

# **EPEC for Veterans**

Education in **P**alliative and **E**nd-of-life Care for Veterans

## **Trainer's Guide**

### **Module 8**

## **Psychosocial Issues in Veterans**

**Emanuel LL, Hauser JM, Bailey FA, Ferris FD, von Gunten CF, Von Roenn J, eds. EPEC for Veterans: Education in Palliative and End-of-life Care for Veterans. Chicago, IL, and Washington, DC, 2012.**

EPEC® was created with the support of the American Medical Association and the Robert Wood Johnson Foundation. Subsequent funding has been provided by the National Cancer Institute and the Lance Armstrong Foundation. The EPEC for Veterans Curriculum is produced by EPEC and the EPEC for Veterans Work Group through funding provided by the US Department of Veteran Affairs. Acknowledgment and appreciation are also extended to Northwestern University's Feinberg School of Medicine, which houses EPEC.

Special thanks to the EPEC for Veterans team and all other contributors and reviewers.

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## Module 8 trainer's notes

### Principal message

Psychosocial issues such as Posttraumatic Stress Disorder, military sexual trauma, substance use and homelessness may cause problems throughout the lives of Veterans, may also become more severe near the end of life, potentially complicating palliative care. Sensitivity to the unique experiences of Veterans allows all clinicians to improve care and reduce suffering.

### Module overview

This module addresses some key psychosocial issues that are important to consider in the care of Veterans. The four issues discussed in this module are: Posttraumatic Stress Disorder, Substance use disorder, military sexual trauma and homelessness. These issues are not unique to Veterans, although they may be more common in certain Veteran populations. For example, while Posttraumatic Stress Disorder (PTSD) is recognized as a common condition among combat Veterans, not all combat Veterans have PTSD and non-Veterans may have PTSD related to nonmilitary related trauma. However, VHA has expertise in the recognition and management of these conditions and has often developed programs to address the specific needs of Veterans.

### Preparing for a presentation

#### 1. Assess the needs of your audience

Choose from the material provided in the syllabus according to the needs of your expected participants. It is better for participants to come away with a few new pieces of information, well learned, than to come away with a deluge of information, but remembering nothing. In this module with four specific topics, make sure your budget time appropriately for your audience. A presenter will usually do only one topic in a 45 minute session.

#### 2. Presentation timing

Allow sufficient time to collect participants' demographic data and complete the pre-test.

The suggested timing for each part of this module is:

Introduction	2-3 minutes
Presentation	40 minutes
<u>Summary</u>	<u>2-3 minutes</u>
Total	44-46 minutes

### **3. Number of slides: 44**

### **4. Preparing your presentation**

The text in the syllabus was not designed to be used as a prepared speech. Instead, the slides have been designed to trigger your presentation. Although the slides closely follow the text of the syllabus, they do not contain all of the content. Their use presumes that you have mastered the content. You may want to make notes on the slide summary pages to help you prepare your talk in more detail and provide you with notes to follow during your presentation. You may choose not to use all of the slides. By giving a handout, you can refer participants to it for the information you choose not to cover. Since there are few major issues (PTSD, substance use disorder, military sexual trauma, and homelessness), choose which you want to focus on.

Practice your presentation using the slides you have chosen, and speaking to yourself in the kind of language you expect to use, until it is smooth and interesting and takes the right amount of time.

### **5. Preparing a handout for participants**

The syllabus text and slides in the **Trainer's Guide** were designed to be reproduced and provided to participants as a handout, either in its entirety, or module by module. If the entire curriculum is not being offered, please include the following in each handout:

- **EPEC for Veterans Front Cover Page**
- **EPEC for Veterans Acknowledgment Pages** (to acknowledge the source of the material)
- Syllabus and slides for **Module 8**

### **6. Equipment needs**

- computer with DVD capability or separate DVD player
- flipchart and markers for recording discussion points

## **Making the presentation**

### **1. Introduce yourself**

If you have not already done so, introduce yourself. Include your name, title, and the organization(s) you work for. Briefly describe your clinical experience related to the information you will be presenting.

## **2. Introduce the topic**

Show the title slide for the module. Tell participants the format and time you will take to present the session. Identify any teaching styles other than lecture that you intend to use.

## **3. Review the session objectives**

Show the slide with the session objectives listed. Read each objective and indicate those that you are planning to emphasize.

## **4. Show the trigger video or present the clinical case**

After reviewing the objectives for the session, show the trigger video or present the clinical case below. It has been designed to engage the audience and provide an appropriate clinical context for the session. It was not designed to demonstrate an ideal interaction, but to ‘trigger’ discussion.

### **Clinical case**

There are two trigger videos for this module.

For PTSD, the trigger video consists of two cases of Veterans who have struggled with PTSD.

1. Mr. Nichols, a WWII Veteran, with prostate cancer. He discusses his experience with prostate cancer and with PTSD.
2. Mrs. Alston, the wife of Sam Alston, a Vietnam Veteran who died from hepatitis and cirrhosis. She discusses his struggles with PTSD during his illness.

For homelessness, the experiences of several recently homeless Veterans are profiled.

### **Discussion**

If the discussion is slow to start, you may want to ask more direct questions, like:

- Have they had similar patients?
- What was unstable about the Veterans’ experiences in the videos?
- What are the implications for palliative care?

### **Setting limits to discussion time**

Limit discussion of each scene of the trigger video to no more than 5 minutes, then move on to the presentation. To help move on if the discussion is very engaged, try saying something like:

- Let’s hear two last points before we move on.

- Now that you have raised many of the tough questions, let's see how many practical answers we can find.

## **5. Present the material**

### **Recommended style: Interactive lecture**

An interactive lecture will permit you to engage your audience, yet cover the material within 45 to 60 minutes. You may want to use case experiences of your own as examples. You may want to ask participants for comments and examples during the presentation. However, be careful that they don't get derailed in such a way as to prevent you from covering the material you want.

## **6. Key take-home points**

1. Posttraumatic Stress Disorder (PTSD) is more common in Veterans than the general population.
2. Manifestations of PTSD include hyper-vigilance, intense flashback and avoidance of reminders of the trauma.
3. PTSD is associated with multiple other psychological problems including substance use disorder and depression.
4. The Primary Care PTSD Screen is a 4-item tool used throughout VA to screen for PTSD.
5. At the end of life, some of the triggers for PTSD can return.
6. Military sexual trauma (MST) includes both sexual harassment and sexual assault.
7. Although it is more common in female Veterans, there are male Veterans who have been the victim of MST.
8. Being a victim of MST is associated with multiple physical and mental health disorders including PTSD, depression and substance use disorder.
9. Invasive medical procedures or personal care may trigger memories of MST.
10. Veterans are slightly more likely than the general population to suffer from substance use disorder.
11. Palliative care teams should work with VA mental services when substance use disorder is identified.
12. Veterans who suffer from substance use disorder should still be given opioids for pain. They may require higher doses and closer monitoring but they should still receive pain relief.
13. Almost one quarter of the total homeless population in the U.S. is Veterans.

14. There are multiple programs at VA for homeless Veterans that can assist in housing options.
15. There are Homeless Veteran Program Coordinators at each VA facility that can help Veterans access services.

## **7. Summarize the discussion**

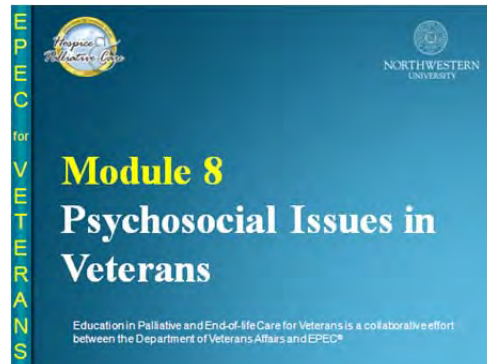
Briefly review each part of the presentation. Recap 2 or 3 of the most important points that were discussed.

## **8. Post-test/evaluation**

Ask the participants to evaluate the session.

## Abstract

Slide 1



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Slide 2



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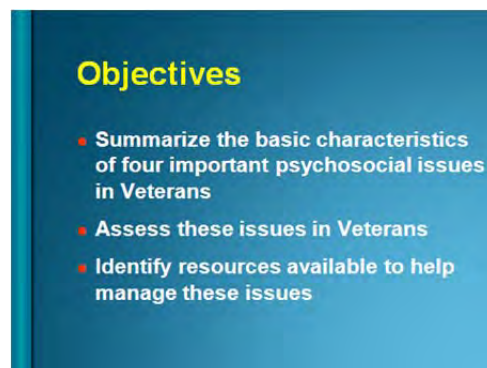
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This module addresses four key psychosocial issues that are important to consider in the care of Veterans in palliative care: Posttraumatic Stress Disorder (PTSD), Military Sexual Trauma, Substance Use Disorder and Homelessness. These issues are not unique to Veterans, although they may be more common in certain populations of Veterans. For example, while PTSD is recognized as a common condition among combat Veterans, not all combat Veterans have PTSD and non-Veterans may have PTSD related to nonmilitary related trauma. However, VHA has expertise in the recognition and management of these conditions and has often developed programs to address the specific needs of Veterans.

## Objectives

Slide 3



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After studying this module, clinicians will be able to:

- summarize the basic characteristics of four important psychosocial issues in Veterans;
- assess these issues in Veterans; and
- identify resources available to help manage these issues.

## Clinical case

Slide 4



There are two trigger videos for this module.

1. For PTSD, the trigger video portrays two Veterans who struggled with PTSD.
  - a. Mr. Nichols, a WWII Veteran with prostate cancer. He and his son discuss his experience with prostate cancer and with PTSD.
  - b. Mrs. Alston, the wife of Sam Alston, a Vietnam Veteran who died from hepatitis and cirrhosis. She discusses his struggles with PTSD during his illness.
2. For homelessness, the experiences of several recently homeless Veterans are profiled.

## Introduction

Although posttraumatic stress disorder (PTSD), military sexual trauma (MST), substance use disorder and homelessness may cause problems throughout the lives of Veterans, they can become more severe near the end of life and can complicate palliative care. Sensitivity to the unique experiences of Veterans will allow all clinicians to improve care and reduce suffering.

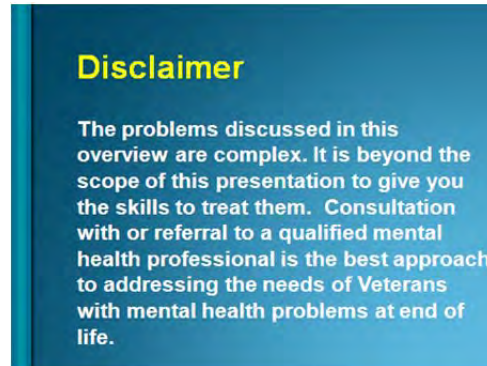
While all of these subjects deserve more attention than a single module can provide, the purpose of this module is to raise clinician awareness and provide sufficient resources for further exploration and continued education and skill-building. Consultation with or referral to a qualified mental health professional is the best approach to addressing the needs of Veterans with mental health conditions near the end of life.

The EPEC for Veterans Project appreciates the work of colleagues on the Military History Toolkit. Some of the slides in this module are adapted from the Military History

Toolkit. For a complete description of the Military History Toolkit and its contents see the “Read Me: How to Use the Military History Checklist, Guide and Toolkit” on the Talent Management System (TMS) and on the National Hospice and Palliative Care Organization website ([www.nhpco.org](http://www.nhpco.org)) through the *We Honor Veterans* campaign.

## Disclaimer

Slide 5



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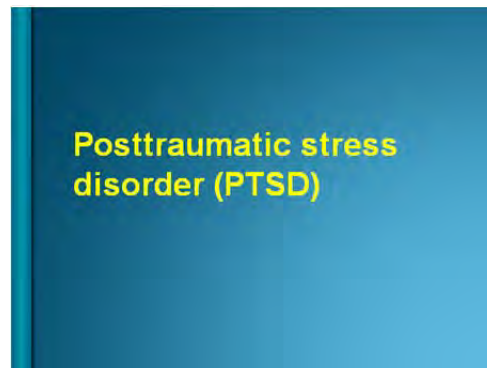
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The problems discussed in this module are complex. It is beyond the scope of this material to give you the tools to treat them. Consultation with or referral to a qualified mental health professional is the best approach to addressing the needs of Veterans with mental health problems at the end of life.

## Posttraumatic stress disorder

Slide 6



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## Definition

Slide 7

**What is PTSD?**

- An anxiety disorder that can occur after a traumatic event
- Examples of traumatic events include:
  - combat or military exposure
  - child sexual or physical abuse
  - sexual or physical assault
  - serious accidents, such as a car wreck
  - natural disasters

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Posttraumatic Stress Disorder (PTSD) is an anxiety disorder that can occur after an individual has experienced a traumatic event, such as the violence of war or a horrific accident. While combat exposure is often the trauma that leads to PTSD in Veterans, there are other types of trauma that Veterans and non-Veterans may experience including sexual trauma and natural disasters. To meet DSM-IV-TR criteria for PTSD, the individual must have experienced, witnessed, or been confronted with an event involving actual or threatened death or serious injury, or a threat to the physical integrity of the individual or others. Additionally, the individual's response to the traumatic event must involve intense fear, helplessness or horror.

Diagnostic features of PTSD fall into three categories: 1) intrusive recollections of the trauma, 2) avoidant behaviors and numbing of general responsiveness, and 3) hyperarousal. The duration of symptoms must be at least 4 weeks, and onset of symptoms can occur quickly after the trauma or be delayed for 6 months or more.<sup>1</sup> These symptoms often disrupt life, making it hard to continue with daily activities. Anyone who has gone through a life-threatening or horrific event can develop PTSD.<sup>2</sup>

## Prevalence

Slide 8

**PTSD prevalence**

- About 30% of men and women who spent time in war zones experience it
- An additional 20 to 25% experience symptoms sometime in their lives
- More than half of all male Vietnam Veterans and almost half of all female Vietnam Veterans have experienced "clinically serious stress reaction symptoms"

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War-related PTSD has been around for a long time, although it has been called by different names such as "Soldier's Heart" in the Civil War era or "Shell Shock" in the World War I and II eras.

PTSD became recognized as distinct psychological syndrome after the Vietnam War. It was more fully characterized and was included in the Diagnostic and Statistical Manual (DSM) Handbook, Third Edition, in 1980. As a consequence, many Veterans may have had symptoms of PTSD that resulted from traumatic events that occurred in WWII and other conflicts that have never been diagnosed. Older Veterans, in particular WWII and Korean War Veterans, tend to be quite stoic and humble about their wartime experiences. Many appear to have coped with their trauma by busying themselves in work and family life. For some, a re-emergence of PTSD symptoms can be experienced on retirement when they have more time to reflect on the past. PTSD symptoms can also re-emerge or become more intense at the end of life. Life review may lead some Veterans and their families to better understand the impact that undiagnosed PTSD has had on the Veteran's life and relationships. For other Veterans, life review may serve as a trigger for their trauma and worsen their PTSD symptoms.<sup>3</sup>

The impact of PTSD on Veterans' health is an area of ongoing study.<sup>4</sup> Currently, the military routinely evaluates service personnel's mental health related to traumatic incidents during service.

Although the exact numbers of Veterans who have PTSD is difficult to determine the impact of these issues on the Veterans as a group can be observed in studies such as the National Vietnam Veteran Readjustment Survey (1990) which reported a number of consequences of trauma, including the following:<sup>5,6</sup>

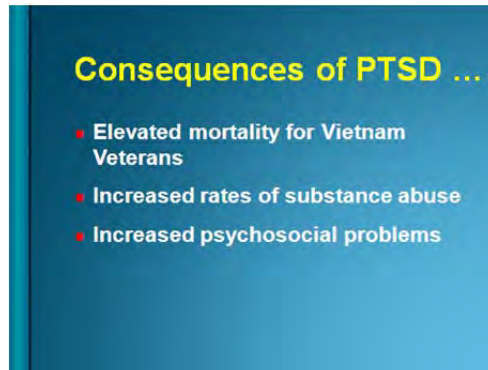
- 14.1% report high levels of marital problems, and 23.1% have high levels of parenting problems;
- almost 50% of all male Vietnam Veterans currently suffering from PTSD have been arrested or in jail at least once; 34.2% more than once;
- 11.5% had been convicted of a felony;
- lifetime prevalence of alcohol abuse/dependence: 39.2%; and
- 40% percent of male Vietnam Veterans have been divorced at least once (10% had two or more divorces).

In general, the presence of PTSD can be correlated with some of the following problems:<sup>3</sup>

- alcohol dependence;
- feelings of hopelessness, shame, or despair;
- employment problems; and
- relationship problems including divorce and violence.

## Impact of PTSD

Slide 9



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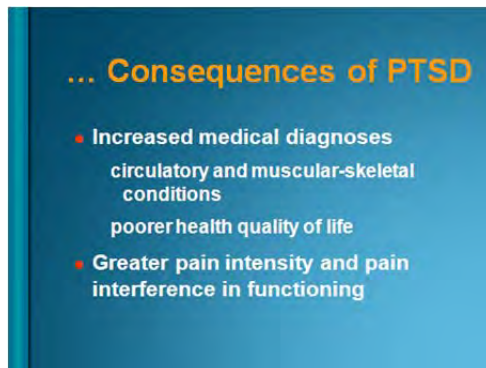
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Slide 10



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Further research has correlated PTSD with a number of medical and psychological outcomes, including the following:<sup>7,8,9,10,11,12,13,14</sup>

- elevated mortality rates for Vietnam Veterans, 2/3 of which are potentially preventable;
- combat exposure related to increased likelihood of recent drug use;
- increased relationship distress and emotional numbing;
- experience of killing others and failing to prevent killings in Vietnam related directly to weakening of religious faith among Vietnam combat Veterans;
- individuals with PTSD report greater intensity of pain. Although it is unclear why this may be the case; it may relate to the hyperarousal of the nervous system, associated with PTSD or due to high levels of anxiety that contribute to distressing reactions to pain; and
- an elevated risk of suicide among Vietnam Veterans with PTSD.

Symptoms of PTSD are often distressing for both Veterans and their families. These intrusive symptoms frequently disrupt an individual's life and lead to difficulties in social and occupational functioning.

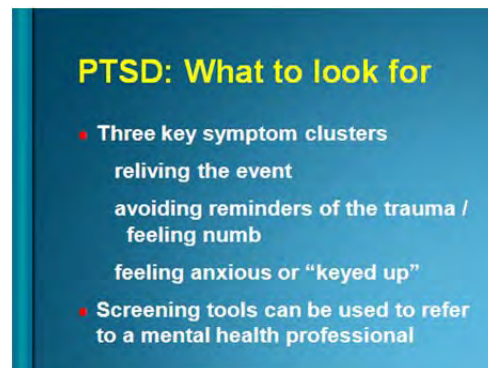
PTSD symptoms usually start soon after the traumatic event, but they may not be fully appreciated until months or years later. In addition, the symptoms may wax and wane

over months and even years. Veterans may be able to manage low grade symptoms over years. However, stressful events such as illness, the death of a loved one, or the loss of a job may trigger a worsening of symptoms and distress.

Diagnostically, the symptoms of PTSD must be present for greater than 4 weeks and result in impairment that interferes with an individual's work, home life and other personal relationships.

Research in PTSD has distinguished three key clusters of symptoms: (1) reliving the event, (2) avoidance/numbing, and (3) hyperarousal. Symptoms from each of the three groups must be present to make a diagnosis. In this module, we discuss the avoidance symptoms and the numbing symptoms separately. One type of symptom may predominate at different times. For instance, reliving the traumatic event can occur in conjunction with delirium very near the end of life.

Slide 11



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## Reliving the event (or intrusive recollection)

Recurring memories of the traumatic event may intrude at any time. Recurring dreams or nightmares about the trauma may occur. Individuals experience intense psychological distress when exposed to cues that resemble an aspect of the trauma, and individuals experience physiologic reactivity such as an increased pulse or sweating when exposed to cues that resemble the trauma, i.e., the fight or flight response.

Flashbacks, or acting and feeling as if the trauma is recurring in the present, can be particularly intense. During such episodes, the Veteran often mistakes the perceived reality of the flashback for reality and may incorporate people and objects as part of the flashback. This might include confusing the clinician for an enemy combatant. Sights, sounds, and other environmental cues can trigger flashbacks.

Triggers might include:

- hearing a car backfire, which can bring back memories of gunfire and war for a combat Veteran;
- seeing a car accident, which can remind a crash survivor of his or her own accident;

- seeing a news report of a sexual assault, which may bring back memories of assault for a woman who was raped; and
- reading a newspaper article about the casualties of a current war can bring back memories of a combat Veteran's own experiences with death.

Weather conditions can serve as triggers, for example snow may bring back memories of the cold Korean winters and thunderstorms may bring back memories of monsoons in Vietnam.

Seeing people of certain ethnic heritage may be a trigger for combat Veterans depending on where they served.

## **Feeling numb/avoiding situations that remind the individual of the traumatic event**

An individual may experience a pervasive sense of emotional numbness. This may be evidenced in a variety of behaviors, such as losing interest and not participating in activities that were once enjoyable; being unable to form close personal relationships; preferring to be isolated; or being unable to experience deep emotions such as love. Some individuals express a sense of foreshortened future, not expecting to live long or have meaningful careers, marriages or family life. When faced with new trauma, such as terminal illness and functional decline at the end of life, the Veteran may experience overwhelming emotional distress and suffering. Unfortunately, as a result of some of the symptoms described above, a Veteran with PTSD may have strained relationships with family and friends and can have very limited social support during such difficult times.

Examples of avoiding situations that remind the individual of the traumatic event include:

- an individual avoids talking or thinking about the trauma;
- an individual avoids places, people, or activities that remind them of the trauma, for example;
- a person who was in an earthquake may avoid watching television shows or movies in which there are earthquakes;
- a person who was robbed at gunpoint while ordering at a hamburger drive-in may avoid fast-food restaurants; and
- an individual may be completely unable to recall certain aspects of the trauma.

## **Hyperarousal**

A persistent state of increased awareness or arousal may be colloquially referred to as feeling *keyed up*, *jittery*, or *on edge*.

A state of hyperarousal may be manifested by behaviors such as:



- suddenly becoming angry or irritable;
- having a hard time sleeping;
- having trouble concentrating;
- fearing for their safety and always feeling on guard (sometimes referred to as hypervigilance); and
- being excessively startled when someone surprises them.

## Assessment for PTSD

Slide 12

**Primary care PTSD screen . . .**

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:

- Have had nightmares about it or thought about it when you did not want to?  
YES / NO
- Tried hard not to think about it or went out of your way to avoid situations that reminded you of it ?  
YES / NO

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Slide 13

**. . . Primary care PTSD screen**

- Were you constantly on guard, watchful, or easily startled?  
YES / NO
- Felt numb or detached from others, activities, or your surroundings?  
YES / NO

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Several brief screening tools for PTSD have been devised. They vary in complexity.

The Primary Care PTSD Screen (PC-PTSD) is currently in use by VA and consists of 4 questions. Current research suggests that the results of the PC-PTSD should be considered positive if a Veteran answers "yes" to any three items.<sup>15,16</sup>

Any Veteran who has a positive screen is referred to a mental health provider with expertise in PTSD for a more complete diagnostic evaluation. More information about this screening tool can be found at:

<http://www.ptsd.va.gov/professional/pages/assessments/pc-ptsd.asp>

The questions on this screening tool include:

**In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:**



Have had nightmares about it or thought about it when you did not want to?

YES / NO

Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?

YES / NO

Were constantly on guard, watchful, or easily startled?

YES / NO

Felt numb or detached from others, activities, or your surroundings?

YES / NO

Another tool is the PCL, a self-report PTSD checklist that screens for 17 symptoms of PTSD. It is used for screening and monitoring of patients with PTSD. More information on its administration and scoring can be found through the VA National Center for PTSD.<sup>17</sup>

## Death/illness as a PTSD activator

Slide 14

**Death/illness as a PTSD activator**

- How can PTSD impact EOL care?
  - death / illness as a PTSD activator
  - challenging social ties, incl. clinician-patient
  - delirium or flashback
  - medication issues
- Goals of care to include reduction in PTSD symptoms

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Facing death in and of itself may be a strong reminder of the vulnerability that Veterans felt during combat, and this can also serve to activate symptoms of PTSD. Veterans may have faced death every day on the battle field. Facing one's own death is a powerful reminder of that experience. One's own impending death may also be a reminder of the losses faced as fellow soldiers died on the battlefield.

Feelings common at the end of life can activate PTSD. This can make the Veteran with PTSD feel vulnerable and that is a powerful reminder of trauma. At the end of life, Veterans often feel like they have lost control of their life. The Veteran may have to rely on others for basic needs. They can't "escape" if they are bedbound. There may also be a potentially negative impact of coming into a hospital or hospice setting for a Veteran with PTSD. It can be very challenging at times for such people to be around others in a congregate living situation with frequent interruptions by strangers.

Triggers for PTSD symptoms can be visual, auditory, other sensory (heat, pain, shortness of breath), situational (dates/anniversaries) or emotional (anxiety, anger, fear and other intense emotions) can activate PTSD symptoms.

## Challenging social ties

There are strong connections between PTSD and many other psychosocial problems, e.g., substance use, divorce, social isolation, anger management difficulties.<sup>2</sup> Consequently, some Veterans with PTSD may be estranged from family and at end of life, and they may be isolated. Some may wish reconciliation. Some may not. In these situations, hospice staff can become a surrogate family, sticking through it to the end—fellow soldiers.

## Clinician-Veteran relationships

Many Veterans with PTSD have anger towards authority, e.g., the government, and don't expect to be cared for properly. These feelings can be transferred to VA clinicians and community health care providers, especially in situations when the Veteran feels he has no control over decision making. Although a Veteran may begin the relationship with mistrust or even hostility, a caring and honest relationship with an emphasis on helping the Veteran feel some control over their treatment can build trust over time and lessen hostility.

## Differentiating delirium from flashback

At end of life, the content of an episode of delirium may be combat related. A Veteran may feel like he is back in Vietnam, or on the beaches of Normandy. Sometimes clinicians may confuse a flashback (re-experiencing a traumatic event as if it is actually happening in the moment) for agitated delirium. Medical data may help differentiate when a Veteran is having a delirium or a flashback. Flashbacks tend to be more short-lived than episodes of delirium.

## Medication use

PTSD and use of medications at the end of life can be challenging for the clinicians for the following reasons:<sup>18</sup>

- many of the medications used to treat PTSD often take time for full effect (SSRIs, tricyclic anti-depressants). Veterans at the end of life may not have time for the medications to be adjusted to the best effect;
- Veterans may be reluctant to take pain medications due to a need to be a *strong soldier*;
- Veterans may misuse medication to self-medicate PTSD symptoms;
- it is important to continue psychiatric medications at end of life to help manage longstanding PTSD symptoms;
- some Veterans with PTSD may feel more vulnerable after taking sedating medications meant to calm them; this can sometimes paradoxically increase

agitation because they feel that they are not “ready to defend” themselves if they need to; and

- disinhibition associated with some medication, e.g., benzodiazepines may have adverse effects, especially irritable and aggressive outbursts.

## Military sexual trauma

Slide 15



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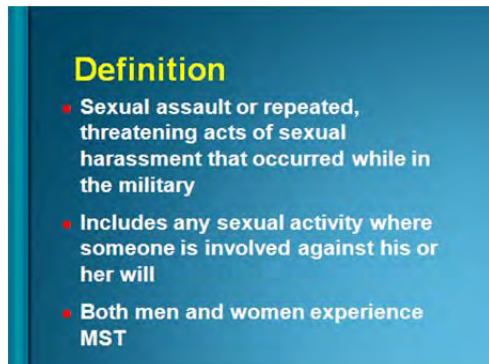
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## Definition

Slide 16



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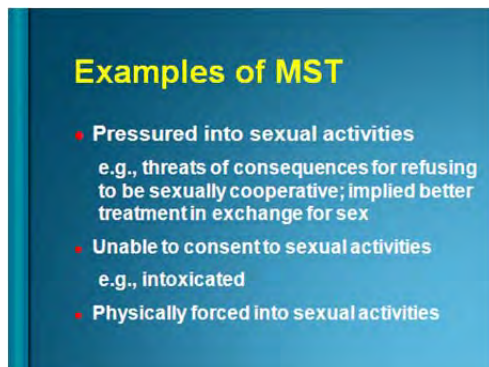
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Slide 17



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Slide 18

### More examples of MST

- Unwanted sexual touching or grabbing
- Threatening, offensive remarks about a person's body or sexual activities
- Threatening and unwelcome sexual advances

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Slide 19

### MST facts

- Higher rates among women but are about equal numbers of male and female survivors due to male-female ratio within military
- Sexual trauma is more likely to result in symptoms of PTSD than are most types of trauma, including combat

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Military sexual trauma (MST) is an experience, not a health condition. VA's definition of MST comes from federal law but is in general sexual assault or repeated, threatening sexual harassment that occurred during a Veteran's military service.

*Sexual assault* is any sort of sexual activity between at least two people in which someone is involved against his or her will—they may be coerced into participation, e.g., with threats; not capable of consenting to participation, e.g., when intoxicated; or physically forced into participation.

*Sexual harassment* involves repeated, unsolicited and threatening verbal or physical contact of a sexual nature. Sexual harassment is itself defined as 'repeated, unsolicited verbal or physical contact of a sexual nature which is threatening in character.' Any of these things occurring while a Veteran was serving on active duty or training for active duty constitutes MST.

In 2002, the Department of Defense conducted a large study of sexual victimization among active duty populations and found that 24% of women and 3% of men reported having experienced sexual harassment in the previous year.<sup>19</sup> In terms of sexual victimization, a recent review documented rates of 9.5-33% of women reporting rape while in the military and 1-12% of men.<sup>20</sup>

In 2006, the Department of Defense conducted a large study of sexual victimization among active duty populations and found that 52% of women and 29% of men reported experiencing offensive sexual behavior in the past year, 31% of women and 7% of men reported receiving unwanted sexual attention in the past year, 9% of women and 3% of

men reported experiencing sexually coercive behavior during the past year and 6.8% of women and 1.8% of men reported having been sexually assaulted during the past year.<sup>21</sup> Some research studies have found rates of sexual trauma in the military to be even higher among veterans using VA health care. For example, one study found that 23% of female users of VA health care reported experiencing at least one sexual assault while in the military.

Slide 20

**Implications of MST ...**

- Interactions with healthcare providers can be complicated for Veterans who experienced MST because the clinician relationship can resemble some aspects of the victim–perpetrator relationship

e.g., power differential, being in physical pain, physical exposure and touching of intimate body parts, feeling a lack of control over the situation

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Slide 21

**... Implications of MST**

- Exams and procedures are intrusive and can physically recreate some of the sensations a Veteran experienced at the time of the sexual trauma

because of this, providers need to employ extra sensitivity and care when working with Veterans who experienced MST

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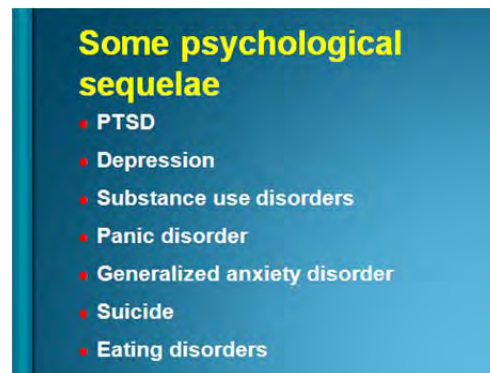
As part of its universal screening program, the VA asks all Veterans seen for health care if they experienced MST. About 1 in 5 women and 1 in 100 men respond “yes” when screened. Among users of VA health care, the mental health diagnoses most commonly associated with MST are PTSD, Depressive Disorders, Anxiety Disorders, Bipolar Disorders, Drug and Alcohol Disorders, and Schizophrenia and Psychoses.<sup>22,23</sup>

Although sexual trauma occurs more frequently among women than among men, the disproportionate ratio of men to women in the military means that within VA system there are actually slightly more men than women who report experiencing MST.

Also important to consider is that sexual victimization experiences fall far outside of the traditional male gender role. Thus, while the types of psychological reactions experienced by men and women are often similar, men may struggle with different issues than women, may feel more shame about their victimization and may be less likely to seek professional help.

## Sequelae of MST

Slide 22



**Some psychological sequelae**

- PTSD
- Depression
- Substance use disorders
- Panic disorder
- Generalized anxiety disorder
- Suicide
- Eating disorders

MST is associated with increased rates of Posttraumatic Stress Disorder (PTSD), depression and substance use disorder with one study documenting 3 times greater rate of depression and 2 times greater rate of substance use disorder among those with MST.<sup>24</sup>

PTSD is the psychiatric diagnosis most frequently associated with sexual assault, with 65% of men and 46% of women who have been sexually assaulted reporting symptoms consistent with a diagnosis of PTSD at some point in their lifetime. These rates of PTSD are higher than those found among men following combat exposure (39%). Major depressive disorder (MDD) is another common reaction following sexual assault, with research suggesting that almost a third of sexual assault victims have at least one period of MDD during their lives.

Victims of sexual assault may also report increased substance use, perhaps as a means of managing their psychological symptoms.

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**Some physical sequelae**

- Chronic pain
  - low back pain
  - headaches
- Gastrointestinal
  - irritable bowel syndrome
- Gynecologic
  - menstrual disorders
  - pelvic pain

In addition to the psychological sequelae there are physical sequelae. These include increased rates of chronic pain, gastrointestinal disorders and gynecological disorders.<sup>25</sup>



## Assessment for and response to a Veteran with MST

Slide 24

**Screening and Connecting to Care**

- VA policy that all Veterans must be screened for experiences of MST using the one-time clinical reminder in CPRS
- Universal screening is good clinical practice

many patients do not spontaneously disclose a trauma history. Asking about MST can be the first step in getting them the help they need

understanding that a patient has a history of MST may provide context for his or her presenting problems

knowing that a patient has experienced MST helps the provider adapt care appropriately

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Slide 25

**Don't be afraid to ask**

- Studies have shown that most sexual trauma survivors favor routine screening for sexual trauma and other forms of interpersonal violence
- However, it's important to be sensitive to barriers to disclosure

shame, especially for men

anxiety about how others will view them, particularly if they have had previous negative experiences disclosing

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With the increasing understanding of the frequency of MST, it is reasonable to screen for this as a distressing psychosocial issue in the palliative care and end-of-life setting. A method of screening that is likely to yield fairly accurate results without being perceived by the Veteran as too intrusive involves two general questions that use descriptive, nonjudgmental wording, “while you were in the military did you ever experience any unwanted sexual attention, like verbal remarks, touching, or pressure for sexual favors?” or, “did anyone ever use force or the threat of force to have sex with you against your will?”<sup>26</sup>

## Triggers for MST

Slide 26

**Examples of triggers...**

- Touch to chest, abdominal, groin, pelvis, buttock, back or neck
- Insertion of enemas, meds, thermometers, feeding / breathing apparatus
- Oral care
- Assisted transfers

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Due to the nature of MST, medical, nursing and personal care that involves touching, bathing, or toileting may be triggers that will bring memories of traumatic experiences to the present again. The issue of dependency and the power differential between the clinician and Veteran are a complex dynamic in the palliative and end-of-life care settings that makes treatment difficult for both the Veteran and the clinician.

Good practice on the part of the clinician is to:

- explain all care and its purpose even if the Veteran does not appear to be alert, and
- observe carefully for physical reactions to these triggers even when/if the Veteran no longer appears to be alert.<sup>20</sup>

Due to the nature of military sexual trauma, certain exams and treatments that involve the urinary and genital region such as pelvic exams, bladder catheters, or simply bathing, cleaning, or changing pads or diapers may be very traumatic. Additionally, distress related to sexual trauma could be triggered by things such as colonoscopy, the need for suppositories or enemas for constipation, oral care and/or restraints of any sort as the exact nature of the trauma may not be known.

## Responding to MST

Slide 28



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When providing care for Veterans who have experienced sexual trauma, it is important to give information, and explain why and what needs to be done, always asking for



permission to touch. Asking the Veteran to assist the clinician with needed personal care and medical treatment can lessen the trauma associated with care.

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### Responding to disclosure

- Respond with empathy
  - "I'm sorry that this happened to you"
  - "I am here to listen to your story"
- Ensure privacy
- Listen if you are able or find someone who can
- Know your limitations

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Due to the sensitive nature of these issues it is important to provide a safe, supportive environment and ensure privacy. Veterans may decline to discuss the issue or deny that MST is an issue. Over time and through an interdisciplinary team approach Veterans with MST issues may feel comfortable discussing these distressing events. Therapeutic relationships between clinicians and Veterans may be helpful even if the issue of MST is never made explicit. It is always important to preserve the privacy, modesty and dignity of Veterans at the end of life. If MST is suspected then additional care should be taken to not exacerbate this trauma. It is helpful to know early in the course of care if a Veteran has a history of MST so that staff may be prepared for possible reactions to care as a Veteran's control declines and care needs increase.<sup>20</sup>

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### The role of VA

- All treatment for mental and physical health conditions related to the MST is provided free of charge
- Service connection or documentation are not necessary
- This may be true even if the Veteran is ineligible for other VA services

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VA is mandated to have a robust response to the need for training clinicians in issues related to MST and to provide Veterans with excellent care that takes their special needs into account. To this end, in 1992 Congress passed a law mandating that VA health care providers be given training and education related to MST; this law also authorized VA to provide counseling services to women Veterans reporting MST. Subsequent laws mandated that VA provide this care to both male and female victims of MST and expanded treatment to include the physical health conditions resulting from MST. VA policy is that this care be provided free of charge. A Veteran does not need to be service connected or have any documentation that his/her experiences of MST occurred in order to receive this care.

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**Where to find help**

- Contact the MST Coordinator at your local VA Medical Center or the MST Specialist at your local Vet Center
- To locate facilities online go to: [www.va.gov](http://www.va.gov) or [www.vetcenter.va.gov](http://www.vetcenter.va.gov)
- Visit [www.mentalhealth.va.gov/msthome.asp](http://www.mentalhealth.va.gov/msthome.asp)
- Call 1-800-827-1000 – VA's general information hotline

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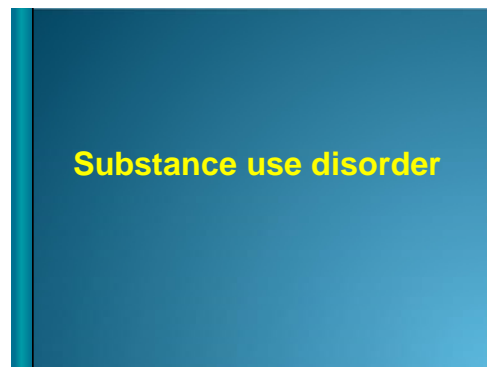
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Vet Centers (Readjustment and Counseling Centers) offer specialized services, such as group, individual and family counseling to help eligible Veterans overcome associated psychological difficulties and to resolve conflicts relating to their military service including military sexual trauma. They also provide referral services which connect Veterans to VA programs and community services. All Vet Centers are required to have a provider designated as an MST Specialist. Veterans do not have to be enrolled in Veterans Health Administration to receive care at a Vet Center.

Military sexual trauma is a common source of distress for Veterans in the palliative care and end-of-life setting. It is imperative the interdisciplinary palliative care team be vigilant for signs of MST, be able to respond appropriately, be aware of the growing knowledge in this area, and reach out to those in VA with expertise in this area as appropriate and needed for the Veterans they serve.<sup>27,28</sup>

## Substance use disorder

Slide 32



**Substance use disorder**

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## Background

Slide 33

**Background ...**

- Of Veterans who access VA health care system each year, approximately a ½ million are diagnosed with substance use disorders (SUD)
- Prevalence of heavy drinking and other substance use are at least as high among Veterans compared to non-Veterans

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Slide 34

**... Background**

- Pain, depression and other mental conditions are associated with increased likelihood of substance use
- Alcohol and other substance use can interfere with effective palliative care (e.g., adherence)

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Substance use disorders (SUD) are common among all segments of society in the US.<sup>29</sup> However, Veterans as a group have a higher rate of substance use and abuse in some areas than the non-Veteran population. For example, the Substance use disorder and Mental Health Services Administration (SAMHSA) National Survey on Drug Use and Health found that in 2003:<sup>30</sup>

- an estimated 3.5% of Veterans used marijuana in the past month compared with 3.0% of their non-Veteran counterparts;
- heavy use of alcohol in the past month was more prevalent among Veterans (7.5%) than comparable non-Veterans (6.5%);
- an estimated 0.8% of Veterans received specialty treatment for a substance use disorder (alcohol or illicit drugs) in the past year compared with 0.5% of comparable non-Veterans; and
- estimated rates of dependence on alcohol and/or illicit drugs did not differ significantly between Veterans and non-Veterans, and rates of those dependent on alcohol and/or illicit drugs but who did not receive treatment in the past year were also comparable.

There are a number of theories regarding the increased rate of SUD among Veterans. SUD correlates with many of the psychosocial issues discussed in this module. It may be an unhealthy coping mechanism (self-medication) in response to PTSD, MST, or

depression. Exposure to combat is highly correlated to SUD. In addition, SUD is correlated with homelessness, difficulty maintaining employment, and impairment in family and social functioning. All of these may also then correlate with suicidal thoughts and behaviors.<sup>31</sup>

SUD is correlated with high risk-taking behaviors that can lead to death and/or injury from motor vehicle accidents, work place accidents, contraction of HIV or Hepatitis B or C, depression, poor impulse control and suicidal behaviors.

## Substance use disorder and end-of-life care

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**SUD implications for end-of-life care**

- Pain management becomes complex
- Potential high tolerance for pain medications
- Choose medications for palliation that minimize adverse drug-drug interactions

SUD may complicate the management of Veterans who are cared for in palliative and end-of-life care settings. Untreated addiction may make adherence to a treatment plan near the end of life difficult. This is particularly true with regard to pain management. Higher doses of opioids for pain control may be needed due to increased tolerance to the medication. In addition individuals with addiction often have a lower tolerance of physical pain. Veterans should never be denied adequate pain relief for their physical symptoms at the end-of-life due to a present or past history of SUD. However, it is important to work closely with the Veteran to develop treatment plans that minimize abuse risk and diversion.

In general, the following key points should be recognized among Veterans in palliative care who may be struggling with substance use disorder:

- Substance use disorder is at least as prevalent among Veterans as in the general population, especially among those with current pain, depression or other mental health conditions.
- Palliative care teams should inquire about alcohol and other substance use in all palliative care patients and work with VA mental services when substance use disorder is identified as complicating palliative care.
- Veterans who suffer from substance use disorder should still be provided effective pain management, including opioids when indicated. They may require higher doses and closer monitoring but they should still receive pain relief.

## Approach to Veterans with substance use disorder

Slide 36

**How to help ...**

- Ask about current substance use and implications for pain management
- Adopt a non-judgmental approach to discussing substance use issues
- Collaborate with patient on goals regarding quality of life
- Develop an interdisciplinary treatment plan for end of life care which considers substance use

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Slide 37

**... How to help**

- Offer referral to SUD specialty care for patients who identify SUD recovery as an end-of-life goal
- Consult with a SUD specialist on a case-by-case basis to manage substance use behaviors consistent with providing effective palliative care

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While it is important to foster care in the least restrictive environment and one that is the preference of the Veteran and his family/friends, there may be times when end-of-life treatment will need to be offered in a more controlled environment, such an inpatient unit, so that medications such as opioids can be used effectively and safely.

It is important to have an open, frank and nonjudgmental approach for discussing substance use and abuse. Veterans are usually, but not always, aware of the dangers and problems addiction has caused in their lives. They are sometimes embarrassed, depressed and disappointed at their own inability to control their substance use and abuse. In this way, they may already be their harshest judges and need the support and collaborative assistance of the Palliative Care or Hospice team.

Frequently engaging the Veteran in developing the goals of care regarding substance use disorder will help the team and the Veteran develop a therapeutic relationship. The Veteran and the interdisciplinary team can often arrive at possible solutions to safely manage medications that ensure access to the medications that will be needed to control pain and other symptoms. If the plan is reasonable, a time trial with contingency plans for care if substance use continues may be a viable option. The treatment plan may need to change to ensure safety for the Veteran, family and caregivers.

The VA health care system and SAMHSA have developed a robust programmatic response to SUD and treatment.<sup>32</sup> It is important for the clinicians who are working in the



palliative care and hospice settings to work in a collaborative and interdisciplinary way with the substance use disorder counselors and other professionals.

## Homelessness

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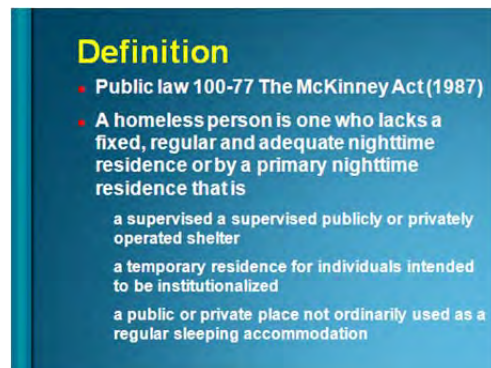
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## Definition

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The McKinney Act (1987) provides a working definition for homelessness that is used by VA:

“An individual who lacks a fixed, regular, and adequate nighttime residence, or an individual who has a primary nighttime residence that is: (a) a supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill); (b) a public or private place that provides a temporary residence for individuals intended to be institutionalized; or (c) a public or private place not designed for, or ordinarily used as, regular sleeping accommodations for human beings.”<sup>33</sup>

Homelessness is correlated with many of the issues discussed in this module. In addition, homelessness is associated with increased morbidity and mortality and poorer health care outcomes in the general population.<sup>34</sup>

For patients near the end of life, research has documented the difficulty of providing effective palliative and hospice care services in settings where the homeless live.<sup>35</sup> This

may lead to a need for inpatient or residential care locations at the end of life. For some Veterans, care in a confined setting with forced social interactions can cause significant distress.

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### Causes of Veteran homelessness

- Limited access to affordable housing, livable income, and health care
- Lingering effects of PTSD
- Substance abuse disorder
- Lack of family and social support networks

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There are a complex set of factors affecting all homelessness, such as a shortage of affordable housing, lack of livable income, and limited access to health care. In addition a significant number of Veterans who are homeless or at risk to become homeless live with lingering effects of PTSD and SUD, compounded by a lack of family and social support networks.<sup>36</sup>

## Who are the homeless Veterans?

Slide 41

### Homeless Veterans facts ...

- 23% of the homeless population are Veterans
- 13% of all sheltered homeless adults are Veterans
- 47% of homeless Veterans served during the Vietnam Era
- 33% were stationed in a war zone

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Slide 42

### ... Homeless Veterans facts

- 45% suffer from mental illness
- 70% suffer from substance abuse problems
- 58% have health / physical problems
- 46% are age 45 or older compared to 20% of non-Veteran homeless citizens

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The following are some statistics about the homeless Veteran population in the United States:<sup>37</sup>

- 23% of the national homeless population are Veterans;
- 13% of all sheltered homeless adults are Veterans;
- 47% of homeless Veterans served during the Vietnam era;
- 33% of homeless Veterans were stationed in a war zone;
- 89% of homeless Veterans received an honorable discharge;
- 45% of homeless Veterans suffer from mental illness;
- 70% of homeless Veterans suffer from substance use disorder problems;
- 58% of homeless Veterans have health/physical problems; and
- 46% of homeless Veterans are age 45 or older compared with 20% of non-Veteran homeless citizens.

The nation's homeless Veterans are mostly males (4% are females). The vast majority are single, most come from poor, disadvantaged communities, 45% suffer from mental illness, and half have substance use disorder problems. America's homeless Veterans have served in World War II, the Korean War, the Cold War, the Vietnam War, Grenada, Panama, Lebanon, the Persian Gulf War, Operation Enduring Freedom (Afghanistan), and Operation Iraqi Freedom. Forty seven percent of homeless Veterans served during the Vietnam Era. More than 67% served our country for at least three years and 33% were stationed in a war zone.<sup>36</sup>

## Specific programs include:

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VA has had a programmatic response to the issue of homelessness among Veterans.<sup>38</sup> These programs include Homeless Veteran Program Coordinators at each VA facility who can be an important source of information about VA services for homeless Veterans. Services include outreach, case management, referrals to benefits counselors, linkage to health care, and housing assistance. Each facility is unique and services vary among each medical center.

VA provides health care to about 100,000 homeless Veterans, and compensation and pension benefits to nearly 40,000 annually. The Department offers homeless Veterans



employment assistance and help obtaining foreclosed homes and excess federal property, including clothes, footwear, blankets and other items. VA has committed funding for more than 12,000 beds in transitional housing programs while continuing to provide about 5,000 Veterans each year with residential services in VA hospital-based programs.

Many of the programs fall under Project CHALENG (Community Homelessness Assessment, Local Education and Networking Groups) which requires each VA facility to:

- assess the needs of homeless Veterans living in the area;
- make the assessment in coordination with representatives from state and local governments, appropriate federal departments and agencies, and nongovernmental community organizations that serve the homeless population;
- identify the needs of homeless Veterans with a focus on health care, education and training, employment, shelter, counseling, and outreach;
- assess the extent to which homeless Veterans' needs are being met;
- develop a list of all homeless services in the local area;
- encourage the development of coordinated services;
- take action to meet the needs of homeless Veterans; and
- inform homeless Veterans of non-VA resources that are available in the community to meet their needs.

At the local level, VA medical centers and regional offices designate CHALENG Points of Contact (POCs) who are responsible for the above requirements. These CHALENG POCs - usually local VA homeless center/project coordinators - work with local agencies throughout the year to coordinate services for homeless Veterans.

The guiding principle behind Project CHALENG is that no single agency can provide the full spectrum of services required to help homeless Veterans become productive members of society. Project CHALENG enhances coordinated services by bringing VA together with community agencies and other federal, state, and local governments who provide services to the homeless to raise awareness of homeless Veterans' needs and to plan to meet those needs.<sup>39</sup>

## **Specific programs include:**

**Health Care for Homeless Veterans (HCHV)** operates at 135 sites, where extensive outreach, physical and psychiatric health exams, supported housing programs, Drop-In Centers, treatment, referrals and ongoing case management are provided to homeless Veterans with mental health problems including substance use disorder.<sup>40</sup>

**Domiciliary Care for Homeless Veterans (DCHV)** provides biopsychosocial treatment and rehabilitation to homeless Veterans. The program provides residential treatment to

approximately 5,000 homeless Veterans with health problems each year and the average length of stay in the program is 4 months. The domiciliaries conduct outreach and referral, vocational counseling and rehabilitation, and post-discharge community support.<sup>41</sup> Other overall resources for homeless Veterans are available at <http://www.va.gov/homeless/>.

In addition, most Veteran Service Organizations (VSOs) have regional/county Veteran service officers who help Veterans obtain benefits to which they are entitled. Some help homeless and at-risk Veterans find the supportive services they need. Finally, the National Coalition for Homeless Veterans, an advocacy group funded through the Department of Veterans Affairs and U.S. Department of Labor has resources ([www.nchv.org/index.cfm](http://www.nchv.org/index.cfm)).

The Department of Veterans Affairs has made addressing the causes and needs of Veterans who are homeless a programmatic priority. Although this is still a serious problem the programs and policies outline in this module are correlated with a significant reduction in homelessness.

In a study released in 2008, the Department of Veterans Affairs found that the number of Veterans homeless on a typical night had declined 21 percent in the previous year, and that this was linked to the services offered by VA and its partners in community and faith-based organizations, plus changing demographics and improvements in survey techniques.<sup>37</sup> This represented a reduction of homeless Veterans from more than 195,000 to about 154,000.

## Summary

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Psychosocial issues such as posttraumatic stress disorder, military sexual trauma, substance use disorder, homelessness, and suicide may cause problems throughout the lives of Veterans, and can also become more severe near the end of life and can complicate palliative care. Sensitivity to the unique experiences of Veterans allows all clinicians to improve care and reduce suffering.

## Key take-home points

1. Posttraumatic Stress Disorder (PTSD) is more common in Veterans than the general population.
2. Manifestations of PTSD include hyper-vigilance, intense flashback and avoidance of reminders of the trauma.
3. PTSD is associated with multiple other psychological problems including substance use disorder and depression.
4. The Primary Care PTSD Screen is a 4-item tool used throughout VA to screen for PTSD.
5. At the end of life, some of the triggers for PTSD can return.
6. Military sexual trauma (MST) includes both sexual harassment and sexual assault.
7. Although it is more common in female Veterans, there are male Veterans who have been the victim of MST.
8. Being a victim of MST is associated with multiple physical and mental health disorders including PTSD, depression and substance use disorder.
9. Invasive medical procedures or personal care may trigger memories of MST.
10. Veterans are slightly more likely than the general population to suffer from substance use disorder.
11. Palliative care teams should work with VA mental services when substance use disorder is identified.
12. Veterans who suffer from substance use disorder should still be given opioids for pain. They may require higher doses and closer monitoring but they should still receive pain relief.
13. Almost one quarter of the total homeless population in the United States is Veterans.
14. There are multiple programs at VA for homeless Veterans that can assist in housing options.
15. There are Homeless Veteran Program Coordinators at each VA facility that can help Veterans access services.

## Resources

NHPCO grants regarding Veterans/homelessness and EOL Care:

[http://www.nhpco.org/files/public/Veterans/Deliverable\\_Three\\_Handout.pdf](http://www.nhpco.org/files/public/Veterans/Deliverable_Three_Handout.pdf)

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