June 30, 2021

The Honorable James M. Inhofe
Ranking Member
Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Senator Inhofe:

In accordance with the reporting requirement of section 538(c)(1) of the William M. (Mac) Thornberry National Defense Authorization Act for Fiscal Year 2021 (Public Law 116-283), please find enclosed the Department of Veterans Affairs and the Department of Defense joint report on residential treatment for sexual trauma survivors.

In addition, a statement of cost for preparing the report is included. We are sending similar letters to the other appropriate congressional committees.

Carolyn M. Clancy, M.D.
Acting Deputy Secretary
Department of Veterans Affairs

Virginia S. Penrod
Acting Under Secretary of Defense for
Personnel and Readiness
Department of Defense

Enclosure:
As stated

June 30, 2021

The Honorable Jerry Moran
Ranking Member
Committee on Veterans' Affairs
United States Senate
Washington, DC 20510

Dear Senator Moran:

In accordance with the reporting requirement of section 538(c)(1) of the William M. (Mac) Thornberry National Defense Authorization Act for Fiscal Year 2021 (Public Law 116-283), please find enclosed the Department of Veterans Affairs and the Department of Defense joint report on residential treatment for sexual trauma survivors.

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Department of Defense

Enclosure:
As stated

June 30, 2021

The Honorable Jack Reed
Chairman
Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

In accordance with the reporting requirement of section 538(c)(1) of the William M. (Mac) Thornberry National Defense Authorization Act for Fiscal Year 2021 (Public Law 116-283), please find enclosed the Department of Veterans Affairs and the Department of Defense joint report on residential treatment for sexual trauma survivors.

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Department of Defense

Enclosure:
As stated

June 30, 2021

The Honorable Mike D. Rogers
Ranking Member
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

Dear Representative Rogers:

In accordance with the reporting requirement of section 538(c)(1) of the William M. (Mac) Thornberry National Defense Authorization Act for Fiscal Year 2021 (Public Law 116-283), please find enclosed the Department of Veterans Affairs and the Department of Defense joint report on residential treatment for sexual trauma survivors.

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Virginia S. Penrod
Acting Under Secretary of Defense for
Personnel and Readiness
Department of Defense

Enclosure:
As stated

June 30, 2021

The Honorable Lloyd J. Austin III
Secretary of Defense
Washington, DC 20301

Dear Mr. Secretary:

In accordance with the reporting requirement of section 538(c)(1) of the William M. (Mac) Thornberry National Defense Authorization Act for Fiscal Year 2021 (Public Law 116-283), please find enclosed the Department of Veterans Affairs and the Department of Defense joint report on residential treatment for sexual trauma survivors.

In addition, a statement of cost for preparing the report is included. We are sending similar letters to the appropriate congressional committees.

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Acting Deputy Secretary
Department of Veterans Affairs

Virginia S. Penrod
Acting Under Secretary of Defense for
Personnel and Readiness
Department of Defense

Enclosure:
As stated

June 30, 2021

The Honorable Mike Bost
Ranking Member
Committee on Veterans' Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Representative Bost:

In accordance with the reporting requirement of section 538(c)(1) of the William M. (Mac) Thornberry National Defense Authorization Act for Fiscal Year 2021 (Public Law 116-283), please find enclosed the Department of Veterans Affairs and the Department of Defense joint report on residential treatment for sexual trauma survivors.

In addition, a statement of cost for preparing the report is included. We are sending similar letters to the other appropriate congressional committees.

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Acting Deputy Secretary
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Virginia S. Penrod
Acting Under Secretary of Defense for
Personnel and Readiness
Department of Defense

Enclosure:
As stated

June 30, 2021

The Honorable Adam Smith
Chairman
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

In accordance with the reporting requirement of section 538(c)(1) of the William M. (Mac) Thornberry National Defense Authorization Act for Fiscal Year 2021 (Public Law 116-283), please find enclosed the Department of Veterans Affairs and the Department of Defense joint report on residential treatment for sexual trauma survivors.

In addition, a statement of cost for preparing the report is included. We are sending similar letters to the other appropriate congressional committees.

Carolyn M. Clancy, M.D.
Acting Deputy Secretary
Department of Veterans Affairs

Virginia S. Penrod
Acting Under Secretary of Defense for
Personnel and Readiness
Department of Defense

Enclosure:
As stated

Department of Veterans Affairs and Department of Defense Joint Executive Committee Sexual Trauma Working Group

Joint Report on Residential Treatment for Survivors of Sexual Trauma in Fulfillment of National Defense Authorization Act Fiscal Year 2021 Section 538(c)(1)

The estimated cost of this report or study is approximately $2905.49 in Fiscal Year 2021. This includes $2,905.49 in VA and DoD labor and $0 in production and printing costs.

Carolyn M. Clancy, M.D.
Acting Deputy Secretary
Department of Veterans Affairs

Virginia S. Penrod
Acting Under Secretary of Defense for Personnel and Readiness
Department of Defense

June 30, 2021

The Honorable Mark Takano
Chairman
Committee on Veterans' Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

In accordance with the reporting requirement of section 538(c)(1) of the William M. (Mac) Thornberry National Defense Authorization Act for Fiscal Year 2021 (Public Law 116-283), please find enclosed the Department of Veterans Affairs and the Department of Defense joint report on residential treatment for sexual trauma survivors.

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Acting Deputy Secretary
Department of Veterans Affairs

Virginia S. Penrod
Acting Under Secretary of Defense for
Personnel and Readiness
Department of Defense

Enclosure:
As stated

June 30, 2021

The Honorable Jon Tester
Chairman
Committee on Veterans' Affairs
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

In accordance with the reporting requirement of section 538(c)(1) of the William M. (Mac) Thornberry National Defense Authorization Act for Fiscal Year 2021 (Public Law 116-283), please find enclosed the Department of Veterans Affairs and the Department of Defense joint report on residential treatment for sexual trauma survivors.

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Virginia S. Penrod
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Personnel and Readiness
Department of Defense

Enclosure:
As stated

Table of Contents

National Defense Authorization Act for Fiscal Year 2021 Reporting Requirements

Section 538(c) of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2021, Public Law 116-283 (January 1, 2021) (the "Act") created, among other reporting requirements, a Congressional reporting requirement for the Department of Veterans Affairs (VA) and the Department of Defense (DoD) related to residential treatment programs for survivors of sexual trauma. Due June 30, 2021, this is the first of the mandated reports; it addresses the availability of these programs, including any barriers to access and the resources needed to reduce them.

Background

I. Definitions and Terms

The terms of 38 United States Code (U.S.C.) § 1720D(a)(1) require the Secretary of VA to operate a program under which VA provides counseling, appropriate care and services to former members of the Armed Forces who the Secretary determines require such counseling, care and services to treat a condition, which in the judgment of a health care professional employed by the Department, resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the former member of the Armed Forces was serving on duty, regardless of duty status or line of duty determination (as that term is used in section 10 U.S.C. § 12323). Per 38 U.S.C. § 1720D(f) and for purposes of 38 U.S.C. § 1720D(a)(1), the term "sexual harassment" means "unsolicited verbal or physical contact of a sexual nature which is threatening in character."

VA uses the term "military sexual trauma" (MST) to refer to the experiences described in section 1720D(a)(1). VA provides treatment related to an individual's experiences of MST free of charge.

Although the term "MST" is used in this report when referring to VA activities, policies, and personnel, it is important to note that DoD does not use the term "MST," but rather uses the terms "sexual assault," "sexual harassment," and "sexual abuse" separately to align with definitions in military law and policy.

In the introductory and concluding sections of this report, the term "sexual trauma" is used as an overarching term to encompass experiences described by VA as MST and by DoD as "sexual assault," "sexual harassment" or "sexual abuse."

II. Impact and Treatment

Sexual trauma is an experience, not a diagnosis or a condition. Sexual trauma experiences are associated with a wide range of mental health and physical health conditions. Although post-traumatic stress disorder (PTSD) is the mental health condition most frequently associated with sexual trauma, other mental health conditions commonly associated with sexual trauma are depressive disorders, anxiety disorders, bipolar disorders, and substance use disorders. Experiences of sexual trauma are associated with increased risk of suicide, even after accounting for mental health conditions like PTSD and depression.

Treatment of sexual trauma-related conditions involves applying best practice treatment interventions for the specific health condition(s) with which the individual is struggling, while also attending to and addressing treatment themes that commonly arise in working with survivors of sexual trauma. For example, if an individual has been diagnosed with PTSD, treatment would involve drawing on best practice treatment approaches for PTSD. Research has shown that these treatments can be used without major modifications to treat PTSD secondary to sexual trauma, as compared to PTSD secondary to other forms of trauma, although providers use their clinical judgment and shift the content and specific focus of therapy to address themes and issues that can be more common among sexual trauma survivors, as needed. For example, sexual trauma survivors diagnosed with PTSD may struggle more or in different ways with interpersonal relationships and issues related to trust, self-blame, and shame than individuals with PTSD secondary to combat or other forms of trauma. Clinicians adapt treatment to ensure ongoing assessment for and additional emphasis on targeting these issues, to ensure needs specific to sexual trauma are addressed.

III. VA and DoD Population Differences

VA and DoD serve distinct populations, and the available treatment services each Department provides are tailored to address the different needs and treatment preferences of these populations. Specifically, DoD serves current Service members, for whom a key priority may be to maintain readiness and deployability and to mitigate any negative career impacts associated with being considered not deployable. This may impact treatment preferences. For example, Service members may be motivated to limit their time away from their unit, to maintain connections, a sense of belonging and readiness, and thus prefer outpatient care. Veterans, in contrast, may be more open to participation in residential treatment, as factors such as deployability no longer apply. On an individual basis, background, family history, and personal circumstances may inform the level and type of care a provider recommends.

Additionally, best practices for treatment of mental health conditions typically involve starting with the least intensive option needed to address the individual's needs. As such, outpatient treatment is typically the first line treatment, with progression to an intensive outpatient treatment program, if necessary, and then further progression to residential or inpatient treatment if needed. On average, Service members are often younger than Veterans, and Service members' experiences of sexual trauma, onset of mental health difficulties, and need for treatment are often more recent. As such, and consistent with these best practices for the progression of care, Service members appropriately and predominantly engage in outpatient care, as this is typically their first episode of care related to their sexual trauma experience(s). Participation in residential treatment is more common among Veterans, as many have already engaged in outpatient and/or intensive outpatient care either while in the military, prior to receiving treatment from the Veterans Health Administration, or during their initial periods of care in the Veterans Health Administration.

An additional factor of note is that VA serves a broad age range of Veterans, and this includes Veterans who experienced sexual trauma in years or decades prior to the widespread availability of sexual trauma outpatient or residential treatments in VA or DoD, or who faced additional barriers to reporting on the basis of sexual orientation or gender identity, and who start receiving these VA services later in life. Veterans may have experienced additional traumas or life

stressors in the years following military discharge, and this can compound their treatment needs and potentially increase the need for a more intensive level of care.

The services available through each Department and differences in utilization of residential treatment within each Department reflect these population differences, as well as the differences in coverage for care as outlined below.

Part 1: DoD Residential Treatment Programs for Sexual Trauma Survivors

I. Overview

Literature Review

Given the possible consequences of such an event, proper support and treatment following a sexual trauma are essential. The DoD recognizes the importance of such high-quality services, and to provide Service members with the necessary support, the Department of Defense has established policies and programs intended to develop an integrated network of victim/survivor services. DoD established the Sexual Assault Prevention and Response Program that integrates numerous support services. Central to this program are specially-trained Sexual Assault Response Coordinators and Victim Advocates who are responsible for helping victims/survivors obtain services, referrals, and support (DoD Directive 6495.01). DoD also established the Special Victims' Counsel and Victims' Legal Counsel, providing victims/survivors with legal representation and assistance navigating the military justice system (Directive Type Memorandum 14-003). Additionally, DoD developed certification programs such as the Sexual Assault Advocate Certification Program, required for anyone providing direct services to victims/survivors (DoD Instruction 6495.03). DoD also implemented a restricted reporting option that enables Service members who report a sexual assault allegation to access health care and other support services without triggering an investigation (DoD Instruction 6495.02) and command notification. The DoD Safe Helpline, a contract DoD administers through the Rape, Abuse, Incest National Network, provides 24/7, anonymous crisis intervention support, information, and resources worldwide (DoD Instruction 6495.02). Lastly, DoD policies established the health care response to sexual trauma, including medical forensic examinations and availability of associated mental health care (DoD Instruction 6310.09).

Due to the severe and complex possible consequences of sexual harassment and assault, effective treatment is essential. Depending upon survivor needs, outpatient psychotherapy, intensive outpatient programs, and residential treatment can be options. Typically, Service members seek outpatient care and may increase the level of care due if their individual needs cannot be met with outpatient treatment. Outpatient psychotherapy often involves weekly psychotherapy sessions of 45-75 minutes duration over the course of several months, whereas intensive outpatient treatment programs provide focused mental health care on an outpatient basis for a short period of time, usually for four weeks or less. These focused programs offer multiple sessions per day, several days per week. Intensive outpatient treatment programs offer more focused interventions and allow the integration of multiple treatment modalities in service of treatment gains.

Intensive outpatient treatment programs are very effective for treatment of mental health consequences of sexual trauma (Zalta, et al., 2018; Harvey et al, 2018). Several studies have

shown the effectiveness of intensive outpatient treatment programs. One such study evaluated 39 Active Duty Service members participating in a three-week intensive outpatient treatment programs that involved daily group therapy, medication management, cognitive behavioral therapy and art therapy (Lande et al., 2011). The study revealed that participation in the program resulted in significant reductions in PTSD and depressive symptoms (Lande et al., 2011). Additionally, the 2018 Zalta et al. study of 191 Service members and Veterans completing a three-week intensive outpatient treatment program offering cognitive processing therapy and mindfulness-based resiliency training demonstrated a rapid reduction of post-traumatic cognitions. Post-traumatic cognitions are thoughts and beliefs which often contribute to feelings of self-blame, perceptions of pervasive danger and concerns that situations are dangerous (Beck et al, 2014). Results found that decreases in PTSD cognitions also predicted decreases in symptoms of PTSD and depression. This study suggests that evidence-based intensive outpatient treatment programs are effective in treating the psychological consequences of sexual trauma.

While residential treatment is considered an option for some survivors of sexual trauma, it may be most effective for those with co-occurring mental health concerns, a history of multiple traumas, or when outpatient psychotherapy or intensive outpatient treatment has not been effective. Further, residential treatment may not be considered feasible for some. For those concerned about the length of time required to complete residential programs and the impact of being away from family or other obligations, intensive outpatient treatment programs are an effective alternative.

DoD-specific Definitions and Terms

For the purposes of this report, the following definitions are utilized in the DoD portion of this report.

The TRICARE Program Manual provides the following definitions for residential treatment, intensive outpatient treatment programs and outpatient psychotherapy:

a) Residential treatment: A psychiatric residential treatment center provides extended care for children and adolescents who have mental health disorders (substance abuse disorders cannot be the primary diagnosis) requiring treatment in a therapeutic environment 24/7. Residential treatment may be required for children and adolescents who are stable enough not to require acute inpatient hospitalization but do require a structured, therapeutic, residential setting to stabilize their condition so that they can function at home and in an outpatient setting in the future.
b) Intensive outpatient treatment program: An intensive outpatient program includes assessment, treatment, case management and rehabilitation for individuals who do not require 24-hour care for mental health and substance use disorder. Intensive outpatient treatment programs provide at least six hours of therapeutic services per week.
c) Outpatient psychotherapy: Psychotherapy is discussion-based mental health therapy. Sessions are typically up to 60 minutes long, although crisis sessions may extend up to 120 minutes.
d) TRICARE: The DoD medical and dental programs, operating pursuant to chapter 55 of Title 10, U.S.C., under which medical and dental services are provided to DoD health care beneficiaries.

Data Methodology

DoD reviewed medical records of Active Duty Service members who disclosed sexual trauma to a health care provider in FY 2020. These records were isolated to identify care associated with their disclosure, as confirmed using diagnosis codes consistent with sexual trauma. Those diagnoses included those listed in Table 1 below. This data does not include Service members who made a formal report of sexual trauma and sought care outside the Military Health System or did not disclose that sexual trauma in the course of their health care.

Table 1: *ICD-10 Codes Utilized*

T74.2	Sexual abuse, confirmed (Not Billable)
T74.21	Adult sexual abuse, confirmed
T74.21XA	Adult sexual abuse, confirmed, initial encounter
T74.21XD	Adult sexual abuse, confirmed, subsequent encounter
T74.21XS	Adult sexual abuse, confirmed, sequela
T76.2	Sexual abuse, suspected (Not Billable)
T76.21	Adult sexual abuse, suspected
T76.21XA	Adult sexual abuse, suspected, initial encounter
T76.21XD	Adult sexual abuse, suspected, subsequent encounter
T76.21XS	Adult sexual abuse, suspected, sequela
Z04.4	Encounter for examination and observation following alleged adult rape
O9A.4	Sexual abuse complicating pregnancy, childbirth, and the puerperium (Not Billable)
O9A.41	Sexual abuse complicating pregnancy (Not Billable)
O9A.411	Sexual abuse complicating pregnancy, first trimester
O9A.412	Sexual abuse complicating pregnancy, second trimester
O9A.413	Sexual abuse complicating pregnancy, third trimester
O9A.419	Sexual abuse complicating pregnancy, unspecified trimester
O9A.42	Sexual abuse complicating childbirth
O9A.43	Sexual abuse complicating the puerperium
T74.2	Sexual abuse, confirmed (Not Billable)

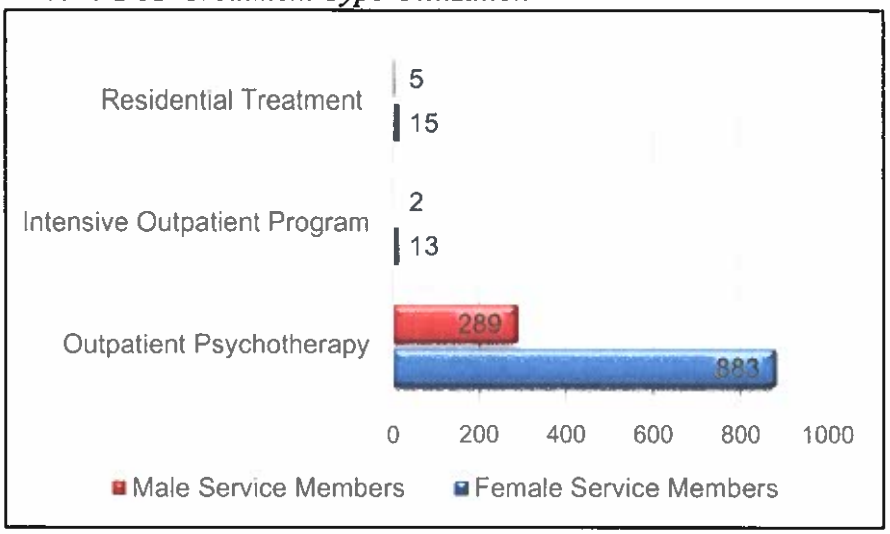
Findings

The analysis of the FY 2020 data found that outpatient psychotherapy is the most utilized level of care for most Service members and successfully meets their treatment goals. However, a small number of Service members engaged in more intensive levels of care in FY 2020. Among 1,239 Service members who disclosed sexual trauma in their medical records in FY 2020, 883 female Service members and 289 male Service members engaged in outpatient health care, 13 female Service members and 2 male Service members engaged in Intensive outpatient health care, and 15 female Service members and 5 male Service members engaged in residential health care. Overall, of the total number of Service members who disclosed sexual trauma in FY 2020, only 1.5 percent engaged in residential health care.

The DoD data reflects that the majority of Service members who report sexual trauma utilize outpatient psychotherapy, with a smaller percentage utilizing Intensive outpatient health care,

and even fewer utilizing residential treatment. Table 2 below provides a breakdown of utilization of Service members by gender.

Table 2: *FY 2020 DoD Treatment Type Utilization*



For Service members requiring a higher level of care than outpatient mental health care, limited residential options are available. This is due in large part to the fact that residential care is not covered by TRICARE for beneficiaries age 21 and over, as explained below in Section II of this report.

In addition, medical records data confirms that survivors of sexual trauma did not utilize residential mental health treatment for the psychological consequences of sexual trauma. The data indicates no Service members over the age of 21 sought residential mental health treatment for the psychological consequences of sexual trauma in FY 2020. To better understand whether this was an anomaly, a similar data pull was conducted for the prior five years (2016-2020). The new query (non-hospital residential services) returned only a single individual. This female Service member received care in 2016 at a civilian program. There were no cases associated with such residential services between 2017 and 2020.

II. Availability of Residential Treatment Programs

Within the DoD, residential treatment programs for survivors of sexual trauma are available for survivors under the age of 21. TRICARE does not currently authorize residential treatment for beneficiaries age 21 or over under the TRICARE Basic benefit. However, Service members requiring residential treatment may receive it through a Supplemental Health Care Program waiver completed by their health care provider and approved by the Director of the Defense Health Agency. TRICARE benefits for Service members are determined by statute. Therefore, specific treatments and treatment modalities are statutorily determined. By regulation, residential treatment is not currently authorized for beneficiaries age 21 or over. In short, while regulation does not authorize this benefit for Service members over the age of 21, when clinically indicated, health care providers can request exceptions, based upon the needs of individuals.

III. Barriers to Access to Care

While TRICARE does not authorize residential treatment for beneficiaries over the age of 20, the data indicates that for the majority of survivors, outpatient psychotherapy sufficiently addresses their needs at that time and the option for intensive outpatient treatment programs is available for those needing a higher level of care, with the opportunity to request an exception to TRICARE policy for medical necessity. The intensive outpatient treatment is logically the next step in care for Service members needing more than weekly outpatient psychotherapy. The intensive outpatient treatment options may appeal to Service members requiring a higher level of care, because of the ability to maintain important functions, such as their job, caring for family and staying in the home environment. At the same time, data indicates that utilization of intensive outpatient treatment programs are minimal, indicating that outpatient psychotherapy is the most sought-after care by Service members who experience sexual trauma. Because utilization of more intensive modalities of care such as intensive outpatient programs and residential treatment, is low across DoD, it appears that current resource levels for these intensive modalities, are sufficient for the need. However, it's unclear whether the regulation on TRICARE authorization or waivers process presents a barrier to residential care for Service members, or whether utilization is the result of minimal use of intensive outpatient programs or unique concerns of Service members to maintain their readiness status. More information is needed before determining whether residential treatment would be greater utilized by Service members if it were to be a TRICARE authorized service, rather than available via a waiver.

IV. Resources Required to Address Barriers to Access

The data suggests that outpatient psychotherapy is the most highly utilized treatment modality used during military service. Given that intensive outpatient programs, the next logical step in care, are not widely used by Service members, it is likely that the utilization of evidence-based practices results in desired treatment outcomes without additional intervention for most survivors of sexual trauma, who access health care, during military service. However, more information is needed to determine whether additional resources are needed for residential treatment. At this time, DoD would benefit from more funding for additional mental health care providers, particularly at the PhD level, to augment current staffing levels at clinics. Through additional funding for more mental health care providers, DoD can ensure that all Service members who desire health care associated with their sexual trauma receive timely access to care and can be assessed for more intensive treatment modalities as needed.

In addition to increasing available mental health care providers, the DoD would also benefit from funding to develop additional specialty training for mental health care providers. Although continuing education is available, it is difficult to find specialty training in the mental health consequences of experiencing sexual trauma without incurring great personal expense or time away from the work to complete the training. Creation of comprehensive specialty training that is readily available to all mental health care providers will ensure providers remain proficient in current evidence-based practices for mental conditions related to sexual trauma.

V. References

Beck, J. G., Jacobs-Lentz, J., Jones, J. M., Olsen, S. A., & Clapp, J. D. (2014). Understanding posttrauma cognitions and beliefs. L.A. Zoellner & N. C. Feeny (Eds.), *Facilitating resilience and recovery following trauma*, 167-190.

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Lande, R.G., Williams, L.B., Francis, J.L., Gragnani, C., Morin, M.L. (2011) Characteristics and Effectiveness of an Intensive Military Outpatient Treatment Program for PTSD. *Journal of Aggression, Maltreatment & Trauma, 20*(5), 530-538.

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Zalta, A.K., Held, P., Smith, D.L., Klassen, B.J., Lofgreen, A.M., Normand, P.S., Brennan, M.B., Rydberg, T.S., Boley, R.A., Pollack, M.H. & Karnik, N.S. (2018). Evaluating Patterns and Predictors of Symptom Change during a Three-Week Intensive Outpatient Treatment for Veterans with PTSD. *BMC Psychiatry, 18*(1), 1-15.

Part 2: VA Residential Treatment Programs for MST Survivors

I. Availability of Residential Treatment Programs

As previously discussed for Service members, outpatient mental health treatment is the most appropriate level of care for most Veterans with a mental health condition, including Veterans with a condition related to experiences of MST, and can successfully meet their treatment needs. However, a small proportion of Veterans may require or benefit from residential treatment at some point in their recovery from MST-related mental health conditions, and the Veterans Health Administration has Mental Health Residential Rehabilitation Treatment Programs available to meet this need. The Veterans Health Administration also has inpatient mental health units available to treat Veterans with severe, acute treatment needs, such as suicidal behavior. These latter units, which focus on crisis stabilization, are not considered residential treatment programs, and therefore are not described in this report.

The Veterans Health Administration has over 250 Mental Health Residential Rehabilitation Treatment Programs with over 7,600 beds that provide 24-hour supervision, daily professional and peer services, and comprehensive care addressing mental health, substance use, and medical concerns as well as psychosocial needs. Programs provide specialized treatment for PTSD, substance use disorders, serious mental illness and other mental health concerns that can be associated with experiences of MST. It is important to note that within the Veterans Health Administration, no Mental Health Residential Rehabilitation Treatment Programs are officially designated as MST treatment programs; rather, programs are defined based on the diagnoses and symptoms for which treatment is provided (for example PTSD Residential Rehabilitation Treatment Programs) with some having a track within the program that specifically focuses on care related to MST.

Currently, most of the Mental Health Residential Rehabilitation Treatment Programs (94.1 percent) provide MST-related treatment to Veterans participating in the residential program who require it, although they vary in how they provide this care. The majority of Mental Health Residential Rehabilitation Treatment Programs (64.5 percent) have staff within the residential program itself to provide this care, while the remaining programs arrange for Veterans to receive this care from a facility outpatient provider with expertise in MST. In addition to these MST-related services provided through Mental Health Residential Rehabilitation Treatment Programs, a subset of programs (n=seven) identify themselves as having a track specifically dedicated to addressing MST. These programs serve as national resources and are not just available to Veterans at the facility where they are located.

Population Served

The Veterans Health Administration Mental Health Residential Rehabilitation Treatment Programs typically provide over 30,000 completed episodes of care each year. However, in response to the coronavirus disease 2019 (COVID-19) pandemic, admissions were curtailed as programs closed to support surge capacity to ensure the safety of both Veterans and staff or were operating at significantly reduced capacity for a portion of 2020. This report includes both FY 2020 and FY 2019 data to convey both recent and pre-pandemic (typical) utilization.

In FY 2020, there were 24,636 discharges from Mental Health Residential Rehabilitation Treatment Programs, with more than 3,900 (16.1 percent) of those discharges being Veterans who had experienced MST. In FY 2019, there were 34,751 discharges, over 5,400 of which were discharges of Veterans who had experienced MST (15.7 percent).

The Veterans Health Administration Mental Health Residential Rehabilitation Treatment Programs also occasionally provide care to current Service members, some of whom have experienced MST. The Veterans Health Administration is unable to provide specific numbers as the Veterans Health Administration providers do not systematically screen current Service members for MST. (The Veterans Health Administration does, however, screen all Veterans for experiences of MST) This is for privacy and confidentiality reasons, as records for current Service members' care at VA medical facilities are visible to DoD through VA-DoD open health care record sharing. Documentation of any experiences of sexual assault or harassment the Service member had experienced could compromise the survivor's option to file a DoD report of sexual assault under Restricted Reporting.

The majority of Veterans served by Mental Health Residential Rehabilitation Treatment Programs are men, with an increasing proportion of women being served each year. For FY 2020, 66.9 percent of women completing an episode of care in a Mental Health Residential Rehabilitation Treatment Program had experienced MST, as compared to 11.5 percent of men. These numbers were comparable to FY 2019 when 67.4 percent of women had experienced MST, as compared to 11.1 percent of men. During FY 2020, Mental Health Residential Rehabilitation Treatment Programs provided over 1,300 episodes of care to women and almost 2,600 episodes of care to men who had experienced MST. During FY 2019, Mental Health Residential Rehabilitation Treatment Programs provided over 1,900 episodes of care to women and over 3,500 episodes of care to men who reported having experienced MST.

Consistent with PTSD being the mental health condition most commonly associated with MST, the proportion of Veterans who experienced MST is highest in VA's PTSD Mental Health Residential Rehabilitation Treatment Programs. In FY 2020, 24.7 percent of Veterans served in PTSD Mental Health Residential Rehabilitation Treatment Programs had experienced MST. In FY 2019, 23.0 percent had experienced MST. VA's General Mental Health Residential Rehabilitation Treatment Programs and Substance Use Disorder Domiciliary Mental Health Residential Rehabilitation Treatment Programs serve the largest total number of Veterans who experienced MST.

Effectiveness

Notably, at least one study has demonstrated the effectiveness of VA Mental Health Residential Rehabilitation Treatment Program care for Veterans who have experienced MST. Specifically, a study by Holliday et al. (2020) of Veterans who had participated in a VA PTSD Mental Health Residential Rehabilitation Treatment Program found that Veterans who had experienced MST had a greater reduction in PTSD symptoms upon completing the program compared to Veterans who had not experienced MST.

II. Barriers to Access

The Veterans Health Administration has identified the following barriers as affecting MST survivors' access to VA Mental Health Residential Rehabilitation care:

a) Capacity and Other Barriers to Admission

A Veterans' access to residential treatment can be delayed or compromised by a number of factors, including timely availability of a bed, with geographic disparities in the distribution of Mental Health Residential Rehabilitation Treatment Program beds that impact availability; stringent admission criteria; staffing challenges necessitating reduced admissions; transportation challenges; and extended admission procedures that delay admission.

The Veterans Health Administration's analyses do not indicate that Veterans who experienced MST are differentially determined to not be appropriate for admission to a Mental Health Residential Rehabilitation Treatment Program. Rates of MST among Veterans who were admitted and received Mental Health Residential Rehabilitation Treatment Program care are comparable to rates of MST among Veterans screened and determined to not be appropriate for MH Mental Health Residential Rehabilitation admission.

However, analyses do indicate that Veterans who experienced MST wait statistically longer for admission to a Mental Health Residential Rehabilitation Treatment Program. Analyses indicate that this does not appear to be attributable to gender but is more likely due to bed availability in the type of program a Veteran needed to address MST-related treatment needs.

Timeliness for admission to a Mental Health Residential Rehabilitation Treatment Program are a significant concern for the Veterans Health Administration, and a range of efforts have been undertaken to ensure more timely access to residential treatment, including:

- the establishment of national, standardized admission criteria designed to minimize the impact of stringent admission and exclusion criteria;
- standardizing screening processes to improve understanding of reasons Veterans may be denied admission to residential treatment; and
- targeted training to increase awareness of residential resources and to reduce barriers to admission.

Specific to MST, the Veterans Health Administration has added new data elements to its Mental Health Residential Rehabilitation Treatment Program review that will help with ongoing monitoring of potential disparities in timeliness and is considering adding additional data elements that could better identify MST-specific needs and barriers to care. The Veterans Health Administration will also continue to examine existing data to better understand factors contributing to the longer wait times experienced by Veterans

who experienced MST and will identify appropriate actions to address this disparity based on the results of those analyses.

b) COVID-19

As mentioned earlier, the Mental Health Residential Rehabilitation Treatment Program continuum within the Veterans Health Administration has been significantly impacted by the COVID-19 pandemic. Roughly 50 percent of the Veterans Health Administrations' residential capacity has been reduced as programs temporarily closed or reduced admissions to ensure the safety of Veterans and staff. During this time, the needs of Veterans who had experienced MST who may have historically been served by a Mental Health Residential Rehabilitation Treatment Program are being met through a number of mechanisms. For example, many sites have implemented intensive outpatient services via telehealth. When it is determined that a Veteran's needs cannot be met through intensive outpatient services and the Veteran is willing to engage in residential treatment, efforts are made to admit the Veteran into an open residential treatment bed within the Veterans Health Administration or in the community when beds are not available within the Veterans Health Administration.

c) Transportation

As some Veterans may need to travel out of their local area to attend a Mental Health Residential Rehabilitation Treatment Program, travel time and costs have historically been potential barriers to care. The Veterans Health Administration provides treatment for MST-related conditions free of charge but eligibility criteria for Beneficiary Travel reimbursement is separate from this, which has created complications for Veterans needing geographically distant Mental Health Residential Rehabilitation Treatment Program care who are not eligible for Beneficiary Travel. The Veterans Health Administration's Mental Health Residential Rehabilitation Treatment Program National leadership is working with VA's National Veteran Transportation Program to explore authority beyond Beneficiary Travel to support travel to a residential program geographically distant from the Veteran's home. The Veterans Health Administration is hopeful that a solution will be identified which is expected to significantly decrease travel costs as a barrier for Mental Health Residential Rehabilitation Treatment Program care for many Veterans. However, for Veterans with limited financial resources, and for those who may have costs related to paying for childcare or pet care, or taking unpaid time off work, time and costs can continue to present a barrier to residential care.

d) Clinical Issues

Some of the issues Veterans struggle with clinically after experiences of MST can also create barriers to participation in Mental Health Residential Rehabilitation Treatment Program care. For example, living away from home, in a strange environment, and in a residential setting can be profoundly stressful for many trauma survivors, MST survivors included. Some Veterans who have experienced MST find it particularly difficult to have a roommate, to eat in group dining halls, to be in settings with schedules, policies or language that serve as reminders of military environments, or to be in a setting where

groups of people or groups of men, in particular, congregate, as is typical at Veterans Health Administration facilities. Some Veterans also report that the travel process to attend residential care (for example, being in lines, crowded areas, enclosed spaces like planes, unfamiliar locations) may trigger MST-related symptoms and present another barrier to care. Being away from the comfort and potential supports of home may exacerbate fears some Veterans have related to engaging in treatment generally. Having experienced MST is associated with an increased incidence of physical health difficulties, and therefore changing medical care providers, and ensuring ongoing medical follow-up, is also a concern for some Veterans who attend programs outside of their local area.

Mental Health Residential Rehabilitation Treatment Program staff work with Veterans to develop safety plans and to individualize care to mitigate stressors wherever possible. Additionally, residential treatment programs routinely provide opportunities for Veterans to develop coping skills and overcome stressors within the context of care. For many Veterans, what appears to be an obstacle at the outset of treatment (for example, having a roommate) becomes a significant part of the healing experience (for example, developing a capacity to be around others again, and thus feeling less alone). Outpatient providers are included in the treatment planning process before and after residential attendance to help anticipate and plan for challenges related to attending care and to ensure seamless follow-up.

Engaging in treatment can, in and of itself, be emotionally complicated and stressful for Veterans. Some types of Mental Health Residential Rehabilitation Treatment Program structures and foci will align well with a Veteran's needs and mitigate his/her concerns, while others will not. For example, some Veterans may want to attend an MST-specific program to connect with other Veterans with similar experiences. Other Veterans may find that being around others with similar experiences intensifies trauma reminders and worsens their symptoms, which may outweigh the benefits of attending an MST-specific program. Additionally, they may wish to keep MST-related issues private (often an even greater concern for men) and have concerns about being treated in a program identified as MST-specific. To the extent there is a misalignment between program structure and focus and Veteran needs and preferences, this can create a barrier to care and/or affect a Veteran's willingness to engage in care.

Recognizing this, the Veterans Health Administrations' Mental Health Residential Rehabilitation Treatment Program's utilize a range of models to ensure that a range of options are available to meet Veterans' diverse needs and preferences. Having a variety of options allows Veterans to choose programs that fit their individual treatment goals and priorities at various stages of their recovery. For Veterans who prefer connecting with other Veterans who have experienced MST in order to feel less alone and/or to have a greater proportion of treatment groups focused on MST-specific issues, such as related to intimacy or MST-specific triggers, the Veterans Health Administration offers several Mental Health Residential Rehabilitation Treatment Program's with MST-specific tracks. Alternately, mixed-trauma (non MST-specific) PTSD or other programs can also be a good fit for Veterans who have experienced multiple types of traumatic events (for example., combat or childhood trauma), which is often the case for MST survivors, or who would like to keep the type of trauma for which they are seeking care more private.

III. Resources Required to Reduce Barriers to Access

The Veterans Health Administration believes that existing resources are sufficient to meet the residential treatment needs of MST survivors and that additional resources are not needed to address access barriers identified in this report. As previously noted, the Veterans Health Administration will continue its analysis of factors impacting access to residential treatment in order to address potential disparities in access. One means of continuing to improve access is to ensure Veterans Health Administration providers' awareness of relevant Mental Health Residential Rehabilitation Treatment Program services. To assist with this, the Veterans Health Administration has established tools to assist providers in identifying residential treatment programs able to provide MST-related care. In addition, the Veterans Health Administrations' National MST Consultation Program and National PTSD Consultation Program regularly support providers in identifying appropriate resources for Veterans in order to facilitate access to care.

IV. References

Holliday, R., Smith, N. B., Holder, N., Gross, G. M., Monteith, L. L., Maguen, S., Hoff, R. A., & Harpaz-Rotem, I. (2020). Comparing the effectiveness of VA residential PTSD treatment for veterans who do and do not report a history of MST: A national investigation. *Journal of Psychiatric Research, 122*, 42-47. doi:10.1016/j.jpsychires.2019.12.012

Part 3: Summary

VA and DoD are committed to ensuring survivors of sexual trauma have access to the treatment and other services needed to assist them in their recovery. Need for and utilization of residential treatment programming differ across the Service member and Veteran populations, and the treatment services each Department has available reflect and are tailored to address the different needs and treatment preferences of these populations. This report describes the availability of residential treatment programs for survivors of sexual trauma in each Department as well as barriers to access and resources required to reduce these barriers.