Adrianna: Welcome everybody to the series of The Spotlight on Women’s Health Cyber Seminar. And we are joined today by Dr. Karissa Fenwick from VA Greater L.A. And our discussant today is Dr. Patricia Hayes from the Office of Women’s Health. So just a brief introduction on both of our speakers today. Dr. Karissa Fenwick is a core investigator like I said with the VA Greater Los Angeles at the Center for the Study of Healthcare Innovation Implementation and Policy. Her research focuses on improving quality of care for women veterans through implementation of evidence-based practices and reduction of gender-based harassment at VA. She was part of the research team that received the 2020 HSR&D award for Health System Impact for the work on addressing gender-based harassment of women veterans and staff. Dr. Fenwick also has a background in clinical social work and has practice in mental health and medical settings.   
  
And just a little bit on our on our discussant today. Dr. Patricia Hayes is the Chief Officer of the VHA Office of Women’s Health. And Dr. Hayes has successfully work across VHA to really expand initiatives for women veterans healthcare into a broad range of areas of importance including cardiac health, reproductive health, and birth defect prevention infertility, and a comprehensive evaluation of care provision to women veteran. And with that, I will hand it over to our speaker Dr. Karissa Fenwick.

Unidentified Female: Karissa, you are still muted. At the bottom of your screen there is that mute button. Or we do have Becky Yano on the call right now if we want to turn it over to her for a minute or two.

Unidentified Female: Yeah, Becky let us know if you want to say a few words or if we should get started.

Dr. Yano: Thank you so much and sorry for the technical difficulties on my end. I’m just really grateful for Dr. Fenwick and Dr. Hayes in presenting the work today that is really emanated from a substantial body of work now that needs much more in the future on the experiences of harassment on VA grounds. So let’s actually have you dive in Karissa on the work.

Dr. Fenwick: Sounds great. So thank you so much Adrianna for that introduction and to the Women’s Health Research Network and to CIDR for supporting and sponsoring this seminar. And then thank you also to the audience all for being here even though it now it’s close to grants, it’s almost a VA holiday. So it truly is a privilege to be talking with you all today. So I’m going to start just with a roadmap of where we’re going in this presentation. I’ll begin by explaining why addressing harassment from patients is and needs to be a priority at VA. And then I’ll be drawing on findings from qualitative work that we’ve done with VA staff to illustrate multilevel factors that influence harassment as well as some recommendations for addressing it.

Dr. Yano: Karissa, I’m sorry to interrupt. I just realized that I had forgotten to turn over slides to you and I’m doing it right now. So we can see your background slide now, but just wanted to give you heads up that we hadn’t seen the earlier slides.

Dr. Fenwick: Well, I guess you were changing them right at the time I wanted them changed, because I thought I was doing it. Alright, yeah, it seems like I have control now. Thanks for the heads up about that. So I’m going to started by just getting us all on the same page with some definitions because we know that there are different forms of harassment that occur at the VA. But the work in this session is focusing on sexual harassment primarily by male patients towards women staff or patients. And research from the social sciences tells us that there three main types of sexual harassment. But the two that we see most commonly in this area work are unwanted sexual attention which is unwelcome, unreciprocated expressions of romantic or sexual interest. And gender harassment which is behaviors that convey hostile or degrading attitudes about members of a particular gender.   
  
So I’ve heard it said that an easier way to remember the difference is that, unwanted sexual attention is the come ons and then gender is the put downs. And then the third type just for your information is sexual coercion. So things like offering professional favors in exchange for sexual activity. But again, this third type isn’t something that we see much we talk about harassment from patients. So just a couple of quick knows about these definitions is our sociopsychological definitions. So they don’t necessarily align with what you may know as the legal definitions. They are based on the experience of the person targeted rather than the intent of the person harassing. And they reflect that some harassment is not by sexual interest as is sometimes a common misperception. But they can be motivated by things like wanting attention or power as well.   
  
So let’s move onto talking about what patient perpetrated harassment looks like at the VA. Starting with harassment directed towards staff. This isn’t something that is been explored a lot at the VA yet, but information we do have suggest that it’s prevalent. A recent study found that 97 percent of women and 77 percent of men internal medicine physicians at one VA facility said that they had ever been harassed by patients. Though some of their common experiences included remarks on body and dress that were unwanted. Sexist jokes. Staring or layering. Denigration of professional competence. And then less commonly, unwanted touching. And while there aren’t any VA studies looking at impact of harassment on staff yet, work in other healthcare settings shows that it has negative impact both on staff’s career outcomes. So things like productivity and retention and staff well-being in terms of mental health and sense of safety at work. And then even more concerning, we see that harassment is especially harmful for staff with multiple marginalized identities such as those are members of racial ethnic minority groups.   
  
So in addition to harassing staff, patients may also harass other patients. Some of our team members found that 25 percent of women veterans experienced harassment from men veterans on VA grounds. So about one in four. And the common incidents here included catcalls, stairs and gestures, propositions, statement suggesting that women were too pretty to be veterans, and other denigration of women’s veteran status. And we saw that women who experience harassment felt less safe, less welcome, and were more likely to delay or miss needed care the VA. So harassment really is an access to care issue. So to guide efforts to address harassment, we wanted to learn more about some of the factors that encourage or inhibit it here at the VA.   
  
We conducted semi structured interviews with 24 stakeholders, and these participants were primarily leaders and clinicians who had experience providing care to women veterans or in managing disruptive patient behavior. And one of the questions we asked them was, what are the challenges to addressing harassment at VA? And we found that, the influences and challenges they talked about span organizational levels. So this is consistent with the social-ecological framework that the CDC uses for understanding and preventing sexual violence.   
  
So I’m going to be using this framework as I walk you through these results. And I don’t know is if this model goes anyone else grad school flashbacks like it does for me, but in case you’re not familiar with it, I’m going to go over just some of the main assumptions. And one is that factors at the societal organizational interpersonal and individual levels all combined to then influence the behavior of interest. Which in this case is patient harassing behavior. And then factors at one level can spill over to influence factors at the next. So that’s illustrated here by these overlapping or concentric circles that you can see in the model.   
  
So the broadest level is the societal level, which encompasses things like societal laws, or norms, and values. And relevant to this level, participants pointed out that it’s difficult to stop harassments at VA when it’s still supported by some of the larger norms and values elsewhere. So as one said, the VA is microcosm of the world. So culture change here is culture change in world, which is a pretty tall order. Participants also talked more specifically about the VA’s connection with larger military culture and how the norms that are seen there may trickle-down and then impact patient behavior at the VA.   
  
For example, some suggested that permissiveness towards harassments and emphasis on group cohesion that can be seen in the military might then combine to enable harassment at the VA. So as one said, it’s important among veterans to continue to have some sense of bonding. And unfortunately, historically, culturally in the military, a great deal of that bonding inferring among men veterans has been cemented by sexual harassment. So these challenges related to military culture are something that is unique at the VA compared to other healthcare settings.   
  
And the next level in our model is the organizational level. And for our purposes, this is referring to the organizational context at the VA. So things like organizational culture and climate, policies, and procedures, and leadership. And one of the strongest findings that emerged throughout these interviews was participant descriptions of a climate of tolerance for harassment. So as one participant put it, harassment is just tolerated and once things are tolerated, it becomes a culture not even seen any more as a bad thing. And this was an important finding because research from other settings shows that the organizational climate or the shared perceptions about an organization’s practices, policies, and procedures related harassment is one of the strongest predictors then of harassment prevalence.   
  
So related to and feeding into this climate were some other factors at the organizational level. Participants describe a lack of clear policies for reporting and managing harassment by patients as illustrated here by this participant who just simply said, there isn’t really a clear procedure for reporting things like this. And even though some participants were aware of our reporting mechanisms that do exist, so like the disruptive behavior reporting system or campus police, they weren’t always sure if these were appropriate for addressing what some called lower-level harassment. So things like catcalls, comments, which then often just lead to them brush off the experience. And this is something that we continue to see even in our more recent work as well.   
  
So finally, some participants identified leadership’s lack of support for addressing harassment or sometimes just lack of awareness about the scope of the issue as a factor. So this participant said, even though we know it on the bottom end—meaning that harassment is a problem—I think sometimes the top doesn’t see everything. And of course, if leaders aren’t prioritizing something, then it’s usually not going to be brought to the table and not going to be examined. The next level of our model is the interpersonal level. And in the social-ecological model, this refers to relationship with other people who can either support or hinder the behavior of interest. And for our purposes, this level is going to pertain to factors that influence VA staff’s ability to address harassment by patients. Since that staff patient relationship is one of the most central ones when we’re talking about healthcare settings.  
  
Though an important factor at this level was, participant concerns about negatively impacting staff, patient dynamics by addressing harassment. So participants were worried about damaging the therapeutic relationship or provoking retaliation from patients. For example, one participant described an experience where they were harassed by the patient and then they said, if I were to confront that patient yesterday, that would’ve made my entire interaction with him more difficult. It just wasn’t worth it. Participants also described how the staff can be unsure about when patient behavior constitute harassment or that warrants intervention. Again, especially in some of those cases of verbal harassment. So one director said, employees may not recognize situations as harassment or they may not feel they’re prepared to address it. So in an overt situation, they would know to do. But something more minimal or a conversation or comments then they sort of implied that staff wouldn’t really be sure how to handle that.   
  
And then participants also talked about just a lack of time and resources for dealing with patient harassment as opposed to the many other competing priorities that our staff have. So as an example, one said, you can have the police officer taking a harassment report or they are they going to be on a mental health unit dealing with an issue up there? And then more recently we’ve heard that competing priorities have been even more pressing with COVID. So staff only have so much bandwidth to address everything they’re supposed to address and sometimes harassment just doesn’t make the cut. And then last, we are at the individual level. So this level refers to things like individual demographic characteristics, beliefs, or knowledge. And for our purposes, this level pertains to characteristics of the patients who are doing the harassing as opposed to the ones who are being harassed. Since the harassing behavior is what we’re trying to actually target with this work.   
  
So at this level, participants said that some patients just lack awareness and don’t realize that their behaviors can be construed as harassment or that they can be harmful. So these statements were sometimes tied to older patient age. Like in this participant who said, there are some men veterans who make comments especially to younger women who probably wouldn’t view their comments or behavior as abhorrent. It was just how they grew up and the culture of their time. So participants really struggled with whether and how to address harassment in these cases and some viewed it as a bit of a lost cause like, this is just where some patients come from. And there may not be much we can do about that. And then participants also explained that certain clinical diagnoses, especially those related to psychiatric or cognitive impairments could complicate assessments of whether or not harassment was intentional. So one said, you have to discriminate particularly on the mental health unit whether someone is impaired in the reality testing and has no sense of boundaries. So of course, that can sometimes be a real challenge to tease out.   
  
To summarize what we’ve covered so far. We have seen that there are a number of factors influencing harassment at VA that span multiple levels and some of which are pretty long-standing. And then we can also see how these factors relate to each other both within and across levels. So for example, if we’re looking across levels and see that if we lack clear policies for addressing harassment at the \_\_\_\_\_ [00:19:28] level, then staff are going to have a harder time intervening in harassment at the staff level, which then enables a lack of awareness in the patients who harassed at the individual level. And we can see how all of those things together can then maintain that climate of tolerance for harassment that I was talking about earlier which is a major predictor of harassment prevalence. So the implication of all of this in line with what the social-ecological model does say is that, we need prevention and we need intervention strategies that can act across multiple levels.   
  
So going to shift gears a little bit now and introduce you to some additional data we collected. Was asking staff to share their recommendations for addressing harassment at VA. We conducted three virtual groups. One with physicians, one with mental health providers, and one with support staff such as peer support specialists at a large urban VA facility. And this was right in the middle of COVID, so recruitment was unfortunately a little difficult as you can see in some of these numbers. But luckily, we did have some great people participating who had really good ideas. And we chose a modified deliberation group method for this to help participants feel safer discussing a potentially contentious issue like harassment. What we did was first we opened the group with a summary of definitions, of prevalence, and factors related to harassment VA. Sort of like of a condensed version of what I presented so far, and that was just to get persons on the same page from beginning.   
  
And then we asked participants to discuss among themselves the question, what is needed to address patient perpetrated harassment of women staff and patients at VA? And here different from kind of a regular focus group, we didn’t offer any additional comps after that to avoid influencing or inserting our opinions into the discussion. So similar to our findings about the factors influencing harassment, we found that participant recommendations also aligned with multiple organizational levels. And as I go through each of these recommendations, I’m also just going to be briefly touching upon what the VA has done or is doing in each of these areas. And as indicated here on the slides if you can see them by the colored bullets, to give you a little bit more context about where we’re at with some of these things right now, because there is a lot of work going on.   
  
So starting with recommendations at the organizational level. These focused on communicating that VA does not tolerate harassment. So one way that participant suggested doing this is through leadership saying that leadership voices are heard a little louder than other people’s. Some participants wanted leaders to explicitly convey that addressing harassment is a priority and that they support efforts to address it. And some leaders have been doing this. So as part of the Stand Up to Stop Harassment Now campaign, it was in 2019 that started, facility leaders made public declarations that they would address harassment and support incident reporting. And then more recently, VA Sec. McDonough also said in his first public statements that, he will not accept discrimination or harassment at any level at the VA. So these are some great examples of how this recommendation can be implemented. Just kind of fairly simple, but still meaningful things leaders can do to step up.   
  
So another way of communicating that VA doesn’t tolerate harassment is by improving policies for reporting perpetrators and holding them accountable. So specifically, participants wanted clarity around where and how to report different types of harassment that is targeting staff versus that that’s targeting patients. And then also improving follow-up to communicate that the report was taken seriously and that something was done, and it wasn’t just brushed under the rug. So part of this is thinking about how we can effectively apply corrective actions to patients and then what mechanisms are needed to better close the loop with reporting parties. Again, there is a lot of work happening in this area. The Deborah Sampson Act is requiring the facilities to all have clear well-publicized procedures in place for reporting and is also actually mandating that staff are required to report any harassment that they witness. So lots of changes happening with reporting.   
  
At the staff level, participant recommendations centered around increasing improving staff capacity to address harassment by patients. And I talked about this in several different ways. So one was by teaching staff to be able to intervene in harassment that they witness occurring. And this strategy is also known as Bystander Intervention. And Bystander Intervention trainings have shown effectiveness for addressing sexual violence in other settings. It’s widely used in education and in the military. And VA has also been offering Bystander Intervention trainings during some of its campaigns. Like in harassments, the Stand Up and Stop Harassment Now. And some of you may have even taken trainings. But some staff who can use these are probably not signing up for them on TMS. And participants also told us that staff still face a lot of barriers to feeling able to intervene in harassment. So ongoing work is still needed here.   
  
In addition to helping staff respond to harassment that they witness, participants also suggested empowering staff to be able to respond to or report the harassment that is directly targeting them as staff members. So to do this, participant suggested any ways to make sure that guidance for responding to harassment is part of regular dialogue at VA such as by teaching strategies at new employee orientation or making it part of curriculum for our trainees, and stuff like that. Participants said it could help staff feel like they have the tools and importantly that they have the permission to be able to handle harassment when it happens. And finally, participants suggested training key staff who have high levels of patient interaction. So this could be examples who are coffee vendors or front desk or security staff training them to be good role models in their interactions with women with the idea that this can help to send messages to the broader VA community about what kind of behaviors are appropriate.   
  
So the last group of participant recommendations focused on educating patients about harassment. So one suggestion for doing this was through social marketing. And what that means is things like posters, and flyers, or banners on VA websites. And social marketing has been a major part of some of the previous campaigns I’ve already mentioned. And is still something that’s ongoing. So some of you may have noticed or will be noticing new messaging up online or in your facilities. And then another patient suggestion for or a participant suggestion for educating patients was embedding anti-harassment messaging into routine patient procedures, such as new patient orientation or patient agreements or patient mailings. Again, just to help this become part of the regular dialogue. And participants noted that this isn’t something you can just do once. There needs to be consistent reminders to patients about what harassing behavior actually is and that is not to be tolerated at the VA.   
  
So we’ve seen in this section that addressing harassment requires acting across multiple organizational levels, which is in line with what we saw when we were looking at the factors influencing harassment earlier. So just to bring things back now to our social-ecological model, I combined these two sets of findings that we’ve been through into a framework for understanding and addressing harassment that I’m showing here. And I want to say that this framework is not inclusive by any means. Meaning that there are other factors that influence harassment and other ways of addressing harassment in addition to what we’ve talked about here. And maybe you can mention some of these in our Q&A. But what this is going to do is kind of illustrate how we can take a holistic approach and need to take a holistic approach when we’re thinking about how to move forward with this work.   
  
So we have covered a lot here already. I’m going try and tie everything together for you in our discussion. First some take away points. Findings suggest that harassing behavior is the product of multiple levels of influence and so we need multifaceted approaches to addressing harassment. And this means that we need to continue to implement a number of different changes together to really make a difference. And since the influences on harassment are related across levels, we need to make sure that we have adequate support at the top at the organizational level in terms of leadership buy-in, and policy infrastructure to then facilitate effective interventions like encouraging staff to report or educating patients at those lower staff and patient levels.   
  
So I hope that this presentation has conveyed two things, really two main things. One that we have made a lot of progress both in terms of understanding harassment at VA and in implementing interventions to address it over the past several years. And two that we know that there is still more work to do. And this is summarized and one of my favorite participant quotes from this work at the bottom here which was, “Things didn’t get messed up in a day and it's gonna take more than a day to fix it.” And this statement is consistent with organizational research that shows us that change is often slow and require sustained efforts, especially when we’re talking about large complex organizations like that VA. So having said that, I’m going to end no by talking about what some of that future work looks like.   
  
And I’ve already mentioned some of interventions that are underway, and we are lucky enough today to have Dr. Patty Hayes here who’s played such a central role in this area and can hopefully share some more about some of the initiatives or answer any questions. But one of the major drivers of future harassment work is the 2020 Deborah Sampson act, which included requirements for improving reporting as I already mentioned. Increasing dissemination of antiharassment messages. So things like sending mailings to patients, posting banners on VA websites with antiharassment messages, and quarterly focus groups with women veterans at each facility that include discussions of harassment. And those are just a few of the provisions among many other things in that legislation.   
  
So the VA is also still rolling out Bystander Interventions and Bystander Intervention trainings. And these are now going to be offered to some patients as well as staff to encourage more people to step up and address harassment when they see happening. And then the Women Veterans Healthcare Modernization IPT is our national level group that has been and is continuing to work on changing culture related to treatment of women at the VA. Some research related to harassment is ongoing as well. The Women’s Health Research Network has been tracking women veterans experiences with harassment through brief annual surveys. And is currently gearing up to collect next wave of data.   
  
And then some other new projects are going to be focusing on things like evaluating Bystander Intervention, improving support and guidance for staff who experience harassment, and finding out more about what the VA climate related to harassment looks like. We also have a new harassment research workgroup and you should be hearing from some of its other members in future upcoming cyber seminar, so be sure to keep a lookout for those. And also, you can contact us or contact Women’s Health Research Network if you would like to be a part of that workgroup. So to close out this portion of the seminar, just again, I want to thank you so much for the opportunity to present this work. And I like end on this slide acknowledging some of the many people who contributed to all of this as well as the funding that made this possible. So I’m now going to turn things over to our discussant Dr. Patty Hayes.

Dr. Hayes: Hello everyone. Thank you for this great presentation about your work that’s ongoing and I think presents a perspective that’s been hard to otherwise quantified because as you’ve been talking about, the problem of harassment while attending medical appointments or while working at a VA medical setting is one that is somewhat unique to VA. Although, we’ve heard and found some data and some of you researchers have done a great job of looking at other systems. We understand that there something goes on in VA that is not so common and that we need to understand differently in order to be able to attack it. We’ve worked for number of years now on the proposal that we must end harassment of all veterans by veterans, by staff, by individuals while at VA. And as you outlined, there’s some things that are ongoing and some new efforts that are going to be taking place.   
  
But I did want to kind of go back to the beginning of when you talked about the staff being harassed, you talk about veterans harassing other veterans, and that idea that is cultural and comes from the military, and I think something that while people label it that way I don’t believe we understand it yet. So I think that the issue is going to, be why is it that if you go to university…UCLA’s medical visit, you’d never expect that someone in the waiting room will say something to you, will try and take pictures of you, will try and sit next to you. Because if they did, someone would probably call security. But in the VA, there is that idea that somehow, it’s been accepted in the culture. And if we have the kind of acceptance, first of all, I think we don’t have to accept it and I think we have to challenge it as a harassment climate. But then we also have to have culture change. And how do we have culture change has been a topic that we’ve been trying to tackle from a number of different elements, a number of different angles for a couple years now.   
  
You did outline that VA at a very high level is addressing this. The Secretary not only pledged to do this but has also established a VA wide antiharassment program. And then VHA has established a new office that is the Sexual Assault Harassment and Prevention Office at the level of the Undersecretary. Some of the items that you were just told about, you’ll see more and more coming out from that office. For example, yes, we have to VA tell veterans that VA does not tolerate harassment. There is a letter and a brochure currently being vetted that will soon go out to every veteran as part of the Deborah Sampson Act law that is being complied with. But it’s also a message from Secretary that, we have zero tolerance. If you are harassed, this is how you can report it and give specific information. And throughout our systems you will soon see a lot of information again, flowing out staying, if you are harassed there’s mechanism to report it. And you can start with the patient advocate.   
  
There’s is also an anti-harassment person at the medical center director’s office, and there’s a whole team of folks that are carrying out the Secretary’s directives about stopping harassment. We think there are many other things that leaders can do not only declaring locally that they pledge to stop harassment, but I think that they need to do things on a number of levels. I believe it’s important to have a culture change committee at an individual medical center. Because you can have all the procedures and brochures that you want, but if you don’t have folks are engaged in culture change, it’s difficult to get that actuated. I think that there are things it can be done to the physical space so that you reduced the places where people are walking the gauntlet or where they can be cornered or other ways, preyed upon.  
  
I think that we can continue the issues about how do we tell veterans that their behaviors are inappropriate. We’ve been doing that with a series of different posters and messaging. The most recent in the last six months are messaging about what’s appropriate and also with the effect is. For example, we have new posters that just say can’t take pictures with your cellphone in this hospital. We have a poster that says, you’re not giving her a complement. You’re giving her the creeps. There are six or seven posters in that series that are designed to be edgy and are designed to get attention and have veterans think about…and male visitors, staff members think about their effect in terms of gender harassment and sexual harassment. The Stop Harassment program is about all forms of harassment. And so we believe that it’s important to attack all of the harassing behaviors that are going on.   
  
Wanted to also say something about how individuals can be trained to deal with harassment that’s directed towards them. And again, this is a multifaceted approach any of which are open to research evaluation. I think there has been message from the leaders at your facility that you can stand up to harassment. That you can stop it. That you can intervene. That you can react to it. Durham VA did a great video by the leaders as messages that, not only do you not have to take it, but we’re going to have a team approach to addressing it. We know that it takes training. Bystander Intervention training is one of them. Another type of training is training for staff and actual role-playing and how to address harassing behavior.   
  
So there’s an example that was done that’s a whole module done for inpatient psych for the nursing staff and the rest of the staff about how to address sexual harassment and gender harassment comments made by patients on that unit. And it does in some ways bring up this other question, because not every person who targets others is bringing that same thing to the table. And there actually was very good seminar put on some time ago by mental health folks about, if you’re the provider, if you’re the staff person, you may need to figure out the veteran’s intent and their capabilities. So it could be for example that an older veterans so something to you about your appearance and they actually are being very socially awkward. They want to somehow make a connection. Their goal is to become connected with you, but they don’t know how to do it. How you react to that comment is going to be different from realizing that someone is being aggressive. That they are not trying to connect with you, but their intent is malevolent and that they’re trying to harm you.   
  
And whenever we think about role-playing and thinking about the person in the primary care provider role, I think that it’s important that we help people look at the various types of behaviors that are being brought forth and be able to adjust our response to them and practice our response to them. Because then it will not necessarily make the interaction with our patient fall apart. So it’s possible for example in that primary care visit when the veteran so something about the doctors appearance for that person to reassure the veteran say, I know you’re trying to be connected with me, but how you’re doing wasn’t very appropriate. Let’s see if we can talk about things in a different way. Versus the person who is being very aggressive and inappropriate, and you may want to say, I’m going to end this intervention right now. We’ll come back to it in a few minutes when you can behave differently. Similar kinds of role-playing is designed for the inpatient psych units.   
  
I think those are some of the big things are happening. As I said, you will see multipronged approaches to what leadership is doing, how you can report harassment, the role of the patient advocate, the role of the antiharassment coordinator, and I think the role of a culture change committee at a local level. The other thing that we didn’t talk about is that VA has designed what are called recovery interventions for those who report harassment. And there’s an entire toolkit now so that if a veteran goes to the patient advocate and says this happened to me. That we’re going to respond to them. And anything from a phone call from one of the leaders, a letter from one of the leaders. There’s going to be a response and depending on the severity and intricacy of the of the complaint, there’s various tools that might be utilized to let someone know that it’s not just falling in a black hole. Women veterans have told us before that they’re hesitant to report because they don’t think anything is going to be done.   
  
So the fact that we are thinking about how to intervene, how to stop it, making sure veterans know that we’re intervening, culture change on a number of levels including the physical. We have to redesign some of these entrances in other areas. Messaging. And then recovery. And I’m going to pause because I think others might want to jump in and make comments about what I’ve said. I didn’t know if Dr. Yano was going to comment.

Dr. Yano: Just that I think in this area of research, it’s been incredibly fortunate to have operational partnerships at all levels. And to also make sure that we have continued in the work that Dr. Fenwick and others done. Bring in the voice of the veteran in the work that’s been done and the work moving ahead. And I think that having the opportunity to conduct this kind of work in ways that contributes to evidence-based practice and policy is the reason we get engaged in this kind of work to support safe environments, to support trauma informed care and the like. So just really appreciate your time this afternoon and the work that Dr. Fenwick and others are doing.

Dr. Hayes: So one other thing—I got one minute—I didn’t mention and that is that VSignals which some research folks are not very familiar with but is a survey that goes out to veterans. It goes out to…it’s actually oversampled. It goes out to at least 50,000 women. Has a number of questions added. One that we added about a year ago saying, do you feel comfort and respect on your last visit? We’re not sure exactly what it’s measuring, but we now have a lot of data, so we have trends. There’s already questions about trust and there’s a new question that was just added saying, did you feel safe at you last VA visit.   
  
And interestingly the men have been putting back comments saying, I don’t understand this question. Why are you asking that? But we’re still waiting for a lot of the data to come in on whether people feel safe. And it may fit with that culture as being accepted too. We’re not sure that it correlates exactly with experiences of harassment. It may be that people still feel somewhat safe even though they’re being harassed. But it’ll be an interesting thing to follow as we go forward. I sincerely appreciate the ongoing work of these researchers and the others that are working in this area and our partnership with you all as we tackle this difficult subject area.

Dr. Yano: Thank you Dr. Hayes. Dr. Fenwick just wanted to check to see if you had any closing remarks you’d like to make before we close the session out today.

Dr. Fenwick: No, thank you so much Dr. Hayes for those points that you made. I thought that all of them were important and really appreciated you bringing up some of the upcoming things or some of the ideas in terms of facility level cultural change. I think having a committee at each facility would be really helpful, especially because we know that most people say, one VA is one VA. And so harassment can look really different depending on which VA we’re talking about. And also the need for some structural changes and the recovery interventions for what happens next if a patient does report and does go to the patient advocate. So thank you so much for highlighting those among other things and for being here today to give some context to this work and share your views.