that "the military context constrains their options for responding to and coping with" these experiences of violence.

Potential Health Sequelae of Sexual Trauma, including MST

Sexual assault, including MST, results in a host of negative physical and mental health problems. Research on the mental health sequelae of MST—including, in relation to other sexual traumas—is the most developed part of the literature, with less research dedicated to investigating the physical health sequelae or the interactions between mental and physical health outcomes.

Mental Health

MST is associated with a host of mental health problems—elevated rates of PTSD, depression, generalized anxiety disorder, suicidal ideation and suicide attempts, decreased mental and cognitive functioning, maladaptive coping behaviours, increased use of addictive substances, eating disorders, insomnia, and more, leading to an overall reduced quality of life (Brown et al., 2016; Klingensmith, Tsai, Mota, Southwick, & Pietrzak, 2014).

The relationship between **PTSD and MST** is the most heavily researched topic in this literature (Blais & Geiser, 2019; Cater & Leach, 2011; Creech & Orchowski, 2016; Luterek, Bittinger, & Simpson, 2011). PTSD is usually examined as a sequelae of MST, but MST is also examined as increasing and complicating the comorbidity of PTSD (Maguen et al., 2012b). Both childhood sexual assault and more recent experiences of IPV increase PTSD symptoms for MST survivors (Creech & Orchowski, 2016; Mahoney, Shayani, & Iverson, 2020). Research comparing sexual and non-sexual trauma in women veterans find that sexual trauma is associated with greater levels of PTSD, depressive symptoms, and suicidal ideation as well as lower sexual satisfaction (DiMauro, Renshaw, & Blais, 2018). Sexual assault, including MST, has a higher association with PTSD and depression than combat-related trauma (Goldstein, Dinh, Donalson, Hebenstreit, & Maguen, 2017b; Sexton, Raggio, McSweeney, Authier, & Rauch, 2017).

Other research shows that MST and combat exposure together increase women's risk of experiencing PTSD symptoms (Cobb Scott et al., 2014; Gross et al., 2019). Perceptions of **institutional betrayal** are significantly associated with more severe depression and PTSD symptoms in women MST survivors and MST survivors in general, indicating the need to address not only the sequelae of MST itself but of injurious institutional responses (Andresen, Monteith, Kugler, Cruz, & Blais, 2019; Monteith, Bahraini, Matarazzo, Soberay, & Smith, 2016b).

Research underscores the importance of studying sex and gender differences in risk and resilience of MST survivors to facilitate targeted interventions and treatment (Averill et al., 2019; Portnoy et al., 2018). For example, women veterans are more likely to screen positive for

MST and depression and less likely to screen positive for PTSD compared to men veterans in one study (Haskell et al., 2010). But research underlines that women have higher exposure than men to sexual abuse, interpersonal violence, and MST, and women with MST face a heightened risk for PTSD and depression compared to their men counterparts (Tannahill et al., 2020). Low unit relationship quality and the lack of social resources contribute to posttraumatic stress symptoms associated with MST experienced by women service personnel during deployments (Laws, Mazure, McKee, Park, & Hoff, 2016). For men with MST and/or childhood sexual abuse, PTSD, depression, and guilt are significantly higher compared to men who had no history of sexual victimization, even when taking combat exposure into account (Juan, Nunnink, Butler, & Allard, 2017; Wolfe-Clark et al., 2017).

The literature also notes particular vulnerabilities faced by **subpopulations of MST survivors** when it comes to mental health sequelae. MST has been shown to have detrimental mental health sequelae for both heterosexual and sexual minority women (e.g., lesbian and bisexual) (Lehavot & Simpson, 2014), but a history of suicide attempts are more pronounced among sexual and gender minority women veterans who are survivors of MST (Sexton et al., 2018). MST is a significant risk factor for homelessness, and veterans who are both homeless and MST survivors have significantly higher rates of mental health conditions compared to other women and men experiencing homelessness, including of PTSD, depression, anxiety disorders, substance use disorders, bipolar disorders, personality disorders, and suicide (Pavao et al., 2013). The mental health sequelae of MST are important to consider in the context of women's reproductive health as women veterans who are MST survivors face a heightened risk for perinatal depression and suicidal ideation (Gross, Kroll-Desrosiers, & Mattocks, 2020b).

A prominent subtheme in the literature on the mental health sequelae of sexual trauma including MST is increased risk for **suicidal ideation, suicide attempts, and suicidal self-directed violence** (Blais & Geiser, 2019; Monteith et al., 2016a; Monteith, Bahraini, & Menefee, 2017; Monteith, Holliday, Schneider, Forster, & Bahraini, 2019b; White et al., 2018; Wiblin, Holder, Holliday, & Suris, 2018). Sexual trauma experienced during deployment is significantly associated with suicidal ideation for both women and men (Monteith, Menefee, Forster, Wanner, & Bahraini, 2015). Research has also shown that for women, MST-related PTSD, more so than combat- or deployment-related PTSD, is associated with suicidal ideation (Blais & Monteith, 2019). **Eating disorders** are another subtheme found in the literature. Research shows that MST, but not combat exposure, is a predictor of eating disorders among women (Breland et al., 2018). Women with MST-associated PTSD symptoms are more than twice as likely to have eating disorders compared to women who had not experienced MST (Forman-Hoffman, Mengeling, Booth, Torner, & Sadler, 2012), and the same seems to hold true for male survivors of MST (Blais et al., 2017). MST is associated with a higher likelihood of PTSD, depression, **substance use**, and relapse in substance use and addictions for both women and men veterans (Gilmore et al., 2016; Hannan, Thomas, & Allard, 2019; Seelig et al., 2017). A

history of MST and other sexual traumas is associated with a greater risk for substance use disorders and higher recreational use of cannabis in women veterans (Booth, Mengeling, Torner, & Sadler, 2011; Browne, Dolan, Simpson, Fortney, & Lehavot, 2018; Goldberg et al., 2019; Yalch, Hebenstreit, & Maguen, 2018). Veterans living with MST have been found to experience **insomnia**, and at higher and more severe rates compared to the general veteran population (Jenkins et al., 2015).

Physical Health

MST has detrimental impacts on physical health (e.g., gastrointestinal, genitourinary, musculoskeletal, neurological symptoms) and is consequently associated with lower physical functioning in women veterans (Booth et al., 2012; Smith et al., 2011). Pain conditions, especially chronic pain, are a well-documented sequelae of MST, both for women and men survivors of MST (Cichowski et al., 2017; Turner, Harding, Brier, Anderson, & Williams, 2020). As research shows, MST survivors—mostly these studies examine women veterans specifically—face increased risk of developing sexual health problems such as sexually transmitted infections (STIs), sexual dysfunction symptoms, or sexual pain (Blais, 2019; Blais, Geiser, & Cruz, 2018; Garneau-Fournier, Habarth, & Turchik, 2018; Goyal et al., 2017; Pulverman et al., 2019a; Pulverman & Creech, 2019; Pulverman et al., 2019b; Turchik et al., 2012b). Furthermore, sexual assault during service can lead to childlessness among women veterans—pregnancy termination, delay or avoidance (i.e., voluntary childlessness) as well as infertility (i.e., involuntary childlessness)—and increased risk of gynecological conditions associated with hysterectomy (Ryan et al., 2014; Ryan et al., 2016).

Multi-factor Health Considerations

A small but not insignificant subset of the literature aims to understand the interactions and intersections of the mental and physical health sequelae of MST. In particular, sexual health problems among veterans are a key concern as they may signal other important health issues, both mental and physical (Sadler, Mengeling, Fraley, Torner, & Booth, 2012; Sadler et al., 2011). The literature looks at the impact of MST, often within the broader context of sexual assault histories, on mental health, gynecological health, and sexual functioning (Sadler et al., 2012; Sadler et al., 2011), trauma and pregnancy resulting from sexual assault during military service (Zaleski & Katz, 2014), the association of sexual trauma with risky sexual behaviour (Combellick et al., 2019), the negative impact of MST and combat exposure on physical and mental health (Godfrey et al., 2015), the complex relationships between lifetime trauma, PTSD, depression, physical health, and quality of life (Kelly, Skelton, Patel, & Bradley, 2011), sexual assault as a risk factor for mental health problems and obesity (Cheney et al., 2014a; Pandey, Ashfaq, Dauterive, MacCarthy, & Copeland, 2018), the association between fibromyalgia and childhood sexual abuse and/or MST (Gerber, Bogdan, Haskell, & Scioli, 2018a), and decreased heart rate variability—often associated with physical and psychological disorders—in veterans with MST (Lee et al., 2013).

Benefits and Health Care for MST survivors

It is well documented in the US context that MST survivors face an unfair evidentiary burden when it comes to MST-related mental health VA claims, especially in comparison with combat-related claims (Gum, 2016; Kappelman, 2011; Schingle, 2010). Seamone and Traskey (2014) have developed a review and guide for MST survivors and their advocates in securing and maximizing VA benefits. The importance of access to health care is underscored by the fact that MST survivors use VA/VHA health care at higher rates than veterans who are not survivors, and not only for MST-related services (Brignone et al., 2017). It has been found that one in four women who use VA/VHA health care screen positive for MST (Bergman, Hamilton, Chrystal, Bean-Mayberry, & Yano, 2019a). Women with MST make up a substantial portion of VHA facilities users, while MST patients who are men tend to use MST specialty clinics (Valdez et al., 2011) but overall are less likely to use MST-related VA/VHA care (Turchik, Pavao, Hyun, Mark, & Kimerling, 2012a).

Barriers to VA/VHA health care for MST survivors is a central theme in the literature. Barriers to seeking help and utilizing healthcare include a survivor's sense of institutional betrayal (Holliday & Monteith, 2019), a survivor's self-stigma (Andresen & Blais, 2019), a survivor's conceptualization of the traumatic experiences (Dardis, Vento, Gradus, & Street, 2018), perceptions among women MST survivors that they are not receiving equitable care compared to men veterans (Kehle-Forbes et al., 2017), and gender-related distress experienced during health care visits (Monteith et al., 2018).

The literature underscores the importance of ensuring effective **MST (and IPV) screening** across VHA facilities to support both MST-related and general women's health care delivery (Bovin et al., 2019; Goyal et al., 2014; Hyun, Kimerling, Cronkite, McCutcheon, & Frayne, 2012; Meredith et al., 2017a; Reddy et al., 2019). One study shows that only half of the women survivors of MST report using VA health care, which highlights the need for more outreach and education about existing VA resources for MST survivors (Calhoun et al., 2018). Coordinating the care needs of women veterans with histories of MST across VHA facilities is also mentioned as a concern (Kimerling et al., 2011) as is the need to recognize MST as an important mental health issue for women veterans returning from a deployment who seek VHA health care (Kimerling et al., 2010), and how a history of sexual assault may inform or undermine women's utilization of VA/VHA reproductive health services (Dognin, Sedlander, Jay, & Ades, 2017; Katon, Gerber, Nillni, & Patton, 2019b).

Women VA/VHA users tend to prefer a female clinical provider and gender-targeted rather than gender-neutral materials on MST (Turchik et al., 2014a). Male MST survivors using the VA/VHA also prefer gender-targeted rather than gender-neutral materials on MST, even though such

materials do not appear to increase their utilization of MST-related services (Turchik, Rafie, Rosen, & Kimerling, 2014b). For male MST survivors, stigma presented a key barrier to accessing MST-related mental health services at the VA/VHA. Half of the male participants in one study expressed preference for a female provider, a quarter preference for a male provider, and another quarter no preference (Turchik et al., 2013). For female MST survivors, the literature notes the importance of proper validation and support as well as a range of therapy options to improve the care of MST survivors in the VA/VHA setting (Cichowski, Ashley, Ortiz, & Dunivan, 2019). The research also captures the experiences of VA primary care providers within the VHA setting and their challenges in providing care to women with sexual trauma histories, including insufficient time, lack of proficiency and/or comfort with women's health care specific examinations, and difficulties in building positive patient-provider relationships (Bergman et al., 2019a).

The research also notes the importance of considering the needs of MST survivors **beyond the VA/VHA**, for example, by addressing barriers to the mental health treatment for active duty personnel with sexual assault histories (Zinzow et al., 2015), and developing effective MST prevention programs within the military and providing care for MST survivors within the military setting too (Kintzle et al., 2015; Orchowski, Berry-Cabán, Prisock, Borsari, & Kazemi, 2018). In fact, the issue of revictimization is an important one and necessitates screening for sexual trauma experiences throughout the life span of female veterans (Creech & Orchowski, 2016). This further underscores the need for better training of—and development of training materials for—medical professionals to be able to respond to the needs of MST survivors in the military, VA/VHA, and wider civilian settings (Burgess, Slattery, & Herlihy, 2013). The literature includes articles that aim to inform a particular groups of medical professionals about MST, such as rehabilitation counselors (Cater & Leach, 2011), social workers (Bell, Turchik, & Karpenko, 2014), psychiatric nurses (Williams & Bernstein, 2011), and nurse practitioners (Rossiter & Smith, 2014). In fact, one group of researchers stresses that "[every] woman (and man) in the civilian sector should be asked, 'Have you ever served in the military?'" (Conard, Young, Hogan, & Armstrong, 2014, p. 280). Lessons learned from the VA health care setting in which MST-specific services have been in use for over two decades can help improve care of MST survivors across medical systems, such as providing diverse treatment options and paths, ongoing education and training for providers of care, finding ways to reduce barriers or raise awareness of MST (Foynes et al., 2018), or help improve in patient-centered perioperative care for MST survivors (Hickey, Kirwin, Gardner, & Feinleib, 2017). Homeless veterans who use VHA services report significant rates of MST—39.7 % of females and 3.3 % of males are MST survivors—and rely heavily on mental health care from the VA/VHA (Pavao et al., 2013), underlining the need for specially targeted services for homeless MST survivors (Decker, Rosenheck, Tsai, Hoff, & Harpaz-Rotem, 2013).

The literature also examines the **efficacy of particular treatment modalities or interventions** for survivors of MST and other sexual traumas who have mental health diagnoses, such as Skills Training in Affective and Interpersonal Regulation (STAIR) (Cloitre, Jackson, & Schmidt, 2016; Weiss, Azevedo, Webb, Gimeno, & Cloitre, 2018), Acceptance and Commitment Therapy (Hiraoka, Cook, Bivona, Meyer, & Morissette, 2015), Cognitive Processing Therapy (Holder, Holliday, Pai, & Suris, 2017; Holder, Holliday, & Suris, 2019; Holder, Holliday, Wiblin, LePage, & Suris, 2019; Holder, Holliday, Wiblin, & Surís, 2019; Holliday, Holder, Williamson, & Surís, 2017; Voelkel, Pukay-Martin, Walter, & Chard, 2015; Walter, Buckley, Simpson, & Chard, 2014), the Integrative Psychotherapy program "Renew" (Katz, Cojucar, Douglas, & Huffman, 2014a; Katz et al., 2015; Katz, 2016; Katz et al., 2014b; Katz et al., 2016a; Katz, Park, Cojucar, Huffman, & Douglas, 2016b), and VA PTSD intensive treatment programs (Tiet, Leyva, Blau, Turchik, & Rosen, 2015). This literature exemplifies the range of different approaches taken in treating MST survivors in the US context, underscoring the importance of providing survivors with multiple options.

Family

Overview

A total of 50 peer-reviewed articles are identified on topics related to family. This body of literature focuses on women veterans (*n*=39), sex/gender differences (*n*=8), couples (*n*=2), and men veterans (*n*=1). Two articles examining the experiences of women veterans additionally consider the role of sexual orientation/sexuality in their inquiry (Caska-Wallace, Katon, Lehavot, McGinn, & Simpson, 2016; Dardis, Shipherd, & Iverson, 2017b). All studies were conducted in the United States and research designs include primary research using quantitative (*n* = 40) or qualitative (*n*=8) methodologies, as well as a literature review (*n*=1) and a combined systematic review/meta-analysis (*n*=1). Civilian comparisons are included in these analyses. Three main themes emerge from this research: **intimate partner violence** (*n*=27), **family roles and relationships** (*n*=16), and **childhood adversity** (*n*=7).

Research focusing on **intimate partner violence (IPV)** discusses **prevalence rates** (Albright et al., 2020; Dardis et al., 2017b; Kimerling et al., 2016a; Kwan et al., 2020), **associated health risks and outcomes** (Bartlett, Iverson, & Mitchell, 2018; Brignone, Sorrentino, Roberts, & Dichter, 2018; Dardis, Amoroso, & Iverson, 2017a; Dichter, Cerulli, & Bossarte, 2011; Dichter & Marcus, 2013; Dichter, Marcus, Wagner, & Bonomi, 2014; Dichter, Wagner, & True, 2015b; Gerber, Iverson, Dichter, Klap, & Latta, 2014; Iverson, Dardis, Grillo, Galovski, & Pogoda, 2019b; Iverson, Dardis, & Pogoda, 2017; Iverson, Mercado, Carpenter, & Street, 2013b; Iverson & Pogoda, 2015; Iverson et al., 2015b; Watkins & Laws, 2018), and **health care and interventions** (Danitz et al., 2019; Dichter & Marcus, 2013; Dichter et al., 2017a; Dichter, True, Marcus,

Gerlock, & Yano, 2013; Dichter, Wagner, Goldberg, & Iverson, 2015a; Iverson et al., 2019a; Iverson et al., 2014; Iverson et al., 2015a; Iverson et al., 2013a; Iverson et al., 2016a).

Research related to **family roles and relationships** includes topics of **relational functioning** (Caska-Wallace et al., 2016; Creech, Swift, Zlotnick, Taft, & Street, 2016; Khalifian et al., 2020; Leslie & Koblinsky, 2017; Rosenfeld et al., 2018), **relationship satisfaction** (Blais, Monson, Livingston, & Maguen, 2019; Caska-Wallace et al., 2016; Leslie & Koblinsky, 2017), **relationship/marital status** (London, Allen, & Wilmoth, 2013; Negrusa, Negrusa, & Hosek, 2014), **social support** (Campbell, Gray, Hoerster, Fortney, & Simpson, 2020; Mankowski, Haskell, Brandt, & Mattocks, 2015; Yan et al., 2013), **parenting** (Acker, Nicholson, & DeVoe, 2020; Creech et al., 2016), **adult caregiving** (Lavela, Etingen, & Louise-Bender Pape, 2013; Song et al., 2020), and **family communication** (Wilson et al., 2019b).

All articles examining **childhood adversity** relate to **health outcomes** (Evans, Upchurch, Simpson, Hamilton, & Hoggatt, 2018a; Gaska & Kimerling, 2018; Groer et al., 2016; Katon et al., 2015b; McCauley, Blosnich, & Dichter, 2015; Mercado, Wiltsey-Stirman, & Iverson, 2015; Wooldridge, Bosch, Crawford, Morland, & Afari, 2020).

Intimate Partner Violence (IPV)

IPV takes the form of either perpetration or victimization of physical, sexual, and psychological abuse (Bartlett et al., 2018). Women veterans may be more likely to experience IPV victimization than women non-veterans (Dichter et al., 2011) as Melissa Dichter shows in two studies published in 2013 (Dichter & Marcus, 2013; Dichter et al., 2013). These studies reveal that roughly one quarter of over 500 reviewed VA medical records documented both acute and chronic IPV for women veterans up to the age of 55. Indeed, it appears that women veterans ages 55 years and younger are at higher risk of IPV; other risk factors include parenting children under the age of 18, having economic challenges, having less education, and identifying as LGBTQ (Dardis et al., 2017b; Iverson et al., 2013b; Kimerling et al., 2016a). For example, Dardis et al. (2017b) find that women veterans who identify as lesbian, bisexual, or questioning (LGQ) are two times as likely to experience emotional or physical IPV and three times as likely to experience sexual IPV than women veterans who identify as heterosexual. Women veterans experience higher rates of IPV than their civilian counterparts, and this may be particularly the case among women veterans living in rural communities (Albright et al., 2020). Kwan et al. (2020) demonstrate in their systematic review and meta-analysis that IPV perpetration is higher among military veterans than active duty service members, and men veterans are more likely to perpetrate physical IPV than women veterans.

Pre-military trauma and MST are consistently cited as risk factors for IPV victimization among women veterans (Dichter et al., 2015b; Gerber et al., 2014; Kimerling et al., 2016a). For

example, Iverson et al. (2013b) show that the risk of experiencing IPV is three times higher among women veterans who have experienced childhood sexual abuse and two times higher for those who have experienced unwanted sexual experiences during their military career. Military deployment also increases the likelihood of experiencing IPV among women service members and veterans, and at least one study suggests there is greater risk of experiencing psychological IPV during military service than physical or sexual IPV (Dichter et al., 2015).

A growing body of research on women veterans and IPV victimization shows an association with homelessness (Gerber et al., 2014), as well as multiple physical and mental health sequelae (Iverson et al., 2015b), such as traumatic brain injury (TBI), heart health issues, sleep issues, smoking, heavy alcohol consumption, posttraumatic stress disorder (PTSD), suicidal ideation, depression, anxiety, and eating disorders (Bartlett et al., 2018; Brignone et al., 2018; Dardis et al., 2017a; Dichter et al., 2011; Dichter & Marcus, 2013; Dichter et al., 2014; Iverson et al., 2019a; Iverson et al., 2019b; Iverson & Pogoda, 2015; Iverson et al., 2015b). For example, Dichter et al. (2014) demonstrate that women veterans who have experienced sexual IPV are three times more likely to report lower overall health quality and more severe negative mental and physical health outcomes than women veterans who have no history of IPV, even after controlling for age, race, and income. Dichter et al. (2017a) find that women veterans who have experienced IPV in the past year are twice as likely to have one or more mental health disorder diagnoses than women veterans who have not experienced IPV in the past year. Brignone et al. (2018) echo this finding by showing that the risk of experiencing suicidal ideation and self-harm behaviours is twice as high among women veterans who experience IPV, compared to those who do not.

Notably, research highlights that PTSD and TBI are both risk factors for and potential outcomes of IPV among women veterans. On the one hand, the odds of experiencing IPV are increased for female veterans with PTSD (Gerber et al., 2014)—a risk that is further increased for dual-veteran couples where both partners are living with PTSD symptoms (Watkins & Laws, 2018). IPV in these cases is more likely to be psychological in nature. On the other hand, IPV can also result in PTSD, and the likelihood of PTSD increases when IPV includes stalking by an intimate partner (Dardis et al., 2017a). TBI has been named as a "common but invisible wound of IPV among women veterans" (Iverson & Pogoda, 2015, p. 115), and the symptoms can subsequently place women veterans at risk for additional negative psychosocial health outcomes (Iverson et al., 2019b). A correlation has been observed between PTSD and IPV-related TBI among women veterans. For example, Iverson et al. (2017) find that women with IPV-related TBI are nearly six times more likely to also have probable IPV-related PTSD than those without IPV-related TBI.

Women veterans living with IPV have more primary health care visits (e.g., with the VHA) than women veterans without IPV (Dichter & Marcus, 2013; Kimerling et al., 2016a). Despite this,

some women veterans are reluctant to disclose their experiences to health care providers for reasons such as a lack of comfort, concerns about the repercussions of disclosure (e.g., negative consequences to their military career), and a lack of privacy; other veterans may be less likely to initiate disclosure of their experiences without direct questioning by a health care provider (Dichter et al., 2015a). However, clinical screening programs for IPV among women veterans that engage tools such as the 4-item Hurt/Insult/Threaten/Scream (HITS) (Iverson et al., 2015a; Iverson et al., 2013a), may increase the likelihood of IPV detection and subsequent support. Access to IPV screening programs is facilitated by factors such as "engaged IPV champions, internal and external supports, positive feedback regarding IPV screening practices, and current, national attention to violence against women" (Iverson et al., 2019a, p. 2435). Iverson et al. (2014) establish that women veterans prefer health care support that includes "disclosure options, follow-up support, transparency in documentation, and VHA and community resources" (p. 302). In addition, women veterans perceive clinical practices for IPV to be most effective when they are delivered with "sensitivity and connectedness" (p. 302). Further, women veterans prefer counseling for IPV that is individualized and focuses on enhancing physical safety, mental and emotional health, and coping skills (Iverson et al., 2016a), such as the Recovering from IPV through Strengths and Empowerment (RISE) counseling program (Danitz et al., 2019).

Family Roles and Relationships

The effect of deployment on family roles and relationships is discussed in several studies, highlighting reintegration challenges associated with parenting and family functioning (Acker et al., 2020; Creech et al., 2016; Leslie & Koblinsky, 2017; Negrusa et al., 2014; Yan et al., 2013). For example, as women veterans transition back into their family roles and responsibilities following deployment and separation from the military, they re-adjust to managing challenges with children's behaviour (Leslie & Koblinsky, 2017), and these challenges can lead to decreased parenting satisfaction in women veterans (Creech et al., 2016). In cases where deployment experiences have led to PTSD, women veterans are more likely to report negative impacts on family functioning and reduced intimate relationship satisfaction (Creech et al., 2016).

Social support is a key protective factor for women veterans who experience deployment stressors (Leslie & Koblinsky, 2017; Yan et al., 2013). However, veterans, especially women, appear to have lower social support networks than their civilian counterparts, possibly due to challenges with reintegration and geographic mobility (Campbell et al., 2020). Women veterans may also be reluctant to disclose mental health issues with family members or to seek family support following deployment as a means of protecting others from "the strain of war, post-traumatic stress symptoms, and depressive symptoms" (Mankowski et al., 2015, p. 287; Wilson et al., 2019b). Yet, family support appears to protect against the severity of PTSD in cases where such support is accepted and provided. For example, Caska-Wallace et al. (2016) show

that partner support buffers the impact of PTSD on relationship satisfaction, and this is particularly the case for lesbian veteran partnerships.

In general, outside of deployment factors, veterans' mental health issues also impact their family life. For example, women service members and veterans with an eating disorder may experience decreased relationship and sexual satisfaction (Blais et al., 2019). In addition, one study finds that among couples living with PTSD, decreased sexual functioning is linked to a higher likelihood of suicidal ideation among men veterans than women veterans (Khalifian et al., 2020). Another study shows that women veterans who experience reproductive coercion from their men partners are more likely to be Black, younger, single, have experienced MST, and are less likely to use contraception, which may increase their likelihood of unintended pregnancy (Rosenfeld et al., 2018).

Marital status is impacted by military service, and the likelihood of extramarital sex and divorce may be higher among veterans than non-veterans, particularly among men veterans (London et al., 2013). However, women veterans may be at higher risk for divorce than men when accounting for deployment factors (Negrusa et al., 2014). One study, which compares men with military service to those without, finds that exposure to death during military service may buffer the effects of loneliness during widowhood. Specifically, they reveal that widowers exposed to death during military service report less loneliness than their civilian counterparts, while little differences are found between veterans without exposure to death and civilians (Carr, Ureña, & Taylor, 2018).

Women veterans who provide illness or injury-related care to an adult partner are vulnerable to both mental and physical health issues related to their supportive role, especially mental health issues. For example, Song et al. (2020) find that women veteran caregivers (providing care to an adult partner) are more vulnerable to stress-related sleep disturbances and more daytime impairment from sleep disturbances than women veteran non-caregivers. Similarly, Lavela et al. (2013) show that women veteran caregivers provide more support to their partner related to daily living activities than their civilian counterparts and women veteran caregivers are at greater risk for mental health issues than their civilian counterparts. Moreover, women veterans that are parenting young children may experience distress throughout the deployment cycle such as depression and anxiety while deployed and a sense of disconnection during family reintegration (Acker et al., 2020).

Childhood Adversity

The literature on childhood adversity highlights a range of experiences (e.g., childhood homelessness, family member incarceration, parental mental illness, parental substance abuse, witnessing violence, sexual abuse, and physical abuse) that put women and men veterans at

risk for long term mental and physical health issues (Evans et al., 2018a; Gaska & Kimerling, 2018; Groer et al., 2016; Katon et al., 2015b; McCauley et al., 2015; Wooldridge et al., 2020). Childhood adversity is associated with a host of health outcomes such as substance abuse (Evans et al., 2018a; Gaska & Kimerling, 2018), depression, anxiety, PTSD (Gaska & Kimerling, 2018), smoking, disability (McCauley et al., 2015), higher cholesterol, triglycerides, higher stress levels, greater pain and fatigue (Groer et al., 2016), as well as comorbid mental health and chronic physical health conditions (Gaska & Kimerling, 2018; Wooldridge et al., 2020). Notably, women veterans with adverse childhood experiences may be no more likely to have negative health sequelae in adulthood than women non-veterans with adverse childhood experiences (Evans et al., 2018a; Katon et al., 2015b; McCauley et al., 2015).

Veterans who have experienced childhood adversity may also be susceptible to re-victimization, with one study showing that nearly 40% of women veterans with childhood sexual assault have also experienced military sexual assault (Groer et al., 2016). This same study further finds that women veterans have higher cholesterol, triglycerides, perceived stress scores, and greater pain and fatigue than women veterans without childhood sexual assault (Groer et al., 2016). Military service also interacts with childhood adversity, adding a layer to the impact on later health outcomes. Literature suggests that women veterans may have had more adverse childhood experiences than women and men without military service (Katon et al., 2015b; McCauley et al., 2015). Further, women with military service may be at greater risk for long term impacts (e.g., poorer health-related quality of life) than men with military service (Katon et al., 2015b).

Socioeconomic Issues

A small portion of the research on gender and veterans concerns socioeconomic issues (*n*=33) including education, employment, and experiences in the criminal justice system. With the exception of one (Peach, 2019) these studies examine veterans of the United States military. These studies include narrative analyses, cross-sectional analyses, and multiple logistics analyses.

Just under half of the studies (*n*=13) in this group consider the experiences of women veterans who have enrolled in **educational programs**. Women veteran students are more likely than their civilian counterparts to live with chronic pain, financial stress and learning disabilities, and are at higher risk of exhibiting suicidal behaviour (Albright et al., 2019a). Despite their unique challenges, women veterans are less likely to receive information and support on campus for alcohol and substance use, depression and anxiety, intimate partner violence, and stress. Their reluctance to seek help is found to be related to gender norms of warrior culture, which emphasizes self-reliance and emotional control, rejects patient identity and vulnerability, and stigmatizes seeking help and having mental health issues (McDermott, Currier, Naylor, &

Kuhlman, 2017). Gender norms, especially those associated with masculinity, are found to inform help-seeking attitudes among women who are under unique pressures to live up to the male norm and represent their woman veteran cohort positively (DiRamio, Jarvis, Iverson, Seher, & Anderson, 2015). See also (DiRamio & Jarvis, 2011). DiRamio et al. (2015) further find that women veterans experience a sense of self-worth and pride when keeping their problems to themselves. Indeed, masculine norms, discussed in more detail in a subsequent section, also prevent men veterans from seeking mental health support in the education system (McDermott et al., 2017). Adherence to these masculine norms, specifically "hardiness," is associated with lower psychological well-being among women veteran students (Alfred, Hammer, & Good, 2014). Yet, one study finds that women veteran students are less likely to identify as 'veterans' than their men counterparts, meaning efforts to reach them through 'veteran services' in educational settings may be challenged (Iverson, Seher, DiRamio, Jarvis, & Anderson, 2016b).

Gender norms also inform the programs that women veterans enroll in. Atkinson et al. (2018) find that women veterans are attracted to engineering programs, and in particular mechanical engineering, because it is a clear pathway from their military experiences, which provided them with knowledge, skills, and exposure to engineering. This familiarity facilitates women veterans' transition into such a program. Indeed, having experiences in a men-dominated culture assists in their transition into engineering as a similarly men-dominated field (Atkinson et al., 2018). Taking a different angle, Lake, Allen, and Armstrong (2016) argue that women veterans should advance skills developed in the military to the civilian employment economy, especially nursing. They call to consider military nurse officers as applicants "for nursing leadership and educational positions in civilian health care organizations" (Lake et al., 2016, p. 473).

Overall, women veterans perceive the value of Veterans Affairs education benefits to be higher than men veterans (Atkinson et al., 2018). This is substantiated by Boyd and Barnes (2019), who find that women veterans regard education benefits as being more important to meeting their educational goals or obtaining better employment, when compared to men veterans. See also (Messer & Greene, 2014). Still, women veteran students have unique challenges availing of the benefits of education because of their competing demands as caregivers to children and other dependents (Atkinson et al., 2018). Caregiving responsibilities may therefore become a risk factor for academic program completion that is uniquely salient for women veterans who are students (Albright et al., 2019a; Alexander, 2014; Atkinson et al., 2018; Pellegrino & Hoggan, 2015).

Employment also features heavily among the socioeconomic literature on women veterans, accounting for almost half (*n*=15) of the literature examined in this group of research. Women veterans have higher unemployment rates than both men veterans and civilian women (Albright et al., 2019a; Kleykamp, 2013; Reppert, Buzzetta, & Rose, 2014) and suffer higher wage penalties (Vick & Fontanella, 2017). Challenges with employment are especially profound

for American women veterans of the wars in Iraq and Afghanistan (Greer, 2017). Greer (2017) assesses the unique stressors affecting unemployment among women veterans across four spheres and argues that they should be considered in the development and implementation of support. Stressors unique to women veterans are situational (e.g., voluntary or involuntary release, external stress factors such as caregiving responsibilities), self (e.g., gender and age stigma of employers, health factors), support (e.g., family, friends, stability of support), and coping strategies (Greer, 2017).

Women veterans have unique circumstances, which affect their experiences with employment after military service. Women veterans who are unemployed are more likely than men veterans to be single, have less education, have served during wartime, have served in the regular force, and are five times more likely to screen positive for depression and PTSD (Hamilton, Williams, & Washington, 2015). Disability, including service-related disability increases the likelihood of unemployment among women veterans (Prokos & Cabage, 2017), which is especially important given their increased likelihood of military trauma and PTSD (Reppert et al., 2014). Yet, two studies analyze the relationship between traumatic brain injury (TBI) and unemployment, which appears to not be a factor of unemployment and suggests a need for more research into the relationships between specific injuries, such as TBI, and unemployment (Amara, Stolzmann, Iverson, & Pogoda, 2019; Olsen, Hays, Orff, Jak, & Twamley, 2018; Smith, 2014). Geographic barriers to employment for rural women veterans are especially salient given limited opportunities and lack of childcare resources (Szelwach, Steinkogler, Badger, & Muttukumaru, 2011), which is significant given that women veterans are more likely to have dependent children than their men counterparts (Reppert et al., 2014). The caregiving responsibility of women veterans is unique to the challenges they face with unemployment (Reppert et al., 2014; Szelwach et al., 2011).

Women veterans facing unemployment report challenges transferring their service-acquired skills to the civilian employment sector and perceive their military service as not being understood or respected by civilian employers (Hamilton et al., 2015; Mani, 2013). These findings are echoed in the critical feminist study by Hirudayaraj and Clay (2019) who state: "the reality of being a veteran in a civilian work environment was problematized by their gender identity. In the male dominant private sector work environment with specific expectations of femininity, the military background of the women led to them to be perceived as being not 'woman enough'" (p. 473). For women working in a men-dominated milieu where masculinity is privileged, they feel as though they are not "veteran enough." The intersectionality of "two marginalized identities within the private sector left women veterans feeling disregarded, underutilized, and restricted from growing in their careers" (Hirudayaraj & Clay, 2019, p. 473). One study considers the effects of volunteering on reintegration into civilian life, including its impacts on employment (Nesbit & Reingold, 2011), while another examines the impacts of financial stability on health and wellbeing (Shen & Sambamoorthi, 2012). Taking a different

approach, Santhiveeran (2019) examines socioeconomics, such as income and employment, on health outcomes.

A handful (*n*=5) of these studies consider veterans in the **criminal justice system**. Studies measure the gendered differences that increase veterans' likelihood of being incarcerated (Brooke & Peck, 2018; Schaffer, 2014). McCall and Tsai (2018) find that compared with men veterans, women veterans are younger, have significantly lower lifetime arrests and are less likely to have been incarcerated for a violent offense. Finlay et al. (2019) find that each additional year of service increases the likelihood of lifetime arrests in men, whereas women who are older when entering the military, have a longer length of service and have a satisfactory discharge from duty, have significantly fewer expected lifetime arrests. Moreover, experience in combat increases the likelihood of incarceration for drug related crimes among all veterans, which lends support to the research on substance abuse and service-trauma (Finlay et al., 2019). Women veterans who are incarcerated report significantly more sexual trauma, have greater rates of PTSD, and more severe PTSD symptoms, while their men counterparts report earlier criminal justice involvement, are more likely to have served in military combat, and have higher rates of substance use (Stainbrook, Hartwell, & James, 2016). Given the gendered differences among veterans who are incarcerated, a gender-sensitive approach to re-entry into civilian life after incarceration and service is called for (Stainbrook et al., 2016).

Homelessness

Research on veteran homelessness accounts for 33 of the studies examined in this review and focus on the American context. Women veterans are more likely than men veterans to be homeless, and the women veteran population is homeless at a higher rate than civilian women (Byrne, Montgomery, & Dichter, 2013). American rates of homelessness indicate that women veterans are four times more likely than non-veteran women to experience housing insecurity (Hamilton, Washington, & Zuchowski, 2013b). As a cohort, women veterans experiencing homelessness tend to be younger, have higher levels of unemployment, and have lower rates of drug or alcohol dependence or abuse but higher rates of mental health problems than their men counterparts (Byrne et al., 2013). Characteristics associated with homelessness include unemployment, disability, poor overall health, screening positive for anxiety disorder or PTSD, and a history of MST (Hamilton, Poza, & Washington, 2011; Sellers, 2017; Tsai, Pietrzak, & Rosenheck, 2013; Washington et al., 2010). Moreover, women veterans with recent experiences of intimate partner violence are at an increased risk of housing instability, and this is especially pronounced among Black women veterans (Montgomery et al., 2018). Factors such as being a college graduate or married (Washington et al., 2010) have been shown to protect against homelessness among woman veterans. While some of the literature points to overlapping identities, such as the statistic that homeless veterans in the US of both sexes are

more likely to be Black (Montgomery, Dichter, Thomasson, Fu, & Roberts, 2015), there is little intersectional work done on this issue. Higher rates of women veteran homelessness in comparison to men veterans and women non-veterans and given that studies indicate that this in on the rise, signals its importance for continued research and tailored service delivery. Women veterans are at risk of homelessness due to gender specific variables that are interlocking and complex. The literature advocates understanding the root causes of homelessness as an "interconnected web of vulnerability" (Hamilton et al., 2011, p. 204) and not due to a single variable or factor (Montgomery et al., 2015; Washington et al., 2010). The literature can be summarized as pointing to five cumulative risk factors that together increase the likelihood of homelessness among women veterans. First, is a history of pre-military adversity, including violence, abuse, and unstable housing (Hamilton et al., 2011). Gender specific pre-service adversity, such as domestic violence and a history of sexual assault either as children or adults are particularly linked to homelessness in women veterans (Blackstock, Haskell, Brandt, & Desai, 2012; Dichter, Wagner, Borrero, Broyles, & Montgomery, 2017b; Holzhauer, Byrne, Simmons, Smelson, & Epstein, 2019; Tsai, Rosenheck, Decker, Desai, & Harpaz-Rotem, 2012; Whitbeck, Armenta, & Gentzler, 2015). A second significant predictor of women veteran homelessness is military trauma, such as MST and gender-based discrimination and harassment, which is specific to gendered bodies and an institutional culture that privileges masculinity (Kenny & Yoder, 2019; Ritchie, 2019). A third indicator is post-military interpersonal violence, abuse, and termination of intimate relationships (Dichter et al., 2017b; Kenny & Yoder, 2019; Yu et al., 2020). Fourth is post-military mental illness, substance abuse, and medical issues (Axon et al., 2016; Harpaz-Rotem, Rosenheck, & Desai, 2011; Holzhauer et al., 2019; Kenny & Yoder, 2019; Montgomery, Szymkowiak, & Culhane, 2017). Of note, women veterans experiencing homelessness tend to have mental health issues at higher rates than men veterans who are homeless, while women's substance abuse rates are lower than their men counterparts (Tsai, Kasprow, Kane, & Rosenheck, 2014b). The last predictor of homelessness is unemployment (Hamilton et al., 2011; Washington et al., 2010). The literature also indicates contextual factors that increase the likelihood of homelessness for women veterans: a lack of social support and resources; a sense of isolation; a pronounced sense of independence that inhibits care-seeking; and access barriers to medical, mental health, and social services (Hamilton et al., 2013b). Together these studies suggest that engaging with the issue of homelessness among women veterans as a multifaceted issue, as opposed to single issue, offers opportunities at various points for early intervention by service providers. Moreover, engaging with gender specific roots of homelessness, such as the tendency for women veterans to experience abuse and trauma is especially important to developing services (Byrne et al., 2013; Tsai, Rosenheck, & Kane, 2014c). Finally, homelessness after military discharge is found to first occur 6−10 years after discharge (Tsai, Szymkowiak, & Pietrzak, 2020). Dubbed by Tsai et al. (2020) as the 'sleeper effect' of homelessness, they call for prevention and interventions at many points, and for more than 10 years after military discharge.

A great deal of the literature on homelessness and its intersections with gender examines sex and gender specific dynamics of **service utilization and barriers for support** (Tsai, Rosenheck, & McGuire, 2012; van den Berk-Clark & McGuire, 2014). These studies call for service delivery that is attentive to gendered needs for homeless veterans, such as abuse and trauma support for women veterans, versus the physical health injury and substance abuse support needs of homeless men veterans (Byrne et al., 2013). Indeed, the lack of women-only housing and its intersections with histories of gendered trauma and assault prevents many women veterans from seeking housing support through the VA (Kim, Matto, & Kristen, 2019). This is complicated by the fact that women veterans are more likely to have dependent children under their care, meaning they have unique housing challenges and needs (Tsai et al., 2014b). Barriers to accessing veteran services specific to those experiencing homelessness are often challenged by travel and geographic restrictions (Hamilton, Poza, Hines, & Washington, 2012). Women veterans in particular have difficulty accessing family planning and sexual health services, which is found to be linked to high rates of unwanted pregnancy among veterans experiencing homelessness (Gawron et al., 2018a; Gawron, Pettey, Redd, Suo, & Gundlapalli, 2017a; Gawron et al., 2019).

The research evaluated here points to **gaps** in the literature and provides suggestions for future research including the impact of homelessness and parenting among the women veteran population (Ritchie, 2019; Tsai, Rosenheck, Kasprow, & Kane, 2015); on access to health and other services among women veterans who are homeless (Byrne et al., 2013); gendered uses of VA supports (Montgomery, Dichter, Thomasson, & Roberts, 2016); whether women veterans, who have dependents, are more likely to engage in support programs designed for civilians (Montgomery & Byrne, 2014); and research on whether deployment and service-related experiences affect homelessness (Hamilton et al., 2013b). Research would benefit from intersectional analyses of homelessness among female veterans, such as Indigeneity (Serrato, Hassan, & Forchuk, 2019).

GBA+ Considerations

Intersectionality

Only a small portion (*n*=22) of the articles reviewed are deliberate in their analyses of veterans across more than one identity group, such as sex, gender identity, race, and Indigeneity. Intersections of race/ethnicity and gender (*n*=19) are the most commonly examined research topics in relation to veterans' issues. Two of the studies consider sexuality at the intersection of gender and age, while one study examines gender and its intersection with age. Of note, race is operationalized by distinguishing between White, Black, Hispanic, and Asian veterans. Only one article includes Indigenous women veterans as a subset of 'race,' but excludes Black veterans (C'De Baca et al., 2016). Another study views Indigenous women as a distinct group of veterans

(Almasarweh & Ward, 2016). The remaining articles examine veterans at the intersection of gender and sexuality; race/gender/sexuality; and gender and age. The collection of research examining multiple identities focuses exclusively on veterans of the United States' military.

A handful of the research focuses on the **physical health** of women veterans in relation to race (*n*=4). These studies find, for example, that Black women veterans are more likely than White women veterans to have diabetes, hypertension, and obesity, while Hispanic women veterans are more likely than White women veterans to have diabetes and smoke, but less likely to have hypertension (Burgess et al., 2014; Rose, Farmer, Yano, & Washington, 2013). Another study examines contraceptive beliefs across women veterans in relation to race, finding that preferences, attitudes, and practices varied by race/ethnicity, which may help explain observed racial/ethnic disparities in contraceptive use and unintended pregnancy (Callegari et al., 2017). Research examining the physical health of older women veterans, aged 80 and above, find that they report significantly lower perceived health, physical function, life satisfaction, social support, quality of life, and purpose in life scale scores compared with women non-veterans (LaCroix, Rillamas-Sun, & Woods, 2016).

Mental health topics account for the majority of the research (*n*=9) which examines veterans' issues in relation to two or more identity categories. Most of these studies focus on the relationship between mental health and gender and race (Kimerling et al., 2015a). Studies find that race/ethnicity is related to diagnoses of mental health disorders, such as a lower likelihood of Asian/Pacific Islanders (A/PIs) veterans to be diagnosed with mental disorders than White veterans of any gender, while American Indian/Alaska Native (AI/AN) men are diagnosed with mental illness at higher rates than White males (Koo, Madden, & Maguen, 2015b). Yet, compared to their White counterparts, Asian/Pacific Islander (A/PI) women and Black men are more likely to screen positive for PTSD (Koo, Hebenstreit, Madden, & Maguen, 2016). Personality disorders are almost three times higher among Black women veterans than for White or Hispanic women veterans, which the authors suggest might be related to the high rates of paranoia among this groups as an adaptive response to racial discrimination (C'De Baca, Castillo, & Qualls, 2012; C'De Baca, Castillo, Mackaronis, & Qualls, 2014). Also focusing on women veterans, but at the intersection of sexual orientation and race Lehavot, Beckman, Chen, Simpson, and Williams (2019) find that across depression, anxiety, and sexism, White heterosexual women report the least distress, while racial minority heterosexual women veterans report the most. Further, among White women, sexual minority women report greater levels of depression, anxiety, and sexism than heterosexual women, while the effects are the opposite among racial/ethnic minority women, in which heterosexual women report similar or worse depression, anxiety, and sexism than sexual minority women (Lehavot et al., 2019). One study reports the importance of specific cultural beliefs and practices as being protective against suicide among African American women veterans, such as faith in God, religious beliefs

and practices, and informal assistance from family and friends (Brooke, Monteith, Spitzer, & Brenner, 2018).

The remainder of this research focuses on **equity in health care** (*n*=8) and use across more than one identity category, with many of them focusing on women veterans. Studies examine unique barriers to care for Native American women, such as lack of information, difficult and complicated application processes, challenges with distance and cost of travel, and conflicts with work schedule (Almasarweh & Ward, 2016). Another study examines inequality in reproductive health for women veterans according to race, such as consistency with contraception coverage and prescription (Borrero et al., 2013), while Callegari et al. (2019a) examine the rates and types of hysterectomies by racial and ethnic differences (Callegari et al., 2019a). One study examines satisfaction with VA services across gender and race, finding that men, Black, and Hispanic patients treated in VA hospitals tend to report more positive experiences than women and White patients treated at the same facilities, while less positive experiences are reported by patients overall in hospitals that serve larger populations of women and racial/ethnic minorities (Hausmann, Gao, Mor, Schaefer, & Fine, 2014b). In a systematic review of the veteran health care literature, Carter et al. (2016) find that while much research exists on health disparities between women and men veterans and between race, very few studies consider racial disparities between women in the VA healthcare system.

Methodologically this group includes qualitative studies, which examine the unique experiences and perceptions of veterans in relation to their gender and race through interviews, surveys, and thematic analyses (Almasarweh & Ward, 2016; Brooke et al., 2018; Zickmund et al., 2018). Most of the studies considering multiple identity categories engage in quantitative analyses. Many of these studies use retrospective population analyses of VA databases comparing data across variables such as sex, race, and lab/clinical results (Backus, Belperio, Loomis, & Mole, 2014; Koo, Hebenstreit, Madden, Seal, & Maguen, 2015a; Koo et al., 2015b). Similarly, studies use multivariable logistics regression to examine various causal relationships according to gender and race (C'De Baca et al., 2012; C'De Baca et al., 2014; Davis, Deen, Fortney, Sullivan, & Hudson, 2014; Hausmann, Gao, Mor, Schaefer, & Fine, 2014a; LaCroix et al., 2016; Smith, Goldstein, & Grant, 2016).

As the majority of studies are quantitative and examine the relationship between two identity factors, they are unable to engage questions of systemic power and inequalities in relation to overlapping identities, per intersectionality. Indeed, of the 22 articles in this group, only one explicitly cites intersectionality in their method (Dernberger, 2017). This work, which surveys socioeconomic issues in veterans, specifically criminal justice, "examines ways in which existing literature is intersectional and highlights the lack of analyses about systems of power that amplify or moderate former prisoner re-entry and veteran transition for those identifying as LGBT" (Dernberger, 2017, p. 104). Rather than comparing different social groups, Dernberger

uses a system-centered approach, which centers findings within the context of structural inequality and unequal power relations (Dernberger, 2017, p. 110). Specifically, Dernberger (2017) argues that "studies of former prisoner re-entry and veteran reintegration are empirically intersectional, but reflect binary norms based on individual categories and do not account for any fluidity of other gender or sexual orientation identities. Moreover, there is very limited structural analysis of how systems of power influence the reintegration experiences of those with LGBT identities. This lack of system-centered intersectional analysis may be due to the nature of excluding institutionalized populations from survey analysis, small sample sizes, and the perceived importance of studying marginalized populations, especially those who identify as LGBT" (pp. 121-122).

LGBT+

The literature almost exclusively uses the term LGBT, and on occasion LGBTQ. We use LGBT+ to acknowledge the wider group to whom these findings may be relevant, such as Queer and Two-spirited veterans. Literature about LGBT+ veterans accounted for 76 of the retrieved articles and focus only on this subset of veterans in the United States. The majority of these studies consider questions of health including physical health (*n*=7), mental health (*n*=21), and health-care utilization (*n*=35). A small portion of this folder includes analyses of discriminatory and anti-discriminatory policies within military and veteran associations, and their relationship to health and wellness (*n*=8). Finally, a handful discuss socioeconomic issues affecting LGBT+ veterans (*n*=5). Studies in this collection include policy analysis, cross sectional design, descriptive correlation, longitudinal studies, case studies, focus groups, interviews, and surveys.

The collection of studies on **physical health** is smaller in comparison to mental health and health care utilization. This literature finds that LGBT+ veterans experience poorer physical health in comparison to the veteran population as a whole (Downing, Conron, Herman, & Blosnich, 2018; Lindsay et al., 2016; Mark et al., 2019; Pelts, Albright, McDaniel, Laski, & Godfrey, 2019). One study focuses specifically on sexual minority women veterans, finding that they have three times greater odds of poor physical health than their sexual minority non-veteran counterparts (Blosnich, Foynes, & Shipherd, 2013b). LGBT+ veterans experience particular physical health related issues, such as: higher reports of smoking, but lower results of diabetes among sexual minority veterans, and higher rates of being overweight and smoking among same-sex partnered veterans than same-sex partnered non-veterans, but lower rates of being overweight and smoking than opposite sex partnered veterans (Blosnich, Bossarte, Silver, & Silenzio, 2013a); higher rates of cancer among sexual minority women (Lehavot et al., 2016a); and sexual minority women are more likely to misuse alcohol than other veteran subgroups (Lehavot, Williams, Millard, Bradley, & Simpson, 2016b). Higher rates of cancer among sexual minority veterans is consistent with the rates of cancer among sexual minority non-veterans,

however it is the higher rates of cancer mortality for sexual minority women compared to hetero women veterans that is statistically significant, pointing to issues related to health care equity, especially screening (Lehavot et al., 2016a).

This literature contends that LGBT+ veterans experience poorer **mental health and well-being** and experience more sexual trauma than the general veteran population (Mark et al., 2019). Minority stress theory is used by Livingston, Berke, Ruben, Matza, and Shipherd (2019) to explain the psychosocial toll of having minority sexual and gender identity in the context of the military, which privileges heterosexuality and traditional gender performances. LGBT+ veterans disclose a range of clinically relevant stressors, including traumatic events, such as increased instances of MST (Lucas, Goldbach, Mamey, Kintzle, & Castro, 2018), minority stress and microaggressions, such as interpersonal and institutional discrimination perpetrated by fellow service members/veterans, citizens, therapy group members, and health care providers (Livingston et al., 2019). Events such as MST are linked to higher rates of PTSD and depression (Lucas et al., 2018). One study finds that among LGBT+ individuals, military experience is associated with a four-fold increased risk in reporting a past-year suicide attempt (Blosnich, Gordon, & Fine, 2015). LGBT+ veterans' increased risk of suicide are due to factors such as low social support and victimization (Matarazzo et al., 2014).

A portion of the literature on mental health in this population focuses exclusively on **sexual minority veterans**. Studies report that LGB veterans are more likely to screen positive for posttraumatic stress disorder (PTSD), depression, and alcohol problems than the comparison sample (Anderson-Carpenter, Rutledge, & Mitchell, 2020; Cochran, Balsam, Flentje, Malte, & Simpson, 2013; Cortes, Fletcher, Latini Dm PhD, & Kauth, 2019). Anxiety around concealment of one's sexual orientation while in the service is related to depression and PTSD symptoms (Blosnich, Mays, & Cochran, 2014). Relatedly, more lesbian, gay, and bisexual (i.e., sexual minority) veterans report suicidal ideation compared with heterosexual veterans, which is correlated to decreased social and emotional support (Blosnich, Bossarte, & Silenzio, 2012). A couple of studies focus exclusively on sexual minority female veterans, who are at a higher rate of mental distress than heterosexual women veterans (Blosnich et al., 2013b; Lehavot, Browne, & Simpson, 2014a). Sexual minority women veterans are more likely to experience childhood sexual trauma and MST, which account for poorer mental health conditions and substance abuse issues (Lehavot et al., 2014a; Mattocks et al., 2014b; Mattocks et al., 2013). One study focuses exclusively on bisexual veterans, finding that they have 3 times the risk of severe depression and 1.9 times the risk of PTSD as compared to lesbian/gay veterans, meaning that the high rates of mental health conditions among the LGBT+ may be distorted (McNamara, Lucas, Goldbach, Kintzle, & Castro, 2019). McNamara et al (2019) and suggests that research should assess bisexual veteran veterans as a distinct group.

Another piece of the literature on mental health in this population focuses on mental health of **transgender veterans**. Transgender and gender diverse (TGD) individuals, especially veterans, experience elevated rates of non-suicidal self-injury (NSSI) and suicide related behaviours compared to gender majority individuals (Aboussouan, Snow, Cerel, & Tucker, 2019; McDuffie & Brown, 2010). Indeed, the rates of suicide among transgender veterans is higher than the general population and they die by suicide at younger ages than their veteran peers (Blosnich, Brown, Wojcio, Jones, & Bossarte, 2014). One study suggests that rates of suicide-related events among veterans diagnosed with gender identity disorder are more than 20 times higher than the general veteran population (Blosnich et al., 2013c); while another suggests transgender veterans die by suicide at twice the rate than their cisgender veteran peers and at approximately 5.85 times the rate of the general population (Tucker, 2019; Tucker et al., 2019). Identity stigma is significantly related with high rates of depression and a low quality of psychological well-being (Hoy-Ellis et al., 2017). Factors that enhance the mental health and well-being of transgender veterans are trans-related medical intervention, both hormone intervention and surgery on chest and genitals (Tucker et al., 2018); and transgender advocacy and community building (Chen, Granato, Shipherd, Simpson, & Lehavot, 2017). Understanding the effects of minority trauma, such as MST, on poor mental health among LGBT+ veterans is advocated as essential for service providers in the provision of the best care (Lane, Sewell, Singh, Heidari, & Smilowitz, 2019).

The access and use of **health-care services** accounted for a significant portion of this literature. This literature points the discrimination against LGBT+ veterans and their poor experiences and perceptions of VA services, such as denial of services, dismissal of same sex partners, and bureaucratic exclusions in forms and policies (Ruben, Livingston, Berke, Matza, & Shipherd, 2019; Sharpe & Uchendu, 2014). Survey participants of this group identify concerns that providers often hold to heterosexual cultural norms; and identify incorrect provider assumptions about sexual orientation and sexual practices as frequently compromising their care (LaVaccare et al., 2018). For example, Brown and Jones (2016) find that assumptions about breast cancer, and subsequent screening, result in transgender women veterans experiencing higher fatalities than transgender men veterans do. See also (Brown, 2015; Brown & Jones, 2015b). Likewise, LGBT+ women veterans are more likely to experience harassment and feeling unwelcome and unsafe at VA spaces than any other group, usually from men veterans in the form of distressing comments and actions (Rosentel, Hill, Lu, & Barnett, 2016; Shipherd, Darling, Klap, Rose, & Yano, 2018; Shipherd et al., 2016; Shipherd, Ruben, Livingston, Curreri, & Skolnik, 2018). Re-traumatization for LGBT+ women veterans in the VA system is especially significant, given that they experience heightened levels of discrimination, victimization and violence prior to and during service, which complicates their recovery processes (Lehavot & Simpson, 2013; Livingston et al., 2019). Because of negative past experiences with service providers and in the VA system, many veterans of LGBT+ communities are reluctant to or delay

seeking help (Hinrichs & Christie, 2019; Lehavot, Katon, Simpson, & Shipherd, 2017a; Mark et al., 2019; Simpson, Balsam, Cochran, Lehavot, & Gold, 2013) and hesitate disclosing their gender and sexual identities to service providers (Mattocks et al., 2017a; Mattocks et al., 2015b; Sherman et al., 2014a; Sherman, Kauth, Shipherd, & Street, 2014b; Shipherd, Mizock, Maguen, & Green, 2012). The remainder of this section of the literature focuses on the general lack of knowledge about LGBT+ patients among service providers (Rosentel et al., 2016) and emphasizes the importance of providing services tailored to the unique needs of LGBT+ veterans (Dietert, Dentice, & Keig, 2017; Mankowski, 2017; Proctor & Krusen, 2017; Puntasecca, Hall, & Ware, 2019; Ramirez et al., 2013; Ramirez & Sterzing, 2017; Ruben, Blosnich, Dichter, Luscri, & Shipherd, 2017; Sherman et al., 2014b; Shipherd et al., 2012). One study finds that half of providers do not alter their treatment plans even if they know the veteran is lesbian, gay, or bisexual (Sherman et al., 2014a). Training modules and pilot programs are assessed to show amelioration in knowledge and attitudes of service providers (Donaldson, Smith, & Parrish, 2019; Johnson, Shipherd, & Walton, 2016; Sullivan, Mills, & Dy, 2016), such as provider training for trans-affirmative healthcare in the VA and military setting (Chen et al., 2017; Shrader et al., 2017; Valentine, Shipherd, Smith, & Kauth, 2019). See also (Kauth, Blosnich, Marra, Keig, & Shipherd, 2017; Kauth & Shipherd, 2016; Kauth et al., 2014; Kauth et al., 2015). A lack of research on and data about LGBT+, especially transgender veterans, is also identified as a barrier to creating appropriate services and care for this population (Lutwak et al., 2014).

A handful of the articles on LGBT+ veterans refer to the **legacies of discriminatory policies**, especially the United States' Don't Ask Don't Tell (DADT), on mental health, such as PTSD and depression, and health care access, such as institutional norms and service provider attitudes (Kuzon, Sluiter, & Gast, 2018; Sharpe & Uchendu, 2014) and the lack of trust in service providers (Blosnich & Silenzio, 2013; Goldbach & Castro, 2016). In another way, two studies argue that the repeal of DADT diverts attention away from the ongoing victimization experienced by LGBT+ members and veterans (Burks, 2011), especially the unique experience of transgender veterans (Alford & Lee, 2016). Finally, a couple of studies investigate current policies, including the challenges with ongoing shifts concerning service eligibility and medical coverage for transgender members (Ford & Schnitzlein, 2017; Kuzon et al., 2018); and the benefits of employment discrimination protection for LGBT+ veterans on mental health (Blosnich et al., 2016).

Lastly, a minority of studies consider the **socioeconomic conditions and needs** of LGBT+ veterans, such as health disparities when they are incarcerated (Brown & Jones, 2015a); the rates of housing instability for transgender veterans as being 3 times higher than cisgender veterans, especially if they are women, young, unmarried and White (Carter et al., 2019) see also (Montgomery , Shipherd , Kauth , Harris , & Blosnich 2020); and the experiences of lesbian widows of veterans and their financial and social challenges (Hinrichs & Christie, 2019).

Race and Indigeneity

Research that addresses veteran and transition related issues for racial and ethnic minority veterans are predominantly of the American veteran population, except a study on Indigenous veterans in Canada (Abdulwasi, Evans, & Magalhaes, 2016). The pieces on race and veterans mostly consider questions of physical health, mental health, and utilization of health-related services provided by the VA. These studies involve critical narratives analyses, regression analyses, retrospective cohort studies, and cross-sectional surveys.

Of the (*n*=80) articles in this collection, (*n*=20) focus primarily on the impacts of race and ethnicity on veterans' **physical health**, and another (*n*=3) on the combination of physical and mental health issues. Studies uncover various correlational relationships with race such as: pain and opioid treatment (Burgess et al., 2016); vitamin D insufficiency and the impacts of chronic illness (Cartier, Kukreja, & Barengolts, 2017; Peiris, Bailey, Peiris, Copeland, & Manning, 2011); prostate cancer (Sterling, Weiner, Schreiber, Mehta, & Weiss, 2016); hypertension risks (Finkelstein & Cha, 2013); cardiovascular issues (Kovesdy et al., 2015; McClerking & Wood, 2016; Norris et al., 2016); the relationship between rank and health outcomes (Maclean & Edwards, 2010); abnormalities in calcium metabolism and heart conditions (Lu et al., 2016); outcomes in spinal cord injury (Myaskovsky et al., 2017); the relationship between PTSD, insomnia and obesity (Lee & Gabriele, 2018); diagnoses of hepatitis C (Benhammou et al., 2018); and mortality (Landes, Wilder, & Williams, 2017). The literature suggests that veterans' physical health issues will differ according to race, requiring tailored services. For example, Black veterans are more likely to experience and need support for HIV/AIDS and schizophrenia, while White veterans are more likely to have chronic illness related to heart disease and bipolar disorder (Breland, Chee, & Zulman, 2015a). Importantly, Black, Hispanic and other racial minority veterans experience worse, and report poorer physical health than White veterans (Sheehan, Hummer, Moore, Huyser, & Butler, 2015). Other factors influencing poor health among racial and ethnic minority veterans are living in rural areas for Hispanic and Indigenous veterans, while living in urban areas increases the health issues of Black veterans (Gebregziabher et al., 2018). However, studies show that mortality risks are lower for racial and ethnic minority veterans, which (Sheehan & Hayward, 2019) suggest is due to the socioeconomic support offered through military service in the United States.

The impact of race and ethnicity on **mental health** feature prominently in this literature, accounting for (*n*=14) of the articles in this section. These studies reveal that racial minority veterans are more likely to screen positive for PTSD compared to White veterans (McClendon, Perkins, Copeland, Finley, & Vogt, 2019) and Black veterans are more likely to experience suicidal ideation and exhibit self-harm behaviour after surgery (Copeland et al., 2014). Poorer mental health among racial and ethnic minority veterans is found by Muralidharan, Austern,

Hack, and Vogt (2016) to be related to greater perceived threats in combat and more family-related concerns and stressors during deployment. Of note, racialized female veterans report the highest level of post-deployment symptoms, due to more traumatic and stressful deployment experiences (Muralidharan et al., 2016). Poorer mental health might account for the increased rates of alcohol use disorder among male and female Black veterans in comparison to Hispanic and White veterans (Williams et al., 2016). However, these trends are challenged by Kaczkurkin et al. (2016), who find that after controlling for PTSD, Hispanic veterans have higher alcohol consumption than African American or White veterans, while Rackin (2016) finds that Black veterans experience similar self-esteem to White veterans. The relationship between mental health and sexual health is explored by Gobin and Allard (2016) who find that for Black women veterans of the US military the combination of PTSD and depression informs their sexual health, whereas for European women veterans of the US military it is only PTSD. To support Black veterans' mental health, positive collaboration and relationships with health care providers have the greatest impact on reducing the negative effects of psychosis and mental illness in this population, compared to White veterans (Ali et al., 2018).

Black and racial minority veterans report **less satisfaction with veterans' services** and report perceived discrimination when accessing support. The largest component of the section on race concerns equity in health care utilization, services, and outcomes, comprising (*n*=30) of the (*n*=80) articles. The bulk of this literature is concerned with discrepancies by race in accessing services and treatment, such as racial minority veterans' reduced likelihood for: knee replacement (Hausmann et al., 2017a); nephrology consultation (Suarez et al., 2018); kidney transplantation (Freeman et al., 2017); quality HIV care and receiving combination antiretroviral therapy (Richardson et al., 2016); alcohol use disorder treatment (Williams et al., 2017); likelihood of receiving medicine from VA for alcohol use disorders is lower among Black veterans (Williams et al., 2016); readmission rates (Kheirbek, Wojtusiak, Vlaicu, & Alemi, 2016); colorectal screening (Changoor et al., 2018); low emergency severity screening (Vigil et al., 2015); variations in mortality (Ibrahim, 2018); and quality end of life care, including family satisfaction and receiving a chaplain (Kutney-Lee et al., 2017). A handful of studies uncover racial disparities in reproductive health services, pointing to the unique experiences of women-identifying veterans such as: increased rates of infertility and decreased likelihood of receiving infertility treatment among racial minority veterans (Goossen et al., 2019); higher rates of excess hysterectomy among Black women veterans as compared to White women veterans (Katon et al., 2019a); lower likelihood of being prescribed with contraception, especially uterine devices and implants and perceived discrimination by Black female veterans (MacDonald et al., 2017; Misra & Giurgescu, 2017; Quinn et al., 2020; Rosenfeld et al., 2017).

Studies on the racial disparities in the provision of mental health service find Latinos, African Americans, and Asian/Pacific Islanders are less likely than White veterans to receive any

individual therapy (Spoont, Sayer, Kehle-Forbes, Meis, & Nelson, 2017); and Black veterans have the worst perception of the interpersonal qualities and patient/client relationships with practitioners diagnosing for disability, such as PTSD (Rosen et al., 2013). The perception and evaluation of mental health programs and providers are an especially important factor in retaining Black and Hispanic veteran clients (Spoont, Nelson, van Ryn, & Alegria, 2017). A portion of these pieces analyze the relationship between race and satisfaction with support and services: Black veterans report less satisfaction and trust with VA service provider and health care, especially outpatient care (Zickmund et al., 2015); racial differences in veterans satisfaction with addiction treatment services (Jones et al., 2015); and satisfaction ratings are lowest among Hispanic veterans and for VA facilities that serve a high concentration of Black veterans (Hausmann et al., 2017b). Indeed, racialized veterans report worse experiences than White veterans with access, comprehensiveness, communication, and office staff helpfulness/courtesy (Jones et al., 2016).

The impacts of race on the likelihood of engaging in services provided by the VA is another theme in the health care utilization research (Hebert & Hernandez, 2016; Hernandez et al., 2016; Shaw, Luk, Chen, Wrenn, & Chen, 2017). Black veterans represent the largest portion of high-utilizing veterans (Breland et al., 2015a), pointing to the significance of the service trends outlined above. As it concerns mental health services, Asian-American veterans are the least likely racialized group to engage in these services because of perceived stigma around mental illness (Chu, Garcia, Koka, Wynn, & Kao, 2018). Likewise, Brooks et al. (2015) and Herbert, Leung, Pittman, Floto, and Afari (2018) find that Asian Americans experience less psychological resilience and less social support by their peers and communities than White counterparts. The authors call for more research on the link between social support and psychological resilience in relation to ethnic culture (Herbert et al., 2018). Initiation of treatment for alcohol abuse is found to be more likely by Black veterans and Hispanic veterans than by White veterans (Bensley et al., 2017). Barriers to seeking care and support include inadequate information and lack of visit preparation—barriers which are more prevalent in ethnic minority populations (Eliacin, Rollins, Burgess, Salyers, & Matthias, 2016a, 2016b; Washington et al., 2017) and inadequate resources, such as internet (Calhoun et al., 2016; Kramer et al., 2011). In non-VA healthcare systems, veterans who are racial minorities, have less education, and are without private health insurance are less likely to use services, which emphasizes the importance of socioeconomic context in health disparities and racial disparities in service utilization (Tsai, Desai, Cheng, & Chang, 2014a).

Despite the aforementioned findings, and its relationship with the physical and mental health and well-being of veterans, **socioeconomic studies** do not feature heavily in the collection of research on racial and ethnic minority veterans. Only (*n*=5) of the (*n*=80) studies compiled under this section address issues such as employment, education, and criminal justice. In terms of employment and race, Moore et al. (2015) find that after completing employment plans with

VA, White veterans' likelihood of returning to work is 1.5 times higher than those of African Americans, and that African American female veterans have the lowest probability for successfully returning to work. Cancio (2018) finds that technical military jobs more than nontechnical military jobs are likely to positively influence the educational and employment outcomes of American Hispanic veterans. In terms of housing, Black veterans are more likely to experience and need support with homelessness (Breland et al., 2015a) and mortgage lending programs in the United States are used more by Black veterans (Fischer & Rugh, 2018). Finally, a piece on incarceration suggests that a history of military service protects against the likelihood of incarceration of racial minorities in comparison to racialized civilians (Tsai, Rosenheck, Kasprow, & McGuire, 2013).

Indigenous veterans are treated in the literature as a distinct group (*n*=8), separate from those considering 'race', which is typically conceptualized in the American literature as Black, Hispanic, Asian and White. A comprehensive outline of the Indigenous veterans' experience in the United States is offered by (Brooks et al., 2015). They find that American Indian/Alaska Native (AIAN) and Native Hawaiian/Pacific Islanders (NHPI) are more likely to be female, report MST, and utilize the VA for posttraumatic stress disorder, traumatic brain injury, depression, addiction, anxiety, hypertension, and diabetes care (Brooks et al., 2015; O'Keefe & Reger, 2017). Mental health care and support for substance abuse is a pressing need for this population but barriers to service result from high rates of rural residence among this population. Indigenous veterans living on reserve are found to be particularly challenged in accessing services because of the lack of culturally competent care, transportation problems, and difficulties navigating the system (Kaufman et al., 2013; Kaufman et al., 2016; Villa, Harada, & Huynh-Hohnbaum, 2010). Thus, family members are often the main caregivers for Indigenous veterans; however, these family caregivers often lack necessary resources (e.g., information, support services and financial means) to procure adequate care (Kaufman et al., 2016). Many of the studies emphasize the importance of flexibility of programs and tailoring programs to the unique needs of racialized sub-populations, such as tele-health options to combat geographic barriers (Kramer, Cote, Lee, Creekmur, & Saliba, 2017; Kramer, Creekmur, Cote, & Saliba, 2015; Noe, Kaufman, Kaufmann, Brooks, & Shore, 2014; Onoye et al., 2017; Pollack, 2017; Shore et al., 2012). Moreover, studies, including the Canadian study, emphasize the importance of collaboration between veteran departments with Indigenous departments and local communities (Abdulwasi et al., 2016; Kaufman et al., 2016).

Masculinities

There is a small group of literature (*n*=12) that enquires into constructions of masculinity in relation to veterans and transition, and includes both qualitative and quantitative studies in about equal measure. The focus is on the US context with the exception of one UK-based

(Green, Emslie, O'Neill, Hunt, & Walker, 2010) and one Canadian-based article (Shields, Kuhl, & Westwood, 2017). The majority of articles focus on the relationship between masculinities and the mental health and well-being of service men and veteran men. As already noted in the introduction to the scoping review, the literature often conflates sex and gender, talking about male veterans and masculinity without problematizing the equation of one with the other. We have chosen to use the term military and veteran men (rather than male service members and veterans) below in order to separate the discussion of gender from sex.

The research finds that the traditional gender norms fostered by militaries create expectations for men to act in ways that are not seen as emotional or weak, making it more difficult for them to acknowledge, and seek help for, mental health problems (Burns & Mahalik, 2011; Danforth & Wester, 2014; Garcia, Finley, Lorber, & Jakupcak, 2011; Jakupcak, Blais, Grossbard, Garcia, & Okiishi, 2014; Jakupcak, Primack, & Solimeo, 2017). Men in the military and veteran population who endorse traditionally masculine norms such as emotional toughness are found to have an increased likelihood of screening positive for PTSD and depression (Jakupcak et al., 2014). The dilemma here is that endorsement of masculine norms may increase men's risk of mental health problems, but at the same time undermine the potential for men's help seeking. Garcia, Finley, Lorber, and Jakupcak (2011) find a significant association between PTSD avoidance symptoms and several measures of masculine behaviour, such as restrictive emotionality, inhibited affection, and exaggerated self-reliance. However, the research also finds that traditional masculine military norms, such as camaraderie and caring, may have the opposite effect and in fact can be adaptive and protective (Garcia et al., 2011; Green et al., 2010). Other studies are less clear in their findings about the relationship between norms of masculinity, PTSD, and health behaviours. For example, Morrison (2012) finds that it is not an endorsement of traditionally masculine norms but masculine gender role stress that impacts veteran men's health behaviours. A similar finding is made by Shields, Kuhl, and Westwood (2017) who argue that the struggle against a shame-based or abject masculinity that contrasts with their former military-masculine status helps explain a host of challenges that male veterans face during their transition, from adjusting to civilian life to mental health problems and low rates of health care utilization. Several of the articles call for gender-sensitive approaches to outreach and treatment of veteran men that take into account military norms of masculinity and veteran men's struggles with gender role stress (Danforth & Wester, 2014; Kivari, Oliffe, Borgen, & Westwood, 2018; Shields et al., 2017).

Three of the articles in this section examine questions of belonging, community reintegration, and transition more broadly. Researchers find that veteran men's community reintegration after TBI can be negatively impacted by adherence to traditional masculine norms (Meyers, Chapman, Gunthert, & Weissbrod, 2016). Another article looks at retired veterans to examine how they perform masculinity in the face of depression and aging, finding that years after releasing or retiring, their military identity was still an important anchor (Medeiros &

Rubinstein, 2016). Gardiner (2013) places individual men's MCT within the broader context of a military-civilian disjuncture that leaves veterans in the lurch and creates a disconnect between them and civilians. The editors of a special issue on "Examining the Implications of Masculinity within Military and Veteran Populations" underscore the need for further research into how traditional gender norms in the context of a male-dominant and masculine institution such as the military may impact not only men but also women, especially as they are called to increasingly take on combat-related roles traditionally associated with masculinity (Jakupcak et al., 2017).

Government Resources, Programs, and Initiatives

Looking at the Five Eyes partner countries, there are major differences in the extent to which they have addressed sex, gender, and GBA+ issues. The **United States** has by far the longest history—starting in 1983—and most comprehensive set of government programs and initiatives in place for women veterans (U.S. Department of Veterans Affairs, n.d.-f). It also has, though to a lesser extent, policies, programs, and initiatives in place for 'minority' veterans—ethnic, racialized, and Indigenous veterans—and LGBT+ veterans, but mostly these exist in silos. An intersectional approach, or an attempt to think about the intersection of identity categories and systems of inequality and marginalization, are rare. **Australia** began paying attention to the issue of women veterans much later, with the first landmark report published in 2012 (Crompvoets, 2012), and similarly, **Canada** began to pay attention to women veterans only in the past few years. **New Zealand** has barely begun the process of recognizing the importance of a sex and gender lens in veterans and transition issues, and the **UK** government has so far not taken any steps in this direction (however, the UK third sector has). Intersectionality in the form of GBA+ is an explicitly stated goal only in Canada, though GBA+ has so far not been integrated into veteran policy, programming, and initiatives in a comprehensive way. The following high-level overview of government policies, programs, and initiatives across the Five Eyes partner countries draws on 114 government documents and websites, with the overwhelming majority being from the United States (*n*=85), followed by Canada (*n*=16), Australia (*n*=7), the United Kingdom (*n*=5), and New Zealand (*n*=1). This discussion focuses on the time period since 2010, but also discusses initiatives that date further back if they continued after 2010 or are necessary to give historic context (such as in the US case).

UNITED STATES

In the United States, the Department of Veterans Affairs (VA) and its Veterans Health Administration (VHA) provide the vast majority of initiatives related to women, LGBT+ as well as ethnic, racialized, and Indigenous transitioning members or veterans. The Department of Defense, Department of Labor, and state-level governments also contribute in more minor

ways to addressing the needs of historically marginalized veterans. The VA Department's Office of Inspector General, the US Government Accountability Office, and US Congress play a significant role in terms of oversight and policy development.

Department of Veterans Affairs

Programming and research for women veteran health has been firmly established within the VA/VHA. Programming and research for other vulnerable veteran subpopulations is much less developed within the VA. Intersecting characteristics and vulnerabilities are rarely analyzed in concert. Even in the *National Veterans Health Equity Report*, published in 2013 by the VHA's Office of Health Equity, the health issues and VHA healthcare use of women veterans, racialized and ethnic minority veterans, older veterans, rural veterans using VHA health care, and of veterans with serious mental illness are examined side by side rather than through an intersectional lens (U.S. Veterans Health Administration/Office of Health Equity, 2016). What follows is an overview of the main relevant VA initiatives.

Advisory Committee on Women Veterans

The VA has had an Advisory Committee on Women Veterans since 1983—tasked with assessing women veterans' access to VA programs and services and making recommendations for improving their access. The Advisory Committee on Women Veterans publishes biennial reports and posts their minutes online, which give insight into ongoing concerns for this subpopulation (U.S. Department of Veterans Affairs, 2010b, 2012a, 2014a, 2016b, 2018b). The Committee's most recent available report highlights in its recommendations the continued need for identifying and addressing barriers faced by women accessing VA benefits, for "a comprehensive needs assessment of the women Veteran population" as well as for documenting "occupational and other hazardous exposures women Veterans encounter during their military services," among other things (U.S. Department of Veterans Affairs, 2018b, pp. 6-7). In 1999, a Subcommittee on Minority Women Veterans was created within the Advisory Committee on Women Veterans, showing an acknowledgment of intersecting identities and vulnerabilities within the women veteran population, but we could not find information about its current work or whether it is still in operation (U.S. Department of Veterans Affairs, n.d.-f).

Women Veteran Coordinators

Originally established in 1985, there have been Women Veteran Coordinators in every regional VA office since 1986 (U.S. Department of Veterans Affairs, n.d.-f). They "function as the primary contact for women Veterans" and "provide specific information and comprehensive assistance to women Veterans, their dependents, and beneficiaries concerning VA benefits and related non-VA benefits" (U.S. Department of Veterans Affairs, 2019d). They also provide assistance to women veterans in "the claims intake, development, and processing of military sexual and personal trauma claims" (U.S. Department of Veterans Affairs, 2019d). The VA has held

National Conferences for VA Women Veterans Coordinators in the past (U.S. Department of Veterans Affairs, n.d.-f).

Centre for Women Veterans

The VA's Center for Women Veterans was established by the US Congress in 1994 (U.S. Department of Veterans Affairs, n.d.-f). The mandate of the Center for Women Veterans is to monitor and coordinate the administration of VA benefits, services, and programs for women veterans. As the VA explains on its website, "The Center advocates for a cultural transformation that recognizes the service and contributions of women Veterans and women in the military, and also raises awareness of the responsibility to treat women Veterans with dignity and respect" (U.S. Department of Veterans Affairs, 2019d).

National Summits on Women Veterans Issues

The first National Summit on Women Veterans Issues took place in 1996, with follow-up summits every few years since then. The goal of the upcoming October 2020 Summit, which is aimed at a cross-sectoral audience, is "to identify challenges and opportunities facing women Veterans and innovative solutions and best practices in serving them" (Women Veterans Alliance, n.d.).

Veterans Health Administration

The Veterans Health Administration (VHA) is the part of the US Department of Veterans Affairs which provides and implements the VA healthcare program. It operates 1,255 health care facilities, which include 170 VA Medical Centers and 1,074 outpatient sites serving more than 9 million veterans (U.S. Department of Veterans Affairs, 2019b). The VHA has a special focus on Women Veterans Health Care and provides Women's Health Services. Health Care Services specifically for women were first established in 1988, but have since been restructured (U.S. Department of Veterans Affairs, n.d.-e). Sex-specific health care services for women veterans include: primary health care services; intimate partner violence services; MST services; maternity health care services (in vitro fertilization and emergency contraception, but not abortions, abortion counseling, or therapeutic abortions); and newborn health care services. There are designated Women's Health Primary Care Providers (WH-PCP) at every VA care site to "ensure women Veterans receive equitable, timely, high-quality primary health care from a single primary care provider" (U.S. Department of Veterans Affairs, 2020d). In fact, the VA states in its policies that it "strives to be a national leader in the provision of health care for women, thereby raising the standard of care for all women" (U.S. Department of Veterans Affairs/Veterans Health Administration, 2012a, p. 1). The VHA also seeks to provide specialized mental health services aimed at women veterans, referred to by the VA as "Gender-Specific Care." In doing so, the VA acknowledges that "Mental health services need to be provided to those who need them in a manner that recognizes that gender-specific issues can be important components of care" and states it offers patients seeking treatment at VA facilities the option

of choosing when they want a same-sex or opposite-sex provider (U.S. Department of Veterans Affairs/Veterans Health Administration, 2008 (amended 2015), 2017). Furthermore, each VA medical center across the United States should have a Women Veterans Program Manager who advises and advocates on behalf of women Veterans. The Women Veterans Program Manager is responsible for coordinating services for women veterans, identifying gaps in services, and more (U.S. Department of Veterans Affairs/Veterans Health Administration, 2012b, 2018).

Women Veterans Task Force

A Women Veterans Task Force was stood up in 2011 and "charged with developing a comprehensive VA action plan for resolving gaps" in how the VA serves women veterans (U.S. House Committee on Veterans Affairs, n.d.). As a result, the department developed a 2012 Report "Strategies for Serving Our Women Veterans." The proposed strategies were: "capacity and coordination of services," "environment of care and experience," "employment and training," "data collection and evaluation of services," and "organizational accountability, collaboration, and transparency" (U.S. Department of Veterans Affairs/Women Veterans Task Force, 2012). It acknowledges that women veterans have unique care and service needs that have to be addressed through a comprehensive strategy and action plan that is implemented across the department.

VA Outreach to Women Veterans

The webpage of the Center for Women Veterans is a portal to many resources for women veterans (U.S. Department of Veterans Affairs, 2020b). But the VA also reaches out to women veterans by placing relevant content throughout its webpages. Many VA webpages have a subsection specifically addressing women veterans, see for example, the VA webpage on homelessness (U.S. Department of Veterans Affairs., 2020), on VA Benefits and Health Care (U.S. Department of Veterans Affairs, 2019d), and others. The VA also has a Women Veteran Call Center that is mandated to connect women veterans with VA services (855-VA-Women or 855-829-6636). The VA also engages women veterans through videos and podcasts about women veteran issues and research (U.S. Department of Veterans Affairs, 2020b).

VA/VHA Research on Women Veterans

The VA has established itself as a national leader on women's health research, and women veteran research more specifically. Research is viewed by the VA as a central component in order to appropriately address women veteran issues and it has pursued a comprehensive research agenda on women veterans' health over the past two decades. Research accelerated post 2001 as a result of women's greater involvement in the US wars in Afghanistan and Iraq. By 2008, VA's Health Services Research & Development Service was funding 27 research projects on women veteran issues. In 2010, the VA hosted a Women's Health Services Research Conference on the theme of "Using Research to Build the Evidence Base for Improving Quality of Care for Women Veterans" (U.S. Department of Veterans Affairs, n.d.-f). By 2013, the VA was

investing in 86 studies on women veterans health and women veterans health research was being conducted at 37 VA sites (U.S. Department of Veterans Affairs, n.d.-f). Today, VA research on women veteran health is continuing to expand. Dozens of research studies on women veterans have been and continue to be carried out by the VA through the VHA and its facilities and research networks. The VA Center for Women Veterans has a dedicated webpage on Research for Women Veterans which includes a call for women to participate in VA research in general (to avoid male biased research data) and a list of VA reports and research, academic research, and PubMed resources specifically on women veterans' health (U.S. Department of Veterans Affairs, 2020c). The VA also engages women veterans and women veteran health researchers within and beyond the VA/VHA by sharing research findings through email updates (VA Women's Health Research listserv), videos, podcasts, and webinars, and publishing Women Veterans' Research Highlights (U.S. Department of Veterans Affairs, n.d.-g). The research resources on women veterans' health that are available through the VA website are extensive and a thorough description is beyond the scope of the current project, however, some key themes include: research on the demographic characteristics of the women veteran subpopulation, such as fact sheets (U.S. Department of Veterans Affairs, 2017a) or the Million Veteran Program (U.S. Department of Veterans Affairs, 2019c); on the effects of military service and deployment on women's health (Batuman et al., 2011; U.S. Department of Veterans Affairs/VA Health Services Research & Development, 2016; Zephyrin et al., 2014); research on the experiences, needs, and characteristics of women seeking care in the Veterans Health Administration (Frayne et al., 2010; Frayne et al., 2012; Frayne et al., 2018; Frayne et al., 2014; U.S. Department of Veterans Affairs, 2015c); and research on suicide among women veterans (U.S. Department of Veterans Affairs/Office of Mental Health and Suicide Prevention, 2017, 2018, 2019). Another key research tool the VA uses to learn more about women veterans' characteristics and needs is statistical analysis and data collection. Through its National Center for Veteran Analysis and Statistics, the VA regularly publishes a profile of women veterans (U.S. Department of Veterans Affairs/National Center for Veterans Analysis and Statistics, 2016b, 2017b) as well as reports on women's military service history and VA benefits utilization (U.S. Department of Veterans Affairs/National Center for Veterans Analysis and Statistics, 2011, 2017b).

Women Veterans Homelessness

The VA provides "gender-sensitive homelessness services of women veterans" through their extensive VA Programs for Homeless Veterans (U.S. Department of Veterans Affairs., 2020). As the VA states on its website:

> many women Veterans face challenges when returning to civilian life, including raising children on their own or dealing with the aftereffects of MST. Without intervention, these and other issues can put women Veterans at greater risk of homelessness. The VA

> also strives to address the individualized needs of women throughout its specialized programs for homeless Veterans (U.S. Department of Veterans Affairs., 2020).

The same VA webpage on "Veterans Experiencing Homelessness" features an 8-minute video about women veteran homelessness and how the VA aims to provide gender-sensitive homelessness services (U.S. Department of Veterans Affairs., 2020).

MST Survivors

Every regional VA office and VA medical center is supposed to have a man and a women acting as MST Coordinator who can serve as a contact person for MST-related issues (U.S. Department of Veterans Affairs, n.d.-a). The MST Coordinator can inform veterans about accessing VA services and programs as well as other federal, state-level, or community resources. Regardless of whether the veteran is a VA client, has a service-connected disability or injury, is planning to make a VA claim, or has reported or documented an MST incident, the VA provides specialized services to MST survivors. These services include free, confidential counseling and treatment, and residential or inpatient programs (U.S. Department of Veterans Affairs, n.d.-a). The VA also provides an array of resources on its webpage such as brochures for survivors, educational tools for providers, and articles to inform survivors and providers about MST and VA's free MST-related services (U.S. Department of Veterans Affairs, n.d.-b).

LGBT+ Veterans

The VA/VHA exclusively uses the term LGBT, even as some of its relevant policies go beyond the LGBT population to explicitly include intersex veterans. There are currently two key VHA directives laying out care standards for LGBT+ veterans at VA facilities, one focusing on providing equitable care to gay, lesbian, and bisexual veterans and the other focusing on transgender and intersex veterans. The directives overlap in key elements as VHA policy directs staff to "provide clinically appropriate, comprehensive, Veteran-centered care with respect and dignity" to lesbian, gay, bisexual, transgender, and intersex veterans (U.S. Department of Veterans Affairs/Veterans Health Administration, 2017, amended 2019, 2018, amended 2019). Furthermore, every VA facility is required to have an LGBT Veteran Care Coordinator who works to ensure veterans receive "culturally competent, patient-centered, and effective care," identifies needs and gaps, recommends changes, provides education, serves as an advocate and "problem-solver for LGBT Veteran-related health care issues," and more (U.S. Department of Veterans Affairs/Veterans Health Administration, 2017, amended 2019, 2018, amended 2019). The VA also aims to reach LGBT and intersex veterans and their family members by highlighting them as a "Special Group" on the VA Benefits and Health Care webpage as well as on the VA webpage on Patient Care Services for Veterans with Lesbian, Gay, Bisexual and Transgender (LGBT) and Related Identities (U.S. Department of Veterans Affairs, n.d.-d).

Racialized and Indigenous Veterans ('Minority' Veterans)

The VA has a Center for Minority Veterans that was established in 1994. The mandate of the Center for Minority Veterans is "to ensure all veterans receive equal service regardless of race, origin, religion, or gender" (U.S. Department of Veterans Affairs, 2020a), but its main focus is on racialized and Indigenous veterans. The Center develops policies and programs and engages in outreach to and advocacy on behalf of minority veterans, who it defines as including Black or African American veterans, American Indian and Alaskan Native veterans, Asian American and Pacific Islander veterans, and Hispanic or Latino veterans. Minority Veteran Reports are published annually by the VA's National Center for Veterans Analysis and Statistics to capture the characteristics and needs of this growing subpopulation of veterans (U.S. Department of Veterans Affairs/National Center for Veterans Analysis and Statistics, 2013, 2014, 2015, 2016a, 2017a). There is also a VA Secretary's Advisory Committee on Minority Veterans, with annual reports available (U.S. Department of Veterans Affairs, 2010a, 2011, 2012b, 2013, 2014b, 2015b, 2016a, 2017b, 2018a). As the most recent report acknowledges, one third of women veterans are also minority veterans in the definition used here, underscoring the need to look at overlapping sex, gender, racialized, ethnic, and Indigenous vulnerabilities in the veteran population (U.S. Department of Veterans Affairs, 2018a). In 2019 the VA held its first National Minority Veterans Summit. The summit objectives were "To provide minority Veterans and the local/state/Federal/NGO partners who serve them, with information about VA benefits and services," "To engage in transparent dialogue about issues impacting minority Veterans," "To share minority-focused research and innovations," "To receive feedback from minority Veterans and connect with community partners," and "To identify unique issues and concerns of minority Veterans that impact their Veteran experience" (U.S. Department of Veterans Affairs, 2019a).

Our scoping review also located two reports specifically about Native American veterans: one addresses homelessness and strategies to end homelessness among Native American veterans and the other is based on a 2013 community survey of American Indian and Alaska Native Veterans. As the report on homelessness explains, "Women Veterans and their children have even fewer options for shelter" in tribal homeless shelters, which reflects the evidence found for non-tribal homeless shelters (Kaufman, Shangreau, Dailey, Bair, & Shore, n.d., p. 19). The other report looks at the demographic, socioeconomic, and health status statistics of American Indian and Alaska Native Veterans, and states that women are overrepresented in this subpopulation compared to "all other races" (U.S. Department of Veterans Affairs, 2015a, p. 4). While the intersectional lens is not well developed in these reports, these statements do point to the need to include such a lens.

VA Office Inspector General

The VA Department's Office of Inspector General serves an oversight function within the department (U.S. Department of Veterans Affairs, n.d.-c). Primarily, this office is concerned

with promoting efficiency and effectiveness of VA activities, criminal activity, waste, abuse, and mismanagement. However, the office has also conducted important reviews of programs as they relate to women veterans and made important recommendations about improving women veterans' equitable access to benefits and health care (U.S. Department of Veterans Affairs/Office of Inspector General, 2010, 2017; U.S. Department of Veterans Affairs/Office of Inspector General (Office of Audits and Evaluations), 2018).

Department of Defense

By comparison with the VA, the Department of Defense (DoD) does not offer as developed an array of initiatives aimed at historically underrepresented service members as they embark on transition. However, the US DoD Women's Health webpage does explain: "While women and men have many of the same health issues, women may be affected differently than men. And, some conditions are unique to women" (U.S. Department of Defense/Military Health System, n.d.). It lists sex-specific health issues that female service members, family members, and retirees should be particularly attentive to such as breast diseases, menopause, pregnancy, and reproductive health. It includes news on relevant research such as, for example, the sex-specific impacts of concussions. The US DoD also created the Women's Health Task Force in 2011 (U.S. Army, 2015) to address the 23 recommendations that came out of the analysis of the Women's Health Assessment Team regarding the concerns of women serving in the Afghanistan theater of operations (Naclerio, Stola, Trego, & Flaherty, 2011), thus acknowledging the sex-specific health impacts of service and deployment on women that can have long-term impacts on their transition to civilian life.

Joint Initiatives between VA and DoD

There is a dearth of joint initiatives between the VA and DOD on transition issues, despite the growing recognition that doing so is likely to improve outcomes for veterans. Only two joint initiatives were found in our scoping review. The first concerns an upcoming Women's Health Transition Training that is being provided jointly by the VA Women's Health Services Office and the DoD. Its goal is to inform servicewomen about the women's health services available to them within the VA health care system (U.S. Department of Veterans Affairs, 2020e). Another joint initiative is the VA and US National Guard Demobilization and Reintegration program aimed specifically at outreach to women veterans of the Iraq and Afghanistan wars (Gunter-Hunt, Feldman, Dendron, Bonney, & Unger, 2013).

Department of Labor

The US Department of Labor has a Veterans' Employment and Training Service (VETS) Women Veteran Program (U.S. Department of Labor, n.d.). Its website has a series of factsheets and webinars specifically speaking to women veteran employment issues, research gaps, as well as several publications on women veterans and employment (U.S. Department of Labor/Veterans' Employment and Training Service, 2015, n.d.), indicating cross-departmental concern about women veteran issues.

US Congress

In 2019, the House Veterans' Affairs Committee of the US Congress launched a Women Veterans Task Force (U.S. House Committee on Veterans Affairs, n.d.). The Task Force is concerned with

> creating a cultural transformation in which women veterans are visibly recognized for their service to the nation, and have a sense of belonging. In order to access the resources that are available to them, the Department of Veterans Affairs must first foster an environment that is safe and respectful. The Women Veterans Task Force will develop policy specifically focused on supporting women veterans, and on transforming existing systems and institutions with an eye on equity, through outreach, oversight, and legislation (U.S. House Committee on Veterans Affairs, n.d.).

Policy priorities of the Task Force are to include "Ensuring a welcoming and inclusive culture at the VA", "Providing equity and access to VA healthcare, including women-specific care, such as gynecology and obstetrics", "Improving economic opportunities for women veterans and their families", "Guaranteeing that women veterans have equal access to VA benefits, including education, disability, and pension benefits" (U.S. House Committee on Veterans Affairs, n.d.). In November 2019, the Deborah Sampson Act—"To amend title 38, United States Code, to improve the benefits and services provided by the Department of Veterans Affairs to women veterans, and for other purposes"—was introduced in Congress and is now undergoing hearings. It proposes a host of changes that would expand readjustment assistance, legal services, care of women veterans' newborns, barriers to health care, and data collection and reporting (U.S. Congress, 2019-2020). Finally, the US Government Accountability Office, "an independent, nonpartisan agency that works for Congress" plays an important oversight function over government (U.S. Government Accountability Office, n.d.). Over the past decade it has published three reports regarding women veterans (among many other related reports on women in the military) and made important recommendations about improving women veterans' equitable access to benefits and health care (U.S. Government Accountability Office, 2010, 2014, 2016). The US Government Accountability Office has also published a report on the

need to better identify and address racial and ethnic disparities in VA Health Care (U.S. Government Accountability Office, 2019).

US State-Level Policies

Policies targeting women veterans exist at the US state-level too: "At least 15 states—California, Connecticut, Georgia, Hawaii, Illinois, Indiana, Kentucky, Maine, Massachusetts, Nevada, New Jersey, New York, Oklahoma, Oregon and Texas—have established a female veteran program or division or named a female veterans coordinator to oversee state benefits and services" (U.S. National Conference of State Legislatures, 2019). Some US states such as Oregon, also have an LGBTQ veteran coordinator who "works to build a strong community of and for LGBTQ veterans in Oregon, while also helping shape Oregon laws for the LGBTQ and veteran communities through advocacy and direct recommendations to the Legislature" (U.S. Oregon Department of Veterans Affairs, n.d.). Some US state departments of Veterans Affairs also hold Women Veteran Summits, such as the Washington State Department of Veterans Affairs, which does so annually (U.S. Washington State Department of Veterans Affairs, n.d.).

AUSTRALIA

In Australia, a landmark report on the health and wellbeing of women veterans was delivered to the Department of Veterans' Affairs in 2012 by researcher Samantha Crompvoets (Crompvoets, 2012). The report was the first study of its kind in the Australian context and drew on interviews with women veterans and stakeholders. The report found significant barriers for women veterans in accessing services, significant gaps in policy, information, and resources for women veterans, and gaps in knowledge that detrimentally affect women veterans' health and well-being as well as service provision. It made a series of key recommendations from targeted supports for women veterans, visibility of services for women veterans and of women veterans themselves, training of civilian health care providers on women veteran health issues, family friendly practices, to developing a research agenda on women veteran health (Crompvoets, 2012). In response to the report, the ADF [Australian Defence Force] Service Women Steering Committee was established, jointly chaired by the Department of Veterans' Affairs and the Department of Defence, which made 27 recommendations. The recommendations covered issues across what the report refers to as the "Support Continuum" framework that includes prevention, health care and recovery, liability determination, member support, return to work, transition, and post-transition care and support (Australia. Department of Veterans' Affairs/Department of Defence, 2013). They included issues such as providing a common information portal for serving and former ADF member, providing information on women's health, developing research (e.g. on the impact of military service on fertility), applying a "gender lens" in information products, and highlighting

available services to women veterans, and more (Australia. Department of Veterans' Affairs/Department of Defence, 2013). The Department of Veterans' Affairs furthermore has held yearly consultations ("Policy Forums") with women veterans and veterans' family members since 2016. The forums focus on information exchange between women veterans, stakeholders, and the department, such as learning circles, and identifying policy challenges and solutions (Australia. Department of Veterans' Affairs, 2017a, 2017b, 2018, 2019). Except for 2017, when a separate forum was held for women veterans, the forum includes both women veterans and families. More recently, in 2018, the Australian Department of Veterans' Affairs announced the establishment of a Council for Women and Families United by Defence Service. As the DVA explains, "The Council will build on the work of the Forum by providing a formal mechanism for providing advice to the Minister on high level and complex strategic matters relating to women and families impacted by defence service" (Australia. Department of Veterans' Affairs, 2020a). The stated goal is

> to ensure the needs of women and families united by defence service are understood and visible, and their voices are heard. The Council brings these voices together to provide timely and comprehensive advice to Government on matters that involve or affect them, drive coherent policy outcomes and advocate on behalf of these women and families (Australia. Department of Veterans' Affairs, 2020b).

NEW ZEALAND

There is only one noteworthy initiative by the New Zealand Government—the International Webinar series and Working Roundtable Program on Military, Veterans and Families Wellbeing chaired Robert Lippiatt. This Webinar series was initiated by Veterans Affairs New Zealand and the New Zealand Defence Force and is sponsored by Veterans Affairs New Zealand (We Served, 2020). The Webinar series, which began in August 2019, aims to connect researchers, policymakers, advocates, and service providers across the Five Eyes partner countries through presentations by 'thought leaders' on veteran and veteran family issues. In June 2020, the Webinar series embarked on a new focus area exploring the needs and issues impacting women, LGBT+, and racialized and Indigenous veterans. It also includes topics such as military sexual trauma and intimate partner violence (We Served, 2020). New Zealand currently has no other government initiatives or government publications or resources that bring a sex, gender, or GBA+ lens to MCT or veteran issues.

UNITED KINGDOM

The UK Ministry of Defence, and its Office for Veterans' Affairs, have no publications, resources, or other initiatives aimed at bringing a sex and GBA+ lens to MCT or veterans issues, despite

recently publishing a defence diversity and inclusion strategy (U.K. Ministry of Defence, 2018a). None of the key documents on veterans issues and policy, such as the Veterans' Transition Review from 2014, known as the Ashcroft Report, the Strategy for Our Veterans from 2018, nor the Holistic Transition Policy from 2019 make mention of women specifically, nor of gender or any GBA+ related terms (Ashcroft, 2014; U.K. Ministry of Defence, 2018b, 2019). While outside of the scope of this review, it is worth noting that the third sector has recently begun to address women veteran issues. There are two new studies—one by Salute Her which focuses on the mental health of UK women veterans (Edwards & Wright, 2019) and another which is funded by Forces in Mind Trust carried out by Cranfield University and the Institute for Employment Studies and which focuses on releasing women members (termed service leavers in the UK context) as they transition to civilian employment (Parry, Battista, Williams, Robinson, & Takala, 2019.). Both reports indicate sex- and gender-specific vulnerabilities and risk factors (e.g., lower employment rates of women compared to men) and the need for targeted supports for women veterans.

CANADA

Over the past few years, first steps have been taken in Canada toward developing gender-informed policy and programming for MCT and veterans. In 2016, the House of Commons Standing Committee on Veterans Affairs report on *Improving Service Delivery to Canadian Veterans* recommended "That Veterans Affairs Canada and the Veterans Review and Appeal Board accelerate their efforts to hire as many veterans as possible in all sectors and at all levels of their organizations, using a gender-balanced approach that would reflect the adequate proportion of female veterans" (Canada. House of Commons, 2016).

Beginning in 2017, Veterans Affairs Canada took steps to introduce gender-based analysis plus (GBA+) into policy, research, and service delivery. VAC appointed a GBA+ Champion, Ms. Charlotte Bastien, who was tasked with promoting "GBA+ awareness and disseminat[ing] tools and best practices to support consistent implementation of GBA+ throughout the Department" (Veterans Affairs Canada, 2020a). In 2018, the GBA+ Champion helped establish a *GBA+ Network* with 60 representatives across the Department in diverse regions across the country. The goal of the Network is to "discuss current initiatives and share information related to GBA+" and develop a *Departmental GBA+ Action Plan* around the pillars of tools and training; compliance; reporting and data analysis; information and awareness; and ongoing monitoring. The Department's 2018-19 *Employee Pulse Survey* Preliminary results show that 31.71% of staff reported to be aware of GBA+ and an additional 42.63% of respondents indicated that they were both aware and understood how GBA+ affected their work environment (Veterans Affairs

Canada, 2019a). In May 2020, VAC was planning to finalize its new GBA+ framework (Veterans Affairs Canada, 2020a).

In May 2019, VAC held the first Women Veterans Forum in Charlottetown, PEI (Veterans Affairs Canada, 2019b). It brought together stakeholders groups, women veterans, VAC and DND/CAF officials, and researchers to discuss the sex- and gender-specific experiences and needs of women veterans. The agenda for the day was developed by members of the VAC Stakeholder Engagement and Outreach team, with some consultation of subject matter experts and stakeholders. The objectives of the Forum were threefold, namely to: "Develop ideas and potential solutions to policy and program challenges facing women Veterans and their families," "Present existing research on Canadian women Veterans and discuss directions for future research," and "Promote collaboration and build strong networks among women Veterans and stakeholder groups" (Veterans Affairs Canada, 2019b). As the summary report of the Women Veterans Forum shows, the discussion highlighted barriers encountered by women veterans in accessing services and benefits in a system designed on the norm of the male veteran. Participants emphasized that VAC needs to change the typical image of the veteran as well as its policies and programs to better meet women's specific needs and circumstances. VAC was also encouraged by forum participants to find ways to more effectively communicate with women veterans, and ensure women receive equitable services and peer supports (Veterans Affairs Canada, 2019b). As this report to the CAF TG is being finalized, VAC is launching a four-part virtual series titled the Women Veterans' Forum Update and LGBTQ2+ Roundtable.

In March 2020, VAC officially announced the opening of its new Office of Women and LGBTQ2 Veterans (Veterans Affairs Canada, 2020b). The mandate of the Office is "to work with Veterans, key stakeholders, experts and other Government departments to identify and address challenges and issues specific to women and LGBTQ2 Veterans and their families" (Veterans Affairs Canada, 2020b). The Office works horizontally across VAC to raise awareness about the needs of women and LGBTQ2 veterans as well as about GBA+.

VAC's Research Directorate has also taken up the task of integrating GBA+ into its work over the past few years. This has led, for example, to a working group on "Female Veterans: What do We Know and Where Do We Go from Here" at the 2018 Forum of the Canadian Institution for Military and Veteran Health Research (co-organized by Michelle Morrison and Mary Beth MacLean from VAC and Maya Eichler from Mount Saint Vincent University). Most significantly, VAC's Research Directorate has developed a large-scale profile of female and male veterans in Canada and continues to examine their data collection through a sex and GBA+ lens to determine gender-specific experiences and most urgent GBA+ related research needs. VAC research shows that women veterans in Canada face a steeper decline in income after release,

have lower rates of labour force participation, are more likely to attend school, are more likely be engaged in caregiving, and are 1.8 times more likely to die by suicide than women in the general population (MacLean et al., 2014a; MacLean et al., 2018; Simkus, VanTil, & Pedlar, 2017; Veterans Affairs Canada/Veterans Affairs Canada Research Directorate, 2018). A 2017 report by the VAC Research Directorate acknowledged the importance of various veteran identities based on sex, gender, sexualities, language, race, ethnicity, religious, and Indigeneity, but this has so far not resulted in any truly intersectional research (Thompson et al., 2017).

The Office of the Veterans Ombudsman has also recently turned its attention to women veterans as one of its focus areas for 2020. An internal scoping review has been conducted, and research on and stakeholder engagement with women veterans are under way. A 2018 report by the Veterans Ombudsman found that women veterans faced longer wait times on their claims decisions compared to men veterans (Office of the Veterans Ombudsman, 2018).

DND/CAF adopted GBA+ in 2016 and is in the process of integrating a GBA+ lens into its transition programing but does not currently have any programming specifically aimed at releasing service women or other historically marginalized service members. However, some reports have begun to acknowledge the need to pay attention to the unique challenges and stressors experienced by service women which may impact their transition to civilian life (Canada. Department of National Defence/Assistant Deputy Minister (Review Services), 2019; Manser, 2015).

A Report by Employment and Social Development Canada found that "the rate of episodic homelessness is particularly high among female Veterans, at 16.8% compared to only 6% among female non-Veterans" (Segaert & Bauer, 2016).

Very little attention has been paid in the Canadian context to racialized and Indigenous service members who are in transition and/or racialized and Indigenous veterans, with the exception of two reports that address the experiences of Indigenous service members and veterans, one by the House of Commons Standing Committee on Veterans Affairs and one by the Office of the Veterans Ombudsman (Canada. House of Commons, 2019; Office of the National Defence and Canadian Forces Ombudsman, 2017). Neither of them pays particular attention to contemporary women or gender issues in relation to MCT, though there is mention of the higher representation of women among the Rangers compared to the rest of the CAF.

NATO

NATO has several potentially relevant groups such as the Committee on Gender Perspectives as well as a Research Task Group on Transition to Civilian Life and the Research Task Group on Sexual Violence in the Military. However, it is not apparent whether there have been any

attempts to combine these efforts or any other initiatives to address sex, gender, and intersectionality in relation to military-to-civilian transition.

Part III: Discussion and Recommendations

Discussion

Research Question #1: Through a GBA+ lens, what challenges do non-traditional, historically marginalized military service members face when preparing for and/or undergoing MCT?

As our scoping review shows, there is only a small amount of literature in Canada and internationally that focuses **specifically on the transition experiences and MCT process** of non-traditional, historically marginalized military service members—and when it does, the focus is foremost on women veterans. This literature on MCT alerts us to important questions such as premature release as a result of negative military experiences, post-deployment health challenges, and social disconnection and lack of social supports upon release for this subpopulation. It also problematizes a linear and temporally limited understanding of transition and acknowledges MCT within the context of multiple life transitions across the domains of well-being. There is no existing research that **explicitly applies a GBA+ lens** and only a select few articles that attempt to apply an intersectional lens to transition and veteran issues. Most of the literature we discussed focuses on sex and is primarily found in the area of health research. There is a smaller number of articles that provide a gender perspective (primarily qualitative research of various domains of well-being), as well as a small amount of research that focuses on LGBT+, racialized, and Indigenous veteran experiences and outcomes of MCT. The existing research for the most part treats these different identity categories as separate rather than intersecting. Therefore, the following discussion highlights these different categories rather than presenting them through a truly intersectional lens. Our scoping review did not capture any literature that explicitly addresses the experiences and needs of non-binary serving or releasing/retiring members. Also, it should be noted that, except when explicitly focusing on transgender veterans, earlier studies on women likely did not include transwomen, and their experiences might therefore not be well represented in the findings. Overall, it needs to be underlined again that terminology and its changing, different, and inconsistent use across the research literature present significant challenges when dealing with this topic area.

Health Challenges

Because there is so little research specifically focused on MCT, we cast a wider net to locate research that is relevant to understanding the potential challenges that non-traditional, historically marginalized military service members face when preparing for MCT or after having left the military. Here we found **health issues** to be at the forefront of the literature, including mental health, physical health, and multifactor health concerns. It is well established in the literature that **service women and released/retired women veterans** face heightened risks for

injuries and illnesses as a result of occupational contexts and hazards. Based on the reviewed research, these include a long list of concerns: PTSD, depression, self-harm and suicide, eating disorders, insomnia, chronic pain conditions, reproductive health, sexual health, traumatic brain injuries, musculoskeletal conditions, cardiovascular conditions, irritable bowel syndrome, cancer, diabetes, and more. Increasingly, the research is recognizing the multifactorial and complex nature of women veteran health challenges, by addressing correlates between mental and physical health conditions and delineating links to military-related factors.

The potential health sequelae experienced by both men and women who are **MST survivors** are well documented in the literature across mental and physical domains of health, while noting that women veterans are at higher risk of experiencing MST than men veterans. The literature notes that MST exists within a continuum of sexual and gender-based violence experienced by women more broadly, which means that traumatic military experiences are often intertwined with complex cumulative trauma histories.

The literature also addresses the unique needs of **LGBT+ service members and veterans** who: experience poorer physical health; are at increased risk of experiencing MST; have poorer mental health, such as higher rates of PTSD and suicidal ideation resulting from minority stress; and face discrimination and harassment, if not culturally insensitive services from providers.

Racialized and Indigenous veterans are found to experience higher rates of trauma and PTSD following service (which is exacerbated for women veterans), are less likely to receive diagnoses and medical support for mental and physical health issues than their White counterparts, and experience unique socio-demographic challenges, such as living in rural areas which creates challenges for accessing services. As the literature shows, subpopulations of service members and veterans face unique health challenges that can impact their transition outcomes.

Socioeconomic Challenges

In addition to health issues, women and other minority veterans experience **socioeconomic challenges post-release**. Women veterans face a greater income decline after release and experience higher rates of unemployment than both veteran men and civilian women. Indeed, women veterans experience unique challenges with unemployment and earnings due to their increased likelihood for early release for reasons such as MST, disproportionate responsibility for caregiving, and perceived stigma about their identity and abilities by potential civilian employers. Racialized and Indigenous veterans face unique challenges with geographic barriers and transportation, employment security, access to care, integration into communities, and access to culturally and gender appropriate care and programs. LGBT+ veterans are at an

increased risk of experiencing housing instability and their conjugal partners experience discrimination with services, such as end of life care and economic support.

MCT Across Time, Domains of Well-Being, and Beyond the Individual

Existing research highlights the need for a long-term view on transition. The health consequences of military service can manifest many years and decades after release (e.g., see research on menopause), underlining the need for a **longitudinal view of transition** embedded within the broader context of multiple life transitions. As noted in the research above, it would be a prudently helpful measure for service and health care providers to ask every woman, sexual and gender minority, racialized or Indigenous person if they ever served in the Canadian military.

Health research is overwhelmingly emphasized in the literature, with less attention to socio-economic research or research that explores the interconnected and complex issues of MST. However, these health challenges are often intertwined or lead to social, socio-economic, housing, employment, and criminal justice issues, even though the majority of research tends to treat these issues as separate, reflecting disciplinary divisions between the medical and social sciences. Nonetheless, the existing literature offers some glimpses into the complexity of transition issues for historically marginalized veterans. The literature on MST underscores the need to **connect the dots between health and other domains of well-being**, as, for example, MST poses a heightened risk factor for homelessness among women veterans. These insights underline the importance of a more holistic view of transition that does not compartmentalize health issues from other important social, socio-economic, and other well-being concerns.

While most of the literature focuses on the individual, some research emphasizes the importance of addressing the MCT challenges of historically marginalized releasing/retiring members **within their social eco-system**. Family, for instance, is an important, mutually dependent consideration for historically marginalized veterans as they undergo transitions during their military career (e.g., deployment) and as they transition to civilian life. The consequences of balancing the unique demands of a military career with family do not end abruptly upon service completion. Indeed, potential family issues, such as relational disruption, may be exacerbated by military service and extend into civilian life. Moreover, the higher likelihood that women veterans, especially those identifying as sexual minorities, will experience gender-based violence (GBV), such as MST and IPV, than their civilian counterparts, poses potential long term risks for veterans and their family members.

Blind and/or Biased Systems

Notably, this research shows that the health and other challenges that non-traditional, historically marginalized veterans face take place within structures and systems that are not tailored to their needs and are instead often built on the norm of the White, male, heterosexual, cisgender service member and veteran. Military and veteran systems have historically been blind to, and characterized by, systemic biases and research gaps toward all non-traditional historically marginalized soldiers and veterans. Civilian health research and health care systems are still addressing their male/masculine/heteronormative/cisgendered/ non-Indigenous/racist-normative assumptions and biases, as is also the case for military and veteran health care. Not only do existing supports and structures not respond to their needs and therefore may not be utilized by non-traditional, historically marginalized veterans, the lack of tailored services may exacerbate the challenges faced by non-traditional, historically marginalized veterans. The research literature unequivocally calls for the development of specifically tailored programs and care that can meet the needs of women veterans, MST survivors, and other vulnerable subpopulations of veterans such as LGBT+, Black, First Nations, Inuit, Métis, and People of Colour.

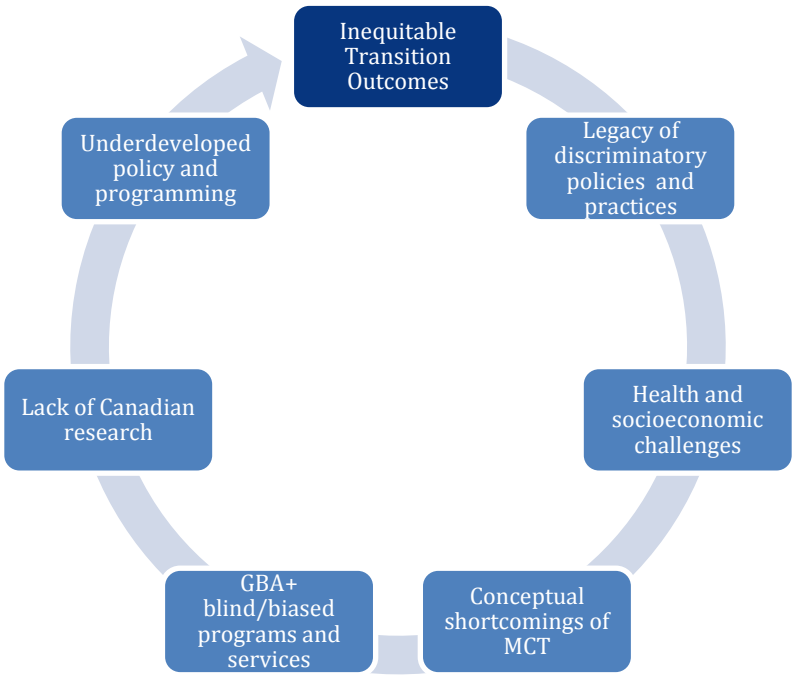
Lack of Canadian Research

The results of our scoping review clearly highlight the paucity of peer-reviewed GBA+ related literature on veteran issues in Canada (*n*=12, including one article with UK-Canada focus and one with a US-Canada focus, not including 16 government resources). The reviewed literature is overwhelmingly based on the unique US context. It is important to keep in mind that due to different deployment cycles, emphasis on combat exposure, the existence of a VA health care system, continuing medical education about veteran needs, and other factors, the context in which the US research is embedded is significantly different from the Canadian context. Nonetheless, the themes identified in the scoping review regarding vulnerabilities and risks faced by non-traditional service members and veterans highlight the need to conduct more such research in the Canadian context. While we can surmise from the US research what some of the likely challenges are, there is a huge gap that needs to be urgently filled in terms of qualitative and quantitative research on the experiences of non-traditional, historically marginalized service members and veterans in Canada.

In view of the recent LGBT Purge class action settlement regarding discrimination against LGBT+ service members, RCMP and civil servants, the Canadian Armed Forces/Department of National Defence Sexual Misconduct settlement, and the ongoing class action lawsuit on racist discrimination in the CAF, as well as the findings of the 2015 Deschamps Report, the importance of applying a GBA+ lens to transition programing to ensure equitable outcomes for all veterans is further reinforced. Producing evidence-based Canadian research is key to

developing and informing policies, programing, and other government initiatives aimed at women veterans, LGBT+ veterans, racialized and Indigenous veterans, and MST survivors. Moving forward, this research needs to take not only a sex and gender lens but an intersectional lens as is called for in GBA+ to truly capture the intersecting and confounding vulnerabilities experienced by non-traditional, historically marginalized veterans. Ideally, what is needed is research that can examine the multiple identity and structural factors that produce the specific and unique challenges across health and socioeconomic domains described in the scoping review.

Figure 2. Factors impacting transition outcomes for women, LGBT+, racialized, and Indigenous veterans.



Research Question #2: What MCT policies and programs that address GBA+ considerations have been developed so far by Australia, Canada, New Zealand, the United Kingdom, and the United States?

The US VA has made great strides towards identifying and addressing the needs of women veterans and to a lesser extent the needs of LGBT+, racialized, and Indigenous veterans through: research; designated personnel (e.g., women veteran coordinators, MST coordinators, LGBT coordinators); sex-specific programing and service-delivery models; and the use of

technology. Even so, as the existing research shows barriers still exist and the needs of these veteran subpopulations are not yet being met in equitable ways. The US case, however, demonstrates the need for a top-down integrated strategic approach to create institutional and policy initiatives to support women veterans as well as sexual, gender, ethnic, and racialized minority veterans. The United Kingdom and New Zealand have hardly begun to pay attention to the issue, while Australia and Canada have emphasized consultation and engagement with stakeholders and veterans over policy development and accountability, thus taking less of a strategic and centrally coordinated approach than the United States. However, recent developments in Canada, such as the creation of an Office of Women and LGBTQ2 Veterans, offer potential to go beyond such a limited approach. The US case also highlights the importance of a government-driven and supported research agenda that can cover a wide range of types of research from biomedical, demographic, statistical, to qualitative, particularly when it comes to women veteran health. In fact, much of the peer-reviewed research literature captured in this scoping review was conducted by US VA/VHA researchers. Military health research specifically on women service members, and sex-specific vulnerabilities and risks, is needed in Canada. Overall, Canada would benefit from a concerted DND/CAF driven research agenda focused on women and all historically understudied marginalized service members/veterans that could help identify vulnerabilities and intersectionalities that arise during and after service for these subpopulations.

Figure 3. Comparative scope of Five Eyes policies and programming related to sex, gender, and GBA+.

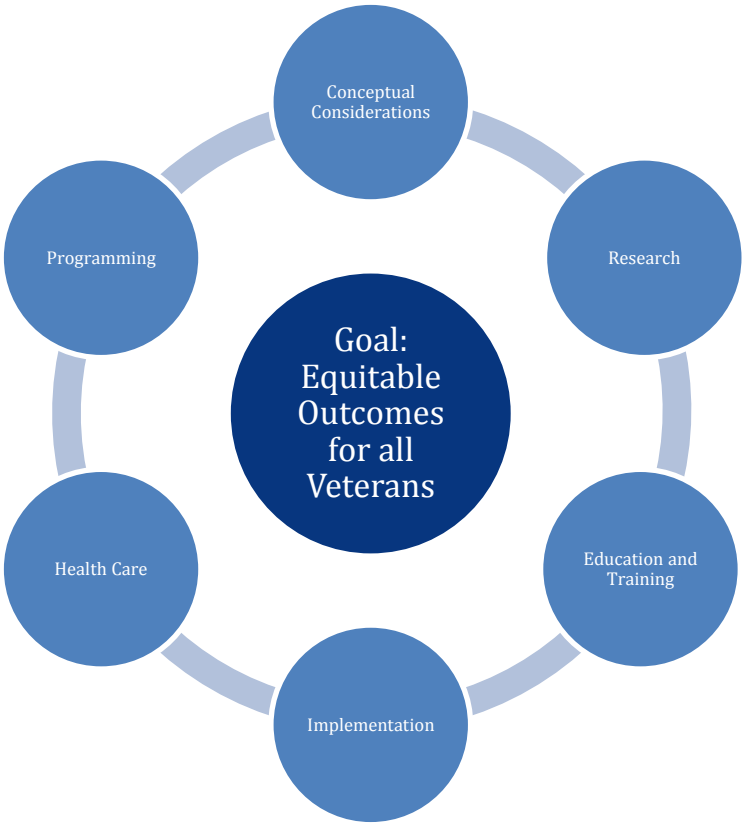
Recommendations

Research Question #3: How can the CAF, and the TG more specifically, better integrate a sex, gender, and GBA+ lens into its work on MCT?

This section provides recommendations and advice on best practices for integrating a sex, gender, and GBA+ lens into MCT policy, programming, services, and research. Three caveats should be noted. First, these recommendations and best practices draw on the preceding review of the scholarly literature and of existing international policies and programs, but also on consultations with, and input from, the experts on our team. The experts on our team have a wealth of experience and knowledge from which we were able to round out the recommendations that flowed from the review of the literature and policies/programs. Second, while many of the recommendations that follow have direct relevance to the work of the CAF TG, many of them are aimed at a broader audience. We felt it was hard to isolate the work of the CAF TG from the broader ecosystem in which it operates, including the DND/CAF, VAC, and civilian researcher and service provider communities. Third, we acknowledge that the DND/CAF may already be implementing some of these recommendations and best practices. Our goal was not to assess current practices at the DND/CAF, but to provide as comprehensive a set as possible of recommendations and advice on best practices from which the DND/CAF can draw in the future.

The broad set of recommendations and advice on best practices that follows highlights the many ways in which the CAF TG can advance the integration of a sex, gender, and GBA+ lens into its work. Ideally, the efforts of the CAF TG will be supported and enhanced by a broader integration of such a lens into MCT policy, programing, education/training, and research across government departments and civilian organizations including the DND/CAF, VAC, civilian health care and service providers, government-recognized and funded peer supports and veteran organizations, and the civilian research community.

Figure 4. Target areas for recommendations aimed at achieving equitable outcomes for all veterans through application of sex, gender, and GBA+ lens.



Recommendation 1

Within DND/CAF we recommend setting the *strategic goal* of achieving equitable outcomes for historically marginalized service members and veterans. The US case shows how crucial it is for there to be a top-down, coordinated, concerted, and ongoing effort by government departments to address historic inequities experienced by veterans. When setting such a strategic goal special attention needs to be paid to *prevention*—as many of the vulnerabilities and risks described in the literature are the result of systemic and structural conditions, and policies and histories of discrimination.

Conceptual considerations

Conceptualizations and definitions of MCT that focus on the peri-release period (6 months prior to release and two years after release) are too limited and do not capture the much more complex nature of transition(s). Applying a GBA+ lens is a challenging task as it requires careful ongoing conceptual work and may in and of itself not be sufficient to capture the experiences and needs that non-traditional, historically marginalized military service members face when preparing for and/or undergoing MCT.

Recommendation 2

We recommend DND/CAF and VAC take into consideration pre-military phenomena, significant military-related factors (e.g., deployment-related traumas, MST, discrimination and harassment, physical and mental injuries), and structural and systemic issues (e.g., lack of systems in place to prevent or effectively address known occupational hazards) in its conceptualization of transition. This includes the following:

- focus on the releasing member's life course—which calls for life course research (before, during, and after service in the military) to inform prevention and intervention strategies for optimal life after service outcomes
- replace the current time-limited, one-time, unidimensional conceptualization of transition with an approach that takes into consideration how vulnerabilities are experienced over time, in interconnected ways, and across the well-being domains, as well as identifies sources of resiliency
- treat transitions as holistic processes that encompass a wide range of factors (health, socio-economic, social, spiritual, resilience, systemic and structural), and that occur at the micro, meso, and macro level (e.g., individual, familial, community, national level)
- consider how different marginalized realities (e.g., for LGBT+, women, racialized veterans) may differently impact the transition of Reservists versus Regular Force members

Recommendation 3

We recommend that in order to better integrate a GBA+ lens DND/CAF take the following considerations into account:

- the need to additionally include a sex-based lens to capture differences in health vulnerabilities of serving female members preparing for release or retirement
- the need for a separate sex- *and* gender-based lens to capture the sex and gender differences and sex/gender intersections experienced by women preparing for release or retirement
- a GBA+ lens that examines intersections between identity factors and lived experiences of marginalization, including sex, gender, ethnicity, race, Indigeneity, ability, sexuality, marital status, age, religion, geographic location, and more

- ensure that GBA+ not be applied in a way that lumps groups with very different histories and experiences together, but rather in a way that captures unique experiences and needs, e.g., of a Black lesbian servicewoman preparing for transition
- avoid conflating terms such as sex and gender, gender and women, ethnicity and race, etc.
- recognize that GBA+ related terminology will need regular updating based on ongoing debates and lived experiences

Programing

We recommend integrating a sex, gender, and GBA+ lens into all DND/CAF and VAC resources and services related to transition, and the application of a holistic understanding of MCT in programing that recognizes the needs of historically marginalized service member and veterans across their life-time, across the domains of well-being, and within the context of her/his/their specific family and support system. This requires a deliberate move away from the dominant 'one size fits all' approach.

Recommendation 4

We recommend that sex-specific, gender, Indigenous, Black, People of Colour, and LGBT+ relevant information be incorporated into the materials provided to releasing/retiring members by the CAF TG, (e.g., its Transition Guide). Additional group-specific transition guides would be most appropriate given the differences highlighted in the literature. The goal is to:

- inform releasing members of subpopulation-specific health vulnerabilities, especially for LGBT+, Indigenous, Black, People of Colour, women veterans, and MST survivors, but also for men (e.g., help-seeking behaviour)
- move beyond silo thinking (e.g., health as disconnected from employment etc.) and provide information that speaks to transition as a longitudinal and complex interconnected web of phenomena (e.g., MST as an upstream determinant of such known downstream health and socio-economic sequelae as PTSD, suicide, and homelessness), yet also recognizes strengths and resilience factors in transitioning/retiring members

Recommendation 5

We recommend that sex, gender, and GBA+ considerations be integrated into all transition programing and services; for example, offer generalized programing where common issues and needs are examined for all and offer separate group programing for the historically marginalized releasing/retiring members so that group-specific (e.g., women, gender minority, sexual minority, Black, First Nations, etc.) issues can be discussed within a safe and respectful environment. However, do not lump all historically marginalized members together in one group. There needs to be separate programing for each subpopulation, including, for example, within the LGBT+ communities as transgender members have unique needs. Cisgender and transgender men may also benefit from separate sex/gender programing to address sex- and gender-specific issues, e.g., on help-seeking behaviour, mental health, or MST among men.

Recommendation 6

We recommend the development of targeted programs and services that address the needs of historically marginalized, non-traditional releasing/retiring members. This could include, but is not limited to, targeted and accessible programs and resources that address the needs of:

- women service members/veterans
- LGBT+ service members/veterans
- transgender service members/veterans
- survivors of abuse (women and men, separately) who are service members/veterans
- Black and People of Colour service members/veterans
- Indigenous service members/veterans
- family members and children of historically marginalized service members/veterans

These programs and resources could, for example, take into account:

- the need for safe spaces, e.g., all-women spaces for survivors of abuse and gender-based violence (GBV)
- accessibility considerations for the uptake of programs and resources (e.g., travel and distance considerations for employment and therapy)
- parenting and caregiving responsibilities disproportionately carried by women
- holistic Indigenous cultural needs and specificities (e.g., spirituality, reserve environments)

- housing needs of specific subpopulations, including women veterans with children or Indigenous veterans

Recommendation 7

We recommend programs (prevention and intervention) at multiple and interconnected sites that address known determinants of adverse health sequelae and socio-economic outcomes, such as:

- MST and its connection to PTSD, homelessness, and suicide
- Gender-based violence, including IPV, and its multifactor health sequelae
- housing vulnerabilities, which are higher for members of LGBT+ communities (especially transgender veterans) and racialized veterans
- employment insecurities, which are higher among women veterans (especially racialized)

Recommendation 8

We recommend CAF TG establish capacity building partnerships with government departments and civilian organizations, communities, and groups, to enhance evidence-based transitioning services, programing, resources, and opportunities for still serving and releasing/retiring members and veterans. It is crucial that partnering occur with, for example:

- post-secondary institutions to develop sex, gender, GBA+ informed, and (military) culturally competent programs (see e.g., existing VA US training programs for cultural competency)
- Indigenous groups, communities, and their local and individual governing bodies
- women's advocacy organizations
- racialized communities and their organizations
- Canadian Medical Association
- municipal-level governments such as city councils
- other government departments
- and other relevant government and non-governmental agencies and groups

Education and Training

We recommend updating the education of all DND/CAF staff involved in release processes—from clerks and commanding officers to health care providers.

Recommendation 9

We recommend all DND/CAF staff be provided education on the experiences of women, LGBT+, Indigenous, Black, People of Colour, and other historically marginalized, non-traditional releasing/retiring members. This should include the history of sexist, homophobic, and racist discrimination and its impacts on marginalized cohorts in order to equip CAF staff with a better understanding of the lived realities and needs of all releasing/retiring members.

Recommendation 10

We recommend that DND/CAF staff and service providers be educated on the needs of these various marginalized subpopulations, and trained in culturally competent, equitable, and sensitive service delivery, including:

- trauma-informed training
- anti-racism training
- transgender affirmative health care, including the use of transgender inclusive language
- how to develop harassment and discriminatory-free spaces
- impacts of minority stress on certain groups such as Indigenous, Black, People of Colour, sexual and gender minority veterans
- training with regard to specific Indigenous issues and ways of healing that are non-western and non-medicalized and culturally appropriate to the three different groups of First Nation, Métis, and Inuit. We recommend reviewing Call to Action 57 of the Truth and Reconciliation Commission's Report, which speaks to professional development and training for public servants.

It is crucial that this type of recommended training be co-developed and delivered by the very people from the groups that are being addressed. It is also important that these forms of training examine systemic and structural issues, as noted above in Recommendation 9.

Recommendation 11

We recommend similar training and education for all VAC staff who interact directly with veterans, including case workers, case managers and intake staff, as well as those supported by VAC to provide services to veterans (e.g., counsellors, occupational therapists, peer support providers) and all those involved in the adjudication and review of claims and in developing policies and programing for veterans.

Recommendation 12

We recommend that DND/CAF and VAC-funded civilian and peer support services be required to apply sex, gender, and GBA+ considerations to ensure all veterans are welcome and their unique needs are recognized.

Recommendation 13

We recommend DND/CAF and VAC establish best practices, ethical guidelines, conflict of interest protocols, and training and education resources for peer support and civilian service providers to ensure all veterans are welcome and their unique needs are recognized.

Health Care

We recommend a continuity of care approach by military (federal) and civilian health care providers for military members and veterans with known vulnerabilities and risks, upon release and into the future. We recommend this include dedicated SGBA and GBA+ plans and resources for the Canadian Forces Health Services and more military cultural competency training for civilian health care providers.

Recommendation 14

We recommend updating and standardizing knowledge, skills, and best practices of military medical staff in support of, but not limited to, the following:

- women's health prior to deployments: birth control options and complication management, menstrual suppression techniques and management, IUD removal and complication management, sexual assault management, breast lump management, vaginal discharge management, dysfunctional bleeding management, and more
- women's health prior to release: reproductive health care, and trauma-informed screening and interventions (e.g., be aware of reluctance to disclose issues such as IPV or MST—and the need to ask about these directly)

Recommendation 15

We recommend that best practices should take the following release types and red flags into consideration:

- medical release checklists that take sex, gender, and GBA+ into consideration and are attuned to heightened vulnerabilities and risks for women, LGBT+, Indigenous, and racialized releasing/retiring members
- red flags to inform screening and follow-up (e.g., PTSD, IPV, depression, substance use, eating disorders)
- mental health diagnoses that can be red flags for comorbid mental health diagnoses or risk factors (e.g., depression, IPV, MST, housing and employment insecurities)
- release types and experiences that can be red flags (e.g., early service leavers and older leavers may be at higher risk of self-harm)
- particular deployments that may be red flags for adverse health outcomes

Recommendation 16

As civilian health care providers are typically under-equipped to understand and identify the needs of historically marginalized veterans, we recommend the following:

- provide training and resources to civilian health care providers on issues specific to women, LGBT+, Indigenous, Black, and People of Colour veterans, and potential intersections of their experiences and vulnerabilities (e.g., trauma-informed care, MST, service-related women-specific injuries, gender-specific supports, and mental health treatment for women veterans)

- develop and disseminate best practice guidelines for the treatment of women, LGBT+, Indigenous, Black, and People of Colour veterans (e.g., routinely ask patients and clients: 'Did you ever serve in the military?')
- provide training to support health care providers on military culture and experiences so that if their patients did serve they will know some of the risk factors and issues at stake and be able to better explore potential difficulties and provide more focused individualized care

Research

We recommend a sex, gender, and GBA+ lens be better integrated into DND/CAF, VAC, and civilian research.

Recommendation 17

We recommend DND/CAF establish a strategic MCT research agenda, with a sex, gender, and GBA+ lens, that:

- disaggregates all data by sex, gender, race, Indigeneity, sexuality, etc.
- focuses on Canadian women and other non-traditional, historically marginalized service members
- includes the military workplace as a focus of study (e.g., organizational behaviour, military workplace stress—operational and non-operational, work design features, organizational justice, workplace sexual harassment, career transitioning, etc.)
- examines transition holistically across the domains of wellbeing
- prioritizes understudied intersections of health, socio-economic, structural, and systemic challenges for historically marginalized veterans
- examines the impacts of military service across the life course and across multiple forms of transition
- explores specific phenomena that are particularly relevant to historically marginalized service members (e.g., premature departure/attrition, including why members are leaving and what their specific vulnerabilities and transition outcomes are)

- is deliberate in its use of terminology and does not conflate sex and gender, women and gender, or other categories such as race and ethnicity
- is truly intersectional, i.e. looks at intersecting individual identity factors and structural inequalities. Intersectionality is not about 'adding' more identity factors but examining how gendered insecurity, oppression, and marginalization intersect with and are compounded by other forms of marginalization rooted in colonialism, racism, ableism, ageism, heteronormativity, and more
- is informed by the lived experience of historically marginalized service members and veterans

Recommendation 18

We recommend that the Government of Canada require that all government-funded veteran and transition research adhere to Sex and Gender Equity in Research (SAGER) guidelines (Heidari et al., 2016) and include a GBA+ lens.

Recommendation 19

We recommend developing channels for knowledge sharing and knowledge transfer across DND/CAF, VAC, and communities of civilian researchers, on sex-specific, gender and GBA+ relevant research related to MCT and veteran issues specifically.

Implementation: Outreach, Input, Accountability, and Collaboration

The US case shows how crucial it is for there to be lived experience input, such as in the form of advisory committees, as well as accountability in addressing and rectifying the inequitable outcomes experienced by historically marginalized service members and veterans. The US VA has multiple forums through which such input is given and multiple internal and external mechanisms for accountability and collaboration.

Recommendation 20

For DND/CAF and VAC, outreach to and input from those with lived experience at all stages of research and program development is key to successfully achieving equitable transition

outcomes. We recommend that the TG, and DND/CAF more broadly, implement the integration of a sex, gender, and GBA+ lens in ways that draws on lived-experience based knowledge, for example, through advisory committees, service member and veteran community engagement boards or similar mechanisms that allow for input. Furthermore, leadership buy-in and accountability are key to achieving the goal of equitable MCT outcomes for all releasing/retiring service members, and especially for those whose needs have historically not been recognized and reflected in existing policies, programs, and initiatives. Finally, implementing a sex, gender, and GBA+ lens will require collaboration with other groups within DND/CAF, key among them being the Canadian Forces Health Services, as well as with groups and organizations beyond DND/CAF as noted throughout the above recommendations.

Limitations

Limitations of this study include its time frame—its focus being on research and government programs since 2010 with a focus on members and veterans who served in wars since 2001. Our review did coincidently capture some studies that include older US veteran cohorts (US Vietnam and Gulf War veterans) and examine the intersections of aging and transition outcomes for women veterans. However, we did not capture the full range of the existing US or other research on elderly and aging historically marginalized veterans in this scoping review. Therefore, the long-term MCT outcomes of historically marginalized veterans have not been fully captured in our findings.

Overall, we recommend follow-up literature reviews be conducted on understudied cohorts and time periods, specifically in regard to Canadian service members and veterans. Such follow-up reviews would be crucial to capturing a longer-term perspective of experiences. This is important in the Canadian context as, for example, the 1990s was the first decade that women in Canada gained entry into all the military trades and occupations and when LGBT+ service members could openly serve. Follow-up reviews should focus on specific subpopulations for whom our review identified vulnerabilities. A broader cross-sectional review could cast a wider net beyond transition outcomes, e.g., by focusing on service member health issues as they impact transition outcomes, to hone in on the experiences of specific Canadian military subpopulations. Finally, considering the huge volume of medical research, we suggest conducting a separate medical study of the MCT health needs of women and of LGBT+, Indigenous, and racialized service members and veterans. And lastly, in light of ongoing concerns about veteran homelessness, we recommend a sex, gender, and GBA+ review of the extent, nature, and determinants of women veteran homelessness and of veteran homelessness policies and supports in Canada.

Conclusion

This scoping review shows that sex, gender, and GBA+ are important to consider in military-to-civilian transition experiences because women and other historically marginalized military members such as LGBT+, racialized, and Indigenous members have distinct service experiences. Contrary to popular belief, neutral—whether 'gender-neutral' or otherwise blind—policy and programing tend not to deliver equitable outcomes. A paradigmatic shift towards the systemic integration of sex, gender, and GBA+ into strategic planning and implementation of MCT policies and programs (and upstream) is urgently needed.

By providing a big picture of the sex, gender, and intersectional dimensions of MCT, as well as concrete recommendations for integrating GBA+ considerations into CAF Transition Services, we hope this report will inform DND/CAF and VAC transition (and upstream military workplace) research, policies, and practices. Intersectional research has the potential to improve transition experiences for *all* releasing/retiring members as it helps identify areas of concern and needs that may have remained invisible in research based solely on the experiences of White, heterosexual, cisgender military men (Eichler & Smith-Evans, 2018).

While the commitment and investment required to implement the above recommendations for the integration of a sex, gender, and GBA+ lens into strategic planning by DND/CAF and VAC may be substantial, they are necessary to ensure not only equitable outcomes but successful recruitment and retention of a more diverse military work force. The long-term benefits for individual members and the institution itself are significant, but buy-in from the leadership and accountability mechanisms will be important to move these recommendations forward. While many recommendations are specific and focused on individual groups, they speak to broader systemic issues that need to be tackled in order to change the legacies of historic discrimination.

Appendix A: List of all references identified and included in the literature review

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Appendix B: List of background references in final report but not included as part of the literature review

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13. ABSTRACT/RÉSUMÉ (When available in the document, the French version of the abstract must be included here.)

The findings of this scoping review unequivocally establish the importance of applying a GBA+ lens to military-to-civilian transition research and policies, programs, and services. While there is a dearth of Canadian research on the topic, the extensive international studies and government sources we collected provide valuable insight into the potential challenges encountered by women, LGBT+, Black, People of Colour, and Indigenous members who are medically or voluntarily releasing or facing retirement. These potential challenges include increased vulnerabilities and risks across the various domains of well-being—in health outcomes, complex trauma histories, employment and housing insecurities, lack of tailored services, social disconnection, and more. While the vulnerabilities and risks are experienced at the individual (and sometimes familial) level, they are often caused by systemic and structural issues such as histories of discrimination and marginalization, sexual and gender-based violence, lack of adequate equipment and services, and more. These vulnerabilities and risks are further exacerbated by societal inequalities and civilian lack of knowledge about non-traditional veterans. Thus, setting the strategic goal of achieving equitable transition outcomes for historically marginalized service members and veterans requires both individually targeted solutions and broader structural change. Measures that can help prevent or ameliorate the vulnerabilities and risks of women, LGBT+, Black, People of Colour, and Indigenous releasing/retiring members are important. Likewise, we recommend tailored and separate programing as well as education/training for DND/CAF staff (and knowledge transfer to VAC, civilian service and health care providers, and Canadian society at large) that reflect the lived experiences and needs of these releasing/retiring members. Considering the large amount of health research uncovered in this scoping review, it would seem prudent to develop an additional stand-alone health research program that focuses on the needs of these members, especially women veterans. In fact, our findings stress the importance of collaboration with the Canadian Forces Health Services and civilian health care providers to prevent and reduce vulnerabilities and risks well before release/retirement in order to set members up for a successful transition. The importance of including lived experience voices at all levels of research and program development also emerged as a key factor for success. The implementation of our recommendations should include consultation with the respective subpopulations of concern, for example through outreach, advisory committees, and community engagement boards that include upstream knowledge and experience from serving members as well as downstream input from released/retired members. Redesigning transition services to meet all releasing/retiring members' needs is not an easy task and buy-in by leaders and accountability mechanisms are important factors that will affect its success. Considering the lack of research and programing in Canada or internationally that directly and explicitly applies a GBA+ lens to MCT, the CAF TG has the unique opportunity to advance this important work. However, conventional conceptualizations of both MCT and GBA+ emerged as too limiting to address the problem of inequitable transition outcomes, calling for a broader intersectional sex and gender lens that can capture multiple transitions across time/life.

Les conclusions de cet examen de la portée sont sans équivoque : ils établissent l'importance de travailler sur la recherche, les politiques, les programmes et les services relatifs à la transition de la vie militaire vers la vie civile du point de vue de l'ACS+. Les travaux de recherches canadiens sur le sujet ne sont pas nombreux, mais les études internationales approfondies et les sources gouvernementales que nous avons rassemblées fournissent des renseignements précieux sur les défis potentiels auxquels font face les femmes, les personnes LGBT+, les Noirs, les personnes de couleur, et les Autochtones libérés pour des raisons médicales ou de façon volontaire ou qui s'apprêtent à de prendre leur retraite. Tous ces groupes sont notamment davantage touchés par des vulnérabilités et des risques dans les divers domaines du bien-être : problèmes de santé, antécédents de traumatismes complexes, insécurité en matière d'emploi et de logement, manque de services adaptés, déconnexion

sociale, et plus encore. Bien que les vulnérabilités et les risques soient vécus au niveau individuel (parfois familial), ils sont souvent le résultat de problèmes systémiques et structurels comme la discrimination et la marginalisation, les violences sexuelles et fondées sur le sexe, le manque de matériel et de services adéquats, et plus encore. Ces vulnérabilités et ces risques sont exacerbés par les inégalités sociales et le manque de connaissances des civils sur ces anciens combattants qui ne sont pas les anciens combattants « habituels ». Par conséquent, pour pouvoir établir l'objectif stratégique d'atteindre des résultats équitables concernant la transition pour les membres des forces armées et les anciens combattants qui ont longtemps été marginalisés, il faut à la fois des solutions ciblées individuellement et un changement structurel plus vaste. Il est important de mettre en place des mesures qui peuvent aider à prévenir ou à améliorer les vulnérabilités et les risques auxquels font face les femmes, les personnes LGBT+, les Noirs, des personnes de couleur et les Autochtones qui sont libérés ou qui prennent leur retraite. De même, nous recommandons la création de programmes sur mesure et distincts, ainsi que de la mise sur pied d'une formation à l'intention du personnel du MDN et des FAC (et un transfert de connaissances à Anciens Combattants Canada, aux fournisseurs de services civils et aux fournisseurs de soins de santé, et à la société canadienne en général) qui traite des expériences vécues et des besoins de ces militaires libérés ou à la retraite. Compte tenu du grand nombre de recherches en santé étudiées dans le cadre de cet examen de la portée, il serait prudent d'élaborer un autre programme de recherche en santé autonome qui s'intéresse aux besoins de ces membres, en particulier les femmes ex-militaires. En fait, nos constatations soulignent l'importance de collaborer avec les Services de santé des Forces canadiennes et les fournisseurs de soins de santé civils pour prévenir et réduire les vulnérabilités et les risques bien avant la libération ou la retraite afin que la transition des militaires soit réussie. L'importance d'inclure des expériences vécues à tous les niveaux de la recherche et de l'élaboration de programmes est également ressortie comme étant un facteur de réussite essentiel. La mise en œuvre de nos recommandations devrait être accompagnée de consultations avec les sous-populations concernées, comme des activités de sensibilisation, la création de comités consultatifs et de conseils de mobilisation communautaire qui permettront aux membres actifs de parler de leurs connaissances et de leur expérience (amont) et aux membres libérés ou retraités (aval) d'apporter leur contribution. Il n'est pas facile de remanier les services de transition pour qu'ils répondent aux besoins de tous les membres libérés ou à la retraite, et l'adhésion des dirigeants et des mécanismes de responsabilisation est un facteur important dont l'incidence ne sera pas négligeable. Étant donné que peu de travaux de recherche et de programmes au Canada ou à l'étranger appliquent directement et explicitement l'ACS+ à la transition de la vie militaire vers la vie civile, le GT FAC a aujourd'hui l'occasion de faire progresser cet indispensable travail. Cependant, les conceptualisations conventionnelles de la transition de la vie militaire vers la vie civile et de l'ACS+ se sont révélées trop limitées pour s'attaquer pleinement au problème de l'iniquité des résultats de la transition. Il faudrait donc adopter un point de vue intersectionnel plus large du sexe et du genre, capable de restituer les multiples transitions dans le temps et la vie.