Unidentified Female: Welcome to the VA HSR&D Investigator Insights podcast series. In this episode, research content editor Maria Hecht talks with Laurel Copeland, research scientist with the VA Central and Western Massachusetts Healthcare System. They're discussing her work in the area of understanding new women veterans' use of VA and or community care.

Laurel Copeland: I'm Laurel Copeland. I'm a research scientist at the VA Central and Western Massachusetts Healthcare System. I work in the research service in the medical center in Leeds, Massachusetts. And this is a relatively new research service. It was developed since 2011 by Christian Maddox. I was actually the first health scientist hired there. I arrived in July of 2016. After 12 years in Texas, I was in both South Texas and Central Texas VAs. And before that, eight years in the VA Ann Arbor.

Maria Hecht: Great. Thanks so much. Generally speaking, what drew you to the VA? You've got some extensive experience being in the VA. You've been in South Texas. You're now in Western Massachusetts, and specifically to VA and its health services research program. So how did you get here?

Laurel Copeland: How did I get here? Yeah. So I was working as a research assistant in the University of Michigan in Ann Arbor. And I had acquired some data skills at that point. Along the way, I completed my Master's of Public Health and started on my doctoral studies.

And in about 1996, I saw a job posting for a data analyst position within VA Ann Arbor. And the job was in Serious Mental Illness Treatment Research and Evaluation Center, SMITREC, which is still funded today.

Maria Hecht: So what about VA keeps you here?

Laurel Copeland: I really like the topic area, the substantive area of mental health, as sort of an overriding comorbidity that the veterans can sometimes have to deal with. And also, I was very enchanted by the quality of the databases.

Maria Hecht: A lot of people who want to kind of deal with a very data-rich environment and a very deep data-rich environment are attracted to VA's extensive one because it is the only integrated health care system in the country. And so there are some unprecedented and really very unique opportunities for someone to evaluate a very long time stream of information, which must be exciting.

Laurel Copeland: It is. And we did get involved in the Health Care Systems Research Network, which had formerly been HMORN, the HMO Research Network. And that attempted to do outside of a federal system what the VA had been doing since the 80s by bringing large health care systems together. And the health care systems had embedded researchers, and the goal was to use the big data from these large systems together to conduct public domain research.

Maria Hecht: You have been looking at a study about new women veterans and their use of VA versus non-VA health care. If you could just sort of briefly describe why women veterans who are new to VA services might use it and sort of why they might not use VA.

Laurel Copeland: When the women veterans get out of military service, they have a full plate of practical and psychological issues to contend with. So they're coming out, they need to line up a job, they need to line up housing, they need to figure out a new way of interacting with their families and deal with a different social milieu compared to when the military managed their day-to-day lives. So I think part of that transition process is necessarily putting together health care for themselves and possibly for other family members. And time is very short.

But still, expertise is very important, especially if they're dealing with serious mental health issues. And so I think if the VA is convenient and the women feel they'll get good care, that that will be an attractant. But it's also important that they not feel hassled when they go to the VA.

And so if all those things are in place, then they might choose the VA. I bring up the issue of getting hassled at the VA because harassment of women veterans and of women working in the VA, women staff, has been a very important topic that we've been discussing lately. Women in all roles need to be able to utilize the VA without receiving comments about their appearance or their imagined intent. And in a male-dominated environment, this has really proven to be a very significant goal, possibly I should say challenge. It's something that people are working on, and I appreciate all of the efforts. Among the women veterans that we surveyed in the Veterans Metrics Initiative, we noticed that 75% used health care in the first 15 months after separation from the military, but only 50% used the VA health care.

Maria Hecht: Interesting. That's a pretty big number.

Laurel Copeland: That's a big difference. So we need to really think about two different groups when we're thinking about women veterans who aren't using the VA. We need to think about the ones who aren't using the VA but are getting health care elsewhere. We need to think about those who aren't getting health care at all.

Maria Hecht: And it's interesting you bring up the issue of stranger harassment because some of your VA HSR&D colleagues have just released a pretty big study on the issue of stranger harassment, and unfortunately, it is a major issue. And as you mentioned, it is extremely off-putting. So if you are not getting care at the VA, it may be one of your only opportunities to get care. Are you getting care at all? So that's a big issue. And it's interesting to see the dovetail, the concurrence between the work that you're doing and the harassment issue.

Laurel Copeland: That's a good point. When we were at the Central Texas VA in Temple, Texas, we were moving, you know, you always have a problem with structures, buildings. Where can we put this clinic and that clinic? We were moving some of the military sexual trauma, the MST counseling, to actually a part of the DOM.

Maria Hecht: The DOM is the domiciliary or the residential rehabilitation wing.

Laurel Copeland: Where mostly the patients were recovering male alcoholics. And because of some sort of restriction on what type of doors you can have in use, the women had to go through the DOM, like the common areas of the DOM, to get counseling. And it was very off-putting.

Maria Hecht: Wow, it sounds like there might be an interesting partnership between potential architecture and research. Because as we all know, when architects design spaces, they're designing them to be utilized in a very certain way and the form and the function go together. So I wonder if there's some sort of natural affinity. But that's another research question for another day.

Laurel Copeland: No, I totally agree. And the stakeholders and the architects are working to address this exact type of structural problem. In fact, in our Leeds VA, we just renovated a very old building. It's a set of very old buildings to house, essentially, the DOM there. It's really a PTSD inpatient treatment unit. And they designed a separate women's wing that has appropriate privacy and separation. So this will be the first time we can actually provide inpatient treatment to women who have PTSD.

Maria Hecht: Was there a particular finding that was very surprising for you in this work?

Laurel Copeland: Yes. I think the connection between housing instability and use of health care was most surprising to me. That is, it's not surprising that people who are concerned about whether they have housing next month don't go to the doctor. That's not surprising. But why would that relationship only arise for the women veterans and not for the men? Is it because their housing insecurity is more persistent, so you see the effect? Or are the male veterans somehow getting the help they need more quickly? Are the male veterans using the VA outreach to homeless veterans more effectively? Or is the type of outreach or the services provided somehow working better for the males than for the females? So I did find this result to be very thought-provoking.

Maria Hecht: That really is, because then you also can think about potential ramifications for women who may have experienced a military sexual trauma incident, who may then be more prone to potentially an abusive relationship after discharge, which could conceivably contribute to housing instability in that role. It's an interesting question, but, yeah, that is sort of a surprising finding. And then, of course, those wraparound services. Is there gender bias involved in how we approach our male veterans? Are we unconsciously embedding more services for them as opposed to looking at women veterans as, oh well, aren't they getting the same services? Well, no, maybe they're not. So it's a very surprising question.

Laurel Copeland: And it's often not an intentional bias. It's because services and ways of delivering those services develop based on who your clients are. But when your client base changes, there's a mismatch.

Maria Hecht: Of course. And organizations are large and don't necessarily change quickly, which is, of course, one of the things with our query counterparts that we're trying to change and be a little bit more nimble and implement more quickly. Based on the outcome of your work, what would you like to see happen? Changes in policy, an implementation change, a practice change? Is there something ultimately you'd love to say, in my ideal world, I'd love to have X happen, X be the outcome?

Laurel Copeland: I would like to see the researchers working with leadership to delve into this question about housing insecurity amongst new veterans, which was reported by 10% to 12% of our cohort of 10,000.

Maria Hecht: That's a pretty big number.

Laurel Copeland: It was surprising to me, yeah, and particularly when the research is being conducted to include the gender question because obviously there is a difference in where the correlations are. We need to know why they're affected differentially from men. And, of course, I hope that the stakeholders will continue to work on making VA a place that's welcoming to women veterans and that they do continue to work on restructuring buildings to accommodate women in a way that makes them feel safe and respected. I do work with veterans who are employed in research, and I'd like to have access to veterans' points of view because it helps keep the research up relevant, obviously.

Also, my dad was a veteran of World War II with Navy, and he died last Christmas Eve at 92, and he was a great source of inspiration, but I have many other veterans within the VA to help me try and keep my research real.

Maria Hecht: That's great, and I think keeping the research real is such a great way to frame it because if you're not really in touch with those stakeholders, and they are really the ultimate end user of all of the information that we do here in HSR&D.

Unidentified Female: The views and opinions expressed in the preceding podcast are concerned with the scope of recently concluded or ongoing VA HSR&D-funded research and do not necessarily reflect current or to-be-implemented VA policy. To learn more about this research, visit the VA HSR&D website at www.hsrd.research.va.gov.