

**THE RELATIONSHIPS BETWEEN MILITARY SEXUAL
ASSAULT, POST-TRAUMATIC STRESS DISORDER
AND SUICIDE, AND ON DEPARTMENT OF DE-
FENSE AND DEPARTMENT OF VETERANS AF-
FAIRS MEDICAL TREATMENT AND MANAGE-
MENT 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

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FEBRUARY 26, 2014
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<i>VISN & Facility:</i>	VISN 21: VA Palo Alto HCS/Menlo Park Division (Menlo Park, CA)
<i>Category:</i>	General Program, But Multiple Staff With Expertise in MST/Sexual Trauma
<i>Program name:</i>	Men's Trauma Recovery Program
<i>Phase of treatment targeted:</i>	Emphasis on trauma processing and development of coping skills.
<i>MST-specific treatment available:</i>	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.
<i>Notable admission criteria:</i>	Must have five consecutive days free of substance use. No severe cognitive impairment. No active psychosis. No active suicidality.
<i>Treat both men and women?</i>	Men only. Usually 2-3 MST survivors in the program at any given time.
<i>Rolling vs cohort admissions & length of program:</i>	Rolling admission. Typical length of stay is 60-90 days.
<i>Contact information:</i>	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 long-standing 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 there 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. 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 GILLIBRAND. Senator Ayotte?

Senator AYOTTE. Thank you very much.

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 system-wide, 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.

[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 policies 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.

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 SARC's, 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 SARC's 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 SARC's. To support this effort, VA has provided informational materials about VA's MST-related services to SAPRO and individual SAPR programs for distribution to SARC's, 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 SARC's 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 through 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

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

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 assist 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 IDDES 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.

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 Services 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.