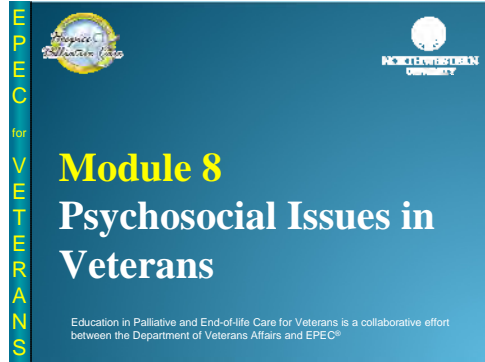


Abstract

Slide 1



Slide 2



This module addresses some key psychosocial issues that are important to consider in the care of Veterans in palliative care. These issues are not entirely unique to Veterans, and although they may be more common in certain Veteran populations. For example, while Post Traumatic 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 non-military 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.

Slide 3



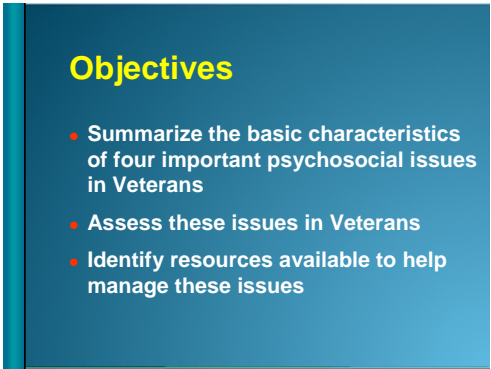
The following are specific issues that will be briefly presented:

- post-traumatic stress disorder (PTSD)

- military sexual trauma (MST)
- substance abuse
- homelessness

Objectives

Slide 4



Objectives

- Summarize the basic characteristics of four important psychosocial issues in Veterans
- Assess these issues in Veterans
- Identify resources available to help manage these issues

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 5



Clinical case

This trigger tape consists of one Veteran and his son, and the wife of a second Veteran.

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.

Introduction

Slide 6

Overall statistics

- 26.4 million Veterans
- The largest group is Vietnam Veterans (8.4 million)
- 17% of all Veterans use VA for medical care
- Over 150 medical centers, 800 outpatient clinics, 135 nursing homes

Although post-traumatic stress disorder (PTSD), military sexual trauma (MST), substance abuse 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 Learning Management System (LMS).

Disclaimer

Slide 7

Disclaimer

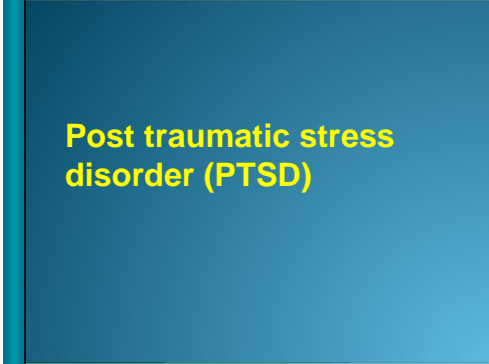
The problems discussed in this overview are complex. It is beyond the scope of this presentation to give you the skills to treat them. Consultation with or referral to a qualified mental health professional is the best approach to addressing the needs of Veterans with mental health problems at end of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

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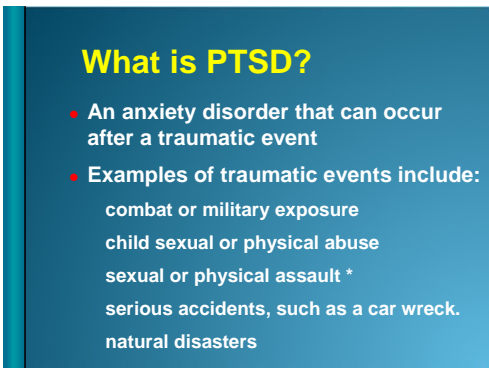
Post traumatic stress disorder

Slide 8



Definition

Slide 9



Post traumatic 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: intrusive recollections of the trauma, avoidant behaviors and numbing of general responsiveness, and 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.¹ 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.²

PTSD background

- 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"

War-related PTSD has been around for a long time, although it has been called by different names such as “Soldiers 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 Diagnosis and Statistical Manual (DSM) Handbook 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 war-time 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.³

The impact of PTSD on Veterans’ health is an area of ongoing study. Currently, the military routinely evaluates service personnel’s mental health related to traumatic incidents during service. This process is difficult due to the large number of service individuals, a lack of trained mental health personnel and assessment tools, and the potential of active duty military personnel and Veterans to minimize PTSD symptoms due to both the real and perceived social stigma related to mental health diagnosis and treatment.

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:^{4,5}

- 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 is often correlated with some of the following problems:

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

Slide 11

Consequences of PTSD ...

- Elevated mortality for Vietnam Vets
- Increased rates of substance abuse
- Increased psychosocial problems

Slide 12

... Consequences of PTSD

- Increased medical diagnoses
 - circulatory and muscular-skeletal conditions
 - poorer health quality of life
- Greater pain intensity and pain interference in functioning

Further research has correlated PTSD with a number of medical outcomes, including the following:^{6,7,8,9,10,11,12,13}

- elevated mortality rates for Vietnam Veterans, 2/3 of which are potentially preventable;
- combat exposure related to increased likelihood of recent drug use;

- increased severity of PTSD symptoms related to increased relationship distress, emotional numbing, and key symptom clusters;
- 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, though 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 for 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: reliving the event, avoidance/numbing, and 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 be predominating at different times. For instance, reliving the traumatic event can occur in conjunction with delirium very near the end of life.

Slide 13

PTSD: What to look for

- Three key symptom clusters
 - reliving the event
 - avoiding reminders of the trauma / feeling numb
 - feeling anxious or “keyed up”
- Screening tools can be used to refer to a mental health professional

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 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

Several brief screening tools for PTSD have been devised. They vary in complexity; none are diagnostic. 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.^{14,15} 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

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, inc. doc - patient
 - delirium or flashback
 - medication issues
- Goals of care to include reduction in PTSD symptoms

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.² Consequently, many 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:¹⁶

- 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 reject pain medication 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 with sedating medication meant to calm them and this can increase agitation as they are not “ready to defend” themselves if they need to; and

- disinhibition associated with some medication, e.g., benzodiazepines may have adverse effect.

Military sexual trauma

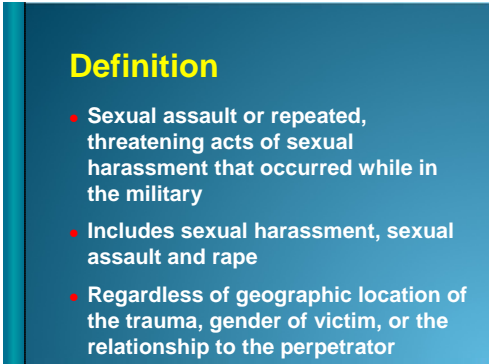
Slide 15



A blue rectangular slide with the text "Military Sexual Trauma" in yellow font.


Definition

Slide 16



A blue rectangular slide with the title "Definition" in yellow. Below the title is a bulleted list of three items.

Slide 17



A blue rectangular slide with the title "Examples of MST" in yellow. Below the title is a bulleted list of three items.

MST facts

- Most commonly experienced by women but more than half the survivors are men due to male-female ratio within system
- Individuals are up to six times more likely to develop PTSD from MST than from combat trauma, particularly men

While military sexual trauma (MST) is not a DSM IV-defined diagnosis, it is a recognized condition by the Department of Veterans Affairs. MST is defined by Title 38 U.S. Code 1720D as “psychological trauma which in the judgment of a mental health professional employed by the Department, resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment.”¹⁷

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.

Homosexuals or those perceived as homosexuals may be targeted for abuse and harassment and be especially fearful of reporting perpetrators of abuse.¹⁸

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.¹⁹ 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.²⁰

The VA routinely screens for MST using 2 questions: “While you were in the military: (a) Did you receive uninvited and unwanted sexual attention, such as touching, caressing, pressure for sexual favors, or verbal remarks?; (b) Did someone ever use force or threat to have sexual contact with you against your will?” Of 2,925,615 male Veterans screened in 2003, 1.1% screened positive. Of 137,006 female Veterans screened, 21.4% screened positive. In both men and women positive screening was associated with PTSD, depression and substance abuse.²¹

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 19



Sequelae of MST

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

The sequelae of MST include increased rates of Post-Traumatic Stress Disorder (PTSD) - with one study documenting that up to 60% of women with MST had PTSD;²² and increased rates of depression and substance abuse, with one study documenting 3 times greater rate of depression and 2 times greater rate of substance abuse among those with MST²³.

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.

Barriers to reporting

Slide 20

Barriers to reporting . . .

- Cohesiveness of military units prevents reporting
- Perpetrator may have been the superior of the victim
- When reported in the military, no action may have been taken except against the victim

Slide 21

... Barriers to reporting

- When reported in the military, no action may have been taken except against the victim
- The process of life review and the loss of control at end of life may lead to revelation at end of life.

There may be career-related consequences for victims of MST in that perpetrators are frequently peers or supervisors with the power to influence work evaluations and decisions about promotions. Even if this is not the case victims may choose to leave the military, sacrificing career goals to protect themselves from future victimization.

The high value on unit cohesion may make it taboo to divulge any negative information about a fellow service member. As a result victims may be encouraged to keep silent and their reports may be ignored.

Assessment for and response to a Veteran with MST

Slide 22

Physical symptoms

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

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?”²⁴

Slide 23

Medical procedures

- Can pose a problem in patients with a history of sexual trauma
- Patient provider relationship resembles some aspects of the victim-perpetrator relationship
 - power differential
 - inflicting pain
 - lack of control over the situation

Site and Frame 2003

Slide 24

What do you do?

- 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

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 in 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.¹⁸

Triggers for MST

Slide 25

Triggers for MST ...

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

Slide 26

... Triggers for MST

- Washing of the patient's body by others
- Applying lotions or oils
- Soft or other restraints including chemical restraints

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.¹⁸

Slide 27

Medical triggers

- Pelvic exam
- Colonoscopy
- Other invasive (e.g. rectal, oral, nasal)
- Fundoscopic exam
- Chemical sedation

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.

Slide 28

Tips for lessening trauma

- Information-patient education
- Asking permission and offering to stop if patient requests
- Language - use non-threatening terms

Saxe and Frayne 2003, Wallis 1984

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.

Slide 29

The role of VA

- Any Veteran who reports a history of MST is entitled to treatment for conditions related to the MST (whether mental or physical) free of charge
- This may be true even if the Veteran is otherwise ineligible for VA services

The 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.

Slide 30

Where to find help

- Contact the MST Coordinator at your local VA Medical Center
- Contact your local Vets Center and ask for the MST Specialist
- To locate facilities online go to: www.va.gov or www.vetcenter.va.gov
- Call 1-800-827-1000 – VA’s general information hotline

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 the 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 or symptoms 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.^{25,26}

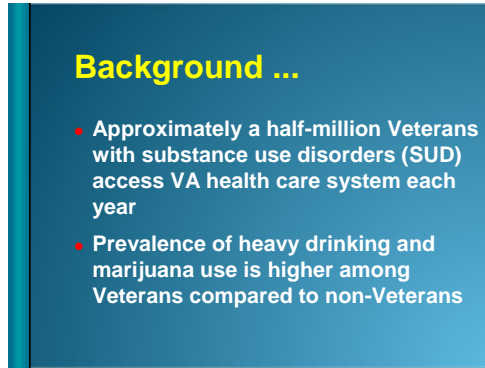
Substance use disorder

Slide 31

Substance use disorder

Background

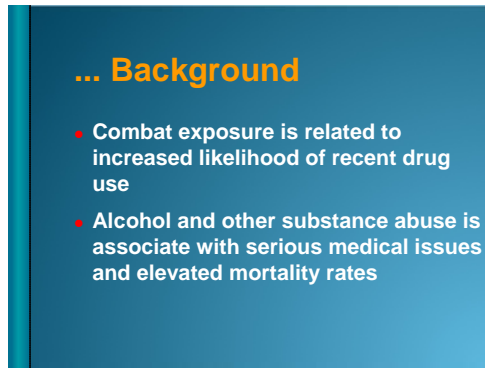
Slide 32



Background ...

- Approximately a half-million Veterans with substance use disorders (SUD) access VA health care system each year
- Prevalence of heavy drinking and marijuana use is higher among Veterans compared to non-Veterans

Slide 33



... Background

- Combat exposure is related to increased likelihood of recent drug use
- Alcohol and other substance abuse is associated with serious medical issues and elevated mortality rates

Substance use disorders (SUD) are common among all segments of society in the United States.²⁷ However, Veterans as a group have a higher rate of substance use and abuse in some areas than the non-Veteran population. For example, SAMHSA's National Survey on Drug Use and Health found that in 2003:²⁸

- 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%);
- 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; and
- 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.

There are a number of theories regarding the increased rate of substance use disorders (SUD) among Veterans. SUD correlate 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 are 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.²⁹

Long-term SUD is related to serious medical conditions such as but not limited to cirrhosis of the liver and brain injury. In addition, 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.

Slide 34

SUD implications for end-of-life care

- Pain management becomes complex
- Often people with a history of substance abuse will have a high tolerance for pain medications
- When possible, choose medications for palliation that minimize abuse risk

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.

Slide 35

How to help ...

- Adopt a non-judgmental approach to discussing substance abuse issues
- Collaborate with patient on goals regarding substance abuse
- Develop an interdisciplinary treatment plan for end of life care which considers substance abuse history

... How to help

- Consult with a substance abuse specialist on a case by case basis to manage substance use behaviors while also providing effective palliative care

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 abuse 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 insure 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 insure safety for the Veteran, family and caregivers.

The VA health care system and the substance abuse and mental health services administration have developed a robust programmatic response to SUD and treatment.³⁰ 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 abuse counselors and other professionals.

The clinicians in VA who work with Veterans with SUD can be a rich resource for both the Veteran and the interdisciplinary team. Over time, Palliative and Hospice care teams can develop their knowledge, skill and experience with the special challenges of providing excellent end-of-life care for Veterans who have addiction issues. There are resources that can help clinicians learn more about this important topic.

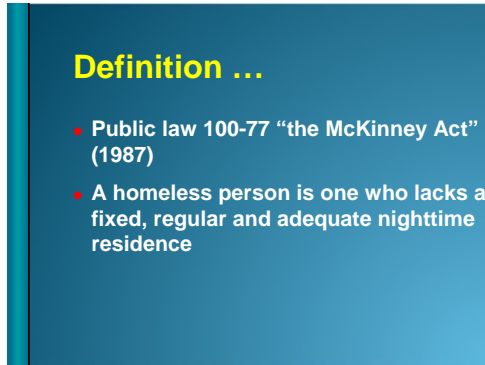
Homelessness

Slide 37

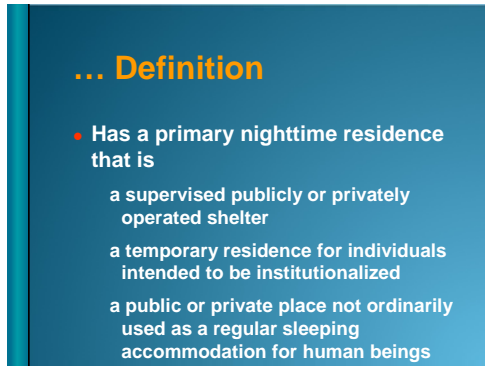


Definition

Slide 38



Slide 39



The McKinney Act provides a working definition for homelessness that is used by VA health care system, “namely 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.”³¹

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.³² It is also often difficult to provide effective palliative and hospice care services in these settings. 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.

The 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. The 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. The VA Benefits office is working collaboratively with VA health care system, VSOs, and state Veterans programs to help Veterans obtain benefits, such as disability benefits. Examples include developing an understanding of how chronic PTSD can cause disability. Lack of income because of inability to work or maintain employment is a major cause of homelessness. This is another example of how these unique psychosocial issues are interconnected.

Slide 40

Causes of Veteran homelessness

- Limited access to affordable housing, livable income, and health care
- Lingering effects of Post Traumatic Stress Disorder (PTSD)
- Substance abuse
- Lack of family and social support networks

There are a complex set of factors affecting all homelessness, such as an extreme 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.³³

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

Reference: <http://www.nchv.org/background.cfm#facts>

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

Reference: <http://www.nchv.org/background.cfm#facts>

The following are some brief statistics about the homeless Veteran population in the U.S.:³⁴

- 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 abuse 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 VA reports that the nation's homeless Veterans are mostly males (4% are females). The vast majority is single, most come from poor, disadvantaged communities, 45% suffer from mental illness, and half have substance abuse 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.

Slide 43

VA homeless programs

- Every medical center has a homeless Veteran services coordinator
- Health Care for Homeless Veterans Program (HCHV)
- Project CHALENG
- Nearly 40% decrease in the number of homeless Veterans from previous estimates of 250,000
- Domiciliary Care for Homeless Veterans Program (DCHV)

The VA has had a programmatic response to the issue of homelessness among Veterans.³⁵ These programs include the Homeless Veteran Program Coordinators at each VA facility can be an important source of information about the services for homeless Veterans provided through the Veterans Health Administration. 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.

Project CHALENG (Community Homelessness Assessment, Local Education and Networking Groups) requires each 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.³⁶

Health care programs for homeless Veterans

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 abuse.³⁷

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.³⁸

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).

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. This represented a reduction of homeless Veterans from more than 195,000 to about 154,000.

Summary

Slide 44



Psychosocial issues such as post-traumatic stress disorder, military sexual trauma, substance abuse, 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. Post-Traumatic 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 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.

Resources

NHPCO grants re: Veterans/homelessness and EOL Care:

http://www.nhpco.org/files/public/Veterans/Deliverable_Three_Handout.pdf

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