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Wounded Warrior Survivors: A Study of the Transition of Female Active-Duty Military Sexual Trauma Survivors from the Department of Defense to the Department of Veterans Affairs

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WOUNDED WARRIOR SURVIVORS:

A Study of the Transition of Female Active-Duty Military Sexual Trauma Survivors From the Department of Defense to the Department of Veterans Affairs

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Table of Contents

Abstract

Fourteen-thousand nine-hundred active-duty United States military men and women said they were sexually assaulted in fiscal year 2016. When these survivors of military sexual assault (MSA) end their active-duty military service, they transition from being managed by the Department of Defense (DoD) to the Department of Veterans Affairs (VA). A seamless transition from the DoD to the VA is key to a survivor's continuum of care. This study examines the exit from active-duty military service to the entrance into the VA system for female survivors of MSA. The data for this study was collected using structured interviews with a survivor, and key subject matter experts in the DoD, VA, and Transition Assistance Program (TAP). Additionally, a survey of female active-duty and veterans was conducted to learn more about their personal experiences with the DoD, VA and sexual assault. Relevant scholarly literature and practitioner studies were checked to examine the MST phenomenon; the DoD's efforts to prevent and respond to MSA; and DoD, TAP and VA outreach programs and processes for exiting active-duty service female MSA survivors, some of whom have developed military sexual trauma (MST) and post-traumatic stress disorder (PTSD) from their sexual assault experiences. The goal of this research is to provide recommendations to key decision-makers at the DoD and VA on ways to guarantee exiting active-duty service female MST survivors receive the VA's permanent, no-cost MST medical benefits, support and services.

Chapter 1 Introduction

Background of the Problem:

According to the Department of Defense Sexual Assault Prevention and Reporting Office (SAPRO), 14,900 soldiers, sailors, airmen and Marines said they were sexually assaulted in fiscal year 2016. Some of these military members remained in their respective services (Army, Navy, Air Force, Marine Corps). Others exited the military for a variety of reasons, including the end of contractual obligations. Exiting military members transfer from the overarching care of the DoD to a new status of veteran becoming eligible for myriad benefits from the Department of Veterans Affairs (VA) and its Veterans Health Administration (VHA).

Not every veteran is eligible for every VA and/or VHA benefit. What is guaranteed for survivors of MST are permanent health benefits from the VHA for MST-related care. In order to identify MST survivors, ALL veterans entering the VHA are asked if they have experienced sexual trauma (VA Fact Sheet, 2014). However, becoming a registered member of the VHA sometimes requires initiative and tenacity to navigate the labyrinth system. For example, when she was discharged from the Army, Jessica Kenyon, a former Army private first class and MST survivor, said during sworn testimony at a Senate Hearing that she did "…try to go to the VA multiple times and was redirected to other locations, other services, and eventually gave up" (The Relationships, 2014).

Besides the quest for medical and mental health care services, the end of military active-duty service often finds MST survivors, and all exiting service members, searching for a new job, affordable housing, and health care all previously provided by the DoD. To assist exiting service members the DoD, in an interagency collaboration with other federal entities, implemented a mandatory week-long transition course in 2013 called the Transition Assistance

Program (TAP). The TAP curriculum includes resume' writing, and job interview coaching. Information on how to register for healthcare services at VHA hospitals and clinics is also made available to the exiting service members during TAP. (Department of Defense TAP, 2015).

Statement of the Problem Female MST service member survivors do not receive the requisite medical care and benefits when they leave military active duty and transition to the VA. When survivors exit the military they often are traumatized by the experiences of military sexual assault and its debris. A warm hand-off between the DoD and VA entities, key to a continuity of medical and mental health care, is not occurring.

Research Question

Does the female active-duty MST population who exit the military receive healthcare services for their MST-related health issues from the VHA?

The research question and sub-questions were developed after discussions with a Navy Sexual Assault Response Coordinator who lamented there was a gap in services when some of her survivors transitioned from active-duty to veteran. The main research question examined in this study asks if there is a disconnection between the DoD and VHA when survivors exit the military.

Research Sub-Questions

1. Does the VA connect with the female MST veteran population who exit the military? One of the first steps for all exiting service members is to register with their local VA facility. Uninterrupted management of their health and mental health conditions created by the circumstances of their assault that occurred while they served in the military is not occurring.

2. Is there a seamless transition between the DoD to the VA in treatment and rehabilitation for the female veteran population? The transition point from DoD to VA is the logical confluence to examine when investigating the continuity of care for female MT survivors.

Research Hypothesis

Female veterans are not receiving care from the VHA for MST-related care.

Purpose of the Study

This study examines the transition of MST survivors from active-duty military to veteran to identify and help close gaps in their medical benefits and support from the VA. The linkage between the two organizations was examined to determine the connection between the DoD and the VA so women like Kenyon are better able to enter the VA system as they exit active-duty. The goal of this research is to provide recommendations to key decision-makers at all DoD and VA organizations who are responsible for guaranteeing exiting active-duty service female MST survivors receive the VA's permanent, no-cost MST medical benefits, support and services. Additionally, TAP will be examined as the connective tissue between the DoD and the VA system.

Significance of the Study

This research study investigates whether the essential TAP connection will strengthen the chain of support in medical care and narrow the gap between the DoD and the VA. This gap coverage between DoD and the VA is especially critical for women who may require further MST counseling services. The alignment of the two entities could ensure exiting MST survivors receive continued services through the VHA. From entry-level military recruits and their parents, to mental health care providers, to Congress and the President of the United States, this study is intended to help provide all stakeholders with confidence in the capabilities of two

federal government organizations to provide services to survivors. The results of this study will expectantly ensure permanent MST services for the nation's female wounded warrior survivors. The alignment of the two entities will help ensure access to VA health care for exiting female MST survivors who are eligible for free, permanent, military sexual trauma health benefits as signed into Public Law, (38 U.S. Code 1720D).

Assumptions and Limitations: While there is a population of male survivors of MST, this study limits its scope to the larger female MST survivor population. This study will not examine the origins of MST, or the social factors which contribute to the high incidence of MST in the military. Psychological research on this topic will not be investigated.

Definition of Terms

Active-duty - Status of members of the United States' armed forces who sign a contract to serve and swear an oath of allegiance to support and defend the Constitution of the United States of America.

Military Sexual Assault (MSA)- The Uniform Code of Military Justice (UCMJ) criminalizes rape, sexual assault, and other sexual offenses in Article 120. Generally, sex offenses in the military are similar to sex offenses in the civilian sector. The U.S. Army Study Guide states: "Sexual assault is a crime defined as intentional sexual contact, characterized by use of force, physical threat or abuse of authority or when the victim does not or cannot consent. Sexual Assault includes: Rape; Non-consensual Sodomy (oral or anal sex); Indecent Assault (unwanted, inappropriate sexual contact or fondling); and Attempts to commit these acts." (Army Study Guide: "Army Sexual Assault Prevention and Response Program". Retrieved 4 June 2013.)

Military Sexual Trauma (MST)- The VHA adopted the term to refer to "…psychological trauma, which in the judgment of a VA mental health professional, resulted from a physical assault of a

sexual nature, battery of a sexual nature, or sexual harassment which occurred while the Veteran was serving on active duty, active duty for training, or inactive duty training," (VA, 2004) (Title 38 U.S. Code 1720D).

Military Sexual Trauma - Military sexual trauma is used by the United States Department of Veterans Affairs (VA) and defined in federal law (Title 38 U.S. Code 1720D) as "psychological trauma, which in the judgment of a VA mental health professional, resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the Veteran was serving on active duty, active duty for training, or inactive duty training."

Military Sexual Trauma Coordinator – VHA's representative who oversees the screening and treatment referral process for victims of MST.

Post-Traumatic Stress Disorder (PTSD) - "A mental health problem that some people develop after experiencing or witnessing a life-threatening event, like combat, a natural disaster, a car accident, or sexual assault," (VA, 2004).

Sexual Assault Prevention and Response Office (SAPRO) – Established in 2005, the single point of DoD authority with the designated mission to "prevent and respond to the crime of sexual assault in order to enable military readiness and reduce—with a goal to eliminate—sexual assault from the military."

Sexual Assault Response Coordinator (SARC) and Sexual Assault Prevention and Response Victim Advocate (SAPR VA) – Under the direction of SAPRO SARCs and SAPRs "provide non-clinical crisis intervention, referral, and ongoing non-clinical support to adult sexual assault victims. Supervise and conduct awareness, prevention and response training."

Sexual harassment - Includes "repeated, unsolicited verbal or physical contact of a sexual nature which is threatening in character. The behavior may include physical force, threats of negative consequences, implied promotion, promises of favored treatment, or intoxication of either the perpetrator or the victim or both."

Survivor - A preferred term to describe an individual who has been sexually assaulted, the term victim is also widely used.

Universal screening - Mandated screening for military sexual assault of all veterans entering the VHA in response to widespread incidents of sexual violence in the military and the lasting deleterious effects of sexual assault. If a veteran screens positive for MST, it is noted in the veteran's electronic health record, (Kimerling, Gima, Smith, Street, Frayne, 2007).

Veteran - Status of former members of the U.S. armed forces who served in the military.

Veterans Health Administration (VHA) – Provides healthcare services for veterans including treatment for veterans who have medical or mental health symptoms related to their MST experiences. Types of services will vary based on each veteran's individual treatment needs. The VA Palo Alto Health Care System has a variety of female-specific programs at its Women's Health Center, Women's Counseling Center, and through its Women's Trauma Recovery Program, (VA, 2018).

Warm hand-off – A strategy used in the healthcare industry seen as a valuable safety net tool to transfer care from clinicians or specialists in the presence of a patient to ensure there is not a communications breakdown.

Wounded Warrior – A term penned by the researcher as a moniker for MST survivors.

Expected Impact of the Research:

By examining the transition between the DoD and the VA, this research will seek to identify if

there is a gap of healthcare services for female active-duty service members who are MST survivors. This research could aid in the future recovery of female veteran MST survivors. Additionally, this study could serve as a guide for further research of the two massive government entities tasked with overseeing and managing the MST-related healthcare needs of the nation's wounded warriors.

Chapter 2 – Literature Review

Introduction

This chapter provides a scholarly review on what academics have written and practitioners have studied on the history and prevalence of military sexual assaults on active-duty female service members and how the Department of Defense (DoD) is responding to survivors. Literature examining the Department of Veterans Affairs (VA) and the cross-over services it provides for female service members leaving the DoD and entering the VA is also analyzed. This chapter provides summaries of the following themes discovered in this literature review and includes: (1) women and sexual assault in the military; (2) DoD's response to sexual assault in the Armed Forces; (3) the transition of service members from active-duty to veteran.

Women and Sexual Assault in the Military

A minority in the hyper-masculine environment of the United States military, women have elevated through the ranks the past 240 years from an auxiliary service to positions of authority and occupational specialties traditionally held only by men. Today, women in the military have moved into combat and combat-related jobs previously restricted to their gender. Modifications to Department of Defense (DoD) policies expanded combat roles for women in 1992 during the Persian Gulf War when women served in combat construction, trucking, security and aviation support functions. It was also during this war when the DoD began to robustly investigate and prosecute allegations of sexual assault. The increased interest was sparked when high-visibility sexual abuse cases captured international media attention, such as the 1991 Tailhook Scandal, a series of incidents where more than 100 United States Navy and U.S. Marine Corps aviation officers were alleged to have sexually assaulted 83 women and 7 men

(Retroreport, 2013). Sexual abuse by their comrades and superiors such as experienced at the Tailhook Convention have led to a subset population of military women veterans who are survivors of military sexual assault (MSA).

In addition to the military having its own brand of sexual assault, during the 1990s the VA coined the term Military Sexual Trauma (MST) to note the overarching consequences to include the potential for long-lasting and deleterious effects suffered by military victims of sexual assault. The negative effects that have been noted in sexual assault victims include psychological, physical and social consequences such as trust issues, shame, and diminished safety perceptions. Often these amalgamated experiences can lead to post-traumatic stress disorder (PTSD), and one study suggests females MST victims are at an increased risk for developing PTSD when compared to male combat veterans (Kimerling, et al., 2007). Another study by Fontana and Rosenheck looked at a groups pre-military, military, and post-military experiences discovering sexual stress in the military is "particularly toxic for the development of PTSD," (Fontana & Rosenheck, 1998, pp. 658-662). Furthermore, the study found sexual stress in women was almost four times more influential in the development of PTSD than duty-related stress. These studies suggest sexual assault experienced in the military can lead to trauma and is a possible pre-cursor to PTSD.

There are thousands of victims, or *survivors*, each year. During the course of research, it was learned "such framing does matter," (Hockett & Saucier, 2015). The pair concluded that survivors favor verbiage that suggests "empowerment" versus "oppression." An interview with a survivor, featured in Chapter 4, determined she prefers a confidence-building moniker to describe herself.

In 2016 an estimated 14,900 active-duty service member survivors experienced "some kind of sexual assault," (Department of Defense [DoD], 2017), the DoD Sexual Assault Prevention and Response Office (SAPRO) reported. In 2016, there were about 3.5 million service members with 204,628 (15.9 %) women. There is a higher prevalence of sexual assault perpetrated on military women with DoD SAPRO reporting in 2016 an estimated 4.3 percent of military women, and 0.6 percent of men, indicated some kind of sexual assault. The prevalence of sexual assault in the military is high or higher when compared to society in general. However, studies of civilian victims used a timeline of *lifetime,* while the rates of sexual assaults for military members took place during military service, typically four to 30 years, equating to much higher rates than the general population, (Turchik & Wilson, 2010). Other sources echo the higher prevalence of MSA in military women when compared to sexual assault in the general population. In a mixed-methods study of 52 female veterans who served from World War II to recent conflicts in Iraq, 90 percent said they had been subjected to a form of MSA, (Department of Veterans Affairs [VA], 2016). The Military Environment and Women's Risk of Rape study of 640 women respondents found rape occurred most frequently at military installation barracks suggesting this is where perpetrators have easy access to their victims. Sadler also found there is a higher risk of both harassment and assault for women in occupations dominated by males (Sadler et al., 2001). Researchers found there is a higher prevalence of sexual assault in military women and theorize one of the reasons is because they are a minority in a male-dominated profession. Secondly, unique lifestyle components exist in a military environment not experienced by the general population. For example, military personnel often live and work in the same general areas, and cannot quit their job and move on if a perpetrator is in the work place.

The command climate, or tone, set by leadership can also play a role, researchers discovered. Leaders who set an example by exhibiting demeaning sexually-charged, gestures and behaviors give the green light to lower ranking soldiers to perpetrate sexual assault and harassment against female soldiers, (Lee, 2017). Close quarters, a high ratio of men to women, and command climate can create a fortuitous trifecta of opportunity for perpetrators of sexual assault. Research show these factors have contributed to the military phenomenon which led the military and the VHA to create their own *brand* of sexual assault and trauma. The brand is further defined in the article *Military Sexual Trauma* which found there are "more severe physical and mental health consequences" (Suris & Lind, 2008) for sexual assault victims in the military where work tempo and unit cohesion may cause sexual assault victims to hesitate in reporting another member of their unit for fear of reprisals and ostracizing. In her report on MST and the experiences of women veterans, Sarah Louise Aktepy also reported unit cohesion can breed of culture of victim blaming where survivor are encouraged to not report sexual assault offenses, (Aktepy, 2010). Fear of an authority figure has been found to create another facet of military sexual assault not experienced by civilians. Abuse of rank and authority by senior ranking members who sexually assault junior-ranking soldiers is another form of victimization experienced by some (Stander & Thomsen, 2016). One exploratory study sought to identify the characteristics of rape victims, perpetrators and the environmental work factors related with military service rape, (Sadler et al, 2003). These studies show that living in a military environment bubble where work converges with lifestyle can further victimize sexual assault victims in the military and perpetuate a continuum of harm. The cumulative effects of sexual assault when combined with the stressors of operational deployments can lead to an overwhelming sense of anxiety, researchers said.

DoD's Response to Sexual Assault in the Armed Forces

Recognizing it had a problem that could affect its readiness, and with pressure from the President of the United States and Congress, the Department of Defense (DoD) responded in 2004 with the creation of its Sexual Assault Prevention and Response Office (SAPRO). SAPRO's mission is to lead DoD's prevention attempts, and act as a structure that includes a way to provide victim care. Sexual Assault Response Coordinators (SARCs), with responsibilities at every military installation in the world, provide a "human element" (DoD SAPRO, 2018) to the DoD's response. Often a first responder for victims of sexual assault, the mission of SARC is to help victims through the process of reporting the assault, receiving counseling services, and the way ahead (DoD SAPRO, 2018). The SAPRO system urges bystander intervention and draws attention to the issue of sexual assault throughout the year, with April set aside as Sexual Assault Awareness and Prevention Month. During the month SARCs and volunteer victim advocates dispense paraphernalia such as pens displaying the DoD's Sexual Assault Hotline number, and hang banners at military installations with anti-sexual assault messages, (DoD SAPRO, 2018). There is relevant research on the DoD's prevention and response programs with one study looking ahead to bystander intervention as the approach to "produce population-level change in military cultural norms and attitudes toward sexual aggression," (Stander et al, 2003). However, the researchers discovered "even the most willing individual may not act depending upon immediate situational factors." According to a SAPRO fact sheet on the topic, intervention could be influenced by a number of factors including the bystander does not understand there could be an emergency, a bystander's apathetic mood, or the personal cost is perceived as "too high," (DoD SAPRO, 2018). Whether it is prevention or intervention, SAPRO's role to identify ways to adjust attitudes and redefine

norms in the military institution will continue as stakeholders demand a decrease in military sexual assaults.

DoD's prevention efforts did not satisfy a primary stakeholder, Congress, after the DoD submitted its 2014 Annual Sexual Assault Report. During the opening statement at Senate Hearing 113-480, Feb. 26, 2014, Senator Kirsten E. Gillibrand, Chairman of the U.S. Senate's Committee on Armed Services said, "there is zero doubt that sexual violence is occurring at an unacceptable rate within our military," (The Relationships, 2014). Stakeholders like Gillibrand and her peers will continue to scrutinize DoD and hold it accountable for the rate of sexual assault in the military.

In conclusion, SAPRO's efforts to eradicate sexual assaults from the military ranks will mature and perpetuate as it evaluates its current programs in order to devise the next generation of prevention and response program materials. Bystander intervention could be at the forefront for decreasing sexual assault in the military. However, DoD cannot rely solely on bystander intervention as a prevention technique due to factors that may inhibit a bystander's immediate response. Instruction for troops on intervention methods is recommended as part of the regular sexual assault prevention syllabus. Meanwhile, DoD leadership will continue to be held accountable for its prevention and response methods with a goal of eliminating sexual assault from the ranks.

The transition from active-duty to veteran.

Before service members leave active-duty they must attend a week-long program mandated by Congress in 2011. Originally designed as a program to ensure success in the civilian job market, all service members attend pre-separation counseling called the Transition

Assistance Program (TAP). Focused primarily on job search and relocation assistance, a section presented by the VA includes information on health care and how to apply for benefits, (TAP 2018). The VA sees TAP as an important element in its outreach efforts. A VA pilot program is underway that includes a daylong block of instruction on VA and its benefits, and includes a field trip to a VA medical center, said Kayla Williams, Director of VA's Center for Women Veterans (CWV) during a telephone interview June 27, 2018. She added VA leadership will closely monitor the pilot program to assess its effectiveness and possibly implement it nationwide. TAP would be a logical initial point of contact with a DoD SARC and a VA MST coordinator meeting together with survivors who leave active-duty. To avoid a break in mental healthcare treatment they may be receiving while in the care of the DoD it is important survivors have a connected transition into the VA's VHA, the survivor's new health care provider.

According to the Government Accounting Office (GAO), "the Department of Veterans Affairs' (VA) Veterans Health Administration (VHA) operates one of the largest health care delivery systems in the nation, with over 160 medical centers and more than 1,000 outpatient facilities. The VA reports about one in four of its some 2,000,000 female patients are MST survivors. The total population of women Veterans is expected to increase at an average rate of about 18,000 women per year for the next 10 years, (VA, 2015). While female veterans may find their way to a VHA facility, the GAO noted VA providers may "inappropriately discontinue or change mental health medications for transitioning service members because the DoD and VA formularies are different and VA's related policy is unclear." As survivors transition from active duty to the status of veteran, the continuity of care between the DoD and VA is a weak link in connecting veterans with services after they have left the DoD's active-duty roster. Suggestions from service members include "a records and database in which they both work will go a long

way to something as simple as a records transfer," (The Relationships, 2014). The transfer would only have to be from DoD to the VA because while it does occur occasionally, it is rare veterans return to active-duty therefore the DoD would not need access to VA's medical records. However, the status of reserve troops going on/off active-duty should also be considered. There are also confidentiality laws that must be adhered to under the provisions of the Health Insurance Portability and Accountability Act (HIPAA).

Attorneys Evan Seamone and David Traskey discovered although survivors have access to the VA's care for "MST-related psychiatric and physical conditions, it struggles to overcome significant hurdles facing MST survivors." The pair discovered an array of hurdles including "reluctance to request services for sexual assault and revisiting the details of their abuse; gender insensitivity by the VA; the VA is seen as having a connection to the military, the very organization that possibly ignored survivors' complaints or even retaliated against the survivor for making a complaint; an adjudication system requiring MST survivors to prove by a 50% chance or greater that their assault occurred; and VA's frequent MST PTSD claim denial rate," (Seamone & Traskey, 2014). Meanwhile, leadership at VA headquarters in Washington, D.C., is listening to the complaints and driving a sea change. When VA learned of the frequent MST denials it responded with a review of its procedures for identifying PTSD developed from MST. Previously all PTSD screenings were limited to looking for markers related to combat trauma-related PTSD. "The VA did some training, rewrote rules and procedures, and identified what markers they would consider as evidence for PTSD caused by MST, especially for those who did not file a report when the assault happened. Those efforts worked and now PTSD for MST is screened differently than for combat-related PTSD," said Director Williams, an Army combat veteran, who emphasized significant outreach activities and other achievements during her reign

are in part an effort to change the VA's image. Williams also spoke of an outreach exhibit displayed online and at VHA medical centers nationwide. The photo display of VA employees features its female veteran population. "We are not just faceless bureaucrats. We want women to see our pics and realize we are them. We care very passionately about serving them effectively with innovative and interesting ways to conduct as much outreach as possible," Director Williams said. Her Center's website backs up her claims with its female veteran advocacy posture and an array of resources available for veterans to access. (Director Williams's entire interview is featured in Chapter 4.)

Once a veteran reports to their local VHA healthcare facility, he or she is screened for MST during mandated universal screening. A 2005 study of veterans after they received screening concluded the screening is effective in the "detection of sexual trauma and access to mental health care can help to reduce the burden of psychiatric illness for those who have experienced military sexual trauma," (Hyun et al, 2009). Mandated screening by the VHA is in response to the widespread exposure in universal screening military and the lasting deleterious effects of sexual violence, (Kimerling et al, 2007). This universal screening that began in 1999 is seen as a model for response to sexual violence and as a means to begin and continue care (Husby, 2014). To continue care within the VHA system, women veterans who have a history of MSA or PTSD have reported feeling like a minority in an "unwelcoming environment, surrounded by men," (Kehle-Forbes et al, 2017). The Kehle-Forbes et al research echoes the hesitancy of trauma victims to receive VHA Care. The researchers pointed out VHA administrators are hyper-sensitive to female veterans and do not want to perpetuate stigmatizing women and contribute to a "perception of otherness," (Kehle-Forbes et al, 2017). That perception is exactly what Williams and her Center are combating, "this is not your grandpa's

VA," Williams emphasized. Universal screening and its widespread success at identifying victims, and a sensitivity to the male-dominated environment of the VA and its VHA, will be central to the VA organization meeting the long-term health and mental health care needs of female veteran survivors of MST.

During Senate Hearing 113-480, Feb. 26, 2014, Senator Kirsten E. Gillibrand, Chairman of the U.S. Senate's Committee, pointed out it is important to understand the "long-term psychological toll on the survivors of sexual trauma in the military and the best practices for effective treatment," (The Relationships, 2014). *Effective treatment* is as varied as the individual victims and their array of deleterious effects from their MST experiences. Many feel out of touch, and suffer from "paralyzing amounts of depression, grief, anxiety, sadness, rage and/or shame," (Spence, 2017). These feelings can often manifest in the form of self-medicating with alcohol and drugs, and self-harm, researchers said.

With fragile feelings and a fear of betrayal, there are many keys to peace of mind for survivors. Research shows DoD and VA are aware of the fragility of the MST survivor population as they identify ways to provide healthcare and other services to them. Ensuring there is not a gap in mental health treatment and medications is fundamental to survivor rehabilitation.

Conclusion

Literature, congressional hearings and their own websites suggest the DoD and VA are independently working to ensure care for survivors of MST. The DoD's SAPRO role extends to prophylactic actions in an effort to decrease sexual assaults within the ranks through bystander intervention and other prevention efforts. In turn, the number of female MST survivors entering

the VA system could decline in future years. This research shows why the connected transition is important to gain the trust of the niche group of female MST survivors. As it stands, two of the government's largest entities are individually providing MST care for female active-duty and veterans. Combining their efforts could lead to a more robust, thoughtful, and thorough response for survivors of military sexual assault and trauma.

Chapter 3 – Research Methodology

Introduction

The goal of this research is to learn how survivors of military sexual trauma are accessing free, permanent, military sexual trauma health benefits. The research design for this project is a mixed-methods, qualitative case study to evaluate if the Department of Defense (DoD), Transition Assistance Program (TAP), and Veterans Health Administration (VHA) are ensuring an unbroken connection to healthcare services for female MST survivors who leave active-duty and transition from DoD to VHA.

Main Research Question

Does the female active-duty MST population who exit the military receive healthcare services for their MST-related health issues from the VHA? This question steered the research towards female active-duty veterans to learn if they were eligible for MST care, receiving care, and to learn about their individual experiences with the quality of care. Qualitative and quantitative data was collected from the female veterans by survey. Additionally, an email interview was conducted with a female veteran MST survivor to learn of her experiences both on active-duty and her transition to the VA.

Sub-question 1:

Is there a seamless transition between the Department of Defense (DoD) to the VA in treatment and rehabilitation for the female veteran population? This question guided research in the direction of three entities that are in contact with survivors at the point of exit from the DoD. A DoD TAP coordinator and DoD SARC from a military installation responded to questions

about the transition of veterans from DoD to VA via TAP. While interviews with VA representatives were sought in five different VA venues, multiple attempts were unsuccessful.

Research Hypothesis:

Female veterans are not seeking care for MST-related care from the VHA. Explain your research hypothesis in terms of collecting data. The research hypothesis for this study was that female veterans are not seeking care for MST-related care from the VHA. To determine whether or not this hypothesis could be supported, this researcher collected data from actual female veterans from multiple military service organizations. MST victims and non-MST victims were sought out to seek answers to whether or not they were aware of and took action to obtain care and support from the VHA for their MST-related condition.

Operational Definitions:

Continuum of care - A seamless transition of care for discharged female military members who have MST.

Department of Defense (DoD) - The mission of the Department of Defense is to provide a lethal Joint Force to defend the security of the country and sustain American influence abroad, according to its website. DoD is the federal agency tasked with the defense of the United States of America through four distinct and separate military services – Army, Marines, Navy, and Air Force. As of April 2018, there were some 1.4 million service members on active-duty, about 14% are female, (DoD, 2018.)

Department of Defense Transition Assistance Program (DoD TAP) – An interagency collaboration between the DoD, the Department of Veterans Affairs, Department of Labor, Small Business Administration, Department of Education, and the Office of Personnel Management.

Designed to assist transitioning service members and their families with more easily accessible resources. The week-long, mandatory TAP that includes instruction in resume' writing, and job interview coaching. (DoDTAP, 2018).

Department of Veterans Affairs (VA) and Veterans Health Administration (VHA) - According to its website is "America's largest integrated health care system, providing care at 1,240 health care facilities, including 170 medical centers and 1,061 outpatient sites of care of varying complexity (VHA outpatient clinics), serving 9 million enrolled Veterans each year," (VA, 2014). The VA provides myriad services for veterans. For the purpose of this study, the focus will be on the VA Palo Alto Health Care System.

DoD Definition of Sexual Assault - In the DoD, the term sexual assault does not refer to one specific crime; rather, "it encompasses a range of sex crimes between adults that represent a broad spectrum of offenses from rape to forcible sodomy to abusive sexual contact, as well as attempts to commit these offenses. Consequently, the definition of sexual assault in the military is broader than the crime of rape," (DoD SAPRO, 2018).

Increased outreach - Each branch has a mandatory, one-week long transition assistance class to help service members with their transition into post-military service life. The transition assistance syllabus includes lessons in resume' building, job interview techniques, employment placement assistance and a short brief from the VA, (DoD TAP, 2018). Increased outreach for the purpose of this study would apply to the information provided in TAP.

Military Sexual Trauma (MST) – Defined by the federal government as "psychological trauma resulting from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the Veteran was serving on active duty, active duty for

training, or inactive duty training," (VA, 2004). The Department of Veterans Affairs stipulates that while "veterans are not granted compensation for the traumatic event itself, they may receive disability compensation for conditions that result from MST," (VA, 2004). The VA has published a list of signs, events, or circumstances it calls markers that can be used to determine if someone has suffered from MST. Those markers include substance abuse, depression, panic attacks, and sexual dysfunction, (VA, 2004).

Sexual Assault Prevention and Response Office (SAPRO) - Established within the Department of Defense in 2004 in response to a high prevalence of sexual assault throughout the armed forces. "Serves as the single point of authority for program accountability and oversight, in order to enable military readiness and reduce - with a goal to eliminate - sexual assault from the military," (DoD SAPRO, 2018).

Data Collection Plan Overview

Primary data for this exploratory, mixed-methods study was collected by survey and interviews. Interview questions were sent electronically to subject matter experts in the DoD, TAP and VHA. Secondary qualitative data was collected from the study *Experiences with VHA care: a qualitative study of U.S. women veterans with self-reported trauma histories* was used to reinforce primary data sources. The *Experiences* study was referenced because of its similarities to this study. After analyzing qualitative interview responses, it was clear the similarities were more than imagined with this study's respondents mirroring the responses of 37 female Vietnam and post-Vietnam (1975-1988) era veterans who were interviewed for the *Experiences* study.

Population Sampling Strategy:

The random sampling of female veterans was a nationally representative sample of active-duty and veterans who served from the 1970s to present. Female active-duty and veterans were contacted on three Facebook pages and asked to take a survey about their experiences in their transition from active-duty to veteran, and affiliation with the VA.

Procedure:

A nine question survey designed in Survey Monkey (See Appendix A: Survey Questions) was posted to a female Navy E-7 and above Facebook page, a California Women Veterans Facebook page, and an MST survivor's Facebook page garnering a combined 52 total respondents.

Semi-structured telephonic and email interviews were conducted to determine the DoD's and TAP's procedures in directing MST survivors to VHA services. This assisted in establishing a benchmark of what is being done currently. Two survivors of MST were sent interview questions electronically, with one responding (See Appendix B for copy of interview questions).

Data Processing and Analysis

A nine-question survey designed in *Survey Monkey* was deployed on a female Navy E-7[1] and above Facebook page with 5,089 members, a California Women Veterans Facebook page with 1,425 members, and an MST survivor's Facebook page with 290 members. Fifty-two women responded to the survey. (See Appendix __ for a list of the survey questions asked in this study.) This first quarter of the four-part survey identified the current status of respondents and when they served. The second quarter determined if the respondents received services from stakeholder agencies TAP and VHA. The third part of the survey identified if the respondents

[1] E-7 is a senior grade non-commissioned officer.

are survivors of MST. Finally, respondents were given an opportunity to write a narrative about their DoD and VHA healthcare experiences. Of note, the MST survivor's page netted three respondents, suggesting a reluctance to respond by self-identified MST survivors. The two Facebook groups that did not have an MST affiliation found more than 50 percent of the respondents answering they are MST survivors.

Since this was a qualitative study relying on subject matter experts, interview data across the two stakeholder entities (DoD, TAP, VA) was compared and analyzed to identify similarities or themes. Questions were emailed to a Navy Sexual Assault Response Coordinator, and the coordinator of a DoD Transition Assistance Program (TAP) at a Navy base. A telephone interview was conducted with the Director of the VA's Center for Women Veterans (CWV).

Internal and External Validity and Limitations

The representative sample of a female active-duty and veteran population interviewed and surveyed helps to provide the internal validity for this study. The qualitative data gleaned from the subjects' narratives provided insight into the transition and experiences of active-duty female MST survivors from the DoD to the VA.

A similar study coupled with congressional testimony and scholarly literature reviews back-up the research with external validity. For example, similar narratives expressing distrust in the male-dominated cultures of the DoD and VA were found in other data sources. The number of participants was small, however this a large study by qualitative standards. A two-month time frame to complete the study restricted the amount of time to pursue and collect additional key informant interviews. This study and its data collection demonstrate internal reliability.

Dependent and Independent Variables

The dependent variable examined in this study was VHA treatment for female DoD MST survivors. The independent variable examined in this study was the proper transitioning system used to provide care for MST women separating from the DoD to the VHA care system. The study attempted to identify if female MST survivors are seamlessly connected to continued care through the transition from DoD to the VHA system.

Conclusion

This qualitative, mixed-methods study examined the personal experiences of MST survivors through their eyes. Data collected reflected these personal experiences and are considered fundamental elements to learn if there is disconnect between DoD and VHA medical support services for victims of MST. The research discovered more than half of those who could be eligible for permanent MST-related care from the VA are not receiving care from the nation's largest healthcare provider. Subject matter experts who are key to ensuring survivors receive VHA services revealed there could be a formalized hand-off between the DoD and VA which would create a continuum of care for wounded warrior survivors.

Chapter 4 - Results and Findings

Data Collection – General

This study used qualitative interview and survey methods to gather data on the experiences of female active-duty and veterans. Some of the respondents are survivors of military sexual trauma. A review of secondary quantitative and qualitative sources were also used in this multi-faceted compilation of data.

Qualitative Interview Data Results

In a structured, emailed interview with a survivor of military sexual assault, Survivor 1, who served as an officer in a military branch of the DoD, gave a candid glimpse at her sexual assault that occurred in the 1990s.

Q1. As a victim of military sexual assault, what type of support or services were provided to you by your branch of service?

It doesn't make me upset or angry, and I'm not at all P.C., but I prefer "survivor." **To answer your question, none.** In fact, the possibility of an accusation of adultery (my assailant and I were both married at the time, and had had consensual sex previously) was enough to put me off from reporting for more than a year. By that time, I had filed for divorce, and was in the individual ready reserves and no services were available — I used the Monterey Rape Crisis Center to get counseling and help. My assault wasn't vaginal, so pregnancy wasn't a concern, and there was a minimum of injury (both of which, ironically, made me less believable).

Q2. What, if anything, do you think should have been done by your branch of service to make your post-assault experiences more effective and better/more positive?

Acknowledging how bad it was would have been a good start. Coming up with a way to report and be removed from the person's chain of command pending an investigation would be

nice, too. But here's the thing — until we have prospective soldiers arrive at basic training with an understanding of (1) what sexual assault is, (2) how devastating and life-changing it can be and (3) that it has very little to do with sex — the military is going to continue to reflect the ignorance that's prevalent in society.

Q3. Upon leaving Active-Duty, how was your healthcare transitioned to the Veterans Health Administration (VHA)?

It wasn't. As near as I know, I don't qualify for any services.

Q4. Did the VHA initiate contact with you?

Not that I recall.

Q5. What would you like to add about your experience in the transition from active-duty military healthcare to the VHA?

The whole experience of leaving the military was very difficult to begin with. It's an abrupt transition, to say the least. One minute you have the ultimate steady job. You're surrounded by people with a common experience, purpose, language and culture and the next minute, you're on your own (I was RIF'd[2]) — the one thing the Army trains you NEVER to be. Even though all but one or two of my fellow soldiers never knew I'd been assaulted, the comfort and safety in numbers, the uniform, the physical training and the consistent structure were sufficient to make me feel safe and like I'd be OK most of the time. Once all of that was taken away, my world fell in. That's when I went to counseling. Medically, I got tested for HIV/AIDS through a non-profit because I didn't want any of that on my Army record. Truly, though, the

[2] RIF'd – Reduction in Force, another term for downsizing the organization

emotional and spiritual aftermath echoed for close to 10 years. I don't know if I'd have taken medical services if they'd been offered through the military (to include mental health services) because I'd have been suspicious at best of the intent. Statistically, not much has changed in terms of sexual assault on active duty, and that makes me beyond sad. No woman (or man) who signs the check up to and including their lives to their country should bear the additional burden of sexual assault. It's insane. If I'd have gotten punched in the face by a stranger in an officers' club, there'd have been an out-and-out brawl, almost regardless of how it happened. I'd have heard about what a coward the guy was to hit a woman, I'd have gotten immediate medical attention, no questions asked, and he'd have been under arrest. Instead, I was asked by CID to repeat my story several times; my character was called into question, and there's absolutely no way I would have gone to a military doctor under those circumstances. Even now a large number of women report their assaults only to be chapter-13'd [3]out of the military for general "unfitness." The worst thing about the whole experience wasn't the assault itself. It was the heartbreak of realizing my buddies didn't always have my back; there were exceptions for women whose "buddies" assaulted them. Finally, I would like to say, making sexual assault about sex is like making being assaulted with a bat about the evils of baseball. The choice of weapon has nothing to do with the fact it's an assault. Period. Full stop.

Qualitative Interview Findings

In addition to sexual assault, this survivor's experience illustrates the challenges she faced in *reporting* her sexual assault. The Army's law enforcement agency, the Criminal Investigation Command (CID), had her retell the details of her sexual assault over and over. She

[3] Discharged from service based on either unfitness or unsuitability

made the decision to not seek the care of a military doctor when her character was called into question by law enforcement. In addition to this survivor's recall of negative experiences, including skepticism by those in a position to help her, many survivors in primary and secondary datasets expressed "distrust" of the male-dominated DoD and VA institutions. This interviewee also emphasized her preferred terminology is *survivor*, not *victim*.

Survey Results and Findings

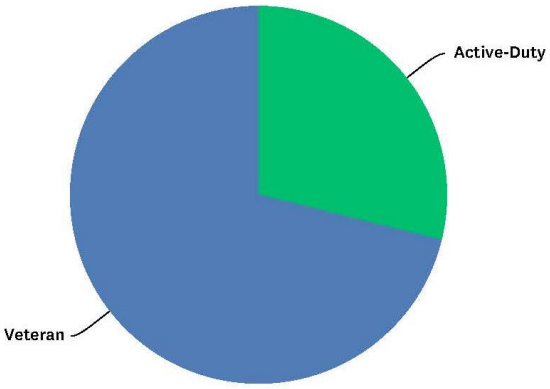
Collection – General

A nine-question survey designed in *Survey Monkey* was deployed on a female Navy E-7[4] and above Facebook page with 5,089 members, a California Women Veterans Facebook page with 1,425 members, and an MST survivor's Facebook page with 290 members. (See Appendix A for a list of the survey questions asked in this study.) This first quarter of the four-part survey identified the current status of respondents and when they served. The second quarter determined if the respondents received services from stakeholder agencies TAP and VHA. The third part of the survey identified if the respondents are survivors of MST. Finally, respondents were given an opportunity to write a narrative about their DoD and VHA healthcare experiences.

[4] E-7 is a senior grade non-commissioned officer.

Q1 Please indicate below whether you are on active-duty or a veteran member of the United States of America Armed Forces.

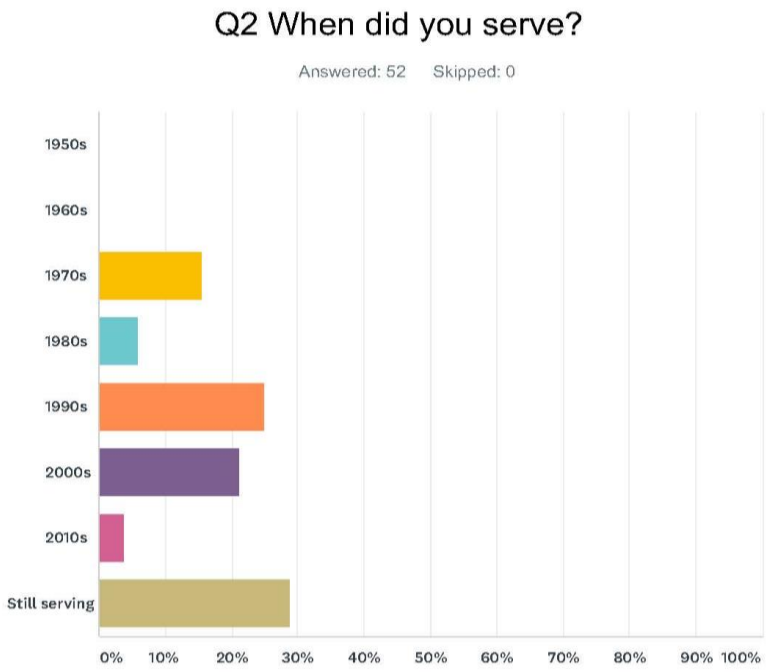
Answered: 52 Skipped: 0



ANSWER CHOICES	RESPONSES	
Active-Duty	28.85%	15
Veteran	71.15%	37
TOTAL		52

N = 52

The raw data for question number one shows that 71% of the respondents (37/52) are veterans. The 3 to 1 difference could be attributed to the fact that the California Women's Veterans page solely veterans, not active-duty members. The E7 and above and the MST Survivors' pages are a mix of active-duty and veterans.



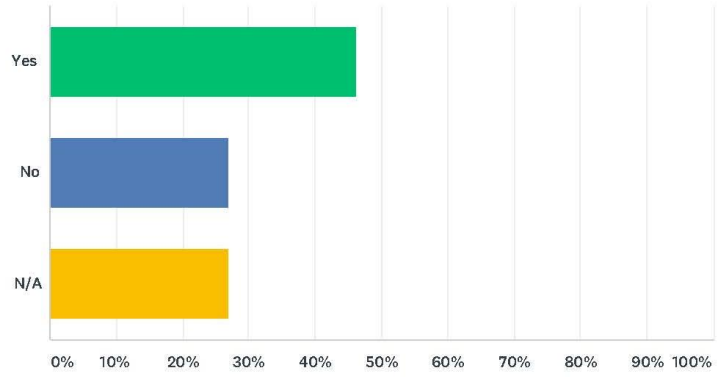
ANSWER CHOICES	RESPONSES	
1950s	0.00%	0
1960s	0.00%	0
1970s	15.38%	8
1980s	5.77%	3
1990s	25.00%	13
2000s	21.15%	11
2010s	3.85%	2
Still serving	28.85%	15
TOTAL		52

N=52.

The respondents served from the 1970s until present. The largest segment of respondents, almost 29% (15/52) are still on active duty and represents “real time” data regarding the answers provided for this study. These 15 servicemembers provided input on the services/supports/experiences they are encountering in the DoD. They would not have information about the VA . The next two time period respondents were from the 1990s 25% (13/52) and the 2000s, 21% (11/52). It would be inappopriate to speculate why these respondents were more inclined to respond versus service members from the 1980s (5.77%) or the 2010s (3.85%).

Q3 When (if) you left active-duty, did you attend a Transition Assistance Program (TAP) class?

Answered: 52 Skipped: 0



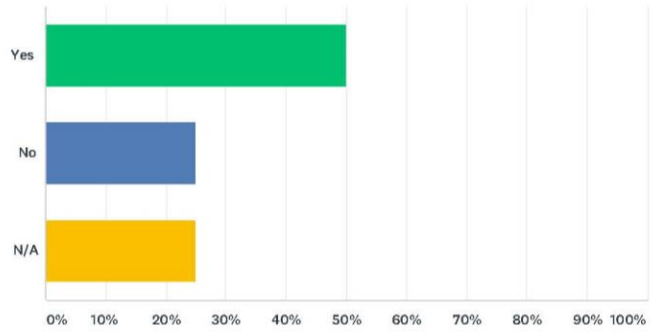
ANSWER CHOICES	RESPONSES	
Yes	46.15%	24
No	26.92%	14
N/A	26.92%	14
TOTAL		52

N = 52.

24 of the 37 respondents were *veterans* in Question 1. 24 attended TAP while 14 did not. TAP was established by Congress with the National Defense Authorization Act (NDAA) for fiscal year 1991 to ease the transition from active-duty to civilian. Congress later mandated the program in 2011 as a means for providing pre-separation counseling to active-duty service members. These responses could be explained in that the "yes" attendees served post-1991 while the "no" respondents left the military prior to the establishment of the program.

Q4 When (if) you left active-duty did you seek out the services of the Department of Veterans Affairs (VA), Veterans Health Administration (VHA)?

Answered: 52 Skipped: 0

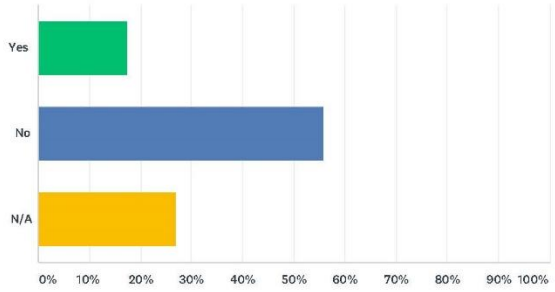


ANSWER CHOICES	RESPONSES	
Yes	50.00%	26
No	25.00%	13
N/A	25.00%	13
TOTAL		52

This response represents the number of veterans who used VHA care after they left the military. Half of the respondents said they sought the services of the VHA while one-quarter did not. The remaining quarter is not eligible for VHA services. This figure is notable when compared to question 7 that asks if MST survivors are using the VHA for services.

Q5 When (if) you left active-duty, did the VA or VHA reach out to you to offer services?

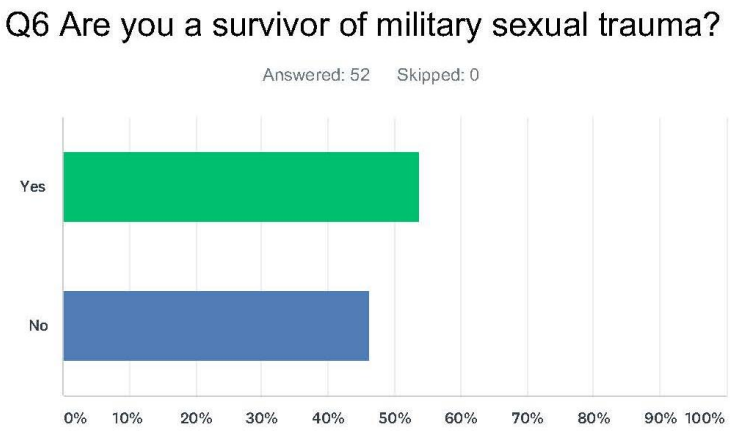
Answered: 52 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	17.31%	9
No	55.77%	29
N/A	26.92%	14
TOTAL		52

N = 52

Of those who left active-duty, nine said the VA reached out to them while 29 said the VA did not reach out to offer its services. Considering only 14 of the respondents did not attend TAP as noted in question 3, 29 "no" responses does not make sense because the VA would have had a presentation during TAP. This could mean the respondents either missed the VA's TAP presentation or were not paying attention to the presentation.

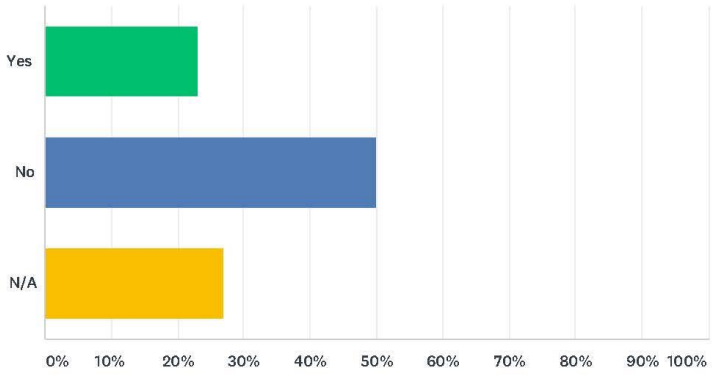


ANSWER CHOICES	RESPONSES	
Yes	53.85%	28
No	46.15%	24
TOTAL		52

N = 52. More than 50% of respondents said they were survivors of military sexual trauma. Considering the majority of respondents were not from Facebook pages devoted to MST survivors, the number of women who reported they were survivors is a notable statistic.

Q7 Are you currently using the VHA for MST care?

Answered: 52 Skipped: 0

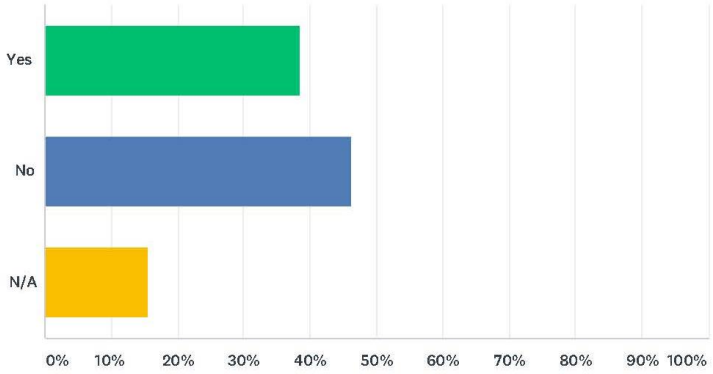


ANSWER CHOICES	RESPONSES	
Yes	23.08%	12
No	50.00%	26
N/A	26.92%	14
TOTAL		52

N = 52. Fifty percent who may be eligible for MST care from the VHA are not using the VHA for MST care. The narratives of the respondents, listed below, spell out a variety of reasons why survivors are not using VHA care including length of time to get an appointment, and an environment designed "by men, for men." In an interview with the Director of the Center for Women Veterans, Kayla Williams noted that some female veterans may not be using services because they are *thriving* and possibly using health insurance provided by their employers.

Q8 Do you know that you may be eligible for permanent Military Sexual Trauma-related services from the VHA?

Answered: 52 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	38.46%	20
No	46.15%	24
N/A	15.38%	8
TOTAL		52

N = 52

Nearly half the respondents do not know they may be eligible for permanent MST-related services from the VHA. With so many respondents unaware that they may be eligible for permanent MST-related services from the VHA this shows that an improved hand-off from the DoD to the VHA, and increased outreach to the exiting DoD population, could mean more women seek care from the VHA.

Narratives of Survey Respondents

Question # 9: What would you like to add about your healthcare experiences in the transition from active-duty military to the VA?

Response 1: Veteran who served in the 2000s - It took me 10 years to seek help, and then it was blindly, out of desperation, not because I knew what I was entitled to. If the VA had reached out to me effectively, I suspect I would be much further along in my healing process by now. And if I had never found them at all, I might have become a statistic. The VA healthcare has been really

helpful and important in getting me back on my feet. That said, it could also be so much better than it is. I really wish they would operate women's clinics, where traumatized female vets did not have to feel like they were running the gauntlet just to receive care. This could even be on the same location, utilizing the same staff, if they would just have a female-only wing, or a separate entrance and waiting room. The VA, just like the military, still very much feels like it is an organization created of and by and for men, and women are merely tolerated, and only as long as we don't expect any consideration for our needs.

Response 2: Veteran, served in the 2000s, MST survivor - The VA doesn't like telling veterans what services they're entitled to and even when they can identify you have PTSD from MST before you can, they don't volunteer that valuable information to you. You must do all the research yourself and then demand that they give you the care you need. They also try to minimize costs by not telling you that other conditions can be attributed to your PTSD, such as GI issues, anxiety, and dental problems or that you are entitled to do a claim.

Response 3: Active duty still serving - I told my pcm[5] that I survived sexual assault and that I didn't want to report, but I wanted to see a counselor out in town. They wouldn't let me because they said I needed to see mental health on base where everyone knows you are being treated. No privacy. So ultimately no help

Response 4: MST survivor, veteran 2000s - The wait times for VA services is VERY long. To get into the mental health system for counseling and medication, it took about 9 months.

Response 5: Active-duty - I will be transitioning within the next 30 days, I would prefer to continue the treatment I'm currently using.

[5] Primary (health) Care Manager

Response 6: Not an MST survivor - Not super impressed. Every time I go to the VA, I have to jump through hoops to get various updates to my record, name change, vet id, etc. That said, the quality of medical care I receive is on par with what I've received while on Active Duty (I'm currently a reservist who left AD after 10 years; 2006 to 2016 AD, 2016 to present Reserves)

Response 7: MST survivor who is not using the VA for services even though she knows she is eligible for permanent services - The VA didn't believe me because I didn't have police report number and didn't have a SAPR report. I even had a buddy statement who took me to the police and hospital to get a rape kit and still didn't believe me.

Response 8: Veteran who uses VHA not an MST survivor - There are vast differences in the level of care in different VA locales.

Response 9: Veteran, 90s, MST survivor does not know she is eligible for permanent services - I had a hysterectomy, including the removal of my cervix. The VA scheduled a Pap smear/ gyn checkup for me. The Gyno and I had a good laugh!!!

Response 10: Veteran, 90s, no MST - My healthcare experience with the VA was horrible. I waited a couple of years because I had private insurance. Then some friends told me to get established with them anyway. Made an appointment for a physical. A year later got notice from my private insurance that the VA charged them $600 for a physical!!! Six hundred dollars for a physical that would have been free at my primary care doctor's office. I won't go back ever unless I'm desperate.

Recurring themes in the narratives of the respondents included dissatisfaction and disappointment in the VHA system because of its skepticism and lengthy appointment times. An

active-duty respondent reported the health system at her military installation was of no help because she could not be ensured privacy.

Key Informant Interview Results and Findings

Key Informant One is a female Army veteran and the Director of the Veterans Administration's Center for Women Veterans (CWV), Kayla Williams. According to its website, the mission of the CWV is to "monitor and coordinate VA's administration of health care, benefits, services, and programs for women veterans and serve as an advocate for cultural transformation, both within VA and in the general public, in recognizing the service and contributions of women veterans; and raise awareness of the responsibility to treat women veterans with dignity and respect," (VA CWV, 2018).

1. In what ways does your organization connect with the female veteran population who exit the military?

Several ways the department tries to do this. All transition svc members go thru TA and that is one way we are involved in touching every service member. Right now, we are piloting an enhanced TAP for transitioning woman, an additional day that targets women. We will be able to take a deeper dive into care for women to ensure a warm transition and getting folks enrolled in VA as they are transitioning. We will take them to tour a local clinic during the class. We will be monitoring the success of the pilot very closely. During the pilot phase, we are going to assess whether or not women have the perception the VA is for their grandpas. We are working very hard to dispel that myth.

2. What is the transition procedure between the Department of Defense (DoD) to the VA in treatment and rehabilitation for the female veteran population?

Same as for males, no real difference. Nobody can make you use government healthcare. When we try to think about what success looks like for VA and driving up overall, utilization is not the only metric to look at. If folks are using civilian health care that is their choice. For me the issue is equity, we want to ensure women are using the VA in equal rates to men. Maybe the reason they are not coming to the VA and using its services is that they do not need us because they are thriving.

3. If your organization provides services for Military Sexual Trauma (MST) survivors, what types of services do you provide?

My office does not provide any. My office makes sure we are helping convey the message to MST survivors the broad array of resources the VA has available. Moreover, particularly to make sure those from prior generations are getting the message about how much progress VA has made. We want to find those women and telling them about how far VA has come and encourage them to seek care for MST if they have been silent. We want to increase their comfort level. We have an oversight role. When I came here quite a few years ago, we did some data analysis when veterans applied for PTSD disability compensation that was caused by MST. We found claims granted at lower rates for PTSD caused by MST versus PTSD from combat. As a result, the VA did some training, rewrote rules and procedures, and identified what markers they would consider as evidence for PTSD caused by MST, especially for those who did not file a report when the assault happened. Those efforts worked and now PTSD for MST is screened differently than for combat-related PTSD.

4. What kind of outreach do you use to connect with the female veteran population?

We have ramped up digital outreach. We try to publish one blog a week on a wide variety of topics. We want to encourage dialogue, not just push out information to women veterans. We are trying a couple of innovative ways to accomplish multiple goals. We know women veterans often feel invisible or unrecognized. We are trying to change that and in 2017, we launched a women veteran's art exhibit program. The VA collaborated with non-profits and displayed these art exhibits in other VA medical centers. We have resources available to help women to stay healthy and active throughout their lifecycle. We partner with local communities, encourage women veterans to connect with one another, and connect with us at VA to improve overall health outcomes. The VA is just not for your grandpa. There are all kinds of comprehensive support to provide women veterans here thru VA. We are also expanding a program that was started in Oregon. In celebration of March 2018 Women's History Month, we launched a virtual exhibit that shows VA Central Office employees who are women veterans. By spotlighting the many faces of this diverse and important segment of the Veteran community, I Am Not Invisible (IANI) aims to increase awareness and dialogue about women veterans, as well as open viewers' eyes to the myriad levels of expertise of veterans serving veterans as VA Central Office employees. We are not just faceless bureaucrats. We want women to see our pics and realize we are them. We care very passionately about serving them effectively with innovative and interesting ways to conduct as much outreach as possible.

5. What is the process to transition active-duty female survivors of MST to veteran status in the VHA?

There is no difference between males and females. All veterans are treated with the same dignity and respect.

6. How are health records shared between the DoD and VHA?

The electronic medical health record integration is going to be tricky because the information in the records is confidential. There are folks in the Guard and Reserves who go back and forth between active and reserve duty.

7. Is there anything you would like to add about the process of transitioning female survivors of MST from active-duty to veteran status?

All VA medical centers have an MST coordinator. One way we assess how we are doing is we have so-called secret shoppers who make cold calls to VA medical centers to see if they are connected to the right person. We conduct regular training and spots checks. On the benefits side of the house we have both males and females responding so that a survivor can talk to whatever gender they are must comfortable speaking to about sensitive issues. Our goal is to handle issues sensitively, and we will meet their needs whatever those are.

Director Williams's role as primary advisor to the VA Secretary on the Department's polices, programs, and legislation that affect women veterans is a responsibility that has far-reaching consequences for her fellow comrades in arms – other female veterans. It will take people like Williams to advocate for all veterans and ensure they are aware of, and if necessary, receiving care from the VA and its VHA.

While Williams is focused on the over-arching goals of the VA and its care for female veterans, including MST survivors, Key Informant Two is reacting at ground zero and is focused on victim care. As a Sexual Assault Response Coordinator (SARC) at a DoD military installation, Informant Two reinforces the reliability of this study by noting survivors should have a warm hand-off between the DoD and VA in order to ensure continued, uninterrupted

services. She also pointed out the importance of obtaining a formal report form from DoD that guarantees survivors will receive permanent services from the VHA for MST-related care,

1. In what ways does your organization connect with the female veteran population who exit the military?

When a survivor exits the military, they are reminded their DD 2910 (Restricted/Unrestricted) reporting form will assist them in getting continued services after they transition out. My program does not connect them any further than that. Fleet & Family Support Center does have a VA representative come in at the TAP class to discuss the services they provide.

2. What is the transition procedure between the Department of Defense (DoD) to the VA in treatment and rehabilitation for the female veteran population?

For the Sexual Assault Awareness and Response program, there is not transition except what is stated in number 1.

3. If your organization provides services for Military Sexual Trauma (MST) survivors, what types of services do you provide?

The services provided for Military Sexual Trauma survivors are the DoD SAPR Program. This program provides a SARC, SAPR Victim Advocate/Uniformed Victim Advocate, counseling services, Victim Legal Counsel (VLC), medical, Forensic exam, Chaplain, and if an unrestricted report is made; investigation by law enforcement/NCIS, military protective order, civilian protective order, and expedited transfer.

4. What kind of outreach do you use to connect with the female veteran population?

The SAPR program holds information booths, collaborates with other stakeholders on the installation as well as in the community, posters, and other resource information is posted around the installation, trainings, Sexual Assault Awareness Prevention Month (SAAPM) activities, and command events.

5. What is the process to transition active-duty female survivors of MST to veteran status in the VHA?

I am not aware of any transition process other than TAP class, and SARC/Advocates explaining to survivors that they need to advocate for themselves to receive continued assistance when they transition.

6. How are health records shared between the DoD and VHA?

Unsure.

7. Is there anything you'd like to add about the process of transitioning female survivors of MST from active-duty to veteran status?

It is crucial to the long-term care of MST survivors for there to be a warm-handoff between the current military team to the veteran team. A survivor should not lose services once they transition. It is important that the SAPR program and veteran programs work together to ensure a smooth transition; should the survivor wish to continue services. If a survivor's case is closed, it is important for the veteran assistance provider to have the survivor reach out to the SARC at their past duty station where the report was made to get their DD 2910 if necessary for services with the VA.

Key Informant Three is a clinician who schedules the Transition Assistance Program classes for a DoD entity.

1. In what ways does your organization connect with the female veteran population who exit the military?

Connections are made in several different ways, as some may be transitioning to civilian or require certain trainings. It is mandatory for all service members who are separating or retiring from military to take the TAP 5-day course. Depending on their circumstances and or any health issues determines how they will complete TAP as there is an option to take the course online but the completion is the same for all.

2. What is the transition procedure between the Department of Defense (DoD) to the VA in treatment and rehabilitation for the female veteran population?

What I have noticed is that all service members are treated equally. I complete their forms on DoD TAP before sending to the command and if the service member does not meet some of the requirements there is a handover to the VA and/or the Department of Labor which can both help the service member. As a counselor I would call the local VA where the service member would be living and make an appointment for them.

3. If your organization provides services for Military Sexual Trauma (MST) survivors, what types of services do you provide?

My office houses the Sexual assault Response Coordinator and she is continuously active helping victims and providing training to all units and commands. My office also had three non-medical counselors, a victim advocate, along with the family advocacy program.

4. What kind of outreach do you use to connect with the female veteran population?

I personally do not initiate contact aside from TAP, any optional tracks, or job searching, I have done marketing for all classes I hold and I have continuous communication with commands and other career counselors, however if I am aware of a situation with any service member that needs assistance I will provide the necessary referral for that individual, and/or let my director know of that particular situation.

5. What is the process to transition active-duty female survivors of MST to veteran status in the VHA?

TAP has a full 1 day briefing from a VA representative and there is a lot of information provided during this time, however what I have been told by some service members is that they have started the VA process before attending TAP and depending on reason for exiting their military service depends on the process of involvement with the VA at that time. The Transition process for military to Civilian has a required by law component so the process is the same for all service members who are transitioning.

6. How are health records shared between the DoD and VHA?

I am not sure

7. Is there anything you'd like to add about the process of transitioning female survivors of MST from active-duty to veteran status?

I feel there are many survivor of MST, however in my role unless they tell me about their situation, have questions, or they ask for help I am unaware of their situation and/or needs. With

that being said I can also state that my office has a lot of resources that can help victims and all who work there will do everything they can to help that individual.

Key Informant Two reinforced the importance of TAP as a transition point, but in her role is unaware who could be a survivor in her week-long TAP classes. She notes the VA does have a day-long presentation during the program, but notes it is more focused on the job-search elements of TAP in coordination with the Department of Labor.

Interview and Survey Data Significant Findings

An interview with a survivor of MST, survey results from female active-duty and veterans, and key informant interviews from entity subject matter experts revealed a consistent litany of institutional and individual attitudinal dysfunction in the DoD's response to violent sex crimes, and the subsequent VA support of survivors. A purposive sampling survey of female active-duty, veterans, and MST survivors showed an unexpected population of survivors. Considering the majority of survey respondents were **not** from Facebook pages devoted to MST survivors, the number of women who reported they were survivors, 37 of 52, is a notable statistic. A disconnect in continuity of care is illustrated by the fact the majority of survivors did not know they are potentially eligible for permanent, free MST-related VHA healthcare. Respondents who sought VHA care noted when they reported to the VHA it was difficult to receive appointments, services and information. The VA responded from the top rungs of its leadership that it is actively pursuing and attempting to appeal to the female veteran population with creative outreach programs. The survivor interview and one survey respondent reported skepticism by law enforcement of their sexual assaults. The MST interviewee recalled having to repeat the details of her sexual assault to skeptical law enforcement officers, while the survey respondent said the VA denied her MST services when she reported to a VA hospital with a

police report. The topic of the male-dominated DoD and VA institutions provided another aspect of survivors' negative beliefs and perceptions of the cultures. One survivor felt the institutions were created for men, and that women are merely tolerated. This belief was validated by secondary data cited in a qualitative study of women veterans with trauma histories who perceived the VHA's environment as "unwelcoming" where one felt she was "surrounded by men," (Experiences with VHA Care, Kehle-Forbes et al). Generally, the survey responses illustrated survivors' negative beliefs and perceptions about their treatment from initially reporting a crime to seeking care from the VHA. There were a few veterans who reported positive experiences and they were grateful for the care provided by the VHA.

Key informant interviews with DoD, VA and TAP subject matter experts show the three are operating independently to provide services, while acknowledging coordination between the three could improve continuity of care for survivors. The researcher's perception of the trio is they are committed to the issues of female survivors of MST and do whatever is in their power to help that niche population.

This study, while small in scope, is hoped to be massive in positive impact, serving as a prompt for further research on the experiences of female veterans, in particular, MST survivors. This study uncovered gaps in the transition of active-duty females with MST into the VHA system, and could be important in finding solutions to fill those gaps. The ultimate goal of this study is to strengthen the VHA's future, continued care of female veterans who are survivors of military sexual trauma.

Chapter 5 - Conclusion and Recommendations

This final chapter provides the conclusions and recommendations derived from this research study on the transition of female active-duty MST survivors from the DoD to the VA. Data was collected using interviews and survey questionnaires and combined with an extensive literature review of scholarly work and practitioner studies which helped form the findings, conclusions and recommendations for this research project.

CONCLUSION

The intended purpose of the recommendations is to provide recovering survivors who exit the military with managed and facilitated services and care. Strengthening the integration of electronic medical records and case management between the DoD and VA will align services and aid wounded warrior survivors in their recovery from the after-effects of sexual assault. Based on interviews, survey questionnaires and an extensive literature review of scholarly work and practitioner studies I arrived at the conclusion that sexual assault will never be totally eradicated from the ranks of the armed forces. However, ongoing prevention and awareness activities, and the adoption of bystander intervention as a method to change the culture, could help the DoD realize a downturn in sexual assaults within the ranks. Until that time, the DoD and VA must work together to close the tenuous gap in services experienced by many MST survivors.

The DoD's efforts to eliminate sexual assault from its ranks will continue to be a priority second only to the department's primary mission accomplishment of defending national interests. Despite a plethora of sexual assault prevention paraphernalia, an entire month dedicated to awareness and prevention, and positive command climates, the enemy called sexual assault will likely be ever-present within the ranks of the nation's warfighters. The fight to

protect troops from their shipmates and battle buddies will continue to be waged by DoD with defensive awareness and prevention strategies. One battle that can surely be won is that of continued victim care during the transition from DoD to VA. A cultural sea change is underway at the VA with more female veterans moving into leadership positions and effecting changes to the VA's procedures, brand, and image. The key to victory for sexual assault wounded warrior survivors is a seamless transition between agencies. The battle can be won with continued DoD prevention, awareness and intervention efforts; a structure that ensures a coordinated hand-off between agencies; an integrated electronic medical record system; and a united, comprehensive case management program.

POLICY RECOMMENDATIONS

Recommendation One

Methodical hand-off between DoD and VA

The hand-off from DoD to VA for survivors of MST should begin at every military installation's TAP. This initiative could begin within 90 days. The TAP coordinator at each military installation should schedule DoD SARCs and VA MSTs for presentations during TAP. This mandatory class is the appropriate venue for DoD SARCs and VA MST coordinators to integrate into the mandatory transition program. An in-person hand-off between sexual assault coordinators with the survivor present would not be practical based on where a survivor exits the military and wherever they return at the end of active-duty service, such as their home of record on file with the DoD. An electronic structure should be developed to track a survivor's whereabouts. To ensure clarity, continuity, and collaboration, the tracking structure should include a means of three-way dialogue between DoD's SARCs, VA's MST coordinators, and survivors.

The office of the DoD SAPRO should take the lead to develop a tracking system which includes policies and standard operating procedures to better integrate DoD SARCs, VA MST Coordinators and MST survivor.

Next steps recommended to implement this recommendation include:
By Oct. 1, 2018, DoD and VA establish working committee to draft MST survivor collaboration tracking system. Members of this committee should include DoD SAPRO, VA MST office, and survivors' advocacy groups.

By December 2018, the committee should submit to the Secretary of Defense and Secretary of Veterans Affairs a final draft on MST survivor collaboration tracking system for approval by the President of the United States.

A pilot test should be conducted for six months, January to June 2019, using the test system at the Balboa Medical Center in San Diego, Calif., a large fleet-concentration area with many exiting services members, to evaluate real-world and real-time support activities for MST survivors.

Based on the results of the pilot test, an additional larger test should be conducted at VA region Southwest for six months to better understand the results of the MST survivor collaboration tracking system prior to implementing world-wide. World-wide implementation should be based on the results of the two pilot tests and activated for year 2020.

Of note, the integration of the SARC into the TAP process is underway at the researcher's Navy installation as a result of this research.

Recommendation Two

Integrate DoDs Electronic Medical Records with VA

The integration of the DoD's electronic medical records into the VA's system would also help ensure collaboration, clarity and continuity as survivors transition from DoD into the care of the VA. The integration would only need to go one-way, from DoD to VA. While occasionally a veteran may return to active-duty, it would overall not be necessary for the DoD to have access to VA medical records. The senior information systems executives for the DoD and VA will convene by Oct. 1, 2018, to strategize how to integrate the DoD's electronic medical record system into the VA system. By May 1, 2019, big-data storage, or another integration solution will be implemented to ensure DoD electronic health records are transferred into the VA electronic health record system.

Recommendation Three

Create an Integrated Case Management Program

Build a case management program modeled after the Federal Recovery Coordination Program (FRCP) implemented in 2008 and designed for severely wounded and ill service members who enter the VA system from the DoD. Like the FRCP, this care coordination program would be under the administrative control of the VA and serve as the single point of contact for coordination of DoD and VA case management. This program would include an individual care plan with a system that guides and tracks patients over time through a comprehensive array of health services spanning all levels and intensity of care. Clinicians and case workers would be charged with guiding veterans through the bureaucracy and intricacies of the VA. The one-on-one guidance would be critical to the success of the treatments that could last a lifetime. Under the direction of the DoD VA secretaries, an FRCP specifically for MST survivors would be staffed and implemented by Jan. 1, 2019. Care coordinators and case

management specialists from both the DoD and VA would work together to create coordinated care plans for each MST survivor.

Recommendation Four

End Sexual Assault in the Military

If the DoD ends sexual assault in the military, and stops producing survivors, then the transition of MST survivors into the VA system is a moot point. Until that day, the Secretary of Defense should direct his SAPRO and service secretaries to continue to devise sexual assault awareness and prevention strategies. Part of the prevention strategy should include ways to show military members how to intervene.

By Feb. 1, 2019, DoD along with individual service secretaries establish a working committee to draft a way ahead to end sexual assault in the military. Members of this committee should include DoD SAPRO, and individual service SARCs.

Topics for further research

DoD's prosecution of serious crimes in the military should be examined. The Military Justice Improvement Act proposed by Senator Kirsten Gillibrand wants to take sole decision-making power over whether cases go to trial out of the hands of commanding officers. The Act proposes serious crimes should be performed by independent, trained, professional military prosecutors, not by a commanding officer that could have a bias. Uniquely military crimes within the chain of command, such as dereliction of duty or absence without leave, would remain under the jurisdiction of commanding officers.

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About the author: Melinda Larson is a veteran of the United States Navy who served for 27 years both on active-duty and in the Navy Reserves. She retired in 2009 from the Navy Reserves as a Senior Chief Mass Communications Specialist.

Appendix A

Questionnaire for female active-duty and veterans:

My name is Melinda Larson and I am currently completing my master's degree in public administration at Golden Gate University. I am inviting you to participate in a brief survey to obtain your personal perspectives on the transition of MST-related healthcare from the Department of Defense to the Department of Veterans Affairs. .

This survey should take you approximately 10-15 minutes to complete (and is being conducted via www.surveymonkey.com). You can start the survey now and complete it later; your response will be considered finished only when you press the "submit" button. Neither your name nor ID number is required to complete this survey. Your answers will be kept confidential and anonymous. The survey will only be used by me to complete my project. I will not publicly release your responses or other information about you. If you have questions or difficulty completing the survey, e-mail me at melindallarson@gmail.com My hope is that you complete the survey by June 2, 2018. Thank you in advance for participating and for helping complete my research study. Your participation and input is important.

1. Please indicate below whether you are on active-duty or a veteran member of the United States of America Armed Forces.

a. Active Duty

b. Veteran

2. When did you serve?

a. 1950s

b. 1960s

c. 1970s

d. 1980s

e. 1990s

f. 2000s

g. 2010s

h. Still serving

Appendix A Continued

3. When you left active-duty, did you attend a Transition Assistance Program (TAP) class?

a. Yes

b. No

c. N/A

4. When you left active-duty did you seek out the services of the Department of Veterans Affairs (VA), Veterans Health Administration (VHA)?

a. Yes

b. No

c. N/A

5. When you left active-duty, did the VA or VHA reach out to you to offer services?

a. Yes

b. No

c. N/A

6. Are you a survivor of military sexual trauma?

a. Yes (please go to question 7)

b. No (please go to question 9)

7. Are you currently using the VHA for MST care?

a. Yes

b. No

c. N/A

Appendix A Continued

8. Do you know that you may be eligible for permanent Military Sexual Trauma-related services from the VHA?

a. Yes

b. No

c. N/A

9. What would you like to add about your healthcare experiences in the transition from active-duty military to the VA?

Appendix B

Questions for survivor of MST

I am inviting you to participate in a brief interview on the experiences of female veterans who are survivors of military sexual trauma and the cross-over of care from the Department of Defense to Department of Veterans Affairs. My name is Melinda Larson and I am completing my master's degree in public administration at Golden Gate University. I'd like to get your personal perspectives on your transition to the Veterans Health Administration (VHA). This interview should take approximately 30 minutes to complete. Your answers will be kept confidential and anonymous and will be used by me only for the purpose of completing my degree. Your input is important. Thank you for participating and for helping complete my research study.

1. As a victim of military sexual assault, what type of support or services were provided to you by your branch of service?
2. What, if anything, do you think should have been done by your branch of service to make your post-assault experiences more effective and better/more positive?
3. Upon leaving Active-Duty, how was your healthcare transitioned to the Veterans Health Administration (VHA)?
4. Did the VHA initiate contact with you?
5. What would you like to add about your experience in the transition from active-duty military healthcare to the VHA?

Appendix C

Questions for provider agencies Department of Defense (DoD), Transition Assistance Program (TAP), Veterans Health Administration (VHA)

I am inviting you to participate in a brief interview on the experiences of female veterans who are survivors of military sexual trauma and the cross-over of care from the Department of Defense to Department of Veterans Affairs. My name is Melinda Larson and I am completing my master's degree in public administration at Golden Gate University. I'd like to get your personal perspectives on the Transition Assistance Program, Department of the Navy, Veterans Health Administration. This interview should take approximately 30 minutes to complete. Your answers will be kept confidential and anonymous and will be used by me only for the purpose of completing my degree. Your input is important. Thank you for participating and for helping complete my research study.

1. In what ways does your organization connect with the female veteran population who exit the military?
2. What is the transition procedure between the Department of Defense (DoD) to the VA in treatment and rehabilitation for the female veteran population?
3. If your organization provides services for Military Sexual Trauma (MST) survivors, what types of services do you provide?
4. What kind of outreach do you use to connect with the female veteran population?
5. What is the process to transition active-duty female survivors of MST to veteran status in the VHA?
6. How are health records shared between the DoD and VHA?
7. Is there anything you'd like to add about the process of transitioning female survivors of MST from active-duty to veteran status?