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**STATEMENT OF
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FOR THE RECORD
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
UNITED STATES HOUSE OF REPRESENTATIVES
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Mr. Chairman and members of the Subcommittee:

Thank you for inviting DAV (Disabled American Veterans) to submit testimony for the record on this important hearing looking at the Department of Veterans Affairs (VA) support for survivors of military sexual trauma (MST). DAV is a non-profit veterans service organization comprised of more than one million wartime service-disabled veterans that is dedicated to a single purpose: empowering veterans to lead high-quality lives with respect and dignity.

The discussion on this issue is critical as the health and well-being of far too many veterans—both male and female—has been negatively impacted because of this type of personal trauma. Many DAV members use VA's specialized mental health services and rely on the veterans health care system to assist them in recovery from their post deployment mental health challenges.

Sadly, the most recent report (2018-2019) from the Department of Defense (DoD) Sexual Assault Prevention and Response Office (SAPRO) confirms there is increased prevalence of sexual assaults among service members in the active force and at military service academies between 2014 and 2018.

In fiscal year (FY) 2018, growing rates of sexual trauma were reported by all branches of the armed forces. Over a one-year period, 6.2% of service women and .7% of service men reported experiencing MST. Rates of exposure for service women ranged from a low of 4.3% in the Air Force to a high of 10.7% in the Marines. For service men, the rates ranged from a low of .5% in the Air Force to a high of 1% in the Marines. In all cases, these rates are higher than those reported in 2016.¹ The rates also far exceed the 1.6% of women in the general population who have experienced

¹ 2018 Workplace and Gender Relations Survey of Active Duty Members. DoD Office of People Analytics. Defense Sexual Assault Incident Database, and DoD Sexual Assault Prevention and Response Office.

rape in the preceding 12 months (numbers of men were too low to be considered representative).²

In addition, in the same survey, more than 24% of service women and 6% of service men reported experiencing sexual harassment during the past year of service. Significant numbers of service members who reported experiencing sexual trauma also reported experiencing harassment.

The impact and aftermath of sexual assault or harassment can be devastating and long lasting and many veterans turn to the Veterans Health Administration (VHA) following military service for treatment to address conditions such as post-traumatic stress disorder (PTSD) or depression related to MST. VA has a universal screening policy for MST to help identify veterans who may require treatment for health conditions associated with personal trauma.

According to VA, in FY 2019, 142,929 or 30.6% of female veterans and 80,884 or 1.7% of male veterans seen for health care at a VA facility reported a history of MST when screened by their VA health care provider. Because of differences in the definition of MST in VHA, which also includes sexual harassment of a repeated and threatening manner, these numbers may not directly correspond with those reported by the military.

Every VHA health care system provided MST-related outpatient care to both women and men in FY 2019, with more than 2 million MST-related outpatient visits provided. VA has specialized, high-quality mental health care to include a full range of outpatient, inpatient and residential services. Individual and group therapy is available at Vet Centers, VA medical centers and some community-based outpatient clinics.

VA also has designated MST coordinators at each VA healthcare system to assist MST survivors seeking care. The MST Coordinator position is a collateral role which can make fulfilling the responsibilities of this position difficult. DAV encourages the Subcommittee to investigate whether MST coordinators have adequate time to fulfill their responsibilities and required duties and, if not, ensure that VHA receives adequate resources to designate a full time employee to this critical position at all facilities. In addition, VA has developed specialized programs for eating and substance use disorders and intimate partner violence, which can be co-occurring issues for many MST survivors. DAV would like to see VA make information about accessing these programs more accessible to veterans who may need them, including the clinicians that may refer them to such care.

DAV's 2018 report, *Women Veterans: The Journey Ahead*, detailed the story of DAV member and Navy veteran, Leeia Isabelle, who, like so many survivors, did not report the crime against her claiming she wanted to "bury it and make it go away."

² Prevalence and Characteristics of Sexual Violence, Stalking and Intimate Partner and Sexual Violence Survey, United States, 2011. Centers for Disease Control and Prevention. Sept.5, 2014.

“I was just going through the motions and I wasn’t really fully engaged in my life,” she reported. Seeing the negative effects that MST had on her relationships and overall well-being motivated her to begin the long road to recovery for which she credits VA group therapy with other women veterans, cognitive behavioral therapy, and involvement with DAV. Leeia’s story is typical of many veterans with PTSD. Chronic symptoms of feeling numb, hypervigilant, anxious, irritable, and a lack of interest in the people or activities that once brought them joy can be overwhelming. These changes can strain relationships, threaten employment, lead to homelessness and isolate them from their families and communities.

Public Law 113-146, the Veterans Access, Choice and Accountability Act of 2014, required VA to report on its treatment of conditions caused or exacerbated by MST, specifically identifying the differences in treatment of men and women with these conditions. The most common diagnosis among those screening positive for MST for both men and women is post-traumatic stress disorder (55.4% and 58.3%, respectively) followed by depressive disorders (39.2% and 48.7%). Substance abuse is the next most common diagnosis for men (15.6%) while anxiety follows for women (18.7%).³

VHA routinely uses cognitive behavioral therapy and rapid eye movement desensitization therapy, which are identified as effective treatments for veterans with PTSD due to a personal trauma. Most importantly, VHA primary care and mental health staff complete mandatory training for treating veterans with MST-related PTSD. This specialized training includes a focus on gender-specific issues that may arise in treating veterans of both sexes. VA also conducts education that highlights the importance of sensitivity to the needs of both male and female veterans who have experienced MST. VHA policy “strongly encourages” facilities to allow veterans to seek care from a provider of their preferred sex when clinically appropriate, but VHA maintains that there are benefits to be derived from both gender-exclusive and gender-neutral MST care settings and that men and women seeking care may request either of these types of care settings. Peer support specialists can also be helpful in assisting veterans with treatment engagement, goal setting and identifying motivators to move forward with their recovery. DAV urges VHA to use the broadest latitude in allowing veterans who have experienced MST to choose the sex of their provider.

All health care providers conducting VA disability examinations must also complete MST-specific training that addresses gender-specific issues for both male and female veterans. This is an especially important policy that directly affects veterans filing disability claims for conditions resulting from MST. For years, DAV heard complaints from women veterans who believed their disability claims for MST-related PTSD were being erroneously denied. Based on continued complaints from women veterans, VBA took action following an initial review and assessment of MST-related claims and established a specific protocol for development and adjudication of such claims.

³ Department of Veterans Affairs. Report on Treatment and Services Available for Military Sexual Trauma in Response to Section 403 of PL 113-146.

VBA guidance created in 2011 requires that the same-sex MST Coordinator at the regional office ask the claimant if the incident for which he or she is seeking compensation was reported. If so, the MST coordinator determines how best to obtain the incident report and does so. Veterans Service Representatives (VSRs) contact veterans to follow up by letter if MST coordinators are unable to reach the veteran by phone. VSRs are also charged with gathering evidence in support of claims. In the case of claims for MST they are also required to obtain all military personnel files and in addition to advising claimants of alternative evidence that may be provided to substantiate the stressor such as journals, or statements of confidants or clergy who were aware of the incident around the time it occurred.

Once received, VSRs review the evidence to confirm the stressor and also identify any additional “markers” in military or other records that may indicate the stressor took place around that time such as a request for transfer, changes in job performance, changes in behavior such as increased use of leave or medical care, documented pregnancy tests, or recognition of new medical or mental health conditions. If any markers are present, a medical exam must be ordered. Claims should not be denied unless there is no evidence of a stressor, or of a behavioral marker or of symptoms of a mental health disorder that may be related to MST.

Once again, reports surfaced that VBA was falling short in upholding its own guidance that better assures fair adjudication of claims for MST-related PTSD.⁴ The Inspector General (IG) found that since VBA ended its practices of special queuing and audits for claims of PTSD related to MST, progress it made in correcting inequitable awards has been lost.⁵ In 2018, the IG determined, based on VBA policy, that almost half (46%) of MST-related claims reviewed were processed incorrectly, and that almost half of denials (49%) were not processed correctly meaning that, had the adjudicated claims been processed appropriately, the claimant may have been awarded compensation and with it received higher priority for VHA health care treatment.

The IG recommended reestablishing specialized queues for MST and other claims requiring special handling, reestablishing an additional level of “special focused” review for complex claims, and updating training manuals and claim development checklists for adjudicators. We request the Subcommittee verify if VBA made changes based on recommendations in the IG report to ensure these claims are being adjudicated correctly.

DAV fully supported the IG’s recommendations and adopted DAV Resolution No. 043 at our 2019 National Convention, urging VA to conduct rigorous oversight of its adjudication personnel and review of data to ensure the present policy and practices for evaluating disability claims associated with military sexual trauma, are being faithfully

⁴M21-1 Adjudication Procedures Manual, Part IV, Subpart ii, Chapter 1, Section D, topic 5, Developing Claims for SC for PTSD Based on Personal Trauma.

⁵ VA Office of Inspector General. Denied PTSD Claims Related to Military Sexual Trauma. VA OIG 17-05248-241. August 21, 2018, p.2.

followed and standardized in all VA regional offices. Last year, DAV also testified in support of legislation, H.R. 1092, the Servicemembers and Veterans Empowerment and Support Act of 2019. This bill would help to ensure that VA adheres to current policy regarding the adjudication of claims for mental health conditions, including PTSD, associated with MST. Unfortunately, Congress has not taken any further action on H.R. 1092 or the Senate companion bill, S. 374.

VA reports that information about MST-related treatment and disability compensation is provided to every transitioning service member as part of the Transition Assistance Program and is available through key DoD resources like the Safe Helpline. Information is also provided as part of the Separation Health Assessments that VA conducts. We are pleased that VA engages in extensive outreach efforts to make sure MST survivors know help is available and that VA has specialized programs and treatment for recovery, but we want to ensure there are policies in place for a “warm handoff” of MST survivors between DoD and VA.

Likewise, we are pleased that VA has established a Women’s Mental Health Mini-Residency and National Reproductive Mental Health Consultation Program. These burgeoning programs cover a broad range of topics related to the treatment of women veterans, such as understanding suicide risks in female patients and working with women whose mental health problems are influenced by hormonal changes. This type of training helps to increase a clinician’s competency to provide gender-sensitive care to women veterans and should be fully supported and resourced appropriately.

Another factor that adds complexity to the issue of MST is reported patient-to-patient harassment on VA grounds. Sexual harassment creates a significant barrier to care for many women veterans seeking treatment. According to a recent study of women veterans one of every five women veterans seeking VA care reports facing harassment (considered unwanted comments or behavior) from male veteran patients.⁶ Researchers found that women veterans who reported experiencing harassment were more likely to have experienced MST and to miss or delay care because of these incidents.

Stranger harassment can create significant anxiety for veterans who have previously experienced trauma and in fact be re-traumatizing. This may occur anytime individuals who have experienced trauma in the past are exposed to environmental “triggers” that remind them of a traumatic incident, including sexual trauma or harassment. In health care settings, the potential for triggers can be heightened—i.e., exposure to practitioners of the opposite sex or a new clinician, tight spaces where it is difficult to maneuver or exit easily, having to undress for a clinical examination in unsecured areas or where privacy is limited. VA must work to improve how it addresses and remedies safety, privacy and culture deficiencies reported in annual environment of care surveys and better assure that entrances to VA facilities are harassment-free zones and that all clinical space is private, secure and welcoming to all patients.

⁶ Klap, R., et al. “Prevalence of Stranger Harassment of Women Veterans at Veterans Affairs Medical Centers and Impacts on Delayed or Missed Care.” *Women’s Health Issues* 29-2 (2019). 107-115.

VA has responded to complaints by developing the Stand Up to Stop Harassment! Campaign. The initiative aims to educate patients about what constitutes harassment and how staff and others can help stop harassment or intervene as necessary. While more details about the campaign are forthcoming, DAV is eager to assist in the Department's efforts to address this problem, including seeking enactment of the Deborah Sampson Act (H.R. 3224), which includes provisions that require VA to develop a strategy for responding to and stopping stranger harassment at VA facilities.

Finally, because some women veterans must receive a significant amount or all of their gender-specific care in the private sector, VA should work to ensure that its community care partners are also aware of the high prevalence of MST in the veterans' population. VA's Community Care Network (CCN) providers should be required to complete training in dealing with trauma-exposed veterans—and use full-time MST coordinators to help assist with such training. CCN clinicians should also be made aware of VA's national MST-related training webinars conducted throughout the year and about VA's annual conference, both of which routinely address gender-specific issues. Veterans will be able to form more trusting and satisfying relationships with an assigned primary care provider (PCP) and VA must ensure that it designates PCPs for each woman veteran in its care.

While progress has been made and there are many excellent programs and supportive services offered by VA to assist MST survivors in recovery—oversight is still necessary to ensure timely access to high quality care for MST-related conditions is available at all sites of care.

Mr. Chairman, this concludes my statement. I am happy to answer any questions you may have.