



New York State Minority Veteran Needs Assessment

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Introduction and Executive Summary

After 9/11, initial public displays of support for service members coalesced into what has been called a “Sea of Goodwill” consisting of public, private, and nonprofit organizations offering programs and services to military personnel and veterans, their families and caregivers, and survivors. Collaborative efforts have led to tremendous progress in addressing some identified challenges: The number of homeless veterans nationwide has been cut in half, and veteran unemployment has been lower than that of nonveteran peers for nearly two years. At the same time, these gains have not manifested to the same degree across the entire veteran population: Disparities exist between the outcomes of minority veterans and their nonminority veteran peers. This report assesses the extent of those disparities for women; racial/ethnic minority veterans; and lesbian, gay, bisexual, and transgender (LGBT) individuals.

Analyzing the circumstances of minority veterans through focus groups, site visits to veteran-serving organizations, interviews with key stakeholders, and publicly available data, this needs assessment identifies: a) the differences between outcomes for minority versus nonminority veterans, as well as between minority veterans and their minority nonveteran counterparts; b) likely causes for identified variations, and c) recommendations for organizations that serve veterans to enhance equitable outcomes across the population. This needs assessment examines outcomes across four life domains: health, housing stability, financial stability, and social functioning. Supplementing data with the perspectives of minority veterans themselves, along with key stakeholders who support them, provides valuable context for those who wish to better serve this community.

To continue improving outcomes for those who have served the nation, it is imperative to develop a deeper understanding of whether there are specific veteran subpopulations that are faring differently from their peers. By developing a more nuanced understanding of the challenges different groups of veterans face, organizations can better target outreach and interventions to help these underserved populations overcome barriers and thrive.

Among this needs assessment's most significant findings are the following:

- Veteran status is largely protective: Veterans of many minority groups have better outcomes across multiple measures than their nonveteran counterparts. However, minority veterans' outcomes are not on par with those of white cisgender men veterans.
 - » For example, black veterans experience unemployment at lower rates than black nonveterans but higher rates than white veterans, and women veterans have higher incomes than women nonveterans but lower incomes than men veterans.
- There is insufficient data across veteran minority groups and measures to conduct comprehensive analyses, particularly for LGBT veterans overall and for those with multiple minority statuses; more research is needed.
- Women and LGBT veterans often find the environment at traditional veterans service organizations and the U.S. Department of Veterans Affairs (VA) unwelcoming due to harassment and discrimination; this can cause harm across life domains by reducing access to care, benefits, and social support.
- Traditional homeless shelters pose barriers to single mothers and LGBT veterans.
- Health care for Native American veterans is bureaucratically complicated and often difficult to access due to a lack of cultural competency and the significant barriers between Native American institutions and those of the general population.
- CNAS identified a number of recommendations for those who serve and support veterans to improve research, outreach, and equitable services within the veteran community and beyond.

Several caveats limit this research, including that data specific to religious minorities was unavailable for useful comparisons; and multiple additional factors intersect with the examined categories to impact veteran outcomes, including age and disability status, among others. These limitations suggest additional opportunities for future research and analysis.

This project first provides the framework for this analysis and background on minority veterans and social determinants of health (SDH) to give context for the needs assessment. The second section presents the demographics of minority veterans in New York State specifically, and in the United States as a whole. The third section details the findings about minority sub-populations/ experiences in the four life domains. The final section provides recommendations to researchers, veterans service organizations, and the Department of Veterans Affairs and provides a high-level conclusion about these challenges.

Ultimately, the key takeaway from this research is that veterans are members of American society and are affected by many of the same challenges that their nonveteran peers face. Military service can help overcome many, but not all, structural and institutional barriers that have a disproportionate impact on women and minorities. Understanding the needs of minority veterans will serve all veterans, who will similarly see improvements in services and programs. Those who wish to see equity within the veteran population must acknowledge and confront those issues both within the veteran-serving space and the broader community.

Background, Methodology, and Report Design

Background

Members of the military join for a variety of reasons, are drawn from every corner of the nation, serve in a wide array of jobs across the different branches of service for varying lengths of time, and transition back into civilian life across the country. Experiences individuals have before joining, during service, and after becoming veterans intersect in complicated ways to influence their life trajectories. Research and policy recommendations related to veterans often treat this population of over 18 million diverse individuals as a monolith, while also assuming most challenges its members encounter can be attributed to their military experiences. That focus, simultaneously overly broad in conception and too narrowly focused on potential causality, is ultimately counterproductive.

This project disaggregates the overall veteran population to explore whether outcomes across several life domains vary for those who are women; racial/ethnic minorities; and/or lesbian, gay, bisexual, or transgender (LGBT). While seeking to understand specifically the health of post-9/11 veterans in New York State, this research often takes a more expansive lens for several reasons.

First, a growing understanding in the health community emphasizes how social determinants of health (SDH), or the circumstances and environments in which individuals live, work, grow, and age, also impact well-being.¹ For instance, lack of accessibility to healthy food options or the presence of household asbestos both negatively impact individuals' well-being. Similarly, any military discharge status other than "honorable" (OTH) can limit individuals' access to health care and other benefits that could bring enhanced economic stability. Widespread institutional and individual bias may affect a veteran's discharge in the first place, such as when "Don't Ask, Don't Tell" (DADT) was in place.

Those who are part of minority groups often experience different SDHs than non-minority populations, due to racial, class, or other disparities. Chronic social stressors—such as being subjected to racism, sexism, homophobia, poverty, or cultural dislocation—impact and negatively influence well-being. Veterans, particularly minority veterans, face challenges that exist within broader societal challenges and trends. While the foundation of this project's analysis is health, social determinants of health and the interrelated nature

of life therefore demand a broader perspective. For example, non-service-connected health issues for veterans can be geographically influenced in New York State by the presence of pollution-emitting factories or lack of grocery stores with healthy food options in higher-poverty areas.

Second, due to limitations in the existing data, it was not possible for this report to focus exclusively on post-9/11 minority veterans in New York State. Available sources of information do not always capture or publish data by minority status; this is particularly true for data on outcomes for LGBT veterans. Even when data is published at a more granular level—for both civilians and veterans by race, sex, and age, for example—sample sizes are often too small to be reliable, making it impossible to confidently identify trends at the state level or below. To identify possible areas of concern for minority veterans, this research accordingly must often rely upon data for a wider age range than only post-9/11 and/or a wider geographic area than New York State.

While there has been significant attention paid to key issues for veterans, veterans have largely been treated as a monolith, with little disaggregated research and writing on veteran minority populations. Needs assessments tend to be general to the veteran population or with func-

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tional focus such as student veterans, unemployment, or medical needs.² As the population of women veterans has increased, there has been additional work by advocacy groups to call attention to their specific needs and gaps in service. Government agencies and veterans' groups often collect demographic data on racial/ethnic minorities, but there is little in-depth work on how best to support these specific veteran groups. Very little research or analysis has been completed on LGBT veterans nationally or in New York State.

This report builds off four past regional needs assessments the Center for a New American Security (CNAS) conducted that examined the state of veterans in Maryland, Northeast Virginia, and Washington, D.C.; the Dallas-Fort Worth region; Southwest Pennsylvania;

and the Western United States.³ These needs assessments sought to help local foundations, organizations, and other actors understand the specific challenges veterans faced in their region and what services were most needed. The analyses sought to capture the state of veterans in these regions, how veteran needs were being met, the main efforts to address veteran needs, and what kinds of collaboration or structures were in place to sufficiently address veteran needs. CNAS' past needs assessments acknowledged some disparities experienced by women veterans and minority veterans, but more comprehensive work was needed.

This report seeks to fill gaps in the existing literature by a) determining what if any differences exist between outcomes for minority veterans versus nonminority veterans, as well as between minority veterans and their minority counterparts who have not served in the military; b) identifying likely causes for identified variations; and c) developing a series of recommendations for organizations that serve veterans to enhance equitable outcomes across the population. While this work is focused primarily on Operation Iraqi Freedom and Operation Enduring Freedom (OIF/OEF) veterans residing in New York State, the results may have broad applicability nationwide.

Methodology

This report follows a mixed methods approach using three primary lines of effort to collect information: an evaluation of existing literature and publicly available data, interviews with key stakeholders at the national and local levels, and focus groups with veterans living in New York State.

This analysis began with a comprehensive review of existing data and literature on veteran outcomes across four holistic life domains, as well as existing findings of challenges veterans face. When possible, New York State-level data was used; when not, nationwide trends provided a baseline for minority veterans residing in New York State. Similarly, veteran-specific data was referenced when that data was collected, although in many cases, veteran-specific data on minority groups was not available, such as the number of LGBT veterans or Native American veterans at risk of losing their housing. When veteran-specific data was lacking, researchers referenced trends among these underrepresented populations in the civilian population with the understanding that minority status and veteran status can both play a significant role in outcomes. This analysis cannot address the full scope of health and well-being outcomes due to the interrelated nature of well-being

and therefore used a limited number of representative measures in each life domain as points of reference.

Quantitative research was obtained from government agencies such as the Department of Veterans Affairs (VA), the Department of Labor, the Department of Defense (DoD), the U.S. Census Bureau, and other data sources. CNAS further conducted qualitative analysis on challenges veterans face through review of survey results, reports, and policy papers released by a range of veteran-serving nonprofits, the New York State Health Foundation, and advocacy groups.

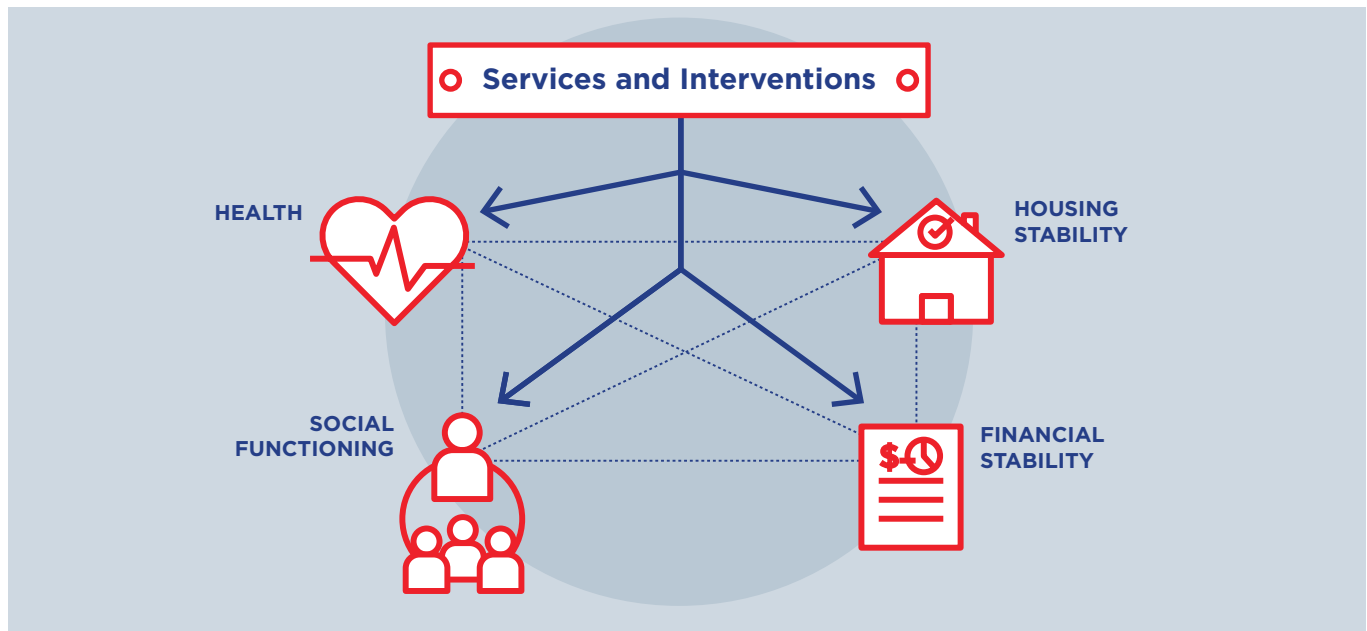
To gain greater insight into the experiences and well-being of minority veterans, as well as organizations' efforts to reach and serve them, CNAS conducted interviews with 23 stakeholders, subject matter experts, and community leaders at the national, state, and local levels. Interviews took place between May and November 2019. To identify experts and service providers, CNAS leveraged institutional contacts, liaised through the needs assessment funder for the assessment, and contacted service providers directly. Experts included civil servants working at the national, state, and city levels; community advocates; organizational leads; and practitioners. Furthermore, CNAS conducted three focus groups averaging eight veteran participants (two in New York City and one in Buffalo). Outreach to veterans was conducted by posting paper and social media notices, as well as working with local community advocates, organizational representatives, and VA representatives. There were numerous hurdles to recruiting sufficient numbers of veterans, particularly in the rural regions. Additional details on this component of the research are presented in Appendix A.

Stakeholder perspectives were critical for gaining a broader view of the space, and veterans' opinions and beliefs provide valuable context on perceptions of barriers and available resources, whether these perceptions appear to be accurate in all cases or not.

Framework and Report Design

This report assesses minority veteran well-being in New York State. For the overarching framework, the research uses a slightly modified version of a holistic model developed by the RAND Corporation that includes four life domains that affect veterans in transition and beyond. The model, called the Holistic Model of Interrelationships and Intervention Opportunities, includes the interrelated life domains of health, financial stability, housing stability, and social functioning, all of which are vital components of overall well-being.⁴ Each influences the others, as shown by the bidirectional arrows in Figure 1, and all can be influenced by the provision of services.

FIGURE 1
HOLISTIC MODEL OF INTERRELATIONSHIPS AND INTERVENTION OPPORTUNITIES



Source: Carra S. Sims, Christine Anne Vaughan, and Kayla M. Williams, “Continuing Down the Road to Reintegration: Status and Ongoing Support of the U.S. Air Force’s Wounded Warriors,” (RAND Corporation, 2016).

Health encompasses both physical and mental health, with special emphasis on the “invisible wounds of war” that are particularly associated with the post-9/11 generation, post-traumatic stress disorder (PTSD) and traumatic brain injury (TBI), as well as frequent co-morbidities such as depression and substance use disorder. Financial stability focuses on employment, unemployment, and underemployment, as well as educational attainment and access to benefits. Housing stability refers to the experience of instability in permanent housing, including homelessness. Finally, social functioning refers to supportive structures offered by marriage, familial relationships, peers, and veterans service organizations (VSOs). Each of these domains is influenced by and influences the others. This report examines each separately while recognizing that health and well-being outcomes are therefore interrelated and multifaceted.

Minority status can also affect outcomes in each of these life domains. This report considers minority status to include racial and ethnic minorities; women; and lesbian, gay, bisexual, and transgender individuals.⁵ Although religious minorities are another worthy category of study, insufficient data is collected on these veterans to conduct a robust analysis. Age is another potentially confounding factor: Black veterans who came of age before the civil rights movement, LGBT veterans

who served before the repeal of “Don’t Ask, Don’t Tell,” and women veterans who served before the combat exclusion policy was lifted will have had different experiences inside and outside the military. This is another area ripe for additional research but beyond the scope of this project.

Furthermore, individuals can hold multiple minority statuses, which could combine to amplify challenges. The interconnected and overlapping nature of multiple identities (including race, gender, and sexual identity/orientation) and forms of discrimination (sexism, racism, homophobia, and classism) is known as intersectionality. Each subset of the veteran population is subject to challenges and successes; while this assessment attempts to look at a variety of minority groups, every permutation was not possible. Recognizing that intersectionality is a critical component of health and well-being outcomes, this report attempts to address the cumulative and combined effects of these statuses when possible, though organizes research results separately for clarity.

The report begins with a chapter containing demographic context on minority veterans. It then presents findings organized by life domain (health, financial stability, housing stability, and social functioning), first addressing overarching trends and then identifying any disparities by minority group (women, racial/ethnic minorities, and LGBT veterans). The final section turns to recommendations about how those who serve veterans can work to increase equity.

As the large conscription-era veteran cohorts pass away, the veteran population is not only shrinking rapidly but also becoming more diverse, echoing broader societal trends that are themselves reflected in the service member population.

Context: Minority Veterans in the United States and New York

The notional image of “what a veteran looks like” that immediately springs to mind for many Americans is of an older white man. This has some accuracy: In 2017, men made up roughly 90 percent of the veteran population; of them, 78 percent were white and the median age was 65.⁶ The post-9/11 veteran cohort is significantly younger: About 74 percent were younger than 45 in 2016.⁷ As the large conscription-era veteran cohorts pass away, the veteran population is not only shrinking rapidly but also becoming more diverse, echoing broader societal trends that are themselves reflected in the service member population. The post-9/11 veteran cohort has a higher percentage of minorities than previous service eras, a trend that will only grow.⁸

With more than 718,000 veterans living in New York State, the state contains the fifth largest statewide veteran population in the country and includes 4 percent of the total veteran population.⁹ Due to the urban-rural population dichotomy of the state, the majority of veterans live in and around the greater New York City metropolitan area. However, the highest concentration of the New York State veteran population is in upstate counties such as Hamilton County and Jefferson County.¹⁰ This aligns with the general New York State trend of upstate populations being older; more than half of its veteran population is older than 65, the majority having served in the Vietnam War era (32 percent) and the Persian Gulf War era (26 percent).¹¹ The relative age of veterans influences multiple aspects of this minority needs assessment: Both the general population and the veteran population are becoming increasingly diverse with younger generations; women are increasing as percentages of the military and the veteran community, and policies and attitudes toward LGBT populations have changed drastically in the last several decades.

The following sections provides an overview of what is known of the demographics of each minority group in the military, the national veteran population, and New York State.

Women Veterans

While women have fought for the nation since the Revolutionary War, various restrictions existed upon their equal service until recently; these were lifted in stages before being completely eliminated in 2015. Since 1973, when the cap limiting female participation was lifted, the number of women in the military has risen substantially. By 2017, DoD reported that women made

FIGURE 2
VETERAN AGE AND GENDER BREAKDOWN

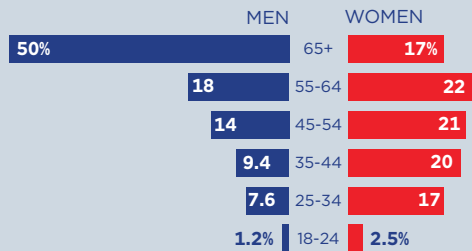


FIGURE 3
WOMEN VETERANS BY RACE AND ETHNICITY

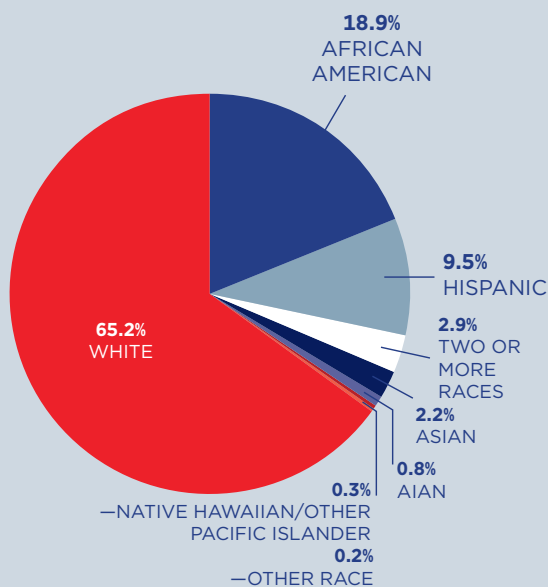
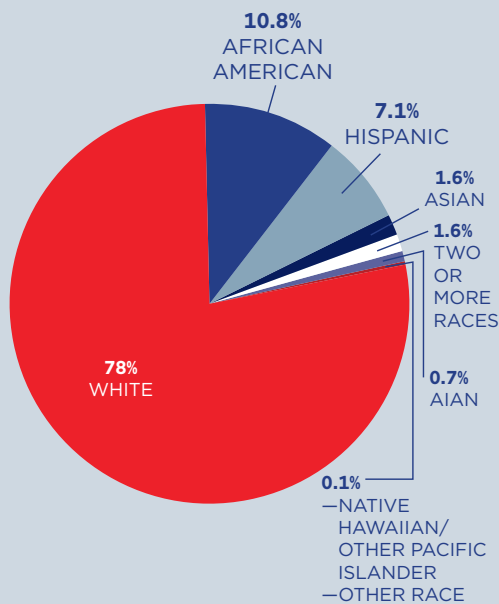


FIGURE 4
MEN VETERANS BY RACE AND ETHNICITY



Source for Figures 2, 3, and 4: "Profile of Veterans: 2017" (U.S. Department of Veterans Affairs, National Center for Veterans Analysis and Statistics, March 2019), https://www.va.gov/vetdata/docs/SpecialReports/Profile_of_Veterans_2017.pdf.

up 17.5 percent of the 2.1 million-member total military force, up from 15.4 percent in 2000.¹² The post-9/11 veteran cohort has a significantly higher percentage of women than previous eras, at 17 percent.¹³ Women are more heavily represented in the officer than enlisted corps, 17.7 percent to 15.9 percent, while representation varies across service branches.¹⁴

Among veterans, VA reports show that women skew younger than men, with a median age of 51 compared with 65, as shown in Figure 2.¹⁵ The number of women veterans is projected to grow in coming decades while the number of men who have served shrinks; accordingly, the percentage of women will rise from 10 percent today to match women's current representation in the total force by 2042. Among veterans, women are more racially/ethnically diverse than men, as demonstrated in Figures 3 and 4. Three-quarters of men veterans are white, compared with 65.9 percent of women veterans. This gap is not entirely explained by the age difference: Among post-9/11 veterans, 67.5 percent of men are white, compared with 55 percent of women.¹⁶

Using 2017 New York State estimates, women make up 7.58 percent of the statewide veteran population, and their proportion will grow over time.¹⁷ New York State has a slightly lower percentage of women veterans than the national average (7.58 percent compared with 9.41 percent). New York City is a hub for all veterans, with a veteran population of 210,808 or 25 percent of the statewide veteran population, 6.5 percent of which are women.¹⁸

Racial/Ethnic Minority Veterans

Veterans overall are less diverse than the civilian population. A quarter (23 percent) of the veteran population identified as nonwhite compared with 38 percent of the civilian population.¹⁹ The percentage of veterans who are black more closely matches the civilian population (11.5 percent of veterans compared with 11.9 percent of nonveterans). The second largest minority group is Hispanic veterans (7.3 percent versus 17.7 percent), followed by Asian veterans (1.6 percent versus 6 percent). This difference is particularly true for men veterans, of whom 78 percent are white, 15 percent are nonwhite, and 7 percent are Hispanic.²⁰ Furthermore, the percentage of Americans, and therefore veterans, identifying as more than one race is on the rise, which highlights the importance of intersectionality in future analysis and

adds to the difficulty of conducting siloed research.²¹ The women veteran population is more diverse, as previously mentioned, with 25 percent identifying as nonwhite, 9.5 percent as Hispanic, and 65 percent as white.

The post-9/11 veteran cohort is more diverse racially and ethnically than previous cohorts, as shown in Figure 5: As of 2017, 15 percent were black, 14 percent were Hispanic, and 3 percent were Asian.²² Of male post-9/11 veterans, 20 percent identify as nonwhite and 12 percent as Hispanic.²³ American Indians and Alaskan Natives (AIAN) constitute the ethnic group with the highest rate of military service in the United States, as well as the strongest concentration of women service members by ethnic group.²⁴ Pacific Islanders are rarely broken out into data but are also overrepresented in the veteran community.

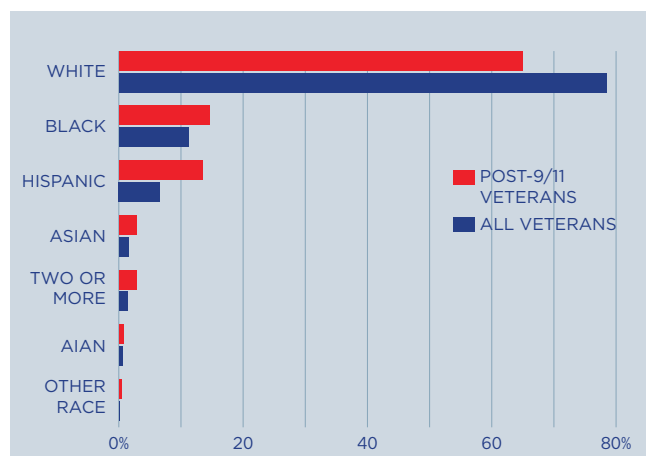
In New York State, as of 2015, 21 percent of the veteran population was made up of racial and ethnic minorities, a rate expected to rise to 37 percent by 2040.²⁵ Of this group, 11 percent identified as African American and 8 percent as Hispanic.²⁶ While state trends follow national trends, the New York City veteran population is significantly more diverse: 41 percent of veterans are nonwhite, including 30 percent who are African American.²⁷ The proportion of minority veterans in New York State will continue to increase as the more diverse post-9/11 cohort comes to dominate the veteran population, in line with nationwide trends.

LGBT Veterans

Military service by openly lesbian, gay, or bisexual individuals was barred until the repeal of DADT in 2011. In 2016, DoD lifted its ban on transgender service members serving openly; the Trump administration reinstated that ban in 2018 and it remains in place while litigation is ongoing. Despite historic and ongoing discrimination, some estimates indicate that the transgender population serves in the military at twice the rate as the general population.²⁸ Because of this fraught legacy, there is little in the way of official historic DoD reports on the percentage of LGBT individuals in the military that would allow assessment of trends through time.

However, 5.8 percent of respondents to the 2015 Health Related Behaviors Survey (HRBS) of the active-duty population identified as LGB: 1.9 percent of men identified as gay, 2 percent of men identified as bisexual, 7 percent of women identified as lesbian, and 9.1 percent of women identified as bisexual.²⁹ Additionally, 0.6 percent of service members identified as transgender.³⁰ Researchers noted these estimates fell within expected ranges when compared with civilians of a similar age

FIGURE 5
PERCENTAGE WHO IDENTIFY AS RACIAL/ETHNIC
MINORITIES BETWEEN VETERAN GENERATIONS



Source: "Minority Veterans Report: Military Service History and VA Benefit Utilization Statistics" (U.S. Department of Veterans Affairs, National Center for Veterans Analysis and Statistics, March 2017), https://www.va.gov/vetdata/docs/SpecialReports/Minority_Veterans_Report.pdf.

profile. As in the civilian population, reported same-sex sexual attraction and activity exceed rates of self-identification as LGB. VA estimates that there are approximately 1 million LGB veterans nationwide, which reflects trends the HRBS identified in the active force.³¹ Published estimates of the number of transgender veterans range from 134,000 to 163,000.³²

There is no longitudinal demographic data available for LGBT veterans, likely due to long-standing DoD policies against LGBT service members openly serving as well as cultural stereotypes and stigmas held by both broader society and the military community. This is exacerbated by the shifting status of LGBT individuals both in terms of court rulings and federal executive branch actions, which could affect both the willingness of organizations to attempt to collect data and of LGBT individuals to disclose their status in surveys. Closing this gap in information is critical to better understanding the needs of LGBT veterans and thus better serving this community.

Veteran demographics provide context for the population that providers and organizations serve. The next section examines outcomes among minority veterans across the four life domains.

Veteran outcomes across these domains depend on a combination of factors: Both pre-service and in-service risk and protective factors intersect with post-service experiences and environments.

Findings

There is a significant body of research on veteran health and well-being across domains.

Government agencies, veteran-serving nonprofits, and corporations have all sought to identify needs and close gaps in services. To comprehensively assess minority veteran needs, this report synthesizes existing literature through the lens of the holistic model, supplemented with input from key stakeholder interviews and veteran focus groups.

Veteran outcomes across these domains depend on a combination of factors: Both pre-service and in-service risk and protective factors intersect with post-service experiences and environments. Pre-service risk factors include exposure to adverse childhood experiences (ACEs), such as experiencing or witnessing abuse, which are strongly associated with a variety of negative outcomes, from health to income.³³ In-service risk factors include experiences ranging from combat injuries to sexual trauma that occur during military service that can cause health conditions or are associated with other negative outcomes among veterans. Protective factors related to military service include access to health care and belonging to a community. After leaving the military, veterans return to civilian communities that also offer both risk and protective factors for being able to thrive across domains, including the ability to access health care and accessibility of affordable housing. How all these factors interact lays the groundwork for veterans' lifelong outcomes; accordingly, significant pre-service or in-service factors are also explored when relevant.

This section breaks out existing findings by health, financial stability, housing stability, and social functioning, categories that are interconnected. Disparities that exist between minority groups have an amplifying effect when well-being as a whole is examined. As one stakeholder highlighted: "You don't just have a housing problem. You have a job problem, which is creating a housing problem. Or you have an addiction problem that is interfering with your employment and therefore jeopardizing housing." Sections also explore opportunities for supportive interventions, including what is known of current usage rates.

Health

Health outcomes are widely considered the baseline for health and well-being. Overall, veterans have access to better, more consistent care than their civilian counterparts; however, veterans experience different risk factors and health outcomes. The interplay of pre-, in-, and

post-service factors can be most clearly conceptualized when it comes to health outcomes. Those who have served in the military during the All-Volunteer Force era, particularly men, have higher rates of many ACEs than those who have not served.³⁴ On the other hand, accession standards include a number of requirements that are protective factors for long-term health. Young people who join the military must have no serious preexisting health issues and be neither underweight or overweight, they must have a high school diploma or General Educational Development (GED) certificate, and they must not have a serious criminal background.

Service puts individuals at greater risk of harm, while providing wraparound resources. Both physical and psychological injuries can occur in training, combat, or garrison environments. Troops may be exposed to various toxins associated with negative health outcomes, from Agent Orange in Vietnam to burn pits in Iraq and Afghanistan to toxic water on bases in the United States.³⁵ However, military service offers active-duty troops subsidized access to health care, food, and exercise. Veterans are disproportionately likely to have mental health conditions such as PTSD, physical injuries including TBI, cancer, arthritis, and cardiovascular disease. Nonetheless, those who have served are also more likely to self-report being in very good or excellent health than those who have not.³⁶

The number of VA users is climbing even as the number of veterans shrinks.³⁷ This is for a variety of reasons, including that the veteran population is aging, health burdens increase with age, and eligibility was expanded for veterans of recent conflicts. Despite criticisms, VA remains a good source of health care, boasting low wait times, high quality, cultural competence, and low cost for many veterans.³⁸ Studies have shown that wait times at VA facilities are shorter than in the private sector.³⁹ Systematic studies have examined the relative quality of care between the Veterans Health Administration (VHA) and outside health care providers and shown that VA provides better or equal outcomes in regard to safety and effectiveness for patients.⁴⁰ VA also provides substantially better-quality mental health care, a prime consideration for veterans.⁴¹ However, not all groups of veterans find VA to be equally welcoming, accessible, or able to provide adequate care, as discussed below. There can also be significant variation across VA Medical Centers (VAMCs), with widely acknowledged challenges gaining initial access to the VA system. Accordingly, as the veteran population changes, so must training and assumptions of VA staff and even fellow patients, as well as what types of care are covered.⁴²

As the veteran population declines, a rise of veterans with service-connected disabilities poses new challenges for VA. From 1990 to 2018, the veteran population shrank from 28 million to 20 million, while simultaneously there was a 117 percent increase in veterans with service-connected disabilities.⁴³ Due to improvements in battlefield care, more veterans are living with disabilities than before, with 36 percent of post-9/11 veterans having a service-connected disability versus 19 percent of all other veterans.⁴⁴

Different veteran populations use the VA at different rates. A smaller share of post-9/11 veterans use VHA than other veterans (26 percent compared with 31 percent).⁴⁵ Post-9/11 service-disabled veterans use VA health care at lower rates (62 percent) than other veteran groups (74 percent).⁴⁶ An overarching perspective assumes all veterans have the same knowledge base about how to access VA health care or disability assistance. Veterans' own perception of self may determine their comfort or willingness in seeking out benefits. Previous experiences specific to minority group populations can deter veterans from using VA for their health care at all. Minority and underrepresented groups, in particular women, racial/ethnic minorities, students, and veterans in rural areas, tend to be at increased risk for negative health care outcomes in large part due to lack of awareness, eligibility for certain programs, and concerns about stigma against them or lack of confidentiality.

WOMEN VETERANS

When it comes to pre-service exposures, women who have served in the military are more likely to have experienced some ACEs, including physical abuse, household alcohol abuse, exposure to domestic violence, and emotional abuse, than women who have not served and more likely than men to have experienced ACEs related to childhood sexual abuse.⁴⁷

In terms of in-service protective factors, active-duty women are less likely to engage in certain unhealthy behaviors, such as smoking cigarettes or binge-drinking alcohol, than active-duty men; similarly, their rates of physical activity are higher than that of civilians.⁴⁸ During service, women are exposed to some risks at rates far higher than civilian women, but still at lower rates than military men. For example, while American civilians overall are very unlikely to see combat, current-era military women are just slightly less likely than military men to have deployed to Iraq and Afghanistan; those who have deployed are less likely to have been killed or wounded in action.⁴⁹ Similarly, women in the military are at decreased risk of TBI compared with men in the military, but their risk is far greater than that of civilian women.⁵⁰

Overall health outcomes for military-affiliated women have been deteriorating over the last 15 years, for both physical and mental health challenges and conditions.⁵¹ Two topics that disproportionately affect military women deserve particular attention: musculoskeletal injuries and sexual trauma. Military women experience higher rates of injuries, especially of the lower musculoskeletal variety, than their male counterparts. Physical differences between men and women and lower overall fitness levels among women constitute biological reasons for some increased susceptibility to injuries. However, equipment used in the military has been designed for male bodies and therefore does not properly fit women, which also contributes to disproportionate rates of injuries.

Women also experience sexual harassment and assault at significantly higher rates than men in both the general population and the military community; military sexual trauma (MST), the umbrella term that covers both severe or pervasive sexual harassment and sexual assault experienced during service, is correlated with a range of negative health outcomes.⁵² According to a DoD survey, in 2018, 6.2 percent of active-duty women and 0.7 percent of men experienced a past-year sexual assault.⁵³ The same survey estimated that 24.2 percent of women and 6.3 percent of men had experienced sexual harassment in the previous year, and 16 percent of women and 2.3 percent of men had experienced gender discrimination. Nationwide, over the course of a lifetime, an estimated 27.5 percent of women and 11 percent of men experience unwanted sexual contact. Subsequently, women veterans may have complex trauma due to exposure to multiple traumatic events prior to, during, and after military service. MST is more strongly correlated to PTSD than either combat trauma or civilian sexual assault; following the high rates of exposure in service, a significant percentage of women veterans screen positive for MST.⁵⁴ This can present a significant area of concern for women seeking care. Of Wounded Warrior Project (WWP) member survey respondents in New York State, 32 percent cited worry over treatment that would bring up traumatic memories as a barrier to seeking care.⁵⁵ Even given these challenges, however, additional studies have categorized military service as positive for women veterans: 73 percent report feeling “stronger mentally, physically, or both as a result of their service.”⁵⁶

Women veterans reported being mistaken for a spouse or partner of a veteran rather than veterans themselves, or otherwise questioned as to why they are entitled to veterans’ benefits.

that individual has within the facility varies substantially. As a smaller share of the veteran population, women

Injuries and conditions suffered before and during military service continue to affect women as they become veterans.⁵⁷ Women veterans age 18-44 who use VHA for health care are more likely to have a service-connected disability rating than men, and slightly over half sought care for a musculoskeletal and/or mental health condition.⁵⁸

Experience with VA health providers informs veterans’ willingness to engage with the system, trust the care they receive, and seek care in the first place. For example, 25 percent of women veterans reported inappropriate/unwanted comments or behavior by men veterans while at VA.⁵⁹ Women veterans who reported harassment were less likely to report feeling welcome to VA, which related to delaying and/or missing care. One stakeholder said about experiencing harassment at VA: “A veteran doesn’t necessarily go back to VA. If they have a negative experience, they’re not coming back.” Women with a history of MST are more likely to find this to be an insurmountable barrier to care. Women veterans strongly encouraged each VA center to have a women’s care coordinator employed to change the all-male culture of VA medical centers. While each VAMC is required to have a women veterans program manager to advise and advocate for women veterans, the amount of influence

that individual has within the facility varies substantially. As a smaller share of the veteran population, women veterans have historically not felt informed of their benefit entitlement or welcomed at VA facilities. A vast disparity between VA users and nonusers illustrated lack of awareness that specifically addressed women’s health services: 67 percent of users received information compared with only 21 percent of nonusers.⁶⁰ One of the biggest factors, according to interviews with stakeholders and advocates for women veterans, is barriers to receiving care. One example given was, “When women show up, they are challenged whether they served; they’re asked questions that their male counterparts aren’t asked.” Said another way, being a woman veteran may not put an individual at higher risk for negative health outcomes directly, but rather indirectly, because women veterans are less likely to seek treatment early and often from VA medical centers.

Stakeholders routinely reported that women are often reluctant to seek services at VA Medical Centers as they

are, or are perceived to be, male-dominated spaces and thus less sympathetic, understanding, or welcoming to women. Women veterans reported being mistaken for a spouse or partner of a veteran rather than veterans themselves, or otherwise questioned as to why they are entitled to veterans' benefits. Women who have experienced military sexual assault are particularly untrusting of VA care and often elect not to reenter a military environment; however, few providers in the civilian setting are familiar with the effects of MST.

For those women who do seek services through VA, treatment is frequently perceived to be less comprehensive or effective than that of their male counterparts. For female amputees, for example, it can be more difficult to obtain prosthetics designed specifically for female bodies, leaving women veterans with ill-fitting, ineffective, or generally aesthetically unappealing prosthetics, especially considering the stylistic differences between men's and women's clothing choices.

Personal schedule was the primary barrier to accessing health care: 50 percent of women compared with 33 percent of men WWP New York State members cited work, school, and family as conflicting with VA health care facility hours.⁶¹ Women veteran focus group participants were in agreement that "Even if it costs money, we need veteran-specific daycare ... at both VA facilities and other locations." Child care coverage to attend medical appointments was difficult for 42 percent of women. Nationally, while the vast majority of women veterans did not express transportation difficulty as a barrier, 72 percent did not use the VA facility nearest to them because women's health services were not available (16 percent) or they did not think the providers were good (12 percent).⁶²

Women veterans face a shortage of obstetricians/gynecologists (OB/GYNs) at VA Medical Centers: While some VA medical centers retain an on-site OB/GYN, as of 2016, 27 percent of VAMCs did not.⁶³ Compared with men veterans who have a one-stop shop in VA Medical Centers, women veterans regularly have to be referred elsewhere for gender-specific health care. This is problematic because women veterans may be referred to other providers for routine matters such as urinary tract infections (UTIs), mammograms, incontinence, and general reproductive health, which reduces the benefits associated with having fully integrated care. While men veterans are also referred to community care providers, across the board advocates' perceptions were of standard care for women being treated as specialty medical treatment. A few focus group participants indicated they have had their health concerns dismissed as either mental health or weight management issues, in gender-specific ways.

A number of advocates highlighted a newly developed partnership between VA and DoD, the Women's Health Transition Training Program, that builds awareness of women's health benefits. Piloted by the Air Force in July 2018 and since expanded to the Army, Navy, and Marine Corps, this training for separating and retiring service-women highlights the health benefits available from a specifically women-centric perspective. This program is a step in the right direction for future generations of women veterans.⁶⁴ Women veterans expressed an overall lack of trust as the barrier keeping many of them from seeking out VA health care, with a heavy skepticism toward outreach without other forms of action.

Despite these challenges, there has been a rapid and significant increase in VHA usage by women veterans—a 45.4 percent increase since 2007, though the women veteran population has increased only by 7.7 percent.⁶⁵ Post-9/11 women veterans use VA health care at rates relatively comparable to men: 36.9 percent versus 34.2 percent.⁶⁶ The organization Veterans of Foreign Wars (VFW) found that the vast majority of its women veteran members use VHA for primary care, with 57 percent using it for gender-specific care and 40 percent for mental health care.⁶⁷ However, of WWP members surveyed, 47 percent of women veterans compared with 28 percent of men veterans cited difficulty receiving physical health care.⁶⁸

RACIAL/ETHNIC MINORITY VETERANS

Members of some racial/ethnic minorities are more likely to have been exposed to health risk factors prior to joining the military. For example, black and Hispanic children have higher levels of ACEs than white or Asian children.⁶⁹ Due to the association between racial and ethnic minority status and poverty, these groups are at higher risk of environmental exposures such as lead and air pollution that are more prevalent in low-income communities.⁷⁰ During service, however, members of racial/ethnic minorities were less likely to use tobacco or engage in risky levels of drinking than white members, and rates of exercise and illicit drug use were not statistically significantly different.⁷¹

In the United States more broadly, studies have shown that racial minorities experience bias in health care that can and does lead to increased fatalities. As the Centers for Disease Control and Prevention published in May 2019, maternal mortality is three times higher among African American and AIAN women than white women in the general population, demonstrating that racial bias in health care causes preventable deaths.⁷² The legacy of the Tuskegee experiments also contributes to lingering

mistrust of the health care system among people of color more broadly. Stereotypes about minority individuals' pain tolerance and symptoms have been reported to influence medical providers into disregarding complaints by minority patients.⁷³ A few focus group participants specifically reported that medical providers at VA medical centers take the pain and symptoms of people of color, particularly women, less seriously than those of their white counterparts, providing a barrier to correct health diagnoses and contributing to a lack of trust.

The VHA Office of Health Equity states, "Equitable access to high-quality care for all Veterans is a major tenet of the VA healthcare mission. The Office of Health Equity (OHE) champions the elimination of health disparities and achieving health equity for all Veterans."⁷⁴ While the Office of Health Equity does not have published data detailing disparities in care between racial minority groups, information briefs are available detailing health risks specific to racial subpopulations.⁷⁵ Advocates for minority veterans argued that providers, representatives, and VSOs are not culturally knowledgeable and are unable to offer culturally competent care. Focus group participants perceived providers as not sufficiently trained on cultural differences or adequately connected to the minority populations they are serving. A number of participants emphasized a lower willingness in the black community to seek out mental health care, and this cultural difference needs to be examined by leadership to better care for black veterans suffering from mental health issues: "In black culture there isn't a lot of tendency to seek help for mental incapacity. You can't just have a doctor say here's a service, come and get treatment. If they understood the cultural aspects, they have to understand talking to a person that there's a reason they're not accessing services."⁷⁶ Similar to the experiences of minority communities, civilian and veteran alike, across other life domains, implicit and explicit biases of health care providers negatively affect minority veterans. Participants felt they received substandard treatment by doctors.

Despite these perceived challenges, between 2005 and 2014, minority veterans enrolled in VA health care at much higher rates, an increase of 43 percent, while nonminority veterans enrollment increased only 24 percent.⁷⁷ The causes for this differential increase in enrollment are unclear and could indicate greater need for VA health care due to economic factors (as discussed below) or be a reflection of growth in the minority veteran population. Increases in VA utilization overall likely reflect enhanced outreach and changes to eligibility that expand access to all combat veterans for five

years after service. The overall VA benefit usage rate was 49 percent: Native Hawaiian/Other Pacific Islander (NHOPI) veterans were the most likely to use VA (59 percent), followed by black (54 percent) and Hispanic veterans (53 percent).⁷⁸ AIAN (45 percent) and Asian (42 percent) veterans were the least likely to use VA benefits. American Indian and Alaska Natives are more likely than their non-Native veteran counterparts to lack health insurance and proper health care.⁷⁹

Native American veterans present a unique case as they are covered by three jurisdictions – federal, state, and tribal. Per Executive Order 13175, federal agencies such as the VA must consult tribal leaders anytime there is a change in federal policy that could affect Native American communities. This mandated consultation has resulted in robust integrated health services: Fourteen VA Medical Centers have sweat lodges, a form of health care popular with Native Americans. Many Native American veterans seek health services from the Indian Health Service (IHS) system as a supplement for or replacement of VA care. This creates more opportunity for care, often by culturally competent and trusted medical staff, largely as a result of the legal federal infrastructure built around providing Native American services. However, it does present challenges for those veterans living away from IHS facilities, who disproportionately face barriers in transportation to VA medical centers and creates some confusion. Representatives from the National Congress of American Indians have testified that cultural competency and familiarity with the Indian health care system and cultural practices would result in more options for Native American veterans and improve their chances of receiving needed and earned health care.⁸⁰

This can result in complementary or overlapping care and navigating the three bureaucracies can present issues. For example, veterans using IHS are never or rarely required to make a copayment, and those same veterans may inaccurately assume this is the case for VA care. A stakeholder expressed frustration with health and jurisdiction discrepancies, stating, "We see the non-Native vets off the reservation. You get access to health, health care, you've got these mobile clinics, you got tele-health. And we're standing there saying, 'Wow, can we get some of that?' And then the answer's no." As AIAN veterans come from the general population of Native Americans, community-wide challenges have an impact on veterans, such as shorter life expectancies, lower income and education levels, and higher unemployment rates, all of which affect overall health and well-being.⁸¹

Of surveyed WWP New York State members, a greater number of black and Hispanic veterans than white veterans cite that their personal schedule conflicts with VA health care facility hours of operation.⁸² Black (44 percent) and Hispanic (38 percent) veterans were more likely than white veterans (32 percent) to report lapses in or inconsistent treatment.

LGBT VETERANS

LGBT veterans are more likely to have experienced sexual assault and trauma prior to and during service, influencing health and well-being outcomes post-service. The LGBT community on the whole is at higher risk of stigma and violence than other groups.⁸³ Youth identifying as part of sexual minority groups are also exposed to significantly higher rates of ACEs compared with their peers.⁸⁴ While health-care-related data regarding LGBT veterans is limited due to historical policy barriers to the disclosure of sexual orientation and gender identity, the Health Related Behaviors Survey has shown that among active-duty personnel, LGBT individuals were more likely to report having ever experienced physical abuse or unwanted sexual contact.⁸⁵ Similarly, a significantly higher percentage of LGB service members reported past-year sexual assault than did their non-LGB counterparts in the 2018 Workplace and Gender Relations Survey (WGRA) of Active Duty Members (which tracked LGB but not transgender service members): 9 percent of LGB women compared with 4.8 percent of non-LGB women and 3.7 percent of LGB men compared with 0.4 percent of non-LGB men.⁸⁶ LGB service members in another study were twice as likely to experience military sexual assault, which was directly linked to PTSD and depression among LGB veterans: 40 percent of LGB veterans have PTSD symptoms compared with 30 percent of non-LGB veterans.⁸⁷

The Healthcare Equality Index, developed by the Office of Health Equity in partnership with the Human Rights Campaign, showed 49 percent of VA Medical Centers were classified as “Leaders,” or “Top Performers,” the two highest designations awarded, as of 2019.⁸⁸ In terms of transgender-specific health care, gender confirmation surgery is specifically excluded from the VA medical benefits package; additionally, VA does not provide any surgery for strictly cosmetic purposes.⁸⁹ This is not in alignment with generally accepted standards of care for those with gender dysphoria.⁹⁰

A damaging misconception is that VA facilities do not include any LGBT health services.

Additionally, because VA health care is considered “minimum essential coverage” under the Affordable Care Act, veterans who are enrolled in VA health care do not qualify for subsidies in the Health Insurance Marketplace; accordingly, these veterans may be financially unable to enroll in a plan that would provide this medically necessary care.⁹¹

This data is reinforced by input from stakeholders and veterans. A common thread across interviews and focus groups regarding LGBT veterans was the importance of cultural competency and mandatory trainings for VA personnel to better serve the LGBT veteran population. Multiple advocates highlighted the variety of barriers LGBT veterans face in accessing health care, many of which are unique to their sexual orientation and/or gender identity. One described it as, “You’re dealing with medical providers that aren’t receiving necessary training to properly assess issues that you’re going through and provide unnecessary treatments.” According to numerous stakeholders, many LGBT veterans tend not to feel comfortable claiming veteran status and are therefore less willing or likely to seek out VA health care. Similar to those barriers for women veterans, LGBT

veterans report a reluctance to visit VA medical centers, specifically

reporting that they are often dominated by older veterans who typically have more conservative views on sexual orientation and gender identity. One stakeholder noted that LGBT veterans experience disproportionate negative health outcomes not because of their identity but rather because of the stigma and discrimination they face for who they are, or due to providers who “don’t understand these implicit things they should about LGBT people.” However, according to the 2015 U.S. Transgender Survey, 87 percent of transgender veteran respondents had reported being treated respectfully at the VA all or most of the time.⁹²

These barriers to care are particularly concerning for the LGBT veteran population given that among the active duty force, a significantly higher percentage of gay service members suffer from PTSD (53 percent) compared with heterosexual service members (17 percent). This is even more acute for lesbian service members, 67 percent of whom suffer from PTSD compared with 19 percent of heterosexual female service members.⁹³ While LGBT status is not causal for PTSD or suicide, sexual orientation is considered a risk factor.⁹⁴ LGBT individuals are more likely to have reported

binge drinking, cigarette smoking, moderate to severe depression, and suicidal ideation and attempts.⁹⁵ Rates of suicidal ideation are two to three times higher for the LGBT community and suicide attempts two to seven times more frequent. Those with gender dysphoria attempt suicide at a rate 20 times higher.⁹⁶ Research has shown that “stigma, prejudice, and discrimination create a hostile and stressful social environment that causes mental health problems,” known as minority stress; efforts to reduce homophobia and transphobia are an important component of broader efforts to improve mental health in the veteran community.⁹⁷ Crucially, observational studies have shown dramatic reductions in suicide ideation, suicide attempts, and suicides among transgender individuals who receive appropriate transition-related care. Excluding this care from the VA medical benefits package does not align with standards of care or VA’s stated commitment to suicide prevention.

Discharge status may have an outsized impact on LGBT veterans, who may have been involuntarily separated from the military under the DADT policy. If separated with an OTH discharge, these veterans would not have the same access to veteran benefits, compounding an overall distrust of the military and veteran system and a feeling of unwelcome. The approximately 14,000 service members separated from the military under DADT may need to appeal their discharge status.⁹⁸ While these individuals can now request a discharge upgrade, they may have been denied access to care and benefits for many years, and the upgrade process takes time. Members of the LGBT community repeatedly report fear and mistrust in deciding whether to access their VA services. One stakeholder noted that an administrative separation code indicates when a discharge was related to homosexual behavior even when a veteran retains access to benefits. Many veterans fear that involuntarily “coming out” to health care providers due to service records will lead to less than optimal care from a provider who does not support their identity or sexual orientation.

A number of stakeholders referenced the current political environment’s impact on minority populations, particularly the LGBT community, and their willingness to access care, in some cases mistaking DoD policy for VA policy. For example, one New York State advocate said debates over the military’s “trans ban” affect ability to provide care to the LGBT community at the state level due to mistrust in the community and confusion over legal status. To combat these perceptions and hurdles, the New York State Division of Veterans’ Services makes a substantive effort to support its disadvantaged

communities, positioning resources and attention to these communities despite different priorities indicated by the federal government. Transgender individuals express fear of being misgendered by health care practitioners, a microaggression in a space that deals with very personal issues that can lead to a lack of trust in the health care system as a whole. Advocates for transgender veterans note that being misgendered in health care environments can lead to negative mental health outcomes, which is supported by studies relating misgendering to increased stress.⁹⁹ In the absence of an inclusive federal-level strategy, it is incumbent upon states to drive more comprehensive care.

A damaging misconception is that VA facilities do not include any LGBT health services. While the absence of available gender confirmation surgery negatively impacts transgender veterans who have not medically transitioned, other LGBT health care options at the VA do exist. Lack of trust in health care providers is insidious and leads to suboptimal health outcomes. For example, providers do not always advertise that they offer pre-exposure prophylaxis (PrEP), making it less likely LGBT patients will obtain a prescription for this vital HIV-prevention drug. Providers also may not explicitly offer screening for sexually transmitted diseases (STDs), putting the onus on the patient, which can be a charged request and difficult without a trusting relationship. A second layer of challenges LGBT veterans face is discrepancies with health care itself. Many LGBT veterans experience a lack of consistency across VA facilities. Each VA Medical Center is supposed to have an LGBT veteran care coordinator (VCC) on hand to serve as a patient advocate and assist LGBT-sensitive staff trainings. However, quality of VCCs varies widely. CNAS site visits identified significant variation in the LGBT-focused materials available in waiting rooms, ranging from confusion over the acronym “LGBT” to comprehensive informational material, welcoming posters, and competent staff. Additionally, other patients can contribute to VA Medical Centers being unwelcoming: One representative of a veteran-serving nonprofit reported witnessing transgender veterans being subjected to inappropriate verbal and nonverbal behavior from fellow patients because of their transgender status.

A number of LGBT advocates noted the lack of effective outreach by VA to these populations. This lack of public awareness leads to increased confusion and/or ignorance of entitlements and benefits. VSOs have historically fulfilled this outreach role, helping veterans and transitioning service members navigate online services and file comprehensive claims. According to advocates

and LGBT veterans, these spaces and organizations are often hostile or triggering spaces, leaving this community without assistance navigating a cumbersome bureaucracy. Improving these spaces is one recommended solution, though additional outreach to nontraditional veteran spaces may be more useful.

LGBT veterans expressed that VA needed to specifically ask about sexual orientation upon intake to normalize and clarify LGBT status from the beginning. Such a question would remove the perceived “dirty secret” aspect of sexual orientation and make it more clinical, rather than something veterans have to worry about. Veterans also agreed that the location of LGBT veteran care coordinators’ offices in VA medical centers on the mental health floor likened LGBT status to mental health issues. Of trans veterans, 40 percent have received health care through VA, of which 75 percent continue to receive health care.¹⁰⁰ Of these veterans, 72 percent said they were out as trans to their health care provider and 47 percent reported they were always treated respectfully. The majority of trans veterans—79 percent—reported satisfaction with VA care, higher than the satisfaction expressed by ethnic minorities and low-income veterans, despite the challenges noted above.¹⁰¹

Financial Stability

Financial stability summarizes veterans’ overall well-being in terms of career, employment, and finances; prominent factors include educational attainment, income, wealth, and unemployment rates. Annual official statistics from the U.S. Department of Labor showed a veteran unemployment rate of 3.5 percent for 2018, slightly lower than the general population unemployment rate of 3.9 percent.¹⁰² Veteran unemployment has been steadily decreasing for 10 years due to efforts by the federal government, nonprofits, and private companies, but veterans tend to have higher job turnover in their first job than their civilian counterparts.¹⁰³ However, after the first post-service transition job, veterans experience lower turnover throughout their working lives than nonveterans.¹⁰⁴

Underemployment, defined as employment below the skill level that a veteran is qualified for, is a significant challenge veterans face: 33 percent of veterans seeking jobs are underemployed, 16 percent higher than civilian job seekers.¹⁰⁵ In some cases, veterans may struggle to find ideal employment due to: “(1) employers’ misperceptions about veteran education and training, (2) a lack of mentors, and (3) a lack of time spent within the desired employment field.”¹⁰⁶ Veterans with higher disability rates may fare differently: Of

WVP’s New York State members, an average 38 percent of veterans cited mental health as a barrier to obtaining or maintaining employment.¹⁰⁷

The educational attainment of veterans overall is relatively similar to that of nonveterans. However, a high school diploma or GED is required to enter the military today; accordingly, this level of educational attainment is nearly 100 percent among service members, compared with only 87.3 percent of all American adults.¹⁰⁸ According to the U.S. Bureau of Labor Statistics (BLS) Current Population Survey, 23 percent of veterans compared with 19 percent of nonveterans had completed some college, and 13 percent of veterans compared with 10 percent of nonveterans had earned associate degrees. Veterans earned bachelor’s and graduate degrees or higher at very similar rates to that of the general population.¹⁰⁹ Among post-9/11 veterans, women veterans were more likely to hold a college degree or be enrolled in college than men veterans, and women veterans were significantly less likely than men veterans to have graduated high school or less (15 percent versus 24 percent).¹¹⁰ Veterans living in New York State have less educational attainment than nationwide averages: 32 percent have some college versus 37 percent of veterans nationwide, while 26 percent have a bachelor’s degree or higher compared with 29 percent nationwide.¹¹¹

On the whole, veterans also out-earn nonveterans.¹¹² Studies have pinpointed the income differential between veterans and nonveterans as \$5 per hour in favor of veterans’ wages.¹¹³ Fewer veterans live at or below the poverty line than nonveterans.¹¹⁴ At the same time, stakeholders and advocates highlighted how co-occurring issues such as substance abuse, which has a negative effect on housing stability and health outcomes, also negatively impact employment stability, further emphasizing the need for holistic needs-based care. Veterans in New York State are overrepresented in the bottom (less than \$25,000) and top two income brackets (\$100,000 to \$199,999 and \$200,000 or more) compared with the national average.¹¹⁵

Veteran financial stability can trace back to the financial stability and backgrounds of service members. New recruits are most commonly drawn from the middle three income quintiles; neighborhoods with average incomes of either lower than \$38,000 or higher than \$81,000 are underrepresented.¹¹⁶ While there has been minimal research regarding the overall financial situations of veterans compared with nonveterans aside from employment and income, veterans experience stronger financial confidence and less anxiety around finances compared with nonveterans.¹¹⁷ A metric developed by

the Consumer Financial Protection Bureau (CFPB) measuring financial well-being using data points from unexpected expenses, savings, and households living paycheck-to-paycheck showed that in 2017 active-duty service members scored 6 points higher than the general U.S. adult population. Active-duty service members earn a steady paycheck with health insurance but experience significant environmental stressors compared with the general population. Financial challenges are not unknown for military members; CFPB showed that fewer than a third had a month of emergency savings and 23 percent of junior enlisted personnel had no emergency savings at all.¹¹⁸

Generally strong trends among veterans mask differences among subpopulations, discussed below. Unfortunately, the Veterans Benefits Administration (VBA) does not publicly release information about all VA benefits disaggregated by gender (although this is tracked internally), race/ethnicity (which VBA has long claimed cannot be tracked although many advocates dispute that assertion), or LGBT status. While it generally appears that minority veterans are utilizing their VBA benefits at rates at least equivalent to their nonminority counterparts, this lack of transparency makes assessing for particular areas of low utilization or possible disparities in grant rates impossible to comprehensively assess.

WOMEN VETERANS

While military service is generally economically beneficial for women, discrepancies show it is not sufficient to make up for financial differences between men and women.¹¹⁹ Women veterans have lower financial stability than men who have served but higher financial stability than women who have not. This holds true across measures: living below the poverty line, living in a household with at least one recipient on food stamps, having no health insurance coverage, and income levels. The problems that affect women nonveterans in areas of employment such as the wage gap also affect women veterans.

Recent studies show women veterans are more likely to be employed and to have college educations than their men veteran counterparts and women nonveteran peers.¹²⁰ Likewise, women veterans have the lowest unemployment rate across groups and are more likely to be in the labor force than both their men veteran and women nonveteran counterparts.¹²¹ However, women veterans reported a lower median income than men veterans: Median income for women veterans was \$35,517 compared with \$40,995 for men, shown in Figure

6.¹²² That figure exceeded the figure for women nonveterans, however, at \$24,653. Figure 7 demonstrates the educational attainment of veterans by gender and shows that women veterans attend and complete postsecondary education at higher rates than their men veteran counterparts. Given that women veterans are more likely to be employed and have college degrees, the higher rates of women veterans living below the poverty line and their lower incomes suggest underemployment and low-wage employment remain problems for this community and show that veteran status is not adequate to overcome structural and institutional sexism.

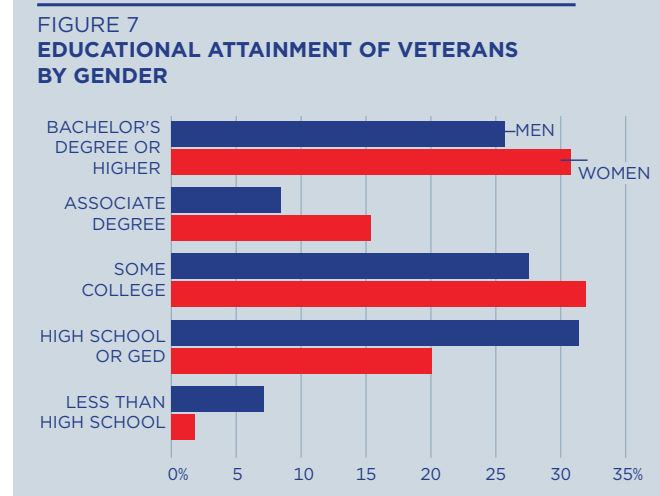
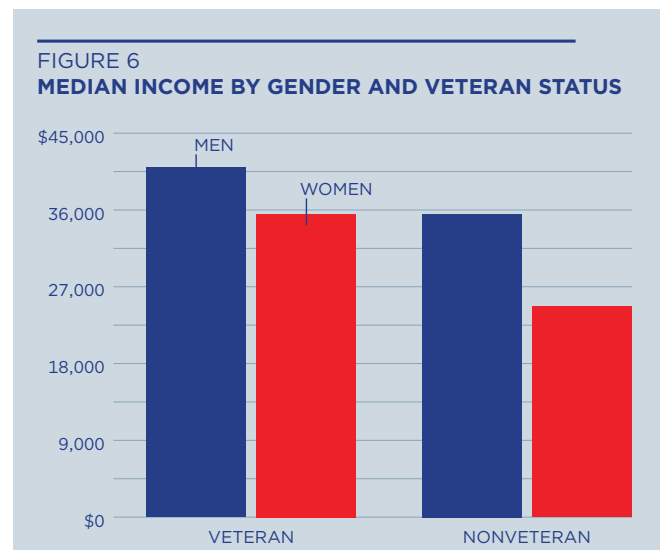


Figure 6 Source: U.S. Department of Labor, Bureau of Labor Statistics, "Findings from 2018 Annual Averages, Current Population Survey."

Figure 7 Source: Neha Nanda, Sandeep Shetty, Samuel Ampaabeng, Teerachat Techapaisarnjaroenkij, Luke Patterson, and Steven Garasky, "Women Veteran Economic and Employment Characteristics" (IMPAQ International prepared for U.S. Department of Labor, February 2016), 14.

VA and DoD provide job-training programs for veterans and transitioning service members in any number of industries. As one advocate argued, however, most of these industries are male-dominated and can be unappealing for women veterans. Stakeholders reported that women veterans are more likely to be caretakers, work part time, or be otherwise underemployed, an observation supported by secondary research.¹²³ Challenges finding and affording child care affect women veterans as well as their civilian counterparts and remain a large obstacle to fully realizing their financial and employment potential. Focus group participants were unanimous in vocalizing the need for child care as a step to improve women veterans' overall financial stability.

Women veterans have lower financial stability than men who have served but higher financial stability than women who have not.

Disability ratings can support a veteran's financial well-being, especially if a service-connected disability negatively affects the ability to attain or hold a job. While this research does not seek to perpetuate the dangerous stereotypes that all MST survivors are women or that all women veterans are MST survivors, stakeholders referred to this specific trauma when discussing financial stability of women veterans. For some, this could be because they were forced out of the military after reporting sexual trauma, possibly with a discharge status that disqualified them for some benefits. Historically, grant rates for PTSD related to MST were also lower due to complications around documentation of sexual assault and harassment, a perception that lingers although the problem has been resolved for women veterans.¹²⁴ Some women veterans remain unaware that MST counts as an in-service event that could qualify them for a service-connected disability. This perception is compounded by VA sending denial letters stating MST does not qualify as service-connected, which are seen as insensitive and confusing (while the experience of MST is not a diagnosis in and of itself, it is a stressor that can contribute to conditions such as PTSD). As one advocate confided, that legacy of MST can affect all life domains, including financial stability, as many industries are still male-dominated and attempting to work in them can induce re-traumatization of MST survivors.¹²⁵

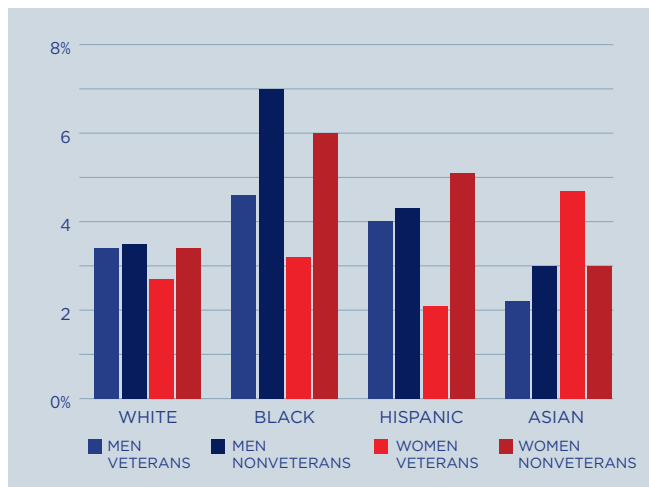
RACIAL/ETHNIC MINORITY VETERANS

Across four major racial/ethnic groups (Asians, Hispanics, whites, and blacks, as tracked and reported by BLS), veterans experience unemployment rates lower than or equal to those of their nonveteran counterparts. However, there was considerable variance within the veteran population when analyzing for race. In 2018, Asian men experienced the lowest unemployment rate of male veterans (2.2 percent), while blacks experienced the highest (4.6 percent) and Hispanics fell in the middle (4 percent), as shown in Figure 8. White men veterans experienced unemployment at rates essentially equal to men nonveterans (3.4 percent).¹²⁶ AIAN veterans are unemployed at higher rates and with lower personal incomes than their non-Native counterparts.¹²⁷ Among women veterans, however, Asian veterans experienced the highest unemployment rate (4.7 percent), followed by black women (3.2 percent), white women (2.7 percent), and Hispanic women (2.1 percent).¹²⁸ These findings suggest an interaction among the variables of race and gender that likely affects veteran employment. Compared with nonveterans, Figure 8 shows that in nearly all categories, minority veterans have lower unemployment rates than their nonveteran counterparts.

Of racial and ethnic minorities, African American and Hispanic veterans use VA benefits overall at slightly higher rates than the overall veteran population (51 percent and 50 percent, respectively, compared with 48 percent).¹²⁹ AIAN veterans have the lowest usage rates at 43 percent. Without additional data, however, it is impossible to determine whether usage varies for minority veterans in terms of specific VA benefits such as disability compensation, home loan guarantees, pension (a benefit for low-income wartime veterans), or education benefits. A CNAS site visit noted that one New York VA regional office had signage to raise awareness of the availability of a women veterans coordinator to support that subpopulation, but no comparable sign to highlight the presence of a minority veterans coordinator.

Stakeholders noted that while veterans from minority populations may see the military as a pathway to higher income levels or classes, they are often unequipped or unprepared for the resources it takes after transition to access available benefits and to secure jobs. Veterans who come from minority backgrounds that are predominantly low-income may face class-related employment challenges that are not present for other veteran subpopulations. One minority veteran recounted being passed over for federal jobs with the sense that his race was what was holding him back from landing employment, even with strong education and experience. A couple of

FIGURE 8
 UNEMPLOYMENT RATE BY RACE, GENDER, AND VETERAN STATUS



Source: U.S. Department of Labor, Bureau of Labor Statistics, "Findings from 2018 Annual Averages, Current Population Survey."

focus group participants also noted that federal hiring preferences for veterans are not relevant in communities that do not have a significant federal workforce, such as Buffalo. Additionally, advocates for immigrant veterans expressed dismay at pressure on noncitizen service members and veterans, with military service being a path to citizenship that seems to be closing due to recent actions by the federal government.

LGBT VETERANS

While data specific to the financial stability of LGBT veterans is an under researched topic, veterans live in the general population and can be assumed to share the burdens of civilian society in acceptance and discrimination because of sexual orientation and gender identity. LGBT status does not constitute a federally protected class in employment. Protections vary by state-level legislation, although 33 states have varying degrees of statutes or executive orders prohibiting employment discrimination based on sexual orientation and/or gender identity. New York State does prohibit discrimination for LGBT status; however, proving discrimination in court can be extremely difficult.¹³⁰ Data specific to LGBT unemployment among either the general or veteran population of New York State was not available.

Overall, financial status among LGBT individuals is difficult to fully aggregate but can be affected by employment-related discrimination. In particular, transgender individuals experience significant economic challenges compared with the general population: One survey found transgender individuals had an unemployment rate three

times higher than the general population (15 percent), which contributed to the 29 percent of respondents who were living in poverty.¹³¹ Government data on LGBT-specific unemployment rates is not representative of the LGBT population, since wide-ranging surveys such as the Current Population Survey and the American Community Survey do not ask about sexual orientation or gender identity.

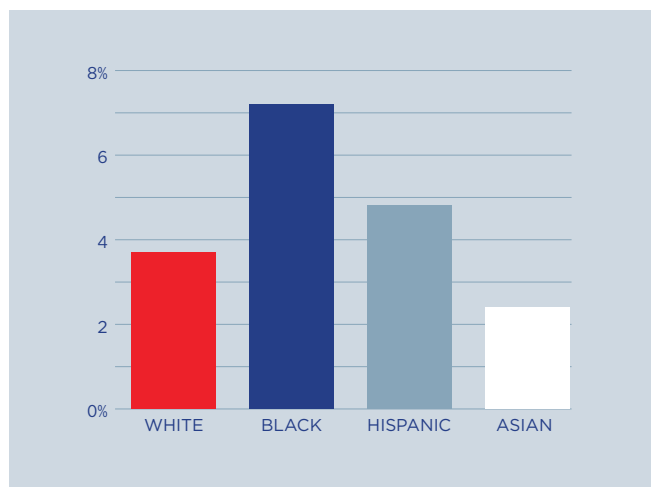
As previously mentioned, the legacy of DADT impacted LGBT veterans' discharge status: 85 percent of service members received an honorable discharge, while 79 percent of transgender veterans received an honorable discharge.¹³² Since World War II, over 100,000 LGB veterans received other than honorable discharges, which has far-reaching effects in terms of eligibility for GI Bill education benefits and VA health care, as well as finding employment. This discharge status can be measured in lost educational and financial opportunities over time. While in 2011 a policy was established to grant discharge upgrades to affected LGBT veterans, the process can be complicated, difficult, and financially prohibitive if hiring legal counsel is required.¹³³

Workplace culture affects LGBT veterans' financial stability, especially when working in hyper-heteronormatively masculine careers. LGBT veterans may not feel comfortable being honest about their sexual orientation or gender identity, creating stress with the need to hide their identities for most of the day. A focus group participant recounted being fired for his sexual orientation, without his veteran status being known to his employer. Another participant revealed that his veteran status plays no part on his resume, declaring, "There's not a lot of crossover between people who are supportive of LGBT status and those who respond well to military service."

New York State

The New York State veteran population had an unemployment rate of 5 percent in 2018,¹³⁴ compared with the national veteran unemployment rate of 3.5 percent.¹³⁵ While data comparing veteran unemployment in New York State by subpopulation is not available, veterans live in the same society with employment trends that can be predicted to include veterans. The New York State average unemployment rate for the general population in 2018 was slightly higher than the national average at 4.1 percent, and unemployment among African Americans and Hispanics was higher than that of the statewide average, at 7.2 percent and 4.8 percent, respectively. White and Asian New Yorkers experienced lower unemployment than the average at 3.7 percent and 2.4 percent, respectively, demonstrated in Figure

FIGURE 9
NEW YORK STATE OVERALL UNEMPLOYMENT RATE
BY RACE



Source: U.S. Department of Labor Bureau of Labor Statistics, "Employment status of the civilian noninstitutional population by sex, race, Hispanic or Latino ethnicity, marital status, and detailed age, 2018 annual averages," 2018, 40, <https://www.bls.gov/lau/table14full118.pdf>.

9. The unemployment rates of Hispanic New Yorkers were equal between men and women, while in each other subpopulation, women experienced lower unemployment rates.¹³⁶ The National Center for Transgender Equality New York State report demonstrated the challenges that transgender New Yorkers face: 37 percent of survey respondents were living in poverty. These challenges likely extend to transgender veterans in New York as well.

Housing Stability

Housing instability connects to many other life domains: Employment, health, and social support all are made exponentially more difficult when housing is not secure, and poverty is a leading cause of homelessness. Veteran homelessness has been sharply declining: Since 2010, there has been a 49 percent drop in the number of homeless veterans, according to the 2018 Annual Homeless Assessment Report (AHAR) compiled by the U.S. Department of Housing and Urban Development (HUD).¹³⁷ Out of the nearly 38,000 homeless veterans specified in the January 2018 AHAR, 23,560 were sheltering in transitional housing programs or emergency facilities.

New York State—and New York City in particular—has made efforts to reduce homelessness in the state, positively impacting veteran homelessness. New York State has the third lowest percentage of homeless veterans nationwide (at 4.7 percent of its veteran population).¹³⁸

This is despite the high cost of living in New York City, which affects both veterans and nonveterans. A number of veterans across focus groups raised the issue of lack of affordable housing and suggested dedicated housing units for veterans. Furthermore, some described being “homeless homeowners” due to unresolved problems with their domiciles or “almost homeless veterans” because of housing instability.

WOMEN VETERANS

Women make up 8.5 percent of the homeless veteran population, a rate slightly lower than their percentage of the total veteran population. However, women account for a higher percentage of unsheltered (9.7 percent) than sheltered (7.8 percent) homeless veterans.¹³⁹ Women veterans face greater challenges when it comes to housing instability and homelessness, including homeownership disparities and the presence of children. Such instability begins when transitioning from service, during which women veterans report greater difficulty finding jobs and housing.¹⁴⁰ Of WWP members, 52 percent of men owned their home compared with only 41 percent of women.¹⁴¹ Women veterans are more likely to be primary caregivers and responsible for providing stable housing not just for themselves.

As women on the whole are more likely to retain child custody, homeless women veterans experience additional difficulty finding shelter. Shelters are often built on a single-individual model; space limitations mean finding more than one bed, or private rooms, for families is very difficult. Stakeholders expressed concern for those women veterans experiencing homelessness while caring for children and mentioned concurrent issues of domestic violence that primarily endanger women veterans’ access to stable housing. While domestic violence can and does affect both men and women, housing instability related to domestic violence disproportionately affects women, both civilian and veteran alike.

RACIAL/ETHNIC MINORITY VETERANS

African American and Hispanic veterans are overrepresented in the homeless veteran community. African American veterans comprised 37.7 percent of veterans experiencing sheltered homelessness and 24 percent of those experiencing unsheltered homelessness, though they make up only 12 percent of veterans.¹⁴² Similarly, homeless Hispanic veterans comprised 11 percent of the homeless veteran population, compared with only 7 percent of all veterans. Among WWP New York State members, white and Hispanic veterans reported 5

percent homelessness while black veterans reported 13 percent homelessness.¹⁴³

For Native American veterans, while services and benefits exist to help secure stable housing, accessing those benefits can present challenges. For example, veterans can apply for the Native American Direct Loan (NADL), which provides money to Native American veterans to buy, build, or improve upon a house on Federal Trust Land, since traditional mortgage lenders will not make loans on Trust Land. Native American unemployment tends to be higher than the national average, adding a layer of complication for those veterans seeking home loans. Furthermore, for individuals to be eligible, tribes have to have a memorandum of understanding with VA.¹⁴⁴

LGBT VETERANS

Federal law prohibits discrimination in housing based on gender or race, but not on sexual orientation and gender identity; accordingly, LGBT individuals—both in the general population and as veterans—could legally face discrimination in 28 states due to their identity. It is illegal in New York State to discriminate in housing based on actual or perceived sexual orientation and gender identity; however, it is possible that such discrimination still occurs. As veterans live among the general population, such biases—which are difficult to detect or document—could impact their ability to access housing. Transgender individuals are also at higher risk for homelessness than the general population. The 2015 Transgender Survey highlighted that a third of respondents had been homeless at some point in their lives.¹⁴⁵

Efforts to address veteran homelessness can run into additional challenges for LGBT veterans. Official rates of LGB veteran homelessness are not available due to the lack of data. The rate of transgender and gender-nonconforming homeless veterans is comparable to estimates of the rate of transgender individuals in the veteran population overall; they are disproportionately likely to be unsheltered.¹⁴⁶ Cohabitation units are often one-gender, which puts stress on the LGBT individual, especially if cohabitants are not accepting of LGBT identities. Older LGBT veterans who hid their LGBT identities while in service often feel uncomfortable seeking out VA housing as they're concerned about their ability to live with their same-sex partner. Homeless shelters are not considered welcoming to transgender veterans in particular as the question of which type of homeless shelter is best suited varies depending on the shelter's familiarity with transgender issues and needs. In addition, a 2019 HUD-proposed rule would weaken protections for homeless

transgender individuals in shelters that receive federal funds, which could further exacerbate these challenges.¹⁴⁷

Social Functioning

Social functioning can serve to mitigate or exacerbate outcomes across the other life domains. Various factors comprise social functioning, from defining demographic traits to real or perceived support. Social trends, such as societal perceptions and treatment of veterans experienced in popular culture or employment settings, also inform social functioning. Social functioning consists of familial relationships, peer support, and broader community support that includes marital status, parenthood, and engagement with or support from VSOs. Inadequate social support or relationships may contribute to the development of negative health outcomes such as depression or substance abuse.

Interpersonal relationships can provide emotional support and guidance and can even contribute financial assistance and shelter in times of crisis.¹⁴⁸ A spouse or immediate family member is often an individual's primary interpersonal relationship, and that person often becomes the caregiver for a veteran with service-connected disabilities or conditions requiring ongoing care. Pre-9/11 caregivers and post-9/11 caregivers differ in terms of their relationship to the veteran needing care: Pre-9/11 caregivers are more often a child of an older veteran, and post-9/11 caregivers tend to be married to the veteran.¹⁴⁹ Marriage rates similarly inform social support and stability; service members are more likely to be married than their civilian counterparts.¹⁵⁰

Perceptions of veterans by colleagues, neighbors, and others in society can have a subtle but constant impact on veteran well-being. For instance, only 30 percent of the public indicated they believe veterans are well off, compared with 60 percent of veterans who reported excellent or good well-being.¹⁵¹ Social disconnect makes veterans feel misunderstood or distanced from society. Misconceptions may also negatively influence veteran employment and job experiences.

VSOs that provide critical support and community to veterans have existed through much of the United States' history, often connected to a specific war or service era. Chapters and posts serve as regional gathering places to access services VSOs offer and to commiserate with other veterans. Given that a quarter of veterans reported mental health as a reason socializing was difficult, spending time with others with shared experience can be a key form of support.¹⁵² Similarly, veterans often learn of benefits through participation in local VSOs, organizations in which women and other minority groups can be less likely to

participate. Due to these organizations' close-knit nature, they are not always perceived as open. Many could do more to be welcoming and accessible to minority populations; until that happens, minority veterans in the modern era are likely to continue publicly voicing their concerns and launching their own organizations, as happened with Minority Veterans of America, an organization that welcomes veterans from across these populations.¹⁵³

WOMEN VETERANS

When it comes to marital status, military women are less likely to be married than military men (45.3 percent to 54 percent, respectively). Post-9/11 women veterans (20 percent) are more likely to be divorced than men veterans (14 percent) and less likely to be married (49 percent of women veterans compared with 57 percent of men veterans).¹⁵⁴ Women veterans are significantly more likely to be in dual-military marriages (44.3 percent versus 7.3 percent), which can lead to greater constraints and less partner support.¹⁵⁵

Veteran status can be particularly fraught for women veterans, who are a minority both during and after serving and face additional misconceptions as veterans. The typical narrative hinges on “combat veterans” who are men, leading to erroneous assumptions that the service of women and gender-nonconforming members is often a “support role” and somehow “less than.” Such perceptions or disbelief about their service can lead to women veterans feeling dismissed and undervalued by their communities.¹⁵⁶ In some cases, women leaving the military wish to leave the military community entirely. Regardless of reason, those women veterans do not take full advantage of benefits for veterans or seek out veteran community support. Because women veterans were traditionally less likely to self-identify as veterans, they also did not always know how to seek out the benefits, opportunities, and services available to them through their veteran status.

Outside research and perspectives showed that some women veterans rejected the veteran label entirely after they separated from the military in order to identify more with their feminine side that had been minimized during their military service.¹⁵⁷ Women veterans generally have less of a veteran community to lean on once they transition out of the military and their veteran status becomes nearly invisible to the broader community, leading to feelings of isolation. Lack of support from VSOs contributes to women veterans' lack of exposure to the realities of veteran-specific benefits and leads to them missing out on crucial changes in policy and eligibility, affecting all aspects of their lives. Depression, often exacerbated by

social isolation and loneliness, can be affected by lack of social support from multiple sources.¹⁵⁸ Women veterans who participated in VSOs are shown to have achieved higher educational attainment than women veterans who did not join an organization, highlighting the benefits that can be realized if social support for women veterans is equal to that of their male counterparts.¹⁵⁹

Women veteran advocates routinely relayed unwelcoming atmospheres in many traditional VSO spaces as predominantly male and male-centric. Activities tend to be focused around stereotypically male pursuits such as drinking alcohol, hunting/shooting, and exercise that a number of women veterans expressed were not interesting to them. The service of women veterans is routinely questioned, and they are either assumed to be a relative of a male veteran or directed toward secretarial duties or auxiliary organizations. On a CNAS site visit to a New York VSO post, the veteran member of the research team was asked if she was inquiring about a “social membership,” which aligns with anecdotes women veterans have reported from around the country. One focus group participant expressed an outsider-looking-in dynamic in part due to the historic ban of women from combat positions as limiting their ability to be “one of the boys.” A stakeholder who was herself a veteran conveyed the lack of inclusion in VSOs, saying she “walked in and the only other people who were there were old white guys. ... The building smells like smoke; there’s nothing appealing about getting me in here.”

As a result, a number of more inclusive VSOs have been created to specifically serve minority communities, to include women veteran organizations. These organizations often face funding and staffing issues due to their limited service audience (often women veterans only), or the perception of the organization as being too political. Due to ongoing debates and changing policies regarding women and the LGBT community in the military, support for organizations can unfortunately be associated with taking a political stance. Service Women’s Action Network (SWAN) is the only veteran-serving nonprofit that focuses on women service members and veterans. The women’s Army Corps Veterans’ Association–Army Women United, Women in Military Service for America Memorial Foundation Inc., Women Marines Association, Women’s Overseas Service League, and the National Association of Black Military Women are additional examples of nonprofits geared toward women veterans. Notably, while women veterans appear to be underrepresented in traditional VSOs, a number of post-9/11 veteran-serving nonprofits seem to be having greater success at attracting women. While a quarter

of Team Red, White, and Blue's membership is civilian, women are overrepresented at 46 percent of members.¹⁶⁰ Similarly, women veterans are overrepresented in Student Veterans of America, Team Rubicon, and The Mission Continues.

RACIAL/ETHNIC MINORITY VETERANS

Veterans service organizations and veteran-serving non-profits dedicated to the social support of racial and ethnic minority veterans also exist. These include the National Association for Black Veterans Inc., African American Veterans Families, All Faith Consortium, Congressional Black Caucus Veterans Braintrust, Japanese American Veterans Association, National American Indian Veterans, and the National Association of Black Military Women. None of these organizations is as well-resourced, well-known, or politically influential as the traditional dominant VSOs.

Advocates and veterans indicated racial/ethnic minorities underutilize organizations set up to support veterans. VSOs can assist with disability and service-connected claims, accessing VA, and seeking other forms of care. However, the cultural infrastructures around existing VSOs are not satisfactorily welcoming to minority communities. While newer VSOs are growing to fill this gap, many partnerships and most funding remain with the traditional VSOs. These traditional VSOs have not embraced the changing demographics of the veteran population or restructured their organizational mission to broaden their inclusivity.

There is not the level of specificity required to analyze marriage rates for racial and ethnic minority veterans. One black focus group participant had mixed feelings on the social community aspects of the veteran population and encouraged targeted outreach and community events to include a broader demographic of veterans. This

Native American tribes are consistently reverent of military service members so Native American veterans are rarely hesitant to publicly identify as veterans.

individual highlighted the prevalence of veteran activities in similar communities and recommended including different neighborhoods in parades and organizational outreach to broaden diversity for minority veterans.

Advocates for Native American veterans described veteran status in that population as a social and occupational enhancer. Native American tribes are consistently reverent of military service members so Native American veterans are rarely hesitant to publicly identify as veterans. Advocates theorized that the lack of cultural familiarity between Native and non-Native communities poses significant barriers to cultural competency and understanding in the general population, which is reflected among veterans and VSOs.

LGBT VETERANS

LGBT advocates routinely reported unwelcoming or hostile environments in a number of the traditional VSOs. While some acknowledged that this could be a misperception based on a history of mistrust, others reported specific incidents of homophobia/transphobia in local chapters. Veterans expressed discomfort with the atmosphere of VSOs; one veteran stated, "There are few places where I fit" as a gay woman veteran. Estrangement from family members due to sexual orientation makes the veteran community even more important for support, and unfortunately VSOs are not always welcoming. Some focus group participants expressed support for an LGBT arm of VSO organizations to be open to LGBT veterans. As one participant noted: "I know at least six vets who are LGBT and afraid to go to meetings like this. They want to join an organization, but they aren't allowed." An individual participant observed that national leadership of veterans' organizations is on the whole more supportive of diversity within the organizations than are the rank-and-file members who would comprise the actionable networks of support.

Social media sites have proved to be a valuable resource for marginalized communities to organize and engage with one another. The LGBT military community has leveraged social media tools to advocate for greater inclusion and acceptance within the military.¹⁶¹ Additionally, the Modern Military Association of America, the Transgender American Veterans Association, and Service Members, Partners, Allies for Respect and Tolerance for All (SPART*A), are examples of organizations geared toward serving the LGBT military/veteran community.

Recommendations and Conclusion

Advocates and stakeholders had a variety of recommendations, from sweeping organizational change to specific actions individuals can take to better support minority veterans. There remains a monopoly of ideology and identity within traditional veteran-serving structures. As one advocate said, “Center the most marginalized and everyone will be lifted up.” Others indicated that bold, aggressive leadership is needed at the state and federal levels to guide a different model of care and priorities that better address the needs of minority veterans.

Overall, a new perspective of care is necessary. An integrated longitudinal system of care would help with continuity for veterans before they formally transition out of the military. Similarly, providers, advocates, and policymakers could benefit from a greater understanding of risk based on social determinants of health and protective factors. A general sentiment is that funding is not allocated to properly support the changing demographics of the veteran population. A different pattern of funding for VA and among veteran-serving nonprofits would drive much-needed systemic change.

To comprehensively address the specific health care needs of LGBT veterans, health care practitioners should be proactive and dignity-affirming in asking patients about their sexual activity and preferences. Checking in with patients to determine preferred pronouns and identities is particularly important for transgender individuals and can set the foundation for a more trusting patient-provider relationship.

More research is needed in determining the barriers and needs of veteran minority communities, not just in New York State, but across the country. This is essential for understanding the specific needs and barriers among underrepresented veteran populations.

Stakeholders and VA users routinely report a wide variance in the level and effectiveness of care from one VA center to another as well as variations in atmosphere between VSO posts. This is likely due, in part, to a lack of system-level understanding of needs, barriers, and best practices. Notably, national-level leaders in both the Department of Veterans Affairs and large veteran-serving nonprofits often expressed awareness of the issues affecting minority veterans and expressed a strong desire to effect change. Stakeholders at the top of organizations are acutely aware of the changing demographics of the populations they serve and represent. They recognize their organizations’ challenges in connecting with a changing veteran population initially through effective

outreach and then providing a welcoming environment for all veterans that will keep them engaged after a first encounter. Many of these senior leaders have rolled out thoughtful programs to improve how they serve minority veterans, and some have actively pursued creative partnerships with other organizations that target younger, more diverse veteran populations. However, ensuring that local-level leaders at diverse sites nationwide implement these efforts equally has proved exceptionally difficult. Overcoming that gap between national planning and local implementation is a key challenge.

For Researchers

- Include analysis and data collection of subpopulations when publishing research on veterans. While a significant body of research about women veterans exists, far less has been published about other groups of minority veterans. Much research that collects demographic data does not publish results by racial/ethnic status, hindering efforts to determine whether disparities exist. Additionally, most research does not even track LGBT status. Knowledge gaps within an array of fields should be identified and filled.
- Disaggregate Asians and Pacific Islanders in data collection and presentation due to the unique challenges and differences between these populations.
- Explore the experiences of the diverse array of LGBT veterans to deepen understanding of how differently presenting and gender-nonconforming individuals may encounter different types of cultural and systemic bias and discrimination.
- Conduct research from an intersectional lens to identify how having multiple minority statuses affects veterans.
- Ensure veterans from various subpopulations are included when recruiting participants for studies. Researchers must go beyond convenience samples of veterans that may disproportionately exclude minority veterans.
 - » Post fliers at veteran-centric facilities such as VA Medical Centers and VSO posts, as well as in non-veteran spaces frequented by minority-identifying individuals.
 - » Work directly with an advocate or member of a minority population to coordinate outreach.
 - » Utilize social media to extend outreach further while being aware and respectful of social media groups’ posting guidelines and parameters.

For Organizations That Serve Veterans

- Ensure that the diversity of the population the organization serves is reflected and institutionally empowered in the organization's leadership, boards of directors and/or advisors, and advertising. Incorporate equity and inclusion as key competencies for senior leaders.
- Require that organizations receiving grants have diverse leadership reflecting the community they serve at the executive and board level.
- Ensure print and online materials use diverse images and inclusive language.
- Chapter-based organizations should carefully strategize on how to ensure that national-level standards and values are represented at local levels:
 - » Consider the possible utility of unannounced site visits or calls to determine whether various locations are equally welcoming to diverse veterans.
 - » Engage sensitively with local-level leaders to increase their understanding of the importance of being truly welcoming to both the local and national organization.
 - » Discuss which posts are performing well and which are struggling during leadership meetings; identify and share best practices and lessons learned.
- Major national-level veteran-serving nonprofit organizations should also raise awareness among their members of the disparate challenges minority veterans may be facing and specific resources available to support them so veteran service officers, local chapter leaders, and individual members can respond sensitively and direct veterans appropriately:
 - » Include feature stories on these issues in organization magazines, websites, and email blasts.
 - » Hold breakout sessions at national conventions on specific topics.
 - » Feature minority veterans on the main stage.
 - » Set clear expectations of behavior at annual conventions that harassment and gender discrimination are unacceptable.¹⁶²
- Use organizational communication platforms to raise awareness about the harm discriminatory and harassing behavior does to fellow veterans—both overall and in terms of their ability to access care—and encourage safe bystander intervention and use of dignifying language.
- Demonstrate ally-ship by participating regularly in commemorative and celebratory events, nationally and locally. For example:
 - » March in annual Pride parades and display Pride banners during Pride Month.
 - » Participate in Juneteenth celebrations.
 - » Recognize organizational members and veterans during various heritage months.
- Veteran-serving organizations should support legislative, policy, and programmatic efforts designed to support marginalized groups, while recognizing that veteran identity exists alongside other forms of identity. Disparities between minority and non-minority veterans cannot be eliminated by focusing exclusively on veteran-specific efforts, because veterans do not exist in a bubble. Broader societal disparities must therefore be addressed. For example, veteran-focused organizations could feature affected veterans as part of supporting broader efforts to:
 - » Eliminate discrimination against LGBT individuals.
 - » Eliminate the wage gap between men and women.
 - » Reform the criminal justice system.
 - » End environmental injustice in minority communities.
- Support elimination of discriminatory policies specific to minority veterans. For example, the Department of Veterans Affairs:
 - Does not cover gender confirmation surgery, a medically necessary and evidence-based treatment for gender dysphoria in transgender individuals.
 - Does not cover in vitro fertilization for same-sex couples.
 - Bars abortion and abortion counseling, with no exceptions for rape, incest, or life endangerment of the woman.
 - May charge a co-payment for birth control for some patients.
 - Support state-level legislation, policies, and programs that protect the rights of women, racial/ethnic minorities, and LGBT individuals.
 - Include LGBT status on standard forms in order to normalize and destigmatize gender identity and sexual orientation as well as collect information in the same format to support comparative analysis.

- Consider offering or supporting legal assistance, the lack of which is shown to compound challenges minority veterans face.
- Enhance awareness of the process by which veterans can request discharge upgrades.
- Given the prevalence of both ACEs and MST in the veteran community, organizations and communities should adopt a trauma-informed model.
- Organizations that are adopting a collective impact or a no-wrong-door model should increase engagement with minority community partners to enhance awareness of and access to resources for minority veterans across domains.

For VA

Stakeholder recommendations for VA to support minority veteran care included suggestions to provide access to health care and benefits to all honorably discharged deported veterans; for VA to partner with the National Center for Veterans Analysis and Statistics to publish information on disability and racial/ethnic award disparities; implement the VA Health Equity Action Plan with the Office of Health Equity; and encourage minority veteran participation in the Rapid Appeals Modernization Program, (RAMP).¹⁶³

While some of the barriers and discrimination facing minority veteran communities are reflections of society in general, VA can directly affect the military-specific barriers facing LGBT and women veterans. This can start with a trauma-informed VA perspective to understand the intricacies of gendering and misgendering, interpersonal violence, sexual violence, natural disasters and accidents, chronic social stressors, and childhood trauma—in addition to military exposures such as combat—on an individual’s resiliency and outcomes.¹⁶⁴

Recommendations to make VA more welcoming for minority veterans include:

- Implement trauma-informed and dignity-affirming care, including effective cultural awareness training for all employees.
- Mandate small changes such as updating waiting room reading material, posters, and television channel default settings to be more inclusive.
- Expand Veterans Experience Office efforts using human-centered design concepts to identify and alleviate disparities in the experiences of minority veterans.
- Expand the nascent End Harassment campaign to include the harassment LGBT and racial/ethnic minority veterans experience.
- Expand the “secret shopper” model of ensuring that front-line staff members are aware of resources for MST survivors such as LGBT VCCs, minority veteran coordinators, and women veteran coordinators at VA Medical Centers nationwide.

Conclusion

As the military continues to diversify, veteran population demographics will change significantly. As the popular perception of the traditional veteran as a heterosexual white man becomes further and further from reality, government agencies and veteran-serving nonprofit organizations must take into account the broader needs of a population of veterans who do not all require the same type of care, who do not receive the same type of access, and who experience different realities. Through their military service, women, LGBT-identifying, and racial/ethnic minority veterans are eligible for veteran benefits and support; however, minority veterans face disproportionate barriers and challenges to their well-being across life domains.

Stakeholders consistently highlighted similar challenges for minority veterans and stressed the need for increased outreach to diverse communities. Veteran focus group participants backed up stakeholders with examples of discrimination and isolation. While some veterans may have incorrect perceptions about, for example, the lack of availability of *any* transgender health care, these beliefs demonstrate a failing to effectively inform veterans of what VA provides. Similarly, perceptions that VSOs do not allow LGBT veterans to join illustrate a gap between local and national efforts. Lack of trust in VA and VSOs stood out as a hurdle to accessing care and services.

There has been significant research on women veterans while considerably less is done for LGBT or racial/ethnic minority veterans. Minority veterans are often members of more than one minority group and thus experience a combined effect of barriers to care or life experiences. As women veterans are the fastest-growing demographic among the veteran population, it is imperative that their needs and concerns are highlighted. Issues facing the LGBT veteran community can be summed up as an appeal to increased cultural competency among staff at VA. While a perception of a lack of LGBT-specific care was prevalent among focus group participants, VA has been increasingly offering training for providers in order to care for veterans in a more inclusive manner. Racial/ethnic minority veterans experience unemployment and homelessness at higher rates than the general veteran population. Co-occurrence between health, employment, and housing issues among minority veterans facing challenges was common. Agencies tend to focus on one of these domains at the expense of the others. For this reason, there is a disconnect between the on-the-ground realities of co-occurrence and the way federal and state governments approach veteran needs.

Comparisons between and within veteran and non-veteran minority populations show that military service remains a societal equalizer. While outside factors such as discrimination and poverty affect both veterans and nonveterans, veterans in minority communities are more financially stable and have greater access to health care than their nonveteran peers. Some stakeholders noted that both DoD and VA bureaucracy force minority veterans to fight for basic dignity, which may contribute to some minority veterans being less likely to identify as veterans after service. Those veterans who do not assume the mantle of veterans are therefore less likely to see or access opportunities offered to veterans. While much progress has been made in diversifying the military community, there is a long way to go in terms of equitably meeting the needs of minority veterans. Recognizing these challenges is the first step organizations must take in solving them.

Appendix

Appendix

Primary research was done in sequence and conducted in three parts. First, a roundtable probed for initial focus areas; second, interviews were conducted with stakeholders and subject matter experts who serve minority veteran communities to gain a better understanding of their experiences as well as the experiences of the communities they serve; and third, building on insights and suggestions gathered in these interviews, questions were developed for focus groups held with veterans themselves. Members of the research team who conducted stakeholder interviews and veteran focus groups took human subjects protection training and followed data safety protocols. Finally, results were coded to extract key themes.

Roundtable

The research team first held a roundtable with national-level representatives of multiple veterans service organizations to identify what they saw as the most significant areas of concern for their members. These included: Iraq and Afghanistan Veterans of America (IAVA), VFW, American Veterans (AMVETS), WWP, Disabled American Veterans (DAV), Paralyzed Veterans of America (PVA), The American Legion, and VetsFirst. In addition, this roundtable set the stage for introductions to local-level leaders in New York and resulted in one organization generously offering to provide additional details on results of its member survey by state. Input from the roundtable was also used to craft the questions used during stakeholder interviews.

Stakeholder Interviews

To gain a greater understanding of the challenges minority veterans face and the work being done to support them, the research team conducted interviews with 25 key stakeholders and subject matter experts. The interviews were semi structured, ranged from 30 minutes to an hour, and were recorded and transcribed. Participants represented both public- and private-sector organizations that serve a range of minority veterans across the four life domains being assessed; a snowball sampling technique helped identify other interviewees.

CNAS interviewed representatives from the following organizations:

- » Office of Health Equity
- » Women's Health Services
- » Veterans Benefits Administration regional office
- U.S. Department of Labor Veterans Employment and Training Service
- Disabled American Veterans Department of New York
- Headstrong
- IAVA
- Minority Veterans of America
- Modern Military Association of America
- New York City Veterans Alliance
- New York Legal Assistance Group (NYLAG)
- New York State Division of Veterans' Affairs
- Oregon Department of Veterans' Affairs
- SAGEVets
- Service Women's Action Network
- St. Regis Mohawk Tribal Court
- Transgender American Veterans Association
- Women Veteran Social Justice Network
- WWP
- Veterans One-stop Center of Western New York

Focus Groups

The research team conducted three focus group sessions, in Brooklyn, Buffalo, and Queens. Eight people took part in the Brooklyn session, which was focused on LGBT veterans; participants were not asked specifically how they identified. The Buffalo focus group was geared towards black veterans and had nine participants. The session in Queens focused on women and included eight participants. The Buffalo and Brooklyn focus groups were mostly men and all three groups included racial minorities.

The researchers found that when conducting focus groups specific to minority populations there was no substitute for having members of those minority groups conduct outreach themselves. This would seem to be due to their position as trusted members of the groups who could verify the legitimacy and purpose of the focus groups they promoted. Although this method of outreach could produce a group of individuals participating who had preexisting relationships, such relationships did not affect the discussion or content of the focus groups themselves.

The research team faced challenges when attempting to request support from local VSO chapters to post fliers: Many had disconnected phone lines, did not post their hours online, and could not be reached during traditional business hours. Local VSO chapters often lacked online footprints. Of the local VSO posts that did respond, most were unhelpful in assisting with raising awareness of the opportunity to participate in this veteran-specific research among their members, even when the parameters, importance, and nonprofit nature of the research were explained. This included two individuals who became brusque at the mention of minority veterans.¹⁶⁵

Site Visits

To supplement these interviews, CNAS also conducted several unannounced site visits in New York to observe the environment and atmosphere of organizations that serve veterans. Researchers visited a VA regional office, two VSO posts, three VA Medical Centers, and two VA clinics.

Coding Interviews and Focus Groups

Interviews and focus groups were coded and analyzed using a combined process-oriented and descriptive approach. To determine how individual veterans perceived their needs as minorities and how organizations are responding—or are not—to targeted challenges, this study developed a list of both descriptive and process categories and coded interviews and focus groups by primary and secondary categories as described below. By dividing up the themes drawn from interviews into descriptive categories and process-oriented categories, we differentiated between unchanging descriptors and actions that could be beneficial to improving veterans’ services to meet the needs of women, LGBT, and racial/ethnic minorities.

Four broad and definitive categories of the descriptors guiding the minority needs assessment were identified: the presence of a problem, minority as a category, veterans’ benefits, and root causes of obstacles for underserved populations. The full list of categories and their definitions is presented below:

Data Code	Category	Definition
100	Current	Current policies or actions by veteran organizations
110	Current	Cultural competency
120	Current	Formal training or education
200	Future	Future policies or actions for veteran organizations
210	Future	Public-private partnerships
220	Future	Representation
230	Future	Directed finances
300	Overcome	How to overcome the challenges of minority veterans
310	Overcome	Trust
320	Overcome	Outreach
400	Problem	Does a problem exist for minority veterans?
410	Problem	Yes
420	Problem	No
500	Minority	Minority veterans
510	Minority	Women
520	Minority	LGBT
530	Minority	Racial and ethnic minorities – including Native Americans
600	Benefit	Veteran Benefits
610	Benefit	Housing
620	Benefit	Health – including physical and mental health care
630	Benefit	Finance – including employment
640	Benefit	Support, such as VSOs
700	Root	Root causes of minority challenges
710	Root	Income
720	Root	Transportation
730	Root	Adverse Childhood Experiences
740	Root	Discrimination – active
750	Root	Unintentional; lack of awareness

Additionally, subcategories were coded to include specific minority populations under research, specific types of veterans' benefits being discussed, and the major root causes of discrepancies in services according to both individual veterans and nonprofit organizations. For example, housing, health care, finances and support are all types of veterans' benefits. While feedback from interviews and focus groups had overarching themes, it is important to distinguish between subpopulations and specific benefit programs to best determine gaps in care and recommendations for the future.

Three categories and seven subcategories were developed to code process-oriented takeaways from focus groups and interviews. The broad categories included current practices targeting the experiences of minority veterans, calls to action to improve benefit usage and outcomes, and broad themes of actions needed to overcome institutional discrepancies among population groups. The subcategories identified are not exhaustive in terms of available actions being taken/to be taken and constitute those most commonly referenced by participants. When processes were raised during interviews that fell outside the chosen subcategories, the process category code was used to identify them as unique. The outcome of interviews with subject matter experts and veteran focus groups led to a rich collection of conversations and impressions to add depth to primary research.

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