

**STATEMENT OF  
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DEPARTMENT OF VETERANS AFFAIRS  
BEFORE THE SUBCOMMITTEE ON HEALTH  
COMMITTEE ON VETERANS' AFFAIRS  
UNITED STATES HOUSE OF REPRESENTATIVES  
HEARING ON CARE AND TREATMENT AVAILABLE TO  
SURVIVORS OF MILITARY SEXUAL TRAUMA  
JULY 19, 2013**

Mr. Chairman, Ranking Member Brownley, and Members of the Subcommittee, thank you for the opportunity to discuss the Office of Inspector General report, *Inpatient and Residential Programs for Female Veterans with Mental Health Conditions Related to Military Sexual Trauma* (December 2012), and the care and treatment available to survivors of military sexual trauma (MST). I am accompanied today by Ms. Karen McGoff-Yost, Associate Director, Bay Pines Office of Healthcare Inspections.

**BACKGROUND**

The Veterans Health Administration (VHA) estimates that approximately one in every five female veterans enrolled in VHA responded “yes” when screened for MST. MST is not a diagnosis in itself. It is an experience that is associated with patterns of psychological and/or physical symptoms. MST is a predictor of psychological distress and is associated with several mental health (MH) diagnoses, most frequently Post-Traumatic Stress Disorder (PTSD). Research on the effects of trauma has found that the experience of rape can be equal to or greater than other stressors, including combat exposure, in the risk of developing PTSD. MST has also been linked to an increased likelihood of diagnoses of anxiety disorders, depressive disorders, eating disorders, bipolar disorder, substance use disorders, and personality disorders.

Not everyone experiencing MST will have the same response. Some individuals who have been victims of traumatic experiences, including MST, develop few symptoms. Others develop severe and complex chronic physical and MH issues. Because the experience of MST may result in a range of physical and psychological symptoms, treatment related to MST may occur in a variety of clinical settings depending on the individual’s needs.

VHA requires that veterans and eligible individuals have access to residential or inpatient programs that are able to provide specialized MST-related MH care, when clinically needed, for conditions resulting from MST. Residential programs (also known as MH Residential Rehabilitation Treatment Programs) generally offer more intensive treatment than typical outpatient MH programs.

In response to a request from the United States Senate Committee on Veterans’ Affairs, we reviewed 14 inpatient/residential programs from a list compiled by VHA’s MST Support Team that identified themselves “as having expertise with MST and/or sexual

trauma more generally and the ability to provide treatment targeting these issues in a residential or inpatient setting.” Because the request was specific to services available to women veterans who experienced military sexual trauma, the scope of our inspection focused on the care provided to a cohort of female veterans prior to, during, and after discharge from these programs. While male veterans were not within the scope of our review, we want to take this opportunity to acknowledge the incidence and distressing impact of military sexual trauma on both female and male survivors.

We reviewed the electronic health records (EHR) of 166 female veterans with a history of MST who were discharged from these programs during the 6-month period between October 1, 2011, and March 31, 2012. Patients were included if they met the eligibility criteria for MST-related care as defined by VHA Directive 2010-033, *MST Programming*. As a result, we included five women who were not veterans; three women who were active-duty military; and two who had served in the Reserves but were otherwise ineligible for VHA care. We also visited eight program sites representing a mix of geographic regions, facility sizes and complexities, and urban and rural locations.

Inspection objectives were to describe the nature of services provided to these veterans, the characteristics of these veterans, the characteristics of providers, and geographic referral patterns and factors influencing access. We also assessed compliance with VHA requirements pertaining to MST care.

The programs highlighted in this inspection represent a higher intensity of care provision than utilized by patients with a history of MST who seek only outpatient treatment. While not covering the entire population of female veterans who have experienced MST, the review provides valuable insights into the clinical complexity, access, and care issues impacting veterans with MST.

## **INSPECTION RESULTS**

### ***Patient Age and Service Era***

Patients ranged in age from 23 to 65 years with an average age of 44 years old. The most common age range was 46 to 50 years. Slightly less than 4 percent of participants were 25 years old or younger and 4 percent were between 61 and 65 years old. In terms of service era, 38 percent of patients served in the post-Vietnam era, 27 percent each in the Persian Gulf War and Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND) service eras, and 6 percent during the Vietnam era. Among the 44 OEF/OIF/OND-era patients, ages ranged from 23 to 51 years with an average age of 34. These patients represent veterans who served in the military during the OEF/OIF/OND-era whether or not they were deployed. A few had also served in prior eras but for purposes of the review, patients were categorized by their most recent era of service.

### ***Mental Health Diagnoses***

The patients in our review were clinically complex and most had multiple mental health diagnoses. PTSD, depression, and alcohol/substance use or dependence were the most common diagnoses. Ninety-six percent of patients had a diagnosis of PTSD, 63

percent had been diagnosed with a depressive disorder, and 70 percent had an alcohol or substance use disorder. Approximately 27 percent of patients also had a diagnosis of borderline personality disorder, further adding to the complexity of clinical presentation. Only 4 percent of patients had a single MH diagnosis. The remaining 96 percent had two or more MH conditions. Of the 160 women with PTSD, only four had this as a sole diagnosis. All of the women with an alcohol and/or substance use disorder were dually diagnosed with one or more MH conditions. Additionally, 13 patients were diagnosed with some form of eating disorder.

### ***Parental, Employment, and Housing Status***

Because parental responsibility and job commitments could be factors affecting participation in a treatment program lasting several weeks or months, we examined the percentage of patients with responsibility for minor children and/or who were employed at the time of admission. Approximately 16 percent of the 166 patients were responsible for the care of minor children, and only approximately 5 percent were employed. Nineteen percent of patients in our review were homeless at the time of program admission.

### ***Service Connection***

Seventy-one percent of participants in our review were service-connected for any condition (physical or mental health-related) and 55 percent were service-connected for a MH condition.

### ***VHA Treatment Preceding Program Admission***

We reviewed aspects of patients' MH care immediately prior to residential program treatment. We found almost 90 percent received outpatient VA MH treatment in the 3-month period preceding program participation. Of the patients not in outpatient care just prior to admission, approximately two-thirds were either in another residential program or were receiving treatment on an acute mental health unit. Most patients received outpatient treatment solely at a VA Medical Center (VAMC) or a Community Based Outpatient Clinic (CBOC). Seventeen percent were receiving treatment at more than one outpatient venue (e.g., VAMC and Vet Center).

More than three-quarters of the patients were engaged in two or more types of outpatient treatment (individual therapy, group therapy, medication management, mental health intensive case management, psychosocial rehabilitation recovery center programs) during the 3-month time frame. Seventy-two percent received individual therapy, 67 percent received medication management, and 37 percent participated in group therapy.

We reviewed the gender of outpatient MH providers seen prior to admission. Most female patients (83 percent) received outpatient MH treatment from a female therapist or clinician during the 3-month period prior to program participation. Of the 138 patients seen for primary care, 75 percent were seen by a female primary care provider, 8 percent by a male provider, and for 17 percent the gender of the provider was unclear from the EHR.

## ***Referral to Specialized Programs***

From EHR review we categorized geographic referral patterns. Although three programs largely served only patients from within the same VISN, most programs drew patients from all areas of the country and these programs appeared to function as a resource for nationwide referral of patients with an MST-related MH conditions.

## ***Program Structure and Treatment Characteristics***

Across programs, we found a diversity of structures, program emphases, and treatment approaches through which programs address treatment of female veterans with MST related conditions. Treatments utilized varied by site, but generally included either formalized evidence based therapies (EBPs), mixed therapies comprised of underlying treatment principles from different EBPs, or both, in conjunction with supportive therapies and medication management. Most sites offered cognitive processing therapy as the dominant approach for trauma processing but incorporated other EBPs into the curriculum.

For approximately 60 percent of patients, treatment planning documentation included provision of individual psychotherapy. In programs where individual therapy was provided, we consistently found that the clinician providing the treatment was female. All of the patients participated in one or more types of group therapy. At some sites, clinicians told us that they saw the group milieu as central to the treatment process and therefore emphasized group-based over individual treatment. Both male and female clinicians facilitated groups. We found that groups that focused on discussion of patients' trauma were usually led by female clinicians.

In recent years, VHA has increased emphasis on the use of peer support in the recovery process. We found peer support technician documentation in the EHR (typically as a co-facilitator of a weekly recovery group) at some of the programs we reviewed.

There were differences in the philosophical stance towards same-gender treatment versus mixed-gender treatment. Proponents of women's only treatment programs argue the benefits of the psychological safety inherent in an all-female environment as women veterans explore traumatic experiences. Other clinicians favor mixed-gender treatment. In this model, the presence of men is believed to be normalizing, prepares women to be better able to integrate into the real world environment after program completion, and provides a means to help women confront their fears while in a therapeutic environment. Some program staff we spoke to were in favor of a blended approach. For example, a female veteran may start MST-related PTSD treatment in an all-female environment, but as progress continues, the team may incorporate male staff or add a mixed-gender group to the treatment plan so that the patient can try out new challenges and increase exposure to stimuli that may be typically avoided.

## ***Aftercare***

Our EHR review showed that aftercare (follow-up MH services after program discharge) was almost always arranged before women left the program. Generally, aftercare was

provided by the referring facility where the veteran had been receiving outpatient MH services prior to admission to the program. This was true whether the referring facility was a medical center, CBOC, Vet Center, or any combination of the above. We usually did not find that treating program staff remained engaged with the veteran after she returned home unless she received her outpatient care at the same facility as the program. Ten women received aftercare from program therapists on an outpatient basis after they relocated to the area where the program was located.

Twenty-two patients were readmitted to an inpatient unit or residential setting within 30 days of program discharge. Three were admitted to medical units, 7 to an acute psychiatry unit within 7 days of discharge and 12 went directly to another MH Residential Rehabilitation Treatment Program program at discharge.

### ***Outreach, Access, and Potential Actions to Enhance Program Utilization***

Outreach and Utilization - Cohort based admissions involve admitting a group together and keeping the group intact through program completion in order to promote group cohesion. For cohort-based programs, capacity can be estimated by multiplying the number of beds by the number of cohorts offered annually. Program capacity is more difficult to determine with rolling admissions. During site visits and from interviews with program leaders, we found that many of the available beds were not occupied. This corresponds with data from VHA's Northeast Program Evaluation Center that indicates most of these programs do not maintain a full census. A challenge commonly cited by facility staff related to maintaining an adequate volume of women veterans in the programs reviewed. Program staff indicated a need for greater outreach to "get the word out" in order to attract an appropriate and consistent stream of referrals.

Availability of Timely Program Resource Information - The MST Support Team intranet site includes a list of inpatient/residential treatment resources for patients with MST. During our site visits, some program staff noted discrepancies and/or outdated information about their programs on the intranet site. The MST Support Team periodically surveys programs to verify information posted is accurate, but otherwise the team relies on facilities to report changes. Some program staff reported an inordinate amount of time spent reviewing and eliminating referrals inconsistent with program focus. Maintaining a current, accurate, coordinated resource list available with comprehensive program descriptions will serve to facilitate awareness and outreach and increase the flow of appropriate referrals from VA clinicians and coordinators.

Role of MST Coordinators - We met with MST Coordinators during our site visits and frequently heard they had limited time (as little as 2 hours per week in some cases) remaining for outreach activities and/or tracking of patients with positive MST screens, which is a key component of their function as outlined by VHA policy. This occurred because most MST Coordinators' time was dedicated to direct patient care responsibilities.

Aligning VHA MST and Travel Policies - We found that patients were referred to programs in facilities outside of their Veterans Integrated Service Network (VISN) and geographic region. During site visits, difficulties obtaining authorization for patient travel

funding was a consistent theme. From EHR review, we noted one veteran whose start date was postponed to the next cohort as the referring facility and treating facility were debating responsibility for transportation costs. One program with a wide national patient distribution indicated that having to pay for roundtrip travel is a challenge, but putting patients first, the program had unilaterally decided to provide funding for bi-directional transportation.

A review of the current policy for MST and the current policy for Beneficiary Travel reveals that the two do not align. The Beneficiary Travel policy indicates that only selected categories of veterans are eligible for travel benefits and payment is only authorized to the closest facility providing a comparable service. Those eligible for travel pay include veterans who: (1) travel for treatment related to a service-connected condition; (2) are service-connected at a rate of 30 percent or more for treatment of any condition; (3) travel for Compensation and Pension examinations; (4) receive a nonservice-connected pension; or (5) are low income as defined by income not in excess of the VA pension rate.

VHA requires that veterans and eligible individuals have access to residential or inpatient programs that are able to provide specialized MST-related mental health care, when clinically needed, for conditions resulting from MST. The MST Directive also states that “at a national level, there is a need to consider developing a number of these programs as national resources and to arrange processes for referral, discharge, and follow-up.” The directive requires that “all health care for treatment of mental and physical health conditions related to MST, including medications, is provided free of charge” and that fee basis should be available when indicated.

We recommended that the Under Secretary for Health review existing VHA policy pertaining to authorization of travel for veterans seeking MST-related MH treatment at specialized inpatient/residential programs outside of the facilities where they are enrolled. VHA concurred with our recommendation and established a workgroup to review issues and provide recommendations to the Under Secretary for Health by April 30, 2013. As of VHA’s last quarterly update in May 2013 to the OIG on the implementation status of our recommendation, VHA reported the workgroup was continuing its review.

## **CONCLUSION**

The programs reviewed are a valuable resource available to serve clinically complex veterans with a history of MST and associated mental health and psychosocial burden. VHA should establish a centrally coordinated, comprehensive, and descriptive MST program resource list; ensure that MST Coordinators have adequate time to fulfill their outreach role; and review existing travel funding for this population. These efforts may promote fuller utilization by those women veterans who have experienced MST and whose individual clinical course indicates the need for a more intensive level of care than is available on an outpatient basis.

Mr. Chairman, thank you again for this opportunity to testify. I would be pleased to answer questions that you or other Members of the Subcommittee may have.