

**STATEMENT OF
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OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEES ON HEALTH AND ON DISABILITY ASSISTANCE
AND MEMORIAL AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
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Messrs. Chairmen and Members of the Subcommittees:

Thank you for inviting the Disabled American Veterans (DAV) to testify at this joint oversight hearing focused on collaboration between the Department of Veterans Affairs (VA) and the Department of Defense (DoD) to better address military sexual trauma (MST) and to identify better ways to treat and properly compensate veterans for conditions related to MST. We also continue to express a fervent hope that DoD is effectively addressing methods to prevent and in fact eliminate the incidence of sexual assaults and harassment within all branches of the military services.

This hearing takes on a topic that is extremely personal and sensitive to many service members, veterans and the respective Departments that are responsible for the safety and well-being of their members. Sexual trauma is not a "sex crime." It is a violent personal crime perpetrated against an innocent and unwilling person, and attended by both physical and mental legacy wounds. In that sense, the title of today's hearing, "Healing the Wounds," is most appropriate. When a service member is wounded by enemy rifle fire or mortar shrapnel on the field of battle, as a society we are shocked and dismayed by the sacrifice and loss of our wounded military personnel, but when someone is wounded by sexual violence, society responds in a very different way. We hope this hearing can begin to heal these deep wounds that are often invisible but have profoundly changed the lives of those affected.

**MILITARY SEXUAL TRAUMA:
AN UPHILL BATTLE FOR VA DISABILITY COMPENSATION**

An area of concern for DAV relates to veterans' compensation claims for disabilities resulting from MST. The prevalence of sexual assault in the military is alarming and has been the object of numerous military reports, media coverage, and Congressional hearings over the past decade and before. Service members who have suffered MST often do not report these assaults during their military service, but many do experience lingering physical, emotional and psychological scars and symptoms following these incidents. Unfortunately, many men and women who experience these types of trauma do not disclose them to anyone until years after the fact.

According to VA, during fiscal year (FY) 2009, 21.9 percent of women and 1.1 percent of men screened by the Veterans Health Administration (VHA) reported MST. We note, however, that the size of each VA clinical population gender cohort (women to men) who reported military sexual trauma within VA treatment programs is almost equal: 53,295 women and 46,800 men, respectively.¹

Another VA study found that of 125,000 veterans screened, about 15 percent of Operations Enduring and Iraqi Freedom (OEF/OIF) women veterans who use VA health care, reported experiencing sexual assault or harassment during their military service.² VA research also indicates that men and women who report sexual assault or harassment during military service were more likely to be diagnosed with a mental health condition. According to VA, women with MST had a 59 percent higher risk for mental health problems, with the risk among men slightly lower, at 40 percent.³ The most common conditions linked to MST were depression, post-traumatic stress disorder (PTSD), anxiety and adjustment disorders and substance-use disorders.

Unfortunately, if an assault is not reported by the victim during his or her military service, establishing service connection later on for disabling conditions related to MST can be daunting. These claims are frequently denied by the Veterans Benefits Administration (VBA) due to lack of required documentary evidence to support the occurrence of a personal assault stressor. Although VHA provides comprehensive treatment for nearly 100,000 MST victims, many would be eligible for compensation benefits but are unable to support their claims with documented evidence of the stressor incidents. According to an Institute of Medicine (IOM) National Research Council report on PTSD compensation, significant barriers prevent women from being able to independently substantiate their experiences of MST, especially in combat arenas.⁴ The IOM report concluded that little research exists on the subject of PTSD compensation and women veterans specifically. The committee noted that available information suggests that women veterans are less likely to receive service connection for PTSD and that this is related to being unable to substantiate noncombat traumatic stressors such as MST. The committee further noted that VA administrative procedures and rules for adjudicating and rating these types of cases address MST related PTSD claims but that little attention is paid to the unique challenges of obtaining documentation of an in-service stressor.

In 2005, the DoD established the Sexual Assault Prevention and Response Office (SAPRO). This organization is responsible for all DoD sexual assault policy and provides oversight to ensure that each military service branch complies with DoD policy. SAPRO serves as a single point of accountability and oversight for sexual assault policy, provides guidance to the DoD components, and facilitates the resolution of issues common to all military services and joint commands. The objectives of DoD's SAPRO policy are to specifically enhance and improve: 1) prevention through training and education programs; 2) treatment and support of victims; and 3) system accountability.

Under DoD's MST confidentiality policy, active duty victims of sexual assault have two reporting options-*restricted reporting* and *unrestricted reporting*. Restricted reporting allows a sexual assault victim to confidentially disclose the details of his or her assault to specified

individuals and to receive medical treatment and counseling, *without triggering any official criminal or civil investigative process*. Service members who are sexually assaulted and desire to file a restricted report under this policy may only report the assault to the Sexual Assault Response Coordinator (SARC), Victim Advocate or an appropriate health care personnel member. According to SAPRO, health care personnel will initiate the appropriate care and treatment, and report the sexual assault to the SARC in lieu of reporting the assault to law enforcement or to the victim's unit commander. Upon notification of a reported sexual assault, the SARC will assign a Victim Advocate to the victim. The assigned Victim Advocate will provide information on the process of restricted versus unrestricted reporting. At the victim's discretion, appropriately trained health care personnel will conduct a sexual assault forensic examination (SAFE), which may include documentation of the injuries and collection of physical evidence. According to SAPRO, in the absence of a DoD provider, the service member can be referred to an appropriate civilian facility for the SAFE [examination].

According to DoD, unrestricted reporting is recommended for victims of sexual assault who request *an official investigation of the crime* in addition to treatment and counseling. When selecting unrestricted reporting, these victims permit current reporting channels to be used, e.g. notifying the chain of command, military police or civilian law enforcement, reporting the incident to SARC, or requesting health care personnel to notify law enforcement. Upon notification of a reported sexual assault, the SARC assigns a Victim Advocate. At the victim's discretion, health care personnel may conduct a SAFE examination, with similar collection of information and potential physical evidence. According to SAPRO policy, personnel access to details regarding the incident are limited to those who have a legitimate need to know.

In FY 2009, DoD reported an 11% increase from the prior year in all categories of sexual assault reporting. There were a total of 3,320 reports to DoD in FY 2009, with 2,516 unrestricted and 714 restricted reports. These reports represent the largest annual increase DoD has seen since yearly data collection began. The rise is attributed to DoD's release of its MST social marketing campaign last year, and SAPRO officials have stated they believe their message appealing for more reporting of MST within the ranks of the active force is achieving breakthrough and generating this recent jump in reporting. Since June of 2005, when the Department implemented the new restricted reporting option for victims of MST, SAPRO has documented 3,486 restricted reports having been filed.⁵

While DoD reports that it prefers complete (meaning, unrestricted) reporting of sexual assaults to activate both victims' services and law enforcement actions, it recognizes that some victims desire only health care and support services, without command or law enforcement involvement. The Department states its first priority is for victims to be protected, treated with dignity and respect, and receive the best possible medical treatment, counseling and care. DAV acknowledges that DoD policy, but we also want to protect MST victims' rights and benefits when they transition to veteran status.

DAV's primary concern is that VA be able to access the *restricted* DoD records documenting reports of MST for an indeterminate period. On several occasions over the past two years, DAV has contacted VBA and SAPRO staff to try to verify that the organizations are

collaborating to ensure access to these records, if authorized by the veteran, in support of a VA benefits claim for conditions related to MST. It is my understanding that they have spoken but that to date there is not an official policy, process or Memorandum of Understanding (MOU) in place to secure such records. To establish service connection for PTSD there must be credible evidence to support a veteran's assertion that the stressful event actually occurred. Once a claim is filed VA has a number of standard sources it examines for records to support a claim for a condition secondary to personal trauma or MST. However, we do not see SAPRO-related reports listed in any of VA's training and reference materials/manuals for developing claims for service connection for PTSD based on MST. At this juncture we are unable to confirm if VBA unofficially searches for "restricted" reports as an alternative evidence source for information to substantiate the veteran's claim. VA does list medical reports from civilian physicians or caregivers who treated the veteran immediately after the trauma as alternative evidence to seek out in these cases; however, we do not know if VBA staff developing these claims are aware of DoD SAPRO policies and would contact the veteran to see if a restricted report was in fact filed, a physical examination conducted and if follow-up medical or mental health treatment records exist.

To maintain confidentiality in the case of restricted reporting, DoD policy prevents release of MST-related records, with limited exceptions. Also, VA is not specifically identified as an "exception" for release of records in DoD's policy, and it is unclear if VA could gain access to these records even with permission of the veteran. Nevertheless, DoD does list VA as an advisor to the DoD Sexual Assault Advisory Council or (SAAC), a council that coordinates policy and review of the Department's sexual assault prevention and response policies and programs. We also have questions with respect to where and how physical assessment records that are completed following the assault and subsequent mental health treatment records related to the restricted MST reports are kept and for how long. It does not appear that these reports, whether restricted or unrestricted, are archived in the individual's official military personnel record, even subsequent to discharge from active duty. We are concerned that VBA adjudication staff may not be aware or attempt to gain access to these records that for privacy reasons are being kept separate from victimized service members' medical treatment and personnel records. Additionally, we are not clear on how each military service branch maintains these records. According to DoD policy, *physical* evidence collected associated with a restricted report of the event is destroyed after one year if the service member or veteran does not wish to pursue civil or criminal sanctions against the perpetrator. However, we are not aware of the policies for maintaining DD Form 2911 (Forensic Medical Report Sexual Assault Examination form) completed by the examining clinician following the reported assault. The information on this form would in many cases validate the stressor associated with subsequent PTSD or other mental health consequences of MST.

We hope to confirm with the Subcommittee's oversight that VA is indeed fully collaborating with DoD to ensure veterans who have suffered MST and have filed claims for benefits for related conditions gain VA's full assistance in accessing these important records in support of their claims for disability. Additionally, we concur with the recommendation made in the 2008 report of the VA Advisory Committee on Women Veterans that suggested VBA identify and track claims related to personal assault/MST to determine the number of claims

submitted annually, grant rates, denial rates, and types of conditions most frequently associated with these claims. The committee stated that development of tracking systems could further guide studies on research on all aspects of MST. Finally, we ask that VBA provide the Subcommittees any information it has in its reference materials for claims developers/raters that reflect its collaboration with DoD/SAPRO and guidance to MST-related claims developers on how to access supporting documentation from each military service in the case of both restricted and unrestricted reporting options, including any differences in records retention, security and disposal policies.

VBA REQUIREMENTS FOR MST-RELATED CLAIMS

Establishing a veteran's service connection for PTSD requires: (1) medical evidence diagnosing PTSD; (2) credible supporting evidence that the claimed in-service stressor actually occurred; and (3) medical evidence of a link between current symptoms and the claimed in-service stressor.

However, if the claimant did not engage in combat with the enemy, or the claimed stressors are not related to combat, then the claimant's testimony alone is not sufficient to establish occurrence of the claimed stressors, and his or her testimony must be corroborated by credible supporting evidence. If a PTSD claim is based on in-service personal assault, evidence from sources other than a veteran's service records may corroborate a veteran's account of the stressor incident. Examples of such evidence include, but are not limited to: records from law enforcement authorities, rape crisis center, mental health counseling centers, hospitals, or physicians; pregnancy tests or tests for sexually transmitted diseases; and statements from family members, roommates, fellow service members, or clergy. Additionally, evidence of behavioral changes following the claimed assault is one type of relevant evidence that may be found in these sources. Examples of behavioral changes that may constitute credible evidence of the stressor include, but are not limited to: a request for a transfer to another military duty assignment; deterioration in work performance; substance abuse; episodes of depression, panic attacks, or anxiety without an identifiable cause; or unexplained economic or social behavioral changes (title 38 C.F.R. § 3.304(f)(4).)

Unfortunately, in many cases, even when the veteran has been diagnosed with PTSD based in part on claimed in-service sexual trauma, his or her claim is denied because there is no independent evidence (credible supporting evidence) to corroborate their statements as to the occurrence of any claimed in-service stressor. Even in cases where a VA physician indicates that a veteran was being followed for symptoms of military related sexual trauma, these lay and medical statements do not constitute credible supporting evidence. For more information, see *Moreau v. Brown*, 9 Vet. App 389, 396, (1996), wherein the court concluded that corroboration of an in-service stressor cannot consist solely of after-the-fact medical nexus evidence.

As noted above, to receive disability compensation for an MST-related condition, the standard of evidence is stricter than for combat injuries, or even for military occupational injuries. Service connection for a condition related to MST is important on a number of levels. Specifically, veterans with service connection have improved access to VA health care—for

veterans with VA disability ratings of 50 percent or more disabling—access to VA health care for any condition. Disability compensation can also make a tremendous difference in a disabled veteran’s financial status. Finally—and most importantly for many MST survivors—being rated service connected for mental and physical disabilities attributed to MST represents validation, connotes gratitude for their service to their country and recognizes the tribulations they endured while serving.

COUNSELING AFTER MST: AN OPEN DOOR FOR VA TREATMENT

In accordance with section 101 of Public Law 103-452, the Veterans Health Programs Extension Act of 1994, any veteran self-reporting a history of in-service sexual trauma is eligible for VA health care for conditions related to that trauma. In compliance with this mandate, all patients are screened for MST, and treatment is available for MST-related conditions at all VA health care facilities. Service connection or disability compensation *is not* required for eligibility for this treatment, and veterans in these MST programs are exempt from co-payments for care provided.⁶

We congratulate VHA for making available on its website, <http://www.mentalhealth.va.gov/msthome.asp>, clear and concise information related to definition, screening and treatment for MST. VHA notes that both men and women have experienced MST during their military service, and that *all* veterans seen in the VA health care system are screened and asked about experiences of sexual trauma. VA provides a fact sheet to answer commonly asked questions including the commonality of MST and ways MST can affect veterans. VA also includes a list of possible signs and symptoms survivors of MST may experience, and most importantly, the website provides information on how and where veterans who experienced MST can get help from VA. Information is provided regarding the Women Veterans Program Managers, the MST Coordinators and VA’s general benefit information hotline. VHA’s website, outreach posters and brochures clearly indicate that VA provides confidential counseling and treatment for mental health and physical health conditions related to experiences of MST, all without copayment. VA also holds that service connection or disability compensation is *not* required to receive VA MST treatment, and that a veteran need not have reported the incident, nor have documented that it occurred, to obtain these services. In some cases a veteran may be able to receive VA MST treatment even if he or she is not otherwise eligible for VA care.

We are pleased that VHA makes a point to convey that recovery from personal trauma is possible; and that VA has the resources and services to help veterans through this extremely difficult challenge. We acknowledge the many experts, specialized research conducted and programs that have been established through the VA’s National Center for PTSD, many of which are focused on MST and its consequences in mental health of victims. Nationwide, VA offers specialized MST inpatient and outpatient services, and evidence-based treatments and counseling by specially trained sexual trauma counselors in its Vet Center community-based facilities. Veterans can also request a same-sex provider if it makes them feel more comfortable in their counseling sessions.

In testimony before the Health Subcommittee on March 9, 2009, VA testified that it had established an MST support team in VA Central Office to monitor MST screening and treatment, oversee MST-related education and training, and promote best practices for screening and treatment.

Despite this progress, VHA staff across the nationwide system needs to be more sensitive and knowledgeable and recognize the importance of environment of care delivery when evaluating these veterans for their physical and mental health conditions. For years we have encouraged VHA to develop a MST provider certification program, guarantee at least 50 percent protected time for MST coordinators to devote to position responsibilities, provide separate and secure women's subunits for inpatient mental health and residential services, ensure privacy and safety, and improve coordination with the DoD in transition of veterans, especially those with complex behavioral health needs related to MST. The Government Accountability Office (GAO) released a GAO "Watchdog Report #12" on April 7, 2010, in which GAO's Director of Federal Health Care stated: "One challenge is a [VA] difficulty in hiring primary care providers with specific training and experience in women's health. For example, officials at many VA facilities we visited noted they had difficulty attracting mental health care providers with experience in treating post-traumatic stress disorder and military sexual trauma, which are prevalent [among] women veterans." Based on the continuing reports we have received from our National Service Officer (NSO) corps and veterans themselves, DAV strongly endorses GAO's observation.

We are pleased that Public Law 111-163, the Caregivers and Veterans Omnibus Health Services Act of 2010, recently approved by the President, includes a provision to mandate graduate education, training and certification for VA mental health providers delivering counseling, care and services for MST-related conditions, to ensure veterans have access to mental health clinicians with specialized expertise in this unique area. DAV urges VA to promptly begin implementation of the MST Congressional mandate in Public Law 111-163, to begin to address some of these unmet needs.

In 2007, VA's National Center for PTSD published the first-ever randomized controlled trial to assess PTSD treatment for active duty women and women veterans. In the study, the women who received prolonged exposure therapy had greater remissions of PTSD symptoms than women who received present-centered therapy. Additionally, the prolonged exposure group was more likely than the present-centered therapy group to no longer meet the criteria for a diagnosis of PTSD and achieve total remission. However, mental health experts report that these case-intensive treatments *are not* universally available at VA medical centers (VAMCs) nationwide. This study documented the importance of spreading this evidence-based practice throughout VA's system. DAV is pleased that VA has developed a program to train its mental health providers to provide the most effective treatment for PTSD due to sexual trauma and combat trauma and is examining how best to address complex combat and MST issues.⁷ However, further expansion of these training programs is still needed.

HOMELESS WOMEN VETERANS AND MST—A SPECIAL CONCERN

Finally, we note another area in relationship to MST that warrants the Subcommittees' attention. VA has excellent programs for homeless veterans but women veterans present some unique challenges for VA within those programs. Frequently women are reluctant to take advantage of VA's stellar programs such as transitional housing, substance-use disorder programs and residential rehabilitation and treatment programs, due to *personal safety concerns* and because often they are the sole or primary caretakers of minor children. In some facilities VA has struggled to maintain a welcoming, *secure and safe treatment setting* especially for women who have serious mental illness and/or have been victims of MST.

According to VA, the overall number of homeless veterans has been declining (now approximately 131,000 on any given night), but the number of homeless women veterans has nearly doubled to 6,500 over the last decade, about five percent of the total homeless veteran population. In a recent newspaper report, VA was cited as reporting that overall, female veterans are now between two and four times more likely to end up homeless than their civilian counterparts.⁸ This alarming jump is coupled with the report that 1 in 10 homeless veterans under the age of 45 are women, and as more veterans return from deployments in Iraq and Afghanistan, these numbers are expected to rise. Combat-related stress and MST are both risk factors for homelessness. These women present unique challenges to the VA system, designed for use primarily by men, and very few VA facilities have homeless programs designed specifically for women, and none are able to accommodate children. It is also noted that about 75 percent of these female veterans have been victims of sexual abuse and many have substance-use and mental health problems that require specialized care. Programs and treatment services for mental health, MST, substance-use disorders, and maintaining independent housing and gainful employment are all essential to this vulnerable population. Therefore, we must ensure that VA programs are properly adjusted to meet the unique and growing needs of women veterans and ensure that women have equal access to these specialized services.

SUMMARY

In summary, DAV recommends the Subcommittees provide oversight to ensure VA, DoD and SAPRO work collaboratively to develop a joint policy directive and system for each military service branch to maintain and share with VA when needed critical medical records related to MST cases; provide service members information on how and where to access these records and information about VA benefits and services should they decide in the future to file claims for disability compensation with VA for conditions related to MST. We also ask that VBA provide the Subcommittees any information it possesses in its reference materials or guidance for claims developers and raters that reflect VBA's collaboration with SAPRO, as well as any guidance to claims developers working on MST-related claims on how to access supporting documentation from each military service branch in cases of both restricted and unrestricted reporting options, including acknowledgements of differences in records retention across branches, and security and records disposal policies within the DoD service branches.

Unfortunately, we continue to see increasing numbers of service members and veterans who report MST and seek care from VA as well file claims for disability compensation through our NSO corps. One of DAV's central purposes is to aid veterans in obtaining fair and equitable VA compensation for their service-related disabilities. We believe our NSO corps provides a premier service to help veterans rebuild their lives, and we have aided millions of veterans since the founding of our organization. In this one particular area, however, our NSOs are deeply frustrated at the routine occurrence of MST claims being denied for lack of evidentiary documentation. For these reasons and more, it seems to DAV that the agencies that are responsible for monitoring and reporting on MST, and providing benefits and services to victims of MST, as well as preventing the problem at its source, to work in concert to lower the burden of this claims process and ensure service members and veterans are fully assisted by the government and their advocates in securing the benefits they deserve and have earned. We believe this issue can be resolved internally by the respective agencies involved through a memorandum of understanding agreed to by both parties, or through some other mechanism short of a new statutory mandate, if they simply agree to work in a cooperative spirit on a seemingly very solvable problem.

Finally, we recommend the Subcommittee on Health request VHA provide a report to the Subcommittee on its safeguards and efforts to ensure all women veterans and especially women veterans with combat-related stress and/or MST histories have access to secure and safe treatment settings in all VA facilities and programs. As indicated above, MST is not a "women's issue" in VA; however, VA is still primarily populated with men and male oriented. As such women's safety, security and comfort must remain a special concern.

Messrs. Chairmen, again we thank you for the opportunity to share our views at this important hearing focused on healing the wounds of military sexual trauma—and your efforts to identify ways to improve treatment and properly compensate veterans for conditions related to MST. We appreciate the attention to these issues and hope the Subcommittees will consider the issues of concern and recommendations we have brought forward in our statement. Thank you once again for the opportunity to provide testimony at this hearing. I would be pleased to address your questions, or those of other Subcommittee members.

¹ Amy Street, PhD., Dept of Veterans Affairs, National Military Sexual Trauma Support Team; *DVA Response to MST*, "PowerPoint presentation for the DCOE Webinar Series, April 22, 2010.

² Dept of Veterans Affairs; *VA Research Currents*. Nov-Dec 2008.

http://www.research.va.gov/resources/pubs/docs/va_research_currents_nov-dec_08.pdf

³ Ibid.

⁴ Institute of Medicine and National Research Council of the National Academies, Committee on Veterans' Compensation for PTSD, Board on Military and Veterans Health, Board on Behavioral, Cognitive, and Sensory Sciences; *PTSD Compensation and Military Service*, 2007.

⁵ Dr. Kaye Whitley, Director, Office of the Sec. of Defense, Sexual Assault Prevention and Response Office; *Sexual Assault in the Military*, PowerPoint presentation for the DCOE Webinar Series, April 22, 2010.

⁶ Dept of Veterans Affairs, Office of the Inspector General; *Health Care Inspection, Review of Inappropriate Copayment Billing for Treatment Related to Military Sexual Trauma*, February 4, 2010. <http://www4.va.gov/oig/54/reports/VAOIG-09-01110-81.pdf>

⁷ Dept of Veterans Affairs News Release; *Health Care Report Card Gives VA High Marks*, June 13, 2008.

⁸ Bryan Bender, The Boston Globe; *More Female Veterans Are Winding Up Homeless*, July 6, 2009.

http://www.boston.com/news/nation/washington/articles/2009/07/06/more_female_veterans_are_winding_up_homeless/