

Clinical Decision Support (CDS) Content and Health Level 7 (HL7)- Compliant Knowledge Artifacts (KNARTs)

Mental Health: Military Sexual Trauma (MST) Clinical Content White Paper

Department of Veterans Affairs (VA)



**Knowledge Based Systems (KBS)
Office of Informatics and Information Governance (OIIG)
Clinical Decision Support (CDS)**

Clinical Decision Support (CDS) Content and Health Level 7 (HL7)-Compliant Knowledge Artifacts (KNARTs): Mental Health: Military Sexual Trauma (MST) Clinical Content White Paper

by Department of Veterans Affairs (VA)

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Table 1. Relevant KNART Information: Mental Health: Military Sexual Trauma (MST)

KNART Name	Associated CLIN
Military Sexual Trauma (MST) - Documentation Template	CLIN0005AA

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VA Subject Matter Expert (SME) Panel

Name	Title	Project Role
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Introduction

The VA is committed to improving the ability of clinicians to provide care for patients while increasing quality, safety, and efficiency. Recognizing the importance of standardizing clinical knowledge in support of this goal, VA is implementing the Health Level 7 (HL7) Knowledge Artifact Specification for a wide range of VA clinical use cases. Knowledge Artifacts, referred to as (KNARTs), enable the structuring and encoding of clinical knowledge so the knowledge can be integrated with electronic health records to enable clinical decision support.

The purpose of this Clinical Content White Paper (CCWP) is to capture the clinical context and intent of KNART use cases in sufficient detail to provide the KNART authoring team with the clinical source material to construct the corresponding knowledge artifacts using the HL7 Knowledge Artifact Specification. This paper has been developed using material from a variety of sources: VA artifacts, clinical practice guidelines, evidence in the body of medical literature, and clinical expertise. After reviewing these sources, the material has been synthesized and harmonized under the guidance of VA subject matter experts to reflect clinical intent for this use case.

Unless otherwise noted, items within this white paper (e.g., documentation template fields, orderable items, etc.) are chosen to reflect the clinical intent at the time of creation. To provide an exhaustive list of all possible items and their variations is beyond the scope of this work.

Conventions Used

Conventions used within the knowledge artifact descriptions include:

<obtain>: Indicates a prompt to obtain the information listed

- If possible, the requested information should be obtained from the underlying system(s). Otherwise, prompting the user for information may be required
- The technical and clinical notes associated with a section should be consulted for specific constraints on the information (e.g., time-frame, patient interview, etc.)
- Default Values: Unless otherwise noted, <obtain> indicates to obtain the most recent observation. It is recognized that this default time-frame value may be altered by future implementations

[...]: Square brackets enclose explanatory text that indicates some action on the part of the clinical user, or general guidance to the clinical or technical teams. Examples include, but are not limited to:

[Begin ...], [End ...]: Indicates the start and end of specific areas to clearly delineate them for technical purposes.

[Activate ...]: Initiates another knowledge artifact or knowledge artifact section.

[Section Prompt: ...]: If this section is applicable, then the following prompt should be displayed to the user.

[Section Selection Behavior: ...]: Indicates technical constraints or considerations for the selection of items within the section.

[Attach: ...]: Indicates that the specified item should be attached to the documentation template if available.

[Link: ...]: Indicates that rather than attaching an item, a link should be included in the documentation template.

[Clinical Comment: ...]: Indicates clinical rationale or guidance.

[Technical Note: ...]: Indicates technical considerations or notes.

[If ...]: Indicates the beginning of a conditional section.

[Else, ...]: Indicates the beginning of the alternative branch of a conditional section.

[End if ...]: Indicates the end of a conditional section.

☐: Indicates items that should be selected based upon the section selection behavior.

Chapter 1. Mental Health: Military Sexual Trauma (MST)

1.1. Clinical Context

[Begin Clinical Context.]

[Clinical Comment: Intended to support documentation of screening-related findings and decisions from screening for military sexual trauma (MST).]

The following preexisting VA materials are regarded as the preferred sources: Documentation Related to Military Sexual Trauma (https://www.mirecc.va.gov/cih-visn2/Documents/Provider_Education_Handouts/MST-Documentation_Handout.pdf) and screenshots from the Portland VA Medical Center (VAMC) (MST screening.docx).]

Table 1.1. Clinical Context Domain

<i>Target User</i>	Any clinician (primarily used by primary care providers, <i>PCPs</i>)
<i>Patient</i>	All patients
<i>Priority</i>	Routine
<i>Specialty</i>	All specialties
<i>Location</i>	Outpatient

[End Clinical Context.]

1.2. Knowledge Artifacts

[Begin Knowledge Artifacts.]

This section describes the CDS knowledge artifact that is specific to MST. Health care professionals are required to screen all Veterans for MST and to document the results of this screening. The scope of MST is broad and includes events that may have taken place on-base or off-base, on-duty or off-duty, and perpetrated by military personnel or civilians.

The knowledge artifact defines this clinical use case. The artifact is the Documentation Template and is described in detail in the following sections.

- A Documentation Template: Mental Health: MST KNART
 - Supports documentation of MST related findings and decisions
 - Includes logic for appropriate display of documentation sections

[End Knowledge Artifacts.]

Chapter 2. Documentation Template - Mental Health: Military Sexual Trauma (MST)

[Begin Documentation Template – Mental Health: Military Sexual Trauma (MST).]

[Clinical Comment: This documentation template is appropriate for all patients seen in any clinical setting in the VHA; however, screening for MST must be done by a trained and licensed clinical provider as described below.]

2.1. Knowledge Narrative

[Begin Knowledge Narrative.]

[See Clinical Context in Chapter 1.]

Military sexual trauma (MST) involves exposure to one or more unwanted sexual experiences during military service and may be associated with a broad range of potential mental health and physical conditions, including depressive and anxiety disorders, posttraumatic stress disorder, substance use disorders, interpersonal difficulties and problems trusting others (even health care providers), self-blame and self-doubt, sexual functioning difficulties and sexual health concerns, issues related to sexuality and identity, difficulties navigating interpersonal boundaries, and increased risk of future victimization (“A Primer...”, VA 2011). Many specific physical health diagnoses have also been found to be associated with MST. The scope of MST is purposefully broad and includes events that may have been labeled as “hazing,” that took place on-base or off-base and while on-duty or off-duty, and that were perpetrated by military personnel or civilians. Health care professionals are required to screen all Veterans for MST and to document the results of this screening. All care for the mental and physical sequelae of MST, including pharmacologic therapy, must be provided free of charge. In support of that requirement, VA health care professionals are required to document when a visit included treatment for an MST-related condition. VA is also congressionally mandated to report on screening rates and treatment rates annually. Successful screening requires that clinicians be aware of the stigma, complexity, and sensitivity related to this screening. All VA clinicians are required to have completed a mandatory training designed to increase their knowledge, skills, and ability to successfully conduct the screening. Increased systematization and standardization of screening processes and tools has the potential to improve rates of identification and treatment of Veterans who have been victims of MST (“Military Sexual Trauma...”, VA 2015).

[End Knowledge Narrative.]

2.2. MST Screening

[Begin MST Screening]

[Section Prompt: MST Screening]

[Technical Note: Provide link to Guidance for asking MST questions (see Appendix B).]

[Technical Note: Provide link to Knowledge Resources for MST screening (see Appendix B).]

[Section Prompt: Would it be okay if I asked about some things that may have happened to you while you were in the military? We ask all veterans these questions because VA offers free care related to these experiences. You can choose not to answer these questions if you prefer, or you may simply say 'yes' or 'no'.]

[Section Selection Behavior: Select one. Required.]

☐ No

Documentation Template - Mental
Health: Military Sexual Trauma
(MST)

☐ Yes

☐ Declines to answer

[Technical Note: Selecting “No” or “Declines to answer” in the question above should auto-populate “Declines to answer” in the two following questions.]

[Section Prompt: When you were in the military, did you ever receive unwanted, threatening, or repeated sexual attention (for example, touching, cornering, pressure for sexual favors, or inappropriate verbal remarks, etc.)?]

[Section Selection Behavior: Select one. Required.]

☐ No, denies prior MST

☐ Yes, reports MST in the past

☐ Declines to answer

[Section Prompt: When you were in the military, did you have sexual contact against your will or when you were unable to say no (for example, after being forced or threatened or to avoid other consequences)?]

[Section Selection Behavior: Select one. Required.]

☐ No, denies prior MST

☐ Yes, reports MST in the past

☐ Declines to answer

[Technical Notes: If “Yes” is selected on either of the two preceding questions, display the following link to VA policy stating care for MST is free for the Veteran: <https://www.gpo.gov/fdsys/pkg/USCODE-2011-title38/pdf/USCODE-2011-title38-partII-chap17-subchapII-sec1720D.pdf>]

[End MST Screening]

2.3. Referrals for MST

[Begin Referrals]

[Section Prompt: Referrals for MST]

[Section Prompt: Even if the Veteran responds “no” to each question above or refuses screening, veterans should still be offered a referral to an MST specialist.]

[Section Prompt: Would you like to speak to a clinical provider about MST treatment?]

[Section Selection Behavior: Select all that apply. At least one selection is Required.]

☐ No, declines referral for MST treatment

☐ No, Veteran is currently in MST treatment

☐ Yes, requests referral for MST treatment

☐ Yes, requests follow up visit for physical symptoms related to MST

☐ Declines to answer

[End Referrals]

2.4. Patient Education

[Begin Patient Education]

[Section Prompt: Patient Education]

[Technical Note: This section should be made available if the answer to either question in the MST Screening section was "Yes."]

☐ Print MST Fact Sheet

[Technical Note: clicking the checkbox above prints the document located at https://www.mentalhealth.va.gov/docs/mst_general_factsheet.pdf.]

[End Patient Education]

2.5. Provider Education

[Begin Provider Education]

[Section Prompt: Provider Education]

[Technical Note: The following references should be provided to users when they are selected.]

Dichter ME, Wagner C, Goldberg EB, Iverson KM. Intimate partner violence detection and care in the Veterans Health Administration: patient and provider perspectives. *Womens Health Issues*. 2015;25(5):555-560.

Jeffreys MD, Leibowitz RQ, Finley E, Arar N. Trauma disclosure to health care professionals by veterans: clinical implications. *Mil Med*. 2010;175(10):719-724.

Kimerling R, Street AE, Gima K, Smith MW. Evaluation of universal screening for military-related sexual trauma. *Psychiatr Serv*. 2008;59(6):635-640.

Meredith LS, Azhar G, Okunogbe A, et al. Primary care providers with more experience and stronger self-efficacy beliefs regarding women veterans screen more frequently for interpersonal violence. *Womens Health Issues*. 2017;27(5):586-591.

Minsky-Kelly D, Hamberger LK, Pape DA, Wolff M. We've had training, now what? Qualitative analysis of barriers to domestic violence screening and referral in a health care setting. *J Interpers Violence*. 2005;20(10):1288-1309.

Roberts ST, Watlington CG, Nett SD, Batten SV. Sexual trauma disclosure in clinical settings: addressing diversity. *J Trauma Dissociation*. 2010;11(2):244-259.

[End Provider Education]

[End Documentation Template]

Bibliography/Evidence

- “National Veterans Health Administration Military Sexual Trauma Support Team. Military sexual trauma (MST) screening for professionals Materials provided by Chris Skidmore).”. *based on original slides by Margret Bell and Kerry Makin-Byrd, in Skidmore Brief MST Slides.pptx.*, November 13, 2017.
- “U.S. Department of Veterans Affairs. A Primer on Military Sexual Trauma for Mental Health Clinicians”. Published March 2011. Accessed October 26, 2017. https://www.mirecc.va.gov/cih-visn2/Documents/Provider_Education_Handouts/MST-A_Primer_on_MST_for_Mental_Health_Clinicians.pdf.
- “U.S. Department of Veterans Affairs. Documentation: Related to Military Sexual Trauma.”. Accessed October 26, 2017. https://www.mirecc.va.gov/cih-visn2/Documents/Provider_Education_Handouts/MST-Documentation_Handout.pdf.
- “U.S. Department of Veterans Affairs. Military Sexual Trauma Clinical Reminder Referral Question and Re-Deployment Activation Patch”. *PXRM*2.0*43: Installation and Setup Guide*. Published June 2015. Accessed October 26, 2017. https://www.va.gov/vdl/documents/Clinical/CPRS-Clinical_Reminders/pxrm_2_0_43_ig.doc..
- “U.S. Department of Veterans Affairs. Reminder Resolution: MST Screening. mst screening.docx”. *Veterans Administration, materials provided in Mental Health-20170921T220116Z-001.zip*. September 21, 2017.
- “Veterans’ Benefits Act, 38 USC §1720D”. 2017.

Appendix A. Existing Sample VA Artifacts

The following images are referenced from the Portland VAMC.

Figure A.1. Reminder Resolution: Military Sexual Trauma (MST) Screening (image 1 of 2)

Reminder Resolution: MST Screening

I'm going to ask about some things that may have happened to you while you were in the military. We ask all Veterans these questions because VA offers free care related to these experiences. You can choose not to answer these questions if you prefer or you may simply say 'yes' or 'no.'

1. When you were in the military, did you ever receive unwanted, threatening, or repeated sexual attention (for example, touching, cornering, pressure for sexual favors, or inappropriate verbal remarks, etc.)?
2. When you were in the military, did you have sexual contact against your will or when you were unable to say no (for example, after being forced or threatened or to avoid other consequences)?

Please check off the appropriate box below based on the Veteran's responses to the above questions:

☐ NO - denies prior military sexual trauma (MST)
(answered 'NO' to BOTH questions)

☒ YES - reports military sexual trauma (MST) in the past
(answered 'YES' to AT LEAST ONE question)

VA refers to this type of experience as 'military sexual trauma' or 'MST' and VA offers free MST-related care for both physical and mental health concerns. Would you like to speak to a provider about this care?

[Offer MST Factsheet](#)

☒ YES - Veteran requested Mental Health services. Referral was made and explained to Veteran.

☐ NO - Veteran declined a referral for Mental Health services at this time. Veteran was made aware that services are available if needed in the future.

☐ NO - Veteran is currently in treatment with a Mental Health

Clear Clinical Maint Visit Info < Back Next > Finish Cancel

CLINICAL REMINDER ACTIVITY
MST Screening:
Patient reports experiencing military sexual trauma (MST) in the

Health Factors: **MST YES REPORTS, VA-MST REQUESTS MH REFERRAL**

Orders: << **MHD MST Consult** >>, << **Order Consult** >>

* Indicates a Required Field

Figure A.2. Reminder Resolution: Military Sexual Trauma (MST) Screening (image 2 of 2)

Reminder Resolution: MST Screening

1. When you were in the military, did you ever receive unwanted, threatening, or repeated sexual attention (for example, touching, cornering, pressure for sexual favors, or inappropriate verbal remarks, etc.)?

2. When you were in the military, did you have sexual contact against your will or when you were unable to say no (for example, after being forced or threatened or to avoid other consequences)?

Please check off the appropriate box below based on the Veteran's responses to the above questions:

☐ NO - denies prior military sexual trauma (MST)
(answered 'NO' to BOTH questions)

☒ YES - reports military sexual trauma (MST) in the past
(answered 'YES' to AT LEAST ONE question)

VA refers to this type of experience as 'military sexual trauma' or 'MST' and VA offers free MST-related care for both physical and mental health concerns. Would you like to speak to a provider about this care?

[Offer MST Factsheet](#)

☒ YES - Veteran requested Mental Health services. Referral was made and explained to Veteran.
 ☐ NO - Veteran declined a referral for Mental Health services at this time. Veteran was made aware that services are available if needed in the future.
 ☐ NO - Veteran is currently in treatment with a Mental Health provider

☐ DECLINE - Veteran declined to answer questions regarding military sexual trauma (MST).

Clear

Clinical Maint

Visit Info

< Back

Next >

Finish

Cancel

CLINICAL REMINDER ACTIVITY

MST Screening:

Patient reports experiencing military sexual trauma (MST) in the

Health Factors: **MST YES REPORTS, VA-MST REQUESTS MH REFERRAL**

Orders: << **MHD MST Consult** >>, << **Order Consult** >>

* Indicates a Required Field

Appendix B. Knowledge Resources for MST screening

Who should be screened? It is VA policy that all Veterans seen for health care be screened for *MST*, and it is congressionally mandated that VA report on screening rates annually.

When should screening take place? Screening should ideally occur during the Veteran's first clinical visit. If not completed on the first visit, screening should occur as soon as possible thereafter in any subsequent visit.

If a Veteran is screened, and then has a subsequent period of military service, the screen should be re-administered upon returning to VA care (see below).

Where should the screening take place? Screening should be conducted only in private clinical settings. It is never appropriate to conduct the screening in a public or group clinical setting.

Who should perform the screen? Screening should be conducted by staff with the ability and training to screen sensitively for *MST*, respond appropriately to disclosure, and connect Veterans with additional care or referrals as needed. Providers and/or clinical associates may screen for *MST*, as determined by local needs and state scope-of-licensure regulations. When screening is done by a clinical associate or registered nurse (*RN*) case manager, who must be familiar with the clinical considerations of screening described below, the licensed, credentialed provider associated with the visit should review the Veteran's response and initiate a follow-up discussion during the same visit, as needed. It is never appropriate to have administrative associates screen for *MST*.

What follow-up is required? It is VA policy that any Veteran who reports *MST* be offered a referral into VA mental health care. It is VHA policy and congressionally mandated that care for *MST*-related mental or physical conditions be provided free of cost to the Veteran.

B.1. Screening Clinical Considerations

This section summarizes key clinical considerations when screening for *MST*. VHA's mandatory *MST*-related training for mental health clinicians and primary care providers reviews some of the specialized knowledge and training in sensitive screening practices. Most users should have already completed one of these, but both are available in the Talent Management System (*TMS*) as helpful references.

B.1.1. Consideration 1: Sensitivity

Sexual trauma is a highly sensitive, highly complex, and frequently stigmatized issue. Clinicians should maintain awareness of these factors when they proceed with screening. For example, it is important to be sensitive to barriers to disclosure, such as shame or self-blame, difficulties in trusting others, and societal stigma associated with sexual trauma (especially for male survivors). In fact, many Veterans may have received unsupportive or even blaming responses in the past if they previously disclosed *MST*, so it is critically important that clinicians offer patient, supportive, and empathic responses.

Veterans with a history of *MST* may also be particularly attuned to otherwise small comments or variations in tone and body language. When screening, use clear, behaviorally based language (e.g., unwanted touching or verbal remarks) and avoid emotionally laden terms (such as "rape" or "sexual assault"), since Veterans vary in the terms they use to describe their experiences and may be hesitant to identify with more stigma-laden terms. It is also important to be aware of your behavior and body language, to make sure you communicate that you are open to hearing what Veterans have to say and that you are ready to help. For example, turn off the volume on phones and other electronic devices, and face Veterans with an attentive posture and warm facial expression.

Clinicians should ask the screening questions below without reading from the embedded script word for word. This might involve practicing in advance to feel more comfortable and confident with the wording. The script is a guide, and should be followed closely, but clinicians can also integrate their own preferred language and words that suit the unique clinical encounter with each Veteran to help enhance the humanness of the conversation. How clinicians say something may be even more important than what is said. For example,

clinicians should make eye contact with Veterans and speak in a quiet, calm, unrushed tone that shows comfort with asking the questions and that the answers are important to them. They should also be turned toward the Veteran, rather than looking away and reading from a computer screen, and body posture should be open and comfortable, rather than sitting forward into the Veteran's personal space or having arms crossed as if tense or closed off to the Veteran's responses. Even the smallest comments or variations in tone can carry great weight for survivors. For example, even asking how the *MST* happened or what a Veteran was wearing at the time could convey blame to the Veteran for what happened, when in fact *MST* is never the survivor's fault. As another example, saying something like, "I can't help with that," could be perceived as a sign clinician do not want to help or hear about their concerns, or even that the entire VA does not want to help. Alternatively, saying "I'm sorry you had to go through that while you were serving your country," in a sincere manner conveys that clinicians believe Veterans and truly care.

When someone responds "yes" that he or she experienced *MST*, it is important to provide the following:

1. A brief, authentic, empathic response, which has the power to be tremendously healing ("I'm sorry that happened to you while you were serving your country.")
2. Education, normalization, and hope ("VA refers to this type of experience as 'military sexual trauma' or '*MST*,' and VA offers free *MST*-related care for both physical and mental health concerns. Many Veterans have had experiences like yours and, for some, it can continue to affect them even many years later. People can recover, however.").
3. Information and connection with care if needed ("Would you like a referral for any physical or mental health care needs related to your experiences of *MST*?").]

You will see a range of reactions when a Veteran discloses an experience of *MST*. Some Veterans may be very emotionally flat and matter of fact; others may become very upset, crying or expressing anger. Some may answer "yes," and then decline to provide any additional information; others might share more details about their experiences. For Veterans who choose to share details about their experiences, it is important to balance following the Veteran's lead with using your clinical judgment about whether the Veteran may be opening up too much, too quickly. In some cases, Veterans may share more details than they would like to, almost as if they cannot help themselves, and then later regret having said so much. Sometimes they even drop out of treatment after a disclosure that made them feel too vulnerable. If you suspect a Veteran may be disclosing more details than will be helpful to them, intervene politely and supportively: "I'm so glad you feel like you can share this with me; that is really important. This may be the first time you have talked with anyone about this, though, and I just want to make sure you're going to feel okay, later, once you leave our appointment. Talking about these sorts of experiences for the first time can often bring some relief, but it can also bring up a lot of emotions. Would it be okay to pause here for now, and transition into figuring out next steps?" As a reminder, the Veteran does not need to provide any details of the *MST* or any evidence that it occurred; the Veteran simply can respond "yes" to either of the screening questions, and then be provided additional information about referrals and resources by the clinician in a sensitive manner.

Many providers also feel discomfort when asking about unwanted sexual experiences due to lack of training or practice, or even mistaken beliefs that this should be kept private or that survivors do not want to be asked. Instead, evidence suggests that survivors do want to be asked and will disclose in a safe environment when they feel ready. Clinicians need specialized knowledge and skills to create that safe environment, and it also requires appropriately inquiring about a referral to mental health and making one if a Veteran desires it. Clinicians also need to be prepared to answer questions about the effects of *MST* and VA's free services for *MST*-related conditions. Training is required to do this well.

B.1.2. Consideration 2: Privacy and Trust

Given the highly sensitive nature of *MST* experiences, privacy is often a central concern for patients. Special care should be taken to conduct the screening, as well as any follow-up conversations, in areas that are clearly private. You are likely already sensitive to privacy as a part of your standard practice, but it is an important issue to highlight clearly when talking about *MST*. Survivors may be vigilant for signs that suggest you are not a safe person to talk to and may be especially attentive to potential privacy breaches. It is useful to avoid things that a survivor may perceive as potential privacy breaches, such as a desk cluttered with paper that looks like patient information or chatting about what might be mistaken as patient information in a hallway. These small signals may be very meaningful to Veterans who are considering whether to disclose experiences of *MST*.

It is important to keep in mind that many sexual trauma survivors do not report their experiences to the authorities and that some do not tell anyone at all. Establishing rapport with the Veteran, helping reduce fear of marginalization or discrimination, and creating the general sense of a safe and trusted environment are crucial to successful screening.

Disclosures may result in a wide range of reactions. Some may be emotionally flat, while others may become very upset. Some may decline to provide any additional details, while others may share extensively about their experiences. It is important to use clinical judgment in determining the appropriate response to those reactions.

Privacy and Trust considerations are especially important when deciding whether the provider or a clinical associate should administer the screen.

B.1.3. Consideration 3: Integration into Care

Screening is a powerful opportunity to assist Veterans who have experienced *MST*, and it may be the first conversation a Veteran has had about experiences of *MST*. Receiving a supportive, empathic response can be very healing for Veterans, and this can help clinicians to assist Veterans in accessing *MST*-related care, if needed. Also, many Veterans will not spontaneously disclose a trauma history, so asking about *MST* can be the first step in getting them the help they need. The specific text of the screening instrument is intended to serve as a guide, not as definitive language. Clinicians should be able to adapt the screening language to create a more human and sensitive screening experience for each Veteran.

The timing of the screening can likewise vary. Some providers choose to ask about *MST* in the context of discussions about the patient's social history or military experiences. Other providers incorporate the screening within the context of broader assessments for general traumatic experiences. Another option is to ask about sexually traumatic experiences in general, and then follow up with more specific questions about whether the experiences occurred in the civilian or military setting. It is important to keep in mind that *MST* survivors may remain silent about their experiences. Most sexual trauma survivors do not report their experiences to authorities, and some do not tell anyone at all; some may remain silent for many years. This hesitancy to disclose can be because a Veteran does not think he/she will be believed, does not think it will make a difference to speak up, or struggles with shame or other strong feelings. A Veteran may also be concerned about stigma related to having experienced trauma or having associated mental health difficulties. Also, for marginalized groups, fear of discrimination or stereotyping can add another layer of difficulty to disclosure and help-seeking. These issues underscore the importance of creating a safe environment to facilitate disclosure, as well as providing supportive responses when disclosure does occur.

Having a discussion with the Veteran about the relevance of experiences of *MST* for your work together conveys that this part of the Veteran's history is important and relevant to you, and that it is safe for the Veteran to speak up about any trauma-related distress that might be experienced during your appointments or otherwise. In addition, understanding that a Veteran has a history of *MST* may provide critical context for the Veteran's presenting problems. Knowledge of *MST* experiences can also help health care professionals in adapting care to better account for potential sensitivities or reactions to medical encounters. A history of *MST* may also generate issues related to trust and other complex reactions that can be better managed with knowledge of those events.

The clinical reminder comes with a downloadable informational fact sheet that should be given to all Veterans who would like a copy, regardless of their decision to participate in additional care. Reaffirm that the Veteran's experiences are relevant and that the Veteran should feel safe in discussing any trauma-related distress as needed. The current edition of the fact sheet can be retrieved from the VA Mental Health *MST* Internet site here: https://www.mentalhealth.va.gov/docs/mst_general_factsheet.pdf. Clinicians should also be prepared to answer potential questions about the effects of *MST* and about VA's free services for *MST*-related conditions.

B.1.4. Consideration 4: Referral to Additional Care

If a Veteran reports a history of *MST*, it is VA policy to offer further information and connection with additional care in the form of a referral question embedded in the *MST* screen (also referred to as the Clinical Reminder below). For Veterans who express an interest in further care, the regular referral process at that local VA facility should be followed. Some facilities will automatically inform the facility *MST* Coordinator upon completion of the clinical reminder.

Many Veterans who experienced *MST* may genuinely be recovering well and do not need care. Alternatively, some Veterans may simply not yet be ready to engage in care. For this reason, when a Veteran declines a

referral, it is useful to first validate and respect that, and then also keep the door open for the future: “If you ever change your mind and want to speak to someone, just let me or one of your other providers know.”

In addition, a Veteran’s response of “no” to the *MST* questions may be a genuine “no.” In case it is not, and the Veteran is just not ready to disclose an *MST* experience, leave the door open for future disclosure: “I’m glad to hear that. I asked because VA has free, specialized services to help Veterans who’ve had these sorts of experiences, so I wanted to make sure to talk to you about those resources if they are relevant now or ever become relevant in the future.”

B.2. Guidance with asking MST Screening Questions

Would it be okay if I asked about some things that may have happened to you while you were in the military? We ask all veterans these questions because VA offers free care related to these experiences. You can choose not to answer these questions if you prefer, or you may simply say 'yes' or 'no.'

☐ No

☐ Yes

☐ Declines to answer

For Veterans who do not decline, the clinician should proceed with asking the following questions, with a comfortable tone and good eye contact, and using the script below as a guide. It should not be read verbatim, but clinicians can have the *MST* Clinical Reminder open on a computer screen or printed out in a packet of standard screening paperwork in their lap if needed as a reference. The language below may be phrased in a slightly different way if necessary to capture language that the clinician is comfortable with in that encounter with that specific Veteran, as long as it fully captures both categories of unwanted sexual experiences.

When you were in the military, did you ever receive unwanted, threatening, or repeated sexual attention (for example, touching, cornering, pressure for sexual favors, or inappropriate verbal remarks, etc.)?

☐ No, denies prior *MST*

☐ Yes, reports *MST* in the past

☐ Declines to answer

When you were in the military, did you have sexual contact against your will or when you were unable to say no (for example, after being forced or threatened or to avoid other consequences)?

☐ No, denies prior *MST*

☐ Yes, reports *MST* in the past

☐ Declines to answer

If a Veteran answers “yes” to either question, the clinician must be mindful to respond in a sensitive, compassionate, and validating manner. For example: “I am very sorry you had to experience that while serving your country. Thank you so much for sharing that information with me. It will help me to better understand what you are going through. VA refers to this as ‘military sexual trauma’ or ‘*MST*,’ and we offer free care to men and women for physical and mental health concerns related to *MST*. Would you like to speak with a provider about this care?” However, the clinician does not need to prompt or ask for more details about the experience, and the Veteran does not need to have told anyone or have any evidence that the *MST* occurred. Service connection is also not required to receive *MST*-related services. If instead a Veteran answers “no,” the clinician should respond with a comment such as, “Thank you. I ask all Veterans these questions, because VA offers free care related to these experiences, and we want to make sure all Veterans are aware of this.”

B.3. Patient Education

OPTIONAL PHRASES:

1. Thank you for sharing that with me. VA refers to this type of experience as 'military sexual trauma' or '*MST*,' and VA offers free *MST*-related care for both physical and mental health concerns.
2. Thank you so much for sharing that information with me. It will help me to better understand what you are going through. VA wants Veterans to know about common difficulties related to *MST* and VA's free *MST*-related services, so it created a factsheet that we can give out to Veterans. It describes what *MST* is, how *MST* may affect you, and how to get help if you would like it. Would you mind if I printed it out and gave it to you to take with you? I am also happy to answer any questions you have. Every facility also has an *MST* Coordinator who is a point person for Veterans on *MST*-related issues. This facility's *MST* Coordinator is _____.

Clinicians should be ready to discuss the handout contents if needed.

B.4. Referrals for MST

Even if the Veteran responds “no” to each question above or refuses screening, veterans should still be offered a referral to an *MST* specialist.

Ask the patient: Would you like to speak to a clinical provider about *MST* treatment?

- ☐ No, declines referral for *MST* treatment
- ☐ No, Veteran is currently in *MST* treatment
- ☐ Yes, requests referral for *MST* treatment
- ☐ Yes, requests follow up visit for physical symptoms related to *MST*
- ☐ Declines to answer

Veterans who request a referral should be connected to mental health services in a timely manner consistent with local policy and procedures. Facilities will vary on how referral requests are handled. Clinicians should explain the referral process to the Veterans and what they can expect next.

In addition, Veterans may say ‘yes’ to the referral question but intend to request a referral only for physical health conditions. It is clinicians’ responsibility to assess the nature of Veterans’ requests for a referral and to make appropriate referrals for *MST*-related physical health conditions via other means if that is the main or an additional need. Also, when a Veteran screens positive for *MST* in primary care and requests a referral for mental health services, primary care team members are encouraged to consider providing a warm hand-off to a primary care mental health provider whenever possible.

1) A Veteran’s subjective experience is sufficient for a positive screen; 2) Can occur on or off base, while a Veteran was on or off duty; 3) Perpetrator identity does not matter; 4) Notes that all health care services (inpatient, outpatient, and pharmaceutical care) for physical and mental health conditions related to *MST* are provided free of charge. In addition, Veterans with additional military service after their original *MST* Clinical Reminder has been completed (for both “yes” and “no” responses) need to be rescreened after they separate from the service again, as they have had additional opportunity for exposure to *MST*.

Appendix C. Acronyms

ADSMs	Active Duty Service Members
CCWP	Clinical Content White Paper
CDS	Clinical Decision Support
DoD	Department of Defense
HL7	Health Level 7
KBS	Knowledge Based Systems
KNART	Knowledge Artifact
MST	Military Sexual Trauma
OIG	Office of Informatics and Information Governance
PCP	Primary Care Provider
RN	Registered Nurse
SME	Subject Matter Expert
TMS	Talent Management System
TO	Task Order
VA	Department of Veterans Affairs
VAMC	VA Medical Center
VHA	Veterans Health Administration