

# **Barriers and facilitators to mental healthcare for women veterans: a scoping review.**

## **Abstract**

Background: Traditionally, veteran research and support has centred on the requirements of a predominantly male population. However, as female participation in the Armed Forces increases and their roles diversify, consideration of women's unique mental health needs is imperative. Women veterans are at greater risk of post-service mental health challenges than their male counterparts, and female mental health outcomes have deteriorated in recent years.

Aims: To determine the provenance of these outcomes, a scoping review considering both barriers and facilitators to female veteran participation in mental health services was conducted.

Methods: A review was carried out following the Joanna Briggs Institute Scoping Review framework outlined by Peters et al (2020). Twenty-four papers were identified, with all but one originating from the US.

Results: This research indicated that whilst women experience barriers common to male veterans (e.g., help-seeking stigma), they also experience unique gender-specific barriers to accessing mental healthcare services (e.g., lack of gender-sensitive treatment options, feeling uncomfortable) and such barriers result in under-utilization of services.

Conclusions: Literature indicates that consideration and mitigation of these barriers might improve access and health outcomes for women veterans. Further research is required outside the US to understand the barriers to mental healthcare experienced by women veterans internationally.

**Keywords:** Women, veterans, military, mental health, barriers, facilitators.

## Introduction

Traditionally, support services have been built around the needs of male ex-service personnel ('veterans'), leading to male-focused healthcare support (Yano et al., 2010). However, a growing number of women entering the Armed Forces (AF) will lead to a commensurate increase in female veteran populations internationally (Dodds & Kiernan, 2019). Furthermore, many countries have now opened all military roles to women, including those involving ground close combat (BBC, 2011; The New York Times, 2013; UK Government, 2016). As female participation in the AF increases and their roles diversify, consideration of their unique mental health needs is imperative.

Whilst, overall, only 2% of veteran research mentions women (Dodds & Kiernan, 2019), health research into women veterans has increased significantly since the beginning of the 21<sup>st</sup> century, predominantly focused on female veterans' mental health in the United States (US) (Bean-Mayberry et al., 2011; Danan et al., 2017). A systematic review of related literature highlights gender differences in the prevalence and presentation of mental health challenges experienced by veterans (Runnals et al., 2014). Indeed, women veterans appear to be at increased risk of experiencing mental health problems as compared to their male counterparts (Harrington et al., 2019; Jones et al., 2020), and longitudinal research suggests mental health outcomes have worsened for women veterans over the last few decades (Thomas et al., 2016).

Barriers to accessing mental health services among veterans are well-researched and include a lack of military specialist healthcare professionals and anticipated mental health-related stigma and discrimination (Bovin et al., 2019; Iversen et al., 2010; Iversen et al., 2011; Rafferty et al., 2017; Williamson et al., 2019). However, research in this area has focused predominantly on male veterans, and the applicability of these findings to women remains unclear. Existing research suggests that women are more likely to seek formal medical help for mental health

problems compared to their male counterparts (Jones et al., 2020; Stevelink et al., 2019), but are underutilizing specialist veteran mental healthcare services (Godier-McBard, Gillin, et al., 2021; Hayes & Krauthamer, 2009; Thomas et al., 2017). Furthermore, women in the US report less satisfaction with specialist veteran mental health services than their male counterparts (Wright et al., 2006). Considering the gender differences evident in veteran mental health outcomes, it is possible that specialist veteran mental healthcare, built around the needs of men, is not meeting women's needs.

To elucidate further the reasons for women's underutilization of specialist veteran mental healthcare services, and to ensure their needs are being met, a better understanding of the unique barriers to mental healthcare experienced by women veterans is needed. This paper aims to provide a comprehensive up-to-date scoping review of what is currently known about the barriers and facilitators experienced by female veterans when accessing mental health services.

## **Methods**

Scoping reviews are utilised to examine the breadth and depth of the available evidence in a particular topic area, to summarise this evidence base, and to identify gaps in knowledge (Peters et al., 2020). Such reviews are appropriate for instances in which the evidence base is diverse in regard to data collection and analysis techniques (Arksey & O'Malley, 2005), and when researchers are seeking to understand the extent and nature of the evidence in a particular topic area (Peters et al., 2020). Considering the diversity in study designs and methodologies in the area of focus, and the broad aim of the review (i.e. to provide a comprehensive up-to-date scoping review of what is currently known about the barriers and facilitators experienced by female veterans when accessing mental health services) a scoping methodology was chosen as opposed to a systematic review.

This review follows the Joanna Briggs Institute (JBI) framework for scoping reviews, as outlined in Peters et al (2020), which considers and updates guidance based on commonly used scoping review frameworks, such as Arksey and O'Malley (2006) and the PRISMA scoping review framework (Tricco et al., 2018). A scoping review protocol was developed and is available from the authors on request. Reporting of the scoping review findings follows the PRISMA-ScR Checklist (Tricco et al., 2018).

### ***Developing the scoping review question***

The research question for this review was developed using the PCC framework (Population: Female Veterans; Concept: barriers and facilitators to access; Context: Mental healthcare services), and was outlined as: *What is known from the existing peer-reviewed literature about the barriers and facilitators to accessing mental health services experienced by female veterans?* These factors were defined in the following ways: 'Female veterans' were defined as any individual who identifies as a woman and has previously served as an active or reserve duty member of a military organisation. 'Barriers and facilitators to access' were defined as factors that influence an individual's ability and intention to access services and support. 'Mental health services' encompasses any formal support services accessed with the purpose of accessing care, treatment and/or support for mental health, including services provided by statutory, private and charitable organisations.

### ***Identifying relevant studies***

The following academic databases were searched for articles published before July 2021 (no date-restricting criteria set): PsychINFO, ISI Web of Knowledge, PubMed, and Scopus. Further searches were conducted in Google Scholar (examining the first 20 pages of search results), along with reference lists of relevant books and journal articles already known to the authors. Keywords such as (but not limited to): 'barriers', 'facilitators', 'mental healthcare' and

‘women veterans’ formed the basic search string for each database in conjunction with Boolean operators (see Table 1). The format and structure of these search strings was tailored to the requirements of each database.

### ***Study Selection***

Inclusion was based on the paper having a substantive focus on barriers and facilitators to mental health utilization by women veterans and meeting the inclusion/exclusion criteria shown in Table 1. Only peer-reviewed journal articles were included in the final review. Titles and abstracts were first screened, followed by full-text reviews of those that appeared relevant by two researchers. The reference and citation list for each article subjected to a full-text review were searched to identify additional relevant articles. Final selections were discussed, and a third researcher was available to arbitrate any disagreements.

Quality assessment was not undertaken, in line with the JBI scoping review framework, which aims “to map the available evidence rather than provide a synthesised and clinically meaningful answer to a question” (Peters et al., 2020, p. 6). However, an outline of the limitations of the evidence base is provided in the discussion section.

[Insert Table 1]

### ***Charting the data***

Articles which met the inclusion criteria were evaluated and tabulated. The following data were extracted and charted: year and origin of publication; sample size; research methods, variable measures, barriers, and facilitators reported. Papers were thematically analysed following the descriptive approach to reflexive thematic analysis outlined by Braun and Clarke (2006, 2022), including both quantitative and qualitative studies, allowing the development of themes describing common barriers and facilitators reported across methodological designs. Descriptive and inferential statistics were extracted from the quantitative studies detailing

prevalence of barriers and facilitators, the relationship between barriers/facilitators and service utilisation, and gender-related differences. These were examined in conjunction with the findings of the qualitative studies to identify where findings converged. A narrative synthesis was then used to summarise the studies.

## **Results**

The search yielded a total of 1682 unduplicated records. Following a review of the titles and abstracts, 91 full text papers remained. Following full text review, 24 papers met the full inclusion criteria (See Figure 1), 23 of which originated from the US and one from the UK. All papers were published after 2006.

[Insert Figure 1]

Thirteen papers used a descriptive design (nine qualitative, four cross-sectional survey studies) and 11 used an observational (analytic) design (eight cross-sectional surveys, two cohort studies and one case-control study). Fifteen studies focused solely on US Veterans Affairs (VA) mental healthcare services, seven studies focused on both VA and non-VA (community) services, and one study focused on US college/university mental health services. The one UK-based study focused on a) veteran-specific National Health Service (NHS) mental health services and third sector services, b) non-veteran-specific NHS and third sector mental health services and, c) private therapeutic mental health services. Participant population was varied across studies (i.e., help-seeking/patients of statutory and/or community services, rural veterans only, Native American veterans only, studies limited to veterans of specific military operations i.e., Operation Enduring Freedom and Operation Iraqi Freedom). Just seven studies included a gender comparison, with one study including a comparison with civilian women. Table 2 shows a summary of each study included in the review.

Due to literature being US-dominated, where not specified, the results discuss US-based findings. UK findings are reported separately due to significant differences between the US and UK healthcare structures and services.

[Insert Table 2]

### ***Prevalence and type of barriers and facilitators to mental healthcare***

Barriers reported by female veterans in the identified studies fell into three subthemes: stigma and discrimination, accessibility-related barriers and gender-specific barriers. Facilitators of access to mental healthcare were predominantly focused on the provision of gender-specific or gender-sensitive mental healthcare.

#### *Stigma and discrimination*

Within six of the cross-sectional quantitative survey studies reviewed, perceived stigma associated with accessing mental healthcare was widely reported, including being seen as weak (20-57% reported across studies), being treated differently by others (17-41%), and concern about potential discrimination from employers (8-41%) (Murray-Swank et al., 2018; Newins et al., 2019; Owens et al., 2009; Tsai et al., 2015). Negative perceptions of mental health services (6-43%; i.e. 'Mental healthcare does not work', 'I don't think treatment will help me'), and a lack of trust in healthcare professionals (7-18%) were also reported (Brunner et al., 2019; Murray-Swank et al., 2018; Newins et al., 2019; Owens et al., 2009; Tsai et al., 2015; Valenstein-Mah, Kehle-Forbe, et al., 2019).

The six qualitative studies largely supported the findings of the quantitative survey research. Perseverance through adversity, being stigmatized and harassed following help-seeking and reporting assault/violence in the military were all cited as barriers to veteran mental health support (AlMasarweh & Ward, 2016; Hamilton et al., 2012; Ingelse & Messecar, 2016; Koblinsky et al., 2017).

### *Accessibility and eligibility-related barriers*

Accessibility to and availability of mental healthcare was a concern for women veterans in cross-sectional survey research, including cost (21-41%), release from work/school (14-35%), difficulty scheduling appointments (14-29%), not knowing where to go for help, and trouble obtaining childcare (13-17%) (Brunner et al., 2019; Murray-Swank et al., 2018; Newins et al., 2019; Owens et al., 2009; Tsai et al., 2015).

Qualitative studies also reported a lack of awareness regarding how and where to access help, as well as eligibility for treatment (especially if participants had not been in combat), particularly among Native American and rural women veterans (AlMasarweh & Ward, 2016; Ingelse & Messecar, 2016). Women additionally perceived a lack of recognition by others that they were veterans and feeling less deserving of care as a result (Kelly, 2021; Koblinsky et al., 2017). Logistical barriers to accessing services, such as location, difficulty getting time off work, childcare provision and parking issues were also reported (Hamilton et al., 2012; Koblinsky et al., 2017). Furthermore, rural women veterans highlighted limited access to mental healthcare, despite reporting this was a significant need in this population. However, it is unclear whether this was compounded by their gender (Ward et al., 2020).

### *Gender-specific barriers*

Two cross-sectional quantitative survey studies reported the prevalence of gender-related barriers to mental healthcare in women veterans, with 22-43% reporting feeling uncomfortable or unwelcome in a veteran treatment-setting due to these services being male-dominated (Kimerling et al., 2015; Owens et al., 2009). Gender-related barriers were reported in five of the qualitative studies, centred on a lack of services that consider the specific needs of women veterans (Brooks et al., 2016; Hamilton et al., 2012; Ingelse & Messecar, 2016; Kehle-Forbes et al., 2017; Koblinsky et al., 2017). Women also indicated that VA mental healthcare did not



meet their needs, and that the predominantly male environment was unwelcoming and insensitive to gender-related trauma experienced in service, including military sexual trauma (MST) (Kehle-Forbes et al., 2017; Kelly, 2021; Koblinsky et al., 2017; Monteith et al., 2020). Rural and Native American women veterans reported negative experiences with mental health services, including feeling humiliated and discriminated against because of their gender (AlMasarweh & Ward, 2016; Ingelse & Messecar, 2016). Additionally, when seeking treatment for MST-related Post Traumatic Stress Disorder through the VA, women reported being mistaken for family members or friends of male veterans, and not feeling recognised as female veterans (Kelly, 2021).

#### *Gender-specific facilitators*

Suggested facilitators to mental health services included increased availability of female service providers, women veteran peer-support groups, women-only treatment programmes, including specific groups for those with a MST history, and separate waiting rooms for women (Brooks et al., 2016; Hamilton et al., 2012; Kehle-Forbes et al., 2017; Koblinsky et al., 2017; Monteith et al., 2020). Additionally, Monteith et al (2020) reported that some female veterans, with a MST history, would like to see alternative and holistic treatments offered, for example tai chi or yoga, whereas male veterans expressed a desire to access standard PTSD programs.

#### ***Associations between barriers and facilitators to mental healthcare and service utilization***

Seven studies investigated associations between particular barriers and facilitators of mental healthcare and service utilization for women veterans, and the factors that mediate these relationships.

#### *Stigma and perceptions of mental health services*

In these studies, stigma and perceptions of mental health were significantly related to changes in service utilization in women veterans, including negative beliefs about treatment-seeking

(OR: 0.898) (Fox et al., 2015) and positive perceptions/prior experiences (Odds Ratio [OR]: 1.036) (Fox et al., 2015). Furthermore, Kimmerling et al (2016) found that perceived quality of VA mental healthcare (OR: 3.69) was positively associated with high patient activation (defined as aptitude and motivation to engage in treatment) in women veterans.

Knowledge of treatment also appears to be related to use of services. Indeed, Williston et al (2020) found that both increased mental health literacy (i.e., the extent to which individuals are knowledgeable about mental health problems and treatment) and perceived need for care were associated with increased service utilization in women veterans, and this relationship was mediated by the impact of these factors in reducing treatment-seeking stigma.

#### *Accessibility and eligibility*

The accessibility and availability of services was significantly related to service utilisation in women veterans, including inconvenient appointment times (OR: 0.25) (Brunner et al., 2019), the availability of integrated primary and mental health services (OR: 2.94) (Seal et al., 2010), and perceived entitlement to VA healthcare (OR: 1.174) (Fox et al., 2015). Furthermore, Kimmerling et al (2016) found ease of accessing care (OR: 2.90) was positively associated with high patient activation (defined above) in women veterans.

Seal et al. (2010) found that whilst integrated primary and mental healthcare was associated with a threefold increase in subsequent mental health evaluations in women, this association was not significant in men. This suggests this may be a facilitator for women only, perhaps due to increased accessibility.

#### *Gender and identity*

Factors related to gender appear to impact women veterans' utilisation of services, with three studies reporting an association between gender-related comfort and engagement/positive experiences with mental healthcare. Kimmerling et al. (2015; 2016) found that gender-related

comfort and having access to gender-specific care (i.e. care in women-only settings) was associated with twice the odds of reporting that care need was met, as well as stimulating higher patient activation. Fontana and Rosenheck (2006) reported that for women attending mental health treatment, the most important factor influencing comfort was the availability of specialist programmes for women. Greater gender-related comfort was associated with greater commitment and attendance at up to eight months follow up (Fontana & Rosenheck, 2006).

Additionally, Di Leone et al (2016) reported that positive regard for veteran identity in women was associated with increased likelihood of using VA mental health services, while higher centrality of women's veteran identity was associated with feelings of belongingness within the VA and choosing VA over non-VA mental healthcare.

### ***Gender and military/civilian comparisons***

Three studies demonstrated a significant gender difference in their analyses of barriers and facilitators to mental healthcare: Fox et al. (2015) and Tsai et al. (2015) found that male veterans scored significantly higher on negative beliefs about treatment, treatment-seeking and mental illness, and concerns about stigma, compared to female veterans. A US study into women veterans' experiences of a post-military return to education found help-seeking stigma to be higher in male compared to female student veterans (Albright et al., 2019). However, women students with military experience were significantly more likely than civilian women students to perceive stigma in seeking mental healthcare (OR: 2.329 with deployment history; OR 1.898 without deployment history). The increased perceived stigma about mental health treatment in male veterans also appears to impact treatment completion. Valenstein-Mah et al. (2019) found that gender moderated the relationship between negative beliefs about psychotherapy and completion of sufficient therapy for PTSD (8 or more sessions), finding that

negative beliefs decreased the likelihood that they would complete sufficient therapy for male veterans, but not female veterans in the sample.

A UK-based cross-sectional study found that female veterans scored slightly higher on measures of stigma, attitudinal (i.e., poor perception of mental health services or treatment) and instrumental (i.e., practical and logistical) barriers to care compared to male veterans, however, this difference was not significant (Godier-McBard, Cable, et al., 2021). In the qualitative portion of this study, both male and female veterans discussed the impact on help-seeking of mental illness being associated with weakness within the military context, but this theme appeared to be more pronounced for women already eager to avoid negative gender stereotypes of weakness that exist in the military culture. Furthermore, female veterans were significantly more likely to report that these gender-related experiences impacted their intention to seek help and their experience of support/treatment. Qualitative responses further revealed that UK female veterans felt a lack of recognition and understanding of their veteran status and in-service experiences by healthcare professionals and reported experiencing negative gender stereotyping associated with women's mental health. Finally, whilst both male and female veterans reported that poor experience of in-service mental healthcare impacted on trust in professionals post-service, this was more prominent theme for female veterans in the sample (Godier-McBard, Cable, et al., 2021).

## **Discussion**

This scoping review sought to identify barriers and facilitators to mental healthcare experienced by women veterans. All but one (UK-based) study originated from the US (n=23) and all studies, except two, related to VA mental healthcare services. Concerns around help-seeking stigma and discrimination, negative perceptions of services, and barriers associated with accessibility and availability of services were identified (Brunner et al., 2019; Godier-

McBard, Cable, et al., 2021; Kelly, 2021; Monteith et al., 2020; Murray-Swank et al., 2018; Newins et al., 2019; Owens et al., 2009; Tsai et al., 2015; Ward et al., 2020), and are seen in the wider veteran literature (Iversen et al., 2010; Iversen et al., 2011; Vogt, 2011; Williamson et al., 2019). Furthermore, a number of these barriers were significantly associated with reduced service utilization and ratings of VA mental healthcare (Brunner et al., 2019; Fox et al., 2015).

A connection between military culture and perceived mental health stigma is generally accepted in the literature (Williamson et al., 2019) and linked to military values of emotional strength and perseverance (Nash et al., 2009). This finding is extended specifically to women veterans in this review, with one study showing an increased likelihood of endorsing help-seeking stigma in military compared to civilian women students (Albright et al., 2019). However, the majority of the studies that included a comparative gender analysis reported that male veterans were more likely to report both help-seeking stigma and negative perceptions of mental health treatment (Albright et al., 2019; Fox et al., 2015; Tsai et al., 2015; Valenstein-Mah, Kehle-Forbe, et al., 2019). Furthermore, one study found that negative beliefs about treatment was associated with reduced treatment completion for PTSD for male veterans, but not female veterans (Valenstein-Mah, Kehle-Forbes, et al., 2019). Nevertheless, whilst traditional stigma-related barriers appear to be more prevalent in male veterans, it is possible that stigma is underscored by unique gender-related experiences for women veterans. Indeed, some studies indicated that there was an additional stigma associated with being a woman in the AF, while others highlighted the negative reactions experienced when women voiced in-service gender-related harassment and discrimination, with these experiences leading to reluctance to seek help post-discharge in male-dominated veteran environments (AlMasarweh & Ward, 2016; Godier-McBard, Cable, et al., 2021; Hamilton et al., 2012; Ingelse & Messecar, 2016; Kelly, 2021; Koblinsky et al., 2017).

Unique gender-specific barriers and facilitators of mental healthcare were also evident. Women veterans reported a lack of gender-sensitive treatment options, including limited access to female providers and women-only groups, acting as a barrier to engaging with veteran mental healthcare (Fontana & Rosenheck, 2006; Hamilton et al., 2012; Ingelse & Messecar, 2016; Kimerling et al., 2015; Owens et al., 2009). In contrast, gender-related comfort in the treatment environment significantly increased the likelihood that women veterans engaged with treatment reported that their care needs had been met (Fontana & Rosenheck, 2006; Kimerling et al., 2015). These findings broadly reflect barriers to VA primary healthcare reported previously by US women veterans (Runnals et al., 2014).

Women also reported feeling unrecognised as veterans in society and by healthcare professionals (Godier-McBard, Cable, et al., 2021; Kelly, 2021), prompting concerns over eligibility for veteran-specific treatment (DiRamio et al., 2015; Hamilton et al., 2012). Furthermore, the prominence and importance of the veteran identity to women was significantly associated with a feeling of belonging within, and likelihood of using, veteran-specific mental healthcare (Di Leone et al., 2016). Previous research with male veterans has similarly found that centrality of veteran identity was associated with a preference for care through the VA (Harada et al., 2002). However, this finding may be particularly pertinent to women veterans as a minority in this context (Di Leone et al., 2016), who may be more prone to feeling as though they do not fit within the VA healthcare system (Brooks et al., 2016; Kimerling et al., 2015).

### ***Limitations***

Some limitations are of note. The identified research relied heavily on observational and descriptive cross-sectional surveys and qualitative studies, which may be prone to bias and confounding, and cannot be used to determine causality. Furthermore, just six studies provided

a gender and/or civilian group comparison. As such, we cannot be sure that the barriers and facilitators reported in the women-only samples are gender or military-specific. The majority of research originated from the US, with most papers focused on barriers and facilitators to accessing VA services, limiting the applicability of the findings outside this context. Several studies are limited by their small sample sizes, and therefore replication of their findings in larger studies would be beneficial. The samples varied, with some focusing on veterans from specific conflicts (i.e., Iraq and Afghanistan veterans); others focusing specifically on rural or Native American veterans; and variation in whether the sample was representative of the wider population or those who have sought help. This inconsistency limits our ability to compare across samples, as these differing groups are likely to have differing needs. However, the studies considered do provide an insight into the additional gender-specific barriers to specialist veteran mental healthcare experienced by women, a theme seen throughout the reviewed research.

### ***Implications for policy, practice and research***

The literature suggests that women veterans may experience unique barriers associated with accessing a male-dominated veteran-specific healthcare system. Several papers recommended the development of gender-sensitive/specific services for women to promote engagement and a positive experience of mental health services (Brooks et al., 2016; Hamilton et al., 2012; Kehle-Forbes et al., 2017; Koblinsky et al., 2017; Monteith et al., 2020). Whilst the US VA has started to implement gender-sensitive/specific mental health services for women, this should be considered by other countries that provide specialist veterans' mental health services to meet the unique needs of women. Indeed, the introduction of gender-specific services within the VA is associated with increased use of healthcare services by women veterans (Vance et al., 2019).

Additionally, some women in these studies reported feeling as though they were not recognised as a veteran due to their gender, and that their military-related experiences were not taken seriously (AlMasarweh & Ward, 2016; Godier-McBard, Cable, et al., 2021; Hamilton et al., 2012; Ingelse & Messecar, 2016; Kelly, 2021; Koblinsky et al., 2017). This led some women to question if they were eligible for veteran mental healthcare (Ingelse & Messecar, 2016), highlighting the need for practitioners to understand the gender-specific context associated with seeking mental healthcare for veterans. Additionally, veteran mental health services should ensure the promotion of women as service users, and specifically brand some services for, and target information to women veterans.

Considering the increase in women joining militaries worldwide, it will be important for future research in non-US countries to consider the unique experiences of women in this context. This is particularly pertinent in countries in which the structure of veteran mental healthcare differs from that of the US VA. For example, in the UK, mental healthcare is provided to veterans via the pan-population NHS, with preliminary findings suggesting that women are more likely to access non-veteran-specific pan-population NHS services than men (Godier-McBard, Cable, et al., 2021). Furthermore, future quantitative research should look to include comparator groups where possible, to enable investigation of gender and military/civilian differences in barriers to mental healthcare, and association with service utilization. Longitudinal research to identify the impact of barriers and facilitators to mental healthcare on service utilization and experience is needed.

## ***Conclusions***

This scoping review identified 24 papers, 23 of which originated from the US, investigating the barriers and facilitators to mental healthcare experienced by women veterans. This research suggests that whilst women veterans experience a number of barriers common to their male



colleagues (e.g., help-seeking stigma, negative perceptions of services), they also experience unique barriers associated with accessing male-dominated veteran-specific mental healthcare environments (e.g., lack of gender-sensitive treatment options, feeling uncomfortable and unwelcome). The available evidence relies heavily on observational and descriptive research and lacks comparator groups to investigate gender and military/civilian differences. Further research is required outside the US VA healthcare system to better understand the barriers to mental healthcare experienced by women veterans internationally, to inform practice and policy.

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