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STATEMENT OF
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ON BEHALF OF THE
INDEPENDENT BUDGET VETERANS SERVICE ORGANIZATIONS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH
UNITED STATES HOUSE OF REPRESENTATIVES
JULY 19, 2013

Messrs. Chairman and Members of the Subcommittee:

Thank you for inviting the DAV (Disabled American Veterans) to testify on behalf of the *Independent Budget* Veterans Service Organizations (IBVSOs) at this oversight hearing. We appreciate the Subcommittee's focus on the care and treatment available to survivors of military sexual trauma (MST), and the current capabilities of the Department of Veterans Affairs (VA) and Department of Defense (DoD) to provide a structured and coordinated continuum of care to facilitate the recovery of MST survivors, from the time of the incident through transition to veteran status. This testimony is adapted from our discussion of MST in the Fiscal Year 2014 *Independent Budget*.

For a number of years, the IBVSOs have advocated greater collaboration between VA and DoD to identify best practices for health care services and claims processing for conditions related to MST. We also continue to express a fervent hope that DoD is effectively addressing methods to prevent the incidence of sexual assaults and harassment within all branches of the military services. We note legislation is pending in the Senate that would make changes related to the Uniform Code of Military Justice related to our concern.

This topic is extremely sensitive to service members, veterans and the respective Departments that are responsible for the safety and well-being of service members and veterans. When a service member is wounded by enemy rifle fire or mortar shrapnel in engagement with an enemy, as a society we recognize the sacrifice and loss of our wounded military personnel; but when a military service member is injured from personal or sexual violence, often perpetrated by a fellow service member, military authorities and society in general respond in a very different way.

What is the Department of Defense (DoD) Doing About MST?

In 2005 DoD established the Sexual Assault Prevention and Response Office (SAPRO) to ensure that each military service activity responsible for handling sexual assault complies with DoD

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policy. SAPRO serves as a single point of oversight of these policies, provides guidance to service branches, and facilitates resolution of common issues that arise in military services and joint commands. The objective of SAPRO is to enhance and improve prevention through training and education programs, ensure treatment and support of victims, and enhance system accountability.

Through SAPRO, DoD has taken a number of steps to improve the situation that confronts service members who have been personally assaulted. These include better reporting, enhanced training and more complete information about the scope of the problem and what needs to be done about it throughout the military command structure.

According to SAPRO, 86.5% of sexual assaults go unreported, meaning that official documentation of many assaults may not exist. Prior to the new records retention laws passed in the 2011 National Defense Authorization Act (NDAA), the services routinely destroyed all evidence and investigation records in sexual assault cases after two to five years, leaving gaping holes in MST-related claims filed prior to 2012. [1],[2]

The President signed an Executive Order in December 2011 that added Military Rule of Evidence (MRE) 514 into military law which took effect on January 12, 2012. DoD views MRE 514 as a rule structured to protect the communications between a victim and a victim's advocate when a case is handled by a military court. This rule allows victims to trust that what is shared with professionals will remain protected, whereas prior to the advent of MRE 514, DoD victim advocates and sexual assault response coordinators in some cases were compelled to testify about their private communications with survivors.[3]

Military sexual assault survivors are also informed by military authorities that they now have a new option to request permanent or temporary transfers from their assigned commands or bases, or to different locations within their assigned commands or bases. Procedures for this new expedited transfer option were issued in December 2011. The Services were also directed to make every reasonable effort to minimize disruption to the normal career progression of service members who report that they are victims of sexual assault, and to protect victims from reprisal or threat of reprisal for filing reports.[4]

In April 2012 Secretary of Defense Panetta announced the establishment of independent special victims units to investigate incidents of MST in the military and indicated that DoD would address some of its historic problems in archiving confirming records. Central to the

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[1] Rachel Kimerling, PhD, Julie Karpenko, MSW; Military Sexual Trauma Support Team, VA Office of Mental Health Services, National Center for PTSD, VA Palo Alto Health Care System; "Mental Health Care for Women Veterans and Treatment for Military Sexual Trauma," PowerPoint May 16, 2012 http://www.naswvc.com/attachments/article/82/2012%20PTSD%20Dr.%20Kimerling.pdf

[2] Testimony of Anu Bhagwati, Executive Director, Service Women's Action Network; U.S. House of Representatives, Committee on Veterans Affairs, Subcommittee on Disability Assistance, "Invisible Wounds: Examining the Disability Compensation Benefits Process for Victims of Military Sexual Trauma," July 18, 2012 http://veterans.house.gov/witness-testimony/ms-anu-bhagwati-0

[3] Witness Testimony of Col. Alan Metzler, Deputy Director, Sexual Assault Prevention and Response Office, U.S. Department of Defense; United States House of Representatives, Committee on Veterans' Affairs, "Invisible Wounds: Examining the Disability Compensation Benefits Process for Victims of Military Sexual Trauma," July 18, 2012 http://veterans.house.gov/witness-testimony/col-alan-metzler

[4] Ibid.

proposed regulations is the elevation of the most serious reports to the attention of a *Special Court Martial Convening Authority*, a uniformed officer holding at least the rank of Colonel or equivalent. In addition to new training for uniformed personnel and their commanders, the proposed regulations include new centralized records of disciplinary proceedings stemming from these incidents, as well as more therapeutic outlets for survivors.[5] Also, DoD will require that sexual assault policies be explicitly communicated to all service members within 14 days of their entry onto active duty. DoD has proposed that commanders be required to conduct annual organizational climate assessments to measure whether they are meeting the Department's goal of a culture of professionalism and maintaining zero tolerance for sexual assault within all commands; and that a mandate will be enforced for wider public dissemination of available sexual assault resources, such as DoD's "Safe Helpline," www.safehelpline.org.[6]

What Data Does DoD Possess on Reported Sexual Trauma?

Many service members who experience MST do not disclose it to anyone until many years after the fact, but frequently exhibit lingering physical, emotional or psychological symptoms. When service members experience sexual assault during military service there are a number of unique factors that can prevent or discourage them from coming forward and reporting the incident.[7]

A report required by the FY 2011 NDAA for the period from October 1, 2011 to September 30, 2012 (FY 2012) showed the military branches received a total of 3,374 reports of sexual assault. Of these, 2,558 were unrestricted reports and 816 were restricted reports. This data represents a six percent increase since FY 2011.[8]

Of the 1,713 alleged offenders under the legal authority of the Department, commanders had sufficient evidence to take disciplinary action against 66 percent of them, an increase from 57 percent in FY 2009. Of those whose court-martials were concluded in FY 2012, 79 percent were convicted of at least once charge, 19 percent had charges dismissed, and 25 percent were granted a discharge or resignation in lieu of court-martial.[9]

What Data Does VA Possess on Veterans Who Report MST?

In its health care system, VA screens all enrolled patients for MST. National screening data show that about one in five women and one in 100 men respond that they had experienced MST.

According to VA for FY 2012, 23.6% of women (72,497) and 1.2 percent of men (55,491) treated in VA facilities screened positive for MST. 72.9% of women who screened

[5] ABC News, "Panetta Introduces Initiatives to Fight Sexual Assault in the Military," April 16, 2012 http://abcnews.go.com/blogs/politics/2012/04/panetta-introduces-initiatives-to-fight-sexual-assault-in-the-military/

[6] Lisa Daniel, American Forces Press Service, "Panetta, Dempsey Announce Initiatives to Stop Sexual Assault," April 16, 2012 http://www.defense.gov/news/newsarticle.aspx?id=67954

[7] Garry Trudeau and Loree Sutton, The Washington Post, "Breaking the Cycle of Sexual Assault in the Military," June 29, 2012 http://www.washingtonpost.com/opinions/breaking-the-cycle-of-sexual-assault-in-the-military/2012/06/29/gJQAK0wNCW_story.html

[8] Fact Sheet on DoD Sexual Assault Prevention & Response Strategic Plan & Annual Report on Sexual Assault in the Military for FY 2012, May 7, 2013

[9] Ibid.

positive for MST received outpatient MST-related care of any kind; 56.7% received MST-related outpatient mental health care. 58.8% of men who screened positive for MST received outpatient MST-related care of any kind; 41.5% received MST-related outpatient mental health treatment. Of OEF/OIF/OND veteran VHA users, 20.5% of women and 0.9% of men screened positive. Among veterans with positive MST screens, 60.4% of women and 53.0% of men received outpatient MST-related mental health treatment in FY 2012**.** According to VA this population utilizes MST-related mental health care at higher rates than other Veterans, suggesting targeted outreach efforts to this population have resulted in higher utilization of VHA services. These rates are almost certainly an underestimate of the actual rate of MST, given that in general sexual trauma is frequently underreported. Also, these data address only the rate of MST among veterans who have chosen to enroll in VA health care; they do not address the actual rate for the veteran population in general. Although veterans who respond "yes" when screened are asked if they are interested in learning about MST-related services available, not every veteran necessarily consents to treatment.[10]

Rates of veterans utilizing MST-related mental health outpatient care have been increasing over time; and recently discharged veterans utilized MST-related mental health services at higher rates than other veterans. [11], [12]

	% of veterans with a positive MST screen who have at least one MST-related Mental Health encounter	
	Women	**Men**
All veterans	55.3%	39.6%
OEF/OIF/OND veterans	58.9%	51.0%

Homeless veterans who use VHA services also report higher rates of MST compared to all veterans and they receive MST-related mental health care at higher rates compared to all veterans who use VA care.[13]

	Women	**Men**
% of homeless veteran VHA users with a positive screen for MST	39.3%	3.3%
% of homeless veterans with a positive screen for MST who have at least one MST-related MH encounter	88.9%	79.4%

[10] Department of Veterans Affairs, National Center for PTSD, Military Sexual Trauma Fact Sheet, August 2012 http://www.mentalhealth.va.gov/docs/mst_general_factsheet.pdf

[11] Rachel Kimerling, PhD, Julie Karpenko, MSW; Military Sexual Trauma Support Team, VA Office of Mental Health Services, National Center for PTSD, VA Palo Alto Health Care System; "Mental Health Care for Women Veterans and Treatment for Military Sexual Trauma," PowerPoint May 16, 2012 http://www.naswvc.com/attachments/article/82/2012%20PTSD%20Dr.%20Kimerling.pdf

[12] Amy Street, PhD; , VA Office of Mental Health Services, National Center for PTSD; "VHA Response to Military Sexual Trauma," PowerPoint Presentation, April 10, 2012.

[13] Rachel Kimerling, PhD, Julie Karpenko, MSW; Military Sexual Trauma Support Team, VA Office of Mental Health Services, National Center for PTSD, VA Palo Alto Health Care System; "Mental Health Care for Women Veterans and Treatment for Military Sexual Trauma," PowerPoint May 16, 2012 http://www.naswvc.com/attachments/article/82/2012%20PTSD%20Dr.%20Kimerling.pdf

What is VHA doing to Help Veteran Survivors of MST?

Every VA health care facility employs an MST coordinator to answer questions veterans might raise about MST services. A variety of resources have been developed and distributed for the use of MST coordinators, including tip sheets, posters, handouts, and contact cards. Emphasis has been placed on the importance of ensuring this information is available at key entry and access points (e.g., telephone operators, information desks, clinic clerks, facility websites). Each facility also has care providers who are knowledgeable about treating MST patients. Many VA facilities have developed specialized outpatient mental health services focusing specifically on sexual trauma, and VA's 300 Vet Centers also offer sexual trauma counseling. VA has almost two dozen programs nationwide that offer specialized MST treatment in residential or inpatient settings for veterans who need more intense treatment and support. Because some veterans are not comfortable in mixed-gender treatment settings, some facilities maintain separate programs for men and women; and all residential and inpatient MST programs require separate sleeping areas for men and women.[14],[15]

What are the Challenges in VA for Veterans Who Experience MST?

According to VA, victims of MST present a wide variety of treatment needs.[16] Although posttraumatic stress disorder (PTSD) is commonly associated with MST, it is not the sole diagnosis resulting from MST. Across a range of studies, VA research indicates that men and women who report sexual assaults or harassment during military service were more likely to be diagnosed with mental health challenges. Women with MST had a 59 percent higher risk for mental health problems; the risk among men was slightly lower, at 40 percent.[17] The most common conditions linked to MST were depression, PTSD, anxiety, adjustment disorder, and substance-use disorder.[18]

In December of 2012, the Office of the VA Inspector General issued a health care inspection report, *Inpatient and Residential Programs for Female Veterans with Mental Health Conditions Related to Military Sexual Trauma*. The IG concluded that women veterans were often admitted to specialized programs outside their Veterans Integrated Service Network (VISN) and that obtaining authorization for reimbursement of travel expenses was frequently cited as a problem for both patients and staff. The Beneficiary Travel policy indicates that only selected categories of veterans are eligible for travel benefits, and payment is authorized only from the veteran's home to the nearest facility providing a comparable service. The IG noted the current directive is not aligned with the MST policy. The directive states that patients with MST should be referred to programs that are clinically indicated regardless of geographic location. Some programs cited challenges maintaining an adequate volume of appropriate referrals; others

[14] http://www.mentalhealth.va.gov/msthome.asp

[15] Rachel Kimerling, PhD, Julie Karpenko, MSW; Military Sexual Trauma Support Team, VA Office of Mental Health Services, National Center for PTSD, VA Palo Alto Health Care System; "Mental Health Care for Women Veterans and Treatment for Military Sexual Trauma," PowerPoint May 16, 2012 http://www.naswvc.com/attachments/article/82/2012%20PTSD%20Dr.%20Kimerling.pdf

[16] Department of Veterans Affairs, National Center for PTSD, Military Sexual Trauma Fact Sheet, August 2012 http://www.mentalhealth.va.gov/docs/mst_general_factsheet.pdf

[17] Department of Veterans Affairs, *VA Research Currents.* November-December 2008. http://www.research.va.gov/resources/pubs/docs/va_research_currents_nov-dec_08.pdf

[18] Department of Veterans Affairs, National Center for PTSD, Military Sexual Trauma Fact Sheet, August 2012 http://www.mentalhealth.va.gov/docs/mst_general_factsheet.pdf

reported to the IG that managing women with eating disorders was a particular challenge. Additionally, many MST Coordinators they interviewed reported that they had insufficient time to adequately meet their women's outreach responsibilities.

We concur with the IG's recommendations that the Under Secretary for Health review existing VHA policy pertaining to authorization of travel for veterans seeking MST related mental health treatment at specialized inpatient/residential programs outside of the facilities where they are enrolled.

Although this Subcommittee is primarily focused on the coordinated continuum of health care for MST survivors between DoD and VA, we offer our comments on the Veterans Benefits Administration's (VBA) claims process for MST-related conditions since there are several gaps that exist between the Departments that are of concern to the IBVSOs and veterans. Many veterans indicate their frustration with the claims process, particularly in cases when the sexual assaults were not officially reported. They express feeling "re-traumatized" in their efforts to gain help from VBA even when they have provided significant evidence; statements from witnesses, friends or family; detailed accounts of the incidents; along with VA and non-VA diagnostic and treatment records—only to see their claims denied.

Compensation and pension examinations can also be traumatic for veterans who have been personally assaulted because examiners often require them to recount in detail these devastating experiences, and to do so with someone uninvolved in their VA care or therapy. These experiences often take years for veterans to overcome. Veteran survivors of MST repeatedly tell us they should not be forced to repeat their experiences about the trauma to strangers who often lack the sensitivity or professional qualifications to counsel survivors of sexual trauma. The trust that is built between an MST counselor or mental health provider and a patient is one that should not be trivialized or ignored. Because of the special nature of these particular conditions, VBA should employ the clinical and counseling expertise of sexual trauma experts within VHA or other specialized providers during the compensation examination phase.[19]

In response to hearing continued complaints about disparities in MST-related PTSD claims, VA acknowledged that due to the personal and sensitive nature of the MST stressors in these cases, victims often fail to report or document the trauma of sexual assault. If the MST event subsequently leads to post-service PTSD symptoms and a veteran files a claim for disability, the available evidence is often insufficient to establish the occurrence of a stressor event. To remedy this, VA developed regulations and procedures that allow more liberal evidentiary documentation requirements and more sensitive adjudication procedures for these particular claims.[20]

[19] Testimony of Anu Bhagwati, Executive Director, Service Women's Action Network; U.S. House of Representatives, Committee on Veterans Affairs, Subcommittee on Disability Assistance, "Invisible Wounds: Examining the Disability Compensation Benefits Process for Victims of Military Sexual Trauma," July 18, 2012 http://veterans.house.gov/witness-testimony/ms-anu-bhagwati-0

[20] Testimony of Thomas Murphy, Department of Veterans Affairs, Director of C&P Service, U.S. House of Representatives, Committee on Veterans Affairs, Subcommittee on Disability Assistance, "Invisible Wounds: Examining the Disability Compensation Benefits Process for Victims of Military Sexual Trauma," July 18, 2012 http://veterans.house.gov/witness-testimony/mr-thomas-murphy-2

In its new procedures and similar to adjudicating other PTSD claims, VBA initially reviews the veteran's official military personnel records (including military health records) for evidence of MST. According to VBA, such evidence may include: 1) DD Form 2910, Victim Reporting Preference Statement; and 2) DD Form 2911, Sexual Assault Forensic Examination Report). Unfortunately, based on several years of work in this field, the IBVSOs have ascertained that DD Forms 2910 and 2911 are not made part of service members' official military personnel records, but are retained in confidential files that have generally been unobtainable, even by a survivor who filed them.

The VBA regulation also provides that evidence from sources other than service records may support a veteran's account of an incident, such as evidence from law enforcement authorities; rape crisis centers; mental health counseling centers; hospitals; physicians; pregnancy tests; tests for sexually transmitted diseases; and statements from family members, roommates, fellow service members, etc.[21]

Documented behavioral changes are another type of relevant evidence that may establish that an assault occurred, such as requests for reassignment; deterioration in work performance; substance abuse; depression, panic attacks, or anxiety without an identifiable cause; and unexplained economic or social behavioral changes. Veterans are requested to submit or identify any such evidence they may possess. When this type of evidence is obtained, VA is required to schedule the veteran for an examination with a mental health professional and requests an opinion as to whether the claimed in-service MST stressor occurred. This opinion can serve to establish occurrence of the stressor, one element necessary for establishing service connection.[22]

VBA reports it is taking steps to assist veterans with resolution of these claims and has placed a primary emphasis on informing VA regional office personnel of the issues unique to MST, and is providing training in improved claims development and adjudication. During August 2011, VBA reviewed a statistically valid sample of approximately 400 MST-PTSD claims with the goal of assessing current processing procedures and formulating methods for improvement. This led to development of an enhanced training curriculum with emphasis on standardizing evidentiary development practices, as well as issuance of a new training letter and other information to all VA regional offices.[23] The training focused on how to identify circumstantial evidence (called "markers") indicating that the claimed MST stressor may have in fact occurred. As a result of these and other actions, VBA is reporting the post-training grant rate has risen from about 38 percent to over 50 percent. This change compares favorably with the overall PTSD grant rate of 55-60 percent, according to VBA. Additionally, in December 2012, VBA's national quality assurance office completed a second review of approximately 300 PTSD claims based on MST that were denied following medical examination. The review showed an overall accuracy rate of 86 percent, which is roughly the same as the current national benefit entitlement accuracy level for all rating-related end products.[24]

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[21] Ibid.
[22] Ibid.
[23] Ibid.
[24] Testimony of Curtis L. Coy, Deputy Under Secretary for Economic Opportunity, Veterans Benefits Administration, Department of Veterans Affairs, United States Senate Committee on Veterans' Affairs, "Pending Benefits Legislation Hearing," June 12, 2013 http://www.veterans.senate.gov/hearings.cfm?action=release.display&release_id=6d839502-3b01-4a1f-9dd2-6292724455a0

In addition to these general training efforts, VBA provided its designated Women Veterans Coordinators with updated specialized training. These employees are located in every VA regional office and are available to assist both female and male veterans with their claims resulting from MST. They also serve as a liaison with the women veterans' program managers at local VA health care facilities to coordinate any required health care. As a further means to promote adjudication of these claims consistent with VA's regulation, VBA has recently created dedicated specialized MST claims processing teams within each VA regional office for exclusive handling of MST-related PTSD claims. Additionally, because the medical examination process is often an integral part of determining the outcome of these claims, VBA has worked closely with the VHA Office of Disability and Medical Assessment to ensure that specific training was developed for clinicians conducting PTSD compensation examinations for MST-related claims.[25]

However, because earlier denied claims did not get the benefit of these new nationwide training resources, the Under Secretary for Benefits determined that VBA would contact those veterans who had received denials and offer them an opportunity to have their claims re-adjudicated. The IBVSOs have been informed that VBA has sent an outreach letter to 2,556 veterans who had been denied service-connection for MST-related conditions.

Unfortunately, VSOs were not notified prior to the letter being sent out to these veterans. The IBVSOs asked VBA officials to inform us of the names of the veterans for whom we hold Power of Attorney (POA), and thus represent, so that we can properly assist them if they wish VBA to re-adjudicate their claims. VSOs are a critical partner in the claims process and ensuring that the veteran fully understands what evidence is necessary or can support their claim, and to ensure these claims are properly re-evaluated by VBA. We also note that the letter that went out contained no information about how VBA has tried to improve the processes, sensitivity and understanding of MST related claims and minimal information about why VBA was inviting re-evaluation of these claims. Finally, the IBVSOs pointed out the letter directs the veteran to contact his or her local regional office to request review of their previously denied claim, but did not provide any contact information. While we are pleased with the Under Secretary for Benefits' efforts to improve claims processing for these complex claims we urge continued Congressional oversight to ensure VBA in fact has a consistent and comprehensive approach, throughout the system, to properly address these claims and more importantly set up a case management system to work with individual veteran survivors of MST in a more sensitive manner so they that they are not re-traumatized during the claims process. For veterans without a VSO/ POA, having a designated person or point-of-contact in VBA would make it much easier and more comfortable for the veteran to have questions answered about correspondence from VBA regarding their claim.

What Are the Challenges Ahead?

Under DoD's confidentiality policy, military victims of sexual assault can file a restricted report and confidentially disclose the details of the assault to specified individuals and receive medical treatment and counseling, without triggering any official criminal or civil investigative

[25] Testimony of Thomas Murphy, Department of Veterans Affairs, Director of C&P Service, U.S. House of Representatives, Committee on Veterans Affairs, Subcommittee on Disability Assistance, "Invisible Wounds: Examining the Disability Compensation Benefits Process for Victims of Military Sexual Trauma," July 18, 2012 http://veterans.house.gov/witness-testimony/mr-thomas-murphy-2

process**.** Despite the progress on the VA's part to include SAPRO information in its M21-1 manual, to maintain confidentiality in the case of restricted reporting, DoD policy prevents release of MST-related records with limited exceptions. However, VA is not specifically identified as an "exception" for release of records in DoD's policy, and it is unclear if VA could gain access to these records even with permission of a veteran survivor. One of the IBVSOs' primary concerns is that VA be able to access restricted DoD records (with the veteran's permission) documenting reports of MST for an indeterminate period. To establish service connection for PTSD there must be credible evidence to support a veteran's assertion that the stressful event actually occurred. Restricted records are highly credible resources but it is questionable if they are readily available, even with the consent of the veteran. With the veteran's authorization, the IBVSOs believe DoD should provide VA adjudicators access to all MST records, whether restricted or unrestricted, to aid VBA in adjudicating these cases.

The IBVSOs strongly believe that survivors of sexual assault during military service deserve recognition and assistance in developing their claims and compensation for any residual conditions found related to the assault. These cases need and deserve special attention and due to the circumstances of these injuries, and survivors who have courageously come forward need to be consistently and fairly recognized by the government.

The IBVSOs are pleased with the progress VA has made with the increased attention on MST-related information that encourages veterans to have more informed conversations with VA staff about the many available services, benefits, and treatment options. On the other hand, while DoD is moving more forcefully to stem sexual assault events in the ranks, DoD and VA need to resolve their differences with regard to MST-related records availability, both to VA health care professionals and to VBA adjudicators.

Summary

The Subcommittee expressed interest in learning about the coordinated efforts between DoD and VA regarding a continuum of care to facilitate recovery of MST survivors from the point-of-incident through veteran status. The IBVSOs have no knowledge that a structured or defined program exists between the two Departments in this regard. SAPRO governs how each of the military services under DoD handles sexual trauma reporting options and access to treatment, but each of the military branches is responsible for developing its own sexual assault and response prevention campaign to address this pressing issue. The IBVSOs are unaware of any specific protocol for interagency hand-off of MST survivors, but we note that DoD included in the revised April 2013 *Sexual Assault Prevention and Response Strategic Plan* the goal of collaborating with VA and the veterans service organization community to develop a victim continuity of care protocol for service members who are being discharged from military service due to sexual assault. The IBVSOs are supportive and urge the implementation of this plan, and we look forward to working with DoD to accomplish it. We also recommend that DoD, VA, or both agencies inform a service member following the report of a sexual assault, or prior to discharge, about the benefits and health care services that are available in VA, and to offer assistance in connecting with an MST coordinator at a local VA medical facility or Vet Center.

For the Subcommittee's purposes, the IBVSOs have developed a number of recommendations for Congress, VBA and VHA in improving health care and benefits procedures related to MST treatment and benefits claims. To conclude our testimony, we offer those

recommendations for the Subcommittee's consideration:

- We urge VBA to identify and map all claims by gender related to personal trauma with a focus on MST to determine the number of claims submitted annually, their award rates, denial rates, and the conditions most frequently associated with these claims, and to make this information available to the public.
- VBA must properly train its claims staff to be compliant with the VBA procedures and policies intended to assist veterans in producing fully developed claims; and VBA should conduct continued oversight to review these claims to ensure the directives that have been issued are in fact being followed.
- Given the complexity of MST-related claims, VBA should revise the current work credit system for rating specialists, which seems to reward speed over accuracy in claims determinations, to ensure these particular claims related to MST are adequately researched and properly resolved.
- VBA should establish a designated person or point-of-contact in VBA for veterans to have questions answered about correspondence from VBA regarding their MST-related claims.
- VA should establish a presumption of soundness of MST-related diagnoses made by VA's own physicians and counselors who are caring for MST survivors in VA facilities; VBA claims reviewers should not be enabled to second-guess evaluations by these VA medical and counseling professionals, or to discount established and official VA treatment records, in favor of single point-in-time compensation and pension evaluations made by contract examiners who may be unfamiliar with the nuances associated with MST.
- The Under Secretary for Health review existing VHA policy pertaining to authorization of travel for veterans seeking MST related mental health treatment at specialized inpatient/residential programs outside of the facilities where they are enrolled.
- DoD and VA need to resolve their differences with regard to MST-related records availability, both to VA health care professionals and to VBA adjudicators.
- Congress should continue its oversight and hearings to stimulate VA and DoD to improve their policies and practices for MST care and claims compensation.
- Given the dual nature of this problem as pointed out in our testimony, and the obstacles that affect both health care and benefits of MST survivors, the IBVSOs urge this Subcommittee to coordinate closely with the Subcommittee on Disability Assistance and Memorial Affairs, as well as the Committee on Armed Services, in a combined effort to find ways to further improve VA's coordination with DoD on these difficult and challenging cases.

Mr. Chairman and Members of the Subcommittee, this concludes my testimony on behalf of the *Independent Budget* veterans service organizations.