

Statement for the Record of

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Presented to the

**United States House Committee on Veterans' Affairs
Subcommittee on Disability Assistance and Memorial Affairs**

Concerning

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I would like to thank Chairman Luria, Ranking Member Nehls, and members of the Subcommittee to offer my views on three (3) items under consideration during this legislative hearing related to military sexual trauma (MST) claims: VA Peer Support Enhancement for MST Survivors Act, [H.R. 2724](#), 117th Congress (2021), [Discussion Draft](#) on Board of Veterans' Appeals hearings involving military sexual trauma and [Discussion Draft](#) on improved coordination between the Veterans Health Administration and the Veterans Benefits Administration.

Since 2018 I have provided *pro bono* assistance to approximately 450 women veterans in conjunction with fellow subject matter expert colleagues preparing claims for military sexual trauma (MST) to include all aspects of initial claims, supplemental claims and higher level review preparation including, but not limited to evidence collection, evidence requests, review of evidence (paper and digital records) for initial and supplemental claims, Board of Veterans' Appeals hearings, and referrals to crisis, peer and medical professional support and treatment. I am myself a 100% permanently and totally disabled post-9/11 veteran completing polytrauma rehabilitation services at the VA and its partners.

I am employed part-time at CUNY John Jay College of Criminal Justice in New York, NY as Adjunct Faculty in the International Criminal Justice Program and Online Faculty Fellow and am appointed as a Visiting Scholar at the Center for International Human Rights. I currently teach undergraduate and graduate courses and conduct research in areas relative to the subjects under consideration: military sexual trauma, gender based violence around the world, conflict-related sexual violence, human rights law, international law (including the law of armed conflict), victimology and victims' rights, and disability justice in addition to my areas of focused specialization in disinformation, cybercrime, online extremism and the impact of artificial intelligence on human rights and comparative criminal justice systems.

###

Introduction

The Veterans Benefits Administration has faced long standing challenges in following prescribed policies and procedures for processing disability claims due to MST, as evidenced by the [GAO Report on Military Sexual Trauma of June 2014](#), the [VA OIG VBA Report of August 2018](#) and the follow up [VA OIG VBA Report of August 2021](#), which determined that not only were the recommendations for corrective action in the 2018 report not followed, the percentage of denied claims improperly processed actually *increased from approximately 49% in the 2018 report to approximately 57% in 2019*. An additional [VA OIG VHA Report in August 2021](#) detailed significant challenges surrounding Military Sexual Trauma Coordinator roles at the Veterans Health Administration including *insufficient protected administrative time, role demands, insufficient support staff and inadequate funding and outreach materials*. In addition, the OIG noted an *absence of a logical relationship between the MST Coordinators' dedicated time and the number of patients who are engaged in MST-related care*.

While the VA provides free healthcare to MST survivors for all physical and mental health conditions resulting from MST regardless of whether the veteran is enrolled in VA healthcare or

receiving VA disability compensation, access to facility level MST coordinators and VA eligibility offices varies considerably nationwide from facility to facility (and across type of facilities: medical centers, community-based outpatient clinics, and readjustment counseling centers, with the national MST Support team falling under the VHA Office of Mental Health and Suicide Prevention. This patchwork approach of accountability and responsibility means that even beyond the issues outlined in the OIG Report on the MST Coordinator role, there is a dizzying array of overlapping and conflicting interpretations of the relevant VHA Directive 1115 on the Military Sexual Trauma (MST) Program of 2018 policy implementing 38 U.S.C. 1720D, 7301(b) at facilities across the nation.

While the ongoing backlog of veterans' claims was adversely impacted by changes due to the COVID-19 pandemic, including delays in compensation and pension examinations, document access and retrieval from the National Archives, the recent announcement by the VA Secretary to [hire and train 2000 additional employees](#) to proactively address the projected 260,000 pending claims backlog (including Nehmer provisions and Gulf War particulate exposure presumptives) is welcome. This is in addition to the FY 2022 budget request for additional Veterans Law Judges (VLJs) and attorneys for the Board of Veterans Appeals. That being said, quickly expanding the claims and appeals workforce without sufficient oversight, training and accountability, given the multiple year deficits in MST claims processing and barriers to accessing MST care, risks further revictimizing and retraumatizing survivors of MST.

In parallel, there have been significant changes in how veterans experience the MST disability claim process online through expansion of the [VA.gov](#) website functionality relative to claims, transition of many aspects of the claims process from the legacy [eBenefits](#) site, and at times daily or weekly changes to how claims information is presented online to the veteran. While many of these updates are welcome efforts of the [Veterans Experience Office](#) for long term improvements, these sudden and unanticipated changes to veterans' experience of the claims process, especially for MST claims, can be both bewildering and anxiety producing.

As a result, male and female veterans who have experienced MST in both combat and non-combat situations continue to face undue administrative burdens, improper claims denials, financial stress and increased risk of homelessness due to delayed or improperly denied claims, delayed access to care for both psychological and physical sequelae from MST incidents, retraumatization and revictimization by systems designed to assist them, increased discrimination and denial of their human rights under articles 2, 5, 7, 8 and 25 of the [Universal Declaration of Human Rights](#). In addition, the continued revictimization, retraumatization and denial of justice for male and female victims of MST is not aligned with best practices in *survivor-centered approaches* to sexual violence and conflict-related sexual violence as articulated by the [World Health Organization](#) and the [United Nations Security Council](#) and further elaborated by the March 2021 Report of the [UN Secretary General on Conflict-Related Sexual Violence](#).

It is within this larger context that I respectfully provide my comments on the proposed legislation and discussion drafts below.

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Discussion Draft on Board of Veterans' Appeals hearings involving military sexual trauma proposed section 7114 regarding "Conduct of hearings regarding claims involving military sexual trauma" takes steps to implementing a more survivor-centered approach through the following provisions:

§7114(b) appellant's request for a Board member of a specific gender

§7114(c) Board members will refrain from asking questions relating to the military sexual trauma of the appellant if the information the Board member seeks is contained in the evidentiary record

§7114 (d) medical examinations

§7114 (d)(2)(A) use of disability benefit questionnaire forms in lieu of medical examinations

I support the provision for an appellant's request for a Board member of a specific gender as an element of survivor-centered approach to justice for victims of sexual violence, especially as the hearings (either in person or via video teleconference) provide for face to face interaction, and thus potential for retraumatization in ways which the other two (2) options for appeals to the Board provided for in the [Veterans Appeals Improvement and Modernization Act of 2017 \(AMA\)](#) do not (direct review or new evidence submission). However, the lack of face to face interaction with a Board member does not necessarily preclude secondary or vicarious retraumatization in the direct review or new evidence submission options, especially if the appellant feels that the misinterpretation of law or facts of the case occurred due to gender bias of examiners or adjudicators at the VA regional office level.

I also support the provision to refrain from unnecessary questions relative to the military sexual trauma stressors in §7114(c) provided such information is contained in the evidentiary record, with qualification. That should go without saying: the Board of Veterans Appeals provides *de novo* reviews of claims and evidence submitted to be remanded back to regional office in question, but doesn't make decisions on the claims itself, nor is its role to determine "if" an in service stressor occurred. There are three issues that Rating Veterans Service Representatives (RVSRs) and C&P examiners at the regional office level are supposed to ascertain include: 1) did the stressor occur during a covered period of military service, 2) did the stressor result in ongoing physical or psychological disabilities, 3) the rating (or extent) of those disabilities. Given the [well documented difficulties in reporting and documenting MST stressors](#), the VBA 2011 updates to adjudicating MST related claims provided for additional and alternative forms of evidence including medical or behavioral markers or patterns of social and occupational functioning that could provide alternative means of documenting the in service stressors. At no time in the claims process is veteran asked to list details of the stressors in question, beyond the minimal requirements of the form itself (approximate date, approximate time, location (if known), perpetrators (if known)). This is consistent with [well-established research and evidence in trauma's impact on memory and cognition](#).

However, based on my experience in initial and supplemental claims assistance since 2018, veterans have repeatedly reported that examiners erroneously, and without regard to VBA guidance or survivor-centered approaches to sexual violence, asked intrusive questions forcing veterans to remember details in a linear fashion, demanded veterans fill in details of traumatic memory they cannot, and called into question the very existence of stressors if veterans cannot

recite details on demand. While those instances are shocking and retraumatizing, the Board's function would not be to repeat by providing a medical examination, that but ascertain if there was an improper examination (untrained provider, lack of appropriate credentials, lack of experience on the part of the provider, lack of documentation, lack of adherence to VA policy), lack of consideration of evidence submitted or other matter of law and evidence. As such it this provision is welcome, although it does not address the fact that it is at the regional level (C&P examiners) where untoward and unnecessary questioning is likely to occur. **I would recommend, however, that all existing and incoming members of the Board of Veterans Appeals be trained in appropriate medico-legal responses to sexual violence (as outlined below) that would include the current provision limiting questions, but also extended to other forms of survivor-centered approaches for judicial personnel.**

In cases where the Board remands a case to the agency of original jurisdiction for the purposes of determining the service connection of an MST claim, I support §7114 (d) medical examinations and §7114 (d)(2)(A) use of disability benefit questionnaire forms in lieu of medical examinations. However, one of the other issues consistently brought to light in the claims I have provided assistance on since 2018 is the disregard for veteran-provided disability benefit questionnaires filled out by their healthcare provider in support of fully developed MST claims. While I welcome the inclusion here for appeals to the BVA, veterans who have chosen the FDC (Fully Developed Claims) process using their own healthcare provider of appropriate credentials and competencies (which not only streamlines the process and reduces opportunity for retraumatization, but also saves taxpayer funds by reducing duplicate efforts), have had their personal provider nexus letter and DBQ ignored and sent for formal C&P examination by the regional authority. As a result, the veterans have had to undergo twice the forensic examination, medical history, evidence review, with twice the evidence with no clear benefit to either the veteran, nor the government. I would recommend that the same requirement to accept DBQs in cases of MST claims as part of fully developed claims be ensured not only at the level of formal hearings at the BVA but mandatory for MST initial and supplemental claims to avoid retraumatizing the veteran.

In the sections of this draft relative to audit and modification of denial letters, it is specified that letters sent to deny covered claims use “trauma-informed language” and that “veterans are not re-traumatized through insensitive language.” I support the intent of these sections, however, recommend the following instead:

1) the use of *survivor-centered language and approaches* should apply to all aspects of written communication with veterans in the MST claims process (initial, supplemental and appeals) and should include both written letter (sent via US Postal Service) as well as electronic communications (on applicable VA.gov as well as the eBenefits website), to include both verbal and visual language used to navigate those portals. This should not be limited only to denial of BVA claims.

2) the use of “trauma-informed” is vague in this context and does not address the specificities of MST. “Trauma-informed” approaches to care, as advocated by [SAMSHA](#) and [the CDC](#) are a step in the right direction but are geared towards all public health emergencies, natural disasters, and can be extended to include combat trauma, but lack the specifics of a survivor-centered

approach to sexual violence to include: victim autonomy, victim safety, victim confidentiality, victim freedom from discrimination and retaliation, victim access to immediate and long term needs (health, psychosocial, legal, economic, safety and security) as well as victim support for to access all aspects of the medico-legal system (transport, child care, online portals, etc.), victim support for other disabilities, etc.

The joint publication by the World Health Organization, the UN Office on Drugs and Crime and the UN Office of the Special Representative of the Secretary-General on Sexual Violence in Conflict of a sexual violence toolkit ([Strengthening the Medico-Legal Response to Sexual Violence](#)) referenced above builds on decades of experience and global best practices in culturally-responsive *survivor-centered approaches* that also address the minimum core competencies for all personnel.

Similarly, §7114 relative to examinations requires the Secretary to “establish protocols for contract medical providers to ensure that the medical providers conduct examinations regarding covered claims using trauma-informed practices.” I support this in part; however MST specific training in survivor-centered approaches should be required of any and all contract medical providers (not simply trauma-informed). This should be required of all contract medical providers regardless of whether they are providing examinations specific to BVA remand requests or initial or supplemental claims. VHA Directive 1115 and VHA Directive 1115.01 (Military Sexual Trauma) MST Mandatory Training and Reporting Requirements for VHA Mental Health and Primary Care Providers, dated April 14, 2017 already provide for the VHA providers to have MST specific training. C&P examiners working at VA Medical Centers have generally already undergone MST training since they are in many cases dual-hatted as both clinicians (VHA) and examiners (VBA). However, the shift to contractor staff has increased with the VA only providing about 15% of the exams after the 2020 pandemic shutdown. [The goal to outsource 100% of these](#) was hailed by some as a cost savings with potentially more flexibility in scheduling, but the number of errors resulting from these, including lack of oversight, training, experience and competencies in highly specialized clinical areas such as Gulf War Syndrome / toxic exposures, military sexual trauma, traumatic brain injury will only further disadvantage MST survivors.

Contractors should not be able to decide for themselves what constitutes “trauma-informed” but should be held to the same training, credentialing, clinical hours and competency standards as outlined in VHA Directive 1115 and VHA 1115.01 to avoid horrifying situations such as the following which I have advised veterans to appeal:

- Female veteran MST survivor assigned to meet a male contract medical provider in a back office behind a nail salon in a strip mall for a PTSD C&P examination
- Female veteran MST survivors being forced against their will to undergo pelvic examinations by contract medical personnel
- Female veteran MST survivors being yelled at by providers for “forgetting” details of gang rapes and told they were lying by contract medical personnel
- Female veteran MST survivors being told that instances of sexual assault prior to the military invalidates their MST claims by contract medical personnel
- Female veteran MST survivors not being referred for appropriate psycho-social support before, during and after the examination by contract medical personnel

- Female veterans MST survivor being examined by contract child and adolescent psychologists with no experience in adult sexual trauma patients or MST, or alternatively, by contract NPs or PAs with no relevant behavioral health training or indeed specialized training in MST
- Female veteran MST survivors being told “that doesn’t sound very stressful to me” by untrained contract medical personnel

In a similar vein, the [Discussion Draft](#) on improved coordination between the Veterans Health Administration and the Veterans Benefits Administration requires the following to be sent to veterans filing claims arising from MST:

- Outreach letters
- Information on the Veterans Crisis Line
- Information on how to make an appointment with a mental health provider
- Other information on available resources for MST

I support this in part; while this could be a valuable tool in connecting veterans who have filed claims with optional VHA or services, there are several areas of concern:

1. Under the survivor-centered principles of autonomy and personal choice in healthcare, veterans who file MST claims are not required to seek services at the VHA. In many cases MST survivors prefer to seek care elsewhere as government agencies are retraumatizing, especially if the perpetrator(s) were government employees. It could be confusing as well if veterans believe they are required to seek care at the VHA instead of a personal healthcare provider.
2. In many cases veterans are already getting mental healthcare for MST (and / or physical healthcare as well) from the VHA, in which case the information would be duplicative. This could also be confusing for veterans already seeking care for MST related conditions.
3. All of these touch points represent potential unwanted incursions into the survivor experience and actively undermine a sense of safety and privacy for the survivor; receiving mail with no warning about military sexual trauma can be retraumatizing, even if the intent was positive.

In the provision for an “automatic notification system” the VBA would notify the VHA immediately before and after a veteran participates in a covered event or receives a covered document relative to MST. I strongly disagree with this provision as it stands in the draft document for the following reasons:

1. Under the survivor-centered principles of autonomy, choice and agency it is unclear what would be the intended benefit to the veteran of such an automatic notification. Veterans with a disability rating are already identified in VHA systems for appropriate personnel; disclosure of MST related claims applications without the veterans’ consent could constitute a gross violation of privacy and confidentiality if the veteran was not ready to disclose to medical personnel yet, or was not ready to or unwilling to disclose to VHA medical personnel.
2. It is unclear why MST-related C&P examinations and hearings before BVA would be automatically disclosed to VHA (and not initial or supplemental claims, for example). It should

be the veteran's choice to discuss those with their provider(s) when and if they choose to disclose and to seek care at VHA when and if they choose to do so.

There are several areas of coordination between VHA and VBA not addressed in this draft that do merit further discussion and elaboration, such as VHA providers responding to veteran requests for nexus letters and disability benefits questionnaires for FDC (fully developed claims).

1. The Fully Developed Claims process is perhaps the most survivor-centered option for MST survivors as it provides the veteran the ability to prepare and upload documentation in the privacy of their home or location of their choosing, allows the veteran to work asynchronously and take breaks when needed in the process, allows veterans to have their current healthcare provider(s) with whom they already have built a relationship of trust and safety fill out nexus letters and DBQs, allows veterans to seek peer support as well as subject matter expert support on their own time and provides information on crisis lines and other related information.
2. The FDC process is also the most streamlined and the most cost effective for the government and the taxpayer since the veteran assumes the burden of gathering all necessary evidence and it could eliminate any government-funded C&P examination.
3. However, veterans filing claims for MST are routinely refused nexus letters and / or DBQs from VHA providers for many reasons, despite VHA Directive 1134 (2) Amended May 11, 2020 which creating guidance for VHA providers to complete VA and non-VA forms, provision of medical statements and DBQs.
4. This is distressing to all veterans filing claims as it effectively eliminates the FDC option for them, but especially distressing for survivors of MST as making the process longer and more drawn out than it already is. Having to undergo additional claims examinations with contract medical personnel who may not even be remotely trained in MST can be profoundly retraumatizing.

Ensuring that veterans filing claims for MST have access to the fully developed claims process, including elimination of duplicate examinations and extended guidance for VHA providers to provide necessary documentation for veterans already receiving MST related care there is critical to ensuring efficiency and accuracy of claims as well as ensuring survivor-centered approach.

Finally, in regards to H.R. 2724 VA Peer Support Enhancement for MST Survivors Act I will echo my statements above relative to survivor-centered approaches. I support wholeheartedly the concept of peer support and peer-informed approaches to survivor recovery and claims. However, it is unclear to me if the current legislation effectively delivers that intent in this form.

Peer support is not necessarily the same as victims advocate roles, although §5109C(b)(1) designates that a peer support specialist "shall be trained as victims advocate." It is not clear whether this role is meant to be a dedicated role or "other duty as assigned," and indeed if the

VBA is the best place for peer support since §5109C(b)(2) states that they “cannot be responsible for any part of adjudicating the claim of any claimant to which the specialist is providing support.”

- Victims’ advocates represent the interests of the victim and provide a voice for victims who may be disenfranchised from or distrustful of the criminal justice system due to trauma, cultural or linguistic barriers, economic hardship, etc. They generally represent victims of violent crimes in navigating complex legal avenues while simultaneously trying to seek medical and / or psychological crisis care.
- This model does not necessarily fit the claims process for victims of MST. The VBA is not a criminal justice agency; and while the claims process can be re-traumatizing and re-victimizing, veterans advocates for the claim process already exist in the form of veterans service organizations and veterans service officers trained and chartered to provide claims advocacy and representation for all claims, including those for MST.
- Peer support is separate and distinct from victims’ advocacy. Peer support refers to social and emotional support from someone who also gone through the same situation (in this case, another survivor of MST) and in many cases persons providing peer support undergo extensive training and supervision from the sponsoring organization, as well as resources to maintain their own mental health.

As it is written, the creation of a peer support role from within the employees of VBA not only presents a potential conflict of interest, it also means that there may not be enough available trained VBA employees who in addition to their existing duties would have an additional role as a peer support specialist.

1. Not all VBA employees eligible for this position as a survivor of MST would be willing to disclose that to their employer or their coworkers
2. Not all claimants would be comfortable receiving peer support from the very agency that is deciding their claim for confidentiality, privacy and safety reasons
3. If this is an “other duty as assigned” role the program faces the same challenges to the “other duty as assigned” MST Coordinator role as outlined in the [OIG Report](#) above
4. Peer support often takes the form of informal or semi-formal discussions, chats, and groups often after work hours to differentiate it from formal counseling services. It is unclear how this model would work into the formal structured work day of a VBA employee otherwise involved in adjudicating claims.

While keeping the intention to provide peer support services is an important part of supporting survivors of MST and adopting a survivor-centered approach, I recommend that peer support options be created and offered through the appropriate agencies (VHA and Vet Centers) already tasked with providing care, VA partners, and / or through VSOs already providing robust models of peer support for combat and non-combat veterans of all eras.

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In conclusion, I would like to thank you for providing me the opportunity to comment on the proposed bills and discussion drafts relative to the MST claims process. I applaud the efforts of the Subcommittee in this regard as well as the efforts of all members of Congress working to bring relief to male and female veterans who have survived MST.

Very respectfully yours,

///SIGNED///

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