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THE RELATIONSHIPS BETWEEN MILITARY SEXUAL ASSAULT, POST-TRAUMATIC STRESS DISORDER AND SUICIDE, AND ON DEPARTMENT OF DEFENSE AND DEPARTMENT OF VETERANS AFFAIRS MEDICAL TREATMENT AND MANAGEMENT OF VICTIMS OF SEXUAL TRAUMA

HEARING

BEFORE THE

SUBCOMMITTEE ON PERSONNEL

OF THE

COMMITTEE ON ARMED SERVICES
UNITED STATES SENATE

ONE HUNDRED THIRTEENTH CONGRESS

SECOND SESSION

FEBRUARY 26, 2014

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WEDNESDAY, FEBRUARY 26, 2014

U.S. SENATE,
SUBCOMMITTEE ON PERSONNEL,
COMMITTEE ON ARMED SERVICES,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:02 a.m., in room SR–222, Russell Senate Office Building, Senator Kirsten E. Gillibrand (chairman of the subcommittee) presiding.

Committee members present: Senators Gillibrand, McCaskill, Blumenthal, Hirono, Kaine, King, Graham, and Ayotte.

OPENING STATEMENT OF SENATOR KIRSTEN E. GILLIBRAND, CHAIRMAN

Senator GILLIBRAND. The subcommittee meets today to receive testimony about the relationship between military sexual assault, post-traumatic stress disorder (PTSD) and suicides, and the Department of Defense (DOD) and Department of Veterans Affairs (VA) medical treatment and management of victims of sexual trauma.

There is zero doubt that sexual violence is occurring at an unacceptable rate within our military. Too often, our service men and women find themselves in the fight of their lives not in a theater of war, but in their own ranks, among their own brothers and sisters.

While Congress is not in full agreement on the extent of the reforms required to solve this crisis, last year's National Defense Authorization Act (NDAA) took positive steps forward, including 36 separate provisions to address sexual assault in the military, which were supported unanimously, and additional important legislation is still under consideration, including my bill, the Military Justice Improvement Act.

No matter where any one person falls in this debate, we can all agree that we must fully understand the long-term psychological toll on the survivors of sexual trauma in the military and the best practices for effective treatment.

Sexual assaults are obviously very traumatic events for victims, traumatic events that have long-lasting, frequently lifelong consequences, including PTSD and suicides. Heath Phillips, a constituent of mine, shared his experience with me recently.

Heath grew up in a family that was devoted to the military. He joined the Navy shortly after he turned 17 and was excited to be part of the Navy family. When he reported to his duty station after boot camp, there was no one there to register him. So they told him he would have to come back.

He met a couple of other sailors from the ship and went into New York City with them. They went out drinking, and he blacked out. When he came to, the other sailors were sexually assaulting him. They threatened him and told him no one would believe him.

He went back to the ship, where he reported the assault, only to be told that it was his own fault because he had been drinking and that he was lucky to not be in trouble for underage drinking. The sexual assaults continued aboard the ship. When his commanders allowed these assaults by his shipmates to continue without any repercussions, Heath went absent without leave (AWOL).

Ultimately, he accepted a dishonorable discharge to end his torture. Not only was he suffering from PTSD, which led him to flee the ship, but now he is not eligible for VA benefits.

It is stories like these that motivated me to have this hearing. I want to make sure this doesn't happen to anyone else and that people like Heath aren't forced to choose between their mental health and the benefits they have earned from the United States Government.

This is not just an issue of anecdotal evidence. One study of Iraq and Afghanistan veterans found that, "Female veterans with a history of military sexual assault or harassment were five to eight times more likely to have current PTSD, three times more likely to be diagnosed with depressive disorders, and two times more likely to be diagnosed with alcohol use disorders compared to female veterans without military sexual trauma (MST)."

Another study of Iraq and Afghanistan veterans seen at the VA found that women and men who reported a history of MST were significantly more likely than those who did not to receive a mental health diagnosis, including PTSD, other anxiety disorders, depression, and substance use disorders.

I also want to address today how DOD and the VA handling of sexual assault reports impact survivors' mental health. The VA's own Web site says that how the military handles military sexual assault has actually made PTSD worse.

"Many victims are reluctant to report sexual trauma, and many victims say that there were no available methods for reporting their experiences to those in authority. Many indicate that if they did report the harassment, they were not believed or encouraged to keep silent about the experience. They may have had their reports ignored or, even worse, have been themselves blamed for the experience. Having this type of invalidating experience following a sexual trauma is likely to have significant negative impact on the victim's post-trauma adjustment."

I am alarmed by the following statistic, as should every person in this room. On average, 22 veterans commit suicide every single

day. Twenty-two brave men and women commit suicide every single day.

It is critical that we look at the links between sexual assault and harassment and PTSD and its role in the intolerable number of suicides. Today, the subcommittee meets to discuss these links, their consequences, and how they are addressed.

On our first panel, we have two survivors of sexual assault. Lance Corporal Jeremiah J. Arbogast, who is medically retired from the Marine Corps, and Private First Class Jessica Kenyon, who served in the U.S. Army. We have invited them to tell us about their experience as survivors of sexual assaults that occurred while they served in the military.

Did they suffer from PTSD? Did they consider suicide? If so, what kind of help did they receive to address these conditions? We hope to learn what worked, as well as what didn't work, and what we in the U.S. Senate can do to improve the care of survivors when sexual assaults unfortunately occur.

On the second panel, we have DOD and VA officials who will testify about the programs DOD and VA have in place to address the needs of sexual assault survivors, including medical therapies for PTSD and suicide prevention efforts of these departments. We understand that DOD and VA maintain an evidence-based joint clinical practice guideline on the management of PTSD. We would like to learn more about how this works in practice and how DOD and VA ensure continuity of care when victims transition from Active Duty to veteran status.

From DOD, we have Dr. Karen S. Guice, the Principal Deputy Assistant Secretary of Defense for Health Affairs; Ms. Jacqueline Garrick, Director of the Department of Defense Suicide Prevention and Response Office; and Dr. Nathan W. Galbreath, Senior Executive Adviser, Department of Defense Sexual Assault Prevention and Response Office.

From the VA, we have Dr. Susan J. McCutcheon, National Mental Health Director, Family Services, Women's Mental Health and Military Sexual Trauma; and Dr. Margret E. Bell, Director of Education and Training, National Military Sexual Trauma Support Team.

I would like to thank all of you in advance for your testimony and for your dedication on behalf of our servicemembers. These are not easy issues to deal with, but they are real consequences of these horrific crimes that are far too common in our military.

There is no greater responsibility for Congress and the military leaders than to care and provide for our servicemembers and their families. The Nation entrusts their sons and daughters to our military, and we must ensure that their service is safe from sexual assault, and if they are assaulted, that they receive best care and treatment possible while at the same time holding perpetrators accountable for their criminal actions.

I look forward to the testimony of our witnesses on the first panel. I encourage you to express your views candidly and to tell us what is working and what is not working. Help us to understand what we can do to address this unacceptable problem of sexual assaults in the military.

I want to thank Senator Graham. It has been a privilege to work with him as ranking member of this subcommittee. I have great admiration for Senator Graham's passion on behalf of our military servicemembers and families. When he joins us, he can deliver his opening remarks.

Mr. Arbogast, would you like to read your testimony?

STATEMENT OF LANCE CORPORAL JEREMIAH J. ARBOGAST, USMC (RET.)

Mr. ARBOGAST. Madam Chairman, distinguished members of this subcommittee, I am saddened to be here, but thankful for the opportunity to share my testimony. I wouldn't be here without the love and support of my amazing wife and caregiver, Tiffany Arbogast.

Before I begin, I want to acknowledge the MST survivors who struggle day-to-day with losing their will to live while fighting for much-needed benefits, stability, and validations for the crimes committed against them, along with the MST victims who are no longer with us due to suicide.

I am a medically retired lance corporal who served in the U.S. Marine Corps. I am compelled by my oath to speak out about the injustices that have been done to survivors. The oath that I took has no expiration date. I urge each of you to stand with survivors of military sexual assault and to take proactive steps to fix the broken system of justice and survivor response.

I am a male survivor of MST. I was drugged, rendered incapacitated, and sexually assaulted by my former staff sergeant from a previous command, a fellow marine, while on Active Duty. After this heinous crime, I was humiliated at the thought of my helplessness while a man and fellow marine took advantage of me sexually.

After 2 months of nightmares, anxiety, depression, and confusion, my world as I knew it was falling apart. I feared being blamed and retaliated against, and I was embarrassed. With the last shred of dignity, I turned to a base social worker, who felt it was her obligation to report the sexual assault to the Naval Criminal Investigative Service (NCIS).

When NCIS started the investigation, they informed me I needed to provide proof of the assault. I felt humiliated because other individuals were now aware of what happened.

At a point during the investigation, I was forced to provide proof by confronting my rapist to try to get a confession. I was asked to make repeated recorded phone calls and then go to his home while wearing a body wire. I asked him to tell me what happened. I got a full confession.

My perpetrator was arrested and charged with several counts, including sexual assault and sodomy. The trial lasted a week.

Even with overwhelming evidence, the court found him guilty of lesser charges. The court decided he would receive a bad conduct discharge, no jail time, and they took his 23 years of service as kudos.

He was ordered to NCIS headquarters for fingerprinting, where they determined he had gnawed the skin from his fingertips on both hands so he could not be fingerprinted. He refused to register

on the sex offenders database by simply saying, "No, I don't have to."

Nothing was done, and to this day, I don't know where my perpetrator is. Not knowing his location leaves me looking over my shoulder for the rest of my life.

I was not afforded the same rights as rape victims in the civilian world. Where are my choices?

While my perpetrator walked away with minimal consequences, I was formally retired from the U.S. Marine Corps due to MST and PTSD. I joined the Marine Corps in order to serve my country as an honorable man. Instead, I was thrown away like a piece of garbage.

According to the American Psychiatric Association, 90 percent of all rapists and serial rapists will commit an average of 3 to 600 rapes in a lifetime. This is not just a problem within the military. It becomes a societal and national security risk to us all.

While I tried to survive and hoped that my life would get better, even years later, the constant stigmatization, personal attacks, ostracism, and PTSD was never ending. Choosing death was my way of taking responsibility for my circumstances. I simply haven't found the resources to cope.

I sit here before you in this wheelchair due to a spinal cord injury that resulted in paraplegia from a self-inflicted gunshot wound from a 9mm handgun. I felt my death would spare my wife, daughter, and myself the dishonor the rape brought upon us.

This should send a clear statement of just how bad things can get in the lives of sexual assault survivors when they feel no hope and are not being offered the appropriate clinical support needed for them and their families. The Armed Forces were severely remiss and still are today in the treatment of MST survivors.

The VA healthcare system is overloaded and fails to keep up with the sheer growing number of MST victims. The VA mental health system lags in offering male MST survivors male-specific support groups, which is badly and urgently needed for millions of male veterans suffering from MST.

Twenty-two veterans are taking their lives every day, only 12 of which are combat related. The American Psychiatric Association estimates that men who are denied proper counseling after rape are likely to attempt suicide at least twice in their lifetime. Therefore, DOD and VA providers and all military leaders need specific training in the nuances of trauma-related sexual assault, human sexuality, and the different effects of rape on both men and women.

The belief system about rape must change within the Armed Forces, and it will only change when the perpetrators are consistently prosecuted and no longer given leniency in their sentencing by their commanders.

In a recent article in the Military Times, a DOD Sexual Assault Prevention and Response Office (SAPRO) official was quoted as saying, "We need to tell perpetrators 'don't rape.'" This approach will not stop rape in the military. You can't train rapists not to commit rape, but you can stop them from harming anyone else. Haven't we heard enough stories of broken lives and lives lost that have been told in front of these committees?

This is an epidemic. In 2012, approximately 14,000 men and 12,000 women were sexually assaulted in the Armed Forces, according to DOD's own Sexual Assault Prevention and Response Report. DOD has been claiming to try to fix this problem for over 20 years and to no avail. Sorry to say we cannot take the attitude of wait and see, not even for 1 more year, which was the recommendation from our Commander in Chief.

Half measures do not work, and neither do false promises. We need Congress to move past ego and political stalemates. These perpetrators must be stopped from continuing in their planned acts of terrorism against their fellow servicemembers. We need a justice system that ensures these criminals are held accountable for their crimes and prevented from victimizing any other servicemembers.

The first step to fixing this problem and ensuring the health and welfare of our servicemembers must be creating a professional impartial justice system because sexual assault is not an occupational hazard. I and countless others have lost so much in this battle. These losses are nothing unless DOD and VA leadership hear our pleas for more accountability, an end to victim blaming and retaliation, and access to humane care for survivors.

Our servicemembers deserve the same duty, honor, and courage from you in solving this epidemic and its consequences that they have shown through their selfless sacrifices for this country. We expect nothing less from Congress when it comes to accountability in providing adequate care to our Nation's warriors. Your help is needed so our military can continue to be the finest fighting force this world has known.

Before I close, I would like to leave you with some words from Gandhi. "You must be the change that you wish to see in this world."

Thank you.

Senator GILLIBRAND. Thank you. Next, Ms. Kenyon.

STATEMENT OF JESSICA KENYON, FORMER PRIVATE FIRST CLASS, USA

Ms. KENYON. Distinguished members of the subcommittee, I want to thank you for having me and affording me the opportunity to speak today. I feel it is my duty, as someone who is able and willing to speak on behalf of myself and those who are unable.

I want to thank my loving husband, Brendan Brinkman, for his continued efforts in supporting me through this extremely difficult struggle, being there throughout unconditionally. I also want to thank the rest of my family who has been there for me and those families who do all they can for other survivors with very little support for themselves.

I joined the military as an Apache crew chief in 2005, a year after the implementation of the new sexual assault regulations. During the initial training, none of us received any training about what to do regarding a real sexual assault situation. The truth was, at that point, I had to Google what to do when it happened to me.

I immediately experienced the flaws and repercussions. From there, it was instance after instance of a failed system in which I became ostracized, singled out, publicly shamed, disciplined for get-

ting treatment, and treated as though I was the one who did something wrong.

From my experience, I can speak clearly to the loopholes in the current system that allows commanders, perpetrators, investigators, and anyone with outside influences and conflicts of interest to distort justice and degrade military discipline and readiness.

These loopholes perpetuate a current state of affairs that when a case is handled or mishandled, I, like many others to this day, can be made an example of and held up as what will happen if you report anything. This shows other victims, as well as perpetrators, how their crimes will be handled.

This prompted me to leave the military and inspired me to expose the injustices they allow. I did not want anyone else to be put through what I was put through, but I also saw the potential for much worse situations, and I could not stand for it whether I was ready to leave the military or not. Given the situation I was put in, I felt no other option than to regretfully leave the military.

My work to help other survivors and families and fix this broken system is my way to continue to serve our country. Since my honorable medical discharge, I have worked with thousands of veterans, Active Duty servicemembers, and their families.

I currently suffer from severe depression, bouts of insomnia, debilitating memories, thoughts, triggers of all sorts, anger, chattering in my head, constant anxiety to the point that I am forced to use all of my focus to appear normal, which hinders my abilities to read, write, have a conversation, and remember much of anything in the short term. This level of keeping my head above water is where I have found what passes for a level of peace.

While I do hope to improve it, it is a very hard road, and some days I am not able to maintain my composure, and my husband and loved ones bear the brunt of it. I have to live with that guilt every day. I am just praying my son doesn't ever know me like this or, worse, what I was like before I gained some balance.

Most of my scars are invisible. So my needs are treated as less than important.

The current command environment makes it hard to keep outside influences away from all criminal cases in a command, regardless of the commander's view or the unit's view of them as commanders. Removing all judicial punishment decisions from the command will keep them clear of all repercussions, including to their command, their career, and the general morale of the unit.

Leaving judicial punishment with commanders is not just a problem in the mishandling of sexual assault cases with the victim blaming, and I have experienced it as well as others. A command environment is simply not a top-down environment.

A new commander may take command in an established structure, and the disruption of the structure, regardless of how honorable their intentions, can lead to challenges in that command. This removal of judicial punishments from the command would remove conflicts both to and from the commander.

This also prevents a commander from lessening the charge to whatever keeps it in the command or at its lowest levels, either out of concern that the accused's talents would be lost or the command would look bad.

As of right now, there is no accountability for those who mishandle cases. But even if the commander wants to do the right thing, there is often pressure from the top to make it go away or downplay the severity. Discipline problems within a command will usually be reflected on the service record and cost them promotions. This is not an environment for justice for victims, for perpetrators, or commanders.

As it currently stands, the VA handles sexual assault in the military similar to civilian cases. But it is critical to note psychologically they are very different. I have found it is much closer psychologically to the results of incest and should be treated as such.

As a civilian, sexual assault does not address the inherent trust victims give their command, nor the betrayal of that trust when a sexual assault occurs and the subsequent case is mishandled. This continues to be true even if the case is handled properly.

Survivors of sexual assault, like many others who suffer from PTSD, are rarely in a state emotionally, financially, or otherwise, to navigate the complex and detailed paperwork and procedures that the VA requires for rating. This paperwork barrier to receiving assistance often exacerbates the survivor's issues and all too often drives them to the point of poverty, homelessness, alcohol and drug abuse, and much, much more.

Rather than proper counseling, it is often the case that medications are prescribed. Many times, pills are almost immediately prescribed by various VA caregivers with no experience of what they might actually do to the mental health of the individual other than the list of warnings, which are often not taken seriously.

These mountains of drugs are also being mixed and matched constantly and most of which were never supposed to be mixed with anything other, let alone the numbers in which the VA doles them out. It is not uncommon to hear of veterans being prescribed dozens of medications at a time.

In more than a few cases, caregivers will refuse treatment if an individual refused to take the prescribed drugs, despite their helping or making things worse. The survivors have little to no recourse if things were to go wrong.

For those of us who do not wish to be drowned in psychoactive drugs, many of our cases are left to wither and our wellness opportunities are hard to come by or are too expensive or unavailable. There is no right way to have PTSD, and therefore, cookie-cutter treatment is not what is most needed. Offering and supporting programs and caregivers outside of the VA would go a long way to lifting their burden.

I also want to point out that servicewomen are more than twice as likely to have PTSD, but only half as likely to get diagnosed with it. They are more likely to be diagnosed with a personality disorder or an adjustment disorder.

Thank you.

Senator GILLIBRAND. Thank you very much for your testimony.

I would now like to turn it over to the ranking member. Senator Graham?

STATEMENT OF SENATOR LINDSEY GRAHAM

Senator GRAHAM. Thank you, Madam Chairman.

I appreciate both of your testifying before the subcommittee.

I think there is almost unanimous support, I would hope, in the Senate for finding a way to provide treatment to people who have been victims of sexual assault. I know it has to be one of the most traumatic experiences one could go through, and I do appreciate your sharing with us what you see as flaws in the current system, the VA counseling.

I really look forward to hearing from the second panel. I think there have been some major monumental changes in the military about how we deal with this problem in terms of reporting, treatment, and awareness.

The one thing I would say, with all due respect to our witnesses and to my fellow colleagues, from my point of view that this is a problem that will never be solved if you tell the commander, "this is no longer your problem."

I have been in the military for 31 years. I do believe that the role of the commander, when it comes to dispensing military justice, is essential, and there is accountability in the reforms we have made.

That when sexual assault cases are brought to a commander and they refuse to prosecute after a lawyer says we should go forward, that decision goes all the way up to the Secretary of the Service. When the lawyer and the local commander say no to moving forward in an allegation of sexual assault, it goes up to the next level of command, which I think is a very good signal to take this seriously.

I would just say to both witnesses, from a military point of view, to tell the commander that this is no longer your problem, would be an absolute disaster for fixing the problem and, I think, erode what the military is all about. It is the commander's problem. It is their responsibility, and we expect them to do their job.

Thank you both, and thank you, Madam Chairman. I look forward to hearing from the next panel.

Senator GILLIBRAND. Thank you very much for your testimony.

I want to talk a little bit about the type of mental health services you did receive. Mr. Arbogast, could you talk a little bit about what type of mental health treatment you received through DOD after your assault and whether you thought it was adequate care, if there are any improvements specifically to that?

Then, after separating from the military, what was the mental health treatment like at the VA? Were there any challenges, any inadequacies there? What recommendations would you make to this subcommittee for DOD or VA to improve the type of mental health services you receive after a sexual trauma?

Mr. ARBOGAST. Thank you.

After my assault, I was pretty much tossed to a back room, I would say, and just left floating around a command after I was transferred. As for care, I didn't receive adequate care from DOD at all for the simple fact is, at the time of my rape, you felt like a dirty little secret that they just wanted to do away with.

The psychologist at Walter Reed Bethesda, they wanted to either put you in groups that were either combat related or other mental illnesses. When you are in these groups and you are talking about this, you just don't feel comfortable talking about it.

Then they move you to outpatient care, which is the same thing. They throw drugs at you, and it could be four or five different prescription drugs. The thing is, is they don't want you to commit suicide, but what are the side effects of these medications? For a lot of these medications it is suicide.

As for DOD, they did absolutely nothing for me but just pretty much gave me a 30 percent discharge from DOD for PTSD and sent me on my way. As for the VA, I only saw one counselor through my whole therapy, who was not trained in MST. He mostly treated Vietnam vets.

I looked for different treatment facilities and different programs at my VA hospital. They were women-oriented, which was fine. But then I asked what can they do for men? She said, "Well, we don't have a men's group yet. We are still in the process of putting that together." This was just last year.

So her recommendation was to go through cognitive therapy, and that is traveling down every day for 6 weeks. That is 90 miles from my home.

Senator GILLIBRAND. After you attempted suicide, what type of treatment did you receive then? Was it a different kind of treatment, or did you receive better care through the VA?

Mr. ARBOGAST. I received—with my spinal cord injury and my paralysis, I receive excellent care regarding that. I go to Richmond at Hunter Holmes McGuire VA Medical Center for their spinal cord clinic, and it is top notch.

Their psychologists there are very good listeners, but again, they are not trained about MST. You bring it up, and they are like "oh." That is like their first thing, their first expression. At that point, you feel like—I am just this dirty thing that they happened to stumble on.

Not that I am downing any of them, it is just the fact that it is a stigma that I feel personally when you get a reply of "oh," when you say that you were sexually assaulted.

Senator GILLIBRAND. Thank you.

Ms. Kenyon, can you share with us your experience in terms of what type of mental health treatment you received and whether it was better in the VA or whether it was better in Active Duty under DOD and whether your records were transferred well, and what impact that treatment had on you?

Ms. KENYON. Yes, thank you.

During my Active Duty service, the recommendation was to go to mental health, and whenever I did, I would get a counseling statement for not doing my job. So after one or two, I believe, I stopped going because of the repercussions in my command.

Senator GILLIBRAND. Did your case go to trial, Ms. Kenyon?

Ms. KENYON. It did not. The Army Criminal Investigation Command (CID) investigated, and he denied everything. Then he was caught lying on his sworn statement later, and they gave him a charge of lying on a sworn statement and indecent assault. He was given an Article 15 punishment and extra duty. So he had no jail time, he lost rank, and that was it.

But my repercussions and the fact that I could not go to treatment, I was punished for going to treatment. So I did not pursue it while I was in the military. However, when I went out, I did.

When I was discharged, I did try to go to the VA multiple times and was redirected to other locations, other services, and eventually gave up.

I restarted recently trying to get more help and get support. What I have found in helping myself and other veterans, is that good counselors are the stuff of legends. They are always 50 miles away.

Survivors are always saying, "I heard of this magical counselor somewhere out of reach." Those types of things happen and are told to other veterans, and they do try and pursue them. But if they are any good, they have a very long list.

Senator GILLIBRAND. A wait list. During your trial, were your mental health records used?

Ms. KENYON. Not to my knowledge, and it was just my commander, it was no formal trial.

Senator GILLIBRAND. Do you know, Mr. Arbogast, if your mental health records were used in your Article 32 hearing or during your trial?

Mr. ARBOGAST. I am not quite sure. But they did use mental instability. The defense tried that approach when they drilled me on the stand.

Senator GILLIBRAND. But your trial was unique. You had taped evidence——

Mr. ARBOGAST. Correct.

Senator GILLIBRAND.—of your perpetrator admitting the crime of drugging you and then raping you. So you had more of an airtight case. But again, for those who joined our hearing later, your assailant received no jail time.

Mr. ARBOGAST. None. Due to his 23 years of service, they thought that was kudos for him. To me, it was disgusting because——

Senator GILLIBRAND. Which is one of the reasons why members of this subcommittee are working so hard to remove the good soldier defense.

Mr. ARBOGAST. Right. I think that is very important because of the simple fact of when I am brought in and I am told that, "oh, well, he is just a lance corporal. I am a staff sergeant. This is how many years I have served." Then you use that good soldier defense, then that weighs upon the jury or the judge, whoever has the case.

Then they are like, "oh, well, he has had this one case." But that doesn't mean that he hasn't had cases in the past.

Senator GILLIBRAND. Thank you.

Senator Graham?

Senator GRAHAM. Thank you very much.

Do both of you agree that if you had access to civilian counseling services, that would be beneficial—if the VA would pay for it?

Ms. KENYON. If I had a little more choice outside of where I did not feel I had to go to the VA and possibly endure other male soldiers who are always threatening to me—it is just a trigger—I do believe that I could see the benefit in not only other outside counselors, but other alternative healthcare, as prescriptions are not sufficient.

Senator GRAHAM. Do you know of anything in your local community that you think would be beneficial to you?

Ms. KENYON. I have heard and seen a lot of benefits to things like meditation or yoga—in combination with a counselor—push through balance and well-being and taking those triggers and those moments of panic and being able to maintain them much better.

Senator GRAHAM. I don't want to butcher your last name. Lance Corporal?

Mr. ARBOGAST. Arbogast, Senator.

Senator GRAHAM. Arbogast. Do you think that would be helpful to you to have access to civilian counseling if VA is inadequate?

Mr. ARBOGAST. I actually do that. I use my TRICARE and Medicare to do that because of the VA counselors not having that expertise.

Senator GRAHAM. Okay. So TRICARE does provide that access to you?

Mr. ARBOGAST. Correct.

Senator GRAHAM. In your case, Ms. Kenyon, that is not the case?

Ms. KENYON. I currently do not receive anything like that, and I pay out-of-pocket for any counseling.

Senator GRAHAM. Okay. Did you get a disability rating at all?

Ms. KENYON. I have not received a rating.

Senator GRAHAM. Is that still ongoing?

Ms. KENYON. It is still ongoing, Senator.

Senator GRAHAM. Okay. What was the date of your assault? Do you recall what time period?

Ms. KENYON. I hate to say this, but which one?

Senator GRAHAM. I mean the one that is the subject of the Article 15.

Ms. KENYON. The one that received the most justice, I suppose, would be in July 2006.

Senator GRAHAM. 2006. Now you said you received letters of counseling going for treatment. Is that correct?

Ms. KENYON. Yes, Senator.

Senator GRAHAM. Would you be willing to make those letters available to the subcommittee?

Ms. KENYON. If I have received a copy of them, I will.

Senator GRAHAM. Okay. I would like to see the letter of counseling, who wrote it, and what they said, if possible.

[The information referred to follows:]

Ms. Kenyon was unable to provide copies of the letters of counseling as requested by Senator Graham.

Senator GRAHAM. Thank you both. I hope that we can find a way to broaden the treatment options available for those who find themselves in your circumstances. I think there are a lot of things outside the VA, outside DOD, that may be beneficial not just in this situation, but in other situations, but particularly in this situation.

Thank you for sharing your testimony with the subcommittee.

Senator GILLIBRAND. Senator Hirono?

Senator HIRONO. Thank you, Madam Chairman.

Thank you both for testifying this morning.

One of the concerns that this subcommittee and the full committee has is the fact that thousands and thousands of these sexual assaults occur, and they are never reported. Would you share with

us particularly from your own experience why this is so, and what we can do to enable more of the survivors to report these crimes?

Starting with you, Mr. Arbogast.

Mr. ARBOGAST. Senator, could you elaborate that question again?

Senator HIRONO. The figures are some 22,000-plus sexual assaults occur in the military in a given year, and only a very insignificant number of these crimes are ever reported to the chain of command. I wanted to ask for your thoughts on why this is so, and what we can do to enable more people to report these crimes, enable more servicemembers to report these crimes.

Mr. ARBOGAST. In DOD, reporting to the chain of command, it is horrific. It could be a perpetrator in your chain of command. It could be your direct supervisor.

In my case, it was my previous supervisor. He used his influences to try to get to me, torment me over the time that I was raped and to the time that the investigation was going on.

Then I endure going to his home wearing a body wire, and then I had to endure the Article 32. Then I had to endure the court martial. So you can see the patterns of different traumas that I was subjected to.

Anybody that would see something like that, any servicemember would be like, I am not going to report this. The VA finds thousands of veterans a year that finally report MST, and I don't have the exact numbers, but I know it is alarming.

Regarding taking it out of the chain of command, I have talked to some Active Duty commanders, and they have specifically said if I don't have to deal with sexual assault and I can continue going on with what my mission is, to make the unit ready and deal with these everyday problems of what needs done in whatever their command is, whether it be engineering, motor, or transport, they would like to do that, concentrate on that. Because a sexual assault is more or less a burden on the command, and then it creates a morale problem and a cohesion problem.

It is just that is the only thing I can think of that would get that, and going back to my testimony where it says that SAPRO official made the comment that, let us just tell perpetrators: "don't rape." Okay. So you get all the perpetrators in a room and tell them "don't rape," but you are still going to allow them to serve?

Senator HIRONO. I note in your testimony that one of those observations you made is that there should be some very specific specialized training in working with survivors of MST. I do agree with you because on the civilian side, there are many States that require prosecutors, for example, to get very specialized training when they deal with rape victims, for example. Apparently, that is something that you would suggest for the military.

Ms. Kenyon, would you like to give us your thoughts on my question?

Ms. KENYON. Yes, thank you, Senator.

I would add, generally, sexual assault is underreported in the civilian world as well and that is not to disregard the military environment in which makes it even more hostile.

I would also point out that I can only correlate it with to make an understanding, who would a cop report a rape to within their own that wouldn't cause other police officers to possibly spread a

rumor? That is the only civilian thing I could possibly think that would correlate with a perversion of justice this way.

I would also stop publicly putting posters up with rape myths like "wait until she is sober." These types of things are a different type of candy-coated victim blaming.

There are a lot of studies in regards to the perpetrators being repeat offenders. They prey on this. It is not a sexual act. It is a power act. It is not about the sex. It is about usually taking victims down a notch.

Senator HIRONO. Would you agree it should also be treated as a crime?

Ms. KENYON. Oh, absolutely.

Senator HIRONO. That is what it is. You work with survivors of MST. So during the period when you had to undergo repeated traumas, have there been some positive changes to how the military helps survivors of MST?

Ms. KENYON. I do believe the 2004 implementation of the SAPRO office, despite it not having power, the option to report unrestricted and restricted did open a few doors. However, the loopholes are so great that the command can still exploit them regardless.

For example, if you were a survivor of sexual assault and you wanted to go to a counselor, but you reported restricted, which is all within your rights, what would you tell your commander? Giving that information to a commander allows them to investigate it and go further with an unrestricted report whether they cooperate or not. This was threatened to me.

Already being ostracized based on a previous investigation, I could not allow the commander who threatened to question everybody in my hangar—that is 260 people—and create that kind of environment which everybody knew what was going on, not just most of them.

Senator HIRONO. So while there have been some improvements, then given the severity of the problem, more can be done?

Ms. KENYON. We have a very long road ahead, it is an amount of baby steps. I do hope that we can take it step-by-step, and public prosecutions will go a long way to showing both victims and survivors or perpetrators as justice can and will be done.

Senator HIRONO. You, too, support removing the chain of command from the decision to prosecute these crimes?

Ms. KENYON. Absolutely. I believe that there is enough on the commander's plate, and the fact that there is just entirely too many conflicts of interest, and even if they do want to do the right thing, there is pressure from every direction that creates an almost impossible environment in which justice could be served, and I hate to say this, but even to the perpetrators.

Senator HIRONO. Thank you.

Thank you, Madam Chairman.

Senator GILLIBRAND. Senator Kaine?

Senator KAINE. Thank you, Madam Chairman.

Questions in two areas that have been raised by just listening to your testimony and answers to questions. First, I will just thank you for being here today. This is hard to do, and I appreciate your courage in coming and letting us ask questions so that we can understand the situation and better decide how to improve it.

Ms. Kenyon, you raised a point in your testimony, and I want to make sure I understood what you meant. You said that you think to some degree, sexual assault in the military gets treated like any other sexual assault, a civilian sexual assault. You said that you thought the better analogy was an incest analogy, and I just want to make sure I understood what you meant when you said that.

Ms. KENYON. Absolutely. Thank you.

I love talking about this in regards to how I even talk to survivors who contact me. In doing that, the betrayal aspect that is very uncommon in the civilian sexual assault is one of the reasons that I left the military feeling, almost crushingly, the betrayal of my command.

We are at this point an all-volunteer military. So they go in, and there is an inherent trust. There is a trust in the system. You are fighting next to your brothers and your sisters. These guys are in charge of your well-being, your food, your exercise, your clothes, everything. Everything in the same psychological aspects as an adult that it would be as a child.

Boot camp is literally there to break you down, to build you back up as a soldier, an airmen, et cetera. That being said, if you were assaulted by your brother, which in many cases psychologically is quite similar, you go to your father, your commander, and what if he didn't want to report it. How would you deal with that?

It is very easy for victims to start blaming themselves because they don't know the perpetrator. So I teach them about the perpetrator so they can put the blame where it belongs and process that correctly.

Both of those go a long way into getting into the right head space long enough so they can work through this bureaucratic system, which is extremely difficult, and it is like a safe. If you get it wrong, you have to start over.

Senator KAINE. So that is very helpful to understand the analogy, the environment that creates a bond. It is not only a crime of violence, but it is also a betrayal of a relationship. So whether in the civilian context, whether it is incest or whether it is sexual assault by someone you know, which a huge percentage of sexual assaults in the civilian context are. The survivors tend to know the perpetrator.

Ms. KENYON. Right.

Senator KAINE. There is an additional betrayal element. That helps me understand what you meant.

Both of you, Ms. Kenyon, in your testimony and, Corporal Arbogast, in one of your answers to the question, you touched upon a topic that I want to have each of you address a little bit. That is the issue of in the treatment phase, concerns that you both have about overmedication.

I just was curious. Is that a concern that you have about the way PTSD is treated from sexual assaults or a more general concern you are sharing with us about the way DOD or VA approaches mental health issues? This is part of a much larger discussion, obviously, about the way we as a society tackle mental health issues. Are we too heavy into just take this prescription and then take two or three more?

I am curious as to whether you think that this might be really focused on the PTSD issue, or is it a more general kind of complaint about the way we do mental health in the military context?

Mr. ARBOGAST. Thank you, Senator.

That context not only goes with combat-related PTSD to MST PTSD. You hear from both groups that they are overly medicated, and you have severe side effects to all these medications.

So you go to these appointments, and you get these medications, you have 6-month gaps before you see a psychologist or psychiatrist. So there are too many long gaps there. Then when you go there, you spend 5 minutes in their office.

So if you live far away, you travel 90 minutes to spend 5 minutes in an office for them to, "Oh, we are going to throw this drug at you," or "We are going to throw that one at you." Like I said before, these side effects are just astronomical in what they can cause.

Ms. KENYON. Thank you, Senator.

Definitely I can speak personally in the PTSD realm. However, in the survivors that I have dealt with, it does bleed over into other—when it comes to like traumatic brain injury (TBI), to any sort of personality disorders, any diagnosed depression, all of these just get—any sort of pain even. Even if you say, "Oh, I hurt my foot," they will throw a pill at you, at least one.

What happens is it usually starts with one or two, "Oh, let us try this out." Like Jeremiah pointed out, there are long spans in getting back in; to take yourself off of some of these drugs is extremely dangerous, and to mix and match is also even worse.

Then you come up with new symptoms, saying, "Well, I dealt with this, but I still—now I feel like I am under water all the time." They will throw another pill at you instead of fixing the one that they previously gave you.

Senator KAINE. We are seeing a huge epidemic of things like heroin addiction these days in broader society that often begins with prescription drug addiction. Then prescription drugs are more expensive than heroin now, and so this prescription drug thing is a significant issue.

If I hear you correctly, as you describe it, you worry a little bit that this overmedication is driven by, we don't have enough counselors to meet with you enough, and so if it is going to be 6 months until you have an appointment, we have to do something. So, here, try this.

It is a stopgap. Probably isn't the best diagnosis, probably isn't the best strategy, but we have to do something because there are not enough counselors to deal with your mental health needs. So there is an issue of probably the number of counselors, the kind of training they get, and you worry that the medications are just being, "Here is something to get you by for a while."

Ms. KENYON. Yes, a band-aid, basically. Even then, it is a band-aid that could kill you.

Senator KAINE. Yes.

Ms. KENYON. Some of them are just—the medications snowball—I personally have looked this up, but I can't find accurate correlations with civilian versus military treatment in medications and how they are doled out. I think that would be important to study——

Senator KAINE. Yes.

Ms. KENYON.—as well as the survivors that have contacted me, out of curiosity, the ones who would volunteer their list of medications, and my husband being a neuroscientist, I hand them over. He says, "How are they still alive?" It is amazing to read just the side effects from some of these things.

Senator KAINE. My time is up, but I think that this raises an interesting area that we probably should explore. If we were able to determine, for example, that folks in the military who are seeking treatment for mental health issues, PTSD or others, were dramatically more medicated than those who were seeking mental health services in the civilian world, that would really strike a big alarm.

That would suggest to us that maybe something is not being done right, and the way you have made that testimony, you have pointed at a potential problem that we ought to explore further.

Thank you for your testimony today.

Senator GILLIBRAND. Thank you, Senator.

Senator McCaskill?

Senator MCCASKILL. Thank you. First and most importantly, I always stand in awe of those of you who have been victimized by this horrific crime and step out of the shadows and not only try to see justice, but then go on and try to do even more. I think while there are some policy differences in the Senate, I think we all are such fans of your courage and your tenacity. So I want to thank you very much for that.

As somebody who spent years as a sex crimes prosecutor and walked into the courtroom hand-in-hand with hundreds of victims, I am painfully aware of the shortcomings of victim services for this crime no matter where it occurs.

One of the things I wanted to visit briefly with both of you about is, first, I want to thank the military because I think it is the research and the recognition of PTSD that has allowed the civilian criminal justice system to begin to get their arms around the fact I think most of the victims I worked with in the late 1970s and 1980s and 1990s were suffering from PTSD, and those that were victims of domestic violence were suffering from PTSD. Our ability to treat this and prevent suicide as a result of this absolutely insidious illness should be at the top of all of our lists.

I think that at least now we are beginning to recognize the problem. We have a ways to go, obviously, with having the services tailored to the type of stress and trauma that has brought about this illness, and I think that is what we are all focused on trying to do now.

If either one of you at the moment you reported, whether it was to a social worker or at a hospital or wherever, whether restricted or unrestricted, if at that moment you had gotten your own lawyer whose only job was to look out for you, do you think it could have made a difference in terms of how you were treated as you navigated this difficult process and the services that you might have been provided?

Ms. KENYON. Thank you, Senator.

I do believe a lawyer would be helpful, especially one that is impartial and not in my command or any way related. I have personally been working on almost a type of Miranda rights where you

can go to anybody as a survivor of sexual assault, and they have to tell you what your rights are before you move forward.

That way, you didn't accidentally go to your commander, and then now you can't report restricted. I mean, that was something that happened to me and that my commander then later made promises that made me confident in the fact that he would lie to me.

That being said, between the lawyer as well as like just being very upfront, commanders, priests, clergy, lawyers, anybody involved in that system should be upfront with what a survivor is allowed to do at that point before he or she can make a decision in that regard.

Senator MCCASKILL. Do you think it would have helped you, Lance Corporal?

Mr. ARBOGAST. Senator, I really don't know because I was young at the time. I can't say because everything was fast paced.

Senator MCCASKILL. Right.

Mr. ARBOGAST. I went from falling apart to where do I go and going to a social worker and everything just trickling down from there. Was I told about anything about, hey, these are your rights, and you could have your own attorney, I think that would have helped as being somebody that was advocated that was not biased within the chain of command for the simple fact is, because you don't know if that person that may be advocating for you, or your so-called lawyer—I don't know if you are referring to a civilian lawyer or a military lawyer. But you don't know if that is a golfing buddy or somewhere down the line that they know each other, and they go back and tell your personal information.

Then where I have had this happen is people found out about my situation from being talked about, and it is like how did they find out?

Senator MCCASKILL. Right. I know that when I was a prosecutor, there were sometimes victims that declined to go forward even after we had gone through a lot of the process and I felt very strongly that the case could be successfully prosecuted. The victim, for a lot of reasons, including mental health issues, PTSD issues, said, "No, I am done."

At that moment in time, the lack of trust that victim may have had in me because I was part of a system. I was associated with the police, if they had had their own independent lawyer that would have been giving them advice just for them, a little bit like we do with court-appointed special advocates for children in the juvenile system in the civilian cases, where there is a lawyer, an advocate for the child that is not associated with any of the other parties in the conflict.

I am hoping that what we have done, which is remarkable that we are going to require this for all victims, is going to set a standard. First of all, this has never been done anywhere in the world. I am really hopeful that it will once again show the way to the civilian system that we have to find the resources. In the civilian system, the victims have no guarantee of any mental health services. None, zip, nada.

There is nothing there. A lot of them don't have insurance. So you have to try to cobble together.

I want to say we are determined to get rid of the good soldier defense. I am confident that is going to happen if not within the next month, then certainly with the next NDAA. I have not encountered opposition to this idea. So I want you to know that before you go.

Finally, we are going to work on this overmedication thing. When I went to Walter Reed after the big scandal there, and I went from room to room in Fisher House and other places over there, every single room, the dresser was all alcohol bottles and pill bottles, and I didn't see one sign for group therapy for addiction treatment. I began then realizing we have a huge overmedication problem when it comes to mental health in the military.

Mr. ARBOGAST. If I could ask you about your question about the attorney. You have my testimony about what I went through, going from reporting to the Article 32. I had nobody, nobody at all.

The thing is that when it came to court martial time, I was drilled. I am being traumatized so many times and being revictimized so many times. I had the prosecutor, but he can only do so much.

But when you are up there and you are getting drilled by this perpetrator's defense attorney, and they are playing the recorded tape that I got on him and saying, "Listen to this. Did you ask for this? You wanted this." The judge does not intervene, it was disgusting.

Senator MCCASKILL. Believe me, I have been in a courtroom as a prosecutor when a judge didn't intervene when there was inappropriate questions, when I have made the objection on rape shield statute and others. The judge just completely did not make the right ruling.

I think judges are better today than they were 20 years ago. We are working now to make sure that the victims today and going forward have that independent lawyer that can be there for them and advise them, and I am very excited about that reform. We all worked very hard on it together. I am really proud of it.

I don't think that how big it is actually has been comprehended by most people because we have been focused on a policy difference rather than on the monumental historic changes that we just got signed into law.

Mr. ARBOGAST. I believe it would help tremendously to have somebody there along supporting you because I had nobody.

Senator MCCASKILL. Right.

Ms. KENYON. May I say to have that as well, that person not be subject to rank. That is very important. I had lawyers who were captains or lieutenants, and they were unable to confront my commander because they were outranked. Or even the SAPRO office, who had no rank and were civilian, cowered under anyone with any bars on them. So to have independence somehow.

Senator MCCASKILL. We have to make sure that happens. You are absolutely right, Ms. Kenyon.

Thank you both very much.

Ms. KENYON. Thank you.

Senator GILLIBRAND. Thank you, Senator.

Interestingly, we have heard incidents where the special victims' counsels have been put in very difficult positions for that reason.

So that is something many of us are going to look into for the next NDAA. I have heard of cases where special victims' counsels have advised not to seek mental health treatment because of the concern it would be used in the Article 32 against them or at least advised you need to be aware that it could be used against you.

I have heard of cases where the question of whether one would report or not was debated because of fear of how they would be treated. I think we have to really look into empowerment of that specific person to make sure they can't be bullied. They can't be retaliated against themselves.

So I think that is something Senator McCaskill and other Senators and I are going to work on for the next round. I think it is really important.

Senator Ayotte?

Senator AYOTTE. I want to thank you, Madam Chairman, for holding this hearing.

I want to thank both of you for being here and for your courage in coming before us. So sorry for everything that you have been through, but to come here before us, it is really important because this issue is one that we want to work together to stop the occurrence sexual assaults in the military, but also to make sure the victims get the full support that they need.

I think this issue of special victims' counsel that Senator McCaskill and I and Senator Gillibrand and others on the committee have worked on is going to be a very important reform. One of the things that the reforms have, too, as well is making retaliation a crime under the Uniform Code of Military Justice (UCMJ). I think, as we go forward with implementing the special victims' counsel, this is something we should look at to make sure that it is clear that any kind of action against a victims' counsel that is helping a sexual assault victim should also be actionable.

I think that is an important thing so that everyone understands that retaliation against a victim is a crime under the UCMJ because we have just made it so. But also any retaliation against someone acting on his or her behalf should be as well, and I think that is something we can make sure as we look at this going forward.

The other issue that Senator McCaskill and I have and others on the committee have thought is really important is this idea of eliminating the good soldier defense. So I am hoping we do that this year. We have done a whole host of reforms, including the special victims' counsel. But this good soldier defense has no place in determining the outcome of these cases in the sense that your conduct should determine the outcome.

If you have committed a crime and have committed these horrible acts, then just because you were a good soldier doesn't mean you shouldn't be held accountable and fully accountable and have the appropriate sentence to go with the crime that you committed. I think that, in the civilian system, we have eliminated a lot of those things, and those reforms now I am hoping we will have some agreement on that. I think there is a lot of agreement to get that passed this year as well.

I just wanted to understand that as you talk about the overmedication issue and the transitions that you have made outside the

military, so how do we improve that transition process? What can DOD and the VA do to improve that transition process from your perspective and to make sure that you have the support system in place if you choose to leave the military and have been a victim of sexual assault?

Last week, I was up in New Hampshire visiting one of our veterans centers, and one of their charges is to treat victims of sexual assault. How do we make sure that that care is there?

I just wanted to get your thoughts on what we can do better on the transition from DOD, those who are leaving to the VA. Obviously, I have heard what you said about the overmedication issue within the VA system so that we are working, even though the Senate Veterans Committee will work on that, we can work on this, I think, in this committee, too. So I just wanted to get your thoughts on how we could do a better job.

Mr. ARBOGAST. Thank you, Senator.

I worked closely with and do adaptive sports with the Wounded Warrior Regiment for the Marine Corps. They have district injured support coordinators. I think the Marine Corps has made a huge step when it comes to that because not only do they follow from the time that they are in the Wounded Warrior Regiment there, to the civilian world, these district injured support coordinators that are still Active Duty who check in on the veterans.

I think that is crucial, and it is also an awesome concept when it comes to that. So that way, the veteran can pick up the phone and say, "Hey, look, this is going on." That desk officer or enlisted, whatever it may be, can contact their resources and make things move along.

So the Marine Corps has done tremendously when it comes to taking care of their wounded.

Senator AYOTTE. So maybe that is a model that we can look at also to make sure that is across Services?

Mr. ARBOGAST. I believe so, ma'am. Like I said, it has been pretty effective.

Ms. KENYON. I would say having the ability for the VA to talk to the DOD. That is something that is very broken right now. The records and the database in which they both work do not communicate at all, and that will go a long way to something as simple as a records transfer. That will help, as well as affording opportunities outside the VA, and I would almost even say a grace period in which PTSD sufferers could have proper assistance in getting themselves to a state of well-being and to navigate that complex system.

As I said, there is no right way to have PTSD, and so there is no real solution, here are my recommendations, and it will work for everybody. However, I think catering and having enough support, even if it was just a single counselor for one individual to help with paperwork to see that he or she receives the proper medications, that they are able to make appointments with one phone number and not sit on hold for days because——

Senator AYOTTE. For days, really?

Ms. KENYON. For hours and hours, and most of the time you give up, and then you try again tomorrow.

Senator AYOTTE. Wow.

Ms. KENYON. So, that does happen quite a bit. If it is okay, I would like to make a comment on retaliation?

Senator AYOTTE. Whatever you would like to.

Ms. KENYON. You said you want to make retaliation a crime, and currently in regulations, it is. However, it is usually the command who does it. As it currently stands, it is the command who would prosecute themselves.

So that is a clear conflict of interest. How would you pursue that? How are you proposing that, say I was retaliated against, who do I go to, and who would handle that case? As well as who would be in charge of making that charge and deciding what was really retaliation and what might have just been a bad night out or any other number of things that the command could downplay it as.

Senator AYOTTE. With what we passed in the legislation further emphasized that retaliation, in particular for these types of crimes, is a clear crime under the UCMJ to further give teeth to that crime under the UCMJ. One of the proposals that is on the table allows going beyond the chain of command, up the chain beyond if there is a conflict at the next level of the chain of command.

So I think that is one way to deal with it, where you are taking it up beyond that person and really upping the issue within so that there is a huge emphasis on it. But obviously, one of the things we want to get with everything we are doing is that we continue to have oversight over this.

I think what you are you hearing from everyone here is that whatever we pass and we have passed some incredibly important reforms in the defense authorization, and we may pass further reforms—that we are going to continue not just to have this be the year where we are emphasizing it, but that we have regular oversight over this. So I think that is an important aspect, too, so that we can further pass whatever needs to be done and also hold people publicly accountable, particularly for those who are leaders to understand that this is part of their responsibility to have a zero tolerance policy and to support victims.

If a leader in our military is found to be retaliating against someone who is a victim or someone helping a victim, that they are going to have a lot of problems, and we will hold them publicly accountable here, too. So I want you both to know this isn't you come here once, and we are just going to have this year of issues because I think all of us around this table are committed to a continuing oversight function next year and each month.

I think that is what in the past we have had this issue where we are all focusing on it and then it goes away, but you all are dealing with the problem still. So, we are committed to remaining continuously engaged on this issue on a bipartisan basis.

So thank you for raising the issue on the retaliation.

Senator GILLIBRAND. Thank you.

Senator King.

Senator KING. Thank you, Madam Chairman.

Like my colleagues, I want to thank you. I wouldn't want to appear before a Senate committee under any circumstances, and you are doing it under particularly difficult circumstances. You are

truly serving your country today and honoring the oath that you took when you joined the Service, and I deeply appreciate it.

I want to focus on the issue of command and chain of command because that term has been used repeatedly. Ms. Kenyon, you said something about it is the command who retaliates. How can they prosecute themselves? My commander lied to me.

I don't need a name, but what rank person are you referring to when you say that?

Ms. KENYON. I actually had multiple ranks retaliate as well as lie to me and make false promises and things of that nature, everyone from my squad leader up to my command sergeant major and my lieutenant colonel. Everyone in that rank who I came in contact with regarding my sexual assault somehow, some more severe than others, let me down or made false promises or outright made my life a living hell.

Senator KING. I understand that. But I think one of the ways that this discussion that we have been having has been somewhat confusing is that we are using the term "chain of command" as if it is multiple people. In reality, as I understand it, under DOD policy, nobody below O–6 makes the decision whether or not to go forward with a prosecution, and those people you just mentioned all are below the O–6 level.

In other words, when you say your commander, you are not talking about a Navy captain or a colonel or above. Is that correct?

Ms. KENYON. Yes, Senator. That is correct. At the time that I served, it was the commander's ability to lessen the charge so an O–6 never—it never came across their desk.

Senator KING. Okay. Now that is an issue we have to be sure that the facts get to the O–6 level because they are the people making the decision. But I think it is important to inform our discussion that when people talk about taking the decision out of the chain of command, you are not taking away from sergeants and majors. You are taking it away from colonels and naval captains. That is a higher level.

Let me change the subject for a moment. You have talked eloquently about the deficiencies of the treatment system. Would one solution be to allow military personnel to use their benefits in a civilian system? In other words, to go outside the military system to get the counseling and those, if there is more availability in the area you live?

For example, we have a program in northern Maine under the VA. It is a pilot program where veterans are able to get their services not by going 4 hours to the VA hospital, but by accessing local civilian services. Would that be something that might be helpful in this situation by broadening the field of available treatment possibilities, Mr. Arbogast?

Mr. ARBOGAST. Thank you, Senator.

Like I stated before, I already use my TRICARE and Medicare for that purpose because of where the VA lacks. I think the VA veterans would not have a problem traveling for good care.

I emphasized on how good my spinal cord injury care is in Richmond, VA, now. So that is a 4-hour drive for us. I would go there every day——

Senator KING. If you were getting adequate care?

Mr. ARBOGAST.—if I was getting adequate care there. I get superior care there.

Senator KING. But you mentioned the 90-mile drive for 5 minutes.

Mr. ARBOGAST. That would be within my VA medical center, which I try to avoid at all costs because they are just out of the loop. They don't have the resources. They don't even have a doctor that specializes in spinal cord injury care. He is just an M.D. who thinks he just knows about it but really doesn't.

But the thing is, if every VA had the resources to deal with every type of injury, illness, whatever, then it wouldn't be a problem to use the VA system. It is the problem that each VA medical center is different in what their care is, and I think it is because they are not being held accountable.

Senator KING. Ms. Kenyon, do you have thoughts about that?

Ms. KENYON. I believe there are a lot of benefits especially in the ability to test other counselors and caregivers to find whom you feel comfortable with, as well as being able to better specialize in what is actually affecting you, as well as PTSD, the prescription and overprescribing problems.

But then there is also identity issues and other addictions that don't fall under narcotics or alcohol, like shopping addictions and things like that that are not treated in the VA. But if you went and sought outside help, I think there is a lot of benefit to getting more specialized treatment.

I think it is, I would say, almost impossible for every VA to have every specialty. With that knowledge, to have the ability to go outside of that would benefit them.

Senator KING. But given the rise of this—I don't want to imply that it hasn't existed before. I am sure PTSD goes back to the beginning of time. But the increasing awareness of it, the volume of it that we are seeing in recent years, I suspect you would agree that this is something the VA should be gearing up for in a very serious way. I am gathering from your testimony that you don't believe that they are?

Ms. KENYON. I don't believe the VA has the ability to move three moves ahead or to see that where the need is coming until they have the problem. Then they approach whomever, and then the money comes in for the problem. But by then, it is 2 years down the road, and the problem is even bigger.

I don't see that there is an adequate system for the VA to apply certain foresight in seeing where they need help and being able to justify it effectively to whomever they have to, to get the proper funding to get it. I would consider looking into that system where you could encourage the individuals, the directors to think three moves ahead and look at what's coming.

Senator KING. What is coming.

Ms. KENYON. Right. Look what is coming. You don't necessarily have to obviously prove it with the numbers in regards to you already have these, and this is what you are funded for. You don't have to have them on backup to justify the need.

Senator KING. The VA isn't within the purview of this committee, but clearly, it is a continuum of concern that we have about our military people, whether they are in Service or veterans.

Thank you very much for your testimony. Thanks again for taking the time.

Mr. ARBOGAST. If I may?

Senator KING. Yes, sir.

Mr. ARBOGAST. There is a very big problem with the VA's retention rate, too, with providers.

Senator KING. Retention rate?

Mr. ARBOGAST. They can't keep doctors, especially where I am. Their Community-Based Outpatient Clinics (CBOC). I went through seeing a doctor who I had seen for years, we are talking about a medical doctor. I had seen him for years, and then I come back in and find out he quit.

Then it takes them 6 months to get a new doctor, so I am left without care for 6 months. They finally get a new doctor. I have to explain everything all over again. I will see you in a month or 2 weeks or whatever it may be. Come to find out, he quit. So then I am left without care for 8 months.

Senator KING. Now do you have a choice in all this? Do you have to go to the VA hospital, or could you use TRICARE to go anywhere?

Mr. ARBOGAST. I could use TRICARE to go anywhere, but the fact is, some civilian providers are just as bad as the VA providers.

Senator KING. Are you suggesting our healthcare system in this country is screwed up? [Laughter.]

Mr. ARBOGAST. It is.

Senator KING. I am shocked. [Laughter.]

Mr. ARBOGAST. It is truly. It is, and it is quite disturbing that veterans, more or less, have to go around and shop for a doctor specialized in this care. What do they know? It is a very disturbing problem.

Senator KING. Thank you.

Thank you, Madam Chairman.

Senator GILLIBRAND. Thank you.

I want to thank this panel for their testimony. This is extremely helpful in our deliberation to understanding these issues, and we are grateful for your service.

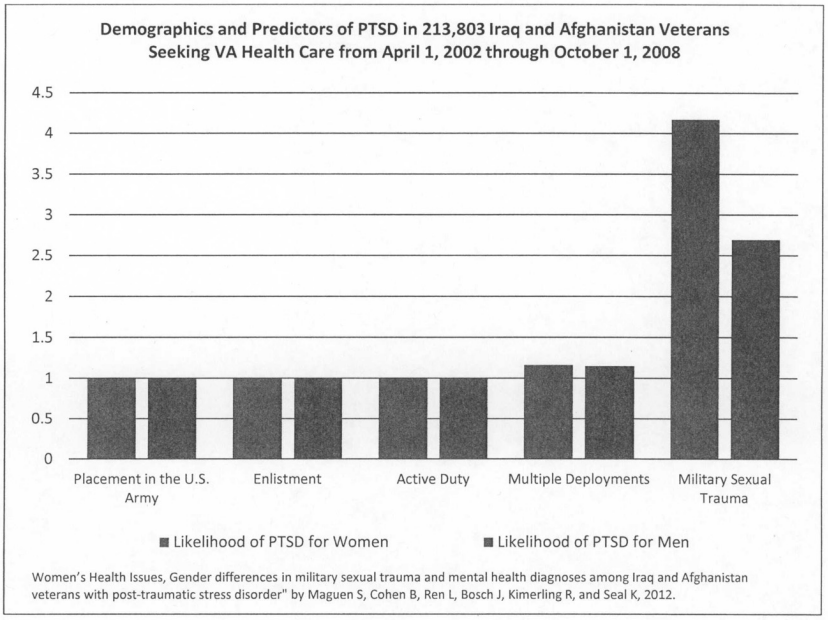
Thank you very much.

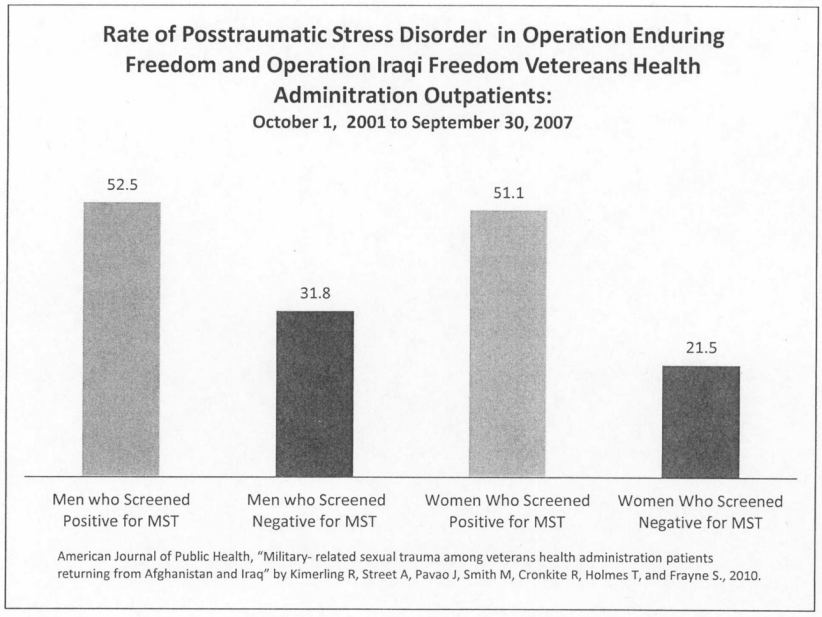
Ms. KENYON. Thank you, Senator.

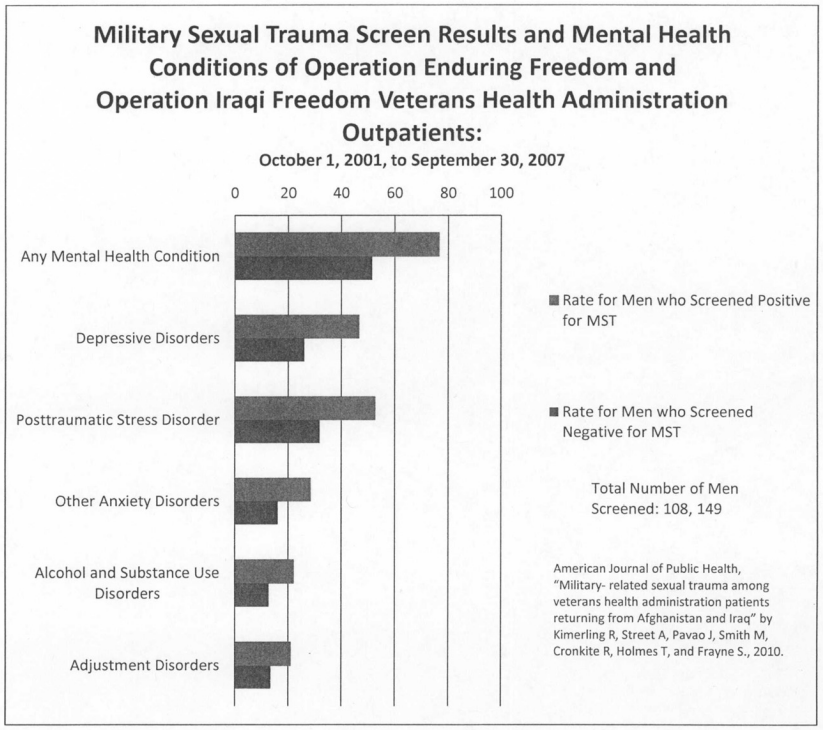
Senator GILLIBRAND. We will now welcome the next panel to join us. On our second panel will be Dr. Karen S. Guice, M.D., M.P.P., Principal Deputy Assistant Secretary of Defense for Health Affairs; Ms. Jacqueline Garrick, LCSW–C, BCETS, Director, Department of Defense Suicide Prevention; Dr. Nathan W. Galbreath, Ph.D., M.F.S., Senior Executive Advisor, Department of Defense Sexual Assault Prevention and Response Office; Dr. Susan J. McCutcheon, RN, Ed.D., National Mental Health Director, Family Services, Women's Mental Health and Military Sexual Trauma, Department of Veterans Affairs; and Dr. Margret E. Bell, Ph.D., Director for Education and Training, National Military Sexual Trauma Support Team, Department of Veterans Affairs.

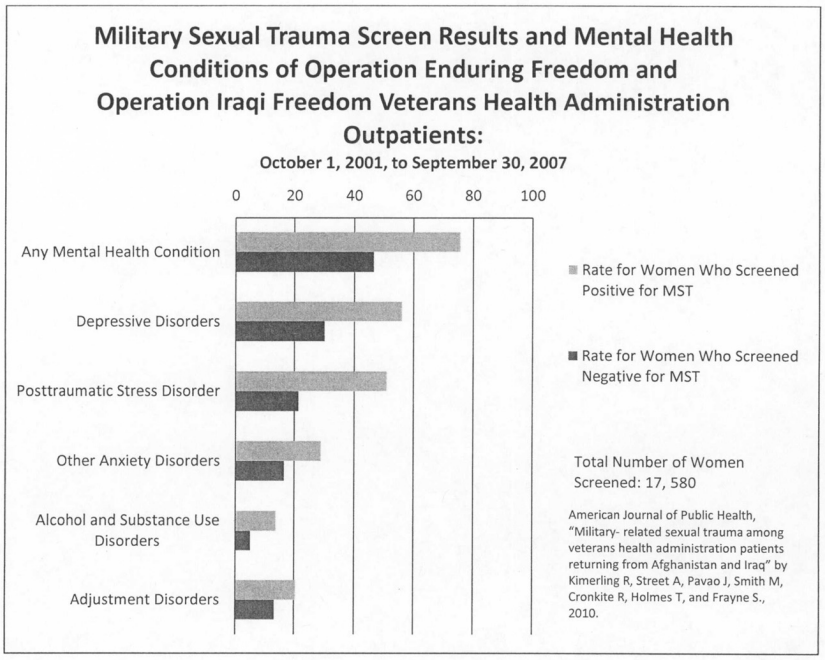
I have handed out some data that we can have for the benefit of the expert panel we are about to have. The first chart shows the likelihood of having PTSD as a result of each action.

[The information referred to follows:]


Demographics and Predictors of PTSD in 213,803 Iraq and Afghanistan Veterans Seeking VA Health Care from April 1, 2002 through October 1, 2008
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
Placement in the U.S. Army
Enlistment
Active Duty
Multiple Deployments
Military Sexual Trauma
Likelihood of PTSD for Women
Likelihood of PTSD for Men
Women's Health Issues, Gender differences in military sexual trauma and mental health diagnoses among Iraq and Afghanistan veterans with post-traumatic stress disorder" by Maguen S, Cohen B, Ren L, Bosch J, Kimerling R, and Seal K, 2012.


Rate of Posstraumatic Stress Disorder in Operation Enduring Freedom and Operation Iraqi Freedom Vetereans Health Adminitration Outpatients:
October 1, 2001 to September 30, 2007
52.5
31.8
51.1
21.5
Men who Screened Positive for MST
Men who Screened Negative for MST
Women Who Screened Positive for MST
Women Who Screened Negative for MST
American Journal of Public Health, "Military- related sexual trauma among veterans health administration patients returning from Afghanistan and Iraq" by Kimerling R, Street A, Pavao J, Smith M, Cronkite R, Holmes T, and Frayne S., 2010.


Military Sexual Trauma Screen Results and Mental Health Conditions of Operation Enduring Freedom and Operation Iraqi Freedom Veterans Health Administration Outpatients:
October 1, 2001, to September 30, 2007
0
20
40
60
80
100
Any Mental Health Condition
Depressive Disorders
Posttraumatic Stress Disorder
Other Anxiety Disorders
Alcohol and Substance Use Disorders
Adjustment Disorders
Rate for Men who Screened Positive for MST
Rate for Men who Screened Negative for MST
Total Number of Men Screened: 108, 149
American Journal of Public Health, "Military- related sexual trauma among veterans health administration patients returning from Afghanistan and Iraq" by Kimerling R, Street A, Pavao J, Smith M, Cronkite R, Holmes T, and Frayne S., 2010.



Senator GILLIBRAND. So, for example, placement in the U.S. Army, it is 1 out of 10. It is 10 percent. Enlisted at 1 out of 10, Active Duty 1 out of 10, multiple deployments slightly higher. But if you have MST, your likelihood of PTSD is 4 out of 10.

So that is just the first chart. The second chart shows the number of people who screen positive for MST, the incidence of PTSD is higher for both men and women. So if you have experienced MST, it is 52 percent of the time you are going to get PTSD if you are a man, and 51 percent of the time you are going to get PTSD if you are a woman.

Then the last two charts show that if you screen positive for MST, you have a higher incidence rate of mental health conditions. Meaning if you have been sexually assaulted, you are 75 percent more likely to have a mental health condition as a man. Slightly higher for a woman. Same for depressive disorders, PTSD, and other anxiety disorders.

Our experts can refer to these charts if they need to. It is just the currently available data for veterans from Iraq and Afghanistan from April 1, 2002, through October 1, 2008.

We also have a statement and materials that we are going to add to the record from Mr. Brian Lewis of Protect Our Defenders. Without objection, I will enter it into the record.

Is there an objection? Without objection, it is entered into the record.

[The prepared statement of Mr. Lewis follows:]

PREPARED STATEMENT BY MR. BRIAN LEWIS

Chairwoman Gillibrand, Ranking Member Graham, and members of the subcommittee, thank you for the opportunity to submit a written statement for the record. When I testified before the subcommittee 1 year ago, it was in the hopes that I would see some substantive changes in the way the Department of Defense and the Department of Veterans Affairs tackle the problem of military sexual trauma. I am sad to say I have been disappointed. Both departments are in fundamentally the same places they were 1 year ago. This is a travesty that must be addressed through congressional oversight to help turn the tide of 22 veteran suicides per day.[1]

DEPARTMENT OF DEFENSE

The Department of Defense still has significant ground to cover in order to recognize military sexual trauma as a male issue. The Department of Defense still does not consult with military sexual trauma advocacy organizations such as Protect our Defenders to inform their work for all survivors of military sexual trauma. In addition, the Department of Defense still does not consult with any credible advocacy organizations dedicated solely to male survivors of military sexual trauma.

Statistics and research within the Department of Defense regarding male military sexual trauma survivors remain scarce at best. One of the most oft-repeated phrases in the 2012 Workforce and Gender Relations Survey of Active Duty Members is that "results for men are not reportable" or that "results for men by Service and paygrade are not reportable."[2] More efforts need to be undertaken by the Department of Defense to ensure that detailed information about male survivors is included in various reports and studies instead of glossed over as they are currently. The Department of Defense still has no training materials featuring or depicting male survivors. Failing to include male survivors in training materials reinforces the rape myth that men cannot be the victims of a sexual trauma. This conduct also serves to marginalize men who have been survivors by communicating the message that their trauma is not important enough to include. A senior advisor to the Air Force Sexual Assault Prevention and Response Office recently acknowledged that one of the biggest challenges currently facing the Department of Defense is "getting individuals properly educated on the issue."[3] When male survivors are ignored in the production of training materials, our servicemembers are not being properly educated on the issue.

The Department of Defense still has very little information concerning perpetrators of sexual violence against male victims. In the latest survey, a large majority of this information for male survivors was listed as non-reportable.[4] Knowing who is doing the perpetrating is an invaluable tool to fighting this crime. As long as the spotlight is on the victim nothing can get done "in a large, meaningful way to take down sexual assault."[5]

Congress also needs information concerning repeat perpetrators. My own perpetrator was a repeat offender. He perpetrated this crime against at least one other sailor aboard the same command. I know I am not alone. Many survivors I talk with report the same experience. Repeat offenders anecdotally appear to be a significant problem the Department of Defense has not addressed.

RETALIATION

Recent efforts to address this crime have been largely focused on what happens to victims and offenders after a report has been filed. In order to fully address this problem in a meaningful way, solutions have to be found to the multitude of problems survivors face before a formal report is filed. A Commanding Officer can exert considerable pressure on a victim to not file a formal report. In order to address

[1] Janet Kemp & Robert Bossarte, Department of Veterans Affairs, Office of Mental Health Services, Suicide Data Report, 2012 (2013) (available at: http://www.va.gov/opa/docs/Suicide-Data-Report-2012-final.pdf)

[2] Lindsay Rock, Defense Manpower Data Center, 2012 Workforce and Gender Relations Survey of Active Duty Members (2013) (available at: http://www.sapr.mil/public/docs/research/2012—Workplace—and—Gender—Relations—Survey—of—Active—Duty—Members-Survey—Note—and—Briefing.pdf)

[3] Kristin Davis, Former Police Officer Brings His Experience to SAPRO, Army Times, Feb. 16, 2014, http://www.armytimes.com/article/20140216/NEWS06/302160007/Former-police-officer-brings-his-law-enforcement-expertise-SAPRO

[4] See Rock at 35.

[5] See Davis (Thomas answer to fifth interview question: "Like what?")

this problem, Congress should take the reporting of this crime away from immediate commanders regardless of rank or pay grade.

If a servicemember does decide to report and face the retaliatory measures commanding officers and others can employ, it is very unlikely that the person retaliating against the survivor will face any punitive actions. A Government Accounting Office investigation found that the Department of Defense Inspector General process substantiated. a mere 6 percent of cases filed as retaliation claims from fiscal year 2006 through fiscal year 2011.[6]

Very often, a retaliatory measure that is taken is to lower the type of discharge a servicemember receives after reporting a crime. My own discharge was lowered to General (Under Honorable Conditions) after reporting the crime. I am not unique in this regard. Many thousands of survivors have had their discharges lowered as a result of retaliation, thereby restricting their eligibility for benefits such as the GI Bill, care at the Veterans Health Administration (VHA), and potentially denial of a compensation claim at the VBA. Many of these survivors have never had a due process hearing. I know I did not. When such a vital liberty interest is implicated such as the nature of a military discharge, a due process hearing should be mandatory for all and not just those who have 6 or more years of service.

BOARD FOR CORRECTION OF MILITARY RECORDS

Another area contributing to a link between suicide and military sexual trauma survivors is the almost impossible process to receive discharge upgrades. Survivors are still misdiagnosed with "weaponized diagnoses"[7] such as Personality Disorders to deny survivors the recognition of their trauma and a potential retirement for post-traumatic stress disorder. The Department of Defense's various Boards for Correction of Military Records are still significant barriers to helping a survivor heal from the wounds of military sexual trauma by refusing to recognize this fact and upgrade erroneous discharges. This low chance of success at the Boards for Correction of Military Records is widely acknowledged.[8,9] I remember being very discouraged to the point of attempting suicide when the Board for Correction of Naval Records denied my petition. To this day, even after numerous media appearances and testimony before this Congress, the Department of the Navy still refuses to change my discharge. Imagine what survivors who have not been speaking out feel.

DEPARTMENT OF VETERANS AFFAIRS

The Department of Veterans Affairs does not perform any better when it comes to the topic of military sexual trauma for a variety of reasons. The Department of Veterans Affairs also still refuses to fully recognize military sexual trauma as a male issue. Both of these issues are probably contributing to an unacceptably high suicide rate among veterans.

VETERANS BENEFIT ADMINISTRATION

The Veterans Benefit Administration still has significant problems with processing and adjudicating claims for military sexual trauma. As of Monday, February 11, 2014, the Department of Veterans Affairs has 686,861 pending claims of which 403,761 or 58.8 percent are considered "backlog" cases meaning they have been pending for over 125 days.[10] The average time to wait for an initial decision on an initial compensation claim is 260 days.[11] These numbers do not include the number of claims that have been appealed to the Board for Veterans Appeals. In the most recent year for which data is publicly available, the Board of Veterans Appeals received 49,611 claims.[12] The BVA estimates that it takes on average approximately 3 years to process an application from the time the appellant files the notice appeal

[6] Dylan Blalock, Government Accountability Project, Senate Approves Military Whistleblower Protection Act Makeover, Dec. 20, 2013, http://www.whistleblower.org/blog/44–2013/3123-senate-approves-military-whistleblower-protection-act-makeover

[7] Credit for this term belongs to Patricia Lee Stotter who is a fellow Advisory Board Member of Protect our Defenders.

[8] See *Clinton* v. *Goldsmith*, 526 U.S. 529 n. 12 (1999)

[9] Connecticut Veterans Legal Clinic, Veterans Discharge Upgrade Manual (2011) (available at: http://ctveteranslegal.org/resources/) (discussing rates for BCMR upgrade rates hovering around 10–20 percent)

[10] Department of Veterans Affairs, Veterans Benefit Administration, Monday Morning Workload Report for Feb. 17, 2014 (2014) (available at: http://www.vba.va.gov/REPORTS/mmwr/)

[11] Board of Veterans' Appeals, U.S. Department of Veterans Affairs, Report of the Chairman: Fiscal Year 2012 (Feb. 4, 2013)

[12] Board of Veterans' Appeals

to final disposition by the Board of Veterans Appeals.[13] I have talked with many survivors who have been given 10 and 30 percent ratings for post-traumatic stress disorder and chose to appeal. Imagine trying to feed your family or support your necessary expenses while engaging this process for almost 4 years. This drawn out process of fighting for benefits that we are due could certainly be contributing to the high suicide rate.

Another problem perpetuated by the Veterans Benefits Administration is requiring "stressor statements" from survivors of military sexual trauma and requiring survivors to have independent confirmation of the assault. This same practice is not required of veterans claiming post-traumatic stress disorder as a result of exposure to combat or terrorist activity. In these cases, a simple statement from the veteran coupled with service records showing combat awards or deployments serve as sufficient corroboration for the claim.[14] The Court of Appeals for Veterans Claims has upheld this difference as a rational exercise of the agency's authority.[15] This distinction is not victim friendly. Imagine having to write down the most intimate details of a crime for anyone to look at and second-guess. I do not know the pain of having to do this at the Veterans Benefit Administration. However, I do know the pain of having a Navy psychiatrist second guess what happened when he was over 6,000 miles from where the crime occurred. It is a truly horrible feeling.

VETERANS HEALTH ADMINISTRATION

The Veterans Health Administration (VHA) has severe deficits concerning proper treatment of male survivors of military sexual trauma. Combining oversight of this issue with the Director of Family Services and Women's Mental Health who is appearing before the subcommittee today demonstrates the complete lack of understanding or caring the Veterans Health Administration gives to male survivors of military sexual trauma. The Veterans Health Administration still does not have military sexual trauma peer support groups available at all of their medical centers. The current emphasis on evidence-based treatments stifles the basic human interactions needed to learn how to cope with being a military sexual trauma survivor. I believe this is contributing to the suicide rate among military sexual trauma survivors. One of the major factors that hindered my recovery for many years was the lack of a peer-support environment within the Baltimore VA Medical Center. When I recently transferred my care to the Minneapolis VA Medical Center 2 months ago, I was rudely informed that their facility did not provide support groups for survivors of military sexual trauma.

The VHA has also failed to open residential treatment programs designed specifically for male survivors of military sexual trauma. Currently the VHA has approximately 12 separate programs designed specifically for treating military sexual trauma survivors. Unfortunately all but one accepts only women. The only one that accepts men is the Center for Sexual Trauma Services at VAMC Bay Pines, FL.[16] This program attempts to treat both male and female survivors in a coeducational environment. As a male survivor, I found this program very uncomfortable. Male survivors should be treated equally with female survivors to include the provision of resources within the Veterans Health Administration. Legislation pending in the Senate offered by Senator Bernard Sanders (I–VT) that would require the VHA to issue "a report on the treatment and services available from the Department of Veterans Affairs for male veterans who experience military sexual trauma compared to such treatment and services available to female veterans who experience military sexual trauma."[17] Male survivors should not need to wait for this bill to be enacted and then wait 630 days for VHA to issue a report, and then wait an unknown amount of time to receive gender equality in the provision of MST services.

Another way the Veterans Health Administration fails male survivors is their failure to conduct research geared at male survivors. Research on male survivors of military sexual trauma is exceptionally limited. A lot of studies have acknowledged this fact. However, the Veterans Health Administration has taken no concrete steps toward fixing this lack of knowledge. The only way to give male survivors quality mental health care is through research. Unfortunately the Veterans Health Administration is unable or unwilling to take this step.

The Veterans Health Administration also fails to treat survivors as whole persons. I endure chronic pain as a result of my sexual trauma, yet the Minneapolis VA Med-

[13] Id. at 19
[14] 38 C.F.R. § 3.304(f)(3)
[15] *Acevedo* v. *Shinseki*. 25 Vet. App. 286 (2012)
[16] See Appendix A.
[17] Comprehensive Veterans Health and Benefits and Military Pay Restoration Act of 2014, S. 1982, 113th Cong. § 364(a).

ical Center has refused to treat this problem in an adequate fashion. This is another area in which I know I am not alone. Many survivors disclose being in physical pain yet are unable to receive appropriate medical interventions to include appropriate medications at their local VA Medical Centers. The constant physical reminders of the sexual trauma without appropriate help from the Veterans Health Administration could also be increasing the suicide problem.

CONCLUSION

Since I testified last year in front of this subcommittee, I have moved to Saint Paul, MN. I graduated with a Bachelor of Science in Paralegal Studies from Stevenson University in May 2013. I graduated with a Master of Science in Forensic Studies degree from Stevenson University in December 2013. I authored my thesis on the topic of military sexual trauma. I have been accepted to Hamline University School of Law as an incoming first year law student. They took a chance on me knowing that I might not be able to be admitted to the Bar in Minnesota. This committee should commend them for supporting a military sexual trauma survivor. All of these degrees I have completed have been without the benefit of the Montgomery GI Bill. I lost that benefit as a result of the General (Under Honorable Conditions) Discharge I was given for attempting to report the trauma and the retaliation by a Navy psychiatrist who accused me of fabricating the trauma. I have accumulated about $70,000 in student loan debt that will quickly climb as I progress through law school. All of these degrees have been accomplished without the assistance of any Department of Veterans Affairs vocational rehabilitation services.

In conclusion, I think Representative Raul Ruiz (D–CA, 36) said it best at a hearing when he said, "It's a triple assault that many of our veterans face."[18] We first become victims of this crime. We are then retaliated against by the military. Then we must endure the lack of care and respect from the Department of Veterans Affairs. Congress needs to act decisively and break up this pattern of abuse before more lives are needlessly lost to suicide.

[Additonal materials provided by Mr. Lewis follow:]

[18] Safety for Survivors: Care and Treatment for Military Sexual Trauma Before the H. Comm. On Vet. Aff, 113th Cong. (2013) (unpub.)

MILITARY SEXUAL TRAUMA / SEXUAL TRAUMA RESIDENTIAL TREATMENT RESOURCES

This list consists of programs identifying themselves as having expertise with MST and/or sexual trauma more generally and the ability to provide treatment targeting these issues in a residential or inpatient setting.

Programs vary widely in the care they have available. For example:

- Some programs identify as "MST programs" and MST-related care is a core part of their programming; others do not identify as MST programs, but do have staff with expertise in MST. In these latter programs, staff can often work individually with veterans who need MST-specific care as an adjunct to the care they receive through the more general program. In these programs, veterans may also be able to receive specialized MST-related group or individual therapy through a local outpatient clinic.
- Some programs see both men and women concurrently but may have single-sex groups or other programming. Several programs serve women only. Only two (Cincinnati and Menlo Park) have men's-only programs, although other programs serve very few women and often end up with men's only cohorts in practice.

Please consider these variables as you think about which program will be the best fit for your client.

MST/Sexual Trauma Treatment Programs (Includes Women-Only Treatment Programs)
Programs explicitly identifying themselves as "MST programs" or as having a specific focus on MST or sexual trauma. This list also includes all women-only treatment programs given that treatment for MST and sexual trauma are often integrated into or are key components of these programs.

VISN 1:	Boston, MA (Brockton) Women's Integrated Treatment & Recovery Program
	Boston, MA (Jamaica Plain) Women Veterans' Therapeutic Transitional Residence Program (TRUST House)
VISN 2:	Batavia, NY Women Veterans' Residential Program
VISN 3:	Lyons, NJ Women's Treatment Unit
VISN 6:	Salem, VA Specialized Inpatient PTSD Treatment Program for Women Veterans
VISN 8:	Bay Pines, FL Center for Sexual Trauma Services
VISN 10:	Cincinnati, OH

Women's Residential PTSD Program

VISN 16: Houston, TX
Women's Inpatient Specialty Environment of Recovery (WISER)

VISN 17: Temple, TX
Trauma Recovery Treatment Center

VISN 19: Sheridan, WY
Residential PTSD Program for Women

VISN 21: Menlo Park, CA
Women's Trauma Recovery Program

VISN 22: Long Beach, CA
RENEW: Women's Trauma Recovery Program
(NOTE: housing is with local U.S. VETS program, through the VA's Grants and Per Diem Program)

West Los Angeles, CA
Outpatient Women's Clinic in conjunction with Domiciliary Residential Rehabilitation and Treatment Program (Women's L.I.F.E. Program)

General Programs, But Multiple Staff With Expertise in MST/Sexual Trauma
Although these programs do not necessarily have an explicit focus on MST/sexual trauma, staff can often work individually with Veterans who need MST-specific care as an adjunct to the care they receive through the more general program. Veterans may also be able to receive specialized MST-related group or individual therapy through a local outpatient clinic.
*****Prior to referring a Veteran for treatment, please be sure to discuss with the program whether the nature and extent of the MST-related services available through the program will be appropriate to your Veteran's expectations and needs.******

VISN 5: Baltimore, MD
Dual Diagnosis PTSD/Substance Abuse PRRTP

VISN 6: Salem, VA
Specialized Inpatient PTSD Treatment Program for Male Veterans

VISN 7: Augusta, GA
MST Clinic & Domiciliary Residential Rehabilitation and Treatment Program

VISN 10: Cincinnati, OH
Men's Residential PTSD Program

VISN 12: North Chicago, IL
Stress Disorder Treatment Unit

VISN 15: Topeka, KS

Stress Disorder Treatment Program

VISN 21: Menlo Park, CA
Men's Trauma Recovery Program

Please see the pages that follow for more detailed information about each program.

This list was produced by the MST Support Team of VA's Office of Mental Health Services. Please contact the team at mst@va.gov with any questions or updates.

MST/Sexual Trauma Treatment Programs (Includes Women-Only Treatment Programs)
Programs explicitly identifying themselves as "MST programs" or as having a specific focus on MST or sexual trauma. This list also includes all women-only treatment programs given that treatment for MST and sexual trauma are often integrated into or are key components of these programs.

VISN & Facility:	**VISN 1:** **VA Boston Healthcare System, Brockton Campus (Brockton, MA)**
Category:	**MST/Sexual Trauma Treatment Program (Women-Only Treatment Program)**
Program name:	Women's Integrated Treatment & Recovery Program
Phase of treatment targeted:	Emphasis on integrated treatment of substance abuse and trauma; group therapy focuses on skills building for maintaining abstinence and managing PTSD symptoms.
MST-specific treatment available:	Individual therapy focused on processing sexually traumatic experiences using a CPT model with and without exposure. Staff members have expertise in the area of sexual trauma.
Notable admission criteria:	Commitment to abstinence. Medically stable. Linked to outpatient care and have a discharge plan. No acute psychotic symptoms, suicidal or homicidal ideation.
Treat both men and women?	Women only.
Rolling vs cohort admissions & length of program:	Cohort admissions with twelve week stay. This may be extended under certain circumstances, if for example a veteran is awaiting housing or needs to meet criteria for another program before admission to that program.
Contact information:	Sharon L. Baker, Ph.D. – (774)826-1833 or (774) 826-1312; sharon.baker3@va.gov

VISN & Facility:	**VISN 1:** **VA Boston HCS/Jamaica Plain Campus** **(Boston, MA)**
Category:	**MST/Sexual Trauma Treatment Program** **(Women-Only Treatment Program)**
Program name:	Women Veterans' Therapeutic Transitional Residence Program (TRUST House)
Phase of treatment targeted:	Flexible, ranges from skill-development to trauma processing. Focus is on psychosocial rehabilitation, not acute stabilization.
MST-specific treatment available:	Veterans receive weekly individual therapy through the Boston Women's Stress Disorder Treatment Team, an outpatient clinic with an explicit emphasis on treating sexual trauma. TRUST House staff also have expertise in this area. Dialectical Behavior Therapy (DBT) skills groups are another core component of the program.
Notable admission criteria:	Ability to work at least 20 hours/week. Able to independently manage medications. Prefer veterans coming from another program (e.g., DOM, SARRTP) or who are established outpatients. This is not typically a good referral from acute inpatient or for those requiring intensive treatment. Prefer 60 days without suicidal behavior. Some criteria are flexible depending on the individual case.
Treat both men and women?	Women only.
Rolling vs cohort admissions & length of program:	Rolling admissions. Ask for commitment of at least 3 months though prefer veterans to stay for at least 6 months; maximum stay is one year.
Contact information:	Kristin Angell, LCSW – (857) 364-2951 kristin.angell@va.gov

VISN & Facility:	**VISN 2:** **VA Western New York HCS/Batavia Campus** **(Batavia, NY)**
Category:	**MST/Sexual Trauma Treatment Program** **(Women-Only Treatment Program)**
Program name:	Women Veterans' Residential Program
Phase of treatment targeted:	Emphasis on trauma processing as well as intensive self-regulatory and interpersonal skill development.
MST-specific treatment available:	Individual and group therapy focused on processing sexually traumatic experiences. Staff members have expertise in the area of sexual trauma and co-morbid substance abuse. Currently have mixed-trauma cohorts, though at times cohorts end up being entirely composed of veterans with sexual trauma histories.
Notable admission criteria:	Do not currently meet criteria for acute psychiatric or medical admission. Have tried a less restrictive treatment alternative, or one was unavailable. Require the structure and support of a residential treatment environment due to lack of stable lifestyle or living arrangement that is conducive to recovery. Not a significant risk of harm to self or others. Be capable of self preservation and basic self care. Have identified treatment and rehabilitation needs which can be met by the program.
Treat both men and women?	Women only.
Rolling vs. cohort admissions & length of program:	Utilize a cohort system with a eight week length of stay. If the cohort has openings, short-term stays of one to two weeks are possible for veterans wishing to focus on skill-building and supportive therapy.
Contact information:	Lauretta Lascu, PsyD – (585) 297-1226; lauretta.lascu@va.gov

VISN & Facility:	**VISN 3:** **VA New Jersey HCS,** **(Lyons, NJ)**
Category:	**MST/Sexual Trauma Treatment Program** **(Women-Only Treatment Program)**
Program name:	Women's Treatment Unit
Phase of treatment targeted:	Emphasis on skill building and trauma processing. Group treatment is central with individual psychotherapy for processing of traumatic material. PE and CPT available.
MST-specific treatment available:	Program as a whole is devoted to MST treatment. Childhood trauma, combat-related PTSD, and SUD also addressed as needed.
Admission criteria:	No psychotic symptoms. Not in need of detox from drugs or alcohol. Ability to work intensively in group format No recent violent behavior and do no present a danger to self or others. Must be medically stable.
Treat both men and women?	Women only.
Rolling vs cohort admissions & length of program:	Rolling admissions. Average length of stay 6-8 weeks
Contact information:	Suzanne Loftus, Psy.D. – (908) 647-0180 x 5896

VISN & Facility:	**VISN 6:** **Salem VAMC**
Category	**MST/Sexual Trauma Treatment Program (Women-Only Treatment Program)**
Program name:	Specialized Inpatient PTSD Treatment Program for Women Veterans
Phase of treatment targeted:	Flexible, ranges from skill-development to trauma processing. Focus is on a holistic approach to healing and recovery.
MST-specific treatment available:	Multiple staff with expertise in the treatment of sexual and combat trauma. Primarily group-based treatment with an emphasis on Acceptance and Commitment Therapy within a therapeutic community setting. Treatment includes psychoeducation, skill building, in vivo exposure work, trauma processing sessions and expressive arts therapies.
Notable admission criteria:	Must have history of combat and/or military sexual trauma (though may focus on any trauma while in the program). Must be alcohol and illegal substance free; not in need of detox; free of benzodiazepines. Medically stable with no acute psychosis; no current self-mutilation; no medically acute eating disorders; not a danger to self or others. No significant cognitive impairment. No pending legal issues; no untreated sex offenders; no court mandated admissions. Able to return to stable housing. Must be linked to established outpatient mental health care and willing to return to outpatient mental health provider for followup care. Ability to function independently in daily life; able and willing to work intensively in group setting. Some flexibility in working with veteran to meet some criteria.
Treat both men and women?	Women only. Also have a separate program for men (see listing further below).
Rolling vs cohort admissions & length of program:	Cohort admissions. Length of stay of 6.5 weeks.
Contact information:	Kay Montgomery, MSW- (540) 982-2463 x 2548

VISN & Facility:	**VISN 8:** **Bay Pines VAHCS** **(Bay Pines, FL)**
Category:	**MST/Sexual Trauma Treatment Program**
Program name:	Center for Sexual Trauma Services, Residential Program
Phase of treatment targeted:	Emphasis on trauma work.
MST-specific treatment available:	Program as a whole is devoted to MST treatment. Patients are assigned a primary therapist who works with them to plan treatment based on individual needs and strengths. Treatment interventions may include Prolonged Exposure, Cognitive Processing Therapy, Skills Training, CBT Group, Therapeutic Recreation, Patient Education and other interventions.
Notable admission criteria:	**Note: The CSTS residential program accepts applications from outside of VISN 8 only when Bay Pines is the closest referral resource for residential MST/PTSD treatment.** History of MST (though can focus on any sexual trauma while in the program). Cannot present a danger to self or others and must be able to manage the residential environment.
Treat both men and women?	Yes. Roommates are same-sex, but men and women are housed in the same area of the Dom and share the common living areas.
Rolling vs cohort admissions & length of program:	Rolling admissions; variable length of stay based on the individual's treatment plan.
Contact information:	Ruth Harter-McBride, MA – (727) 398-6661 x7381; ruth.harter-mcbride2@va.gov or Carol O'Brien, Ph.D. – (727) 398-6661 x7579; carol.obrien1@va.gov

VISN & Facility:	**VISN 10:** **Cincinnati VAMC** **(Cincinnati, OH)**
Category:	**MST/Sexual Trauma Treatment Program** **(Women-Only Treatment Program)**
Program name:	Women's PTSD Residential Treatment Program; also a separate program for male veterans and veterans with PTSD and mTBI.
Phase of treatment targeted:	Focus on treatment of PTSD symptoms with emphasis on trauma processing and cognitive restructuring.
MST-specific treatment available:	Most staff have expertise in sexual trauma. Individual and group treatment; all veterans receive Cognitive Processing Therapy in two individual therapy sessions per week with additional sessions as needed.
Notable admission criteria:	PTSD; no active mania or psychosis; no acute medical or legal issues; no registered sex offenders; able to tolerate group treatment and share trauma accounts in individual therapy; we do accept veterans on benzodiazepines and/or methadone.
Treat both men and women?	Women only. Also have a separate program for men (see listing further below) – programs are separate and have separate living areas but males and females do share cafeteria. No mixed gender groups.
Rolling vs cohort admissions & length of program:	Cohort admissions. Length of stay of 7 weeks.
Contact information:	Program Coordinator: Nicola Caldwell, PhD – (513) 861-3100 x3254; nicola.caldwell@va.gov Intake Coordinator: Andrea Williams, LISW (513-861-3100 x 3134); andrea.williams5@va.gov

VISN & Facility:	**VISN 16:** **Michael E. DeBakey VA Medical Center** **(Houston, TX)**
Category:	**MST/Sexual Trauma Treatment Program** **(Women-Only Treatment Program)**
Program name:	Women's Inpatient Specialty Environment of Recovery (WISER)
Phase of treatment targeted:	Emphasis on stabilization and serving as a step-down after acute inpatient care or as a step-up from outpatient therapy. Strong trauma processing component.
MST-specific treatment available:	Staff with expertise in the treatment of sexual trauma, particularly given the high prevalence of sexual trauma among veterans in the program. Evidence-based group and individual psychotherapy that utilizes an adapted cognitive processing therapy approach focusing on exposure therapy, dialectical behavior skills, and trauma-informed empowerment modules (developed by SAMHSA).
Notable admission criteria:	**Note: Referrals currently limited to VISN 16 only.** Diagnosis of PTSD, substance dependence, mood or anxiety disorder; able to accommodate certain personality disorders. Veterans who are actively psychotic and unable to tolerate or commit to intensive treatment are generally ineligible for admission. Veterans with strong intent for suicidal or homicidal behavior but who otherwise meet admission criteria are potentially admissible but will be first admitted to the local psychiatric intensive care unit for stabilization and evaluation. Veterans must be able to live independently while on the unit and willing to participate in group therapy; must have an outpatient mental health provider for follow-up care. Veterans needing nursing care for medical conditions may be admissible.
Treat both men and women?	Women only.
Rolling vs cohort admissions & length of program:	Cohort admission. Length of stay 21 days.
Contact information:	Wendy Smitherman Leopoulos -- 713-791-1414 x4693; wendy.smitherman@va.gov

VISN & Facility:	**VISN 17:** **Central Texas Veterans HCS** **(Temple, TX)**
Category:	**MST/Sexual Trauma Treatment Program** **(Women-Only Treatment Program)**
Program name:	Trauma Recovery Treatment Center
Phase of treatment targeted:	Emphasis on trauma processing and the development of emotion regulation, interpersonal effectiveness, acceptance, and mindfulness skills.
MST-specific treatment available:	Group and Individual Therapy are offered. Core treatment modalities include Cognitive Processing Therapy (CPT), Acceptance and Commitment Therapy (ACT), and Dialectical Behavior Therapy (DBT) skills training.
Notable admission criteria:	History of rape or attempted rape during active military service or during active duty training OR history of adult civilian rape or attempted rape and also has experienced some form of MST. Must be at least 6 months post most recent sexual trauma. Must be substance free for at least 30 days prior to admission. Must be 30 days post discharge from acute inpatient mental health. Must be committed to and have a plan for post-discharge continuing care and stable living environment. Must be able to actively participate in group treatment in a residential rehabilitation setting. No active psychotic symptomatology. No significant cognitive impairment. No unresolved legal issues or charges (i.e., no pending court dates and/or issues around which a legal decision has yet to be rendered). Does not present a danger to self/others. Not currently pregnant. No major medical problems that will either prevent full participation or require extraordinary medical monitoring. No history of perpetrating acts of sexual assault or violence against others.
Treat both men and women?	Women only.
Rolling vs cohort admissions & length of program:	Cohort admissions. Length of stay of 7 weeks.
Contact information:	Program Support Assistant – 254-778-4811 x 43201

VISN & Facility:	**VISN 19:** **Sheridan VA Medical Center** **(Sheridan, WY)**
Category:	**MST/Sexual Trauma Treatment Program** **(Women-Only Treatment Program)**
Program name:	Residential PTSD Program for Women
Phase of treatment targeted:	Emphasis on trauma processing and skill building.
MST-specific treatment available:	Staff with expertise in the treatment of sexual trauma, particularly given the high prevalence of sexual trauma among veterans in the program. Trauma processing work occurs in individual therapy only, primarily using CPT although PE is also available. Groups include an MST support group, CPT group, women's support group, educational group about grief, loss and trauma, and equine therapy.
Notable admission criteria:	PTSD diagnosis.
Treat both men and women?	Women only.
Rolling vs cohort admissions & length of program:	Cohort admissions. Length of stay is 7 weeks.
Contact information:	Kathy Scholljegerdes, PsyD – (307) 675-3810, kathlene.scholljegerdes@va.gov; Admission Coordinator: Lora Donahue – (307) 675-3891, lora.donahue@va.gov

VISN & Facility:	**VISN 21:** **VA Palo Alto HCS/Menlo Park Division** **(Menlo Park, CA)**
Category:	**MST/Sexual Trauma Treatment Program** **(Women-Only Treatment Program)**
Program name:	Women's Trauma Recovery Program (WTRP)
Phase of treatment targeted:	Flexible, from skills building to trauma processing.
MST-specific treatment available:	WTRP staff members have expertise in the treatment of sexual trauma and in the provision of gender-specific care. Group residential treatment focuses on providing cognitive behavioral therapy in the context of a therapeutic milieu. Military-related trauma experiences are processed utilizing a CPT model. Treatment interventions also include affect tolerance, anxiety management, stress management, skills building, health issues, recreation therapy, and family therapy.
Notable admission criteria:	Alcohol and illegal substance free for 5 days and off of benzodiazepines. No active psychosis. No major medical problems that will interfere with participation in program.
Treat both men and women?	Women only.
Rolling vs cohort admissions & length of program:	Rolling admissions. 60 day to 90 day length of stay.
Contact information:	Marion Gautschi, MSW, Admissions Coordinator – (650) 614-9997 x22843, marion.gautschi@va.gov , Tasha Souter, MD – (650) 614-9997 x23158; tasha.souter@va.gov; Dorene Loew, PhD – (650) 614-9997 x23237; dorene.loew@va.gov

VISN & Facility:	**VISN 22:** **VA Long Beach Healthcare System** **(Long Beach, CA)**
Category:	**MST/Sexual Trauma Treatment Program** **(Women-Only Treatment Program)** *(NOTE: housing is with local U.S. VETS program, through the VA's Grants and Per Diem Program)*
Program name:	RENEW: Women's Trauma Recovery Program
Phase of treatment targeted:	Emphasis on skill development and trauma processing.
MST-specific treatment available:	Program as a whole is devoted to treatment of sexual trauma. Individual and group treatment. Holistic focus.
Notable admission criteria:	6 months sobriety. 6 months without psychiatric hospitalization. 6 months without suicide attempt or self-injury. Ability to remain for the duration of the program.
Treat both men and women?	Women only.
Rolling vs cohort admissions & length of program:	Cohort admissions. Length of stay of 12 weeks. After completion of program, may be eligible for participation in "Bridges" program: 12 week, rolling admissions residential and/or outpatient aftercare program consisting of 12 hours/week of community activity and support groups.
Contact information:	Lori Katz, PhD (program director) -- (562) 826-8000 x4380; lori.katz@va.gov; or Sandy Dee Hoague (program coordinator) -- x4820.

VISN & Facility:	**VISN 22:** **West Los Angeles VAMC** **(West Los Angeles, CA)**
Category:	**MST/Sexual Trauma Treatment Program** **(Women-Only Treatment Program)**
Program name:	Outpatient Women's Clinic in conjunction with Domiciliary Residential Rehabilitation and Treatment Program (Women's L.I.F.E. Program)
Phase of treatment targeted:	Emphasis on trauma processing and development of coping skills. Particularly appropriate for those with comorbid substance abuse and those interested in returning to work.
MST-specific treatment available:	In addition to participation in Domiciliary programming, Veterans receive therapy through an outpatient women's clinic where staff members have expertise in the area of sexual trauma. Offer individual therapy as well as an MST support/psychoeducation group. Therapy includes processing sexually traumatic experiences using a CPT model. Coping and skills training are available as necessary.
Notable admission criteria:	Cannot be actively psychotic. Must be cognitively able to follow a schedule and attend back to back groups and independent in all activities of daily living. May accept Veterans with a history of suicidal ideation depending upon the individual circumstances involved.
Treat both men and women?	Although the Domiciliary treats men more generally, specialized MST-specific programming is for women only. During the week, women are in women's only groups but participate in mixed gender groups on the weekends.
Rolling vs cohort admissions & length of program:	Rolling admissions. Average length of stay 90-120 days.
Contact information:	Mona Lam, PhD -- (310)268-3540, mona.lam@va.gov

General Programs, But Multiple Staff With Expertise in MST/Sexual Trauma
Although these programs do not necessarily have an explicit focus on MST/sexual trauma, staff can often work individually with Veterans who need MST-specific care as an adjunct to the care they receive through the more general program. Veterans may also be able to receive specialized MST-related group or individual therapy through a local outpatient clinic. *****Prior to referring a Veteran for treatment, please be sure to discuss with the program whether the nature and extent of the MST-related services available through the program will be appropriate to your Veteran's expectations and needs.******

VISN & Facility:	**VISN 5:** **VA Maryland HCS/Baltimore Division** **(Baltimore, MD)**
Category:	**General Program, But Multiple Staff With Expertise in MST/Sexual Trauma**
Program name:	Dual Diagnosis PTSD/Substance Abuse Psychosocial Residential Rehabilitation Treatment Program
Phase of treatment targeted:	Flexible, ranges from psychoeducation and skill-development to trauma processing.
MST-specific treatment available:	Multiple staff members with expertise in treating sexual trauma using empirically supported treatments. Individual and group therapy.
Notable admission criteria:	PTSD and substance abuse/dependence. Prefer 30 days sobriety and that have had at least one significant period of sobriety within the past year. Ability to function independently in daily life. Psychiatrically and medically stable.
Treat both men and women?	Yes. Have both mixed and single-sex groups. Women stay in individual rooms with private, non-attached bathrooms.
Rolling vs cohort admissions & length of program:	Rolling admissions. 45 – 56 day stay.
Contact information:	Andrew Santanello, PsyD – (410) 605-7419; andrew.santanello@va.gov

VISN & Facility:	**VISN 6:** **Salem VAMC**
Category	**General Program, But Multiple Staff With Expertise in MST/Sexual Trauma**
Program name:	Specialized Inpatient PTSD Treatment Program for Male Veterans
Phase of treatment targeted:	Flexible, ranges from skill-development to trauma processing. Focus is on a holistic approach to healing and recovery.
MST-specific treatment available:	Multiple staff with expertise in the treatment of sexual and combat trauma. Primarily group-based treatment with an emphasis on Acceptance and Commitment Therapy within a therapeutic community setting. Treatment includes psychoeducation, skill building, in vivo exposure work, trauma processing sessions and expressive arts therapies.
Notable admission criteria:	Must have history of combat and/or military sexual trauma (though may focus on any trauma while in the program). Must be alcohol and illegal substance free; not in need of detox; free of benzodiazepines. Medically stable with no acute psychosis; no current self-mutilation; no medically acute eating disorders; not a danger to self or others. No significant cognitive impairment. No pending legal issues; no untreated sex offenders; no court mandated admissions. Able to return to stable housing. Must be linked to established outpatient mental health care and willing to return to outpatient mental health provider for followup care. Ability to function independently in daily life; able and willing to work intensively in group setting. Some flexibility in working with veteran to meet some criteria.
Treat both men and women?	Men only. Also have a separate program for women (see listing above).
Rolling vs cohort admissions & length of program:	Cohort admissions. Length of stay of 6.5 weeks.
Contact information:	Kay Montgomery, MSW- (540) 982-2463 x 2548

VISN & Facility:	**VISN 7:** **Augusta VAMC** **(Augusta, GA)**
Category:	**General Program, But Multiple Staff With Expertise in MST/Sexual Trauma**
Program name:	MST Clinic & Domiciliary Residential Rehabilitation and Treatment Program
Phase of treatment targeted:	Emphasis on trauma processing.
MST-specific treatment available:	Veterans receive therapy through the outpatient MST clinic where staff have expertise in the treatment of sexual trauma.
Notable admission criteria:	No pending legal issues. No physical assaults in past six months. Current sobriety. Not taking any controlled medications more than two times/day.
Treat both men and women?	Yes. Women stay in lockable two- to four-person rooms. Some women-only groups, but others are mixed-sex.
Rolling vs cohort admissions & length of program:	Rolling admissions. Length of stay for up to 120 days.
Contact information:	Rebecca Jump, Ph.D. -- (706) 733-0188 x7737; rebecca.jump@va.gov

VISN & Facility:	**VISN 10:** **Cincinnati VAMC** **(Cincinnati, OH)**
Category:	**General Program, But Multiple Staff With Expertise in MST/Sexual Trauma**
Program name:	Men's PTSD Residential Treatment Program; also a separate program for women veterans and veterans with PTSD and mTBI.
Phase of treatment targeted:	Focus on treatment of PTSD symptoms with emphasis on trauma processing and cognitive restructuring.
MST-specific treatment available:	Most staff have expertise in sexual trauma. Individual and group treatment; all veterans receive Cognitive Processing Therapy in two individual therapy sessions per week with additional sessions as needed.
Notable admission criteria:	PTSD; no active mania or psychosis; no acute medical or legal issues; no registered sex offenders; able to tolerate group treatment and share trauma accounts in individual therapy; we do accept veterans on benzodiazepines and/or methadone.
Treat both men and women?	Men only. Also have a separate program for women (see earlier listing) – programs are separate and have separate living areas but males and females do share cafeteria. No mixed gender groups.
Rolling vs cohort admissions & length of program:	Cohort admissions. Length of stay of 7 weeks.
Contact information:	Program Coordinator: Nicola Caldwell, PhD – (513) 861-3100 x3254; nicola.caldwell@va.gov Intake Coordinator: Andrea Williams, LISW (513-861-3100 x3134); andrea.williams5@va.gov

VISN & Facility:	**VISN 12:** **North Chicago VAMC** **(North Chicago, IL)**
Category:	**General Program, But Multiple Staff With Expertise in MST/Sexual Trauma**
Program name:	Stress Disorder Treatment Unit (PTSD Residential Rehabilitation Program)
Phase of treatment targeted:	Flexible, from skills building to trauma processing.
MST-specific treatment available:	Individual therapy; clinicians have developed expertise in working with MST, given the number of sexual trauma cases they tend to see.
Notable admission criteria:	Must have combat-related PTSD (combat broadly defined) and be service connected for PTSD. Minimum 30 days sobriety. Medically stable. No active suicidal ideation in the past 60 days. Admission can't be court-related. Must be in outpatient treatment. Prefer no benzodiazepines or anti-psychotic medications. Current PTSD symptoms must be too severe to be treated on an outpatient basis.
Treat both men and women?	Yes. Women with private room, but men and women participate in groups together.
Rolling vs cohort admissions & length of program:	Rolling admissions. Length of stay varies but average is around 35 days.
Contact information:	Karen Paddock – (847) 688-1900 x 83312; karen.paddock@va.gov

VISN & Facility:	**VISN 15:** **VA Eastern Kansas HCS/Topeka Division** **(Topeka, KS)**
Category:	**General Program, But Multiple Staff With Expertise in MST/Sexual Trauma**
Program name:	Stress Disorder Treatment Program (Specialized Inpatient PTSD Unit)
Phase of treatment targeted:	Ranges from skill building to trauma processing.
MST-specific treatment available:	Though have ongoing admissions, try to cluster individuals with sexual trauma-related issues into "mini-cohorts." Staff with training in treatment of sexual trauma.
Notable admission criteria:	30 days sobriety. Military trauma of some type. Treatment can't be court-ordered. No acute suicidal or homicidal ideation. No acute psychosis.
Treat both men and women?	Yes, but see relatively few women. Women and men are potentially, but not necessarily, in the same cohort. They participate in psychoeducational groups together but decisions about participation in trauma processing groups together are made on a case by case basis, depending on the size of the female mini-cohort. Women room together as appropriate but typically have private rooms with their own bathroom.
Rolling vs cohort admissions & length of program:	Rolling admissions. Length of stay of 7 weeks.
Contact information:	For referrals, Terry Falck, M.A. – (785) 350-3111 x 52139; for more information, Jonathan Farrell-Higgins, Ph.D. – x 52118; jonathan.farrell-higgins@va.gov

VISN & Facility:	**VISN 21:** **VA Palo Alto HCS/Menlo Park Division** **(Menlo Park, CA)**
Category:	**General Program, But Multiple Staff With Expertise in MST/Sexual Trauma**
Program name:	Men's Trauma Recovery Program
Phase of treatment targeted:	Emphasis on trauma processing and development of coping skills.
MST-specific treatment available:	Staff members have expertise in the area of sexual trauma. MST survivors participate in general CPT group with men with combat trauma; to prepare for this, MST survivors meet as a subgroup to discuss issues related to disclosure. MST and combat trauma are given equal space and discussion in group. Peer support is a strong focus, with MST survivors in particular encouraged to form supportive relationships with each other.
Notable admission criteria:	Must have five consecutive days free of substance use. No severe cognitive impairment. No active psychosis. No active suicidality.
Treat both men and women?	Men only. Usually 2-3 MST survivors in the program at any given time.
Rolling vs cohort admissions & length of program:	Rolling admission. Typical length of stay is 60-90 days.
Contact information:	Sherry Riney, LCSW – (650) 614-9997 x2-22965, sherry.riney@va.gov; Tasha Souter, MD, Medical Director of Trauma Recovery Program – (650) 614-9997 x2-23158, tasha.souter@va.gov

Senator GILLIBRAND. Thank you to each of you who have joined us on our second panel. I appreciate your expertise that you are going to bring to this discussion. I invite you each to give a personal statement of up to 7 minutes, and your full statement will be submitted for the record.

Dr. Bell, if you would like to start?

STATEMENT OF MARGRET E. BELL, PH.D., DIRECTOR FOR EDUCATION AND TRAINING, NATIONAL MILITARY SEXUAL TRAUMA SUPPORT TEAM, DEPARTMENT OF VETERANS AFFAIRS

Dr. BELL. Good morning, Chairman Gillibrand, Ranking Member Graham, and members of the subcommittee.

Thank you for the opportunity to discuss the intersection of two very important issues involving our servicemembers and veterans, namely MST and suicide.

We just heard the incredibly moving stories of the two veterans that testified who have struggled very much with the issues that we are discussing today. I very much appreciate their willingness to come today and really bring some of the data that I am about to speak about to life and make it more real for us today.

The stories they have shared really underscore the importance of the issues I would like to review in my comments, which is what research and empirical literature tell us about the health impact of MST, as well as the relationship between trauma, MST, and suicide specifically.

MST is an experience, not a diagnosis or a mental health condition. As with other forms of trauma, there are a variety of reactions that veterans can have after experiencing MST. The type, severity, and duration of a veteran's difficulties will all vary based on factors like the nature of the MST experienced, the reactions of others at the time and afterwards, and whether the veteran had a prior history of trauma.

Although the struggles that men and women have after MST are similar and may overlap in some ways, there can also be gender-specific issues that they may deal with. The impact of MST can also be affected by race, ethnicity, religion, sexual orientation, and other cultural variables.

Our veterans are remarkably resilient after experiencing trauma. But unfortunately, some do go on to experience long-term difficulties after experiencing MST. VA medical record data indicate that in fiscal year 2012, PTSD and depressive disorders were the mental health diagnoses most commonly associated with MST.

Other common diagnoses were other anxiety disorders, bipolar disorders, substance use disorders, and schizophrenia and psychotic disorders. Veterans who experienced MST often also struggle with physical health conditions and other problems, such as homelessness.

With regard to suicide, research has shown that trauma in general is associated with suicide and suicidal behavior. This is true for both civilian and military populations. But if we focus on sexual trauma specifically, data from civilian studies have found an association between sexual victimization and suicidal ideation, attempted suicide, and death by suicide. These relationships remain even after you control for mental health conditions like depression or PTSD.

Although less work has been done examining the link between sexual trauma and suicide among veterans specifically, the data that exist show a pattern similar to the studies of civilians that I just reviewed. That is, studies and VA administrative data show that sexual trauma during military service is associated with suicide attempts as well as death by suicide, and this association also holds even after accounting for mental health symptomatology.

Treatment approaches always need to be tailored to the specific needs of the individual veteran and take into account not only comorbid health conditions, but also the veteran's treatment and broader psychosocial history, his or her current life context, and his or her individual preferences.

Regarding treatment for veterans with PTSD specifically, a significant research base has accumulated identifying exposure-based cognitive behavioral therapies, such as cognitive processing therapy and prolonged exposure, as effective treatments for PTSD. Cognitive processing therapy and prolonged exposure in particular were originally developed for the treatment of sexual assault sur-

vivors with PTSD, and they have a particularly strong evidence base in this area.

Although these therapies should be considered a first-choice approach to treatment of sexual assault survivors with PTSD, some veterans may benefit from an initial focus on coping skills development before beginning these emotionally demanding treatments. This sort of phase-based approach can help augment their strategies for managing the emotional distress that may be brought up during completion of the cognitive behavioral treatment.

Psychoeducation about PTSD and the impact of sexual assault can also be an important component of treatment.

Madam Chairman, the VA is committed to ensuring that our veterans get the help that they need to recover from experiences of MST. I really appreciate having the opportunity to speak about some of the research in this area today, as well as thank you for your support of these important issues. I am prepared to respond to any questions you may have.

[The prepared joint statement of Dr. Bell and Dr. McCutcheon follows:]

PREPARED JOINT STATEMENT BY DR. MARGRET BELL AND DR. SUSAN MCCUTCHEON

Good morning, Madam Chairman, Ranking Member Graham, and members of the subcommittee. Thank you for the opportunity to discuss Department of Veterans Affairs' (VA) efforts regarding suicide and military sexual trauma (MST).

The Department is committed to assisting veterans who have experienced MST with their recovery. It can take great courage for a veteran to seek help after experiencing MST. However, there are caring and competent staff and effective programs at VA to assist male and female veterans who have experienced MST.

Veterans Health Administration (VHA) data show continually increasing rates of veterans seeking care. In fiscal year 2013, 93,439 veterans received MST-related care at VHA. This is an increase of 9.3 percent (from 85,474) from fiscal year 2012. The amount of care provided by VHA is also increasing: these veterans had a total of 1,027,810 MST-related visits in fiscal year 2013, which represents an increase of 14.6 percent (from 896,947) from fiscal year 2012.

Suicide prevention is a key priority for VHA, and these efforts are complemented by initiatives specific to veterans who experienced MST. To provide context for these efforts, we first review the existing research on the health impact of MST, with a particular focus on the relationship between MST and suicide. We then review VHA's specialized services to meet the range of difficulties that MST survivors might experience. VA also ensures that providers and key staff receive appropriate training on MST.

THE HEALTH IMPACT OF MILITARY SEXUAL TRAUMA

MST is an experience, not a diagnosis, and veterans will vary in their reactions to MST. Our veterans are remarkably resilient after experiencing trauma, but some do go on to experience long-term difficulties following MST. Specifically, research has found that both women and men are at increased risk for developing post-traumatic stress disorder (PTSD) after experiencing MST. In fact, MST is an equal or stronger predictor of PTSD than other military-related stressor (such as combat) or sexual assault during childhood or civilian life. fiscal year 2012 VA medical record data indicate that PTSD and depressive disorders were the mental health diagnoses most frequently associated with MST among users of VA health care. Other common mental health diagnoses include other anxiety disorders, bipolar disorders, substance use disorders, and schizophrenia and psychotic disorders.

RESEARCH ON MILITARY SEXUAL TRAUMA AND SUICIDE

Between both civilian and military populations, research has shown that experiences of trauma are associated with suicidal behavior. With regard to sexual trauma specifically, data from civilian samples have shown an association between sexual victimization and suicidal ideation, attempted suicide, and death by suicide. These relationships remain even after controlling for comorbid mental health conditions like depression and PTSD.

Studies of suicide among veterans who experienced MST show similar findings. For example, among both Canadian and U.S. military forces, experiences of sexual trauma during military service are associated with suicide attempts and death by suicide. A study of veterans of Operation Enduring Freedom and Operation Iraqi Freedom similarly showed that experiences of sexual harassment and assault are associated with suicidal ideation. Consistent with studies of civilians, the association between sexual harassment/assault and suicidal ideation remained even after controlling for mental health symptomatology. VHA administrative data sources show a similar pattern of findings in that MST is significantly associated with risk for suicide for both women and men, and that this relationship remains even after controlling for age, medical and psychiatric conditions, and place of residence.

MILITARY SEXUAL TRAUMA-RELATED CARE IN THE VETERANS HEALTH ADMINISTRATION

Fortunately, recovery is possible after experiences of MST, and VHA has services spanning the full continuum of care to assist veterans in these efforts.

Recognizing that many survivors of sexual trauma do not disclose their experiences unless asked directly, it is VA policy that all veterans seen for health care are screened for experiences of MST. Veterans who screen positive are offered a referral for mental health services. In fiscal year 2013, among the 77,681 female veterans who screened positive for experiences of MST, 58.7 percent received outpatient MST-related mental health care. Among the 57,856 male veterans who screened positive for experiences of MST, 44.3 percent received outpatient MST-related mental health care.

All VA health care for physical and mental health conditions related to MST is provided free of charge. Receipt of these free MST-related services is entirely separate from the disability compensation process through the Veterans Benefits Administration (VBA), and service connection (upon which VA disability compensation is based) is not required. Veterans are able to receive free MST-related care even if they are not eligible for other VA health care.

Every VA medical center provides MST-related care for both mental and physical health conditions. Outpatient MST-related mental health services include formal psychological assessment and evaluation, psychiatry, and individual and group psychotherapy. Specialty services are also available to target problems such as PTSD, substance use, depression, and homelessness. Many community-based Vet Centers also have specially-trained, sexual trauma counselors. Complementing these outpatient services, VA has mental health residential rehabilitation and treatment programs and inpatient mental health programs to assist veterans who need more intense treatment or support. Some of these programs focus specifically on MST or have specialized MST tracks.

MST Coordinators are available at every VA medical center to assist veterans in accessing these services.

EDUCATION AND TRAINING FOR VA STAFF ON MST AND SUICIDE PREVENTION

Ensuring staff have the training they need to work sensitively and effectively with veterans who experienced MST is a priority for VA. All VA mental health and primary care providers are required to complete mandatory training on MST. VA's national MST Support Team hosts monthly teleconference training calls on topics related to MST. These calls are open to all staff and are available for later review on the VA intranet. Content on suicide and sexual trauma has been included in these and other MST-specific training efforts.

In addition, as part of its strong commitment to provide high quality mental health care, VHA has nationally disseminated and implemented specific, evidence-based psychotherapies for PTSD and other mental and behavioral health conditions. Because PTSD, depression, and anxiety are commonly associated with MST, these national initiatives are important means of expanding MST survivors' access to treatments. Furthermore, several of these treatments were originally developed to treat sexual assault survivors and have a particularly strong research base with this population.

Recognizing the strong link between sexual trauma and risk for suicide, VHA's national MST Support Team has an ongoing collaboration with VA's Veterans Crisis Line (VCL). Some current efforts include the development of specialized materials to further enhance VCL staff's understanding of issues specific to MST and facilitate sensitive and effective handling of calls from veterans who experienced MST. The MST Support Team and the VCL are also working to train and identify staff on the VCL with particular expertise in sexual trauma who can provide consultation to other staff members on issues specific to MST.

Complementing these efforts, MST coordinators, at VA facilities, have been encouraged to develop close working relationships with facility Suicide Prevention Coordinators. These relationships will allow MST Coordinators to ensure local suicide prevention initiatives incorporate information about MST and target the unique needs of MST survivors. They also will facilitate close collaboration in addressing the treatment needs of specific veterans who experienced MST.

VA COLLABORATION WITH THE DEPARTMENT OF DEFENSE

Complementing VA collaborations with the Department of Defense (DOD), VHA's Office of Mental Health Services and its national MST Support Team have a longstanding relationship with DOD's overarching Sexual Assault Prevention and Response Office (SAPRO). SAPRO and the MST Support Team have provided trainings to staff in each Department to ensure that each are aware of the other's services and are able to pass this information along to servicemembers with whom they work. SAPRO and the MST Support Team also communicate, as needed, to help connect individual veterans and servicemembers to services that match their treatment needs.

A top priority has been outreach to newly-discharged veterans and servicemembers transitioning off active duty to ensure they are aware of MST-related services available through VHA. Collaborations between DOD and other VA program offices have led to key accomplishments such as ensuring MST-specific content is part of mandatory outprocessing (i.e., Transition Assistance Program) completed by all servicemembers. Sexual Assault Prevention and Response programs, in each of DOD's Services have been provided with information about VA's services for distribution to DOD Sexual Assault Response Coordinators, other staff, and servicemembers, and information about VA's MST-related services and benefits has been included in DOD Sexual Assault Forensic Examination (SAFE) Helpline, staff trainings, and on the SAFEHelpline Web site.

VHA staff have also been pivotal members of a joint VA–DOD workgroup formed in relation to DOD/VA Integrated Mental Health Strategy Strategic Action #28, which focuses on VA and DOD research and mental health services for servicemembers and veterans who have experienced MST (both male and female).

CONCLUSION

Madam Chairman, VA is committed to providing the highest quality care our veterans have earned and deserve. Our work to effectively treat veterans who experienced MST and ensure eligible veterans have access to the counseling and care they need to recover from MST continues to be a top priority.

We appreciate Congress' support and are prepared to respond to any questions you may have.

Senator GILLIBRAND. Thank you.

Dr. McCutcheon?

STATEMENT OF SUSAN J. MCCUTCHEON, RN, ED.D., NATIONAL MENTAL HEALTH DIRECTOR, FAMILY SERVICES, WOMEN'S MENTAL HEALTH, AND MILITARY SEXUAL TRAUMA, DEPARTMENT OF VETERANS AFFAIRS

Dr. MCCUTCHEON. Good morning, Chairman Gillibrand, Ranking Member Graham, and members of the subcommittee.

Thank you for the opportunity to discuss the VA healthcare services for veterans who have experienced sexual trauma while serving on Active Duty or Active Duty for training, which is known as MST.

I would also like to thank the veteran panel for their detailed testimony of their struggles and the courage to share their stories with us today.

VA is committed to ensuring that eligible veterans have access to the healthcare services that they need to recover from MST. To this end, VA has been developing and executing initiatives to provide counseling and care to veterans who have experienced MST,

monitor MST-related screening and treatment, provide VA staff with training, and inform veterans about our available services.

Fortunately, recovery is possible after experiences of MST, and the Veterans Health Administration (VHA) has services spanning the full continuum of care to assist veterans in these efforts. Recognizing that many survivors of sexual trauma do not disclose their experiences unless asked directly, it is VA policy that all veterans seen for healthcare are screened for experiences of MST.

Veterans who screen positive are offered a referral for mental health services. All VHA healthcare for physical and mental health conditions related to MST is provided free of charge. Receipt of free MST-related services is entirely separate from the disability compensation process through the Veterans Benefit Administration (VBA), and service connection is not required for this free treatment.

Every VA medical center provides MST-related outpatient care for both mental and physical health conditions. Complementing these outpatient services, VA has mental health residential rehabilitation and treatment programs and inpatient mental health programs to assist our veterans who need more intense treatment or support.

We have MST coordinators at every VA medical center, who will assist veterans in accessing these services. It can take tremendous courage for veterans to seek out help after experiencing MST. Fortunately, VHA data shows continually increasing rates of veterans seeking care.

Ensuring staff have the training they need to work sensitively and effectively with veterans who have experienced MST is a priority for VA. All VA mental health and primary care providers are required to complete a mandatory training on MST.

The VA's National MST Support Team hosts monthly teleconference training calls open to all VA staff on topics related to MST. Content on suicide and sexual trauma has also been included in other MST-specific training efforts.

In addition, as part of its strong commitment to provide high-quality mental healthcare, VA has nationally disseminated and implemented specific evidence-based psychotherapies for PTSD and other mental health conditions. Because PTSD, depression, and anxiety are commonly associated with MST, these initiatives are very important means of expanding MST survivors' access to evidence-based treatments.

Recognizing the strong link between sexual trauma and risk for suicide, VA's National MST Support Team has an ongoing collaboration with the VA's Veterans Crisis Line. Current efforts include the development of specialized materials to further enhance all Veterans Crisis Line staff's knowledge of MST-specific issues and facilitate sensitive and effective handling of calls from veterans who have experienced MST.

Complementing these efforts at the local level, MST coordinators have been encouraged to develop working relationships with the facilities' suicide prevention coordinators. These relationships will allow MST coordinators to ensure local suicide prevention initiatives incorporate information about MST and target the unique needs of these survivors. This close collaboration will also facilitate

addressing the treatment needs of specific veterans at their facilities who have experienced MST.

Madam Chairman, the VA is committed to providing the highest quality care that our veterans have earned and deserve. Our work to effectively treat veterans who have experienced MST and ensure eligible veterans have access to the counseling and care they need to recover from MST continues to be a top priority.

I appreciate your support and am prepared to respond to any questions you may have.

Thank you.

Senator GILLIBRAND. Thank you.

Dr. Galbreath?

Dr. GALBREATH. Dr. Guice is going to be presenting for us.

Senator GILLIBRAND. Dr. Guice?

STATEMENT OF KAREN S. GUICE, M.D., M.P.P., PRINCIPAL DEPUTY ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS; NATHAN W. GALBREATH, PH.D., M.F.S., SENIOR EXECUTIVE ADVISOR, DEPARTMENT OF DEFENSE SEXUAL ASSAULT PREVENTION AND RESPONSE OFFICE; AND JACQUELINE GARRICK, LCSW–C, BCETS, DIRECTOR, DEPARTMENT OF DEFENSE SUICIDE PREVENTION OFFICE

Dr. GUICE. Madam Chairman, members of the subcommittee, thank you for the opportunity to assess DOD's support for sexual assault survivors and the relationship between sexual assault, the subsequent development of PTSD, and suicide.

Sexual assault survivors are at an increased risk for developing sexually transmitted infections, depression, anxiety, and PTSD, conditions that can have a long-lasting effect on well-being and future functioning and can precipitate suicidal thought.

To address these and other potential risks, and regardless of whether the survivor is male or female, whether the sexual assault occurred prior to joining the military or during service, or whether the manifestations are physical or emotional, DOD has policy, guidelines, and procedures in place to provide access to a structured, competent, and coordinated continuum of care and support for survivors of sexual trauma. This continuum begins when the individual seeks care and extends through their transition from military service to the VA or care in their communities.

DOD has issued comprehensive guidance on medical management for survivors of sexual assault for all military treatment facilities and service personnel who provide or coordinate medical care for sexual assault survivors. Included in this guidance is the requirement that the care is gender responsive, culturally competent, and recovery oriented.

Any sexual assault survivor who presents to one of our military treatment facilities is treated as a medical emergency. Treatment of any and all immediate life-threatening conditions takes priority. Survivors are offered testing and prophylactic treatment options for sexually transmitted illnesses. Women are advised of the risk for pregnancy and counseled with regards to emergency contraception.

Prior to release from the emergency department, survivors are provided with referrals for additional medical services, behavioral health evaluation, and counseling in keeping with the patient's

preferences for care. In locations where DOD does not have the needed specialized care, including emergency care within a given military treatment facility, patients are referred to providers in the local community.

Last spring, the Assistant Secretary of Defense for Health Affairs issued a memorandum to the Services regarding reporting compliance with these standards. The Services returned detailed implementation plans, and the first of a yearly reporting requirement is due this summer from each of them.

The long-term needs of the survivors of sexual assault often extend beyond the period which a servicemember remains on Active Duty. To support individuals with mental healthcare needs, DOD provides the inTransition program. This program assigns servicemembers to a support coach to bridge between healthcare systems and providers.

You asked about the relationship between suicide, PTSD, and sexual abuse. We know from civilian population research that sexual assault is associated with an increased risk of suicidal ideation, attempts, and completions. Furthermore, this association appears to be independent of gender.

Sexual assault is also associated with mental health conditions such as depression, anxiety, and PTSD. Likewise, these mental health conditions are associated with suicidal ideation, attempts, and completions.

For military populations, the evidence associating sexual assault and subsequent suicidal ideation, attempt, or completion is less well-defined for that of the civilian population. Between 2008 and 2011, the number of individuals who attempted or completed suicide and reported either sexual abuse or harassment in DOD ranged from 6 to 14 per year, or 45 in total. Only nine of those individuals also had a diagnosis of PTSD.

These data show an association that is similar with clinical experience and prior studies in civilians. The data do not, however, describe causation, the nature of the association, its directionality, or potential influence of additional comorbidity factors.

DOD has a variety of research initiatives directed to better understand the variety of issues associated with suicide, including risk factors, the impact of deployment, and possible precursors.

Madam Chairman, members of the subcommittee, thank you for the opportunity to discuss these very important issues. Our policies within DOD are designed to ensure that all trauma survivors, and particularly those subjected to sexual assault, have access to a full range of medical and behavioral health programs to optimize recovery and that their transition from military service back to civilian life is supported.

I also would like to add my thanks to the witnesses today. It is compelling testimony that makes us see ourselves in a better light.

Thank you.

[The prepared statement of Dr. Guice, Dr. Galbreath, and Ms. Garrick follows:]

JOINT PREPARED STATEMENT BY DR. KAREN GUICE, DR. NATHAN GALBREATH, AND MS. JACQUELINE GARRICK

Madam Chairman, members of the subcommittee, thank you for the opportunity to discuss with you the Department of Defense's (DOD) support for sexual assault

survivors and the relationship between sexual assault, the subsequent development of post-traumatic stress disorder (PTSD) and suicide. The Department is committed to ensuring that all servicemembers and DOD beneficiaries receive access to timely, evidence-based health care delivered by competent and compassionate providers. The Department is also committed to a strong prevention strategy for sexual assault and suicide in the military.

POST-TRAUMATIC STRESS DISORDER, SEXUAL ASSAULT, AND SUICIDE

One of the signature injuries from the Operation Enduring Freedom, Operation Iraqi Freedom, and Operation New Dawn conflicts is PTSD, a treatable psychological condition commonly associated with a traumatic event. The Department Armed Forces Health Surveillance Center has tracked a continuously rising prevalence of PTSD in the force, which has doubled from approximately 1 percent of servicemembers to approximately 2 percent in the last decade of war. Unfortunately, not everyone who develops PTSD symptoms seeks care and, for some, PTSD symptoms may not develop until months or years following the traumatic event. DOD routinely screens servicemembers, both pre- and post-deployment, for PTSD symptoms. For those who screen positive, we provide a number of treatment options and are monitoring the outcomes of those therapies. We also have integrated behavioral health providers into the primary care clinics to deliver timely interventions for those who need this type of help and support.

Trauma associated with sexual assault—a term that encompasses a range of penetrating and non-penetrating crimes—is also a treatable psychological condition. In fact, many of the treatments developed for PTSD were designed specifically for sexual assault survivors. Recovery from any form of sexual assault can be very challenging for the survivor and the people that support them. Given the stigma and shame that many survivors experience following the crime, it is often difficult for victims to engage care or even report. Civilian and military research both show that less than a third of sexual assaults are ever reported to law enforcement, with the vast majority of reporters being women; men rarely report these crimes. This is unfortunate because Department of Justice research finds that reporting of sexual assault makes it much more likely that victims will engage care and treatment. Consequently, the Department took the advice of civilian experts and instituted two reporting options in 2005—Unrestricted and Restricted Reporting—to facilitate reporting and help victims to get needed care and services they deserve. Over time, this approach has worked. In 2004, before the Sexual Assault Prevention and Response Program was instituted, the Department received only 1,700 reports of sexual assault. In fiscal year 2013, preliminary data indicates that were about 5,400 reports of sexual assault—more than three times the number received in 2004. While any report of sexual assault is troubling, this increase in reporting of the crime has allowed us to offer many more survivors the assistance and care they need to help restore their lives. Care helps survivors better cope with not only the symptoms of PTSD, but also with other conditions known to impact survivors, such as substance dependence, anxiety disorders, and depressive disorders—which for some may bring about thoughts of suicide.

We know from civilian population research that experiencing sexual assault, especially childhood sexual assault, are associated with increased risks of suicidal ideation, attempts and completions. Furthermore, this association appears to be independent of gender. As I previously stated, the experience of sexual assault is also associated with increased risk for a number of mental health conditions. Some of these mental health conditions may also be associated with suicidal ideation, attempts, and completions.

Overall, suicide deaths among members of the U.S. Armed Forces increased between 2001 and 2012, peaking in 2012 with a rate of 23.3 per 100,000. For 2013, preliminary data shows that this trend is reversing. While there was an increase in female suicides from 2011 to 2012, the majority of suicides are among males, reflective of the overall military population. DOD collects information about suicides, both completed and attempts. This includes information about reported sexual abuse or sexual harassment before and since joining the military, as well as medical conditions, such as PTSD.

Between 2008 and 2011, the total number of individuals who attempted or completed suicide and reported either sexual abuse or harassment ranged from 6 to 14 individuals. During that same time period, only nine individuals who completed suicide also had a diagnosis of PTSD.

For military populations, the evidence associating sexual assault and subsequent suicidal ideation, attempt or completion is less well defined. More work certainly needs to be done in clinical and research spectra. Until we have more conclusive

data, we assume that our military community would have the same risks as those in the civilian community following sexual assault.

In order to address a need for more information, Defense Suicide Prevention Office and Sexual Assault Prevention and Response Office (SAPRO) are jointly sponsoring a study to better understand the prevalence of suicide risk among sexual assault victims. Using data from the Survey of Health-Related Behavior of Active Duty members, the study will assess the existence of statistically significant relationships between self-reported instances of sexual assault and suicidal ideation and attempts. In addition, the study will analyze the extent to which risk factors for sexual assault overlap with risk factors for suicidal ideation and attempts.

DOD will also include a behavioral health-related question in the Defense Equal Opportunity Management Institute's Organizational Climate Survey (DEOCS) for the first time in 2014. The DEOCS questionnaire measures climate factors associated with equal opportunity and employment programs, organizational effectiveness, discrimination/sexual harassment, and sexual assault prevention and response.

In addition to these research efforts, the Department is focusing on reducing stigma, increasing education, and building resilience. Each of the Services offers comprehensive suicide awareness training that teaches servicemembers to recognize the warning signs and symptoms of self-harming behavior, resilience building skills, and to intervene when necessary. A key feature to the training and outreach being done by the Services promotes the use of the Veterans/Military Crisis Line (V/MCL) that is a collaborative effort with the Department of Veterans Affairs (VA), which staffs the call center. The V/MCL is a 24/7/365 confidential crisis line that is available to all servicemembers and their families throughout the United States, Europe, and Japan and online worldwide. For those not in immediate crisis, but seeking solutions, Vets4Warriors provides 24/7/365 confidential peer support and resilience case management for Active and Reserve component members and their families. Using the Reciprocal Peer Support Model, the program assists servicemembers who are facing personal challenges with tools to manage their stress and build their resilience. Vets4Warriors will continue to provide resilience case management and transition assistance to its sister programs at VA throughout the callers military career life-cycle.

DEPARTMENT OF DEFENSE EFFORTS

Because sexual assault and harassment, PTSD and suicide are issues of great concern, DOD has invested in a variety of prevention and treatment strategies, as well as policies and protocols to ensure that appropriate care and support is provided. Sexual assault survivors are at increased risk for developing sexually transmitted infections, depression, anxiety, and PTSD; conditions that can have a long-lasting effect on well-being and future functioning, and can precipitate suicidal thinking.

To address these and other potential risks, and regardless of whether a survivor is male or female, whether the sexual assault occurred prior to joining the military or during service, or whether manifestations are physical or emotional, DOD has policies, guidelines and procedures in place to provide access to a structured, competent and coordinated continuum of care and support for survivors of sexual trauma. This continuum of care begins when individuals seek care and extends through their transition from military service to the VA or to care in their communities.

Department of Defense instructions provide comprehensive guidance on medical management for survivors of sexual assault for all Military Health Service personnel who provide or coordinate medical care for sexual assault survivors. These detailed instructions mandate that the Military Medical Departments meet specific standards of care, including standards for sexual assault forensic exams, health care provider training, and the provision of comprehensive and timely care and support to survivors. DOD requires that care is gender-responsive, culturally competent and recovery oriented. Moreover, healthcare professionals providing care to sexual assault survivors are also required to recognize the potential for pre-existing trauma and the perils of re-traumatization.

According to the Department's instructions, the case of any sexual assault survivor who presents to one of our military treatment facilities is treated as a medical emergency. In the emergency department, survivors receive a comprehensive evaluation that includes a detailed history and physical examination. Treatment of any and all immediate life-threatening injuries takes priority. Once an individual is stabilized, he or she is provided with the services of a Sexual Assault Response Coordinator (SARC) or Sexual Assault Prevention and Response Victim Advocate (VA), and offered a sexual assault forensic examination (SAFE). In addition, survivors are offered testing and prophylactic treatment options for human immunodeficiency virus and other sexually transmitted illnesses. Women are advised of their risk for

pregnancy and counseled regarding options for emergency contraception. Prior to release from the emergency department, health care providers ensure all survivors receive instructions for the treatment provided, as well as referrals for additional medical services and behavioral health evaluation and counseling.

DOD policy requires that standardized forensic examinations are offered to all sexual assault survivors who present for care. The Standardized SAFEs follow the U.S. Department of Justice Protocol, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents." Military Treatment Facilities (MTFs) must have either SAFE trained healthcare providers at the MTF or agreements with local civilian providers to conduct these exams. SAFE kits are available at all Medical Treatment Facilities (MTFs) and providers document their findings using the most current edition of Department of Defense Form 2911 (DD 2911), "DOD Sexual Assault Forensic Examination Report." Furthermore, DOD requires that all collected specimens are appropriately labelled and that the evidentiary chain of custody is maintained.

SARCs and Advocates serve as a single 24/7 point of contact for sexual assault survivors and help coordinate all services provided to survivors including follow-up health care. SARCs are responsible for counseling survivors on the choice between unrestricted and restricted reports, and for coordinating subsequent actions following the survivor's decision on reporting. The DD Form 2911, mentioned above, documents the reporting preference (restricted or unrestricted) of the sexual assault survivor. When a survivor elects to pursue an unrestricted report, SARCs facilitate the initial interaction with a Service's Military Criminal Investigative Organization (MCIO—Army Criminal Investigative Division, Naval Criminal Investigative Service, and the Air Force Office of Special Investigations). SARCS also ensure that SAFE Kits and associated evidence are provided to the appropriate Military Criminal Investigative Organization when unrestricted reporting is selected. Restricted reports are kept confidential and, consistent with the survivor's wishes, criminal investigators and commanders are not notified.

When a survivor requests a SAFE yet elects restricted reporting, a restricted reporting control number is generated for specimen labeling purposes. This approach provides survivors the ability to recover at their own pace, with a degree of desired control and privacy, while preserving the option to convert a case to an unrestricted report at a later date.

DOD provides a wide range of medical treatment for both the physical and emotional injuries that may result following any traumatic event, including sexual assault. Identification of a patient's needs begins when they first seek medical care or with the assistance of a SARC—whether the event was immediate, recent or if it occurred in years past. Individuals are offered evidence-based behavioral health services or a referral for follow-up medical services as clinical conditions and patient preference dictate. Access to both needed evidence-based medical care and behavioral health services is widely available across DOD to address the specific physical and emotional needs of traumatized individuals. In locations where DOD does not have a particular form of specialized care within a given Military Treatment Facility, patients are referred to specialty providers in the local community.

Patient preference and involvement drive the type of approach used in order to achieve maximal recovery. This includes the type of therapy selected, whether or not medication is prescribed, or both. Patient preference for the gender and/or duty-status of the therapist are respected and accommodated. Delivery of medical and mental health care is responsive and sensitive to the patient's gender, sexual orientation, age, and other issues of personal identity.

Patient preference has also motivated us to provide multiple methods of entry into care. Given the stigma, fear, and shame associated with this horrible crime, the Department created DOD SAFE Helpline—a crisis support service for adult servicemembers of the DOD community who are survivors of sexual assault. SAFE Helpline is owned by the Department of Defense and is operated by the non-profit Rape, Abuse and Incest National Network, the Nation's largest anti-sexual violence organization. This service is independent of DOD and all information shared by visitors is anonymous and confidential. SAPRO has also expanded the SAFE Helpline by adding content which specifically addresses concerns and questions asked by male survivors in the military. Based on SAFE Helpline staff interactions with callers, it appears that sometimes men find it easier to first tell an anonymous SAFE Helpline staffer rather than a loved one about their sexual assault. This allows the survivor to speak to someone who is trained to listen and help. Many men find that talking to staff first makes it easier to tell friends and family later.

Survivors of sexual assault may also access care through Military OneSource. While OneSource is not anonymous, survivors may engage a variety of care options through this confidential Department of Defense-funded program that provides com-

prehensive information on every aspect of military life at no cost to Active Duty, Guard, and Reserve component members, and their families. Confidential services are available 24-hours-a-day by telephone and online. In addition to the website support, Military OneSource offers confidential call center and online support for consultations on a number of issues. Military OneSource also offers confidential non-medical counseling services online, via telephone, or face-to-face. Survivors may receive confidential non-medical counseling addressing issues requiring short-term attention. However, should survivors require more intensive support, civilian OneSource providers provide referrals back to the military healthcare system.

We recognize that the long-term needs of survivors of sexual assault often extend beyond the period in which a servicemember remains on active duty. When sexual assault survivors are still actively receiving behavioral health care at the time of separation from the Service, they are linked to the DOD inTransition Program to help ensure that continuity of care is maintained. The inTransition program assigns servicemembers a support coach to bridge support between health care systems and providers. The coach does not deliver behavioral health care or perform case management, but is an added resource to patients, health care providers and case managers to help ensure transition of care is seamless. SAFE Helpline also provides information for sexual assault survivors that may be transitioning from military to civilian life.

Madam Chairman, members of the subcommittee, we want to again thank you for the opportunity to appear before you today to discuss these very important issues. The Department's policies are designed to ensure that all trauma survivors, and particularly those subjected to sexual assault, have access to a full range of health treatments and support programs to optimize recovery. We look forward to any questions you may have.

Senator GILLIBRAND. Thank you all for being here today.

For the DOD witnesses, I don't know who is appropriate, but I think it is perhaps Dr. Galbreath. I have heard from survivors and others that some are stopping therapy because they are afraid that their mental health records will be used against them during the court martial.

For example, the alleged victim in the Naval Academy case stopped going to therapy once she learned her records could be reviewed by a military judge and possibly provided to the accused and his attorneys. I understand that this comes under the constitutional exception to the psychotherapist-patient privilege. But I am concerned about the negative impact on survivors' mental health if they feel like there is no confidentiality for their treatments.

As practitioners, what might be the impact on survivors if they choose not to seek care because they are worried about therapy being made public? Are you seeing this happening? What do you think the risk is?

Related, when a victim and a survivor doesn't report the case, they might not have access to those mental health services because they have not been willing to come forward. So, again, the risk of PTSD or suicide may be higher than it should. I would like your thoughts on that.

Dr. GALBREATH. Thank you, ma'am.

Just to start out, as a psychologist, I am required to inform all patients seeking care with me that there are limitations to privacy and confidentiality in the military. That is part of the informed consent document that everybody that wants to come to see me as a provider has to understand.

Not only do I work through them with those limitations to privacy, and one of those issues is if an administrative or a court proceedings, there might be a situation where those records might become available. I also give them a verbal counseling as well to document that.

That is a concern that I think all therapy providers in DOD have. I haven't seen it happen very often, but it does happen. I am concerned. I have never had anyone quit treatment with me because of that concern, but I have seen other situations where that occurs.

So one of the things that I do, given my law enforcement background, is I am very careful about how I document care, and I also teach others at the Center for Deployment Psychology at the Uniformed Services University. About every 2 months, I teach anywhere from 60 to 70 different providers, and we talk about these issues and how to best protect our patients' care.

So that is something that we are very concerned about. You asked about what the chances are of a person's condition worsening if they don't get care, and that is definitely a possibility. Most people do tend to get better. I think what our research shows is that what we can do for most people is help them get better sooner with our therapy and our care.

However, for some people, they don't get better without care, and we do want to have a number of different ways to provide them treatment. So given those concerns, DOD has looked at a number of different ways to help people sample what is right for them.

Any victim of sexual assault has had a number of different things taken away—their health, their privacy, their sense of being. We want them to be able to sample at the rate that they would like to. The most anonymous way of doing that is through our DOD Sexual Assault Forensic Examination (SAFE) Helpline.

That is run for us by the Rape, Abuse, and Incest National Network (RAINN). It is completely anonymous. Victims can call in from any area, and they can get care and services that they need through there.

Senator GILLIBRAND. Thank you, Dr. Galbreath.

We have some information. I think this is for Dr. Guice. SAPRO gave us some new numbers, and we have raw numbers about restricted and unrestricted reports that have been made. We have a number, about 5,400 reports. Do we have the number of incidents so we can assess whether reporting has gone up or not?

Because when we compared the earlier reports when we had the benefit of looking at 2012 and 2011, the number of reported rapes went up, but the incidence rate went up higher. So, actually, there was a decrease in reporting from 13 percent to 9 percent. Do we know if there is higher incident rate or if we really have a higher reporting rate?

Dr. GUICE. I believe that is Dr. Galbreath.

Dr. GALBREATH. Okay. Ma'am, we don't have a survey this year for that. What I would offer to you is we know that even in 2006, when we had the highest rates of unwanted sexual contact reported, we only got about 2,900 servicemembers coming forward to make a report.

This year, with 5,400, we really do assess that this is due to increased victim confidence and more people hearing our message and understanding that we are going to take care of them. One piece of that that I would offer to you to consider is there are a portion of reports every year that come to us that occurred prior

to military service. This year, that percentage increased from 4 percent in 2012 to 11.5 percent in 2013.

All the offenders in those cases are outside the military justice system. So the only real reason for our survivors to come forward in that situation is to get care and services that we offer through the Sexual Assault Prevention and Response Program. We feel that that is a real——

Senator GILLIBRAND. So we have seen an uptick in reporting prior to service?

Dr. GALBREATH. Yes, ma'am.

Senator GILLIBRAND. Is that the difference between the two numbers?

Dr. GALBREATH. It is not the entire difference. Last year, we had a total of about 132 reports that were for incidents that occurred prior to service. This year, the number is 621.

Senator GILLIBRAND. So that is a huge increase for people who were assaulted before they joined the military.

Dr. GALBREATH. Yes, ma'am.

Senator GILLIBRAND. They are eligible for mental health——

Dr. GALBREATH. Care and services.

Senator GILLIBRAND. A related question. We have heard from survivors that after they report the assault and they attempt to seek mental health treatment, they were diagnosed with a personality disorder and are medically discharged. So this diagnosis is labeled as a preexisting condition and, therefore, effectively cuts off services for the survivor.

Many of these same survivors have said that after the assault, they still wanted to stay in the military and were planning on doing so. But because of the diagnosis of personality disorder, they were kicked out. What has your experience been with that issue, and what is the best way to address it?

I don't know if VA wants to address that or Dr. Galbreath.

Dr. GALBREATH. Do you want to——

Dr. GUICE. What we have done is that no one can leave the military, be separated for a personality disorder without a complete medical review so that we make sure that there is no underlying TBI that is causing the action or the behavior or psychological health issue that needs to be addressed. I think we have actually put a mechanism in place to make sure that we have safeguarded and that people are not leaving without a second look by medical professionals.

Dr. GALBREATH. If I could add to that, ma'am? Section 578 of the NDAA for Fiscal Year 2013, you helped us out with that, and we took your advice and we expanded on it a little bit. For any separation due to retaliation, within a year of the report, it had to be reviewed by a general officer. That was the nature of the law.

I checked in our military instructions, and that has been incorporated into the administrative separation instruction. But we have expanded it just a little. Instead of just a year from the date of report, we took it from a year from the date that the case disposition was made. So it is a much longer period.

Instead of just retaliation, admin separation, we have any separation administratively can be heard in this process and be reviewed. In addition to that, instead of the first general officer, flag

officer in the chain, we took it to the first general officer, flag officer in the chain of that administrative separation authority's chain of command. So it goes beyond that one person.

So we took your good idea and put it into our instructions.

Senator GILLIBRAND. Thank you.

Senator Graham.

Senator GRAHAM. A follow up on that. A personality disorder would make one subject to involuntary discharge. Is that right, Dr. Galbreath?

Dr. GALBREATH. Yes, sir.

Senator GRAHAM. The point we are trying to make is if you are a victim of an assault, one of the consequences, obviously, would be people would be disturbed, and it would show. That we don't want to cut off treatment. We don't want it to be anything other than an honorable discharge. We want to make sure that the person may no longer be able to serve in the military, but they are not denied treatment for what happened to them in the military. Is that correct?

Dr. GALBREATH. That is correct.

Senator GRAHAM. Okay. Now having said that, personality disorder is often used as a way to separate, and we want to make sure that we don't deny people treatment but, at the same time, not deny the military the ability to separate somebody from a unit for a cause.

As to this chart, it makes perfect sense to me that a person who has experienced sexual assault would have a higher propensity to have PTSD simply because of the nature of the attack, compared to anything else. The one category that we left out is combat-related action.

Most of the PTSD cases that I am familiar with come from people who have been involved in a combat-related experience. I would argue that a sexual assault is every bit as traumatic, if not more. So that makes perfect sense to me that that would occur.

Now about two things. The military system is being scrutinized, and that is fair. That is appropriate. We have a problem. You have to admit your problem before you can fix it. The question is how to fix it. That is what the whole debate is about.

I want to also highlight some of the things about the military that are worth noting. I asked the question if one of our staff members were assaulted at work, would they be entitled to medical disability as a result of that assault? I have been told that is not the case.

I just want people to understand that in the workplace in the civilian world, sexual assaults occur. Most employers are not going to be held liable for worker compensation claims based on the criminal acts of a third party. That is a general proposition of law.

In the military, when the assault occurs during employment, you are treated quite differently. I think that is a positive thing. Just realize that if somebody in your own office were assaulted, they are a Federal employee, under the law that exists now, all the things available to a military member would not be available to your staff. That is probably true in the civilian population.

So let us focus on the fact that if you get assaulted in the military sexually, there is an array of benefits and counseling available

to you unlike anything that I know of in the private sector, and I think that is very much appropriate because of your willingness to serve your country.

So how we make that better is the subject of the discussion, but we need to realize that our military members have access to healthcare, to treatment not available to the average person who goes through the similar experience in the workplace. We want to make it better, but we should be proud of the fact, quite frankly, that occurs in our military. We want to make it better.

Now about expanding treatment options. Both witnesses testified that they believe that services available in the civilian sector could supplement or greatly increase the likelihood of a better outcome. The one gentleman, the lance corporal, is TRICARE eligible. The other lady is not.

How do we deal with that dilemma? What do we do as a Congress to make sure that someone who goes through the disability evaluation process—you make a claim. "This happened to me in the military. I was sexually assaulted. As a result, I am having these problems." Once the medical board evaluates in the VA or DOD, you are eligible for compensation based on your evaluation.

This gentleman is eligible for TRICARE because of his disability rating. The lady was not. How do we correct that problem?

Dr. MCCUTCHEON. Senator, I certainly can't speak to the compensation process because that falls under the VBA. But for our veterans who screen positive for MST, and every veteran who comes to the VA is screened for these experiences, these are two questions. One question addresses sexual assault that occurred while you were on Active Duty or Active Duty for training, and the second question is sexual harassment.

If you answer yes to one or both of the questions, you are considered to have screened positive for MST.

Senator GRAHAM. Are you eligible then for civilian treatment outside the VA?

Dr. MCCUTCHEON. Non-VA care is always an option.

Senator GRAHAM. So these two witnesses, has anyone ever told them that? She is shaking her head no. How can that be?

Dr. MCCUTCHEON. What we do do, Senator, is that we have an MST coordinator at every VA facility, and we——

Senator GRAHAM. Is part of the screening process making you aware that you are available for treatment outside the VA?

Dr. MCCUTCHEON. If you screen positive, you are given a referral to mental health. We can always connect you with the MST coordinator, and that person can explore options for you if, for some reason, there is an access issue for you, like the gentleman spoke, as far as like 90 miles to get to treatment or various things.

Senator GRAHAM. Both of the witnesses seem to indicate that while they appreciate the services, they were limited and I understand overmedication. Every problem you have in the military, you have in the civilian world when you deal with these issues. People afraid to report, intimidated. The defense attorneys have to do their job. The rape shield law exists in the military, and exists in the civilian community.

Some of these problems we are never going to solve because somebody accused of a crime has a right to defend themselves, and

where that right starts and stops is always subject to debate. But both witnesses seem to be very much unaware that they had access to healthcare outside of the traditional VA system.

Do you agree with that statement by me? If so, how can we improve that?

Dr. MCCUTCHEON. I think, Senator, in all of our outreach materials, we encourage veterans to contact the MST coordinator at the facility, and that person is in a perfect position to help them as far as coordinating care within the facility or applying for non-VA care.

What we are finding, Senator, is that every year we have been tracking MST-related treatment is our numbers are increasing. We are seeing more and more veterans, after they have screened positive, coming to the VA for services.

Senator GRAHAM. I would just conclude, I want to end on a positive note, I appreciate the gains made and the focus and the attention. This is a very real problem for the military, and I think we are on the right track, but we can learn from these experiences. This has been a good hearing in that regard.

I really appreciate the additional scrutiny and Congress' interest. But for the two witnesses, I do think there is a gap. I think the average—at least these two, if they are representative, there seems to be a disconnect between what is actually available to them and what they perceive to be available to them. So let us try to fix that.

Thank you.

Senator GILLIBRAND. Dr. McCutcheon, I just want to follow up on Senator Graham's question.

Dr. MCCUTCHEON. Yes.

Senator GILLIBRAND. When did the MST coordinators get placed in every VA in the country? Was that in the last year, last 6 months?

Dr. MCCUTCHEON. In 2000, ma'am.

Senator GILLIBRAND. So there has been a MST coordinator at every VA in the United States since then?

Dr. MCCUTCHEON. Yes.

Senator GILLIBRAND. Is that person busy? [Laughter.]

Dr. MCCUTCHEON. Yes, ma'am. It is a position where there is a great focus on looking at our screening data, our treatment data, educating staff.

Senator GILLIBRAND. Do they meet with trauma survivors?

Dr. MCCUTCHEON. As part of their clinical work, yes. A majority of them do also provide treatment. The MST coordinators are predominantly either a psychologist or a social worker, and so as part of their clinical workload, they would be giving therapy, administering therapy as well as looking and monitoring their screening, treatment rates, other rates of the reports we provide.

Senator GILLIBRAND. Okay. I am going to make a formal request afterwards to get data on all the MST coordinators in every VA, how many patients they see a year, what their workload is. Because maybe they are not even known that they exist.

I would like to know what they actually do. So we can work on that later.

Dr. MCCUTCHEON. Thank you, ma'am.

Senator Kaine.

Senator KAINE. Thank you, Madam Chairman.

Thank you all for the work that you do on this important area.

I want to start with a concern that was raised by Corporal Arbogast and directing it to the VA, and that was the concern that he raised about as a man being told, we don't really have a group for men and feeling like the Services weren't at the same level.

I was just curious, Dr. McCutcheon, as I was looking at your title, you are the National Mental Health Director, and it says family services, women's mental health, and MST. Is that the name of a department or division or program? Family services, women's mental health, and MST.

Dr. MCCUTCHEON. Senator, that is a good question. It is actually three areas of responsibility I hold in my position.

Senator KAINE. I see.

Dr. MCCUTCHEON. I have a colleague who is the National Director for Evidence-Based Treatment and Psychogeriatrics.

Senator KAINE. Okay.

Dr. MCCUTCHEON. It just happened to be that those were the special areas. But my title in no way implies that we see MST as a women's issue. We have worked very hard to show it as a gender neutral disorder, and actually, the program responsibility for MST was removed from women's health services to be placed in mental health services in 2006.

Senator KAINE. Good. That is helpful.

Let me ask your reactions, each from the VA and the DOD side, about the discussion in both of our earlier witnesses, their concerns about this overmedication phenomenon. What could you tell me about that?

Dr. MCCUTCHEON. Senator, I will start from the VA. I really can't speak to that because I have no firsthand knowledge of what the VA is doing as far as analyzing the use of medication. So I would need to take that for the record. I am sorry.

Dr. GUICE. I don't know with the degree of specificity that I think really you need to have for this answer. So we would like to take it for the record, too.

Senator KAINE. Then what I will do is we will try to submit a precise question in writing rather than have you have to guess what we mean. That might be a little bit easier, and we will just take that one under advisement.

One concern, just to share a concern that I have heard and I don't know whether it is regionally or more general, is in the suicide prevention area. I think you guys do a good job of trying to publicize to Active Duty and veterans suicide prevention hotlines within DOD and VA.

I had an experience in the last year in the Hampton Roads area of Virginia, where there are a lot of veterans, of somebody saying they were doing a great job of putting out there is a suicide prevention hotline and there will always be somebody there to take your question and deal with you. He said, "But they didn't deal with me right away." I said, "Why not?" He said, "I contacted them right away."

We dug into it, and it was an individual who had emailed the email address. It turned out that the hotline really was a 24-hour hotline if you called on the phone. But if you emailed, it was a cold line, and he made the point to me that if you are in extremis in

a mental health area, it might—even the act of talking to someone can be a little bit tough, and it can be a little bit easier just to write an email and send that "I need help."

He felt like his cry for help was ignored, and as we got to the bottom of it, it turned out that maybe it was treated differently because it was an email. I would just recommend that to your attention that might be fixed or might have been an aberration, might have just been one VA hospital. But I can see why somebody in an extreme situation might feel more comfortable reaching out for help via an email than a phone call.

Ms. GARRICK. Senator, you raise a good point in that we know suicide is complex, and so we like to think that the way in which we deal with suicide also takes a multifaceted approach. So that when somebody reaches out for help that there are options in how they even initiate that contact.

What the VA has as the Veterans Crisis Line, the DOD uses it as well, and we brand it as the "military crisis line." It is the same crisis line.

We also have a Vets4Warriors program that we have funded in DOD that is a peer support program. So it gives you an option of if you just want to talk to a peer and do some problem solving, get a referral, and the peers also provide what we call resilience case management so that they can track and stay with you over the course of your military career.

The goal, though, is to make sure that regardless of whether you do a phone call, an email, a text, a chat, that when you look for help, there are different options and ways for you to find that help.

Dr. GALBREATH. Sir, I would offer that at the DOD SAFE Helpline as well, you can click, call, or text 24/7, and there is somebody there live to answer any kind of a reach-out from the individual.

Senator KAINE. Finally, I would like to go back to Ms. Kenyon's testimony. When I asked her that question about her analogy between incest and military sexual assault because of the betrayal factor, I was curious. In some full hearings before the Armed Services Committee, we have tackled, to some degree, the issue of suicide of Active Duty and veterans. Senator Donnelly on our committee has been really focused on this.

I recall some testimony that while it is a complex phenomenon, a number of military witnesses in the past talking about and enlightening me a little bit about it, that it is less people have come back, seen horrible things and the horrible things are weighing on them and driving them to suicide, and more that people were involved in such a close support network and then came back, and that network, that band of brothers and sisters was no more. Even if they had networks of people around them, they didn't understand what they had been through.

That experience of going from a close support network of colleagues to a feeling of disconnection, that that has been a factor in testimony earlier before the full committee that has been suggested that there is some research that really ties that into this problem of military suicide.

Am I remembering it or basically describing it correctly? Is that one of the factors?

Ms. GARRICK. Again, the causes and associated factors with suicide do tend to be very complex. We know that the primary factors associated with suicide are relationship issues, financial issues, and legal issues.

When we look at relationship issues, I think what you are describing is the loss of a relationship issue. We tend to think about that as an intimate relationship issue, but that does certainly extend beyond, and we know that this is—on the Active Duty side, this is mostly young white males who have died by or attempted suicide.

When they come and go from Active Duty or change units, we have seen the majority of our suicides are among those that in their first year of enlistment and who have never deployed and have not been in combat, and 89 percent have not seen combat.

There are some serious issues that we feel we try to look at, and that is why, again, the peer support and providing community-based care is so important is because we really see that those relationship issues are such a driving factor in relationship to suicide and self-harm.

Senator KAINE. Madam Chairman, just to close the loop with one last question that would then loop back to Ms. Kenyon's point about the betrayal phenomenon.

In a sexual assault within the military, if there is a close connection between colleagues, your superior, a sexual assault within your unit is the sundering of a relationship that you had an expectation that was a relationship based on trust. That suggests a little bit of the connection between sexual trauma in the military and this risk of suicide.

Ms. GARRICK. The Defense Suicide Prevention Office and Dr. Galbreath's office are working on a study right now looking at some of those intersections between suicide prevention and sexual assault response so that we can get a better understanding of how we can move forward on providing support and services to this population.

Senator KAINE. Thank you. Oh, do you want to say something?

Dr. GALBREATH. I was just going to say I couldn't agree more with Ms. Kenyon. It really is tantamount to an incest type of situation, and I think that is a very adequate description.

Senator KAINE. Thank you.

Thank you, Madam Chairman.

Senator GILLIBRAND. But to follow on, isn't the betrayal also that they have to tell their dad, or their dad is the decisionmaker. It is not just the betrayal that you are being raped by your brother. It is that second betrayal that makes it intense.

Dr. GALBREATH. It is depending on who the perpetrator is, ma'am, yes.

Senator GILLIBRAND. No. What I am saying is the second thing about reporting. The decisionmaker is, I have just heard one victim say it is like being raped by your brother, and your father decides the case. So the reference to incest goes beyond who the rapist is. It is also that it is decided as a family matter, and the person deciding has to decide between two children that they both deeply love.

That lack of objectivity to just look at the facts, look at the record, knowing the victim, knowing the perpetrator, according to this one victim, that was the second betrayal. It is not just one betrayal.

Dr. GALBREATH. It is so important now to have so many different ways to report so we can get it outside of that system that you can report to a sexual assault response coordinator——

Senator GILLIBRAND. We are just talking about the decision-maker. Your dad decides. There is no question. I was just trying to clarify the——

Dr. GALBREATH. Oh, okay.

Senator GILLIBRAND. No question.

Dr. GALBREATH. I am waiting, ma'am.

Senator GILLIBRAND. I was just clarifying what I understood the testimony to be, based on other conversations I have had with survivors and how they perceived it. That the incestuous reference is not just about who rapes you, it is also about who decides your future, your fate.

Dr. GALBREATH. That is not one that I had heard from my victims, but I understand what she said.

Senator GILLIBRAND. Senator Ayotte?

Senator AYOTTE. Thank you very much.

I want to thank the witnesses for being here.

I wanted to follow up, Dr. McCutcheon, just to clarify one point that I think it is important for people listening at home to understand is that in terms of sheer numbers, there are actually more male victims in the military of sexual assault than female victims. Isn't that right, just in terms of sheer numbers?

Dr. MCCUTCHEON. Senator, that was correct maybe about 3 or 4 years ago, but what we are seeing right now is there is actually more women who screen positive for MST who choose to come to the VA, who are part of our VA healthcare system. But the numbers are pretty close.

Senator AYOTTE. So we now have more women victims, with the recent numbers, that have come forward?

Dr. MCCUTCHEON. In our last fiscal year, ma'am, we have within our system about a little over 77,000 women who have screened positive for MST, and for the men, it is over 57,000.

Senator AYOTTE. Because the one point I wanted to make is that this isn't a male or a female victim situation. As this issue has come up in our committee and people talk to me about it, they make it an issue of this is an issue of women, and certainly women, there are fewer women in the military, and thankfully, they are taking on greater roles, which is a wonderful thing. I just want people to understand that are home right now that there are a lot of men who are victims as well and who are watching this.

This isn't a male or a female crime. This is a crime committed against anyone could be the victim of this in the military. I think that is important because people need to understand that as we get at this issue that it needs to be addressed for everyone.

One of the questions that I wanted to follow up with you, how long on average does it take for once the referral is entered, for someone actually to see a mental health provider?

Dr. McCUTCHEON. I am sorry, ma'am. I don't have that data with me as far as from screen to treatment. So I will have to take that for the record.

[The information referred to follows:]

It is important to note that Military Sexual Trauma (MST) is an experience, not a diagnosis or mental health condition in and of itself. Not every MST survivor will have long-term difficulties following the experience, and thus not every veteran who screens positive for MST will be interested in receiving MST-related treatment. At this time, data are not available on time to access mental health care among the subset of MST survivors who desire these services. VA is addressing this need through a revision to the MST screening procedures. All veterans are screened for MST via a Clinical Reminder in the electronic medical record that alerts providers of the need to screen the veteran, provides language to use in asking the veteran about MST, and documents the veteran's response to the screen. Currently, all veterans seen in VHA who screen positive for MST are offered a referral for further assessment and/or treatment of health concerns. The forthcoming revision to the MST Clinical Reminder will standardize this automatic referral process systemwide, via an option in the Reminder itself to initiate a referral for services. Incorporating the referral option into the Reminder will provide critical additional data for national monitoring efforts including data on whether veterans who request MST-related mental health services are able to access those services in a timely manner.

MST is associated with a wide range of mental conditions, and MST survivors receive care in a variety of mental health clinical settings. As such, VA policy for all mental health care generally is also relevant to MST survivors who request mental health services. It is VA policy that all new patients requesting or referred for mental health services must receive an initial evaluation within 24 hours, and a more comprehensive diagnostic and treatment planning evaluation within 14 days.

At this time, data are not available on time to access mental health care among the subset of veterans who have experienced MST. Steps are being taken to address the need for these data, as described in the previous response.

Senator AYOTTE. I would appreciate that because I think that is an important question because immediacy is really important, that people are waiting too long to see mental health providers. I hear this from people at home, and I can only imagine that this could be even exacerbated for someone who is a victim of sexual assault.

I would also like for you to take for the record, is that period getting shorter or longer? I think the other challenge we face is what is the situation in terms of providers? Are we facing a shortage of providers?

One of the things I was certainly glad to hear the report of is that more people are coming forward. That is what we wanted. We wanted to feel that people would be able to come forward, and we want more to come forward. Also that will mean that we will need to make sure that we have the providers to give treatment and to give support.

I wanted to get your answer on that one, too. What is our situation on having enough providers in the mental health area? Because my experience has been that even at my State, for example, taking it outside of the military context, we have a shortage of mental health providers within our State. So I would imagine that you may have similar challenges. I wanted to get your thoughts of whether we needed to put more of an emphasis on that.

Dr. McCUTCHEON. Senator, we are required to produce a report on capacity to provide MST-related mental healthcare, and virtually all medical centers within the VA system do have that capacity. So that is something that we do track.

Senator AYOTTE. Okay. If on the follow-up if you can let me know how long does an average person wait once the referral is made?

Also, if you can answer to me what you think the provider challenges are in terms of going forward, as we are going to have more people report, to make sure that we have adequacy of support system there. I would appreciate an answer to that as well.

[The information referred to follows:]

To fulfill the reporting requirements of title 38, U.S.C., section 1720D(e), VA's national Military Sexual Trauma (MST) Support Team completes an annual report to determine whether each Department of Veterans Affairs (VA) health care system has adequate capacity to provide MST-related care. Adequate capacity is assessed by comparing each facility to a benchmark staffing-to-population size ratio. The target benchmark ratio was established by examining facilities that provide a high volume of MST-related mental health care. Facilities that fall within two standard deviations of the staffing-to-population size ratios of these "high volume" VA health care systems are considered to have adequate capacity to provide MST-related care.

The most recent report found that for the analyzed fiscal year 2012, 99 percent of VA health care systems were at or above the established benchmark for MST-related mental health staffing capacity. During the year, over 64,000 veterans received MST-related mental health care from a VA health care facility. These veterans received a total of over 693,000 MST-related mental health care visits from over 17,950 individual providers.

Only one VA health care system was found to be below the target level for MST-related mental health staffing capacity. The MST Support Team and the Veterans Health Administration Office of Mental Health Operations partnered with mental health stakeholders at the health care system and healthcare network levels to develop and implement an action plan to increase documented staffing levels. The MST Support Team in collaboration with Office of Mental Health Operations regularly provide technical assistance and consultation to all VA health care systems to ensure the highest capacity for and quality of mental health care for veterans who have experienced MST.

Senator AYOTTE. Dr. Galbreath, I wanted to follow up on where we are with regard to the reports and the increase that we have seen in the reports. What do you think that that says in terms of you have talked, I think, fairly positively about that as an indicator that we are certainly glad that more people are feeling that they can come forward.

What do you think in terms of the role of the commander? Here, one of the pieces of legislation that we are going to be looking at is, within the system, who keeps the decision in terms of whether the charge will go forward?

The proposal that Senator McCaskill and I have is one that, if there is a difference of opinion between the Judge Advocate General lawyer and the commander, it would go up all the way to the civilian secretary in instances where the decision is not to bring a case. In instances where both are in line that a case should not be brought, then it still goes up for another level of review.

What effect do you see or what role do you believe the commander should have in terms of involvement in addressing this issue, if you have thoughts on this?

Dr. GALBREATH. I will offer, ma'am, I am a clinical psychologist. Clearly, my perspective would come from treating victims. So I know that any——

Senator AYOTTE. Yes, and I am only asking you from your own background and perspective.

Dr. GALBREATH. You bet. I would offer to you that we believe that commanders really do need to be more involved, not less involved in this process because we know that they are going to be critical to setting that climate of dignity and respect in a unit. That

is a kind of unit environment where we know that victims can heal and flourish.

Every single victim who comes forward is influencing, their experience influences other victims that are deciding whether or not to report. Until we get this right and we make sure that commanders are held appropriately accountable to set that climate of dignity and respect and have those tools with them that would allow them to enforce that climate, we really do believe that that is going to allow us to move forward on this and increase even more reports of sexual assault every year.

Senator AYOTTE. Thank you. I appreciate that.

Could you also give us an update, my time is almost gone here. We have talked a lot about the special victims' counsel today, and I think all of us are very supportive of this. This has been legislation that I worked on also with Senator Patty Murray, who was the chair of the Senate Veterans' Affairs Committee, now the chair of the Senate Budget Committee, but very involved in these issues.

Just how are things going? I know this is a very important and large undertaking. So, just as an initial report of what your thoughts are of implementing this important initiative that is going to give every victim counsel that is their counsel, that is there to advocate for them and no one else.

Dr. GALBREATH. Yes, ma'am. Very briefly, all the Services were supposed to have initial operating capability last October. They all stood up their full capability in January.

The Air Force has the greatest number. They had this program going for about a year now.

Senator AYOTTE. They started it as a pilot, and we extended it.

Dr. GALBREATH. They did.

Senator AYOTTE. Yes, that is right.

Dr. GALBREATH. Absolutely. Yes, ma'am.

The information that we have gotten back from the survivors that have used the special counsel is overwhelmingly favorable. I do believe that this is a deal-changer for victims of sexual assault in the military. Having that person to represent you increases their confidence. It allows them to understand what their options are even more from a legal perspective.

Although it is a small number, I would offer to you that what we have heard is of the restricted reporters that have engaged a special victim counsel, their conversion rate from restricted to unrestricted cases that would then bring them into the justice system and participate in a prosecution, their conversion rate is at about 50 percent, 5–0.

Senator AYOTTE. Wow.

Dr. GALBREATH. On average across DOD, we are about 14 to 15 percent conversion rate. Now once again, small numbers, but initial data. But we do think that this is very promising, and from a psychologist's perspective, I think it is great because it builds victim confidence and boosts their abilities and gives them a greater understanding of the legal system.

Senator AYOTTE. Thank you. I think one of the things we will be watching carefully is just making sure that we are updated on how it is being implemented so that every victim can have access to a special victims' counsel.

Dr. GALBREATH. Thank you, ma'am.

Senator GILLIBRAND. Senator King?

Senator KING. Madam Chairman, I am going to be very brief. First, I want to associate myself with your request for the data on the backlog. That is really important, and don't sugarcoat it. We want the straight data on from the day somebody on the average applies to the time they get accepted. Because treatment delayed is treatment denied in many of these cases. That is number one.

Number two, Madam Chairman, I think there is a gap here in coverage in the sense that TRICARE is only available to retirees 20 years or more. So if you can't get service at the VA for your service-related trauma, you don't have any other choices. So I think that is something we need to be thinking about that is not like they can turn around and to go to TRICARE and use their local provider.

Finally, Dr. Galbreath, this isn't really a question. I just want to make a statement. I don't understand why anybody would go to you for counseling if they understand that that record of that counseling can be made available in a later proceeding.

That just makes no sense whatsoever, and I want to revisit that one, Madam Chairman.

Senator GILLIBRAND. Absolutely.

Senator KING. Thank you.

Senator GILLIBRAND. Thank you, Senator.

Dr. Galbreath, I just want to go back over a little bit of your testimony. I agree that we have to set a climate of dignity and be more involved, not less involved for commanders. I agree that commanders need to actually be taking responsibility for setting command climate, making sure there is no retaliation, making sure the victim feels safe to come forward and report the crime, making sure he or she gets the mental health services and the support they need.

No one is actually suggesting commanders become less involved, and, in fact, when they do so, they actually distort the debate because the only commanders today who have the authority to be the convening authority to make a decision about whether to go to trial are very senior-level commanders. It is less than 3 percent of commanders.

So the 97 percent of commanders are as involved as they have ever been involved, and what we have been trying to do in the underlying bill is to make them more responsible by actually reviewing their record on creating a command climate that is consistent with no rape, no assault, that is conducive for victims to come forward.

Those commanders will never have the right to make the legal decision. So whether or not we take that right away from that 3 percent of top-level commanders, the purpose is to instill confidence by the victims.

If you listen to our victims panel and you listened to what they said, one of our victims was retaliated against by all these junior-level commanders. So, her hope that a senior-level commander would have her back doesn't exist because her perception is that all the other in the chain of command are going to retaliate against me so they will believe those commanders over me every time.

I really want you to focus on that because when you say I don't think they should be less involved, I don't think they should be less responsible, no one is arguing them to be less involved or less responsible. In fact, everything we have done in the NDAA is making them more responsible and more involved.

I just want to remove that appearance, and the VA's Web site specifically says that the current system is undermining recovery and is actually creating greater PTSD and undermining the patients. I read it when I did my opening statement. I don't know if you heard it, if you were all here, but it says here, "Many victims are reluctant to report sexual trauma, and many victims say that there were no available methods for reporting their experiences to those in authority." That is a perfect example of what our first witness, Ms. Kenyon, said. She didn't feel like she could tell anybody because everyone in her chain was retaliating against her.

"Many victims are reluctant to report sexual trauma, and many victims say that there were no available methods for reporting their experiences to those in authority. Many indicate that if they did report the harassment, they were not believed—" perfect example with Ms. Kenyon "—or encouraged to keep silent about the experience. They may have had their reports ignored or, even worse, have been themselves blamed for the experience. Having this type of invalidating experience following a sexual trauma is likely to have a significant negative impact on the victim's post-trauma adjustment."

How do you review that VA Web site's analysis?

Dr. GALBREATH. Ma'am, I would offer to you that the system that we have in place today is not the system that we had in place even a few years ago. When Mr. Panetta took the stand in January 2012 and he said we have a problem and he cited numbers associated with that, he put a chain of events in motion that I would offer to you have really substantively changed the landscape of the current military system.

What you see in our numbers this year, this is the system that we have now. This is the system that we have today. I believe that the increase in the number of reports have come from people that believe what our commanders are doing is correct and supporting them.

Senator GILLIBRAND. Dr. Galbreath?

Dr. GALBREATH. Yes, ma'am.

Senator GILLIBRAND. Two out of 10 rape victims are reporting today. I would not pat yourself on the back for 2 out of 10. Granted, according to your number, we know that there are more reports.

Dr. GALBREATH. Yes, ma'am.

Senator GILLIBRAND. But we don't have the base number. We don't know if it is the same thing that happened between 2011 and 2012 where total reports are up, but the incident rate skyrocketed. So, in fact, reporting by a percentage went down.

So please, before we have the evidence and data, we should not be patting ourselves on the back——

Dr. GALBREATH. Ma'am, I——

Senator GILLIBRAND.—on any level. Having 2 out of 10 report is insufficient and is still a significant failure. So please do not say we are succeeding. Because if 8 out of 10 victims stay mum because

they don't believe justice is possible or they fear retaliation, we are failing 8 out of 10, clearly.

Dr. GALBREATH. We have a long way to go. You are absolutely correct. But I would offer to you is that this is evidence of change in the system, and——

Senator GILLIBRAND. We don't know that. If we don't have the raw numbers, we don't know. We know that if you have been raped before you get in the military, there has been an increase in reporting. We don't know what the raw numbers of total rapes within the military were this year. We just know the number of brave individuals who came forward and actually signed their name to a real report.

But if the number of actual rapes went up, well, we are not doing any better. If it is still 1 out of 10 cases, we are still where we were last year.

Dr. GALBREATH. I don't see the data that way, ma'am.

Senator GILLIBRAND. You don't know the raw numbers. You can't see the data any way.

Dr. GALBREATH. We have had very consistent reporting of unwanted sexual contact since 2006. It is somewhere between 4 percent and 7 percent for women. For men, it is between 1 and 2 percent.

In that historical context, I judge that this increase in reporting is progress.

Senator GILLIBRAND. Unless there is an increase in rape, like what we saw between 2011 and 2012.

Dr. GALBREATH. Even so, ma'am, that was just in two instances in two Services. That wasn't across the board.

Senator GILLIBRAND. That is the DOD's report.

Dr. GALBREATH. Yes, ma'am. I was involved in that.

Senator GILLIBRAND. So——

Dr. GALBREATH. I would offer to you, ma'am, that you are exactly right. Next year, when we have a prevalence survey that we are able to judge in better context what this increase in reporting means, we will have a better picture. But given historical data and confirmation from other independent surveys that we have that have been conducted in the last 5 years, that this increase in reporting is a positive sign.

We are not done by any means. We are very cognizant that we have a lot more work to do, and it is not a pat on the back by any means. But I just want to make you understand that we do take this very seriously, and we are doing everything we can to bring more victims forward so they can get the help and care that they need so that they can restore their lives.

Senator GILLIBRAND. So can we go back to the issue of the VA's Web site? What is your impression of that?

Dr. GALBREATH. Ma'am, I would offer to you that was probably a snapshot of time of things in the past history. I don't know this article. I don't know what they are talking about as far as the time aspect goes.

But like I said, since 2012, we have had a number of reforms helped by you and the members of this body, as well as a number of other things that we have done to bring more victims forward.

Senator GILLIBRAND. Dr. Bell?

Dr. BELL. I am really best positioned to speak to research, but it looks like this is coming from the National Center for PTSD's Web site, which is, of course, a VA entity.

What I would turn to, thinking research-wise, is we certainly know that the types of support, the types of reactions that people get after experiences of sexual assault are really pivotal in their recovery. In fact, we know that it is the biggest and strongest predictor of their recovery afterwards and the biggest and strongest predictor of developing PTSD.

I think the systemic responses, I think the support from family and friends, I think the societal response more generally is really going to strongly shape the course of someone's recovery after an experience like this.

Senator GILLIBRAND. Thank you all for testifying. I am extremely grateful for the hard work you are doing. I am extremely grateful that you have taken it upon yourself with both the DOD and the VA to meet the needs of these survivors.

I know this is a very, very, hard, hard, and difficult road ahead of us. But I trust your commitment, and I am grateful for that commitment because you are the difference between men and women receiving the care they need and not.

Thank you so much for your service, and thank you for being here today.

Dr. GALBREATH. Thank you, ma'am.

[Whereupon, at 12:33 p.m., the subcommittee adjourned.]

[Questions for the record with answers supplied follow:]

QUESTIONS SUBMITTED BY SENATOR KIRSTEN E. GILLIBRAND

MILITARY SEXUAL TRAUMA

1. Senator GILLIBRAND. Dr. McCutcheon, you stated in your testimony that: (1) recovery is possible for those who have been diagnosed with Military Sexual Trauma (MST); (2) MST services are provided free of charge at the Department of Veterans Affairs (VA); and (3) there are MST coordinators at every VA Medical Center. Please provide information on the total number of MST coordinators nationwide and the description of their responsibilities.

Dr. MCCUTCHEON. Veterans Health Administration (VHA) Directive 2010–033, MST Programming, provides information about the MST coordinator role and specifies that every VA health care system must appoint an MST coordinator. Some health care systems choose to split the MST coordinator duties among multiple appointees. For example, some health care systems may have one MST coordinator for the VA Medical Center but another for the community-based outpatient clinics associated with the health care system. In March 2014, there were 163 staff members serving in MST coordinator roles across the VA health care system.

MST coordinators have five primary areas of responsibility:

1. Implementation of national, Veterans Integrated Service Network (VISN), and local-level screening and treatment policies. MST coordinators help ensure that veterans being seen for care at the facility are screened for experiences of MST, that veterans have access to needed MST-related services, and that the care is provided free of charge. Coordinators monitor local MST-related programming and make efforts as needed to expand the scope of available services.
2. Implementation of national, VISN, and local-level staff education policies. MST coordinators help ensure that local staff members receive mandated MST education and training and provide training as needed in clinics throughout the health care system to ensure that staff members have the needed knowledge and skills to work effectively with MST survivors.
3. Implementation of national, VISN, and local-level informational outreach policies. MST coordinators engage in outreach to veterans to raise awareness of the availability of MST-related services and to facilitate engagement in care.

4. Serving as local point person for MST-related issues. MST coordinators serve as local points of contact, sources of information, and problemsolvers regarding MST-related issues for both veterans and VA staff. They engage in consultation with local offices and services, serve as advocates for veterans in working with the system, and address systems issues that may create barriers to care.
5. Communicating with national, VISN, and facility-level leadership. MST coordinators stay in regular contact with leadership, stakeholders, their VISN-level points of contact, and other MST coordinators in their VISN, in order to stay apprised of polices and trends related to MST. MST coordinators also respond to requests for information about local MST programming from VA Central Office.

2. Senator GILLIBRAND. Dr. McCutcheon, you stated that these MST coordinators are the single point of contact for every veteran who screens positive for MST. What is the average workload for each of these coordinators? Please include the number of veterans seen annually by these coordinators.

Dr. MCCUTCHEON. To clarify, MST coordinators serve as point people for MST-related issues within their facility. They serve as sources of information and problemsolvers both for veterans and for staff. When needed on a case-by-case basis, MST coordinators consult on care-related issues for particular veterans or serve as advocates to assist particular veterans with navigating the system. Although individual facilities may choose to set up a process wherein the MST coordinator has personal contact with every veteran who screens positive for MST, this is not a model required by national policy.

With respect to MST coordinator workload, VHA Directive 2010–033 permits facilities to designate the MST coordinator as a collateral position, performed in addition to other roles. It is an administrative position in that direct clinical care and case management responsibilities are not part of the role. However, most staff in the MST coordinator position do provide clinical care to MST survivors as part of other roles. The Directive requires facility leadership to ensure that MST coordinators have adequate protected administrative time to fulfill the responsibilities of the position. Currently, no specific amount of protected time is required, as facilities vary widely in their size, complexity, number of veterans seeking MST-related care, and other factors relevant to the MST coordinator role. Facility leadership is encouraged to consider these factors when determining how much protected time is needed.

VA has recent survey data that provide some information about how much protected time MST coordinators are allocated. As part of the Department of Defense (DOD)/VA Integrated Mental Health Strategy (IMHS) Strategic Action #28, a survey of practice was disseminated to VA health care facilities. Among other areas, facility leadership were asked to indicate whether the local MST coordinator had been given protected time for the duties of that role. The majority of facilities (82 percent) reported that the MST coordinator has protected time to devote to MST-related training and administrative activities, although there was wide variability in the amount of protected time per week. Among facilities who provided data, the mean number of hours of protected time per week was 6.2 hours.

3. Senator GILLIBRAND. Dr. McCutcheon, during your testimony you indicated there is mandatory training for VA mental health providers and other health care personnel which includes the MST coordinators. What does that training entail?

Dr. MCCUTCHEON. VHA Directive 2012–004, Mandatory Training of VHA Mental Health and Primary Care Providers on Provision of Care to Veterans Who Experienced MST, established an MST-mandatory training requirement for all VA mental health and primary care providers. This one-time training requirement was established to ensure that all clinicians receive a consistent baseline level of training on MST. Mental health providers fulfill the requirement by completing a comprehensive web-based independent study course that focuses on the treatment of mental health sequelae associated with MST, including an overview of empirically-based treatments for post-traumatic stress disorder (PTSD), depression, and substance use. Mental health providers also have the option to "test-out" of the course by passing an MST knowledge assessment test that demonstrates significant pre-existing expertise in mental health issues related to MST.

Primary care providers must complete the mandatory training requirement by completing a web-based training on "MST for Medical Providers." This training covers information about health conditions associated with MST; issues related to screening for MST; how MST can affect a veteran's experience of health care; how to appropriately adapt care to address the needs of MST survivors; and VA documentation requirements.

Additionally, trainees in health professions which provide clinical services at VA facilities are required to complete the web-based course Mandatory Training for Trainees in their first year and a refresher version of the course each year thereafter. VHA's Office of Academic Affiliations has included information on MST in both the initial and refresher courses to ensure that all trainees have a baseline level of knowledge about MST. In addition, regular close supervision that trainees receive from licensed, VA-credentialed clinicians ensures that all trainees receive training and consultation about MST and veterans' clinical needs on an ongoing basis.

For many years, VHA has also offered a range of voluntary MST-related training programs for continuing education. These allow both providers and trainees the opportunity to develop MST-related knowledge and skills above the baseline provided by the mandatory training described above. Continuing education courses include a monthly teleconference training series on MST-related topics and an annual training conference designed primarily for MST coordinators.

4. Senator GILLIBRAND. Dr. McCutcheon, as we heard from the two survivors at the hearing, they did not appear to be aware of their mental health options available through the VA. What information is supposed to be provided to each veteran who screens positive for MST or who meets with an MST coordinator?

Dr. MCCUTCHEON. VA screens all veterans seen for health care for experiences of MST via a clinical reminder in the electronic medical record. The MST Clinical Reminder alerts providers of the need to screen the veteran, provides language to use in asking the veteran about MST, and documents the veteran's response to the screening. Upcoming revisions to the MST Clinical Reminder will capitalize on screening as an opportunity to provide all veterans with information about VHA's MST-related services, regardless of whether or not they disclose having experienced MST. This will be achieved by the addition of an introductory script that notifies all veterans that VHA provides free MST-related care. Revisions will also provide additional information to those who disclose having experienced MST. Providers will be instructed to offer every veteran who reports experiencing MST a fact sheet which reviews the definition and prevalence of MST, the impact of MST, VA's services for MST, and how to access care. The revised MST Clinical Reminder will also include a mental health services referral question, which will streamline access to care for veterans who express interest in MST-related treatment. It will also facilitate national monitoring of referrals for this care. Individual facilities will decide how this referral will operate locally. Some facilities may decide to route all referrals through the MST coordinator, but many will route referrals to their general mental health service and consult with the MST coordinator, as needed.

In addition, MST coordinators conduct outreach activities year round to help ensure that information about VA's MST services is readily available. For example, MST coordinators arrange for outreach posters to be displayed in visible locations and for outreach brochures to be available in clinic waiting rooms. These materials discuss the availability of MST-related services and provide contact information for the MST coordinator. MST coordinators also often work with local veterans Service Organizations and other community groups to make information available to the veterans they serve. MST coordinators also engage in staff educational activities to help ensure that providers and frontline staff who work with veterans are aware of local MST services, know how to contact the MST coordinator, and are able to make appropriate referrals for care when needed. Facilities often capitalize on Sexual Assault Awareness Month (every April) to host a range of informational and awareness-raising events. These local efforts complement the National MST Support Team's initiatives to disseminate information about VA's MST-related services, some of which are described later in this series of questions and answers.

5. Senator GILLIBRAND. Dr. McCutcheon, what mechanisms are in place to ensure MST coordinators are providing all required information to the veterans they meet with?

Dr. MCCUTCHEON. MST coordinators represent one important source of information for veterans interested in MST-related services, but VA disseminates information about its services broadly to ensure that even veterans who do not come in contact with the MST coordinator are aware of available services. For example, as noted in the previous question, upcoming revisions to the MST Clinical Reminder will standardize the information provided to all veterans during the screening process. For veterans and family members looking for information on the Internet, VA has a Web site on MST (http://www.mentalhealth.va.gov/msthome.asp) with basic information about MST, descriptions of programs and services, and links to other online resources. Also, as described in question 18 below, VA has disseminated in-

formation about MST services to key DOD staff members who work with sexual assault survivors, as well as DOD online resources like the Sexual Assault Forensic Examination (SAFE) Helpline, in order to provide additional avenues for servicemembers to access this information.

Not all veterans interested in MST-related services will necessarily have contact with the facility MST coordinator. However, MST coordinators are well-prepared to address the MST-specific needs of veterans with whom they do meet. VHA Directive 2010–033 requires that the MST coordinator be a professional who is knowledgeable about trauma and mental health and who possesses expertise in issues specific to MST. The MST coordinator role is almost always fulfilled by a mental health provider who is very familiar with local services important for MST survivors and readily able to describe these services. To facilitate provision of information about VA's services more broadly, the National MST Support Team has developed outreach and educational materials for MST coordinators to distribute. In addition to this standardized information, as mental health providers, MST coordinators are skilled at assessing difficulties related to MST and thus readily able to provide information tailored to each veteran's specific treatment needs.

GENDER

6. Senator GILLIBRAND. Dr. McCutcheon and Dr. Bell, the VA has sponsored significant research on the links between sexual assault and harassment, PTSD, and suicide. Based on your research, what can you tell me about the differences in male and female survivors in terms of these links?

Dr. MCCUTCHEON and Dr. BELL. As noted in Dr. Bell's testimony, research has identified a relationship between sexual trauma and PTSD, between PTSD and suicide, and between sexual trauma and suicide. Studies have shown that the association between sexual trauma and suicide holds even after controlling for mental health conditions like depression and PTSD.

With regard to how gender impacts these relationships, research to date has relatively and consistently shown that both men and women have an increased risk for suicide after experiencing sexual trauma. This appears to be true for both civilian and veteran samples. Although some studies have identified some potential differences in the strength or nature of this relationship, it would be premature to make definitive statements about gender differences in this area. However, this is a very active area of research and as the field's knowledge continues to grow, more definitive conclusions about gender differences may be possible in the future.

7. Senator GILLIBRAND. Dr. McCutcheon and Dr. Bell, do female and male survivors of military sexual assault or harassment present with symptoms differently? If so, how do treatment protocols accommodate and respond to these differences?

Dr. MCCUTCHEON and Dr. BELL. It is crucial for VA and others to continue expanding the research base on how gender shapes reactions to and recovery from MST. The literature on gender differences in response to civilian sexual trauma is similarly small but growing.

Generally, studies have shown that men and women experience similar types of mental health difficulties after experiencing MST, with the most common mental health conditions for both being PTSD, depression, anxiety disorders, and substance use disorders (SUD). There is also often considerable overlap in the specific difficulties with which men and women present after experiences of sexual trauma, including struggles with self-blame, difficulties trusting others, and lack of social support.

Some recent work has suggested, however, that the strength of association between MST and negative mental health outcomes may be larger for men than for women. Clinically, it is common for men to present with struggles related to gender role socialization, including questions about their masculinity and/or sexual orientation, particularly if the perpetrator of the MST was male. Men may also be particularly reluctant to disclose experiences of MST for fear of encountering negative reactions from others, given widespread misinformation and stigma related to sexual trauma among men.

Women may also face unique issues in their recovery, such as the possibility that MST may intensify pre-existing concerns about safety, given significant rates of violence against women in U.S. society more generally. There may be factors related to their experience as a woman in the military that affect recovery from MST as well. For example, women are often numerically a minority in their unit, and it is possible that stressors associated with minority status may amplify the impact of MST or create additional challenges for recovery.

Treatment always needs to be tailored to the specific difficulties of each individual veteran. Best practices would include discussing with the veteran how his or her gender and sense of self might be affected by the experiences of MST. Treatment often includes providing psychoeducation to counter rape myths, having discussions about the impact of gender socialization and societal inequalities related to gender, and addressing any gender-specific issues with which the veteran might present. Research examining whether different evidence-based treatment approaches are differentially effective based on patient characteristics is in the early stages but will provide crucial information to allow VA and others to be more targeted in treatment planning. Early data show no substantial gender differences in the efficacy of some of the most commonly used evidence-based psychotherapies, but gender is a key variable for consideration as this literature continues to expand.

8. Senator GILLIBRAND. Dr. McCutcheon and Dr. Bell, do you believe there should be different treatment programs for male and female survivors?

Dr. MCCUTCHEON and Dr. BELL. Limited research exists on the relative effectiveness of single-gender and mixed-gender programming for male and female sexual trauma survivors. This is true both for civilian and military/veteran populations. Both single-gender and mixed-gender treatment environments have advantages and may be clinically indicated at different points in a veteran's recovery. For example, single-gender environments may facilitate addressing safety and gender-specific concerns, while mixed-gender environments may help veterans challenge assumptions and confront fears about those of a different gender. Veterans themselves also vary with respect to their preferences about single-gender versus mixed-gender programming. For example, a man who experienced MST perpetrated by another man may prefer participation in a mixed-gender treatment program. Others may feel that a single-gender environment will best facilitate their recovery. Given these considerations, VHA does not promote one model as universally appropriate for all veterans. The needs and preferences of a specific veteran dictate which model is clinically most appropriate. As such, VHA makes a range of treatment options available to enable veterans to decide, in collaboration with treatment providers, which option will best address their specific difficulties.

9. Senator GILLIBRAND. Dr. McCutcheon and Dr. Bell, are there differences between findings in the civilian world and the military?

Dr. MCCUTCHEON and Dr. BELL. Information about differences in civilian and military/veteran research findings related to gender and treatment is integrated into responses to questions 6, 7, and 8.

STIGMA AND CARE

10. Senator GILLIBRAND. Dr. Guice and Dr. Galbreath, although much is known about PTSD in male veterans and in those who fought in earlier conflicts, less is known about PTSD in female veterans. Several studies have found that MST plays a larger role in explaining PTSD among women veterans than does combat exposure or other wartime stressors. Sexual harassment is also associated with many later mental health symptoms, including PTSD and other anxiety. DOD has spent a lot of time working to reduce the stigma of combat-related PTSD and encouraging servicemembers to get help. What is DOD doing to reduce the stigma of sexual assault and the resultant mental health injuries like PTSD, depression, and suicidal ideation?

Dr. GUICE and Dr. GALBREATH. The potential development of mental health sequel (pathological condition resulting from a disease, injury, therapy, or other trauma) associated with sexual assault, and the victim's potential fear of seeking help, are both of great concern to DOD. Providing multiple points of access to a structured, competent, and coordinated continuum of care for survivors of sexual trauma—regardless of gender or time of the sexual assault—is imperative to reducing the potential long-term mental and physical risks associated with sexual trauma. DOD has implemented policies, guidelines, procedures, programs, and support delivery systems to ensure that care is available and executed in a manner which fosters stigma reduction. This continuum of care extends as long as needed including through assignment or duty status transitions.

DOD's prioritization of the importance of provider education, awareness, and sensitivity has led to the implementation of multiple policies and initiatives to assure that providers are educated to deliver care that is gender-responsive, culturally competent, recovery-oriented and alert to the potential for mental health issues that may develop over time, or be the result of sexual trauma. Health care providers who

care for survivors of sexual assault are trained in the concept of trauma-informed care and must recognize the high prevalence of pre-existing trauma. Additionally, they receive training in the broad range of physical and emotional responses that they may observe. Every servicemember and civilian employee throughout DOD is required to take training about sexual assault, sexual harassment, and trafficking in persons upon entry and annually thereafter. Servicemembers receive instruction on military core values from the moment recruit training starts, and training continues over a member's time in the Service.

A victim's preference for how to access help the type of therapy and services they want to receive are cornerstone precepts for both mitigating the potential fear of stigma associated with reporting the incident and in achieving maximal recovery. To increase and leverage these protective factors, DOD has created multiple options and points of access for obtaining assistance, including private reporting, anonymous points of entry to assistive resources, and available one-to-one support and coaching personnel. This respect for the victim's autonomy and needs extends to accommodating patient preference for the gender and duty-status of the therapist.

11. Senator GILLIBRAND. Dr. Guice and Dr. Galbreath, in 2013, the Government Accountability Office (GAO) found that military health care providers did not have a consistent understanding of their responsibilities in caring for sexual assault survivors because DOD has not established guidance for the treatment of injuries stemming from sexual assault—which requires that specific steps are taken while providing care to help ensure the victim's right to confidentiality. Additionally, while the Services provide required training to first responders, GAO found that some of these responders were not always aware of the health care services available to sexual assault survivors. Has DOD developed Department-level guidance on the provision of care to survivors of sexual assault?

Dr. GUICE and Dr. GALBREATH. Yes, DOD released DODI 6495.02 "Sexual Assault Prevention and Response (SAPR) Program Procedures" on March 28, 2013. Enclosures 7, 8, and 10 outline a comprehensive, standardized policy for compassionate medical response to survivors of sexual assault, including a requirement that health care personnel receive appropriate training. This policy includes guidance for both restricted and unrestricted reporting and treating all sexual assault victims as priority emergencies.

The Assistant Secretary of Defense for Health Affairs (ASD(HA)) issued a memorandum to the Services on April 15, 2013, to notify the Services about the publication of the revised DOD Instruction (DODI). The memorandum noted the enhancements to guidelines for provision of health care support for survivors of sexual assault, including the restricted reporting process. The memorandum noted the minimum standards for health care and training requirements for health care personnel who manage both acute and long-term care needs for victims of sexual assault and for providers who would conduct SAFEs. In that memorandum, the ASD(HA) also requested submission of an annual report to include information on the capability of each military treatment facility (MTF) to provide SAFEs, and information on agreements with local civilian providers in cases where there was not SAFE availability within the MTF. Finally, the ASD(HA) requested that the Services submit written plans with target dates for implementation to meet the requirements of the revised DODI.

DOD received and reviewed the responses from the Services and determined that Service implementation plans already meet the basic requirements of the DODI and also include enhancements to their training programs for Service certification to perform SAFEs. The Services report that their training assures that all health care personnel are aware of restricted reporting requirements. These training programs also include Service-specific criteria for certification to perform SAFEs that are consistent with the guidelines set forth in the U.S. Department of Justice-National Protocol for Sexual Assault Medical Examinations for Adults and Adolescents. The Services also noted that they are enhancing their training programs to include a wider variety of experiences in both care of the victim and courtroom testimony. This includes live examination experiences with standardized patients or volunteers and observation of mock trials.

In an effort to provide the highest quality of care, the Services are continuously evaluating and updating training in this area. Each Service has either already updated its operational policies or will complete their current updates by the end of fiscal year 2014.

The Office of ASD(HA) is monitoring completion of Service program implementation and issued an additional memorandum on March 27, 2014, that outlines all elements of the oversight plan and sets dates for submission of reports. This plan requires an annual update of SAFE provider coverage, training enhancements, and

policy and procedure changes. Additionally, OASD(HA) monitors program performance on an ongoing basis throughout the year at the SAPR Integrated Program Team and Health Affairs Women's Health Issues Working Group meetings, both of which address health care related to the response to sexual assault.

12. Senator GILLIBRAND. Dr. Guice and Dr. Galbreath, what has DOD done to improve first responder compliance with DOD requirements for annual refresher training?

Dr. GUICE and Dr. GALBREATH. The goal of DOD is to deliver consistent and effective prevention methods and programs. It is critical that our entire military community work together to prevent criminal behavior from occurring, when possible, and respond appropriately to incidents when they occur. Sustained leadership attention by commanders and first line supervisors is critical to this effort, as they are central in establishing the climate of dignity, respect, sensitivity, and environmental expectations for conduct at the unit level that can reduce and eliminate these crimes.

In March 2013 (updated 14 February 2014), the Department published guidance to require that all DOD sexual assault responders receive consistent baseline training. DODI 6405.02 "Sexual Assault Prevention and Response Program Procedures," (pages 66–72) outlines who must receive training as well as the topical areas to be presented. Further, this has been followed by the development of core competencies and learning objectives for all SAPR training, starting with pre-command and senior enlisted groups, to ensure consistent learning and standardization across the Services. DOD has worked collaboratively with pre-command and senior enlisted groups to deploy innovation and assessment teams across the Nation to identify promising prevention strategies and techniques.

In addition to the basic first responder training, health care personnel must receive additional training (outlined on pages 72–73 of DODI 6495.02). There are two tiers of training. The first tier provides additional information regarding encounters in MTFs. The training standards and topical areas are set based upon the skill-level and duties of the health care personnel. Therefore, clerks, assistants, and non-skilled personnel receive information at their level of training and health care providers who will assess, interview, and treat sexual assault survivors receive an additional level of basic information. All personnel who will perform SAFEs must take a second tier of training. This training provides detailed information on the conduct of a SAFE, including the specific history taking, physical examination, and handling of evidence. Personnel who take this training are Service-certified to conduct SAFEs. Planned enhancements to SAFE training will expand the variety of experiences and teaching methods, adding additional supervised experiences with live volunteer or standardized patients and mock courtroom experiences by the end of fiscal year 2014.

13. Senator GILLIBRAND. Dr. Guice, I know that the Army has worked to create specialized training for sexual assault investigators to ensure they are not traumatizing victims during interviews. The Services have also created additional trainings for Judge Advocate General (JAG) lawyers working on special victims cases. Finally, we have created a Special Victims Counsel for survivors to access during the process. These are all important steps in supporting our survivors post-attack. What else should the military do to mitigate the follow-on trauma from sexual assaults?

Dr. GUICE. All of the Services have fielded a Special Victims Capability, composed of specially trained and certified criminal investigators, attorneys, paralegals, and Victim/Witness Assistance Program personnel. All of these investigative and legal personnel who are working cases of sexual assault, serious domestic violence, and child abuse are trained and certified in interviewing techniques that minimize re-traumatization and consider the special needs of individuals with trauma-impacted memory. Given the Special Victims Capability, the Special Victims Counsel, the updated specialized training for all criminal investigators, attorneys, Sexual Assault Response Coordinators (SARC), victim advocates, and medical/mental health providers, I believe we are taking great steps to mitigate follow-on trauma. However, as these programs are new, we are continually evaluating how they are working in the field. As we identify additional steps we can take to minimize a victim's re-traumatization, we will update our policy and programs to best support the victims.

14. Senator GILLIBRAND. Dr. Guice, is there additional training that could be given to investigators and JAGs to ensure that victims are not revictimized during the investigative process?

Dr. GUICE. Yes, there is. As part of the Special Victims Capability training, the Department fielded last year, The Military Criminal Investigative Organizations and the Service Judge Advocates, their paralegals, and Victim/Witness Assistance

Program personnel are currently receiving additional training. All investigative and legal personnel working cases of sexual assault, serious domestic violence, and child abuse are trained in interviewing techniques that minimize re-traumatization consider the special needs of individuals with trauma-impacted memory.

SUICIDE

15. Senator GILLIBRAND. Ms. Garrick, suicide is a very complicated issue—every incident of suicide has its own causes. I believe DOD goes through every case to try to understand what happened and what could have been done to prevent each suicide. When DOD assesses cases of suicide in the Services, are you finding that there are cases that are related to sexual assault?

Ms. GARRICK. For DOD, the loss of a single servicemember is one too many; as such, the Department endeavors to examine thoroughly any potential issue that may lead to a servicemember's suicide. Through the DOD Suicide Event Report (DODSER), DOD collects data about military suicide decedents and attempters. The DODSER tracks demographic information such as the cause and manner of death or attempts, substance abuse and psychological health history, and deployment and combat experiences.

In addition, the DODSER tracks servicemembers who had reported cases of sexual abuse and harassment along with cases of sexual abuse and harassment perpetration. Reported cases may include sexual abuse before and since joining the military. Additionally, not all survivors of sexual assaults disclose their histories; therefore, the data contained in the DODSER may not provide a full picture of the prevalence of a sexual abuse history in those who died by suicide. However, based on the available DODSER data, DOD cannot conclude that there is a causal relationship between military sexual assaults and suicides at this time.

In 2012, 10 servicemembers who had reported a history of sexual abuse and 3 servicemembers who had reported a history of sexual harassment had died by suicide. These servicemembers accounted for 3.1 percent and 0.9 percent of all suicides in 2012.

16. Senator GILLIBRAND. Ms. Garrick, what more can you tell me about the study being jointly sponsored by the Defense Suicide Prevention Office (DSPO) and the Sexual Assault Prevention and Response Office (SAPRO) to better understand the prevalence of suicide risk among sexual assault victims?

Ms. GARRICK. The DSPO and the SAPRO are jointly sponsoring a study using data from the Survey of Health-Related Behavior of Active Duty Members. The study will assess whether statistically significant relationships between self-reported instances of sexual assault and suicidal ideation and attempts exist. In addition, the study will analyze the extent to which risk factors for sexual assault overlap with risk factors for suicidal ideation and attempts. DSPO will use the data to assess whether there is a need to modify existing suicide prevention and resilience programs to address any unique risks associated with sexual assault victims. However, it should be noted that those who assist in sexual assault responses are already being trained on suicide prevention.

17. Senator GILLIBRAND. Ms. Garrick, once that study is done, will you come back and update us on its findings?

Ms. GARRICK. DOD will be glad to brief the results of the joint DSPO and SAPRO's analysis of the relationships between self-reported instances of sexual assault incidents and suicidal ideation/attempts from the 2011 Survey on Health-Related Behaviors of Active Duty Servicemembers.

TRANSITION DIFFICULTIES

18. Senator GILLIBRAND. Dr. Guice and Dr. McCutcheon, how do DOD and VA currently transition servicemembers who have been sexually assaulted?

Dr. GUICE. DOD has policies and programs in place to ensure transition of care for servicemembers with mental health and medical care issues, including those who are survivors of sexual assault. These policies are not diagnosis specific because DOD views all of our wounded, ill, and injured, either medically or physically or both, regardless of cause, as equally warranting seamless transition of care between time of discharge from the Active component to continuation of care outside of the Military Health System (MHS).

One of the Strategic Actions in the joint DOD/VA IMHS includes enhancing continuity of care for servicemembers relocating within or across departments who are

receiving ongoing mental health care by implementing the inTransition program. The Joint DOD/VA inTransition program ensures continuity of mental health care, including survivors of sexual assault engaged in treatment, for servicemembers as they move between DOD and VA health care systems or providers. Personal coaches, working with a multitude of resources and tools, provide psychological health care support and connect the newly separated servicemember to a new provider. Coaches locate community resources, support groups, and crisis intervention services, and monitor individuals to ensure a seamless transition of care.

Additionally, servicemembers who have been sexually assaulted may utilize transition services offered as part of the SAFE Helpline. The SAFE Helpline is operated by Rape, Abuse, and Incest, National Network, the Nation's largest anti-sexual violence organization, which also runs the National Sexual Assault Hotline. This helpline provides live, one-on-one crisis support across the enterprise, offers intervention services, emotional support, information, and "warm hand-off" transfers to SARCs, Military OneSource, and the National Suicide Prevention Lifeline. For transitioning servicemembers, SAFE Helpline has a full database of VA and civilian resources to include Veteran's Benefits Coordinators and civilian sexual assault service providers. SAFE Helpline staff provide these resources based on a servicemember's location and include the nearest medical or legal personnel, chaplain, veterans services, and civilian sexual assault service providers.

Dr. McCutcheon. VA has an extensive range of initiatives to facilitate all servicemembers' seamless transition from DOD to VA, in general. To ensure the unique needs of MST survivors are addressed, MST coordinators work closely with their facility Operation Enduring Freedom (OEF)/Operation Iraqi Freedom (OIF)/Operation New Dawn (OND) Program Manager and Care Management Teams, the facility-level staff most closely involved with facilitating transitions between DOD and VA. In addition, MST coordinators provide assistance and consultation on specific cases as needed. MST coordinators are also encouraged to establish working relationships with DOD SARCs associated with local military installations, to help facilitate seamless access to VA services.

A number of outreach and training initiatives complement these efforts. For example, information about VA's MST-related services is included in the mandatory outprocessing (i.e., Transition Assistance Program) completed by all servicemembers.

In addition, VA's national MST Support Team has an established relationship with DOD's overarching SAPRO. SAPRO and the MST Support Team have provided trainings to staff in each Department to ensure that each are aware of each others' services and are able to pass this information along to the servicemembers with whom they work. Information about VA's MST-related health care services is included in DOD's SAFE Helpline, and VA's MST outreach brochure is posted on SAPRO's myduty.mil Web site. SAPRO and the MST Support Team also communicate as needed to help connect individual veterans and servicemembers to services that match their treatment needs.

The MST Support Team has also engaged in conversations with each Department's SAPR programs about how to ensure that transitioning servicemembers and newly-discharged veterans, specifically, are aware of VA's MST-related services. This has resulted in several presentations to SAPR program staff and other DOD program offices, in order to encourage inclusion of information about VA services in outreach and training efforts. One particular area of discussion has been the inclusion of information about VA's MST-related services in SAPR orientation and other training materials for DOD SARCs. To support this effort, VA has provided informational materials about VA's MST-related services to SAPRO and individual SAPR programs for distribution to SARCs, other DOD staff, and servicemembers.

19. Senator Gillibrand. Dr. Guice and Dr. McCutcheon, are there gaps in the hand-off between DOD and VA?

Dr. Guice. There are programs in place to facilitate transition of care and provide warm hand-offs between DOD and VA; however, there is not a mandate specific to the transition of survivors of sexual assault to the VA. While a servicemember who is a survivor of sexual assault is not required to obtain ongoing or follow-up care within the VA care system, one of the DOD/VA IMHS actions is reviewing mental health services for females and males who have experienced sexual assault and identifying opportunities to improve continuity of care and information sharing during transition between DOD and VA. Also, a Sexual Assault Advisory Group (SAAG) was commissioned under the DOD's Psychological Health Council in November 2013. The SAAG has provided a forum to regularly advise DOD Health Affairs and Personnel and Readiness leadership on issues related to sexual assault and prevention and ensure continuous improvement in coordination between DOD SARCs and

health care providers. The Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (TBI) are developing a clinical recommendation tool for providers to guide them in how to ask about sexual assault and sexual harassment and take the appropriate actions when reported. This tool will prompt providers to ask servicemembers about possible transitions in and out of DOD and will recommend a warm handoff to VA for those who are transitioning out of military service.

Dr. MCCUTCHEON. VHA believes that the comprehensive efforts coordinated by its national Care Management and Social Work program office and facility OEF/OIF/OND Program Managers and Care Management Teams provide a solid foundation to ensure seamless transitions for veterans who experienced MST. As noted above, the MST Support Team and the Care Management and Social Work program office have collaborated to ensure that the MST-specific needs of veterans are addressed as part of these existing efforts.

20. Senator GILLIBRAND. Dr. Guice and Dr. McCutcheon, are there gaps in the hand-off between DOD and VA for those who are diagnosed with personality disorders (PD) and discharged from Service?

Dr. GUICE. There is not a mandate specific to the transition of those diagnosed with PDs to the VA. Rather the DOD has policies and programs in place to ensure transition of care and a hand-off for servicemembers with all types of mental health and medical care issues inclusive of a PD. These policies are not specific to one diagnosis such as a PD because the DOD views all of our wounded, ill, and injured, either medically or physically or both, regardless of cause, as equally warranting seamless transition of care between time of discharge from the Active component to continuation of care outside of the MHS.

Dr. MCCUTCHEON. A diagnosis of a PD would not affect a servicemember's transition to VA or eligibility for VA services, provided he or she is eligible under title 38, U.S.C., for VA benefits.

21. Senator GILLIBRAND. Dr. Guice, you said in your written testimony that "When sexual assault survivors are still actively receiving behavioral health care at the time of separation from the Service, they are linked to the DOD inTransition Program to help ensure that continuity of care is maintained. The inTransition program assigns servicemembers a support coach to bridge support between health care systems and providers. The coach does not deliver behavioral health care or perform case management, but is an added resource to patients, health care providers, and case managers to help ensure transition of care is seamless. SAFE Helpline also provides information for sexual assault survivors that may be transitioning from military to civilian life." Can you tell me approximately how many victims are part of this program?

Dr. GUICE. The inTransition program publishes monthly statistics related to the number of new cases, closed cases, and active cases per month and from inception of the program. InTransition does not track information regarding how many clients who used inTransition were victims of sexual assault. The March 2014 report of the program shows program growth from its time of inception, February 2010 through March 2014:

- The inTransition program has opened 5,039 cases since its inception in February 2010. In March, 93 new cases were opened, 46 percent of the referrals were made by servicemembers.
- 98 percent of servicemembers referred to the program accepted services, 88.2 percent were Active Duty, 6.3 percent were discharged, 2.4 percent were retirees, 0.5 percent Active Guard/Reserves.
- The majority 63 percent of cases was from the Army; 15 percent of cases were from the Air Force; remaining cases spread between the Marine Corps, Navy, and National Guard.
- Providers who refer to the inTransition program report that 100 percent stated that the program met their needs with 4.85 out of 5 would refer this program to another provider.

The inTransition coach provides support and assistance to the transitioning servicemember though regular telephonic contact until he or she engages in behavioral health treatment with a follow-on provider, whether that is in the VA health care system, the MHS, TRICARE, or the community. The coaches assist servicemembers during the transition period, empower them to make healthy life choices globally, and are available 24/7. Calls are toll-free.

22. Senator GILLIBRAND. Dr. Guice, is connecting the survivors to VA services part of the mandate of this program? If so, how? If not, why?

Dr. GUICE. There is not a mandate specific to the transition of survivors of sexual assault to the VA. DOD has policies and programs in place to ensure transition of care for servicemembers with mental health and medical care issues inclusive of those who are survivors of sexual assault. These policies are not diagnosis specific because the DOD views all of our wounded, ill, and injured, either medically or physically or both, regardless of cause, as equally warranting seamless transition of care between time of discharge from the Active component to continuation of care outside of the MHS. A servicemember who is a survivor of sexual assault, just as survivors of combat war injuries or other military associated injuries, is not required to obtain ongoing or follow-up care within the VA care system. Should they choose to avail themselves of these services, there are policies such as DODI 6490.10, "Continuity of Behavioral Health Care for Transferring and Transitioning Servicemembers", case management procedures (e.g. Clinical Case Management, (DTM) 08–033—Interim Guidance for Clinical Case Management for the Wounded, Ill, and Injured Servicemember in the MHS and programs such as the inTransition program to facilitate transition to the VA.

23. Senator GILLIBRAND. Dr. McCutcheon and Dr. Bell, VA granted disability benefit claims for PTSD related to MST at a significantly lower rate than claims for PTSD unrelated to MST every year from 2008 to 2012. Because female veterans' PTSD claims are more often based on MST-related PTSD than male veterans' PTSD claims, female veterans overall are disparately impacted by the lower claims rates for MST-related PTSD. For every year between 2008 and 2011, a gap of nearly 10 percentage points separated the overall claims rate for PTSD claims brought by women and those brought by men. Among those who file MST-related PTSD claims, male veterans face particularly low claims rates, when compared to female veterans who file MST-related PTSD claims. What have you done to reform VA regulations on disability claims based on PTSD related to in-service assault?

Dr. MCCUTCHEON and Dr. BELL. Following the direction of Under Secretary for Benefits Hickey, the Veterans Benefits Administration (VBA) began an aggressive program to address the sensitive issues related to MST and PTSD. This involved a nationwide focus beginning in 2011. Less than 6 months after an enhanced nationwide training agenda and deployment of specially trained claims processors and health professionals throughout the country, the percentage of disability claims granted for MST/PTSD increased from 34 percent to about 55 percent. At that time, the grant rate for all PTSD claims was approximately 60 percent. Since then, the grant rates for MST/PTSD claims, as well as all PTSD claims, has fluctuated. For fiscal year 2013, the average grant rate for MST/PTSD claims was 49 percent, compared to 55 percent for all PTSD claims. The higher grant rates for all PTSD claims is likely due to the numerous combat-related claims that are the result of U.S. military operations in Southwest Asia. Regarding gender variations, the grant rate for male veterans claiming MST/PTSD rose to within 7 points of the grant rate for female veterans making the same claim. These rising MST/PTSD numbers show the benefits of the training initiative and special handling.

Additionally, VBA recognized that some veterans' MST/PTSD claims were decided prior to the increased nationwide training and special emphasis on handling these claims. To provide those veterans with the same evidentiary considerations as veterans who file claims today, VBA notified those veterans we could identify through our tracking system of the opportunity to request a review of their previously denied MST/PTSD claims.

VBA efforts have emphasized the liberal evidentiary approach available under current PTSD regulations, which provides for a VHA mental health examination if any circumstantial evidence of a behavior change or MST event is found in the record. The examiner's opinion regarding the occurrence of the MST stressor can then lead to PTSD service connection. These efforts, within the scope of current PTSD regulations, have produced a significant rise in the MST/PTSD grant rate. As a result, VBA does not see the need to alter current regulations.

24. Senator GILLIBRAND. Dr. McCutcheon and Dr. Bell, treatment of MST-related PTSD claims varies widely from one VA regional office (VARO) to another. The VAROs that discriminated most egregiously in 2012 include those in St. Paul, MN; Detroit, MI; and St. Louis, MO. What have you done to improve training and oversight of VA offices with poor records in granting MST claims?

Dr. MCCUTCHEON and Dr. BELL. VBA's Office of Quality Review, within Compensation Service, has obtained data regarding the adjudication of MST/PTSD claims from all VA regional offices. Variations in grant rates have been noted. In

order to promote nationwide accuracy and consistency in adjudication of MST/PTSD claims, VBA's Quality Review staff will call in a percentage of cases from each regional office with a low grant rate and thoroughly review the decisions. If needed, additional training will be provided to these regional offices. This review is scheduled for April 2014.

PERSONALITY DISORDERS

25. Senator GILLIBRAND. Dr. Guice, a PD is a mental health disorder that usually surfaces in pre-adolescence, adolescence, or early adulthood, is stable over time, and involves an enduring pattern of inner experience and behavior that deviates from the expectations of an individual's culture. The Services define PD as a condition pre-existing military service. Yet for many survivors, the PD is only diagnosed after they have reported a sexual assault. What prescreening is done prior to joining a Service to ensure a servicemember does not have a PD?

Dr. GUICE. PD diagnoses cannot be discovered reliably with screening measures during recruit or accession processing. These disorders stem from biological, psychological, or social deficits that manifest early in a person's life, and are characterized by a recurrent pattern of maladaptive behavior in the face of stressors. A PD is always considered to be a pre-existing condition.

All applicants for military service go through a multi-step medical screening process. An essential part of that screening is a medical exam. With respect to PD or other mental disorders, applicants are required to complete a medical pre-screening before reporting. Medical evaluation by a physician includes a review of any history of psychological disorders and current emotional status. All positive responses are addressed by the examining physician at the time of the physical examination. Through the course of interactions with military and medical professionals, any presenting symptoms may result in further examinations. With regard to mental health, if an applicant fails to reveal a history of mental health problems and no symptoms of PD are detected, the applicant would be cleared for enlistment.

The Services typically separate 2 to 3 percent of servicemembers for PD during initial accession and recruit training. Entry level discharges are mandated for individuals who are unable to adapt to the rigors of military training. It is uncommon for a servicemember to be separated for a PD after the initial years of service associated with a first enlistment. DOD currently separates only approximately 300 persons/year (out of 1.4 million servicemembers, or 0.02 percent) due to PDs.

The existence of a PD is not necessarily incompatible with military service and the ability to perform one's duties. Individuals with some types of PD may be able to function well. However, those with other types of PD may not be able to interact or perform successfully in a military environment. If a servicemember has a PD but is able to accomplish the requirements of military training and subsequent duty assignments—with no evidence of aberrant, maladaptive, or disruptive behavior—they would not be likely to be referred for mental health care, or subsequently be diagnosed as having this disorder within the Military Healthcare System.

26. Senator GILLIBRAND. Dr. Guice, how are servicemembers allowed to join without the PDs being detected and remain able to perform their duties for some years?

Dr. GUICE. PD diagnoses cannot be discovered reliably with screening measures during recruit or accession processing. These disorders stem from biological, psychological, or social deficits that manifest early in a person's life, and are characterized by a recurrent pattern of maladaptive behavior in the face of stressors. A PD is always considered to be a pre-existing condition.

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The existence of a PD is not necessarily incompatible with military service and the ability to perform one's duties. Individuals with some types of PD may be able to function well. However, those with other types of PD may not be able to interact or perform successfully in a military environment. If a servicemember has a PD but is able to accomplish the requirements of military training and subsequent duty assignments—with no evidence of aberrant, maladaptive, or disruptive behavior—they would not be likely to be referred for mental health care, or subsequently be diagnosed as having this disorder within the Military Healthcare System.

27. Senator GILLIBRAND. Dr. Guice and Dr. Galbreath, an October 2008 GAO report found that DOD could not be sure that its key PD separation requirements were being followed. A follow-on report conducted in September 2010 also found the military Services had not demonstrated full compliance with DOD's PD separation requirements. The 2008 report recommended, and the 2010 report reiterated, that DOD should: (1) ensure that the Services' PD separations comply with established DOD requirements; and (2) monitor the Services' compliance. Since the GAO reports came out, what has DOD done to determine whether commanders with separation authority are ensuring that DOD's key separation requirements are met?

Dr. GUICE and Dr. GALBREATH. DOD is confident that the requirements as set forth by the GAO report, "Additional Efforts Needed to Ensure Compliance with Personality Disorder Separation Requirements", October 2008 are being met. In January 2009, the Under Secretary of Defense for Personnel and Readiness (USD(P&R)) directed the Military Departments to report fiscal year 2008 and fiscal year 2009 compliance with DOD PD separation requirements. In September 2010, the USD(P&R) extended the requirement for PD separation compliance reporting through fiscal year 2012, and directed the Military Departments to provide status on their efforts to contact veterans who had deployed to combat areas and were later separated for PD without enhanced screening for PTSD.

There were eight separation requirements stipulated by the GAO. Of these, by 2012, the Military Departments have achieved 100 percent compliance in all but two areas:

- "Member was advised that the diagnosis of a PD does not qualify as a disability."—The Army and Navy were 100 percent compliant; the Marine Corps was 78 percent compliant and the Air Force was 87 percent compliant.
- "Member's PD diagnosis was endorsed by The Surgeon General of the Military Department concerned prior to discharge." The Army, Navy, and Marine Corps were 100 percent compliant; the Air Force was 75 percent compliant.

The Marine Corps and the Air Force are committed to remediation of the areas for which 100 percent compliance was not achieved, and have issued supplemental guidance to their field commands. A new requirement from the National Defense Authorization Act (NDAA) for Fiscal Year 2014 requires the Comptroller General to also report the extent to which the Military Departments comply with regulatory requirements in separating members on the basis of a PD. Thus, although the Military Departments' reported compliance for fiscal years 2008 through 2012, as required, this new report will follow up on these requirements for continued monitoring and notification of achieving 100 percent compliance.

28. Senator GILLIBRAND. Dr. Guice and Dr. Galbreath, does DOD have reasonable confidence that its requirements are being followed?

Dr. GUICE and Dr. GALBREATH. DOD is confident that the requirements as set forth by the GAO report, "Additional Efforts Needed to Ensure Compliance with Personality Disorder Separation Requirements", October 2008 are being met. In January 2009, the USD(P&R) directed the Military Departments to report fiscal year 2008 and fiscal year 2009 compliance with DOD PD separation requirements. In September 2010, the USD(P&R) extended the requirement for PD separation compliance reporting through fiscal year 2012, and directed the Military Departments to provide status on their efforts to contact veterans who had deployed to combat areas and were later separated for PD without enhanced screening for PTSD.

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The Marine Corps and the Air Force are committed to remediation of the areas for which 100 percent compliance was not achieved, and have issued supplemental guidance to their field commands.

29. Senator GILLIBRAND. Dr. Guice and Dr. Galbreath, I am interested in the comparison between those suffering from combat-related PTSD and from sexual assault-related PTSD. Can you tell me how many servicemembers have been discharged with a PD that emerged as a result of combat-related trauma versus the number of sexual assault survivors who have been discharged with a PD that is actually PTSD?

Dr. GUICE and Dr. GALBREATH. Empirical research on military populations is smaller than civilian studies but evidence does suggest that sexual assault victims are at higher risk for PTSD than other populations. Both conditions are under-reported which increases the difficulty of obtaining these exact numbers. While DOD does not have statistical data on sexual assault survivors being discharged with PDs, policy protection as detailed in DODI, 1332.14, are in place to ensure individuals with PDs are not discharged inappropriately. Owing to the implementation of this policy and direction issued by the USD(P&R) in 2009 for the Military Departments to report fiscal year 2008 and fiscal year 2009 compliance with DOD PD separation requirements, PD separations have decreased from 4,000 per year (1 in 3,000 members) in 2007 to 300 per year currently (1 in 50,000 members).

DEMOGRAPHICS

30. Senator GILLIBRAND. Dr. Bell, during your testimony, you specified that MST can be affected by demographics. The VA reported some 600,090 veterans are seeking care for MST. What is the demographic breakdown by era of service, gender, and age?

Dr. BELL. Below is a demographic breakdown by gender, age, and era of service for the 93,439 veterans who received outpatient care from VA for either a mental or physical health condition related to MST in fiscal year 2013.

Gender:

Among the 93,439 veterans who received MST-related care in fiscal year 2013, 58,061 (62.1 percent) were female, and 35,378 (37.9 percent) were male.

Age:

Among the 58,061 female veterans who received MST-related care in fiscal year 2013, 24,095 (41.5 percent) were between 18 and 44 years, 31,179 (53.7 percent) were between 45 and 64 years, and 2,787 (4.8 percent) were 65 years or older.

Among the 35,378 male veterans who received MST-related care in fiscal year 2013, 5,837 (16.5 percent) were between 18 and 44 years, 20,802 (58.8 percent) were between 45 and 64 years, and 8,738 (24.7 percent) were 65 years or older.

Era of Service:

Although VA cannot generally provide MST data aggregated by period of service, data is available specific to the cohort of veterans who have been deployed in service of OEF/OIF/OND.

Among the 58,061 female veterans who received MST-related care in fiscal year 2013, 10,451 (18 percent) served in OEF/OIF/OND.

Among the 35,378 male veterans who received MST-related care in fiscal year 2013, 2,830 (8 percent) served in OEF/OIF/OND.

VETERANS RECEIVING VA OUTPATIENT CARE RELATED TO MST FISCAL YEAR 2013

[Percent]

	Women (N=58,061)	Men (N=35,378)
Gender	62.1	37.9

VETERANS RECEIVING VA OUTPATIENT CARE RELATED TO MST FISCAL YEAR 2013—Continued

[Percent]

	Women (N=58,061)	Men (N=35,378)
Age range:		
18–44	41.5	16.5
45–64	53.7	58.8
65 or older	4.8	24.7
OEF/OIF/OND	18.0	8.0

QUESTIONS SUBMITTED BY SENATOR TIM KAINE

OVERMEDICATION

31. Senator KAINE. Dr. Guice, Ms. Garrick, and Dr. Galbreath, overmedication of Active Duty servicemembers has directly led to suicides in recent years. At a Senate Veterans Affairs Committee hearing in Atlanta, GA, in 2013, a caregiver recalled a soldier in the Warrior Transition Unit at Fort Stewart, GA, who was struggling with PTSD and overdosed. After 2 months of inpatient rehabilitation elsewhere, he returned to Fort Stewart. Soon after, his squad leader took him to the hospital because he was complaining of severe pain. The hospital prescribed codeine and sent him back to the barracks. That night he took the codeine pills, crushed them up, and injected them. He died as a result. What is DOD doing to monitor the multiple and various prescription drugs that are given to servicemembers suffering from PTSD?

Dr. GUICE, Ms. GARRICK, and Dr. GALBREATH. DOD has developed several programs to monitor patients who are on multiple prescription medications that pose a risk because of high addiction or lethality potential. The programs listed below provide prescription monitoring for patients on high risk medications that are used for multiple diagnoses, to include complex PTSD with comorbid chronic pain.

- Each MTF's Prescription Restriction Program, available in the electronic Pharmacy Data Transaction Service (PDTS), can set restrictions on prescriptions for patients on high risk medications (those with high dependency and/or lethality potential). PDTS automatically checks new prescriptions against the patient's medical/prescription history before a new drug is dispensed. Drug dispensing histories from MTF pharmacies, retail, and mail-order pharmacy are integrated. This information helps providers to know when to restrict controlled and psychotropic/central nervous system prescriptions.
- The Services' Wounded Warrior Programs provide assistance and advocacy for severely wounded, ill, and injured servicemembers, veterans, and their families.
- The MHS also offers Case Management services to "high utilizer" patients (those with 10 or more emergency department visits in 1 year) and "at-risk" patients, defined as those patients with multiple conditions or diagnoses, or catastrophic conditions such as serious brain injury, spinal cord injury, traumatic amputation, cancer and/or those needing extensive coordination of resources and services.
- The Services' SUD programs provide frequent substance use monitoring through random alcohol and drug testing. Concerns over substance misuse and relapse are communicated to prescribing providers.

32. Senator KAINE. Dr. Guice, Ms. Garrick, and Dr. Galbreath, one of the concerns that I've expressed to the VA Secretary is reducing the wait time for a veteran to schedule an appointment, particularly those veterans with symptoms of PTSD. For servicemembers with PTSD, what is DOD doing to reduce wait times between initial appointments and follow-up at MTFs?

Dr. GUICE, Ms. GARRICK, and Dr. GALBREATH. DOD has been diligently working to increase the availability of care, the number of mental health providers, and to develop multiple portals of entry (not all of them medical) making it easier to obtain care, advice, or assistance. DOD beneficiaries are using mental health services at the highest rate ever. The amount of clocked wait time for a routine follow-up appointment is determined by two primary factors: the servicemember's schedule pref-

erence for the day and time of an appointment and the availability of a sufficient number of mental health providers to deliver follow-on care.

DOD policy mandates specific access standards regarding wait times for the different circumstances requiring care which are the same as the standard followed for medical primary care services. Emergency care is provided immediately. Urgent care appointments are provided within 24 hours. A follow-up appointment is categorized as "routine care" and should be scheduled within 7 days of the servicemember's request for an appointment. A vast expansion of mental health providers into primary care clinics and into line units (for Active Duty servicemembers) allows most patients to be seen same day, even if the need is not urgent. We are at virtually 100 percent compliance for meeting the appointment time requirements for emergency and urgent care. The overall average number of days for receiving follow-on care appointments of any kind for those servicemembers on Active status is less than 10 days. While this is slightly over the 7-day policy requirement, this is often related to servicemember scheduling requirements and preferences. DOD is continuously monitoring appointment wait times, and working to improve access to timely appointments.

33. Senator KAINE. Dr. McCutcheon and Dr. Bell, similar to Active Duty members, overmedication of veterans has been a recent concern. At a hearing for the House Committee of Veterans' Affairs in October 2013, a physician who formerly worked at the VA hospital in Hampton, VA, commented, "There are multiple instances when I have been coerced or even ordered to write [prescriptions] for Schedule II narcotics when it was against my medical judgment." How is the VA looking into situations where doctors may feel pressure to prescribe narcotics against their medical judgment?

Dr. MCCUTCHEON and Dr. BELL. We cannot comment on individual cases. However, individual care plans are developed by clinicians. Currently, VA medical centers are working to provide education for providers to help them develop opioid treatment plans and address their concerns.

34. Senator KAINE. Dr. McCutcheon and Dr. Bell, what is the VA doing to monitor the multiple and various prescription drugs that are given to veterans to minimize the possibility of suicidal behavior?

Dr. MCCUTCHEON and Dr. BELL. VA's duty is to minimize the risk of suicidal behavior no matter what method a patient may be considering. In fact, overdoses represent the most common method for suicide attempts, but not deaths, among VA patients. VA monitors prescribed medications in many contexts.

The first opportunity to monitor medication use to minimize the possibility of suicidal behavior is at the time a VA provider initiates or modifies a patient's medication regimen. During this encounter, the provider reviews all medication prescribed by VA providers, medications the patient reports receiving from non-VA providers, and non-prescription, over-the-counter medications the patient reports using. The information on medications is used in conjunction with other clinical information to maximize the effectiveness of treatment and to minimize the potential for drug-drug and drug-disease interactions as well as the risk of suicide.

There are a number of additional safeguards that occur after this step. First, there are routine reviews of prescriptions by pharmacists during the process of filling and dispensing a prescription to identify prescribing errors. Second, during care transitions there are comprehensive reviews of medications, known as medication reconciliation, where medications prescribed by VA and outside providers are compared with those actually taken by the patient. Third, providers ask about whether patients have accumulated stores of medications or other potential means for completing suicide as part of the safety planning process whenever they identify patients at high risk for suicide.

In recent years, VA identified a number of medications, including anticonvulsants and antidepressants, which had the potential of contributing to the causes of suicide-related behaviors and outcomes. Whenever these effects were observed, VA systematically sent information to providers notifying them about the findings and provided guidance about the need for providing increased monitoring, while ensuring patients with conditions such as seizure disorders and depression received effective treatment.

At present, VA is augmenting these ongoing strategies with two programs. One is the Opioid Safety Initiative, designed to enhance monitoring for all patients receiving opioids for pain management. The other is the Psychopharmacology Effectiveness and Safety Initiative, designed to improve the quality of psychopharmacological treatment as a key component of overall mental health treatment. This program has provided feedback to VISNs and facilities about prescribing pat-

terns and is working to ensure that facilities have the knowledge and evidence-based pharmacology tools to support clinical judgment.

35. Senator KAINE. Dr. McCutcheon and Dr. Bell, one of my concerns that I've expressed to the VA Secretary is reducing the wait time for a veteran to schedule an appointment, particularly those veterans with symptoms of PTSD. For servicemembers with PTSD, what is the VA doing to reduce wait times between initial appointments and follow-up at MTFs?

Dr. MCCUTCHEON and Dr. BELL. The Department is addressing the current and growing demand for mental health services through a summarized strategy covering four major themes: (1) Development of policies that explicitly establish access standards and centralized oversight to track compliance with those standards; (2) Leveraging telehealth and other technologies that extend the reach of brick and mortar facilities into rural communities and digital phone technologies that provide "on demand" veteran access to behavioral health support; (3) Staffing recruitment; and (4) Leveraging community partnerships.

Policies and Standards

First, VHA has redefined access to mental health as a veteran's ability to schedule an appointment within 14 days of his or her desired date for new or established mental health appointments. Fiscal year 2014 data demonstrate that 95.5 percent of established patients are seen within that standard.

Telehealth

In order to reach veterans in rural communities, telemental health efforts have resulted in telehealth psychotherapy mental health encounters tripling between fiscal years 2011 and 2013. In addition, digital phone applications that support the treatment of PTSD (i.e., PTSD Coach) have been developed and downloaded 126,000 times for iPhones and Android smartphones in 75 countries.

Staffing

To meet this growing demand, VA has hired an additional 1,600 mental health clinicians and expanded its mental health workforce to include more than 800 Peer Specialists who are also veterans.

Community Partnerships

VA also recognizes that coordinated, collaborative care is effective care, and in fiscal year 2013, VA hosted local mental health summits at each of our medical centers to broaden the community dialogue. Preliminary data from these summits suggest that they fostered an improved understanding and relationship between VA facilities and the communities in which they are located.

QUESTIONS SUBMITTED BY SENATOR ANGUS S. KING, JR.

CONFIDENTIALITY

36. Senator KING. Dr. Galbreath, you spoke briefly about mental health providers being bound by law to inform servicemembers of the potential that their psychotherapy records may be required to be released for potential use in criminal proceedings against their assailant. Please describe the psychotherapist-patient privilege in the military. Does a similar privilege exist in non-military Federal criminal courts? If so, how do they differ?

Dr. GALBREATH. [Answer provided by the Office of General Counsel]:

Because this question poses purely legal issues, it has been referred to the DOD Office of General Counsel for a response.

A. The military and Federal civilian courts' approaches to privilege rules

The Military Rules of Evidence were modeled after the Federal Rules of Evidence, which apply to the Federal district courts. Most of the Military Rules of Evidence are identical to their Federal Rules counterparts with the exception of using military-specific terminology where it differs from Federal civilian nomenclature. One of the key areas where the Military Rules of Evidence and the Federal Rules of Evidence diverge, however, concerns privileges.

When the Supreme Court proposed the Federal Rules of Evidence in 1972, they included nine rules codifying the law of privileges. One of those proposed rules—Rule 504—would have established a psychotherapist-patient privilege subject to three exceptions. Congress ultimately rejected the Supreme Court's proposed privilege rules. In their place, in 1975 Congress adopted a rule providing that privileges "shall be governed by the principles of the common law as they may be interpreted

by the courts of the United States in light of reason and experience." Fed. R. Evid. 501.

When the President promulgated the Military Rules of Evidence in 1980, he took a different approach, opting to codify privilege rules. As the Military Rules of Evidence's drafters explained, the military justice system vests considerable authority in non-lawyers. For example, the non-lawyer commanders who impose nonjudicial punishment and the non-lawyer military officers who often conduct summary courts-martial must apply the law of privileges in those proceedings. Accordingly, the rules' drafters believed that it was important to provide specific rules of privilege. However, to allow for further development of the rules governing privileges, Military Rule of Evidence 501 provides that privileges generally recognized in civilian criminal trials in United States district courts will be applied in court-martial proceedings to the extent that they are not inconsistent with the prescribed privilege rules.

The Military Rules of Evidence as originally drafted and adopted did not include a psychotherapist-patient privilege. Then, and now, the rules specifically reject a physician-patient privilege. Mil. R. Evid. 501(d).

B. The Supreme Court's recognition of a psychotherapist-patient privilege

In 1996, in the case of Jaffee v. Redmond, the Supreme Court held that "confidential communications between a licensed psychotherapist and her patients in the course of diagnosis or treatment are protected from compelled disclosure under Rule 501 of the Federal Rules of Evidence." 518 U.S. 1, 15 (1996). That case involved a civil action arising from a police officer shooting and killing a suspect. The Supreme Court held that a psychotherapist-patient privilege existed and protected police officers' statements made during counseling sessions with a licensed clinical social worker. The Supreme Court indicated that the privilege was not absolute and "that there are situations in which the privilege must give way," such as "if a serious threat of harm to the patient or to others could be averted only by means of a disclosure by the therapist." Id. at 18 n.2. But the Court declined to define the privilege's specific scope, indicating that future cases would determine the privilege's "full contours." Id. at 18.

C. Military Rule of Evidence 513

In 1999, the President adopted Military Rule of Evidence 513, which provides a psychotherapist-patient privilege. The rule was amended in 2012 to delete a spousal abuse exception and in 2013 to allow a military judge greater discretion to decline to examine the evidence or a proffer in camera. As amended, the rule provides:

Rule 513. Psychotherapist-Patient Privilege

(a) General Rule. A patient has a privilege to refuse to disclose and to prevent any other person from disclosing a confidential communication made between the patient and a psychotherapist or an assistant to the psychotherapist, in a case arising under the Uniform Code of Military Justice, if such communication was made for the purpose of facilitating diagnosis or treatment of the patient's mental or emotional condition.

(b) Definitions. As used in this rule:

(1) "Patient" means a person who consults with or is examined or interviewed by a psychotherapist for purposes of advice, diagnosis, or treatment of a mental or emotional condition.

(2) "Psychotherapist" means a psychiatrist, clinical psychologist, or clinical social worker who is licensed in any State, territory, possession, the District of Columbia, or Puerto Rico to perform professional services as such, or who holds credentials to provide such services from any military health care facility, or is a person reasonably believed by the patient to have such license or credentials.

(3) "Assistant to a psychotherapist" means a person directed or assigned to assist a psychotherapist in providing professional services, or is reasonably believed by the patient to be such.

(4) A communication is "confidential" if not intended to be disclosed to third persons other than those to whom disclosure is in furtherance of the rendition of professional services to the patient or those reasonably necessary for such transmission of the communication.

(5) "Evidence of a patient's records or communications" means testimony of a psychotherapist, or assistant to the same, or patient records that pertain to communications by a patient to a psychotherapist, or assistant to the same, for the purpose of diagnosis or treatment of the patient's mental or emotional condition.

(c) Who May Claim the Privilege. The privilege may be claimed by the patient or the guardian or conservator of the patient. A person who may claim the privilege may authorize trial counsel or defense counsel to claim the privilege on his or her behalf. The psychotherapist or assistant to the psychotherapist who received the communication may claim the privilege on behalf of the patient. The authority of such a psychotherapist, assistant, guardian, or conservator to so assert the privilege is presumed in the absence of evidence to the contrary.

(d) Exceptions. There is no privilege under this rule:

(1) when the patient is dead;

(2) when the communication is evidence of child abuse or of neglect, or in a proceeding in which one spouse is charged with a crime against a child of either spouse;

(3) when Federal law, State law, or Service regulation imposes a duty to report information contained in a communication;

(4) when a psychotherapist or assistant to a psychotherapist believes that a patient's mental or emotional condition makes the patient a danger to any person, including the patient;

(5) if the communication clearly contemplated the future commission of a fraud or crime or if the services of the psychotherapist are sought or obtained to enable or aid anyone to commit or plan to commit what the patient knew or reasonably should have known to be a crime or fraud;

(6) when necessary to ensure the safety and security of military personnel, military dependents, military property, classified information, or the accomplishment of a military mission;

(7) when an accused offers statements or other evidence concerning his mental condition in defense, extenuation, or mitigation, under circumstances not covered by R.C.M. 706 or Mil. R. Evid. 302. In such situations, the military judge may, upon motion, order disclosure of any statement made by the accused to a psychotherapist as may be necessary in the interests of justice; or

(8) when admission or disclosure of a communication is constitutionally required.

(e) Procedure to Determine Admissibility of Patient Records or Communications.

(1) In any case in which the production or admission of records or communications of a patient other than the accused is a matter in dispute, a party may seek an interlocutory ruling by the military judge. In order to obtain such a ruling, a party must:

(A) file a written motion at least 5 days prior to entry of pleas, specifically describing the evidence and stating the purpose for which it is sought or offered, or objected to, unless the military judge, for good cause shown, requires a different time for filing or permits filing during trial; and

(B) serve the motion on the opposing party, the military judge and, if practical, notify the patient or the patient's guardian, conservator, or representative that the motion has been filed and that the patient has an opportunity to be heard as set forth in subdivision (e)(2).

(2) Before ordering the production or admission of evidence of a patient's records or communication, the military judge must conduct a hearing. Upon the motion of counsel for either party and upon good cause shown, the military judge may order the hearing closed. At the hearing, the parties may call witnesses, including the patient, and offer other relevant evidence. The patient must be afforded a reasonable opportunity to attend the hearing and be heard at the patient's own expense unless the patient has been otherwise subpoenaed or ordered to appear at the hearing. However, the proceedings may not be unduly delayed for this purpose. In a case before a court-martial composed of a military judge and members, the military judge must conduct the hearing outside the presence of the members.

(3) The military judge may examine the evidence or a proffer therefore in camera, if such examination is necessary to rule on the motion.

(4) To prevent unnecessary disclosure of evidence of a patient's records or communications, the military judge may issue protective orders or may admit only portions of the evidence.

(5) The motion, related papers, and the record of the hearing must be sealed in accordance with R.C.M. 1103A and must remain under seal unless the military judge or an appellate court orders otherwise.

D. Psychotherapist-patient privilege exception in Federal civilian courts

As previously noted, the Supreme Court left the task of developing the contours of the psychotherapist-patient privilege to the lower Federal courts. The resulting case law has been far from uniform; the privilege is applied in different manners—and different exceptions have been recognized—in various Federal courts.

A comparison of the exceptions recognized under Military Rule of Evidence 513 and in Federal practice follows:

(1) Deceased patient exception

Federal case law on whether the psychotherapist-patient privilege survives the patient's death is sparse. As one Federal district court recently observed, "Whether the psychotherapist-patient privilege survives the death of the patient, or is otherwise affected by the patient's death, is a matter that has not been conclusively decided." *Awalt* v. *Marketti*, 287 F.R.D. 409, 414 (N.D. Ill. 2012). The few courts that have substantively addressed the issue concluded that the privilege survives the patient's death. See id. at 414–15; *Richardson* v. *Sexual Assault/Spouse Abuse Resource Center, Inc.*, 764 F. Supp. 2d 736, 741 (D. Md. 2011). In *United States* v. *Hansen*, 955 F. Supp. 1225, 1226 (D. Mont. 1997), the court did not hold that the privilege is unavailable where the patient is dead, but indicated that "[t]he holder of the privilege has little private interest in preventing disclosure, because he is dead." That ruling, however, preceded the Supreme Court's holding in *Swidler & Berlin* v. *United States*, 524 U.S. 399 (1998), that the attorney-client privilege generally survives the client's death.

Military Rule of Evidence 513(d)(1) expressly excludes dead patients from the protection of the privilege.

(2) Child abuse or neglect exception

There do not appear to be any reported post-Jaffee decisions addressing whether there is a child abuse or neglect exception to the Federal psychotherapist-patient privilege. There are cases, however, in which Federal courts have applied State law child abuse or neglect exceptions. See, e.g., Bassine v. Hill, 450 F. Supp. 2d 1182 (D. Or. 2006) (applying Oregon's statutory exception to psychotherapist-patient privilege for child abuse cases); *United States* v. *Mathis*, 377 F. Supp. 2d 640, 646 (M.D. Tenn. 2005) (applying Tennessee's statutory exception to psychotherapist-patient privilege for child abuse cases).

(3) Duty to report exception

Federal courts are split as to whether the psychotherapist-patient privilege is abrogated where the psychotherapist is under a legal duty to report a statement, such as a threat to another. The United States Courts of Appeals for the Sixth and Ninth Circuits hold that such statements may not be admitted into evidence. *United States* v. *Chase*, 340 F.3d 978 (9th Cir. 2003) (en banc); United States v. Hayes, 227 F.3d 578 (6th Cir. 2000). The United States Courts of Appeal for the Fifth Circuit will not apply a privilege in such situations. *United States* v. *Auster*, 517 F.3d 312 (5th Cir. 2008). Military Rule of Evidence 513 is consistent with practice in the Fifth Circuit. Military Rule of Evidence 513(d)(3) provides an exception "when Federal law, State law, or Service regulation imposes a duty to report information contained in a communication."

(4) Dangerous-patient exception

In Jaffee, the Supreme Court observed that "we do not doubt that there are situations in which the privilege must give way, for example, if a serious threat of harm to the patient or to others can be averted only by means of a disclosure by the therapist." Jaffee, 518 U.S. at 18 n.19. Federal courts, however, have split over what is called the "dangerous-patient exception" to the psychotherapist-patient privilege. The Sixth, Eighth, and Ninth Circuits have rejected such an exception. Chase, 340 F.3d 978; United States v. Ghane, 673 F.3d 771 (8th Cir. 2012); Hayes, 227 F.3d 578. Tenth Circuit case law supports such an exception. *United States* v. *Glass*, 133 F.3d 1356 (10th Cir. 1998); see also *United States* v. *Robinson*, 583 F.3d 1265, 1279 (10th Cir. 2009) (noting that Glass created a narrow exception to the psychotherapist-patient privilege "where 'disclosure [is] the only means of averting [imminent] harm'"). Military Rule of Evidence 513 is consistent with the Tenth Circuit's application of Jaffee.

(5) Crime/fraud exception

The United States Court of Appeals for the First Circuit has held that a crime/fraud exception applies to the psychotherapist-patient privilege. In re Grand Jury Proceedings (Gregory P. Violette), 183 F.3d 71, 77 (1st Cir. 1999). A Federal district court decision from Virginia agrees. In re Sealed Grand Jury Subpoenas, 810 F. Supp. 2d 788, 794 (W.D. Va. 2011). There do not appear to be any reported post-

Jaffee Federal decisions to the contrary. Military Rule of Evidence 513 is consistent with the First Circuit's approach.

(6) Military necessity exception

Military Rule of Evidence 513's exception for ensuring the safety and security of military personnel, military dependents, military property, classified information, or the accomplishment of a military mission is military-specific and has no analog in Federal civilian practice.

(7) Waiver by placing the patient's mental condition in issue

In Jaffee, the Supreme Court recognized that a patient may waive the psychotherapist-patient privilege. Jaffee, 518 U.S. at 15 n.14. Federal courts have generally held that a patient waives the privilege when the patient puts his or her mental health at issue in a court case. See, e.g., Doe v. Dairy, 456 F.3d 704, 718 (7th Cir. 2006); *Schoffstall* v. *Henderson*, 223 F.3d 818, 823 (8th Cir. 2000). Federal courts have, however, differed over the precision with which a patient must place a psychotherapist-patient communication in issue to waive the privilege, though those differing approaches arise in a civil, rather than criminal, litigation context. See generally Koch v. Cox, 489 F.3d 384, 390 (DC Cir. 2007); see also *St. John* v. *Napolitano*, 274 F.R.D. 12, 17–21 (D.D.C. 2011).

Military Rule of Evidence 513's exception 7 removes the privilege only from certain psychotherapist-patient communications by an accused; it does not remove the privilege from any psychotherapist-patient communications by a victim or witness.

(8) Constitutionally required exception

Some Federal courts have held that the psychotherapist-patient privilege recognized in Jaffee, which was a civil case, does not apply against the defense in criminal cases. For example, a United States District Court for the District of Oregon decision held that a criminal defendant's rights of confrontation and due process overcome the psychotherapist-patient privilege. *Bassine* v. *Hill*, 450 F. Supp. 2d 1182, 1185 (D. Or. 2006). The U.S. District Court for the District of Massachusetts reached a similar result. *United States* v. *Mazzola*, 217 F.R.D. 84, 88 (D. Mass. 2003). Other Federal district court decisions have used a balancing test to determine whether the privilege applies in a particular criminal case. See, e.g., *United States* v. *Alperin*, 128 F. Supp. 2d 1251, 1253–54 (N.D. Cal 2001); *United States* v. *Hansen*, 955 F. Supp. 1225, 1226 (D. Mont. 1997). Still other Federal district court decisions have held that the psychotherapist-patient privilege does not yield to a criminal defendant's constitutional rights. See, e.g., *United States* v. *Shrader*, 716 F. Supp. 2d 464, 471–72 (S.D. W. Va. 2010); *United States* v. *Doyle*, 1 F. Supp. 2d 1187, 1189–90 (D. Or. 1998). Following a detailed analysis of competing precedent, a Federal district judge in West Virginia held, "The psychotherapist-patient privilege contemplates an exception where necessary to vindicate a criminal defendant's constitutional rights." *United States* v. *White*, No. 2:12-cr-00221, 2013 WL 1404877, at *13 (S.D. W. Va. April 5, 2013). The court elaborated that "where a requesting party establishes that the guarantees of due process may be implicated by the withholding of evidentiary information, confidential documents otherwise subject to the psychotherapist-patient privilege may be disclosed if they are material, either because they may be exculpatory or because they adversely affect the credibility of the government's witnesses." Id. at #15. In White, the judge ordered the release of certain mental health documents concerning a witness to the defense. Id. at *17.

The United States Court of Appeals for the Tenth Circuit, whose precedent is particularly important for the military justice system because it reviews habeas corpus decisions in cases arising from the United States Disciplinary Barracks, has held that absent an absolute evidentiary privilege, a prosecutor must disclose information to the defense, even if it falls under a psychotherapist-patient privilege, if it is favorable to the defense and material to the defendant's guilt or punishment. Browning v. Trammell, 717 F.3d 1092, 1094 (10th Cir. 2013). Evidence is favorable to the defense if it is exculpatory or impeaching. Id. (citing *Banks* v. *Dretke*, 540 U.S. 668, 691 (2004)). The 10th Circuit noted that the Supreme Court has reserved judgment on a prosecutor's duty to disclose potentially exculpatory evidence where an absolute privilege exists. Id. at 1102 n.8 (citing *Pennsylvania* v. *Ritchie*, 480 U.S. 39, 58 n.14 (1987)).

Military practice, in which the psychotherapist-patient privilege applies but may be overcome by the accused's constitutional rights in a given case, is more protective of the patient than in some Federal civilian jurisdictions and less protective than in others. It is consistent with the middle, contextual approach followed by, among other Federal courts, the United States District Court for the Southern District of West Virginia in White.

E. In camera review of documents to resolve privilege issues

Federal judges considering a party's request for a defendant's or witness's mental health records have often reviewed the records in camera. See, e.g., *United States* v. *Blake*, No. 13–80054–CR, 2014 WL 1764679, at *7 (S.D. Fla. 2014); *United States* v. *White*, No. 2:12-cr-00221, 2013 WL 1404877 (S.D. W. Va. April 5, 2013); *United States* v. *Loughner*, 782 F. Supp. 2d 829, 833 (D. Ariz. 2011); United States v. Robinson, 583 F.3d 1265 (10th Cir. 2009); *United States* v. *Mazzola*, 217 F.R.D. 84, 86–87 (D. Mass. 2003); *United States* v. *Alperin*, 128 F. Supp. 2d 1251, 1255 (N.D. Cal. 2001); *United States* v. *Haworth*, 168 F.R.D. 660 (D.N.M. 1996); *United States* v. *Lowe*, 948 F. Supp. 97 (D. Mass. 1996). But see *United States* v. *Stone*, No. CR. 05–30049, 2005 WL 1845153, at *3 (D.S.D. 2005); Doyle, 1 F. Supp. 2d at 1191. The United States Court of Appeals for the 10th Circuit has held that in camera reviews are appropriate to determine whether the Constitution requires that evidence falling within the psychotherapist-patient privilege be turned over to the defense. Browning, 717 F.3d at 1095.

In military practice, the Navy-Marine Corps Court of Criminal Appeals has identified a three-part inquiry based on Wisconsin case law to determine whether a military judge will conduct an in camera review:

> (1) did the moving party set forth a specific factual basis demonstrating a reasonable likelihood that the requested privileged records would yield evidence admissible under an exception to Mil. R. Evid. 513; (2) is the information sought merely cumulative of other information available; and (3) did the moving party make reasonable efforts to obtain the same or substantially similar information through non-privileged sources?

United States v. *Klemick*, 65 M.J. 576, 580 (N–M. Ct. Crim. App. 2006) (citing *Wisconsin* v. *Green*, 648 N.W.2d 298 (Wis. 2002)).

The procedural approach to resolving psychotherapist-patient privilege issues under Military Rule of Evidence 513 appears to be similar to that applied in most Federal district courts.

37. Senator KING. Dr. Galbreath, please provide your views on legislation that would require the following: If a victim of sexual assault or MST provides details to a therapist about the effect that episode has had on their lives or details of the incident in question, that information should be bound by confidentiality and not subject to subpoena for potential use in military justice proceedings.

Dr. GALBREATH. This question asks for views on hypothetical legislation. It would be inappropriate to comment on such hypothetical legislation. Having actual or draft legislation to review would facilitate an informed assessment.

QUESTIONS SUBMITTED BY SENATOR LINDSEY GRAHAM

COMMANDER'S ROLE IN MEDICAL CARE OF SEXUAL TRAUMA VICTIMS

38. Senator GRAHAM. Dr. Guice, what responsibility does a commander have to ensure a servicemember under his/her command gets appropriate medical care, including mental health care, following a sexual assault?

Dr. GUICE. The Surgeons General of the Military Departments provide guidance on the medical management of victims of sexual assault to ensure there is standardized, timely, accessible, and comprehensive care for every patient. To emphasize the importance, every sexual assault victim is treated as an emergency and given priority treatment. In addition, subordinate commanders have specific responsibilities to ensure servicemembers get appropriate medical care. This information is detailed in the DODI 6495.02, March 28, 2013.

Unit commanders, supervisors, and managers at all levels are responsible for the effective implementation of the SAPR program and policy. Military and DOD civilian officials at each management level shall advocate a strong SAPR program and provide education and training that shall enable them to prevent and appropriately respond to incidents of sexual assault.

Each installation commander develops guidelines to establish a 24-hour, 7-day-per-week sexual assault response capability for their locations, including deployed areas. For SARCs that operate within deployable commands that are not attached to an installation, senior commanders of the deployable commands shall ensure that equivalent SAPR standards are met. In addition, the Installation Commander chairs the Case Management Group (CMG) and can request a high-risk safety assessment be conducted by trained personnel of each sexual assault victim at each CMG meeting. If victim is assessed to be in a high-risk situation, the CMG chair will immediately stand up a multi-disciplinary high-risk response team to continually monitor

the victim's safety, by assessing danger and developing a plan to manage the situation.

SARCs must be notified of every incident of sexual assault involving servicemembers or persons covered in the policy, in or outside of the military installation when reported to DOD personnel. Upon notification, the SARC or SAPR VA shall respond to offer the victim SAPR services. All SARCs shall be authorized to perform victim advocate duties in accordance with Service regulations, and will be acting in the performance of those duties. In the instance of Restricted Reports, the SARC shall be notified by the healthcare personnel or the SAPR VA and in Unrestricted Reports, the SARC shall be notified by the DOD responders. The SARC shall serve as the single point of contact to coordinate sexual assault response when a sexual assault is reported.

SEXUAL TRAUMA AND PTSD

39. Senator GRAHAM. Dr. Bell, what is the prevalence of PTSD in veterans who are victims of sexual trauma?

Dr. BELL. Among the subset of veterans who use VHA care and who received MST-related mental health care in fiscal year 2012, 57 percent of women and 54 percent of men had a diagnosis of PTSD. It is important to note that these data are for only those veterans currently receiving MST-related mental health care and not all veterans who have experienced MST. As such, these data likely represent an overestimate of prevalence of PTSD among all veterans who experienced MST.

40. Senator GRAHAM. Dr. Bell, is history of sexual trauma a major risk factor for PTSD?

Dr. BELL. Research has consistently found that both men and women are at increased risk for developing PTSD after experiencing sexual trauma, whether in civilian or military contexts. Sexual trauma is, in fact, more likely to result in symptoms of PTSD than are most other forms of trauma, including combat. Data suggest this finding holds for sexual assault in the military context as well, with MST being more strongly associated with PTSD and other health consequences than most other types of trauma.

SUICIDE

41. Senator GRAHAM. Ms. Garrick, what is the prevalence of PTSD in servicemembers who are victims of suicide?

Ms. GARRICK. Through the DODSER, the Department collects data about military suicide decedents and attempters. The DODSER tracks demographic information such as the cause and manner of death or attempts, substance abuse and psychological health history, and deployment and combat experiences. The DODSER also tracks the prevalence of PTSD amongst those servicemembers who died by suicide. In 2012, 17 servicemembers or 5.3 percent of those who died by suicide were diagnosed with PTSD. The range in previous years has been 14 servicemembers in 2010 and 19 servicemembers in 2009.

42. Senator GRAHAM. Ms. Garrick, in DOD's experience, is history of sexual trauma a major risk factor for suicide?

Ms. GARRICK. Empirical research from civilian populations suggests that sexual assault victims are at an increased risk for suicidal ideation, attempts, and deaths. The few research studies that have been conducted on the military population also suggest that military sexual assault and harassment victims may be subject to similar risks. However, to date, we do not have enough data to state conclusively what the linkages between military suicides and military sexual assaults are and if there is any correlation.

The DSPO and the SAPRO jointly sponsoring a study to better understand the prevalence of suicide risk among sexual assault victims. Using data from the Survey of Health-Related Behavior of Active Duty Members, the study will assess whether statistically significant relationships between self-reported instances of sexual assault and suicidal ideation and attempts exist. In addition, the study will analyze the extent to which risk factors for sexual assault overlap with risk factors for suicidal ideation and attempts. DSPO will use the data to assess whether there is a need to modify existing suicide prevention and resilience programs to address any unique risks associated with sexual assault victims.

APPROPRIATE THERAPIES FOR SEXUAL ASSAULT VICTIMS

43. Senator GRAHAM. Dr. Guice and Dr. McCutcheon, are DOD and VA providing the most appropriate medical and behavioral health therapies for sexual assault victims? Please explain.

Dr. GUICE. Yes we are. Medical care for survivors of sexual assault is mandated by DODI 6495.02 "Sexual Assault Prevention and Response Program Procedures" and describes the four key comprehensive elements of care provided to survivors of sexual assault.

(1) Timely and standardized health care across the Services

- It is DOD policy that sexual assault victims presenting to a medical facility must be seen and assessed immediately regardless of evidence of physical injury, be gender-responsive, culturally competent, and recovery-oriented.

(2) Comprehensive acute and follow-up medical care

- All survivors receive a comprehensive assessment including a history and physical exam;
- Once victims are medically stable, they are offered a SAFE;
- Offered the services of a SARC;
- Offered testing and prophylactic treatment options for sexually transmitted diseases;
- Offered assessment of pregnancy risk with options for emergency contraception;
- Offered counseling on any necessary or recommended follow-up care and referral services; and
- When feasible, and with the victim's consent, medical management is linked to the patient's primary care manager for follow-up treatment to facilitate continuity of care and support.

(3) Standardized DOD and Service forensic examination procedures requires:

- Standardized SAFE kits at all MTFs;
- Medical providers are trained to follow the "National Protocol" Standard;
- SARC services are offered to the survivors (The SARC or a Sexual Assault Response Victim Advocate is available to respond and speak to victims at any time requested);
- Communication and coordination of care between the SARC responders and healthcare personnel;
- Mechanisms exist to assure confidentiality in cases where the survivor has elected restricted reporting;
- After a SAFE has been conducted, the chain of custody is maintained and handed off to the military Service-designated law enforcement agency (in the case of unrestricted reporting) or Military Criminal Investigative Organization for restricted reports; and
- There is a mechanism for the SARC to generate a restricted reporting control number for labeling in cases of restricted reports to preserve confidentiality of the survivor while ensuring that the chain of custody for evidence will be retrievable if the survivor chooses to proceed with unrestricted reporting at a later date.

(4) Comprehensive behavioral health services

- Survivors are assessed and offered immediate behavioral health services or a referral for follow-up services, as the survivor requests or as clinically indicated.
- The most appropriate medical and behavioral health therapies are based on a thorough clinical assessment and take into account patient centered preferences for treatment if they request treatment. Behavioral health care is guided by the 2010 VA/DOD Post-Traumatic Stress Clinical Practice Guideline that states survivors of trauma (including sexual assault) must be assessed for trauma related symptoms, medical and functional status, pre-existing medical and psychiatric problems, and risk for developing PTSD and other conditions in the aftermath of a trauma. While survivors of sexual assault may develop no symptoms of a disorder, evidence-based treatments are recommended and provided for disorders (e.g., depression, insomnia, and PTSD) when they occur. These treatments include pharmacotherapy and exposure-based psychotherapies, such as Prolonged Exposure and Cognitive Processing Therapy for PTSD.

Dr. MCCUTCHEON. MST is associated with a range of mental health conditions and appropriate treatment will depend on a given veteran's specific difficulties. Over

the past decade, VA has made a significant commitment to ensuring that all veterans have access to cutting-edge, evidence-based psychotherapies. For example, VA national policy requires every VA health care facility to provide evidence-based psychotherapies. VA Mental Health Services has also conducted national rollouts of evidence-based psychotherapies such as Cognitive Processing Therapy, Prolonged Exposure, Acceptance and Commitment Therapy, and Cognitive Behavioral Therapy to train VA mental health providers in these evidence-based approaches. Practice guidelines developed outside VA and DOD, such as the guidelines issued by the International Society for Traumatic Stress Studies and the American Psychiatric Association, concur with the VA/DOD guideline in recommending these treatments and similar cognitive-behavioral approaches for treating sexual assault survivors. These rollouts of evidence-based psychotherapies have particular significance for veterans who experienced MST, as they target mental health conditions that are strongly associated with MST. Also, several were originally tested and developed with sexual trauma survivors. The rollouts are an important means of providing veterans with access to state-of-the-art treatment to assist them in their recovery from MST.

CIVILIAN APPROACHES TO PTSD THERAPY

44. Senator GRAHAM. Dr. Guice and Dr. McCutcheon, DOD and VA both use evidence-based therapies—like prolonged exposure therapy and cognitive processing therapy—to treat PTSD. What do civilian experts recommend as the most effective treatment approaches for PTSD?

Dr. GUICE. Both military and civilian mental health providers rely on the VA/DOD Clinical Practice Guideline for PTSD for recommendations on the most effective psychological treatments currently available. The PTSD Clinical Practice Guideline workgroup brought together DOD, VA, and civilian subject matters experts to develop these guidelines based on military, VA, and academic research. The exposure-based psychotherapies recommended in the PTSD Clinical Practice Guideline—Prolonged Exposure and Cognitive Processing Therapy—were originally developed by civilian psychotherapy researchers specifically to treat PTSD among rape victims, and these treatment approaches are currently considered the state-of-the-art for treatment of PTSD due to various forms of trauma (to include combat as well as sexual assault) for civilians and military personnel alike.

Dr. MCCUTCHEON. Treatment approaches always need to be tailored to the specific needs of individual veterans and take into account not only comorbid health conditions but also the veteran's treatment and broader psychosocial history, his or her current life context, and his or her individual preferences. Psychoeducation about PTSD and the impact of sexual assault can also be an important component of treatment. Regarding treatment for veterans with PTSD specifically, a significant research base has accumulated identifying trauma-focused Cognitive Behavioral Therapy, such as Cognitive Processing Therapy and Prolonged Exposure, as effective treatments for PTSD. Cognitive Processing Therapy and Prolonged Exposure in particular were originally developed to treat sexual assault survivors and have a particularly strong evidence base in this area. Practice guidelines developed outside VA and DOD, such as the guidelines issued by the International Society for Traumatic Stress Studies and the American Psychiatric Association, concur with the VA/DOD guideline in recommending these treatments and similar cognitive-behavioral approaches for treating sexual assault survivors.

CONTINUITY OF CARE

45. Senator GRAHAM. Dr. Guice and Dr. McCutcheon, how do DOD and VA ensure continuity of medical care, including mental health care, as victims of MST transition from Active service to veteran status?

Dr. GUICE. DOD ensures continuity of care to the VA through: (a) care coordination and case management activities; and (b) electronic health record information-sharing initiatives for all patients, to include victims of sexual trauma who receive health care services within the Mental Health Services. Military retirement circumstances determine the type of care coordination Services offered. Four care coordination/case management pathways are presented below to illustrate:

1. An Active Duty servicemember receiving mental health service care is eligible and chooses to retire from Service. This Active Duty servicemember is assigned a SARC and Sexual Assault Prevention and Response Victim Advocate (SARP VA). The SARC is the single point of contact for coordinating care but the SARP VA, therapist, and case manager may also assists with referrals.

2. The Active Duty servicemember is in the Warrior Transition Unit (WTU) and the Integrated Disability Evaluation System (IDES) process with a medical discharge from Military Service. The Active Duty servicemember is assigned a physician Primary Care Manager (PCM) and a WTU Nurse Case Manager (NCM) who coordinates transition of care to the VA. This Active Duty servicemember may have already received care at a VA Polytrauma Center and would already be a shared DOD/VA patient. The SARC and SARP VA can also assist to set up transfer to the VA.
3. An Active Duty servicemember in the IDES process is being medically discharged from the Service but not in a WTU. The PCM and the NCM in the Patient Centered Medical Home would arrange VA care. The SARC and SARP VA can also assist in the transfer.
4. An Active Duty servicemember survivor of sexual assault from a spouse would receive counseling from the Service's Family Advocacy Program. The Family Advocacy Program counselor, the SARC or SARP VA could assist the patient to transfer to VA if the patient is retiring from Service or being medically discharged and not in a WTU.

Recent DOD and VA Integrated Electronic Health Record clinical data-sharing initiatives makes it possible for DOD and VA providers to view medical record information from both departments electronically, which facilitates continuity of care:

1. The Bidirectional Health Information Exchange which offers two-way data sharing for patients who receive care in both DOD and VA. Real time data include: allergies, outpatient pharmacy, lab and radiology reports, demographics, diagnoses, vital signs, problem lists, family history, social history, questionnaires, and theater clinical data.
2. The Clinical Data Repository/Health Data Repository is a two-way (DOD to VA and VA to DOD) repository for patients who receive care in both DOD and VA facilities (shared patients). The Clinical Data Repository/Health Data Repository provides pharmacy and drug allergy data in real time and is computable, which means that data elements can be pulled and sorted. The use of these shared data programs promotes continuity of medical care, including mental health treatment between DOD and VA.
3. The Federal Health Information Exchange provides monthly transfer of data from DOD to VA (one way) on servicemembers separated from Active Duty service. Data include patient demographics, lab and radiology results, outpatient pharmacy, allergies, and hospital admission information.

Dr. McCutcheon. Please see the response to Question 18.

SEXUAL ASSAULTS BEFORE ENTERING MILITARY SERVICE

46. Senator Graham. Dr. Galbreath, we understand that servicemembers are coming forward to report sexual assaults that occurred to them prior to coming into the military. Does DOD report those cases to civilian law enforcement authorities for investigation?

Dr. Galbreath. Yes. At the victim's request, each of the Military Criminal Investigative Organizations (Army Criminal Investigations Division, Naval Criminal Investigative Service, Air Force Office of Special Investigations) can and do connect a servicemember with the civilian law enforcement agency that would have responsibility for investigating a report of sexual assault that occurred prior to his or her joining the military.

POLYPHARMACY AND SUBSTANCE ABUSE

47. Senator Graham. Dr. Guice and Dr. McCutcheon, sexual trauma victims can sometimes experience devastating physical injuries and mental health disorders. Often, medical providers will prescribe multiple medications, including drugs with abuse potential. Some servicemembers will also self-medicate with alcohol or other drugs. What are DOD and VA doing to identify and implement best practices to prevent substance abuse among sexual assault victims?

Dr. Guice. Current policy, screening programs, and collaboration across agencies target the identification and prevention of substance misuse among sexual assault victims, as well as among all servicemembers. DODI 1010.04 "Problematic Substance Use by DOD Personnel," signed February 20, 2014, addresses prevention, screening, and intervention for SUDs. This policy requires regular and systematic medical screening for substance use/early intervention and increased training for healthcare personnel on screening and prevention of SUDs.

For example, DOD is currently implementing Screening, Brief Intervention, and Referral to Treatment (SBIRT) in primary care. SBIRT is an approach endorsed by the Office of National Drug Control Policy, the Substance and Mental Health Services Administration, and the VA. SBIRT includes the routine screening of patients for SUDs using empirically-validated measures along with prescribing interventions stemming from identified risks. Widespread implementation of SBIRT within primary care settings provides an opportunity for early identification of substance misuse, which allows for timely intervention. Finally, to prevent misuse of prescription medication, the dispensing and tracking of prescription medications in a manner that best monitors therapeutic use is a nationwide and DOD priority. The DOD PDTS matches real-time prospective drug utilization with a patient's medication history for each new or refilled prescription before it can be dispensed to the patient. PDTS flags beneficiaries whose cases reveal an excessive number of: controlled substance claims, pharmacies used to obtain controlled drugs, and/or prescribing providers.

Dr. McCutcheon. Substance use is a key concern in the treatment of veterans who experienced MST, as SUDs are one of the top five conditions associated with MST among veterans seen in VA for MST-related mental health care. Facility MST coordinators are encouraged to develop collaborative relationships with other clinical program coordinators, including VA's SUD–PTSD Specialists at each facility, to integrate MST-specific materials into their training for staff and outreach to veterans. MST coordinators are also available to provide consultation to staff on cases involving MST, when needed.

It is VHA policy that veterans treated in VA receive an annual screening for unhealthy alcohol use in Primary Care, Mental Health, or other Specialty Care Clinics. Those veterans who indicate at-risk alcohol consumption receive brief counseling and either a recommendation to reduce their consumption to within recommended limits or to abstain from alcohol, as clinically indicated. Providers of patients with screening results that show the highest risk for alcohol use disorders are prompted to discuss referral to specialty addiction treatment providers for comprehensive evaluation or additional treatment.

VA/DOD Clinical Practice Guidelines for Management of PTSD and Acute Stress Reaction (published in 2010) and the accompanying Pocket Guide (published in 2013) specifically recommend against prescribing benzodiazepines for either acute stress reaction or PTSD, citing evidence of harm from use of benzodiazepines in patients with PTSD. VHA provides training in evidence-based treatment of acute stress reaction and PTSD emphasizing psychotherapy and medications without addictive potential.

Since fiscal year 2013, VHA has implemented a national Opioid Safety Initiative that identifies patients on high doses of opioid medications for pain or patients who are receiving benzodiazepines and opioids concurrently. Consistent with the VA/DOD Clinical Practice Guideline on Management of Opioid Therapy for Chronic Pain, multiple efforts are underway to support more effective pain management strategies, including the availability of alternatives to opioid medications and urine drug testing to monitor those for whom long-term opioid therapy is clinically indicated.

48. Senator Graham. Dr. Guice and Dr. McCutcheon, as sexual assault victims transition from DOD to VA health care, how do the two Departments transfer pharmacy data so healthcare providers have real-time data available to prevent harmful drug interactions and to avert over-prescribing psychoactive and/or narcotic drugs?

Dr. Guice. DOD and the VA transfer pharmacy data through two Integrated Electronic Health Record clinical data-sharing initiatives, which make it possible for both DOD and VA to view each other's medical record information in real time.

1. The Bidirectional Health Information Exchange offers two-way (DOD to VA and VA to DOD) data-sharing on patients who receive care in both DOD and VA. Real time data includes: allergies, outpatient pharmacy, lab and radiology reports, demographics, diagnoses, vital signs, problem lists, family history, social history, questionnaires, and theater clinical data.
2. The Clinical Data Repository/Health Data Repository is a two-way (DOD to VA and VA to DOD) repository for patients who receive care in both DOD and VA facilities (shared patients). The Clinical Data Repository/Health Data Repository provides pharmacy and drug allergy data in real time and is computable, which means that data elements can be pulled and sorted. The use of these shared data programs promotes continuity of medical care, including mental health, between DOD and VA.

To prevent harmful drug interactions and to avert over-prescribing psychoactive and/or narcotic drugs, the DOD Pharmaco-Economic Center has a MTF Prescription Restriction Program available in the electronic PDTS that can set restrictions on prescriptions for patients on high risk medications (those with high dependency and/or lethality potential). PDTS automatically checks new prescriptions against the patient's medical/prescription history before a new drug is dispensed. Drug dispensing histories from MTF pharmacies, retail, and mail-order pharmacy are integrated. This information helps providers know when to restrict controlled and psychotropic/central nervous system prescriptions. This information is available to VA through Bidirectional Health Information Exchange and Clinical Data Repository/Health Data Repository for sexual assault victims transitioning to VA care.

Dr. MCCUTCHEON. Providers and pharmacists can view a patient's prescription records by viewing information in a variety of locations, such as Janus Legacy Viewer, VistAWeb, and Remote Data View. Each of these simply provides a 'view only' option (allowing users to see information entered at other sites), but they do not provide medication alerts.

Limited DOD pharmacy data elements are available through the Clinical Data Repository/Health Data Repository application. Clinical Data Repository/Health Data Repository is a combined effort between DOD and VA. Clinical Data Repository/Health Data Repository is used to exchange clinical data between VA's Health Data Repository and DOD's Clinical Data Repository for Active Dual Consumer patients.

A Dual Consumer is a patient who is eligible for health care under both DOD and VA health plans or a patient who has been assigned to a joint venture site and meets the requirements under a DOD/VA sharing agreement for coverage of specified clinical services. An Active Dual Consumer patient is a dual consumer who has actually been treated by both DOD and VA facilities. Active Dual Consumer patients can have their Active Dual Consumer status set to active or inactive. When an Active Dual Consumer patient's status is set as Active, the sharing of DOD and VA records is initiated. In order to comply with laws and policies that are designed to protect the privacy of patient medical records, Active Dual Consumer patients have their status set to inactive status by default.

Detailed prescription data is not transferred to VA via Clinical Data Repository/Health Data Repository. Even though detailed prescription data is not transferred, if a veteran is marked as an Active Dual Consumer, then Health Data Repository will display data showing all of the drugs the veteran has been prescribed at DOD facilities. The record will not specify whether the veteran is still prescribed these medications, or if the veteran is still taking these medications.

Medication Order Check Healthcare Application compares VA prescriptions against the list of DOD drugs in Health Data Repository. With this information, Medication Order Check Healthcare Application provides an alert for known adverse drug interactions and possible duplicate therapy. This alert prompts the pharmacist or provider to check the viewable DOD records in Janus Legacy Viewer, VistAWeb, or Remote Data View to determine the point in time that the veteran was prescribed the medication and at what dosages.

In addition to providing mediation alerts, Medication Order Check Healthcare Application's duplicate therapy order checks detect over-prescribing by comparing the drug ordered by the provider against a patient's current and past prescription profile using DOD data in Health Data Repository. Finally, dosing checks (which are now being deployed as part of Medication Order Check Healthcare Application 2.0) analyze the dosage of the current order being prescribed in order to ensure that the medication is not being overprescribed. Dosing order checks only occur at the time a medication is ordered. In other words, dosing checks do not occur upon transfer of prescription data from DOD to VA, but rather when a new drug order is made.

At any time, irrespective of whether Medication Order Check Healthcare Application has issued an alert for duplicative therapy or for questionable dosage, the pharmacist or provider can view DOD prescription data using Janus Legacy Viewer, VistAWeb, or Remote Data View. The pharmacist or provider can then use this information to check for duplicate therapy, drug-drug interactions, or allergy concerns.

49. Senator GRAHAM. Dr. Guice, Dr. McCutcheon, and Dr. Galbreath, how do benefits, support, and medical care for victims of sexual assault in the military compare to those offered to civilian victims?

Dr. GUICE and Dr. GALBREATH. I am aware of the following free benefits, support, and medical care for military victims that are not available in the civilian community:

- The DOD SAPR policy requires medical care and SAPR advocacy services are gender-responsive, culturally competent, and recovery-oriented;

• Healthcare providers and SARC shall provide a response that recognizes the high prevalence of pre-existing trauma (prior to the present sexual assault incident). Trauma-Informed Care is an approach to engage people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives. Trauma-informed services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization;
• Free medical care (both initially for immediate or acute care and any follow up);
• Free mental health care, for as long as the member desires treatment;
• Free legal representation by military attorneys at all military justice proceedings through the Special Victims Counsel program;
• The opportunity to request an expedited transfer to another location, if they filed an Unrestricted Report;
• A Military Protective Order that can be issued by a military officer that does not require a court appearance or open court-testimony by the victim; and
• A multi-disciplinary safety evaluation that involves command, law enforcement, the SARC, legal personnel, mental health professionals, and others as required.

Dr. McCutcheon. It would be difficult to provide a concise comparison of VA and civilian services for sexual assault survivors, as there is no comparable equivalent to VA's single-source system of care in the civilian setting; the benefits, support, and medical care accessible to civilian survivors depends greatly on their particular circumstances. VA can, however, summarize aspects of VA health care that are unlikely to be duplicated, at least to the same degree, in civilian systems.

First, it is VHA policy that all veterans seen for health care are screened for MST. This recognizes, importantly, that many survivors of sexual trauma do not disclose their experiences unless asked directly, may not be aware of available MST-related services, and may also not be aware of the extent to which their health conditions are related to sexual trauma. VA uses screening as an opportunity to make all patients aware of care that is available to them and to streamline access for those interested in this care.

Second, individuals who have experienced sexual trauma, both veterans and civilians, may have a range of mental and physical health needs and seek treatment from a variety of clinics and medical settings. As a single umbrella provider, VA is well-positioned to provide coordinated, tailored care that ensures the veteran's history of MST is considered in all treatment provided. VA providers are familiar with internal resources available to address new or emergent treatment needs and can provide timely referrals, as needed. This includes the ability to refer for non-VA care from a private provider, if necessary. VA has a single system to document all MST-related care, regardless of type or setting, in the electronic medical record, which helps ensure that patients are not billed for the MST-related care they receive.

Third, VA has taken extensive steps to ensure that MST-related treatment is available in every VA health care facility. Every facility has providers knowledgeable about mental health treatment of MST, and every facility provides MST-related mental health outpatient services including formal psychological assessment and evaluation, psychiatry, and individual and group psychotherapy. Specialty services are also available to target problems such as PTSD, substance abuse, depression, and homelessness. Outpatient counseling is also available at community-based Vet Centers. For veterans who need more intensive treatment, VA has inpatient programs available for acute care needs, and many VA facilities have Mental Health Residential Rehabilitation and Treatment Programs. Some of these programs focus specifically on MST or have specialized MST tracks. As noted, every VA health care facility has a designated MST coordinator who serves as a point of contact on MST-related issues and can assist veterans with accessing needed services.

Finally, VA provides all medical, mental health, and pharmaceutical care for MST-related conditions free of charge. There are no external payers or insurance plan involvement for this care; no co-pays are required, and there are no time limits on the extent of this care, nor any exclusions for any health conditions.

50. Senator Graham. Dr. Guice and Dr. McCutcheon, we heard testimony about medication being the initial therapy option while sexual assault victims wait a long time to see a counselor for treatment. Is it a common practice in both the civilian and Mental Health Services to offer medications soon after a sexual trauma event?

Dr. GUICE. It is a common practice in both the civilian and Mental Health Services to make clinical decisions based on a thorough assessment, taking into account patient-centered preferences for medication and/or psychotherapy. Based on these individual factors, medication may be indicated to best manage the symptoms associated with the early aftermath of sexual assault.

DOD promotes evidence-based practices. Medication management is included as an evidence-based therapy for PTSD and the common comorbid conditions such as depression, bipolar disorder, substance use disorders, and chronic pain. The 2010 VA/DOD Clinical Practice Guideline for PTSD indicates victims must be assessed for trauma related symptoms, medical and functional status, pre-existing medical and psychiatric problems, and risk for developing PTSD or other comorbid conditions in the aftermath of a trauma. While the Clinical Practice Guideline states that there is no evidence to recommend pharmacotherapy to prevent PTSD, the guideline recommends that symptom-specific treatment should be provided and basic needs addressed in the immediate period following a trauma. A short medication course for specific comorbid symptoms may be needed to address sleep disturbance, management of pain, irritation, and excessive arousal and anger. Patient preferences for treatment are also important considerations, and all patients are reassessed and monitored during clinical follow-up.

DHA evaluates the appropriateness of prescribing practices through: (1) electronic pharmacy surveillance programs; and (2) the peer review process required as part of the credentialing process for individual providers in the direct care system. Electronic surveillance programs include the PDTS which has a MTF Prescription Restriction Program that can set restrictions on prescriptions for patients on high risk medications (those with high dependency and/or lethality potential). The appropriateness of high risk medications are evaluated through use of the pharmacy information alert systems. The credentialing process for individual providers in the MTFs contains safeguards to ensure that individual prescribing practices meet the standard of care for safe and effective medical care. MTFs are accredited by The Joint Commission which requires peer review as part of the credentialing process for individual privileged providers with an independent practice scope of practice. Peer review involves the routine clinical quality monitoring performed by a peer in the same profession and clinical area of expertise as the provider under review. Peer review ensures that each privileged provider meets the standard of care. Results of peer review are summarized in the credentials package submitted every 24 months as part of periodic review for renewal of privileges for individual providers. Any concerns identified about a provider's prescribing practices are addressed as part of the peer review process.

Dr. MCCUTCHEON. The VA/DOD Clinical Practice Guideline for PTSD and other mental health disorders describe evidence-based prescribing of psychotropic medication. The Guideline may be accessed on the Internet at www.healthquality.va.gov. Good clinical practice would typically involve consideration of whether medication might be useful in the management and treatment of any mental health symptoms resulting from sexual trauma, either in the immediate aftermath of the experience or in the long-term. Research has shown that the best mental health treatment outcomes often occur when a combination of psychotherapy and medications are used. Treatment planning in the case of an individual veteran is always a veteran-centric endeavor, with the veteran and health care provider collaboratively determining what will be the best approach to address his or her specific needs. In VA, survivors of MST typically are not coming for care soon after the event (because the event occurred in the military, prior to separation), so VA cannot comment on the use of medications soon after a sexual trauma event.

51. Senator GRAHAM. Dr. Galbreath, does DOD have data to show the average time a sexual assault victim must wait from the initial report to the first counseling session? If so, please explain.

Dr. GALBREATH. DOD does not maintain data to show the average wait time a sexual assault victim must wait from the initial report to the first counseling session. However, the Surgeons General of the military departments provide guidance on the medical management of victims of sexual assault to ensure there is standardized, timely, accessible, and comprehensive care for every patient. Every sexual assault victim is treated as an emergency and given priority treatment. Emergency care is provided immediately. Urgent care appointments are provided within 24 hours. A follow-up appointment is categorized as "routine care" and should be scheduled within 7 days of the servicemember's request for an appointment.

A vast expansion of mental health providers into primary care clinics and into line units (for Active Duty servicemembers) allows most patients to be seen same

day, even if the need is not urgent. We are above 90 percent compliance for meeting the appointment time requirements for emergency and urgent care.

DOD continuously monitors appointment wait times, and works to improve access to timely appointments.

QUESTIONS SUBMITTED BY SENATOR KELLY AYOTTE

EARLY IDENTIFICATION OF MENTAL HEALTH DISORDERS AND INTERVENTION

52. Senator AYOTTE. Dr. Guice, regarding treatment for servicemembers with psychological health problems, the Institute of Medicine found that challenges still exist at both DOD and VA. Among the areas of concern noted by the Institute of Medicine are inconsistencies in the availability of care, as well as a lack of systematic evaluation for treatment programs. How can DOD and VA both work together, and within their Departments, to ensure that high-quality care is better coordinated and delivered in an efficient and effective manner?

Dr. GUICE. DOD and the VA have been working together to ensure that high-quality care is coordinated and delivered in an efficient manner via formal collaboration in the Health Executive Council (Health Executive Council, co-chaired by the VA Under Secretary for Health and the ASD(HA)) and its subcommittees, namely the DOD/VA Psychological Health and TBI Work Group, the DOD/VA Pain Management Work Group, and others.

One initiative of the DOD/VA Psychological Health/TBI Work Group is the DOD/VA IMHS. This is a joint effort between the two Departments to advance an integrated public health model to improve access, quality, effectiveness, and efficiency of mental health services for all Active Duty servicemembers, National Guard and Reserve members, veterans, and their families. The IMHS includes 28 Strategic Actions, and 1 Strategic Action specifically addresses standardization of the quality and clinical outcome metrics used across both Departments to ensure continuous coordination of mental health quality measures.

DOD and VA also adhere to Clinical Practice Guidelines developed by interagency working groups to ensure coordinated high-quality care both within and across Departments. Toolkits for providers, patients, and family members have been developed for the Clinical Practice Guidelines and are available for download at https://www.qmo.amedd.army.mil/pguide.htm.

Most recently, the President's Executive Order on "Improving Access to Mental Health Services for Veterans, Servicemembers, and Families" has charged the Interagency Task Force between DOD, VA, and Health and Human Servcies to develop coordinated solutions to improve access and eliminate barriers to mental health care. Standardization of mental health outcome metrics across the three Departments will facilitate the systematic evaluation of treatment programs and prevention initiatives.

SEXUAL ASSAULT RESPONSE COORDINATOR

53. Senator AYOTTE. Dr. Galbreath, section 1724 of the NDAA for Fiscal Year 2014 (P.L. 113–66) requires each Service Secretary to ensure timely access to a SARC for any member of the National Guard or Reserve who is the victim of a sexual assault. Please provide an update on how DOD is doing in implementing this provision related to SARCs for the Guard and Reserve.

Dr. GALBREATH. The DOD SAPRO provides oversight and guidance to the Services as they implement NDAA for Fiscal Year 2014 provisions. Each of the Services has addressed providing timely access and support of SARC services differently that takes into consideration organizational structure and geographic coverage apart from the military unit. A summary of the status to providing timely access to SARCs for Reserve component servicemembers follows:

- The National Guard has hired one full-time SARC in every State and Territory (54 States and Territories), for servicemembers who are located at the Joint Forces Headquarters and serve in either Title 32 Active Guard Reserve, Technician, or Active Duty Operational Support status. Every SARC is trained to provide service to both Air and Army National guardsmen within the State or Territory. Additionally, the Air National Guard has placed one airman, who serves on full time status to serve in the SARC role as required within each wing. The Army National Guard has one SARC, called the Collateral SARC, at each division down to brigade.
- U.S. Army Reserve policy requires that a servicemember victim be linked to the SARC that is located closest geographically. In addition, the U.S.

Army Reserve maintains 5 hotlines (1 hotline for each of 4 Regional Support Commands and 1 in Puerto Rico) staffed by 35 full-time military technicians and Active Guard and Reserve SARCs. The hotlines are staffed 24/7. These SARCs offer support on the phone when a victim calls, and can refer them to local civilian resources in crisis situations. The hotline numbers, along with the DOD SAFE Helpline phone number, are prominently posted in unit/drill areas. The Army Reserve Command publishes an array of products listing all five hotline numbers.

• Each U.S. Navy Reserve unit is required to have a designated Unit SAPR VA who responds to servicemember victims. In addition, the U.S. Navy Reserve provides SAPR response and services through a Navy Operation Support Center which is aligned with a Navy region with the Installation SARC providing services. The contact number for 24/7 SAPR VA and SARC services is posted in the Navy Operation Support Center and is made available via the DOD SAFE Helpline. Audits are conducted monthly to ensure posted telephone contacts are accurate and victims receive immediate support.

• All U.S. Marine Corps Reserve sites have at least one trained and appointed Uniformed Victim Advocate assigned to the site to provide in-person response to victims of sexual violence. All of the sites have memorandums of understanding with other SAPR military and civilian rape crisis centers in their localities. In addition, the U.S. Marine Corps Reserve maintains a 24/7 Sexual Assault Helpline which provides immediate telephonic crisis response to all Active Duty and Reserve component marines/sailors assigned to the 162 Marine Reserve sites throughout the United States including Alaska, Hawaii, and Puerto Rico. The Helpline is staffed by the SAPR Program Manager, three SARCs, and two civilian Victim Advocates located in New Orleans. Once a report is received, a referral will be made to the Uniformed Victim Advocate to provide immediate in-person response. Uniformed Victim Advocates are required to answer all calls within 15 minutes and to respond in person within 1 hour of notification. All Marine Reserve locations are mandated to post the SAPR Helpline as well as the DOD SAFE Helpline throughout common areas of their facilities.

• The U.S. Air Force maintains a civilian SARC at each of the 11 Host Wings. All Wing SARCs report to the Command SARC who is located at Robins Air Force Base. Each of the SARCs is issued a government cell phone and is on call 24/7. These SARC numbers along with the DOD SAFE Helpline are posted in many locations to ensure airmen are aware of the support.

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