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The Importance of Understanding Military Culture in Delivering Mental Health Care to Veterans: An Educational Intervention and Toolkit to Inform and Assist Civilian Providers

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The Importance of Understanding Military Culture in Delivering Mental Health Care to Veterans: An Educational Intervention and Toolkit to Inform and Assist Civilian Providers

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Abstract

Background and Review of Literature: United States Veterans are a unique population of individuals who require specialized mental health care. A review of literature revealed the Veteran population is primarily treated by civilian providers in the community who are often unaware of the impact of military culture on Veterans. Since this lack of awareness can be very disruptive to treatment and ultimately to the healing process, there is a need for advocacy related to the cultural ramifications of military service. **Purpose:** The DNP project goal was to increase civilian provider knowledge of the Veteran's experience. **Method:** The project was developed and executed over a one-year period and included an education intervention of a one hour long Military Culture Curriculum with Toolkit for 36 civilian providers who are caring for Veterans in community mental health clinics. Civilian providers were issued identical surveys before and after an educational intervention. The Toolkit was provided via email after the zoom session for "at your figure tip" access to the screening tool. **Results:** The results were analyzed using a paired t-test, and included qualitative results from written and verbal participant feedback. Although the survey results were not statistically significant, results were overwhelmingly positive and affirmed that the education was important and well received. **Implications/Conclusion:** Civilian providers who are educated regarding military culture will have better insight and knowledge to improve advocacy and care for the Veteran population.

Keywords: Combat Veteran, Military culture, Military cultural competence, United States Marine Corps, Navy, Army, Air Force, Cultural Competence, Civilian Clinician

The Importance of Understanding Military Culture in Delivering Mental Health Care to Veterans: An Educational Intervention and Toolkit to Inform and Assist Civilian Providers

Introduction

Care of the Veteran with co-morbid psychiatric and medical issues can be complicated. A Veteran's medical issues can be compounded based on Military era (World War II, Vietnam, Gulf War I, Operation Iraqi Freedom, Operation Enduring Freedom, etc.), duration and type of service. The cluster of issues innate to Veterans can include post-traumatic stress disorder (PTSD), mild traumatic brain injury (mTBI), homelessness, substance use disorder, and can often be an experience which the civilian population simply does not share. The Veteran's Administration (VA) is equipped with resources for each era of service and the associated issues. However, the provider shortage at the VA has sent Veterans out into the civilian community seeking care. Consequently, of the 22 million US Veterans, only about 8.9 million utilize the VA, which leaves almost 13 million Veterans receiving care solely from the community (Olenik et al., 2015).

Civilian providers who see most of the Veterans are not usually educated on the specialized care and attention Veterans need to reacclimate to civilian life. It is estimated that 41% of Veterans have a mental health disorder and greater than 82% of Veterans experience a chronic pain syndrome. PTSD rates among Veterans are four times higher than those among the civilian population. Accordingly, Veterans are more apt to develop a substance use disorder (Olenik et al., 2015). Approximately 50,000 Veterans are homeless, which is about 12% of the homeless population (Olenik et al., 2015). Veterans are twice as likely to commit suicide when compared to civilians (Olenik et al., 2015).

Veterans often need treatment for any number of mental health and physical issues that can be attributed to their time spent serving their country. These Veteran cultural issues are salient and require provider understanding to identify and treat them appropriately.

Problem Statement

Caring for the complicated co-morbidities that Veterans experience requires specialized, culturally competent knowledge. Civilian providers are not educated on the unique Veteran experience. Improving provider access to the military cultural education intervention will improve care. The DNP Student's study is a quality improvement project developed to educate civilian providers in the community about the Veteran experience. The educational intervention utilizes an interactive presentation as well as a Toolkit to lend clarity to Veterans' military culture.

Background

Community (civilian) providers are becoming more involved with Veteran care each day without being appropriately taught how to respond to their unique needs. When Mission Act of 2019 was signed by Presidential Order, the purpose was to increase resources and add providers by contracting care of Veterans to the community, thereby reducing wait times and improving access. Care is becoming more accessible, but high quality care remains inaccessible due to a lack of incorporation of military and Veteran education in provider training programs. Predetermined attitudes, stereotypes and behaviors of civilian providers when caring for Veterans can be a barrier for good care. (Tanielian et al., 2014; Olenick et al., 2015). It is estimated that only 1/3 of civilian providers ask for Veteran status (Cogan et al., 2018; Meyer et al., 2016; Miller et al., 2014; Vest et al., 2019), and of those who do ask most do not feel Veteran status should

impact care (Meyer et al., 2016). While Veterans come from all socioeconomic status, race and geographic regions, military culture has been cited as more powerful than any other cultural affiliations (Meyer et al., 2016). Care should be Veteran centric and culturally competent, because understanding Veteran status is key to competent care. The research revealed a basic misunderstanding among civilian providers regarding the importance of Veteran status in diagnostic care and treatment.

Improving the community provider's understanding of the Veteran experience including a review of branch, military history, and the military cultural tradition could improve mental health care delivery to Veterans. Additionally, it will help to improve care and outcomes for the mental health issues that these men and women experience. Caring for a Veteran within the framework of their culture is difficult because most civilian providers have never been educated on military culture. A culturally competent provider would understand that time spent in the military carries additional complications not experienced by civilian patients (Veterans Administration, n.d.). Each branch and era of service has a unique set of associated exposures and subsequent issues; therefore, each era would warrant different types of screenings. Consider, for example, the most recent Combat Veteran: Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF). These Veterans are part of the longest standing war in United States history, presently 19 years and counting. These Veterans are in their mid-20s to 50s, men and women, often people who may not appear to be the traditionally pictured Veteran. OEF/OIF Veterans are typically surviving war, which exposes them to unprecedented complications experienced in previous eras - for example blast injuries, Improvised Explosive Device explosions, burn pits, frequent and long deployments, changes in military structure and

ranking, and moral injury (Vest et al., 2019; Veterans Administration, n.d.) - OEF/OIF Veterans are a high-risk group for several specific combat related clinical issues which are not being addressed in terms of their military service (Vest et al., 2019). Civilian providers are unaware that a connection even exists. Without the context of OEF/OIF Veteran, symptoms such as personality changes, loss of inhibitions, severe substance use and abuse, periods of depression, anger, and hypervigilance may be thought to be a substance use disorder, not mTBI, PTSD, or exposure to depleted uranium. Veteran status is key to differentiating a culturally competent diagnosis.

Veteran cultural competence is a challenge, acknowledged even by civilian providers who recognize their difficulty in caring for this population. Only 7.7-8% of civilian providers report feeling competent caring for Veterans (Meyer et al., 2016; Tanielian et al., 2014). Cogan et al. (2018), found that in a survey of New York state civilian providers only 2- 3% are effectively caring for Veterans using clinical practice guidelines and evidence-based care (Fredricks & Nakazawa, 2015). Use of evidence-based care results in reduction of Veteran care drop out, reducing rates of suicide, homelessness, unemployment, substance use, domestic violence, PTSD symptoms (Vest et al., 2019) and engagement of the Veteran in rehabilitative care (Miller et al., 2014). Training and education should be embedded into all provider educational programs. The education should include the need to screen for military service, military specific issues and appropriate care delivery to meet the needs of the Veteran. Social work programs are incorporating Veteran education into their curriculum, but other provider education systems have only considered rolling out such an initiative (Canfield & Weiss, 2015). Education would increase a provider's understanding of the significant impact the

military has on mental health.

Review of the Literature

The DNP Student examined a current body of research by a search within the Five College Catalog/UMASS Electronic Subscriptions database of the terms or keywords ‘combat Veterans or Veterans or military or war or combat’ AND ‘community psychology and community mental health’ AND ‘military cultural competence’. The search was limited to 2014-2019, full text available, peer-reviewed articles within PsychInfo, ScienceDirect, Gale OneFile: Health and Medicine and Psychiatry Online. The filtered search yielded 106 articles. Articles that were excluded were in a language other than English, studies which included civilians, and studies which erroneously populated into the results. Sixteen (16) total articles were included. Eight (8) qualitative studies, three (3) quantitative studies, one (1) cross sectional review and one (1) case study with circumstantial evidence as well as noted evidence found in one (1) comprehensive literature review and two (2) social commentary pieces, to include a call to research to improve Veteran outcomes post deployment were included in this review. Throughout the literature review it became apparent that military cultural competency is a novel topic. Additionally, there is much misunderstanding around military service and mental health. Common themes which will be discussed in this literature review are military cultural competence, barriers to evidence-based practice, and military specific screenings and behaviors.

Military Cultural Competence

There is a major gap in knowledge and skills for civilian providers when trying to understand the Veteran population. Despite the fact that the war in Afghanistan is the

longest in US history at 19 years and counting, military cultural understanding remains mediocre at best. Only 23% of Tricare (military insurance) civilian providers report an understanding of military culture (Meyer et al., 2016) despite 70% of Veterans receiving health care primarily through civilian providers (Cogan et al., 2018). Certificate and continuing education courses have been developed to assist in provider military competence (Meyer et al., 2016; Canfield & Weiss, 2015) however most civilian providers still do not screen for military service (Cogan et al., 2018; see also Meyer et al., 2016; Miller et al., 2014; Vest et al., 2019), nor do they understand the importance of military service when diagnosing.

Military culture and Veteran status is key in diagnostics. The military creates a lifelong cultural influence which yields specific issues that should be addressed (Meyer et al., 2016). A basic understanding of Veteran and military culture would allow the provider to associate specific types of disorders and issues with the Veteran patient. Upon swift identification most diagnoses are treatable with appropriate evidence-based therapies and care. Civilian providers are integral in caring for this at-risk population, within the framework of their cultural needs.

Specific Military Screenings and Behaviors

The primary step to caring competently for Veterans is screening them appropriately. Screening is key to understand potential combat, environmental and deployment exposures (Vest et al., 2019). The secondary step is realizing that military service impacts diagnosis. The misperception that Veteran status is unimportant delays care. Veteran status allows the provider to frame the patient within the correct lens to delve further into their military cultural history.

Once Veteran status is identified the provider must ask additional qualifying questions. The questions should identify their branch of service, era of war, if and where they deployed as well as their job in the military. These details are critical for understanding how to care for each individual because these answers identify exposures. Attached in Appendix G is a breakdown of exposures listed by era as well as appropriate screenings recommended by the VA. Recommended screenings that should be completed by civilian providers caring for Veterans are the PCL-M screen for PTSD, PHQ-9 for suicidal ideation, the ASSIST tool for substance use and the AUDIT- C for Alcohol use (myHealthvet, n.d.). Additionally an informal screen for homelessness should be completed. These important screenings may be overlooked had the provider been unaware of Veteran status, potentially delaying care.

Once a Veteran has been identified and screened appropriately, providers must understand that caring for them is different than caring for non-military civilians. These differences are complex but two important distinctions are noted as perception of pathology and mental health stigma. While they may share disorders with their civilian counterparts, many maladaptive/pathological behaviors for a civilian are adaptive and lifesaving when in the military (Cogan et al. 2018; Meyer et al., 2016). Members of the military are often “mission oriented, expected to make sacrifices and [are] defined by their ability to function. Servicemembers can have a wary relationship to mental health. Many equate having a mental health diagnosis with being ‘broken ‘ or ‘weak’, while seeking care is perceived as selfish and mission compromising.” (Meyer et al., 2016, p. 29) While mental health stigma is present across many populations, this understanding of mental health is distinctly different from their civilian counterparts in that weakness is

literally trained out of them and they perceive any mental health concern as putting everyone in danger (Meyer et al., 2016; see also Hoge et al., 2014; Miller et al., 2014, 2017;) These finer points are important to understand when providing care.

Evidence-Based Care and Barriers

There are specific and frequently observed mental health issues identified for combat Veterans including PTSD, Moral injury, mTBI, depression, substance use disorders (SUD), homelessness and a high prevalence of suicidality. VA utilizes evidence-based care (EBT) and best practices to care for Veterans who are dealing with these issues because they are effective. Civilian providers do not share this adherence to evidence-based practices when caring for Veterans. It is important to note that best practice would include intensive prolonged Exposure Therapy in theater (the combat zone) closely following an adverse event (Cirang & Peterson, 2017). The minimally adequate evidence-based treatments for PTSD are 8-10 sessions of prolonged Exposure Therapy (PE), Cognitive Processing Therapy (CPT), Stress Inoculation Trainings (SIT), or Eye Movement Desensitization and Reprocessing Therapy (EMDR) (Richards, et al., 2017; Hoge et al., 2014). The community use of these therapies is minimal at best. Reportedly, around 13% of civilian providers understand the unique Veteran perspective and are using the EBT for PTSD (Currier et al., 2017). The poor adherence to EBT delays improvement of symptoms.

EBT is effective and screening Veterans allows civilian providers to properly frame care. However, perception appears to be a preventative factor for both tools. In a qualitative study of community primary care providers, Vest et al., (2019) found that civilian providers perceived Veteran status as not impacting the care plan. They also

cited poor knowledge of military culture and available resources. Miller et al., (2014) performed a qualitative study of civilian providers and found a lack of screening for Veteran status, and if Veteran status was known, lack of screening for Veteran centric issues. The authors also found clinicians were untrained in EBT for mTBI and PTSD (Miller et al., 2014). If they were trained, they remained skeptical of the relevance of EBT in their particular case (Miller, et al., 2014). Other issues in deploying EBT include training and confidence in using the therapies (Finley et al., 2018; Miller et al., 2014; Stirman et al., 2013). Civilian providers could benefit from education on how and when to use EBT with Veterans.

Limitations to the Studies

There were limitations to the body of evidence. Most civilian Veteran care occurs in rural places, where access to the VA is limited (Veterans Administration, n.d.), however most studies included in the literature review did not examine rural civilian providers. The studies tend to utilize small convenience samples. The authors also tend to sample just one branch of military, one era or one group of civilian providers which minimizes the generalizable status of the study (Morissette et al., 2018; Miller et al., 2014). There are very few studies on military cultural competence and finding viable studies to contribute to the body of literature was challenging.

Summary of Literature

The essential information gained through literature review is that joining the military is a life altering experience. Veteran status can lead to several specific mental health experiences which can be treatable with appropriate screening and care. Based on the review of literature providing an educational intervention to civilian providers to

encourage screening for Veteran status and associated follow up screenings (PCL-M, ASSIST, PCL-9, AUDIT-C, homelessness) is the most appropriate method to meet the gap in practice and improve Veteran care in the community.

Theoretical Framework: Stetler Model of Evidence-Based Practice

The Stetler Model of Evidence-Based Practice (EBP) is a theoretical framework which uses EBP to allow for the nurse to become an active participant in the goals and outcomes of patient care (Reavy & Tavenier, 2008). The Stetler Model links research and is best used when there is good evidence to support a change, when the current practice is in need of a change and when the change is possible. The DNP student's project meets these standards in that there is evidence to support the viability of the military being a cultural entity of its own, there is a need for improved care in the community as more Veterans move into the private sector, and the potential for change through knowledge is feasible. The Stetler Model of EBP is essentially a model that helps the DNP student set the phases to the capstone project. The Stetler Model has Five Phases: Preparation, Validation, Comparative evaluation, Translation/ application and Evaluation.

Phase 1

The Preparation Phase requires an assessment of the need for change. The goal would be to determine the need for military culture competent care in a rural civilian mental health clinic; create and modify a military cultural competence pre- and post-survey.

Phase 2

The Validation Phase requires a verification of the efficacy of the evidence. To

achieve validation, a cultural competence pre-survey was administered to civilian providers to determine their interpretation of the importance of current military cultural competence. Concurrently, informal interviews with Veterans were conducted to validate the understanding of what they would like civilian providers to know. As the evidence has been verified, it would now be appropriate to develop a culturally competent curriculum and Toolkit for stakeholders to utilize in practice.

Phase 3

The Comparative Evaluation Phase allows for a step back from the evidence to look holistically at the problem and the proposed solution. Within this phase it was important to complete the developed Toolkit and curriculum utilizing most current available information from the Department of Defense and other experts in care (for example, VA).

Phase 4

Translation/Application is the physical manifestation of the project. Within this phase there was a dissemination of the curriculum and Toolkit to the stakeholders (including mental health case workers/counselors, psychiatrists, psychologists, social workers, psych mental health nurse practitioners and students) involved in Veteran care in a large community provider clinic.

Phase 5

Evaluation phase is an assessment of the expected outcomes versus the true outcomes. After the curriculum had been taught there was an administration of a post test to determine effectiveness and usefulness of Toolkit and curriculum. The post offered feedback about whether the importance of military cultural competence was achieved or

improved from the educational series.

Methods

The Quality Improvement (QI) project was a DNP student-developed curriculum which included an education intervention with Tool Kit (included in Appendix F). The intervention, Veteran Culture Overview Training (VCOT) curriculum (The outline can be viewed in Appendix D), was accompanied by a student-developed pre and post survey (Appendix E).

Goals, Objectives, and Expected Outcomes

The overarching goal of the Quality Improvement Project was to help civilian providers understand the importance of Veteran status regarding mental health care. The project aimed to teach civilian providers at the most basic level how to provide screening and care to a Veteran in the civilian environment. The following goals reflect the project aims.

Goal 1. Educate stakeholders on the importance of military experience in terms of mental health issues and treatment

Objective 1a. Develop a Veteran Culture Overview Training (VCOT) with Toolkit.

Objective 1b. Dissemination to 100% of the staff: training and VCOT Toolkit.

Objective 1c. A 50% improvement in the scores from pre to post survey (Appendix E) indicating improved understanding of importance of military specific issues.

Objective 1d. A 75% improvement from pre to post survey scores indicates an improved likelihood of understanding the importance of culture in terms of obtaining military history.

Goal 2. Provide education which encourages civilian providers to screen for Veteran status.

Objective 2a. Create signage as part of the Toolkit to be hung in provider offices which encourages Veteran status self-disclosure.

Objective 2b. Create a script which civilian providers can use to discuss Veteran status.

Goal 3. Provide education which encourages civilian providers to screen Veterans for mental

health issues based on Veteran status and era and area of service.

Objective 3a. Create a script for screening patients based on era and area of service

Objective 3b. Provide a Toolkit with recommended screenings included for quick reference and use.

Expected Outcome The intent of the project was to educate civilian providers to adjust their perception of understanding regarding the importance of military culture when caring for Veterans, thereby encouraging them to seek out more training.

Population and Project Site

Initial population and project site determination was established August 2020 through December 2020. The project site was a large community-based health center with more than 80 services offered for people in their homes, workplace, community and

schools. The health center services people across the lifespan from all over Western Massachusetts and Connecticut. The stakeholders and those who are participating in the training are civilian providers, specifically: therapists, social workers, patient advocates, psychiatric nurse practitioners, mental health counselors, and their management.

According to the project site website, the stakeholders value cultural diversity and strive to provide multicultural and holistically competent care. At this particular site, the patient population is varied. In the surrounding community there are over 91,000 Veterans in western MA, and only 30% use VA healthcare (National Center for Veteran Analysis and Statistics, 2018). There are over 30,000 Veterans in Hampden and Franklin county, where the large community health centers have locations (National Center for Veteran Analysis and Statistics, 2018).

Measurement Instruments

In order to measure the outcomes of this DNP Project, a student-developed pre/post survey was utilized. The pre/post survey was a 3-point Likert-type scale used to assess provider perception of the importance of screening for military service. The 10-question scale was rated from 0-20. A lower score (0-7) indicates a perception of Veteran status being unimportant to mental health care, a mid-range score (8-14) indicates indifference and a higher score (15-20) indicates a perception of Veteran status being important to mental health care. Each answer was assigned a point value, zero for unimportant, one for neutral and two for important. Since this is a student-developed survey the reliability and strength were not tested, although informal face validity was verified by an expert PMHNP prior to distribution. The 10 questions were selected based on some of the most frequently experienced complications experienced by the Operation

Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) Veteran population. The questions examined the understanding of the importance of Veteran status, combat Veteran status, military experience in terms of mental health care, traumatic brain injury screening, PTSD screening, alcohol and drug use, suicidal, homicidal ideation, homelessness, and understanding of military culture.

Pre Intervention

The Quality Improvement (QI) project began with an abundance of research. In January the DNP student presented an introduction to the project to the Student Advisor, immediately continuing with more research through August 2020. Research involved viewing current military cultural curriculum including the Home Base Curriculum, Psycharmor training, Center for Deployment psychology training, VHA Train and Military OneSource Training; reading books on military and military culture for example, *The Things they Carried* by O'Brien, T.; *Tribe* by Junger, S.; *Afterwar*, Sherman, N.; *Redeployment* by Klay, P.; *Billy Lynn's Long Halftime Walk*, Fountain, B; *The Culture of Military Organizations*, Mansour, P. & Murray, W; *Hillbilly Elegy* by Vance, J. Concurrently, informal conversations with Veterans occurred discussing what they believed their civilian providers should know when treating them. A skeleton of the curriculum was developed in May-June 2020; in July through August 2020 the curriculum, platform and Toolkit were finalized. The DNP student met with the stakeholders' leadership in November. The leadership reported Veteran care is challenging and the staff are not comfortable caring for Veterans, they do not understand the specialized needs specifically because they do not care for Veterans often (2020). Leadership of the clinic accepted the educational intervention, VCO Training and Toolkit

as a viable topic for their February 2021 staff meetings. Incorporating the training into the staff meeting was an effort to create a perception of less work. The staff of the office have quite a heavy workload and to add another training to their plate did yield resistance. Requesting a pre and post training survey was a lot for the civilian providers. The largest barrier to this project was clearly engaging the stakeholders. They appeared to lack awareness of just how many Veterans they serve daily, despite learning this, the civilian providers still found it difficult to make time to complete the pre and post survey. The project was filed with the Internal Review Board to meet the ethics requirements of working with human subjects.

Ethical Considerations/Protection of Human Subject

The University of Massachusetts, Amherst (UMass) Human Research Protection Office reviewed the DNP project and determined it did not meet the definition of human subject research and therefore Internal Review Board approval was not needed.

November 2020 a letter of clearance was received, this letter is not included in the appendix due to privacy constraints. All participants were protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) which, among other guarantees, protects the privacy of patients' health information (Modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules, 2013).

Additionally, the educational intervention was preceded by an announcement from the DNP student that all participation is strictly voluntary; the civilian clinicians were not required to complete the survey to receive the educational intervention. The verbal attestation outlined that the material may be sensitive in nature and all results of pre and post survey will be kept anonymous and confidential, the alpha numeric code is blind to

the DNP student. All information collected as part of evaluating the impact of this project were aggregated data from the project participants and did not include any potential patient identifiers. The risk to stakeholders participating in this project was no different from the risks of students receiving standard educational information.

The Toolkit and survey were emailed in PDF and Word format to the clinic director of operations. A brief email was copied to the civilian providers to encourage them to fill out the pre survey prior to the meeting. Civilian providers were encouraged to code their surveys (pre and post) with their middle initial and numerical day of birth. The presurvey is a baseline measure of the civilian providers understanding of the importance of veteran status. It is a ten question survey that uses a 3 point Likert type scale. The questions are rated from unimportant (0 points) neutral (1 point) and important (2 points). The total score can range from zero to twenty. The first three (3) questions address screening for Veteran status and care plan development. The next five (5) questions discuss the importance of screening for Veteran centric issues: TBI, PTSD, alcohol and drug use, suicide and homicide, and homelessness. The last two (2) questions reflect on understanding the military as a culture. The survey can be found in Appendix E .

Intervention

Due to CoVID-19 the hour long multimedia curriculum was delivered live over Zoom and included the following topics: cultural briefing on different branches; common cultural consistencies within the branches, review of common military terms and their importance, the difference between a combat and non-combat Veteran, common issues related to combat Veteran status, review of the role stigma plays in mental health within the military framework, and discussion of appropriate logistical care for the combat

Veteran. Following the presentation, a Toolkit based on the Veterans Health Administration (VHA) guidelines of care was emailed to the participants. The toolkit included a welcome home sign to encourage Veteran status self-disclosure; helpful resources list, including military family resources, drug and alcohol resources, PTSD assistance as well as a number of other resources; a written script for screening Veteran status; a ranking chart with ribbons; homelessness benefit form; PCL-M, ASSIST V 2.0, CAGE, PHQ-9 and Veteran specific crisis materials (toolkit found in Appendix F). The educational intervention lasted the full 45 minutes available therefore questions were primarily emailed retroactively through the program director to the DNP student.

Post Intervention

Following the VCOT presentation and email delivered Tool Kit, the 36 civilian providers were encouraged to participate in a post intervention survey, through an email delivered by their management. The post survey was identical to the pre survey. It is a ten-question survey that uses a 3-point Likert type scale. The questions are rated from unimportant (0 points) neutral (1 point) and important (2 points). The total score can range from zero to twenty. The first three (3) questions address screening for Veteran status and care plan development. The next five (5) questions discuss the importance of screening for Veteran centric issues: TBI, PTSD, alcohol and drug use, suicide and homicide, and homelessness. The last two (2) questions reflect on understanding the military as a culture. The survey can be found in Appendix E. Twelve civilian providers filled out the post survey. To protect anonymity the survey was coded with a three-digit alpha numeric (middle initial and day of birth) to link the pre and post surveys to allow for matching and comparison. The goal of the surveys was to establish a

baseline then determine changes of perceived importance of military culture on Veteran mental health after completing the education. Surveys were returned to the student through email by way of the program director. The first training yielded twelve civilian providers who all completed the pre and post surveys.

Results

Quantitative data was analyzed using a Matched-pair t-test. The matched-pair t-test was used to determine statistical significance of the data. The pre and post surveys were documented on an excel spreadsheet to allow for simplicity of comparison of the matched scores. Table 1 clearly shows the data. A t of 1.48324 was used with degrees of freedom equaling 11. A 95% confidence interval was assessed with the difference from -0.83 to 0.16. The two tailed p value was 0.1661 which is not considered to be statistically significant at $p < .05$.

Table 1.*Pre and Post Survey Scores with Two tailed t test*

Identifier	Gender	Generation	Pre Survey (x1)	Post Survey (x2)
M15	F	Baby Boomer	20	20
E4	M	Gen X	20	20
J6	F	Baby Boomer	20	20
E28	M	Baby Boomer	20	20
E27	F	Gen X	20	20
K5	F	Millennial	20	20
Z15	F	Millennial	20	20
A17	F	Millennial	18	20
X14	Other	Millennial	20	20
F17	F	Millennial	18	20
B13	F	Millennial	20	20
K7	F	Gen X	20	20
n:	12	Sum:	236	240
df =				
n-1	11	mean:	19.66666667	20
		SD:	0.78	0
		Standard error of difference	0.22	0
		two tailed p value	0.1661	
Confidence interval mean pre-post		95% -0.33	-0.83	0.16

Note: The raw data and calculation results of the pre and post survey scores. SD= standard deviation; F= female; M= male; df=degrees of freedom; n=sample size

Prior to CoVID 19, it was anticipated around 36-40 participants would respond to the surveys, however, for the first intervention only twelve (12) filled out the pre/ post survey. The 10-question scale was rated from 0-20. Each answer was assigned a point

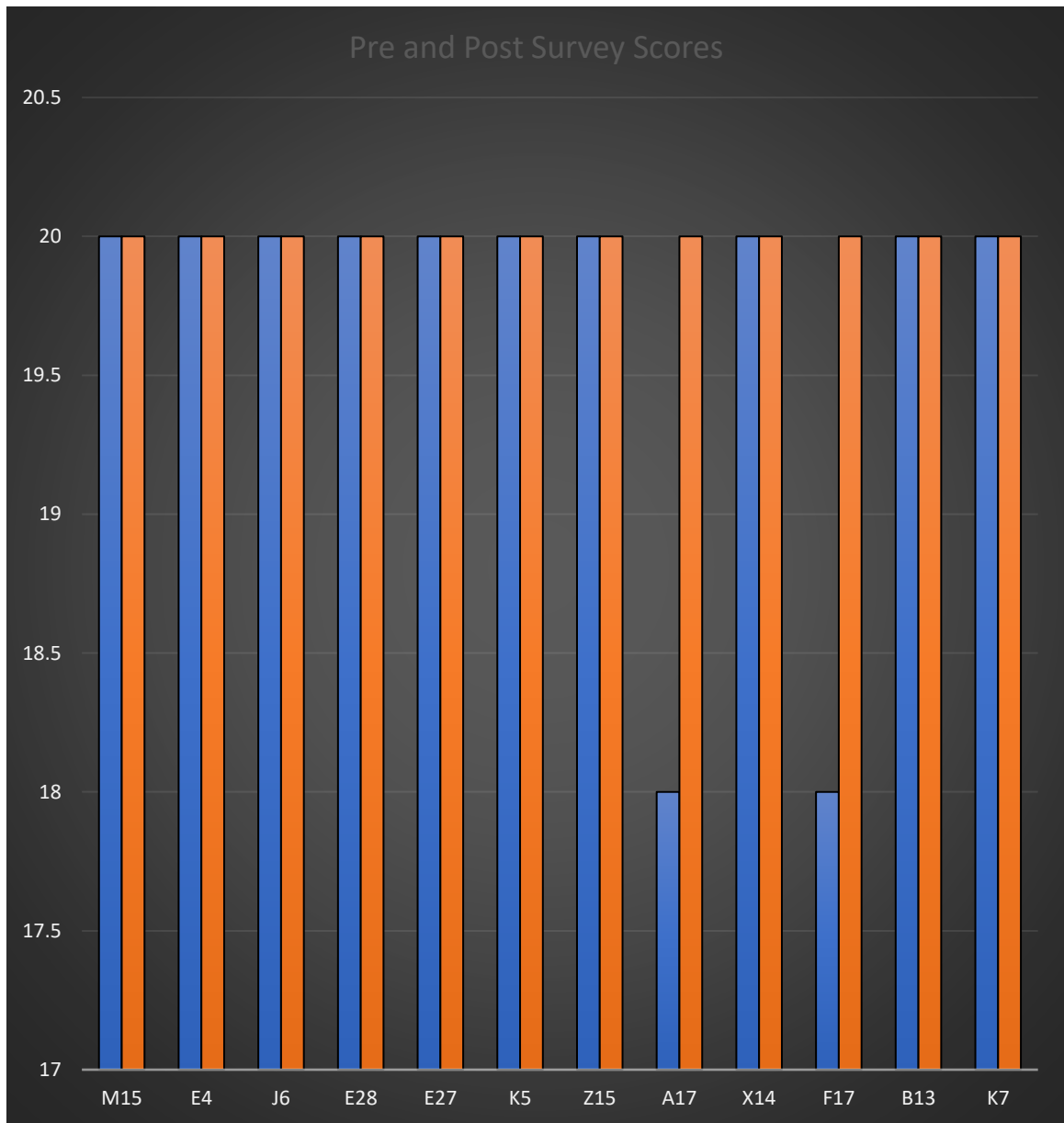
value, zero for unimportant, one for neutral and two for important. A lower score (0-7) indicates a perception of Veteran status being unimportant to mental health care, a mid-range score (8-14) indicates indifference and a higher score (15-20) indicates a perception of Veteran status being important to mental health care.

There have been no studies to date which assess the understanding of importance of military cultural competence, so the questions are based on themes seen in the literature and modeled after recommendations of the VHA. Of the twelve civilian providers only two scored an 18, the other 10 civilian providers scored a 20, which was the highest score possible. The post survey results revealed that all 12 civilian providers scored a 20 which indicated an understanding of the importance of Veteran status in terms of mental health care. Scores are graphed in Figure 1.

The first respondent who scored an 18 on the pretest responded neutrally to questions 9 and 10, the importance of understanding military as a culture as well as the importance of understanding the military. The second respondent who scored an 18 responded neutrally to questions 4 and 9, the importance of screening a veteran for TBI or blast related injury and the importance of understanding the military as a culture. Despite the small sample size, it seems meaningful that of the two respondents who did not score a 20, both cited neutrality when asked about the importance of military as a culture.

Figure 1

Pre and Post Survey Scores for 12 Civilian Providers



Note: Visual representation of the results of the pre survey (in blue) and post survey in orange. A17 answered questions 9 and 10 with a neutral response, F17 answered questions 4 and 9 with a neutral response.

The data acquired from the pre and post surveys were quantitatively analyzed using descriptive statistics, they can be viewed below in table 1. The mean for the pre survey was 19.67, post was 20. Standard Deviation for the pre group was 0.78, post was 0.00. The standard error of difference was 0.225 for the pre group and 0.00 for the post.

In addition to the quantitative results, qualitative data was received. The data came by way of questions and comments emailed to the DNP student, verbal comments after the presentation and written feedback on the bottom of the surveys. The emailed feedback was overwhelmingly positive, citing that the education was important and helpful. Written feedback from two of the participants was as follows: “Thanks for providing a start toward more cultural competence. I learned much, and have more to learn...”; “Your presentation further emphasized the culture of the military and the trauma that a lot of veteran’s experience. Thank you.” The verbal feedback also included reflection on the poignancy of the visuals of the presentation, as well as the pleasure in learning about evidence-based practice and the surprise in learning of stolen valor. While this feedback cannot be quantified, it does speak to the importance of the curriculum.

Discussion

This project was an educational intervention delivered to civilian clinicians (mental health counselors, medication providers, social workers, patient advocates, and program management) in a large community-based outpatient clinic. The intervention included a toolkit and hour-long didactic presentation. The quantitative value of the material was measured using a pre and post survey. The data analyzed in this QI project showed no statistical significance, however considering the small sample size it is difficult to say if this is an accurate portrayal of civilian clinician understanding. Also, the

pretest did not fully affirm the DNP students theory that based on the literature, civilian providers have very little understanding of mental health care for Veterans. Had the sample size been larger, the outcomes likely would have been different.

Following the educational presentation, civilian providers discussed the importance of understanding evidence-based therapies and wanting to learn more, some even discussed different trainings they had sought out to include some of the resources suggested by the DNP student. Many reported that topics surprised them, and that training affects them professionally as well as within their personal families. The feedback received from the surveys, through email, and verbally was overwhelmingly positive and reassuring. The results revealed that participants already understood the importance of Veteran status and most of the stakeholders were involved and encouraged to learn about Veteran culture, Although the majority seemed to glean the importance of the training some of the feedback indicated that more training is needed, Some of the comments implied that there remains a misperception about the number of Veterans likely seen in practice, “I do not work with Veteran’s but...”from an adult mental health civilian provider. Another comment of concern was a discussion about the validity of Hollywood as an accurate portrayal of Military culture.

Thirty-six (36) civilian providers attended the training in all, however only twelve providers completed the pre and post survey which was out of the DNP students’ control. In order to reduce emails sent to the staff, the leadership team preferred to communicate with the civilian clinicians rather than allowing the DNP student to directly email, so the pre and post surveys were sent out as a forward from the civilian clinician management team. While the majority of attendees may not have completed the surveys most of the

participants indicated to their leadership that they will utilize the toolkit regularly and refer back to the presentation for guidance. Likely, communicating directly with the staff rather than through management would have yielded more completed surveys and a comprehensive understanding of the feedback. Efforts were made to increase participation the DNP student sent out the survey twice in word and PDF format. Additionally, to increase participation the DNP student offered to bring in paper copies of the surveys and wait until they were completed by the participants. Perhaps if the information was given out by the DNP student directly with opportunity for follow up, there may have been more participation.

The pre and post surveys were informally validated due to the literature having limitations. The body of evidence is small and much of the literature is a call to action rather than formal studies. The DNP student's survey was the first of its kind and was based primarily on the recommendations of the VHA and small sample studies. Despite this, the study results aligned with the literature in that 16% of respondents on the presurvey cited the importance of the military culture as a neutral point. This is a common misunderstanding (Cogan et al., 2018; see also Meyer et al., 2016; Miller et al., 2014; Vest et al., 2019). While the survey data received was minimal, the data showed that 100% of the scores lower than 20 on the pre survey increased to 20 on the post survey. Further emphasizing the understanding of importance of military culture in mental health care.

Other barriers to the intervention were central around CoVID 19, specifically, target population, the platform delivery system, and time allotted. The original target population numbered around 75 participants. The original plan included making the

DNP student available to the civilian providers for discussion, questions, follow-up etc. However, the impact of Covid-19 pandemic and staffing constraints imposed several limits to the project. The presentation had to be moved from an in-person format to a virtual platform. The virtual platform allowed for less interaction as well as less accountability and did not facilitate an interactive discussion. Also, the education session time was reduced from 3 hours to 1 hour then to 45 minutes due limitations of available staff time. Accordingly, the training material was reduced, and the survey questions were modified to respect the time available. As a cumulative result, only 36 people participated in the presentation. and only 12 completed the pre and post survey.

In future projects, a larger more diverse sample size is recommended in order to demonstrate a change in understanding of veteran culture and statistical significance. Utilizing a rural community health center was optimal because as the literature indicates most of the veteran population does hail from rural communities. Most of the literature utilized a convenience sample of an urban civilian provider population, so this deviation to use rural providers was a strength of the QI project. In next steps offering the education intervention with toolkit to multiple offices across different regions would yield greater participation.

The project was meant to emphasize the importance of screening for Veteran status. The Stetler Model of Evidence Based Practice was used to promote this change in the standard of practice. The model is useful because the feedback that can be used from the patients and trainings creates an environment of consistent viable growth. It would be beneficial to have more time to disseminate this extensive information and to truly assess provider understanding. Additionally, similar projects would improve care for Veterans

by encouraging civilian providers to consider Veteran status when creating care plans and treating their mental health conditions.

The DNP intervention should be offered to civilian mental health clinics in New England and could be presented at conferences virtually and or in person. Furthermore, participation in this educational intervention could improve Veteran adherence to treatment, provider use of evidence-based approaches, reduction in symptomology, Veteran suicide risk and even homelessness. If this project could evolve in the future a goal would be to include more information especially around the logistics of care and evidence based practice.

Conclusion

The military experience is a life altering experience. Considering the complex diagnostic profile, Veterans exhibit, healthcare treatment can be complicated. Civilian providers have rapidly become the primary providers caring for Veterans. Delivering a culturally competent approach to mental health care is essential to caring for Veterans. The initiation of a Veteran culture educational curriculum and Toolkit is the first step in developing a culturally competent provider. The military is an entity that supersedes race, religion and any other culture of origin (Olenik et al., 2015). Moreover, the warrior culture is an elite system with a chain of command which honors selflessness, tradition, code, beliefs, honor, bravery and brotherhood. Individuals who join the military embark on a journey unique to their situation which reworks their cultural identity. Therefore, it is essential that providers understand that military culture requires a unique plan of care to treat mental health issues that are born of military service.

Civilian providers are in a position to make a salient difference in mental health

care for Veterans, utilizing an education curriculum similar to the one provided in the DNP project would be a valuable continuing education. The intervention was well received and was apparently discussed at the directors meeting. The education intervention encouraged clinicians to understand the unique needs of Veteran first and then to treat the identified needs. This DNP student has been asked to present the material at other staff meetings over the next few months. The stated aims of this project were achieved, while the results were not considered statistically significant the anecdotal evidence was overwhelming and necessary. In conclusion the QI project was a call to action for civilian providers to screen for veteran status, seek out training on military culture and to treat Veterans with culturally competent care.

References

- Atuel, H. & Castro, C. (2018). Military Cultural Competence. *Clinical Social Work Journal*, 46(2), 74–82. <https://doi.org.silk.library.umass.edu/10.1007/s10615-018-0651-z>
- Canfield, J., & Weiss, E. (2015). Integrating Military and Veteran Culture in Social Work Education: Implications for Curriculum Inclusion. *Journal of Social Work Education*, 51.
- Carlson, B. (2017). *USDA helps military Veterans answer the questions, “What’s next?”* <https://www.usda.gov/media/blog/2016/03/30/usda-helps-military-Veterans-answer-question-whats-next>
- Center for Human Development. (2020). About Us. <https://chd.org/about-chd/our-approach/>
- Cigrang, J., & Peterson, A. (2017). Stepped-care approaches to posttraumatic stress disorder: Sharpening tools for the clinician’s toolbox. *Pragmatic Case Studies in Psychotherapy*, 13(2), 142–153. doi:10.14713.132.2004
- Cogan, A., Cervelli, L., Dillahunt-Aspillaga, T., & Rossiter, A. (2018). Treating Military Service Members and Veterans in the Private Sector: Information and Resources for Clinicians. *Archives of Physical Medicine & Rehabilitation*, 99(12), 2659–2661. <https://search-ebSCOhost.com.silk.library.umass.edu/login.aspx?direct=true&db=s3h&AN=133137638&site=eds-live&scope=site>
- Currier, J., Stefurak, T., Carroll, T., & Shatto, E. (2017). Applying Trauma-Informed Care to Community-Based Mental Health Services for Military Veterans. *Best Practice in Mental Health*, 13(1), 47–64. Retrieved from <https://search-ebSCOhost->

- com.silk.library.umass.edu/login.
aspx?direct=true&db=aph&AN=123489096&site=eds-live&scope=site
- Finley, E. P., Noël, P.H., Lee, S., Haro, E., Garcia, H., Rosen, C., Bernardy, N., Pugh, M. Pugh, J.(2018). Psychotherapy practices for Veterans with PTSD among community-based providers in Texas. *Psychological Services, 15*(4), 442–452. doi:10.1037.0000143
- Freed, A.(2019). *Mental health worker’s self-reported clinical competencies and expertise in treating Veterans. Dissertation Abstracts International: Section B: The Sciences and Engineering*. ProQuest Information & Learning. Retrieved from <https://search-ebshost-com.silk.library.umass.edu/login.aspx?direct=true&db=psyh&AN=2019-00352-005&site=eds-live&scope=site>
- Hoge, C., Grossman, S., Auchterlonie, J., Riviere, L., Milliken, C.& Wilk, J. (2014). PTSD treatment for soldiers after combat deployment: Low utilization of mental health care and reasons for dropout. *Psychiatric Services, 65*(8), 997–1004. doi:10.1176.201300307
- Home Base (n.d.). *The Training institute for Healthcare Professionals*. The Red Sox Foundation. Retrieved on April 23, 2020 from <https://www.homebase.org/education-training/training-institute/courses-secondary/?type=Professionals#Course-Toggle-Top>
- Meyer, E., Writer, B. & Brim, W. (2019). The Importance of Military Cultural Competence. *CURRENT PSYCHIATRY REPORTS, 18*(3). <https://doi-org.silk.library.umass.edu/10.1007/s11920-016-0662-9>

- Miller, K., Finn, J., & Newman, E. (2014). Are Communities Ready? Assessing Providers' Practices, Attitudes, and Knowledge About Military Personnel. *Professional Psychology: Research & Practice, 45*(6), 398–404.
- Morissette, S., DeBeer, B., Kimbrel, N., Meyer, E., & Gulliver, S.(2018). Deployment characteristics and long-term PTSD symptoms. *Journal of Clinical Psychology, (4)*, 637. doi:10.1002.22535
- Office of Academic Affiliations (2019). *Military Health History Pocket Card*. Veterans' Health Administration. Retrieved April 23, 2020 from <https://www.va.gov/oa/pocketcard/>
- Olenick, M., Flowers, M., & Diaz, V. J. (2015). US Veterans and their unique issues: enhancing health care professional awareness. *Advances in medical education and practice, 6*, 635–639. <https://doi.org/10.2147/AMEP.S89479>
- Reavy K, & Tavernier S. (2008). Nurses reclaiming ownership of their practice: implementation of an evidence-based practice model and process. *Journal of Continuing Education in Nursing, 39*(4), 166–172. doi:10.3928/00220124-20080401-07
- Richards, L., Bui, E., Charney, M., Hayes, K., Baier, A., Rauch, P., Allard, M. & Simon, N. (2017). Treating Veterans and military families: Evidence-Based practices and training needs among community clinicians. *Community Mental Health Journal, 53*(2), 215–223. doi: 10.1007/s10597-016-0013-7
- Stetler, C. (2001). Updating the Stetler Stirman, S., Gutierrez-Colina, A., Toder, K., Esposito, G., Barg, F., Castro, F, Beck, A. & Crits-Christoph, P. (2013). Clinicians' perspectives on cognitive therapy in community mental health

- settings: implications for training and implementation. *Administration Policy Mental Health*, 40:274-285. doi: 10. 100/10488-012-0418-8.
- Tanielian, T. L., Farris, C., Epley, C., Farmer, C. M., Robinson, E., Engel, C.C., Robbins, M.W., & Jaycox, L. (2014). *Ready to serve: community-based provider capacity to deliver culturally competent, quality mental health care to Veterans and their families*. RAND.
- Veterans Administration. (n.d) *Military Exposures*. Veterans' Health Administration. Retrieved on April 23, 2020 from <https://www.publichealth.va.gov/exposures/index.asp>
- National Center for Veteran Analysis and Statistics. (2018). Retrieved from https://www.va.gov/vetdata/Veteran_Population.asp
- Vest, B.M., Kulak, J., & Homish, G. (2019). Caring for Veterans in US civilian primary care: qualitative interviews with primary care providers. *Family Practice*, 36(3), 343–350. doi: 10.1093/078

Appendix A

Timeline

Task	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
Introduce Advisor to Project	X													
Intensive Investigate Culture		x	x	x	x	x	x	x						
Skeleton Curriculum					x	x								
Develop Curricula							x	x						
Develop Toolkit							x	x						
Develop Platform for Curricula								x						
UMASS IRB									x					
Develop Final Pre and Post Test										x				
Final Changes on Curricula										x				
Administer Pretest														x
Teaching														x
Post Test														x

Note. Timeline covers from January 2020 through February 2021.

Appendix B Cost Benefit Analysis

Estimated Cost

The costs for the VCOT project are based primarily on staffing costs, education and materials could also be considered. Most of the needed programs are installed and exist on computer systems and frameworks. The following costs were determined using the gross costing method.

Estimated Cost Savings

The DNP project is quite inexpensive while the benefits and actual cost savings are extensive. Veteran participation in a partial hospitalization program costs about \$2600 per day. A typical stay is 21 days so the cost of treatment is \$54,600 per stay per Veteran. Without culturally competent care and EBP Veterans' mental health issues are not improving therefore increasing the likelihood of readmission. The cost of treating this Veteran, repeatedly is much higher than the cost of disseminating military cultural competency information. With the high readmission rate there is a greater possibility for acute complications, for example provider fatigue and Veteran ambivalence; as well as global issues: increased likelihood of Veteran homelessness, substance use and abuse, issues with violence, and other disabling complications. The project could be examined to determine if the information could be streamlined and delivered over a cheaper platform which would further lower costs.

Appendix C

Summary of Costs

Materials	Cost Breakdown	Cost Subtotal	TOTAL
Materials to create Cultural Competency Toolkit (Books,)	Books approx. \$75	\$75	
Education for staff to properly deliver culturally appropriate care:	36 Social Worker/Mental Health counselor @ \$30/hr. x 1 hr. class	\$1,080	
	Student NP Time and Cost	Free	
			\$1,155.00

Note: Table describing costs of project.

Appendix D. Skeleton of Curriculum

Cultural Briefing on Different branches

USMC

Army

Air Force

Navy

Common cultural consistencies

Background of those who enlist

Support prior to separation/medical discharge

Transition complications military to civilian

Understanding some common terms and their importance

MOS

Chain of Command

Nuances of each branch

What does the military offer for support (unofficially)

Common issues related to combat Veteran status

TBI, Blast injury, Marital issues, child abuse, physical abuse, drug and alcohol abuse, homicidal and suicidal ideation, moral injury, depression, anxiety, loss of purpose/ mission

Understanding the stigma of mental health within the military framework

Warrior culture

What this could do to their career

Identity

Teaching on appropriate physical logistics of caring for the combat Veteran

location in the room

open/close door

threatening behavior

triggering behaviors

Toolkit Skeleton

Welcome home sign

Helpful resources list

Script for screening for Veteran status (available for review in Appendix F)

Ranking chart with ribbons

Homelessness benefit form

PCL-M,

ASSIST V 2.0

CAGE

PHQ-9

Veteran specific crisis materials.

**Appendix E.
Pre/Post Survey**

Pre/Post Assessment: Gender : F M Other

Generation:

Baby Boomers
1946-1964

Millennials
1980-2000

Generation X
1965-1979

Generation Z
2001-present

How important is it to screen for Veteran status?

0. unimportant, 1. neutral, 2. important

How important is it to screen for combat Veteran status?

0. unimportant, 1. neutral, 2. important

How important is acknowledging military experience in terms of mental health care?

0. unimportant, 1. neutral, 2. important

How important is Veteran status regarding developing a care plan?

0. unimportant, 1. neutral, 2. important

How important is it to screen a Veteran for TBI or blast related injury?

0. unimportant, 1. neutral, 2. important

How important is it to screen a Veteran for combat related PTSD?

0. unimportant, 1. neutral, 2. important

How important is it to screen a Veteran about alcohol and drug use?

0. unimportant, 1. neutral, 2. important

How important is it to screen a Veteran about suicidal and homicidal ideation?

0. unimportant, 1. neutral, 2. important

How important is it to screen a Veteran about homelessness?

0. unimportant, 1. neutral, 2. important

How important is military experience culturally?

0. unimportant, 1. neutral, 2. important

How important is it to have a baseline understanding of the military?

0. unimportant, 1. neutral, 2. important

**Appendix F.
Cultural Competency Toolkit**

Cultural Competency Starter Toolkit
WELCOME HOME SIGN
HELPFUL RESOURCES
SCRIPT FOR VETERAN STATUS
RANKING CHARTS WITH RIBBONS
HOMELESS SCREENING/ BENEFIT FORM (SSVF V5. 2020)
PCL-M
ASSIST V 2.0
CAGE
PHQ-9
Veteran Crisis Materials



IT'S YOUR CALL

**Confidential help for
Veterans and their families**

Reference List

WELCOME HOME SIGN

Image retrieved from <https://images.app.goo.gl/4bH4ZcMe4aVp8qei6>
Compiled by Ashlee Costa

SCRIPT FOR VETERAN STATUS

Written By Ashlee Costa, MSN, RN

RANKING CHARTS WITH RIBBONS

Charts retrieved from Halvorson, A. (2010) *Understanding the Military : The Institution, the culture and the People*. Retrieved from https://www.samhsa.gov/sites/default/files/military_white_paper_final.pdf

HOMELESS SCREENING/ BENEFIT FORM (SSVF V5. 2020)

Please utilize form with Guidebook
https://www.va.gov/HOMELESS/ssvf/docs/SSVF_Program_Guide_December_2018_FINAL.pdf

PCL-M

Weathers, F.W., Litz, B.T., Keane, T.M., Palmieri, P.A., Marx, B.P., & Schnurr, P.P. (2013). The PTSD Checklist for DSM-5 (PCL-5). Scale available from the National Center for PTSD at www.ptsd.va.gov.

ASSIST V 2.0

The NIDA-modified ASSIST was adapted from the World Health Organization (WHO) Alcohol, Smoking and Substance Involvement Screening Test (ASSIST), Version 3.0, developed and published by WHO (available at http://www.who.int/substance_abuse/activities/assist_v3_english.pdf). Retrieved from <https://www.drugabuse.gov/sites/default/files/pdf/nmassist.pdf>

CAGE

Ewing, J.A. (1984). Detecting alcoholism: The **CAGE** questionnaire. *JAMA: Journal of the American Medical Association*, 252, 1905–1907. Retrieved from https://www.hopkinsmedicine.org/johns_hopkins_healthcare/downloads/all_plans/CAGE%20substance%20Screening%20Tool.pdf

PHQ-9

Spitzer, R.L. (2002). The **PHQ-9**: A new depression and diagnostic severity measure. *Psychiatric Annals*, 32, 509-521. Retrieved from https://med.stanford.edu/fastlab/research/imapp/msrs/_jcr_content/main/accordion/accordion_content3/download_256324296/file.res/PHQ9%20id%20date%2008.03.pdf

Welcome Home



I would really like to know if you are a
Veteran.

WWII	OEF
Cold War Era	OIF
Korea	OND
Vietnam Era	OF
Persian Gulf War	

Helpful Resources

PTSD	All Encompassing	https://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp
Military Health	Super Helpful	https://www.health.mil/Military-Health-Topics/Conditions-and-Treatments/Adjustments-After-Deployment
Military Behavioral Health	Insightful	https://www.samhsa.gov/sites/default/files/military_white_paper_final.pdf
Family Resource	Vet Centers; Home Base Program; Folds of Honor	https://www.foldsofhonor.org https://homebase.org
Places that Hire Veterans	Home Depot, Lowes, USPS, Department of Defense Contractors	USAjobs.gov https://www.health.mil/About-MHS/Employment
MST	Clear and concise	https://www.mentalhealth.va.gov/docs/mst_general_factsheet.pdf
Homelessness	HUDVASH ;SSVF assistance , Homes for our Troops	https://www.va.gov/HOMELESS/ssvf/docs/SSVF_Homelessness_Prevention_Screening_Toolkit_v2_Website.pdf ; https://www.va.gov/homeless/hud-vash.asp ; https://www.hfotusa.org/top-rated-veterans-charity/?gclid=Cj0KCQiA3NX_BRDQARIsALA3fK7HdQQpw87P6834-tZo0Tt_p9K-V9KlqY3b2hrj9qcADQg3rqKArIaAhBXEALw_wcB
SUD	Good ETOH resources	https://www.va.gov/health-care/health-needs-conditions/substance-use-problems/
Exposure	Exposures by Era	https://www.publichealth.va.gov/exposures/

Sample Script

Provider: HI, how are you? It is nice to see you thank you for coming in today, what are we here for?

Patient explains why they are in the office

Provider: OK, we can absolutely talk about that, now I know we have met a couple times, but I realize I have never asked you if you spent any time in the military...are you a veteran?
Yes, I am a veteran.

Provider: Oh! I did not realize that, I should have asked; What branch were you in?
I was in the (Marines, Air Force, Navy, Army)

Provider: [Pearl*: I typically interject something light here, to let them know they are not going to be assaulted with questions]for example if they say *Army*, I say, "Oh boy, well I won't hold that against you, my family has the Marines and the Navy"

Provider: "How was your experience"

[*Pearl :you will get a million different responses here and you will know if they want to keep talking or not. Do not push either way.]

(likely you will get)"*It was good and bad../It was fine, I saw the world"*

Provider: "Yeah, I have heard that, where were you stationed?"

<<*They will tell you*>>

Provider: " Was it nice there/ was it freezing there/ was it really dry ..." [Pearl * Non Military benign question]

Provider: "What was your Job? or if you are comfortable MOS (with Army/Marines) NEC (Naval Enlisted Classification with Navy) or Air Force Specialty Code (AFSC?)"

<<*They will tell you*,>>

[Pearl * if you use the technical terms they will tell you the numbers, if you use layman's terms they will tell you the civilian answer]

Provider: Were you ever deployed?

<<*They will usually tell you...* and offer the amount of information that they want to give>>

[*Pearl: React the way they want you to, with support likely you can get them to open up a bit more in the future]

Provider: [Pearl* I then transition into the screenings, some people will talk all day long about their service, some it makes them uncomfortable.]

























When I introduce the screenings I try my best to normalize the screening, so they understand they are not being called out ESPECIALLY with the Vietnam Veterans.]

Provider: "I need to do a screening that asks questions about food security and home stability, the reason for this is that in Greenfield homelessness is a huge issue for veterans and we want to ensure all of our veterans are safe, full and warm."

Insignia of the United States Armed Forces – Officers

O-1	O-2	O-3	O-4	O-5	O-6	O-7	O-8	O-9	O-10	SPECIAL
ARMY										
Second Lieutenant (2LT)	First Lieutenant (1LT)	Captain (CPT)	Major (MAJ)	Lieutenant Colonel (LTC)	Colonel (COL)	Brigadier General (BG)	Major General (MG)	Lieutenant General (LTG)	General (GEN)	General of the Army (GA)
MARINES										
Second Lieutenant (2ndLT)	First Lieutenant (1stLT)	Captain (Capt)	Major (Maj)	Lieutenant Colonel (LtCol)	Colonel (Col)	Brigadier General (BGen)	Major General (MajGen)	Lieutenant General (LtGen)	General (Gen)	
NAVY										
Ensign (ENS)	Lieutenant Junior Grade (LTJG)	Lieutenant (LT)	Lieutenant Commander (LCDR)	Commander (CDR)	Captain (CAPT)	Rear Admiral Lower Half (RADM)(L)	Rear Admiral Upper Half (RADM)(U)	Vice Admiral (VADM)	Admiral (ADM)	Fleet Admiral (FADM)
AIR FORCE										
Second Lieutenant (2d Lt)	First Lieutenant (1st Lt)	Captain (Capt)	Major (Maj)	Lieutenant Colonel (Lt Col)	Colonel (Col)	Brigadier General (Brig Gen)	Major General (Maj Gen)	Lieutenant General (Lt Gen)	General (Gen)	
COAST GUARD										
Ensign (ENS)	Lieutenant Junior Grade (LTJG)	Lieutenant (LT)	Lieutenant Commander (LCDR)	Commander (CDR)	Captain (CAPT)	Rear Admiral Lower Half (RADM)(L)	Rear Admiral Upper Half (RADM)(U)	Vice Admiral (VADM)	Admiral (ADM)	

Insignia of the United States Armed Forces – Enlisted

E-1	E-2	E-3	E-4	E-5	E-6	E-7	E-8	E-9	SEVEN EIGHTED NINE			
ARMY												
no insignia Private E-1 (PV1)	 Private E-2 (PV2)	 Private First Class (PFC)	 Corporal (CPL) Specialist (SPC)	 Sergeant (SGT)	 Staff Sergeant (SSG)	 Sergeant First Class (SFC)	 Master Sergeant (MSG)	 First Sergeant (1SG)	 Sergeant Major (SDM)	 Command Sergeant Major (CSM)	 Sergeant Major of the Army (SMA)	
MARINES												
no insignia Private (Pvt)	 Private First Class (PFC)	 Lance Corporal (L CPL)	 Corporal (Cpl)	 Sergeant (Sgt)	 Staff Sergeant (SSgt)	 Gunnery Sergeant (GySgt)	 Master Sergeant (MSGt)	 First Sergeant (1stSgt)	 Master Gunnery Sergeant (MGySgt)	 Sergeant Major (SgtMaj)	 Sergeant Major of the Marine Corps (SgtMajMC)	
NAVY												
no insignia Seaman Recruit (SR)	 Seaman Apprentice (SA)	 Seaman (SN)	 Petty Officer Third Class (PO3)	 Petty Officer Second Class (PO2)	 Petty Officer First Class (PO1)	 Chief Petty Officer (CPO)	 Senior Chief Petty Officer (SCPO)	 Master Chief Petty Officer (MCPD)	 Force or Fleet Chief Petty Officer (FORN/C) (FLTMC)	 Master Chief Petty Officer of the Navy (MCPDN)		
AIR FORCE												
no insignia Airman Basic (AB)	 Airman (Amm)	 Airman First Class (A1C)	 Senior Airman (SrA)	 Staff Sergeant (SSgt)	 Technical Sergeant (TSgt)	 Master Sergeant (MSGt)	 First Sergeant (E-7)	 Senior Master Sergeant (SMSgt)	 First Master Sergeant (E-8)	 Chief Master Sergeant (CMSgt)	 Command Chief Master Sergeant (CCM)	 Chief Master Sergeant of the Air Force (CMSAF)
COAST GUARD												
 Seaman Recruit (SR)	 Seaman Apprentice (SA)	 Seaman (SN)	 Petty Officer Third Class (PO3)	 Petty Officer Second Class (PO2)	 Petty Officer First Class (PO1)	 Chief Petty Officer (CPO)	 Senior Chief Petty Officer (SCPO)	 Master Chief Petty Officer (MCPD)	 Command Master Chief (CMC)	 Master Chief Petty Officer of the Coast Guard (MCPD-CG)		
Warrant												
ARMY					NAVY							
 Warrant Officer (WO1)	 Chief Warrant Officer (CW2)	 Chief Warrant Officer (CW3)	 Chief Warrant Officer (CW4)	 Chief Warrant Officer (CW5)	 Chief Warrant Officer (CW02)	 Chief Warrant Officer (CW03)	 Chief Warrant Officer (CW04)					
MARINES					COAST GUARD							
 Warrant Officer (WO)	 Chief Warrant Officer (CW02)	 Chief Warrant Officer (CW03)	 Chief Warrant Officer (CW04)	 Chief Warrant Officer (CW05)	 Chief Warrant Officer (CW02)	 Chief Warrant Officer (CW03)	 Chief Warrant Officer (CW04)					

**Supportive Services for Veteran Families (SSVF)
Homelessness Prevention (HP) Screening Form** (v.5 January 2020)

SCREENING DATE (e.g. 1/08/2020)

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APPLICANT HEAD OF HOUSEHOLD (IDENTIFY VETERAN MEMBER OF HOUSEHOLD)

First Name	Last Name

OTHER HOUSEHOLD MEMBERS (attach an additional page as needed)

STAGE 1: ELIGIBILITY FOR VA SSVF HP

Eligibility Condition 1. Veteran Status			
<i>Did you serve in the active military, naval, or air service?</i>	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NOT SURE
<i>Were you discharged or released under conditions other than dishonorable?</i> <small>[Staff Note: Bad Conduct discharges are not the same as dishonorable, and as such may be eligible. Furthermore, for Veterans with multiple discharges, the best discharge status may be used for SSVF eligibility.]</small>	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NOT SURE
SSVF STAFF DISPOSITION: Is applicant an eligible Veteran (as defined above)? <input type="checkbox"/> YES <input type="checkbox"/> NO IF "NO", STOP: APPLICANT NOT CURRENTLY ELIGIBLE.			
Documentation obtained? <input type="checkbox"/> YES <input type="checkbox"/> NO IF "NO" AND DOCUMENTATION PENDING, CONTINUE. Please refer to the SSVF Program Manual for further guidance.			
Eligibility Condition 2. Very Low-Income Status			
<i>Household size (all adults/children):</i>			
<i>Total Annual Gross Income from All Sources:</i>	\$		
<i>50% of Area Median Income for Household Size:</i>	\$		
SSVF STAFF DISPOSITION: Is gross annual household income less than 50% Area Median Income for household size (grantee may set lower income threshold)? <input type="checkbox"/> YES <input type="checkbox"/> NO IF "NO", STOP: APPLICANT NOT CURRENTLY ELIGIBLE.			
Documentation obtained? <input type="checkbox"/> YES <input type="checkbox"/> NO			

Eligibility Condition 3. Imminently At-Risk of Literal Homelessness	
3A: Imminent Housing Loss	
Next, we need to know some details about your current housing situation so we can understand how best to assist you.	
[Staff Note: Applicants who are losing their housing because they are fleeing or attempting to flee domestic violence are eligible for SSVF Rapid Re-Housing assistance (RRH) and should instead be screened for RRH assistance.]	
<i>Can you tell me about the place you stayed last night? Is this the primary place you stay or is there somewhere else you normally stay? If there's somewhere else you normally stay, can you tell me about that place?</i>	
<p>Identify the primary place where applicant is staying (check only one):</p> <p><input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher</p> <p><input type="checkbox"/> Staying or living in a family member's room, apartment or house</p> <p><input type="checkbox"/> Staying or living in a friend's room, apartment or house</p> <p><input type="checkbox"/> Rental by client, no ongoing housing subsidy</p> <p><input type="checkbox"/> Rental by client, with HUD VASH subsidy</p> <p><input type="checkbox"/> Rental by client, with other ongoing housing subsidy</p> <p><input type="checkbox"/> Permanent housing for formerly homeless persons (e.g., CoC Program funded unit)</p> <p><input type="checkbox"/> Owned by client, no ongoing housing subsidy</p> <p><input type="checkbox"/> Owned by client, with ongoing housing subsidy</p> <p><input type="checkbox"/> Hospital or other residential non-psychiatric medical facility*</p> <p><input type="checkbox"/> Long-term care facility or nursing home*</p> <p><input type="checkbox"/> Jail or prison*</p> <p><input type="checkbox"/> Residential project or halfway house with no homeless criteria*</p> <p><input type="checkbox"/> Psychiatric hospital or other psychiatric facility*</p> <p><input type="checkbox"/> Substance abuse treatment facility or detox center*</p> <p><input type="checkbox"/> Other (describe): _____</p>	
*If staying in institution, determine if stay there is 90 days or less and if previously stayed in emergency shelter, Safe Haven, or on the street. Such individuals are considered literally homeless and should instead be screened for SSVF RRH assistance.	
[Staff Note: Applicants staying in emergency shelter, including hotel/motel paid for with emergency shelter voucher, a Safe Haven, transitional housing (including GPD), or in a place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside) are considered literally homeless and should be screened for SSVF RRH assistance.	
Do you have to leave this place (or the place you normally stay)? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	
[Staff Note: Briefly describe reasons why applicant has to leave current place they are staying and obtain copy of any written documentation.]	
<i>If yes, what's causing you to have to leave? How long can you continue to stay there?</i>	
<p>Identify why the applicant must leave the primary place they are staying (check only one):</p> <p><input type="checkbox"/> Court-ordered eviction notice to vacate rental unit</p> <p><input type="checkbox"/> Formal written notice from landlord to vacate rental unit (e.g., 30 day Notice to Quit)</p> <p><input type="checkbox"/> Written or verbal notice from family, friend or host to leave doubled-up housing</p>	

<input type="checkbox"/>	Exiting an institution or system of care (e.g., hospital, jail, treatment facility, etc.)
<input type="checkbox"/>	Insufficient resources to continue to pay for hotel or motel
<input type="checkbox"/>	Other (describe): _____
<p>[Staff Note: Applicants who have only received a verbal notice from landlord and applicants who are only behind on utilities and have not received a formal written eviction notice are not eligible for SSVF HP assistance.]</p> <p>By what date must the applicant leave the primary place they are staying: / /</p> <p>[Staff Note: Must be within 30 days of date of application to be eligible for SSVF HP assistance.]</p>	
<p>Have you tried asking for an extension on your rent payment or otherwise negotiating a way to stay in your current housing? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A</p> <p>If yes, what was the result of the conversation? If no, is this an option for you?</p>	
<p>May I contact your current [landlord, host family/friend, other] to see if we can negotiate a solution so you can continue to stay there OR stay there while you find another place to live? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A</p>	
<p>SSVF STAFF DISPOSITION:</p> <p>Is applicant imminently losing their current primary nighttime residence? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A</p> <p>IF "NO", STOP: APPLICANT NOT CURRENTLY ELIGIBLE.</p>	
<p>Documentation obtained? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	
<p>3B: Other Housing Options & Resources</p>	<p><i>We would like to know if you have any other safe and appropriate place to stay – either permanently OR while you look for other housing. We would also like to know if you have family, friends or others you know that may be able to help you financially.</i></p>
<p>[Staff Note: Discuss and record below a summary related to each of the following potential housing options and sources of assistance: 1) family members or relatives; 2) close or trusted friends; and 3) faith-based group or network applicant associates with. Where appropriate, ask if a potential housing option can be contacted by you to help secure housing. Attach additional notes as necessary.] <i>NOTE: If the Veteran household would have become homeless tonight but SSVF assisted in identifying or accessing an alternative to that entry into homelessness (such as family, friends or other networks), the Veteran household would be eligible for Rapid Resolution services under the HP Enrollment.</i></p> <p><i>Do you have a safe, appropriate place where you could live if you lose your current home? Let's talk about different types of options and whether any of these might be available to you as a safe, appropriate place to live, either permanently or while you seek other housing on your own. Let's start with family members and relatives...</i></p>	
<p><i>If you're unsure if relatives, friends or others could help OR if there are any people or groups you have NOT contacted for help, but you think might be willing to assist you...</i></p> <p><i>Would you be willing to contact them OR may I contact them to find out if they can provide you with a place to stay, financial help, or other assistance to keep you from becoming homeless? This might include family, trusted friends or other groups (faith-based, social, etc.) that might be able to help.</i></p>	

<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NOT SURE		
If YES, who should be contacted?		
Name	Relationship to you	Phone number or email
SSVF STAFF DISPOSITION: Briefly summarize efforts and discussion related to other possible housing options and resources and whether applicant lacks other safe/appropriate housing options (either permanent or one they can access while seeking other housing) and resources sufficient to avoid literal homelessness. NOTE: If the Veteran household would have become homeless tonight but SSVF assisted in identifying or accessing an alternative to that entry into homelessness (such as family, friends or other networks), the Veteran household would be eligible for Rapid Resolution services under the HP Enrollment.		
Does applicant have other safe/appropriate housing options and/or resources sufficient to avoid literal homelessness? <input type="checkbox"/> YES <input type="checkbox"/> NO IF "YES", Applicant may be eligible for Rapid Resolution Services.		
3C: Financial Resources	We would like to find out if you have any funds or if there is other assistance immediately available to you and that you could access to help you keep your current housing or immediately find other housing.	
Approximately how much money would you need to pay immediately in order to keep your housing OR obtain other housing?	\$	
Do you have any funds or other assistance <u>immediately</u> available to you and that you could <u>access</u> to help you keep your current housing or immediately find other housing?		
Approximately how much money do you currently have available in savings, assets or other accounts?	\$	
Do you have enough money to pay for your current housing costs, including any rent or utility arrears?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NOT SURE	
Are there other community resources you've applied for, such as other eviction prevention programs, emergency financial assistance programs, utility assistance programs, or other local emergency assistance programs?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NOT SURE	
If you have no other financial resources and are unsure if there are other community resources that could help, we may be able to refer you to other resources that would be more appropriate than SSVF.		
Can we help provide information about other resources? <input type="checkbox"/> YES <input type="checkbox"/> NO		
If YES, identify each resource:		
Resource	Potential Assistance Available	Disposition (e.g., information & referral provided; contacted and not available; etc.)

<p>SSVF STAFF DISPOSITION: Briefly summarize efforts and discussion related to financial resources and whether other (non-SSVF) financial resources are available to avoid literal homelessness. If they will lose housing <i>regardless</i> of their own financial resources or other financial assistance, explain.</p>	
<p>Does applicant have enough financial resources to avoid literal homelessness? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A (Housing loss occurring regardless of financial resources) IF "YES", STOP: APPLICANT NOT CURRENTLY ELIGIBLE.</p>	
<p>Eligibility Condition 4 (Optional). Other Program Eligibility Conditions Additional Grantee Eligibility Requirements (as identified in SSVF grantee's VA approved <i>Grantee Screening Criteria and Targeting Threshold Plan</i>)</p>	
	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
<p>SSVF STAFF DISPOSITION: Does applicant meet other grantee eligibility conditions approved by the VA? <input type="checkbox"/> YES <input type="checkbox"/> NO IF "NO", STOP: APPLICANT NOT CURRENTLY ELIGIBLE.</p>	
<p>Stage 1: Eligibility Disposition</p>	
<p>ELIGIBLE: Meets all eligibility requirements above</p>	<input type="checkbox"/> CONTINUE TO STAGE 2
<p>ELIGIBLE: Rapid Resolution only</p>	<input type="checkbox"/> CONTINUE TO STAGE 2 (refer to Rapid Resolution Compliance Guide for next steps)
<p>NOT ELIGIBLE: Does not meet one or more eligibility requirements</p>	<input type="checkbox"/> STOP (reference HP Screening Form Instructions for next steps)

STAGE 2: TARGETING

TARGETING CRITERIA Use the following criteria to identify if the eligible applicant household is also a priority for SSVF homelessness prevention assistance. Check each condition that is true for the Veteran applicant.	Check if Applicable	Point Value	TOTAL POINTS (enter value for each box that is checked)
URGENCY OF HOUSING SITUATION (May indicate more urgent need for homelessness prevention assistance)			
Referred by Coordinated Entry or a homeless assistance provider to prevent the household from entering an emergency shelter or transitional housing or from staying in a place not meant for human habitation.	<input type="checkbox"/>	5	
Current housing loss expected within... (select only one)			
0-6 days	<input type="checkbox"/>	5	
7-13 days	<input type="checkbox"/>	4	
14-21 days	<input type="checkbox"/>	3	
POTENTIAL BARRIERS AND VULNERABILITIES (May impact ability to quickly secure housing and resolve literal homelessness independently if household is not assisted and becomes literally homeless)			
<u>Current</u> household income is \$0 (i.e., not employed, not receiving cash benefits, no other <u>current</u> income)	<input type="checkbox"/>	5	
<u>Annual</u> Household Gross Income Amount (select only one)			
0-14% of Area Median Income (AMI) for household size	<input type="checkbox"/>	4	
15-30% of AMI for household size	<input type="checkbox"/>	3	
Sudden and significant decrease in cash income (employment and/or cash benefits) AND/OR unavoidable increase in non-discretionary expenses (e.g., rent or medical expenses) in the past 6 months	<input type="checkbox"/>	3	
Major change in household composition (e.g., death of family member, separation/divorce from adult partner, birth of new child) in the past 12 months	<input type="checkbox"/>	3	
Rental evictions within the past 7 years (select only one) [Staff Note: Only include formal eviction actions (i.e., Notice to Quit) taken by a landlord due to lease non-compliance and that ultimately resulted in loss of rental housing.]			
4 or more prior rental evictions	<input type="checkbox"/>	5	
2-3 prior rental evictions	<input type="checkbox"/>	4	
1 prior rental eviction	<input type="checkbox"/>	3	
Currently at risk of losing a tenant-based housing subsidy or housing in a subsidized building or unit	<input type="checkbox"/>	3	

History of Literal Homelessness (street/shelter/transitional housing) (select only one)	<input type="checkbox"/>		
4 or more times or total of at least 12 months in past three years	<input type="checkbox"/>	5	
2-3 times in past three years	<input type="checkbox"/>	4	
1 time in past three years	<input type="checkbox"/>	3	
Head of household with disabling condition (physical health, mental health, substance use) that directly affects ability to secure/maintain housing	<input type="checkbox"/>	3	
Criminal record for arson, drug dealing or manufacture, or felony offense against persons or property	<input type="checkbox"/>	4	
Registered sex offender	<input type="checkbox"/>	5	
At least one dependent child under age 6	<input type="checkbox"/>	3	
Single parent with minor child(ren)	<input type="checkbox"/>	3	
Household size of 5 or more requiring at least 3 bedrooms (due to age/gender mix)	<input type="checkbox"/>	3	
POLICY PRIORITIES			
Any Veteran in household served in Iraq or Afghanistan	<input type="checkbox"/>	3	
Female Veteran	<input type="checkbox"/>	3	
TOTAL POINTS			

Stage 2: Targeting Disposition	
Meets Targeting Threshold VA Approved Targeting Threshold Score: []	[] Continue with SSVF HP enrollment OR other referral if no capacity
Does Not Meet Targeting Threshold	[] Reference HP Screening Form Instructions regarding "Service Directed Housing Interventions" or Rapid Resolution Compliance Guide if applicable

Applicant Certification	
<p>By signing below, I certify that the information provided above is correct, so far as I know and understand, and that I do not have other housing options or sufficient resources or support networks (e.g., family, friends, faith-based or other social networks) immediately available to prevent my household from becoming literally homeless.</p>	
Veteran Name:	_____
Veteran Signature:	_____
Date:	_____
SSVF Staff Certification	
<p>By signing below, I certify that I have worked with the Veteran household to identify housing resources and solutions and believe, based on the information presented, that the Veteran household is eligible for SSVF services and will become literally homeless unless SSVF assistance is provided. Further, I certify that all supporting documentation required for SSVF enrollment has been obtained and verified and is contained in the participant's case file.</p>	
SSVF Staff Name:	_____
SSVF Staff Signature:	_____
Date:	_____
SSVF Staff Certification	
SSVF Staff Signature:	_____
Date:	_____

PCL-M

INSTRUCTIONS: Below is a list of problems and complaints that veterans sometimes have in response to stressful military experiences. Please read each one carefully, then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing <i>memories, thoughts, or images</i> of a stressful military experience?	1	2	3	4	5
2. Repeated, disturbing <i>dreams</i> of a stressful military experience?	1	2	3	4	5
3. Suddenly <i>acting or feeling</i> as if a stressful military experience <i>were happening again</i> (as if you were reliving it)?	1	2	3	4	5
4. Feeling <i>very upset</i> when <i>something reminded you</i> of a stressful military experience?	1	2	3	4	5
5. Having <i>physical reactions</i> (e.g., heart pounding, trouble breathing, sweating) when <i>something reminded you</i> of a stressful military experience?	1	2	3	4	5
6. Avoiding <i>thinking about or talking about</i> a stressful military experience or avoiding <i>having feelings</i> related to it?	1	2	3	4	5
7. Avoiding <i>activities or situations</i> because <i>they reminded you</i> of a stressful military experience?	1	2	3	4	5
8. Trouble <i>remembering important parts</i> of a stressful military experience?	1	2	3	4	5
9. <i>Loss of interest</i> in activities that you used to enjoy?	1	2	3	4	5
10. Feeling <i>distant or cut off</i> from other people?	1	2	3	4	5
11. Feeling <i>emotionally numb</i> or being unable to have loving feelings for those close to you?	1	2	3	4	5
12. Feeling as if your <i>future</i> will somehow be <i>cut short</i> ?	1	2	3	4	5
13. Trouble <i>falling or staying asleep</i> ?	1	2	3	4	5
14. Feeling <i>irritable</i> or having <i>angry outbursts</i> ?	1	2	3	4	5
15. Having <i>difficulty concentrating</i> ?	1	2	3	4	5
16. Being " <i>super-alert</i> " or watchful or on guard?	1	2	3	4	5
17. Feeling <i>jumpy</i> or easily startled?	1	2	3	4	5

PCL Scoring

There are several ways in which to score the **PTSD Checklist (PCL)**. Perhaps the easiest way to score the PCL is to add up all the items for a total severity score. A total score of 44 is considered to be PTSD positive for the general population while a total score of 50 is considered to be PTSD positive in military populations. A second way to score the PCL is to treat “moderately” or above (responses 3 through 5) as symptomatic and anything below “moderately” (1 and 2) as non-symptomatic. Then use the DSM scoring rules to make a diagnosis. That is:

- You need an endorsement of at least 1 B item (question #s 1-5)
- You need an endorsement of at least 3 C items (question #s 6-12)
- You need an endorsement of at least 2 D items (question #s 13-17)

However, please note that it is then possible to get a PTSD diagnosis with a total score of 29, which would be very low. It may therefore be best to use a combination of the two approaches. That is, the requisite number of items within each cluster are met at a 3 or above AND the total score is above the specified cut point.

Questions 1-8 of the NIDA-Modified ASSIST V2.0

Instructions: Patients may fill in the following form themselves but screening personnel should offer to read the questions aloud in a private setting and complete the form for the patient. To preserve confidentiality, a protective sheet should be placed on top of the questionnaire so it will not be seen by other patients after it is completed but before it is filed in the medical record.

Question 1 of 8, NIDA-Modified ASSIST	Yes	No
<p>In your <i>LIFETIME</i>, which of the following substances have you ever used?</p> <p><i>*Note for Physicians: For prescription medications, please report nonmedical use only.</i></p>		
a. Cannabis (marijuana, pot, grass, hash, etc.)		
b. Cocaine (coke, crack, etc.)		
c. Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)		
d. Methamphetamine (speed, crystal meth, ice, etc.)		
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)		
f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Xanax, Librium, Rohypnol, GHB, etc.)		
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)		
h. Street opioids (heroin, opium, etc.)		
i. Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)		
j. Other – specify:		

- Given the patient’s response to the Quick Screen, the patient *should not indicate “NO”* for all drugs in Question 1. If they do, remind them that their answers to the Quick Screen indicated they used an illegal or prescription drug for nonmedical reasons within the past year and then **repeat Question 1**. If the patient indicates that the drug used is not listed, please mark ‘Yes’ next to ‘Other’ and continue to **Question 2** of the NIDA-Modified ASSIST.
- If the patient says “Yes” to any of the drugs, proceed to **Question 2** of the NIDA-Modified ASSIST.

Question 2 of 8, NIDA-Modified ASSIST

2. <u>In the past three months</u> , how often have you used the substances you mentioned (first drug, second drug, etc)?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
• Cannabis (marijuana, pot, grass, hash, etc.)	0	2	3	4	6
• Cocaine (coke, crack, etc.)	0	2	3	4	6
• Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	2	3	4	6
• Methamphetamine (speed, crystal meth, ice, etc.)	0	2	3	4	6
• Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	0	2	3	4	6
• Sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.)	0	2	3	4	6
• Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	2	3	4	6
• Street opioids (heroin, opium, etc.)	0	2	3	4	6
• Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	2	3	4	6
• Other – Specify:	0	2	3	4	6

- For patients who report “Never” having used any drug in the past 3 months: **Go to Questions 6-8.**
- For any recent illicit or nonmedical prescription drug use, go to **Question 3.**

3. In the past 3 months, how often have you had a strong desire or urge to use (first drug, second drug, etc)?

	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Cannabis (marijuana, pot, grass, hash, etc.)	0	3	4	5	6
b. Cocaine (coke, crack, etc.)	0	3	4	5	6
c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	3	4	5	6
d. Methamphetamine (speed, crystal meth, ice, etc.)	0	3	4	5	6
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	0	3	4	5	6
f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.)	0	3	4	5	6
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	3	4	5	6
h. Street Opioids (heroin, opium, etc.)	0	3	4	5	6
i. Prescribed opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	3	4	5	6
j. Other – Specify:	0	3	4	5	6

4. <u>During the past 3 months</u> , how often has your use of (first drug, second drug, etc) led to health, social, legal or financial problems?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Cannabis (marijuana, pot, grass, hash, etc.)	0	4	5	6	7
b. Cocaine (coke, crack, etc.)	0	4	5	6	7
c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	4	5	6	7
d. Methamphetamine (speed, crystal meth, ice, etc.)	0	4	5	6	7
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	0	4	5	6	7
f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.)	0	4	5	6	7
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	4	5	6	7
h. Street opioids (heroin, opium, etc.)	0	4	5	6	7
i. Prescribed opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	4	5	6	7
j. Other – Specify:	0	4	5	6	7

5. <u>During the past 3 months</u> , how often have you failed to do what was normally expected of you because of your use of (first drug, second drug, etc)?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Cannabis (marijuana, pot, grass, hash, etc.)	0	5	6	7	8
b. Cocaine (coke, crack, etc.)	0	5	6	7	8
c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	5	6	7	8
d. Methamphetamine (speed, crystal meth, ice, etc.)	0	5	6	7	8
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	0	5	6	7	8
f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.)	0	5	6	7	8
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	5	6	7	8
h. Street Opioids (heroin, opium, etc.)	0	5	6	7	8
i. Prescribed opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	5	6	7	8
j. Other – Specify:	0	5	6	7	8

Instructions: Ask Questions 6 & 7 for all substances ever used (i.e., those endorsed in the Question 1).

6. Has a friend or relative or anyone else <u>ever</u> expressed concern about your use of (first drug, second drug, etc)?	No, never	Yes, but not in the past 3 months	Yes, in the past 3 months
a. Cannabis (marijuana, pot, grass, hash, etc.)	0	3	6
b. Cocaine (coke, crack, etc.)	0	3	6
c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	3	6
d. Methamphetamine (speed, crystal meth, ice, etc.)	0	3	6
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	0	3	6
f. Sedatives or sleeping pills (Valium, Serepax, Xanax, Ativan, Librium, Rohypnol, GHB, etc.)	0	3	6
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	3	6
h. Street opioids (heroin, opium, etc.)	0	3	6
i. Prescribed opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	3	6
j. Other – Specify:	0	3	6

7. Have you ever tried and failed to control, cut down or stop using (first drug, second drug, etc)?	No, never	Yes, but not in the past 3 months	Yes, in the past 3 months
a. Cannabis (marijuana, pot, grass, hash, etc.)	0	3	6
b. Cocaine (coke, crack, etc.)	0	3	6
c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	3	6
d. Methamphetamine (speed, crystal meth, ice, etc.)	0	3	6
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	0	3	6
f. Sedatives or sleeping pills (Valium, Serepax, Xanax, Ativan, Librium, Rohypnol, GHB, etc.)	0	3	6
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	3	6
h. Street opioids (heroin, opium, etc.)	0	3	6
i. Prescribed opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	3	6
j. Other – Specify:	0	3	6

Instructions: Ask Question 8 if the patient endorses any drug that might be injected, including those that might be listed in the other category (e.g., steroids). Circle appropriate response.

8. Have you ever used any drug by injection (NONMEDICAL USE ONLY)?	No, never	Yes, but not in the past 3 months	Yes, in the past 3 months
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- Recommend to patients reporting any prior or current intravenous drug use that they get tested for HIV and Hepatitis B/C.
- If patient reports using a drug by injection in the past three months, ask about their pattern of injecting during this period to determine their risk levels and the best course of intervention.
 - If patient responds that they inject once weekly or less OR fewer than 3 days in a row, provide a brief intervention including a discussions of the risks associated with injecting.
 - If patient responds that they inject more than once per week OR 3 or more days in a row, refer for further assessment.

Note: Recommend to patients reporting any current use of alcohol or illicit drugs that they get tested for HIV and other sexually transmitted diseases.

Tally Sheet for scoring the full NIDA-Modified ASSIST:

Instructions: For each substance (labeled a–j), add up the scores received for questions 2-7 above. This is the Substance Involvement (SI) score. Do not include the results from either the Q1 or Q8 (above) in your SI scores.

Substance Involvement Score	Total (SI SCORE)
a. Cannabis (marijuana, pot, grass, hash, etc.)	
b. Cocaine (coke, crack, etc.)	
c. Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	
d. Methamphetamine (speed, crystal meth, ice, etc.)	
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	
f. Sedatives or sleeping pills (Valium, Serepax, Xanax, Ativan, Librium, Rohypnol, GHB, etc.)	
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	
h. Street Opioids (heroin, opium, etc.)	
i. Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	
j. Other – Specify:	

Use the resultant Substance Involvement (SI) Score to identify patient’s risk level.

To determine patient’s risk level based on his or her SI score, see the table below:

Level of risk associated with different Substance Involvement Score ranges for Illicit or nonmedical prescription drug use	
0-3	Lower Risk
4-26	Moderate Risk
27+	High Risk



CAGE Substance Abuse Screening Tool

Directions: Ask your patients these four questions and use the scoring method described below to determine if substance abuse exists and needs to be addressed.

CAGE Questions

1. Have you ever felt you should cut down on your drinking?
2. Have people annoyed you by criticizing your drinking?
3. Have you ever felt bad or guilty about your drinking?
4. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?

CAGE Questions Adapted to Include Drug Use (CAGE-AID)

1. Have you ever felt you ought to cut down on your drinking or drug use?
2. Have people annoyed you by criticizing your drinking or drug use?
3. Have you felt bad or guilty about your drinking or drug use?
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?

Scoring: Item responses on the CAGE questions are scored 0 for "no" and 1 for "yes" answers, with a higher score being an indication of alcohol problems. A total score of two or greater is considered clinically significant.

The normal cutoff for the CAGE is two positive answers, however, the Consensus Panel recommends that the primary care clinicians lower the threshold to one positive answer to cast a wider net and identify more patients who may have substance abuse disorders. A number of other screening tools are available.

CAGE is derived from the four questions of the tool: Cut down, Annoyed, Guilty, and Eye-opener

CAGE Source: Ewing 1984

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

ID #: _____ DATE: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite —being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

add columns + +

(Healthcare professional: For interpretation of TOTAL, TOTAL:
please refer to accompanying scoring card).

10. If you checked off <i>any problems</i> , how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	_____
	Somewhat difficult	_____
	Very difficult	_____
	Extremely difficult	_____

PHQ-9 Patient Depression Questionnaire

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder

- if there are at least 5 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder

- if there are 2-4 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.

Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying **PHQ-9 Scoring Box** to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Scoring: add up all checked boxes on PHQ-9

For every ✓ Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

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U.S. Department
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TALKING WITH A VETERAN IN CRISIS

You don't have to be an expert to ask if someone is going through a difficult time or having thoughts of suicide. If you notice changes in a Veteran's behavior or moods and you think they might be in crisis, it's time to respond. The simple act of having a conversation can help save a life.

Here are some ways to approach a conversation with a Veteran who may be suicidal.

First, assess the situation to determine if the Veteran may be in **imminent danger**. Check to see if there are any harmful objects in the area, such as firearms, sharp objects, or lethal drugs. Those at the highest risk for suicide often have a specific suicide plan, the means to carry out the plan, a time set for doing it, and an intention of following through with it.

Asking whether a Veteran is having thoughts of self-harm or suicide may seem extreme, but it is important. Although many people may not show clear signs of intent to harm themselves before doing so, they will likely answer direct questions about their intentions when asked. **Remember, asking if someone is having suicidal thoughts will not give them the idea or increase their risk.**

However, some of those who are at risk may not admit that they plan to attempt suicide. In case the Veteran won't talk about it, be sure to look for warning signs in the box to the right.

Safety Issues:

If you believe a Veteran is at high risk and has already harmed himself or herself, you need to call local emergency services at 911.

- **Never** negotiate with someone who has a gun. Get to safety and **call 911**.
- If the Veteran has taken pills or harmed himself or herself in some way, **call 911**.

Veterans who are in emotional distress and are showing warning signs for suicide can be connected to the 24-hour **Veterans Crisis Line**: Call **1-800-273-8255** and **Press 1**, use the **online chat**, or **text to 838255**. Caring, specially trained responders are available to provide free, **confidential support 24 hours a day, 7 days a week, 365 days a year**. Responders are available to speak to Veterans and their caregivers, family members, or friends.

Warning Signs of Imminent Suicide Risk

Acting recklessly or engaging in risky activities that could lead to death, such as driving fast or running red lights — seemingly without thinking

Showing violent behavior such as punching holes in walls, getting into fights, or engaging in self-destructive violence; feeling rage or uncontrolled anger; or seeking revenge

Giving away prized possessions, putting affairs in order, tying up loose ends, and/or making out a will

Seeking access to firearms, pills, or other means of harming oneself

If you and/or the Veteran are not in imminent danger, start a conversation to help the Veteran open up and to find out how you might be able to help. You can ask questions such as:

- "When did you first start feeling like this?"
- "Did something happen that made you begin to feel this way?"

When responding to answers from a Veteran, remember that simple, encouraging feedback goes a long way in showing support and encouraging help-seeking:

- "You're not alone, even if you feel like you are. I'm here for you, and I want to help you in any way I can."
- "It may not seem possible right now, but the way you're feeling will change."
- "I might not be able to understand exactly what you're going through or how you feel, but I care about you and want to help."

Even for Veterans who do not appear to be suicidal, it is important to direct them to resources to help them face mental health challenges and more.

For more information about the Veterans Crisis Line, visit VeteransCrisisLine.net

For more information about VA's mental health resources, visit www.mentalhealth.va.gov

For access to more than 400 stories of strength and recovery from Veterans and their family members, visit MakeTheConnection.net



U.S. Department
of Veterans Affairs



ANSWERING THE CALL

The simple act of talking with a Veteran by phone can help save a life. For a Veteran in crisis — whose emotional struggles and health challenges may lead to thoughts of suicide — these conversations can mean the difference between a tragic outcome and a life saved. When talking to a Veteran, listen for signs of distress or other clues that might indicate that they need immediate help.

Determine if the caller is in distress.

1. Remain **calm** and **listen**.

2. **Ask the question:** "Sometimes when people are (upset/angry/in pain/etc.) they think about suicide. Are you thinking about killing yourself or someone else?"

NO
NOT suicidal,
homicidal, or
in crisis

YES
Suicidal, homicidal, or in crisis

3. Route caller to appropriate local resources.

You can find resources in your area, including local Suicide Prevention Coordinators and crisis centers, using our Resource Locator here: VeteransCrisisLine.net/ResourceLocator

3. Assess whether the Veteran is at **imminent risk**, and determine if he or she has already inflicted self-harm or injured others or has an immediate plan to do so, with access to means.

Signs of Distress:

- Emotional (crying, loud, yelling)
- Making concerning statements like:
 - My family would be better off if I wasn't here.
 - I can't go on like this.
 - No one can help me.

If you are a staff member of a Veterans Service Organization, suicide prevention organization, or another type of support group:

- a. Notify your supervisor (or other staff) of the situation.
- b. Try to obtain the Veteran's phone number, name, and location.
- c. Have your supervisor (or other staff) immediately contact 911 for a safety check.
- d. Remain on the phone with the caller until emergency personnel arrive.

If you work for a support organization or you are a friend, family member, or acquaintance of the Veteran:

- a. Try to find out where the Veteran is located and whether anyone else is nearby.
- b. Verify the Veteran's phone number and, if possible, the last four digits of their Social Security number.
- c. **Explain** that you will conference a Veterans Crisis Line staff member into the call.
- d. **Call 1-800-273-8255, Press 1.**
- e. **Complete a warm transfer:** When the VCL responder answers, identify yourself, explain what is going on, and provide the Veteran's information.
- f. **Inform the Veteran** that you will hang up and he or she is in good hands with the VCL responder.
- g. **Make sure the Veteran is on the call with the VCL responder** before hanging up.
- h. If you work for a VSO, a suicide prevention organization, or similar, notify your supervisor per facility procedure or protocol.

For more information about the Veterans Crisis Line, visit VeteransCrisisLine.net

For more information about VA's mental health resources, visit www.mentalhealth.va.gov

For access to more than 400 stories of strength and recovery from Veterans and their family members, visit MakeTheConnection.net

Appendix G.

VA recommended military screenings and exposures

Compensation & Benefits

Do you have a service-connected condition?

Would you like assistance in filing for compensation for injuries or illnesses related to your service?

VA Information: 1-800-827-1000 or 844-MyVA311 (698-2311)

Living Situation

Would it be ok to talk about your living situation?

Where do you live and who do you live with? Is your housing safe? Are you in any danger of losing your housing?

Do you need assistance in caring for yourself and/or dependents?

Unwanted Sexual Experiences in the Military

May I ask you about stressful experiences that men and women can have during military service?

1. Did you have any unwanted sexual experiences in the military? For

example, threatening or repeated sexual attention, comments or

touching?

2. Did you have any sexual contact against your will or when unable

to say no, such as being forced, or when asleep or intoxicated?

If Yes: I am sorry; thank you for sharing that. VA refers to this as ‘military sexual trauma’ or ‘MST’ and offers free MST-related care. **If No:** Okay, thank you. I ask all Veterans because VA offers free care related to these experiences. **Exposure Concerns**

Would it be okay if I asked about some things you may have been exposed to during your service?

What... were you exposed to?

- *Chemical (pollution, solvents, weapons, etc.)*
- *Biological (infectious diseases, weapons)*
- *Psychological trauma or abuse*

Health Risks Associated with Specific Eras• *Physical**Blast or explosion Munitions or bullet wound**Radiation Shell fragment Heat**Vehicular crash Excessive noise Other injury***What...** precautions were taken? (*Avoidance, PPE, Treatment*) **How...** long was the exposure?**How...** concerned are you about the exposure?**Where...** were you exposed?**When...** were you exposed?**Who...** else may have been affected? Unit name, etc.**Behavior***Would it be okay if we talked about emotional responses during your service?***PTSD:** Have you been concerned that you might suffer from Post Traumatic Stress Disorder? Symptoms can include re-experiencing symptoms such as nightmares or unwanted thoughts, hyperarousal/being “on guard,” avoiding situations that remind you of the trauma, and/or numbing of emotions. **Depression:** Have you been experiencing sadness, feelings

of hopelessness/helplessness, lack of energy, difficulty with concentrating, and/or poor sleep?

Risk Assessment: Have you had thoughts of harming yourself or others?**Blood Borne Viruses (Hepatitis & HIV)**

• Do you have tattoos? Have you ever injected or snorted drugs, such as heroin, cocaine, or methamphetamine?

• Have you ever been tested for Hepatitis C or HIV? If not, would you like to be tested for these?

Occupational Hazards: Asbestos, Industrial Solvents, Lead, Radiation, Fuels, PCBs, Noise/Vibration, Chemical Agent Resistant Coating (CARC)**Gulf War/Southwest Asia (Afghanistan, Kuwait, Iraq)**

Noise Induced Hearing Loss- Ringing in the Ears
Burn Pit Smoke
Cold Injuries

Heat Stroke/Exhaustion Hexavalent Chromium Mustard Gas
Nerve Agents Pesticides

Contaminated Water (benzene, trichloroethylene, vinyl chloride) Endemic Diseases
Malaria Prevention:

Radiation (Ionizing & Non-Ionizing) Sand, Dust, Smoke, and Particulates Herbicides and
other dioxins like Agent Orange

Mefloquine – Lariam

Animal Bites/Rabies
Blunt Trauma
Burn Injuries (Blast Injuries) Chemical or Biological Agents Chemical Munitions
Demolition Combined Penetrating Injuries Depleted Uranium (DU) Dermatologic Issues
Embedded Fragments (shrapnel)

Mental Health Issues
Multi-Drug Resistant Acinetobacter Oil Well Fires
Reproductive Health Issues
Spinal Cord Injury
Traumatic Amputation
Traumatic Brain Injury
Vision Loss

Immunizations: Anthrax, Botulinum Toxoid, Smallpox, Yellow Fever, Typhoid,
Cholera, Hepatitis B, Meningitis, Whooping Cough, Polio, Tetanus

Infectious Diseases: Malaria, Brucellosis, Campylobacter jejuni, Coxiella burnetii,
Mycobacterium tuberculosis, nontyphoid Salmonella, Shigella, visceral Leishmaniasis,
West Nile Virus

Vietnam, Korean DMZ & Thailand

Agent Orange Exposure

Cold War

Chemical Warfare Agent Experiments

WWII & Korean War

Chemical Warfare Agent Experiments
Cold Injuries

Cold Injuries Hepatitis C Risks

Nuclear Weapons Testing or Cleanup

Nuclear Weapons Testing or Cleanup
Biological Warfare Agents

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