

**Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420**

**VHA DIRECTIVE 1115(1)
Transmittal Sheet
May 8, 2018**

MILITARY SEXUAL TRAUMA (MST) PROGRAM

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) directive establishes authority and policy for clinical care, monitoring, staff education, and outreach related to military sexual trauma (MST) counseling, care, and services at all Department of Veterans Affairs (VA) medical facilities and Community-Based Outpatient Clinics (CBOC).

2. SUMMARY OF MAJOR CHANGES:

a. Amendment dated December 1, 2021 contains the following changes:

(1) Updates VHA policy on MST to comply with provisions of the Deborah Sampson Act (title V of Public Law 116-315), including:

(a) The definition of sexual harassment for treatment eligibility purposes, by dropping the word “repeated”;

(b) The scope of duty periods where sexual assault or sexual harassment qualify as MST, to include any military duty period (Federal or State);

(c) The scope of care for which MST survivors with an Other than Honorable discharge are eligible, to include MST-related medical care as well as mental health care; and

(d) The scope of VA’s treatment authority, to include care for physical health conditions. VA has been providing this care as a matter of policy, but the Deborah Sampson Act safeguards this policy and facilitates the ability for VA medical providers to independently determine when their patient’s condition is MST-related, without any requirement to consult with a VA mental health professional.

(e) Replacing the term “Veteran” with “former Service member.”

(2) Updates VA medical facility Director responsibilities in paragraph 4.d.:

(a) Clarifies the scope of services that may be provided to former Service members eligible for MST-related care but ineligible to receive other VA health care;

(b) Adds a responsibility in relation to the Special Tx Authority Care secondary eligibility code and Restricted Med Benefits VHA Profile in the electronic health record (EHR); and

(c) Adds a responsibility under paragraph 4.d.(7)(c) regarding local alterations of the national MST Screening.

(3) Clarifies eligibility for community care referrals for services provided under the MST treatment authority (38 U.S.C. § 1720D), in paragraph 2.e.

(4) Amends the list of medical conditions that can be treated under the MST treatment authority, in Appendix A, paragraph 4.b.

(5) Updates language describing the requirement for sensitivity to gender issues in paragraphs 4.d.(4)(a) and 4.d.(4)(b).

(6) Updates language to be inclusive of both the Computerized Patient Record System (CPRS) and the Cerner EHR system in paragraphs 4.d.(2), 4.d.(6), and 4.d.(7).

b. This directive:

(1) Updates VHA policy on clinical care, monitoring, staff education, and outreach related to MST counseling, care, and services;

(2) Updates the responsibilities of the Veterans Integrated Service Network (VISN) Director, VISN-level MST Point of Contact, VA medical facility Director, and facility MST Coordinator;

(3) Describes updated eligibility for services, which now includes sexual trauma experiences that occurred during inactive duty training, and makes MST-related counseling services at Vet Centers available to Servicemembers without the need for a referral;

(4) Specifies that MST-related mental health care must always be organized in gender-inclusive or neutral ways; and

(5) Stipulates that each facility must have a designated MST Coordinator who is typically given at least .2 FTE of time specifically dedicated to the administrative responsibilities of the role, and that the MST Coordinator should be a licensed, credentialed clinician or otherwise have extensive knowledge of issues arising in the clinical care of MST survivors.

3. RELATED ISSUES: VHA Directive 1115.01, Military Sexual Trauma (MST) Mandatory Training and Reporting Requirements for VHA Mental Health and Primary Care Providers, dated April 14, 2017; VHA Handbook 1160.01, Uniform Mental Health Services VA Medical Centers and Clinics, dated September 11, 2008. See also 38 CFR 17.2000 and related VA Readjustment Counseling Service policies for MST-related counseling that is provided through VA Vet Centers.

4. RESPONSIBLE OFFICE: The Office of Mental Health and Suicide Prevention (11MHSP) is responsible for the contents of this directive. Questions may be referred to the VHA 11MHSP Mental Health and Suicide Prevention Action group at VHA11MHSPMentalHealthandSuicidePreventionAction@va.gov.

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5. RESCISSIONS: VHA Directive 2010-033, Military Sexual Trauma (MST) Programming, dated July 14, 2010, is rescinded.

6. RECERTIFICATION: This VHA directive is scheduled for recertification on or before the last working day of May 2023. The VHA directive will continue to serve as a national VHA policy until it is recertified or rescinded.

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NOTE: *All references herein to VA and VHA documents incorporate by reference subsequent VA and VHA documents on the same or similar subject matter.*

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MILITARY SEXUAL TRAUMA (MST) PROGRAM

1. PURPOSE

This Veterans Health Administration (VHA) directive provides policy for clinical care, monitoring, staff education, and outreach related to military sexual trauma (MST) counseling, care, and services at all Department of Veterans Affairs (VA) medical facilities and Community-Based Outpatient Clinics (CBOCs). **AUTHORITY:** 38 U.S.C. 1720D, 1720I, 7301(b).

2. BACKGROUND

a. The provisions of 38 U.S.C. § 1720D require VA to provide counseling, care and services to eligible former Service members to treat a condition, which in the judgment of a health care professional employed by VA, resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the former Service member of the Armed Forces was serving on duty, regardless of duty status or line of duty determination. Section 1720D defines sexual harassment as unsolicited verbal or physical contact of a sexual nature, which is threatening in character. VA uses the term “military sexual trauma” (MST) to refer to these experiences. In this directive, the term “MST-related care” refers to counseling, care, and services provided under the special treatment authority of section 1720D to treat conditions resulting from a former Service member’s experience of MST.

b. When used in this directive, the term “former Service members” refers exclusively to former members of the Armed Forces eligible to receive MST-related care under the special treatment authority of 38 U.S.C. § 1720D. **NOTE:** See *VHA Directive 1601A.02(2), Eligibility Determination, dated July 6, 2020*. Two cohorts are eligible: (1) Veterans, and (2) former members of the Armed Forces who meet the criteria described in 38 U.S.C. § 1720I(b).

(1) The requirements for Veteran status are given under 38 U.S.C. § 101(2); individuals must have:

(a) Served in the active military, naval, air or space service, which generally refers to full-time Federal active duty (other than active duty for training), or a period of active duty for training or inactive duty training where the individual incurred a service-connected disability; and

(b) Been discharged or released from the above service under conditions other than dishonorable.

(2) To be eligible under 38 U.S.C. § 1720I(b), individuals must meet all of the following requirements:

(a) Be a former member of the Armed Forces, including from the reserve components, who served on active military, naval, air or space service.

(b) Have been discharged or released from the above service under a condition that is not honorable but not a punitive discharge by court-martial or subject to a statutory bar to VA benefits under 38 U.S.C. § 5303 or other provisions of Federal law.

(c) Not be enrolled in the VA health care system under 38 U.S.C. § 1705.

(3) Former Service members discharged under a condition that is not honorable require a character of discharge adjudication by the Veterans Benefits Administration (VBA) to determine if a statutory bar applies but are eligible to receive MST-related care while this adjudication is pending if the other requirements under 38 U.S.C. § 1720I(b) are met.

(4) As noted, VA's treatment authority under 38 U.S.C. § 1720D is limited to former Service members who served on active military, naval, air or space service. This means a former National Guard/Reserve member who did not serve on Federal active duty and does not have a service-connected disability could have experienced MST during Guard or Reserves duty and yet not be eligible for MST-related care.

c. Section 1720D is a special treatment authority; former Service members who meet the requirements in paragraph 2.b.(1) or 2.b.(2) of this directive may receive MST-related care regardless of their eligibility for other VA services.

(1) Enrollment in the VA health care system is not required to receive MST-related care; eligibility requirements that apply only to enrollment do not apply to MST-related care. Former Service members are eligible with any length of active military, naval, air or space service (i.e., do not need to meet the minimum active duty service requirement set forth in 38 U.S.C. 5303A) and may receive MST-related care regardless of income level or priority group placement.

(2) Former Service members do not need to have a rated service-connected disability or file a claim for disability compensation to receive care for MST-related conditions. When service connection is used to meet the active military, naval, air or space service requirement (see paragraphs 2.b.(1)(a) and 2.b.(2)(a)), the service-connected disability need not be related to the former Service member's MST experience.

(3) Former Service members do not need to initiate MST-related care within a certain period of time following the MST experience or their discharge or release from active military, naval, air or space service.

d. Former Service members may receive care for any mental or physical health conditions determined by a VA provider to be a result of MST (in accordance with the guidelines in Appendix A). Both mental health and medical providers may make these determinations.

(1) Former Service members can receive any treatment services in the standard medical benefits package to treat an MST-related condition. Special treatment services outside of the standard medical benefits package (e.g., dental care, in vitro fertilization)

are not covered under the MST treatment authority and are available only if the former Service member meets the separate eligibility requirements for the service in question.

(2) A former Service member who is not enrolled in the VA health care system may only receive care for MST-related conditions (or care authorized by other special treatment authorities for which they are eligible). Care for non-MST-related conditions or other general health care services available to enrollees are not authorized.

(3) All MST-related care, including medications, is provided free of charge. Section 1720D does not impose any limitations on the duration of MST-related care.

(4) VA also provides MST-related care at VA Vet Centers in the form of counseling services. This care is available to any former Service member who meets eligibility requirements under 38 U.S.C. § 1720D (see paragraph 2.b.), regardless of eligibility for readjustment counseling under 38 U.S.C. § 1712A. Refer to 38 C.F.R. § 17.2000 and VHA Directive 1500(1), Readjustment Counseling Service, dated January 26, 2021, for information on the implementation of these services.

(5) In accordance with 38 U.S.C. §1720D(a)(3), VA may provide MST-related counseling through a contract with a community provider when, in the judgment of a VA mental health provider, it is clinically inadvisable to provide counseling in a VA facility, or when VA facilities are not capable of furnishing care economically because of geographical inaccessibility. MST-related care by a community provider is limited to treatment services described in paragraph 2.d.

e. Section 1720D(a)(2) authorizes VA, in consultation with the Department of Defense (DoD), to provide MST-related care to current members of the Armed Forces (including members of the National Guard and Reserves) without the need for a referral.

(1) Current Service members can receive MST-related counseling services from VA Vet Centers, regardless of duty status or eligibility for readjustment counseling under 38 U.S.C. § 1712A. This care is confidential and does not require a referral.

(2) At present, however, general VA policies implementing 38 U.S.C. § 8111 still apply to care at VA medical facilities (i.e., VA medical centers and outpatient clinics). Current Service members can receive care at VA medical facilities in emergency situations or upon referral by a military treatment facility through a sharing agreement or TRICARE arrangement. VA medical facility treatment records are shared with DoD.

f. All staff involved in the provision of MST-related care must receive appropriate training on MST-related issues.

g. VA seeks to ensure that former and current Service members are informed about MST-related care available through VHA. This type of outreach information should be made available and visibly posted in VA facilities, and should be accessible through other public information sources, such as VA websites.

3. POLICY

It is VHA policy to provide MST-related care free of charge; to ensure that all health care providers and other staff receive the training necessary to provide sensitive, appropriate, and high quality services to MST survivors; and to conduct regular outreach to inform former and current Service members about VA MST-related care for which they may be eligible.

4. RESPONSIBILITIES

a. **Office of Mental Health and Suicide Prevention (OMHSP)**. In coordination with other offices, as appropriate, OMHSP is responsible for overseeing VHA's national MST Support Team, which assists with:

(1) Establishing, maintaining, and communicating national policy regarding MST.

(2) Identifying and promoting best practices for MST-related care.

(3) Conducting national MST-specific monitoring.

(4) Expanding national MST-specific education and outreach efforts, revising and updating education and outreach information as needed, and otherwise ensuring that such efforts comply with the statutory requirements of section 1720D.

(5) Communicating directly with VISN-level MST Points of Contact, facility MST Coordinators, and VA staff to provide MST-specific consultation, training, and resources and also to collect information about the field's implementation of this policy.

b. **Veterans Integrated Service Network Director**. The Veterans Integrated Service Network (VISN) Director is responsible for ensuring:

(1) **Appointment of VISN-level MST Point of Contact (POC)**. Each VISN must have a designated VISN-level MST POC whose responsibilities are those described in subparagraph 4.c. The VISN-level MST POC needs to be a professional knowledgeable about mental health and informed about MST and treatment of its aftereffects. This is a collateral position, but the MST POC needs to be given adequate protected time (i.e., dedicated administrative time) to fulfill the responsibilities of the role. This protected time should be labor mapped as administrative time.

(2) **Access to Specialized Sexual Trauma-Related Residential Care**. VISNs and VA medical facilities should consider the full range of available options when considering referral for residential treatment and must ensure that former Service members have access to programs with expertise in MST and/or sexual trauma more generally that is appropriate to meet the former Service member's needs. In some cases, this may necessitate a referral to other VISNs or VA medical facilities. Note that virtually all of VHA's Mental Health Residential Rehabilitation Treatment Programs (MH RRTPs) can make available treatment to address mental health symptoms related to MST. However, some programs are explicitly identified as dedicated MST programs, as

having a specialized track focusing on MST, or as serving a significant number of former Service members who have experienced MST with services targeting their experiences of MST. In these programs, treatment is more comprehensively focused on treatment needs directly related to MST.

c. **VISN-level MST Point of Contact.** The VISN MST POC is responsible for:

(1) Monitoring and helping to ensure national and VISN-level policies related to MST are implemented at individual facilities and associated CBOCs within the VISN.

(2) Providing support, assistance, and opportunities for communication and networking to MST Coordinators within the VISN.

(3) Communicating with national, VISN, and facility-level leadership and other stakeholders.

d. **VA Medical Facility Director.** The VA medical facility Director is responsible for ensuring:

(1) **Appointment of an MST Coordinator.** Every facility must have a designated MST Coordinator. This may be a collateral position, in which case the MST Coordinator must be given protected time, typically at least .2 FTE, specifically dedicated to the responsibilities delineated in subparagraph 4.e. This protected time should be labor mapped as administrative time and is independent of any time the MST Coordinator spends providing clinical care to former Service members who experienced MST as part of their duties associated with other roles. Additional FTE/dedicated administrative time may be necessary based on factors, such as facility size and complexity, number of associated CBOCs, the size of the facility's catchment area, and the number of former Service members in the local patient population who have experienced MST. The MST Coordinator must also be provided with additional FTE/dedicated administrative time if a facility determines that all MST Clinical Reminder-initiated referrals for MST-related care will be sent to the MST Coordinator, as described in subparagraph 4.d.(2)(a). (See subparagraph 4.e. for a detailed discussion of the MST Coordinator's duties.) Given that part of the role of the MST Coordinator is to provide information and assistance to former Service members in accessing MST-related care at the facility and associated CBOCs, the MST Coordinator should be a licensed credentialed clinician or otherwise have extensive knowledge of issues arising in the clinical care of MST survivors, in order to handle these contacts appropriately.

(2) **Universal Screening.** All former Service members seen in VA medical facilities must be screened for experiences of MST.

(a) Screening must be done using the appropriate standardized mechanism for the electronic health record (EHR) in use at VA medical facility sites: MST Clinical Reminder for VA medical facilities using the Computerized Patient Record System (CPRS) or MST Screening Recommendation for VA medical facilities using the Cerner EHR (see subparagraph 4.d.(7)(a)). The MST Screening includes a referral question asking if the former Service member would like a referral for MST-related care, which

must be completed following a positive response to the MST screening questions. Facilities are to decide locally how to manage requests for care initiated by this referral question.

1. VA medical facilities using CPRS must determine which clinic, group, provider, or other staff, such as the MST Coordinator, will receive these requests and refer them for follow-up action. If a specific clinic (e.g., mental health clinic) is designated to receive all referrals initiated by the referral question, providers may need to initiate other referrals as well, as needed to address a former Service member's specific care needs (e.g., if MST-related medical care is required).

2. In the Cerner EHR, a referral template will be automatically generated and the Refer To location of that template will be pre-populated with "MH MST". VA medical facilities must determine who will be responsible (e.g., Behavioral Health staff, MST Coordinator) for triaging referrals to that location and redirecting to other services if appropriate.

(b) Screening is to be conducted in private clinical settings by VA clinical staff who are trained to screen sensitively for MST, respond to disclosures, and connect former Service members with appropriate care or referrals. National training resources are available on the VA intranet at vaww.mst.va.gov, but it is the facility's responsibility to ensure that staff who conduct MST screening have the training and skills to do so appropriately. Providers and/or clinical associates may screen for MST, as determined by local needs and consistent with their VA Scope of Practice. When screening is done by a clinical associate, the licensed credentialed provider associated with the visit should review the former Service member's response and initiate a follow-up discussion with the former Service member during the same visit. MST screenings are not to be conducted by administrative associates.

(3) Availability of Appropriate MST-related Care. All VA medical facilities must have appropriate physical and mental health care services available to treat conditions related to MST. Providers of both medical and mental health services must ensure that a former Service member's history of MST is considered in the provision of care and that treatment is adapted, as needed, to be sensitive to and able to address the former Service member's MST-related concerns. A former Service member's MST-related care is also to be coordinated with the delivery of other VA care the former Service member is receiving.

(a) Outpatient and inpatient mental health programming must be available to treat MST-related conditions such as post-traumatic stress disorder (PTSD), substance use, depression, and/or other issues, in a way that is sensitive to the unique ways MST influences the development and presentation of those conditions. Depending on local demand and resources, it can also be beneficial for facilities to offer additional targeted programming, such as groups open only to MST survivors or groups that address common MST-related difficulties (e.g., problems with intimacy, sexuality, or interpersonal relationships.).

(b) All VA medical facilities must provide outpatient care for MST-related mental health conditions on-site, and inpatient care for MST-related mental health conditions either on-site or through referral to other VA medical facilities. CBOCs must provide access to such care directly (on-site) or through use of clinical video teleconferencing (telemental health), referrals to VA medical facilities or other CBOCs, or referrals to nearby Vet Centers.

(c) Facilities must ensure that there are a sufficient number of clinicians available to adequately meet the demand for treatment for mental health conditions related to MST. Care must be provided in a timely fashion, consistent with the requirements of VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Points of Service.

(d) Evidence-based mental health care must be available to all former Service members diagnosed with mental health conditions related to MST.

(4) Sensitivity to Gender Issues. MST-related services must be provided in a gender-sensitive manner.

(a) MST-related mental health care must always be organized in gender-inclusive or neutral ways (e.g., facilities should not administratively house all specialty MST-related care in women's mental health or women's health clinics; parallel men's and women's MST clinics are acceptable, however.) Treatment environments should be sensitive to gender-related concerns (e.g., cisgender and transgender men, and gender diverse former Service members, should not need to meet with providers in a "women's clinic").

(b) Facilities must ensure they have appropriate services available to meet the treatment needs of all former Service members who experienced MST, regardless of sexual orientation or gender identity.

(c) Former Service members with a history of MST may express preferences regarding the gender of their providers and/or whether they receive treatment in single- or mixed gender environments or therapy groups.

1. Former Service members may derive clinical benefit from working successfully with providers of different genders. However, when clinically indicated, facilities must accommodate former Service members' preferences regarding the gender of their provider for MST-related treatment.

2. There are potential clinical benefits to both single-gender and mixed-gender therapy groups and mental health treatment environments. However, in some cases former Service members with a history of MST may not be best served in mixed-gender settings. For these former Service members, facilities must offer, when clinically indicated, options for single-gender MST-related mental health care, including but not limited to: single-gender group therapy; individual therapy; clinical video teleconferencing (telemental health); community care; or referral to a Vet Center.

(5) Business Operations Considerations. Copayments do not apply to the receipt of MST-related care; this includes outpatient treatment, inpatient treatment, residential

treatment, and medications. Neither former Service members nor their private health insurance plans should be billed for the cost of their MST-related care.

(a) Consistent with the guidance set forth in the Appendix, clinical responsibility lies with the provider of service, not the business office, to determine whether care furnished to an individual is/was related to an experience of MST and therefore authorized by section 1720D. The provider must properly document this clinical eligibility determination in the former Service member's electronic medical record (see paragraph 4.d.(7)).

(b) The copayment exemption applies to MST-related care provided to former Service members awaiting character of discharge adjudication; however, the former Service member may be billed for services received if adjudication eventually determines that a statutory bar to eligibility applies.

(6) Services for Former Service Members Not Eligible for Other VHA Services. Former Service members who are eligible for MST-related care under section 1720D but ineligible to receive other VA health care may receive only services to treat MST-related conditions. This includes services that are prerequisites to required MST-related care (e.g., a medical exam required prior to admission to an MH RRTP).

(a) Facilities must ensure that former Service members who are not eligible for other VA care are provided the opportunity to be screened for MST by a VA provider and, as needed, evaluated at no cost to determine whether they have any MST-related health conditions requiring treatment.

(b) Former Service members who screen positive for MST will have the secondary eligibility code Special Tx Authority Care (STAC) and the Restricted Med Benefits (RM) VHA Profile (VHAP) applied automatically to their health record (unless a more expansive core VHAP is already assigned). Facilities must ensure that former Service members with STAC or RM eligibility have access to the appropriate clinical services, regardless of whether their EHR primary eligibility or enrollment status indicate ineligibility for other VA health care.

(7) Documentation of MST Screening and Treatment. To ensure that national data on MST screening and MST-related care are accurate:

(a) All national patches necessary for functioning of the MST Screening must be installed in the EHR in use at VA medical facility sites (MST Clinical Reminder in CPRS and MST Screening Recommendation in the Cerner EHR). Former Service members who screen positive for MST will have an option activated to designate care as MST-related: either a checkbox on their encounter forms in CPRS or a selectable special treatment authority within the service connection module in the Cerner EHR.

(b) All episodes of MST-related care must be designated using the appropriate option (depending on the EHR in use). Documentation in associated treatment notes must be consistent with Revenue Utilization Review guidelines for documentation of all care provided for service-connected conditions or under VA's special treatment

authorities. At a minimum, the treatment note should document which treated conditions are MST-related and include a brief description of the treatment provided. Note that a former Service member's MST experiences do not necessarily need to be discussed during a visit for the care to be considered MST-related.

(c) VA medical facilities should not make local alterations to any national elements of the MST Screening. For example, VA medical facilities using CPRS should not alter the national Clinical Reminder dialog form or resultant health factors, nor utilize any localized replacement Reminder. Attaching a menu of referral order options to process requests for care initiated during screening in CPRS (see subparagraph 4.d.(2)(a)(1)) is the only permissible localization.

(8) **Education.** Staff must receive education and training about MST-related issues appropriate to their role with former Service members.

(a) Given VA's policy to conduct universal MST screening and the fact that former Service members who experienced MST may present with both mental and physical health comorbidities, it is important for clinical staff in all relevant service lines to be knowledgeable about MST. Pursuant to the statutory requirements of section 1720D(d), all primary care and mental health providers must complete the mandatory MST training requirement specified in VHA Directive 1115.01, Military Sexual Trauma (MST) Mandatory Training and Reporting Requirements for VHA Mental Health and Primary Care Providers. In general, all providers of clinical services must at a minimum be aware of the requirement to screen for MST, know how to screen sensitively (when appropriate to their role), and know how to make a referral when MST-related care is requested. They must also be knowledgeable about how a history of MST may affect their provision of care and know how to properly document MST-related treatment. Education should inform providers about the availability of ethics consultation to help resolve conflicts or concerns about values that may arise during the provision of MST-related care (e.g., related to limits on confidentiality of care for current Service members when medical records are shared with the Department of Defense; to the scope of services provided to former Service members eligible only for MST-related care; or to decision-making about whether referral for non-VA MST-related care in the community is warranted); available resources include the local facility Ethics Consultation Service and the National Ethics Consultation Service at the National Center for Ethics in Health Care.

(b) At a minimum, clerks, telephone operators, and other administrative frontline staff must be: familiar with the terms "military sexual trauma" and "MST"; readily able to direct individuals to the MST Coordinator when appropriate; and attentive to privacy concerns and the need for sensitivity when assisting former Service members. Depending on their role (e.g., assisting former Service members with eligibility issues), these and other non-clinical staff may also need to be aware of national, VISN, and facility policies specific to MST. National training resources to assist in local training efforts are available on the VA intranet at vaww.mst.va.gov.

(9) **Outreach.** Information regarding VA's services related to MST must be made available through appropriate public information services and must be visibly posted or displayed in appropriate places within the facility. This may be accomplished via posters, other physical media or an equivalent alternative (such as electronic messaging boards or public monitor displays). Facilities are strongly encouraged to ensure the MST Coordinator has a non-shared telephone extension and voicemail in order to facilitate privacy when communicating with former Service members.

e. **Facility MST Coordinator.** The facility MST Coordinator is responsible for:

(1) **Supporting the implementation of national and VISN-level policies related to MST-related care at the facility and associated CBOCs.** The MST Coordinator is the primary designee of the facility Director for monitoring and coordinating implementation of MST-related administrative responsibilities described in subparagraph 4.d.(2) through 4.d.(9). The MST Coordinator monitors systems and processes within the facility to ensure that MST-related policies are implemented properly. The MST Coordinator also ensures processes are in place to allow for effective implementation of policies, such as protocols to address the administrative complexities associated with former Service members who are only eligible for MST-related care. When the MST Coordinator becomes aware of an issue pertaining to MST-related services at the facility, he or she explores the matter in question, works with relevant staff/offices to help facilitate corrective action, and as appropriate, offers recommendations to leadership for further action, as needed.

(2) **Serving as a point person and source of information for MST-related care issues at the facility and associated CBOCs.** The facility MST Coordinator is a point person for former Service members and staff to contact when they need assistance with an MST-related care issue. In this capacity, MST Coordinators address systems issues that may create barriers to former Service members entering care and act as an advocate for former Service members in their interactions with relevant VHA clinics and offices. As the local subject matter expert on MST, the MST Coordinator offers consultation to providers and other staff on MST-related clinical and policy issues, as needed/requested.

(3) **Directing and providing staff education to improve MST-related care.** The MST Coordinator directly provides or ensures other mechanisms are in place to provide education to improve staff members' awareness of MST and knowledge and skill in working with MST survivors. This may include, for example, education on clinical topics for mental health providers, or education on policy or sensitivity issues for administrative staff. This is in addition to corrective instruction to solve identified implementation problems.

(4) **Directing and engaging in outreach activities within the facility and with community allies.** The MST Coordinator plans, directs, and conducts outreach within the facility, with nearby Vet Centers, and in partnership with community stakeholders. This may include, for example, high-visibility local events (e.g., an event in honor of Sexual Assault Awareness Month), or ensuring representation at community institutions

and events (e.g., community organizations that serve former Service members, local colleges and universities, military bases, Stand Downs).

(5) **Developing facility-wide partnerships.** Developing a network of relationships with other key staff at the facility not only facilitates problem-solving about systems issues but also allows for collaboration on education and outreach efforts, consultation about how MST-specific issues might intersect with clinical or administrative situations, and partnerships to address common concerns. Because of this, it is important that MST Coordinators have strong working relationships or otherwise ensure mechanisms are in place for regular consultation and collaboration with Coordinators and Program Managers of other special programs (e.g., Suicide Prevention Coordinator; Transition Care Management Team Program Manager; Women Veterans Program Manager; Homelessness Programs Coordinator) and clinical directors in Mental Health, Primary Care, and other relevant clinical areas. Consultation and collaboration with administrative offices, such as the facility Information Resource Management Service, the Business Office (or other offices dealing with enrollment, eligibility, and billing issues), and the facility Public Affairs Officer, are also key. The MST Coordinator may also participate as appropriate in standing facility committees, such as mental health leadership councils or Veteran consumer councils.

(6) **Communicating with national, VISN, facility-level leadership, and other stakeholders.** The MST Coordinator is to remain informed about policies and trends related to MST via participation in MST-specific email lists, conference calls, and other information dissemination networks. The MST Coordinator also communicates regularly with the VISN-level POC and other MST Coordinators in the VISN in order to engage in local knowledge-sharing and collaboration. While respecting the appropriate chain of command, MST Coordinators communicate with local leadership and ensure that they are aware of the current status of MST services and initiatives at the facility. Also, in appropriate coordination with the facility Public Affairs Office, MST Coordinators establish collaborative partnerships with key federal allies, such as local Department of Defense Sexual Assault Response Coordinators, Veterans Benefits Administration, and community stakeholders.

5. REFERENCES

- a. P.L. 116-315.
- b. 38 U.S.C. 1703; 1712A; 1720D; 1720I(b); 5303; 5303A; 7301(b); 8111.
- c. 38 CFR 17.2000.
- d. VHA Directive 1115.01, Military Sexual Trauma (MST) Mandatory Training and Reporting Requirements for VHA Mental Health and Primary Care Providers, dated April 14, 2017.
- e. VHA Directive 1601A.02(2), Eligibility Determination, dated July 6, 2020.

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f. VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics, dated September 11, 2008.

**GUIDANCE FOR DETERMINING WHETHER A FORMER SERVICE MEMBER'S
HEALTH CONDITION IS RELATED TO MILITARY SEXUAL TRAUMA**

1. Section 1720D of Title 38 U.S.C. requires that a VA health care professional determine whether a former Service member's health condition is a result of military sexual trauma (MST), such that care for the condition is provided free-of-charge. These determinations are based on the provider's clinical judgment in view of the facts of each individual case; definitive evidence of causation or association is not required. Both VA mental health and medical providers may make these clinical determinations.

2. For eligibility purposes, a condition is a result of MST if it was directly caused by the MST or if the condition is a direct consequence of chronic traumatic stress resulting from the MST. To assist with these determinations, the Under Secretary for Health, through the Office of Mental Health Services and Suicide Prevention, has developed guidelines to identify conditions or clinical sequelae (whether physical or mental health in nature) that are generally recognized to have resulted from, or be related to, MST. As a result, treatment for these conditions is deemed as a matter of policy to be included within the scope of the treatment authority in 38 U.S.C. § 1720D.

3. A wide range of both mental and physical health problems and conditions are associated with MST. However, a problem or condition may be MST-related for a particular patient even if not associated with MST in general. As alluded to above, providers must consider each patient's individual circumstances in making this determination. In many cases, basic logic and the provider's normal assessment and clinical judgment will together readily identify any link between a condition and the patient's self-reported experience of MST. For example, symptoms or conditions that are consistent with a patient's description of their MST experience (e.g., when a sexual assault involved being kicked in the knee and other physical assault: subsequent knee pain) or that are foreseeable outcomes or behavioral changes after such an experience (in the same example: weakened or damaged knee, hip, or other musculoskeletal structures due to direct damage or compensatory efforts; depression related to pain or limitations in physical functioning; distressing nightmares; generalized anxiety) are likely MST-related.

4. In general, scientific research has found the broad classes of conditions, syndromes, and clinical signs and symptoms listed below to be frequently associated with, or the result of, an experience of MST. This information should inform providers' decision-making, but as noted, providers must still consider the clinical facts of each case individually to determine whether that patient's condition is related to MST.

a. Physical injuries and conditions consistent with a sexual assault (e.g., contusions, bone fractures, joint dislocations, pelvic or rectal pain, sexually transmitted diseases); this includes both acute injuries and their long-term chronic sequelae. Pre-existing injuries and conditions exacerbated by a sexual assault are also included.

b. Medical conditions caused or exacerbated by physiological reactions to traumatic stress (e.g., headaches or chronic neurological or musculoskeletal pain; gastrointestinal problems such as irritable bowel syndrome; sexual dysfunction; sleep disorders).

c. Medical conditions caused or exacerbated by a patient's behavioral reactions to or attempts to cope with traumatic stress (e.g., conditions associated with drug or alcohol abuse, such as liver disease; conditions associated with nicotine use, such as chronic obstructive pulmonary disease or cardiovascular disorders; conditions associated with disordered eating behaviors, such as obesity or severe weight loss; conditions associated with risky sexual behavior, such as AIDS).

d. Mental health conditions and symptoms. Given the broad variety of ways psychopathology may be triggered following an experience of traumatic stress, this includes not just explicitly trauma-linked conditions (e.g., posttraumatic stress disorder) but also mood disorders, anxiety disorders, psychotic disorders, substance use disorders, eating disorders, or others.

Given the wide range of potential trauma-related reactions and consequences, these guidelines should not be considered exhaustive or limiting. Conditions that, in the clinical judgment of the provider, do not fall within the scope of these guidelines may still have resulted from or be related to MST. Although not required, referral or consultation with a VA mental health professional with particular expertise in MST can be beneficial when determining whether a condition outside the scope of these guidelines is a result of MST.