Invisible No More: Substance Use Disorders Among Women Veterans – Trauma-Informed, Veteran-Centered, and Community-Driven Solutions

Presented by
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PRESENTER

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Worked in community Mental Health, Private Practice and Corrections system

Focus is on Providing Trauma-informed care to Veterans and First Responders and Service members and their families

A Case to Keep in Mind

Maria

- 38 years old
- 8 Year Army Vet
- Lives in rural New Hampshire
- Single parent
- Works full-time
- Interacts with multiple parts of the healthcare system

Why This Conversation Matters

- Women veterans are one of the fastest growing veteran populations
- Substance use among women veterans is under-recognized and under-treated
- Many systems were built for male veterans, and it shows
- If we don’t name the problem, we’ll keep missing it

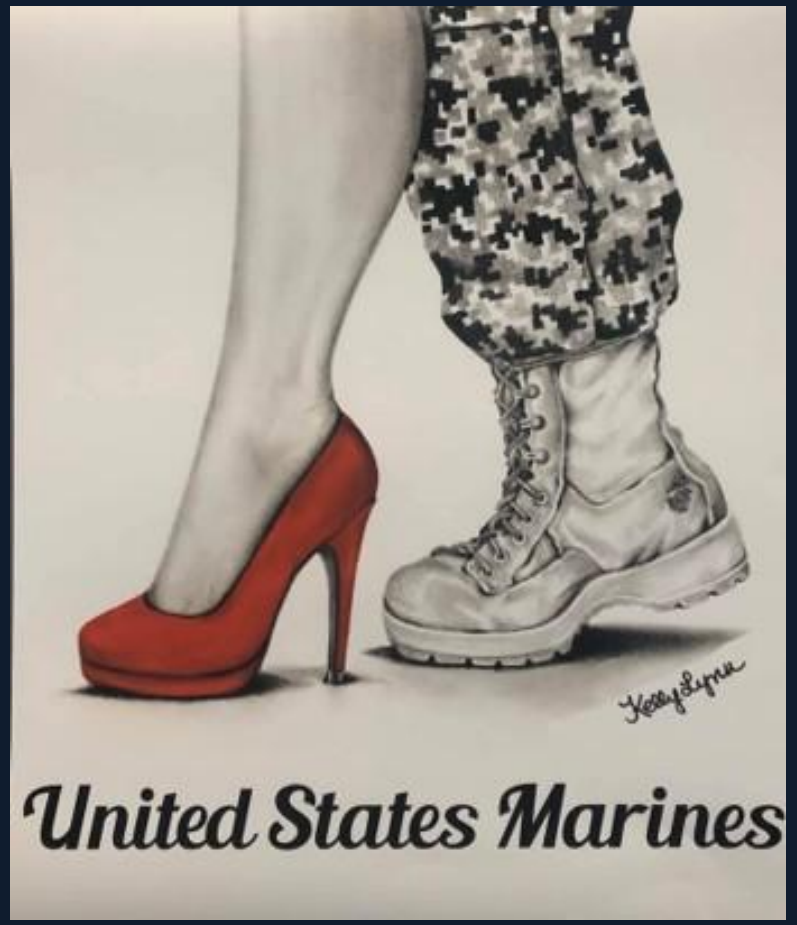
Learning Objectives

- **Identify** 3 population-specific risk factors for SUD among women veterans
- **Apply** 2 trauma-informed, veteran-centered engagement strategies
- **Describe** 1 community-level intervention to improve access and outcomes in NH

Who This Session Is For

- Behavioral health & SUD providers
- First responders & law enforcement
- Peer recovery specialists
- Public health & prevention professionals
- Educators & school-based clinicians
- Community health workers
- Veteran service organizations
- Policy & advocacy professionals

Women Veterans: The Landscape



- Women are the fastest growing segment of the veteran population
- Increasing reliance on civilian systems instead of the VA
- Higher likelihood of being misidentified as “civilian”
- More likely to be caregivers, single parents, or economically vulnerable

Women Veterans in New Hampshire

- Approximately 16,000 women veterans live in NH
- Many receive care entirely outside the VA
- Rural geography creates access barriers
- Privacy concerns impact help-seeking
- Civilian systems are often the first point of contact

Substance Use Trends Among Women Veterans

- Alcohol misuse
- Prescription sedative or pain medication misuse
- Polysubstance use
- Substance use framed as coping for trauma
- High functioning patterns that delay identification

Risk Factor Stacking

- Military Sexual Trauma (MST)
- Intimate Partner Violence (IPV)
- PTSD and depression
- Chronic pain and medical trauma
- Moral injury and identity loss
- Caregiving burden post-service

Military Sexual Trauma (MST)

- Occurs at significantly higher rates in women veterans
- Strongly associated with SUD, depression, and suicidality
- Often underreported or minimized
- Creates distrust in systems, including healthcare

Role Of Military Culture

- Conditioning around toughness and self-reliance
- Fear of being seen as weak or problematic
- Alcohol normalized as stress relief
- Help-seeking delayed until crisis
- Identity Disruption after leaving service

Misidentification: A Structural Failure

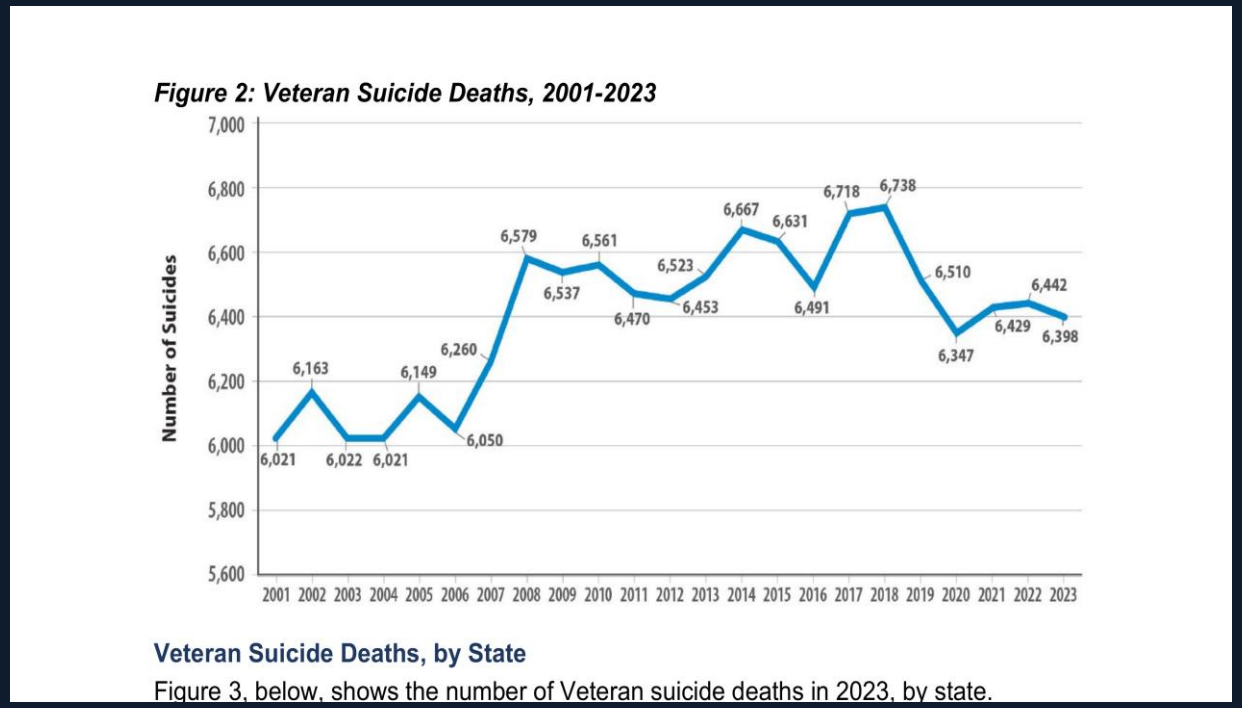
Often missed because:

- Intake forms do not ask about military service
- Gender-based assumptions occur
- Veterans are assumed to be spouses rather than service members
- Veteran-specific referrals are missed

Barriers to Care (Especially in New Hampshire)

- Rural geography and transportation challenges
- Limited veteran-informed providers
- Long wait times in suburban areas
- VA–civilian system fragmentation
- Stigma amplified in small communities

Veteran Suicide



- ~6,398 Veteran suicide deaths (most recent VA data)
- ~17.5 Veterans die by suicide daily
- **61% not engaged in VA care at time of death**
- Suicide rates increased for men and women Veterans

Suicide Risk Among Women Veterans

- Higher suicide rate than non-veteran women
- Firearms most common method among Veterans
- Trauma, SUD, pain, and housing instability increase risk
- Many women veterans are not connected to care systems

Why Traditional SUD Models Miss Women Veterans

- Male-centered program design
- Limited trauma integration
- One-size-fits-all recovery narratives
- Programs rarely designed around caregiving responsibilities
- Recovery narratives that ignore Military Identity

What This Means for Civilian Systems

- Women veterans are already in community care
- Military identity is frequently missed
- Trauma and substance use are intertwined
- Identification changes treatment pathways

Trauma Informed + Veteran Centered Care

- Safety (physical, emotional, cultural)
- Choice and collaboration
- Trust and transparency
- Cultural humility around military identity
- Trauma recognized as adaptive

Strategy #1: Veteran Centered Engagement

- Ask about military service every time
- Use veteran-informed language
- Normalize ambivalence toward treatment
- Address moral injury and identity loss
- Respect autonomy

Strategy #2: Integrated Harm Reduction

- Acknowledge alcohol as a primary issue
- Support safer use strategies
- Integrate mental health, pain, and SUD care
- Reduce all-or-nothing expectations

Strategy #3: Peer Based Recovery Supports

- Veterans trust veterans
- Shared language reduces stigma
- Peers increase engagement and retention
- Especially effective for women veterans

Strategy #4: Community Level Interventions

- Cross-training civilian providers
- **Standardized military service screening in intake systems**
- VA–community partnerships
- Peer outreach
- Mobile and low-barrier access

What Works in Mixed Civilian Military Communities

- VA is not the only entry point, but connection to VA resources remains important
- Warm handoffs across systems
- Shared responsibility
- Community trust as an asset

Case Scenario: Maria 38 yo Army Veteran

- Served 8 years active duty with two deployments
- Lives in rural New Hampshire
- Single parent with two children
- Works full-time

Recent changes:

- Increasing alcohol use to sleep
- Chronic pain and headaches
- Missed two primary care appointments
- Recently prescribed sleep medication

System involvement:

- Primary care
- Behavioral health
- School counseling for children

Maria has never been identified as a veteran in her medical record.

Group Debrief

- What risk factors do you see in Maria's situation?
- Where did the system have opportunities to identify military service?
- What intervention could realistically happen tomorrow in your organization?

Where Could the System Have Intervened for Maria?

Maria's Path Through the System

- 38-Year-Old Army Veteran
- Single Parent with 2 Kids
- Chronic Pain, Sleep Issues
- Drinking to Cope

Where Maria Falls Through the Gaps

Primary Care Visit	Behavioral Health Visit	School Counseling
No Question About Military Service	Trauma History Not Assessed	Parent Stress Not Addressed
Missed Veteran ID	Missed Veteran ID	Missed Veteran ID

Disconnected from Veteran Resources

Practical Tools

Small changes with big impact:

- Ask: “Have you ever served in the military?”
- Adjust language to acknowledge service
- Build one veteran-specific referral pathway
- Include peers early in recovery
- Design care with flexibility and dignity

Key Takeaways

- Women veterans are not a niche population
- Substance use is often trauma-driven
- Veteran-centered care improves outcomes
- Community solutions matter—especially in NH

Call to Action

- Identify women veterans intentionally
- Advocate for veteran-informed programming
- Integrate harm reduction and peer support
- Stop waiting for crisis

Thank You

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