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DEPARTING THE UNITED STATES MILITARY: TRANSITION OF FEMALES TO VETERAN-CIVILIAN STATUS: AVAILABILITY AND EFFECTIVENESS OF DEDICATED SUPPORT SERVICES TO FACILITATE REINTEGRATION TO THE CIVILIAN SECTOR

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DEPARTING THE UNITED STATES MILITARY: TRANSITION OF FEMALES TO VETERAN-CIVILIAN STATUS: AVAILABILITY AND EFFECTIVENESS OF DEDICATED SUPPORT SERVICES TO FACILITATE REINTEGRATION TO THE CIVILIAN SECTOR

A DISSERTATION APPROVED FOR THE

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Dedication

This dissertation is dedicated to my spouse, Bobby Gene Roberts, whose unwavering support has been the constant source of strength throughout my educational endeavors and life in general. To you, Bobby, I extend my sincere gratitude and love. I would also like to thank my children, Kristie, Neil, Michael, Kia, Ben and TK, who continuously and unknowingly, are my inspiration to not ever quit. I would also like my grandchildren to understand, there are no limits to what they can achieve. Life is not always experienced sequentially. One of my many favorite quotes by Dr. Seuss in his book entitled, "Oh the Places You'll Go" states, "You have brains in your head, you have feet in your shoes. You can steer yourself any direction you choose…." (Geisel, 196, p. 2). As a veteran, I would like to also dedicate this dissertation to our military members, past and present, with special recognition to our women warriors. Lastly, I would like to dedicate this to aspiring children who unfortunately are subjected to an inequitable educational system based on geography and distribution of resources. I realized that being on the honor roll was relative to the standards of the educational system to which you were subjected. I learned what I was taught. I later learned that what I was taught was insufficient and not on par with my peers who also attended public institutions. I encourage you to glean knowledge from every encounter. Challenge yourself and your teachers and never, ever become discouraged or complacent. Be the determinant of your fate and remember this quote from the book, "I Can Read with My Eyes Shut" by Dr. Seuss, "The more that you read, the more things you will know. The more that you learn, the more place you'll go" (Geisel, 1978, p. 27).

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Wilson, was supportive while keeping me on point. Her frequent reminders kept me focused on the parameters of my topic. To the members of Cohort V and Dr. Joe Rodgers, thank you for your friendship, teamwork, encouragement, and collaboration.

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Abstract

In 1948, Congress passed the Women's Armed Services Integration Act granting women permanent status in the military, entitling them to veterans' benefits. The purpose of the current study is to identify resources and earned benefits that facilitate or impede the successful transition of women veterans to civilian status. The current study builds upon a model developed by Burkhart and Hogan (2015), by specifically investigating resources and benefits that are key to successful transition from the military beginning with planning of the departure until one achieves full reintegration as a veteran-civilian.

A two-part study was conducted to determine female veterans' perceptions regarding the role support resources and benefits played in their transition from military to civilian life. The study also examined how the lack of specific resources hindered the transition of some female veterans to feel fully integrated into civilian society. The first part of the study was survey-based to collect demographic information regarding participants' military service and their utilization of veterans' benefits and resources. There was a total of 131 viable responses from participants. The second part of the study entailed the conduct of telephone interviews; a total of 52 telephone interviews were conducted.

The results of the survey indicated the respondents utilized the VA benefits they were authorized to receive. Employment, housing and mental and physical healthcare were recurring themes in terms of areas of greatest support used. The Burkhart and Hogan (2015) model did address the medical situation of female veterans; however, the model did not examine resources female veterans need to manage their transition. The current study fills this gap regarding the female veteran transition experience. Results are expected to directly benefit female veterans who are transitioning or who will transition in the future by providing insight into the challenges

faced by the participants. It also illustrates how the use of resources and benefits, prior to and after departure from the military can alleviate some of the stressors associated with transitioning from the military to the civilian sector. Additionally, results of the current study can help inform military administration as well as ancillary helping agencies and civilian employers regarding additional support needs for female veterans during the transition process.

SECTION ONE: INTRODUCTION

Introduction to the Problem

Women have played a vital role in the history of the United States military. They endured the challenges of war commensurate to their male counterparts from direct engagement to personal and collateral support for more than a century beginning with the Revolutionary War. Women served on the battlefields, and endured the experiences of war; however, they did not receive the same recognition or compensation as the men who they fought beside. President Harry Truman signed into law The Women's Armed Services Integration Act of 1948 which gave women formal permanent status in the Army, Navy, Air Force, and Marine Corps and entitled them to veteran's benefits 173 years after the Revolutionary War and the six wars subsequent to it. Based on policy changes, women are now eligible to compete for assignments in all military occupational specialties and positions. Women currently are the fastest-growing subpopulation of both military and veteran communities (Disabled American Veterans [DAV], 2018).

According to the U.S. Department of Veterans Affairs (VA) National Center for Veterans Analysis and Statistics, as of September 30, 2018, the female veteran population was 1,902,553; that number is projected to increase by 102,214 within the next 5 years (VA, 2018b). Female veterans range in age from less than 20 years to more than 85 years old. As shown in Table 1.1, living wartime women veterans totaled 1,485,666 which included veterans who participated in World War II (1941-1945), the Korean War (1950-1955), the Vietnam War (1954-1975), the Persian Gulf War (1991), the War in Afghanistan (2001-Present), and the War in Iraq (2003-2011). There were 416,887 female veterans who served during peacetimes defined as the time prior to, between or after a war.

The proliferation of women who have served in the military became widely recognized during the 1980 Census when, for the first time, U.S. citizens were asked if they had ever served in the armed services; approximately 1.2 million female veterans responded "yes" to this historic question (VA, 2014). These responses prompted Congress and the VA to co-sponsor an initiative to inform women veterans of their benefits and entitlements given that so few of those identified veterans used VA services at that time (VA, n.d.). Findings of a 1982 General Accounting Office (GAO) study entitled, "Actions Needed to Insure that Female Veterans Have Equal Access to VA benefits" indicated that (1) women did not have equal access to VA benefits, (2) women treated in VA facilities did not receive complete physical examinations, (3) the VA was not providing gynecological care, and (4) women veterans were not adequately informed of their benefits under the law (GAO, 1982).

According to a Women Veterans Report published by the National Center for Veteran's Analysis and Statistics (2017), 840,000 women veterans used at least one VA benefit or service; the report also indicated that the percentage of female veterans using benefits increased from 31.2% in 2005 to 41.1% in 2015 (VA, 2017a). While government agencies responsible for supporting female veterans may recognize the unique needs of women veterans following their military service, adequate resources have not been allocated to support the growing population of female veterans as they transition to the civilian sector (DAV, 2018).

Allocation of gender-specific resources for military women transitioning to veteran status as well as recognition of both their unique experiences and needs would facilitate women's transition from the structured environment of the military to civilian life which is imbued with great uncertainty. The variability of support from the government and the absence of information

Table 1.1

Number of Women Who Served in the Military and Casualty Counts, by Wartime Period

Military Conflict	Inclusive Dates	Number Served	Wounded	Casualties
The American Revolution	1775 - 1783	Undocumented	N/A	N/A
The War of 1812*	1812 - 1815	Undocumented	N/A	N/A
Mexican American War*	1846 - 1848	Undocumented	N/A	N/A
American Civil War	1861 - 1865	Undocumented	N/A	N/A
Spanish American War*	1898 -1898	1,500	N/A	20+
World War I*	1914 - 1918	10,000+	N/A	172
World War II*	1939 - 1945	400,000	N/A	217+
Korean War	1950 - 1953	120,000	N/A	2
Vietnam War	1955 - 1975	7,000	N/A	8
Persian Gulf War	1990 - 1991	41,000	N/A	15
Iraq War[1]	2003 - 2011		12	1
Afghanistan War	2001 - Present	200,000+	1,022	166

*Denotes formally declared wars.

[1] The number served for the Iraq War was combined with the number served in the Afghanistan War. The source of this data is in response to a Freedom of Information Act Request number FOIA 18-F-01989, United States Member Deaths, Female Service Members Only, Wars and Operations since 1900, Produced by the Defense Manpower Data Casualty Analysis Systems as of December 14, 2017.

regarding women's roles in the military have created a sense of invisibility for women veterans. Many people still associate military service exclusively with men. Additionally, as a result of undiagnosed symptoms of post-traumatic stress disorder (PTSD), some women exhibit self-deprecating behavior that belie their veteran status and therefore they are less apt to take advantage of their earned benefits (Gonzalez-Prats, Harris, & Summer, 2018).

The purpose of this research paper is to examine the unique challenges women veterans face following separation from the military. The current study focuses specifically on resources available to female veterans which aid in their transition to civilian status. Additionally, lack of resources specific to the unique needs of female veterans will also be discussed including how availability of such resources can facilitate female veterans' transition experiences.

Background

Prior to enactment of the Women's Armed Service Integration Act of 1948, the women who supported the soldiers on the battlefield or actively engaged in battle, had no expectations for post-war sustainment or care associated with their service to their country. Nevertheless, prior to the Women's Armed Services Integration Act, women engaged in military service; in fact, in some instances, there was no distinction between the war zone and one's homestead such as during the Revolutionary War. Only a few women received pensions or other honors subsequent to their service on behalf of the military. For instance, Margaret Corbin was the first American woman to receive a disabled veteran's pension. Margaret sustained injuries to her arm and chest from cannon fire while filling her husband's artillery position in the battle of Fort Washington in November 1776. In 1779, Corbin was granted a stipend of $30 and a lifelong pension of half a soldier's pay (Frank, 2013a). Mary Ludwig Hays McCauley received an annual pension of $40 from the Commonwealth of Pennsylvania for her support of the Continental

Army as a water girl and Deborah Sampson, disguised as Timothy Thayer, received a pension from the Massachusetts legislature for her service as an enlisted soldier. As compensation, the legislature awarded her $4 per month, commencing on January 1, 1803. In 1816, the legislature increased her pension to $6.40 per month and, in 1819, to $8.00 per month (Frank, 2013a). Union nurses began receiving pensions at the rate of $12 a month beginning in 1892 if they served at least six months, received an honorable discharge, and were otherwise unable to support themselves (Gorman, 2012). Ellen May Tower, a U.S. Army nurse who died of Typhoid Fever in Puerto Rico during the Spanish-American War was the first nurse to die on foreign soil and the first woman to receive a hometown military funeral (Frank, 2013b).

Although some women veterans received pensions and the honor of military burials, according to Parkinson (2015), the women who were allowed to serve as uniformed nurses in the U.S. military from 1901 to 1917 were considered civilian employees and thus were denied ranks and insignia as well as retirement and disability pensions (see Appendix A). In contrast, in November 1918, following WW1, 12,000 female yeomen and 305 marinettes served in the U.S. Marines; these women earned $28.75 a month salary comparable to their male peers and commensurate responsibilities, pay grades and benefits (Bellafaire, 2006).

As a result of the Women's Integration Act of 1948, women veterans are eligible to apply for VA benefits to include: disability compensation, a pension, education and training benefits, health care, home loans, insurance, vocational rehabilitation and employment, and burial allowances (see Appendix B). The VA is often the first stop for veterans in transition. Prior to 1948, women lived with the consequences of war and victimization. There were no options for transition assistance, depression and sexual trauma counseling, or any of the other health care benefits and resources that female veterans needed to enhance their well-being. Currently, due to

stigma and lack of information about their benefits and rights, some female veterans still suffer in silence from the consequences of their military service. Nevertheless, the VA has made significant strides in trying to meet the needs of the growing population of female veterans (see Appendix C). According to a DAV report, the VA, in collaboration with the Department of Defense, plan to initiate an Air Force pilot program to introduce an additional day of women-specific training in the Transition Assistance Program which is mandatory for all separating military members (DAV, 2018).

Burkhart and Hogan's (2015) Coping with Transition Model

Some research has been conducted to understand the experiences and unique needs of female veterans who were subjected to the atrocities of war and objectification. Burkhart and Hogan (2015) addressed the lifecycle of a female veteran from choosing the military, adapting to the military, being in the military, and more specifically, being a female in the military and finally to departing the military. The current study focuses on this final stage in Burkhart and Hogan's (2015) Coping with Transitions model in order to further understand the types of resources and processes that facilitate and/or impede this transition for female veterans. Burkhart and Hogan's (2015) research indicated that "The initial transition out of the military resulted in cultural shock and feeling unprepared for civilian life, while also adapting to life as a veteran in a civilian society" (p. 6). Burkhart and Hogan (2015) used a grounded theory approach which showed that while coping with the transition from "civilian" to "veteran-civilian" status, women used camaraderie as a positive coping mechanism. Those who were eligible to use VA benefits did not utilize the available resources to help cope with, or alleviate the stressors associated with transitioning from the military to civilian culture. The current study seeks to further understand

how women become aware of resources and if aware of resources, why they do or do not utilize them.

Gender Stereotypes and Stratification

Historical accounts demonstrate that women have participated in wars for centuries. Stereotypes and presupposition about women's abilities and roles in society have inhibited policy and legislation that would have brought them to parity with their male military peers. Normative beliefs regarding male and female roles have undermined the disposition of female veterans and their contributions as soldiers, airmen, sailors, coast guardsmen and marines (Gonzalez-Prats et al., 2018). It is difficult to deconstruct stereotypical gender roles which have become embedded in civil society and institutionalized within the military. As a result, women veterans often feel underappreciated and, in some aspects, invisible to those for whom they stood watch (see Figure 1.1).

Figure 1.1. We are not invisible poster. This poster was created to spotlight women and to provide visibility on this important segment of the veteran community. I Am Not Invisible (IANI) aims to increase awareness and dialogue about women veterans. The project was initiative by PSU Veterans Resource Center Director Felita Singleton and ODVA Women Veterans Coordinator Elizabeth Estabrooks. Retrieved from https://www.va.gov/womenvet/acwv/iani.asp.

Although not malicious or deliberate in most cases, these ubiquitous impressions of the "typical" veteran contribute to female veterans' reluctance to seek care for trauma associated with their military experiences as well as the support they need to facilitate their transition to

civilian life including assistance in maneuvering through various governmental systems in order to take advantage of earned benefits. Additionally, services more tailored to the needs of female veterans are not equitably distributed across the United States nor are they distributed in a way that closely aligns with the geographic concentrations of female veterans (see Appendix D).

Veteran's Benefits

The Veterans Administration (VA) is a primary source of support for veterans upon separation from the military. The Department of Defense (DD) Form 214, Certificate of Release or Discharge from Active Duty, is issued to each servicemember upon discharge and provides a summary of their service and specifies the type of discharge they received upon their exit from their respective branch of service (see Appendix E). This form determines their eligibility to receive VA benefits. Upon determination of eligibility veterans are offered disability compensation, a pension, education and training, health care, home loans, insurance, vocational rehabilitation, employment training and resources and burial services (see Appendix F). Although women veterans are now eligible for benefits like their male peers, institutional messages still treat them as anomalies. For instance, the mission statement of the VA is, "To care for *him* who shall have borne the battle and for *his* widow, and *his* orphan" which is adapted from President Lincoln's Second Inaugural Address more than 150 years ago (VA, 2018a, para. 1). The VA's mission has not been updated to reflect the composition of the contemporary military even though the Iraq and Afghanistan Veterans of America (IAVA) asked VA Secretary David Shulkin in November 2018 to change the statement they described as sexist and outdated. The VA denied the request stating the mission statement represented "the heart of our noble mission" (Wentling, 2018). According to statistics provided by the National Center for Veterans Analysis and Statistics, in 2015, 840,000 women veterans used at least one VA benefit or

service; the number of women veterans who used at least one VA benefit or service has steadily grown from 34.7% in 2007 to 46.9% in 2016. According to the report, in 2015, 35.9% of women veterans were enrolled in the Veterans Health Administration (VHA) health care system; however, not all women who enrolled in the health care system ultimately became health care users. Additionally, during the period from 2005 to 2015, the number of women veterans enrolled in the VA health care system increased 54.3%, going from 397,024 in 2005 to 729,989 in 2015. During that same period of time, the number of women veterans using VA health care increased 52.1%, from 237,952 to 455,875. In 2005 about 13.1% of all women veterans used VA health care while that figure rose to 22.4% in 2015. Also, in 2015, approximately 405,418 women veterans received compensation from the VA for a service-connected disability in 2015, representing about 20.1% of the total population of women veterans. Of those women, 54% had a combined disability rating of 50% or higher and approximately 6% received individual unemployability compensation representing approximately 1.3% of the total women veteran population. Furthermore, 27,083 out of 131,607 veterans participating in the Vocational Rehabilitation and Education (VR&E) program in 2015 were women representing approximately 21% of participants. Additionally, in 2015, 149,375 women veterans used education benefits, which represented about 7.4% of the total population of women veterans in that year. Roughly, 61.2% of women veterans who used education benefits did so when they were 25 to 34 years old. The overall use of benefits and the comparison of male and female utilization for 2017 is displayed in Figure 1.2.

Problem Statement

Women have made significant strides in their struggle towards equality in the military. Women no longer have to disguise themselves as men to participate in war. Effective January

2016, all military occupations and positions were opened to women without exception. All barriers have been lifted to allow women to serve inclusively alongside men. Women now can drive tanks, lead infantry soldiers into combat, and compete for elite positions including Army Rangers, Green Berets, Navy SEALs (Sea, Air and Land), Marine Corps Infantry, Air Force parajumpers and all other fields previously restricted to men (Tobia, 2015).

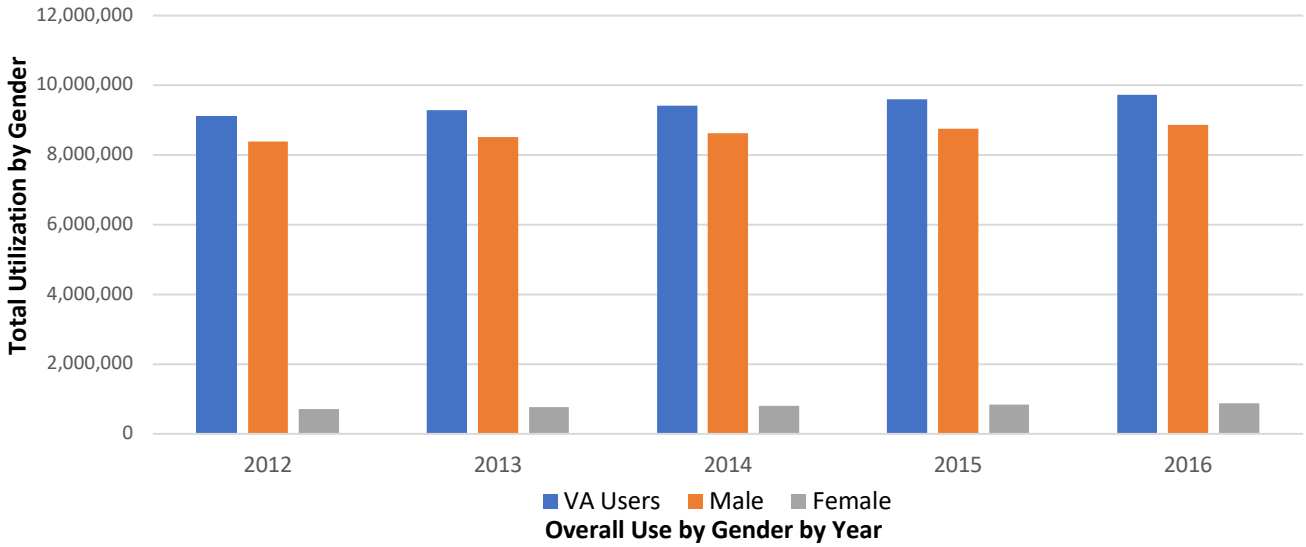

Figure 1.2. Overall use of VA benefits and services by gender. (U.S. Department of Veterans Affairs, National Center for Veterans Analysis and Statistics, 2017, p. 8).

Women veterans, however, still sense invisibility and experience a degree of inferiority to their male counterparts. In general, the subjugation of female veterans is a systemic problem. The stereotypical perceptions of women's roles and their capabilities held by some military males can negatively affect how women veterans perceive themselves. The lack of female-specific resources and the geographical sparcity of facilities to assist women veterans in transition to veteran-civilian status exacerbates the problem. Furthemore, common perceptions of those in the civilian sector compounds this problem given widespread misunderstandings regarding female veterans (see Figure 1.3). Thus, women veterans often devalue their own military service and contributions.

There has been an increase in women's utilization of services offered by the VA since they began offering resources specific to female veterans. Presumably, the use of the benefits to which veterans are entitled should alleviate the challenges of transition from military to civilian status.

Figure 1.3. Handwritten note placed on female veteran's car. Someone left this note on the car of Rebecca Landis Hayes, a former Navy doctor. Source: www.blogs.va.gov/VAntage/28724/ women-vets-see-hear-thank/ (DAV, 2018).

SECTION TWO: LITERATURE REVIEW

The extant of literature regarding the transition of veterans focuses predominantly on preparation such as education, training, resumes, and job interviews which are relevant, but not specific to veterans given their applicability to the generalized populace. Research that is specifically relevant to women is limited and is primarily focused on mental and physical health issues and the specific needs associated with the well-being of women veterans. The Barriers to Care for Women Veterans (VA, 2015) study funded by the Department of Veteran Affairs in 2010 revealed the following barriers to women verterans' healthcare: (1) perceived stigma associated with seeking mental health care services, (2) effects of driving distance and availability of other forms of transportation to the nearest medical facility and access to care, (3) availability of childcare, (4) acceptability of integrated primary care, women's health clinics, or both, (5) comprehension of eligibility requirements for, and the scope of services available under, hospital care and medical services, (6) perception of personal safety and comfort in inpatient, outpatient, and behavioral health facilities, (7) gender sensitivity of health care providers and staff to issues that particularly affect women, (8) effectiveness of outreach for health care services available to women veterans, (9) location and operating hours of health care facilities that provide services to women veterans, and (10) other such significant barriers considered appropriate (see Appendix G; VA, 2015). While serving and through to their transition, women are subjected to certain behaviors that may impact their ability to be successful once they separate from the military.

Military Sexual Trauma (MST)

The resounding but undiagnosed symptoms of MST plagued some women veterans for decades. MST is defined by Title 38 U.S. Code 1720D ("Counseling and treatment for sexual

trauma," 2006) as "psychological trauma resulting from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the veteran was serving on active duty, active duty for training, or inactive duty training." Sexual harassment, is defined as "repeated, unsolicited verbal or physical contact of a sexual nature which is threatening in character" ("Counseling and treatment for sexual trauma," 2006). There were approximately 5,277 reports of sexual assaults reported, of that amount, 74% were filed by women which is up 13% from FY 16 (Ferdinando, 2018). By law, VA treatment facilities must screen and provide care for problems resulting from sexual trauma. VA service providers assess MST by asking two questions during intake:

> While you were in the military (1) did you receive uninvited and unwanted sexual attention, such as touching, cornering, pressure for sexual favors, or verbal remarks? and (2) did someone ever use force or threat of force to have sexual contact with you against your will? (Street & Stafford, 2018, p. 1)

This screening program provides the VA with epidemiological data regarding the lifetime prevalence of MST among veterans who use VA services.

In a study administered by researchers at the VA Salt Lake City Health Care System and VA's National Center for PTSD, being a victim of military sexual trauma is a risk factor for homelessness. Results of the study showed that among the 601,892 veterans who participated, those who screened positive for MST experienced homelessness at rates of 1.6% within 30 days, 4.4% within 1 year, and 9.6% within 5 years. The rates for those who did not screen positive for MST were 0.7% within 30 days, 1.8% within 1 year, and 4.3% within 5 years. Of the sample, 12.3% were female. According to Brignone et al. (2016, p. 588), "These results underscore the

importance of the MST screen as a clinically important marker of reintegration outcomes among veterans."

Homelessness

The U.S. Department of Housing and Urban Development (HUD) defines homelessness as someone who is lacking a fixed, regular, and adequate nighttime residence. In November 2018, 37,878 veterans were reported to be homeless including 10,689 who were housed in emergency shelters; 12,623 who were in sheltered transitional housing; and 14,566 who were unsheltered (HUD, 2018). The VA, in collaboration with HUD's VA Supportive Housing (HUD-VASH) Program provides assistance to veterans and their families to find housing through the use of a voucher system. Veterans who are eligible to use VA health care services and who are homeless are able to apply for assistance. The VA offers several programs to assist the housing needs for veterans, although not all-inclusive, is extensive and includes: the Supportive Services for Veteran Families program, intended for very low income families to prevent imminent loss of a home; the Homeless Providers Grant and Per Diem program, which provides funding to organizations to provide transitional housing and services for homeless veterans; and the Domiciliary Care for Homeless Veterans program that provides residential care of disabled or emotionally-challenged veterans (VA, 2019).

Transition Assistance

To assist transitioning service members, veterans are mandated to attend and participate in a service-specific Transition Assistance Program (TAP) customized for their branch of service. For example, the Air Force recently revised its transition program to be incorporated with the DoD Military Lifecycle model. Airmen are required to prepare a development plan to be used as a dynamic plan through the duration of their service commitment. Starting 1 Oct 2019,

service members across all branches of the military will have to complete their initial counseling with a TAP adviser and complete their personal self-assessment, also known as an individual transition plan, no later than 365 days before retirement or the end of their enlistment. Part of the transition process includes mandatory briefings according to Title 10, United States Code, Chapter 58. Table 2.1 illustrates the mandatory briefing topics covered in the Air Force TAP.

Table 2.1

Mandatory Attendance to VA Benefits Briefing I and II

1.	The Department of Veterans Afairs (VA)
2.	Education Benefits (Post 911 GI Bill, Chapter 33), (Montgomery GI Bill, Chapter 30), (Veterans Educational Assistance Program), (Vietnam-era, etc.)
3.	VA Health Administration
4.	VA Health Care
5.	VA Dental Care
6.	VA Vet Center
7.	State and Local Health Care and Mental Health Services
8.	Other VA Health Care and Other Benefits Administered under the Laws by the Secretary of Veterans Affairs
9.	Continued Health Care Benefits Program
10.	Veterans Group Life Insurance (VGLI)
11.	Service members' Group Life Insureance (SGLI)
12.	Traumatic Injury Protection under Service members' Group Life Insurance (TSGLI)
13.	Family Service members' Group Life Insurance (FSGLI)
14.	Service-Disabled Veterans Insurance (S-DVI)
15.	Veterans Mortgage Life Insurance (VMLI)
16.	VA Life Insurance
17.	Transitional Health Care Benefit
18.	VA Disability Benefits
19.	Benefits Delivery at Discharge (BDD) and Quick Start

Note. Mandatory briefing topics are in accordance with Title 10, United States Code (USC), Chapter 58, Section 1142 and Department of Defense Instruction (DDI) 1332.35, February 29, 2016. Department of Defense Transition Assistance Program, Service Member Pre-Separation/Transition Counseling-Executive Summary Sheet.
TAP information is available at the following links. DD:. https://www.dodtap.mil; https://www.sfl-tap.army.mil; https://www.cnic.navy.mil; https://www.AFPC.af.mil; https://www.USMC-MCCS.org; and https://www.DCMS.USCG.mil.

These briefings are given by a collective group of subject matter experts to include representatives from the Veterans Administration and the Department of Labor. Supplemental briefing topics, which are also mandatory, are located in Appendix H.

Resources

Adjusting to the sphere of veteran-civilian life can be a daunting experience without adequate resources and support following a military experience irrespective of the time served. Military service is an anomaly when compared to the U.S. civilian life; the active duty force comprises only 0.4% of the U.S. citizen population (Department of Defense [DD], 2018). While relocating from one installation to another, deploying, or temporary duty assignments require some form of adjustment; such interagency temporary transitions do not prepare members to be fully independent of the military. The military provides benefits that free its members from worrying about their basic needs such as access to medical and dental care, housing, fitness, training, allowances, and life insurance. Military installations are self-contained microcosms of a city. Each state within the U. S. also offers unique benefits for the veterans residing in that state (see Appendix I). The transfer of responsibility accompanied by social readjustment to the civilian sector can be challenging.

Transition Theories

Sociologist George Homans (1991) theorized about the social exchange process and its connection to social behavior. This theory was not developed specifically to explain military transition but the elements of the theory are applicable. The theory asserts that the value resulting from the benefits and costs one perceives in a relationship determines whether or not an individual chooses to continue that relationship. In this case, a relationship is defined by the way in which two or more people or organizations regard and behave toward each other (Cherry, 2018). When a veteran

attempts to reintegrate into the civilian sector, social exchange theory posits that the veteran will weigh the costs associated with the transition with the anticipated benefits. For instance, the veteran may consider whether the civilian environment meets his or her expectations and weigh how it compares to the military environment. The veteran also may have a sudden realization that no civilian environment will compare to the military. Another aspect of Homan's (1991) theory is the "honeymoon phase" of a transition. The honeymoon phase is a phase in which the transitioner may ignore an imbalance in the likely costs and benefits of transition. In the case of transitioning from the military for instance, a veteran may sacrifice relationships with familiar military friends (cost) and exaggerate how well the reintegration is going (benefit) as a result. According to the theory, the honeymoon phase is a finite phase; at some point the veteran will experience a prompt that encourages a re-evaluation of the exchange balance. If the balance is tipped too far from even, the new relationship may be abandoned and the veteran may renounce the familiar safe place and end up feeling like he or she does not fit in anywhere (Cherry, 2018). Transition success or failure is not gauged by a single action and a measurable scale has not been developed regarding what constitutes success or failure especially with medically-challenged veterans (Hawkins & Crowe, 2017).

Transition: 4S Theory. Another theory applicable to transition from the military to the civilian sector is Goodman, Scholssberg, and Anderson's (2006) Transition Theory also known as the 4S Theory. According to Goodman and colleagues (2006), the transition process involves 4Ss: Situation, Support, Self and Strategies. The model refers to an individual's life transitions in general. Though the model was not designed exclusively for military transitions, it can be applied to the transition of a female service member to life as a civilian (see Figure 2.1). According to the model, the meaning of transition for an individual is assessed based on three elements: type,

context and impact. *Type* depicts whether the transition was anticipated, unanticipated, or perceived to be a non-event. *Context* refers to the transition's setting. Finally, *impact* involves how one's daily life is altered as a result of the transition (Goodman et al., 2006).

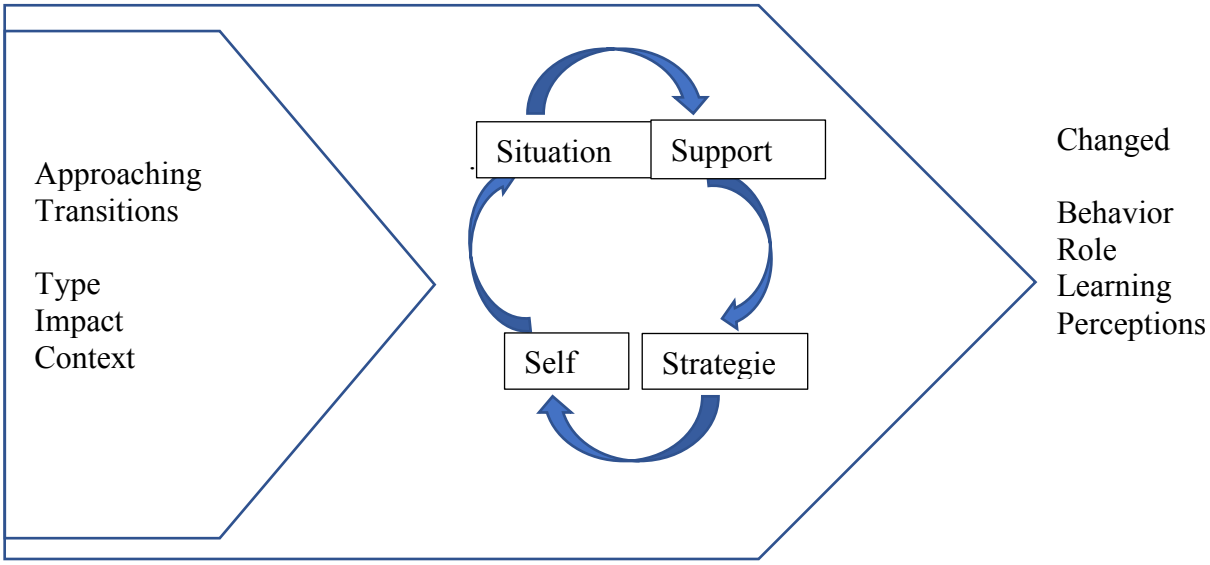

Figure 2.1. The Individual Transition Process – Changing Reactions over Time.
Source: Goodman, J., Schlossberg, N. & Anderson. M. (2006). *Counseling adults in transition: Linking practice with theory*. New York: Springer Publishing Company.

As posited by Goodman et al. (2006), "Often people in the midst of one transition experience other transitions, which makes coping especially difficult" (p. 40). The 4s Theory can be applied to female veterans on a broad scale as it is relevant to "any event or non event that results in changed relationships, routines, assumptions, and role" (Goodman et al., 2006, p. 33). A change from military to civilian life encompasses changes in all four of these aspects of life, thus involving all 4 Ss described in the model. Application of 4s Theory to women veterans during their transition to civilian life is described below.

Situation. Various factors can precipitate a transition. In the military, transition triggers include situations such as: high year of tenure, retirement eligibility, health issues, dissatisfaction with the current environment or the desire to do something else. The timing of the transition also

is a situational element which can impact financial readiness, psychological preparedness and the stability of the family unit. When a trigger event occurs, such as re-enlistment time, the veteran has to assess whether to avoid the transition by re-enlisting or not retiring or to move forward in the transition and plan accordingly. Veterans may experience concurrent stressors at the time of their transition. Such stressor may include but are not limited to: the need to cope with PTSD and/or MST, reduced income, reduced availability of and increased need for medical or psychological care, changes in housing and housing availability, adjusting to and adjustment by family members, the need for employment training, changes in social support network, changes in employment, and changes in status within one's community. Additionally, the veteran's identity also undergoes a transition during the transition to civilian status. The assessment of the situation involves trying to figure out who is responsible for the transition. When veterans transition from the military whether of their own volition, caused as a result of family circumstances or based on regulatory guidelines, they may attribute responsibility for the transition to a specific someone or military organization. Upon reconsideration, some veterans might experience regret towards the transition, some may rationlize their decision, and others are likely to experience contentment. Military members often have numerous experiences of transitioning including transitioning from a deployment, a temporary duty assignment or relocation based on orders for a permanent change of station. The experience of transtioning out of the military into the civilian sector varies with each individual; transition may be perceived as relatively uneventful, extremely traumatic or something in between.

Support. During pre-transition out of the military, during the transition phase, and shortly after transition, a signifiant portion of female veterans seek support from various entities to help in the transition process. Individual support is sought from spouses or significant others, immediate

and extended family members, military battle buddies, wingmen, supervisors, peers and mentors, and friends and social media networks while organizational support is sought from entitites such as the VA, DAV, DOL, the American Legion, military bases, transition assistance programs church, and community organizations. Each entity, whether intimate relationships, family units, networks of friends, institutions and communities, all comprise a familiar and intersecting network of professional and personal resources who provide physical and psychological support. The support to address the specific needs of women veterans are evolving, however, based on research and accounts of individual experiences, the impression of "support" varies among women veterans. Seemingly, the perceptions of support are based on indivual situations, experiences, location, and expectations. Additionally, support is provided from a variety of sources to facilitate wellness, employment, education, assimilation, and sustainment. Social media appears to be a viable source of support for veterans, however, this venue has yet to be explored. Although not all-encompassing, Appendix J provides a list of groups and pages available to servicemembers to connect with fellow veterans. Individuals tend to associate themselves with those with whom they share related attributes and experiences. Female veterans share a common bond of serving in the military and the challenges, sacrifices and experiences associated with serving. They understand the military jargon and perils faced during a deployment or multiple deployments. They can console each other and empathize with one another. They share information about how to file a VA claim and how to achieve a VA disability rating commensurate with their injuries or physical dispositions. On another relatable level, they converse about their marriages, children and how they achieved another day in which they were survivors (see Figure 2.2).

Kirsten Holmstedt, author of *Soul Survivors-Stories of Wounded Women Warriors and the Battles they Fight Long After They've Left the War Zone* (2016), captured the perspective of

more than a dozen women on what they would like to see regarding the treatment of female veterans by civilians. In the book, female veterans conveyed their thoughts regarding their need to be able to share their stories with members of their communities in a trusting environment. Some of their responses expressed the need to establish a sense of community through familiarity. One veteran suggested a civilian find a veteran in need and stay with that person for two years, through life's events to help the female veteran find a stronghold to move forward within the community (Holmstedt, 2016).

Figure 2.2. The poster displays a veteran in uniform doing what he was trained to do on the battlefield. It appears he has not made the distinction between being in the war zone and living in a community. The poster implies, to him, there is no difference. The picture can be interpreted in several ways based on individual military experiences (A.B.G. Design, n.d.) Retrieved from: https://www.facebook.com/search/top/?q=veteran%202%20veterans&epa=SEARCH_BOX.

Self. Female veterans align themselves within certain categories: veteran, veteran-civilian, dependent (e.g., spouse of a military member who is currently serving), veteran-civilian-spouse, along with other identifiers not associated with military service. Goodman et al. (2006) specfied two categories that relate to self: (1) personal and demographic characteristics and (2) psychological resources. The contention is that characteristics affect how individuals view life through such things as their socioeconomic status, gender, economic status, age, stage of life,

state of health and ethnicity. The psychological aspect of self focuses on ego development, outlook, and commitment and values.

Psychologist Albert Bandura defined self-efficacy as "one's belief in one's ability to succeed in specific situations or accomplish a task" and indicated that "one's sense of self-efficacy can play a major role in how one approaches goals, tasks, and challenges" (as cited in Goodman et al., 2006, p. 33). The attitude of female veterans towards their status plays an important role in how they view themselves post-military. Some female veterans view themselves as unworthy when making comparisons to their male counterparts. In addition, society has not completely accepted the idea that females, grandmothers, mothers, daughters, sisters, aunts and wives, are actually the persons who served. In March 2017, the Center for Women Veterans launched a campaign "to advance the conversation of how female veterans are seen in our military circles and especially, by the general public" (VA, 2018c). In a series of public service announcements (PSA), female veterans relate their experiences in an effort to change these "societally-ingrained misassociation[s]" (VA, 2017a).

Personal stories from female veterans recount their experiences of being slighted and overlooked when in the presence of male veterans. They commented that strangers shake the hands of male veterans while thanking them for their service, not knowing that it was the female standing beside him who actually served. As the understanding of women's roles in the military evolve within society and people begin to recognize that women are also a part of the veteran population, women will feel more accepted and become confident and secure in owning their status as airman, soldier, sailor, coast guardsman, or marine veteran.

The suicide rate of women veterans further emphasizes the need for females to be self-assured, be able to cope with and manage multiple roles, develop an identity post military and

understand their limitations and capabilities and know when to seek help. The impact of the military and war, and the devaluing or dismissal of women veterans' contributions to the war efforts are detrimental factors that may negatively influence how they view themselves and their evaluation of their self-worth. Some women veterans do not anticipate the negative encounters. It is not a topic addressed during transition briefings therefore, they are unable to employ a coping strategy to manage the behavior where possible. The VA publication entitled *Facts About Suicide Among Women Veterans* dated August 2017 stated, "The suicide rate among women using VHA services has increased in recent years, from 14.4 per 100,000 in 2001 to 17.3 per 100,000 in 2014" (VA, 2017b, p. 1, para 3).

Strategies. Goodman et al. (2006) proposed three strategies be considered in the transition process; these strategies include those that modify the situation, those that control the meaning of the problem, and those that aid in managing the stress in the aftermath. One important strategy, as researched by Hawkins and Crowe (2017), is that "community reintegration requires finding a new normal" (p. 2). Respondents to their research on *Injured Female Veterans' Experiences with Community Reintegration: A Qualitative Study,* indicated there were increased challenges adjusting to the mental and physical differences in themselves. They explain that transition is not just a transfer from one setting to another, but usually involves a change in identity too. It is this change in identity which brings significant emotional challenges. According to Hawkins and Crowe (2017), the inability to convey one operable identity in one context to another can be problematic during transition (Hawkins & Crowe, 2017).

There are available resources to enable female veterans to cope with the psychological and physical challenges associated with transition; however, only a small percentage use services

provided through the VA. It would seemingly be more facilitative if veterans were able to strategize about their impending transition based on the knowledge of available resources, their eligibility to receive benefits, and the process to be enrolled and be seen at the VA for medical treatment.

Make the Connection (2013) recommends several actions transitioning veterans can take to be successful, including reaching out to other veterans or veteran's groups for social support and exercising regularly to maintain good nutrition. Additionally, it is recommended that veterans transitioning to civilian life use relaxation techniques to help de-stress and recognize that others may not always agree or understand the military service of a veteran; agree to disagree. Discussing and making plans for the transition with family members while also being prepared for insensitive questions or topics of conversation in order to practice how to respond ahead of time or respectfully declining to engage those conversations can also be helpful while transitioning out of the military. Make the Connection (2013) also recommends creating a list of goals for the transition, prioritizing sleep, and avoiding unhealthy quick coping fixes such as drinking alcohol and substance abuse.

Gender Role Theory. The inclination that females and males have separate and distinct roles is a social construct that has been perpetrated throughout history and is still prevalent in today's society (Shimanoff, 2009). Women are characterized as the weaker sex and have historically been relegated to domesticity. Men, on the other hand, have been distinguished as providers, strong and stoic. Women are descriptively delicate and nurturing and most importantly, women don't go to war. Men have dominated the political arena, implementing legislation that impacted women's rights for decades. Men have maintained the dominant role in our society; however, the gender gap is closing.

The military exercised legal discrimination of women based on perceived physical and mental capabilities in which they restricted entry into certain career fields and combat duty. The restrictions have been vacated; however, there is still a cloud of resistance within some coveted specialized fields such as Navy Seals and Army Rangers even though women have proven themselves to be mentally and physically capable in meeting the rigorous training associated with these elite occupations.

The established structure of VA health care for veterans was based on the needs of male veterans. The transformation of facilities to accommodate women's health clinics to care for female veterans has not kept in sync with the growing population of female veterans. The awareness of female veterans' needs was known; however, the acknowledgement of the specific needs of female veterans was not acted upon or the progress was laggard. Women have had the authorization to utilize their VA benefits since 1948 and have participated in wars with similar mental and physical health outcomes as their male counterparts. Unfortunately, the unique needs of females were unattended. The situation is systemic and although progress has been made to alleviate the disparity in treatment and counseling, female veterans believe there is still gaps in service and recognition for their tours of duty.

Female veterans are vulnerable to stereotype threat in which they live up to a negative stereotype associated with being a female veteran based on individual perceptions (Steele & Aronson, 1995). The threat is also applicable if the female veteran anticipates a certain behavioral reaction to their status of being a veteran-civilian when engaging civilians or employees at the VA. Although the threat may be situational, persistent encounters can be detrimental and result in diminished confidence and desire to assimilate within their respective community.

Being a Female Veteran: A Grounded Theory of Coping. Burkhart and Hogan's (2015) research encompassed unique pre-military histories and military experiences of female veterans ranging from choosing the military to being in the military, being female in the military and departing the military which involves experiencing stressors of being a civilian and making meaning of being a veteran-civilian. The purpose of the grounded theory study was to "discover the categories and processes grounded in the experience of female veterans who transitioned into, through and out of the military (Burkhart & Hogan, 2015, p. 113).

During the discovery process, the researchers specifically asked questions regarding the respondents' lives prior to entering the military, their experiences while in the military and concluded with questions about their transition. Upon departing the military, the respondents felt they were unprepared for civilian life, were living two lives and were impacted by symptoms of PTSD. According to Burkhart and Hogan (2015), participants also indicated trying to make meaning of being a veteran-civilian by belonging to a veteran-civilian community and having pride in their new status (Burkhart & Hogan, 2015). The goal of the current study is to expand upon Burkhart and Hogan's (2015) findings and model by specifically examining the transition process and experiences of woman veterans (see Figure 2.3).

Some key elements surfaced during Burkhart and Hogan's (2015) study in reference to experiencing stressors of being a civilian. Under the category of feeling unprepared for civilian life, Burkhart and Hogan (2015) reported that individuals experienced the "culture shock of having difficulties meeting the necessities of life, establishing financial stability, finding employment, and navigating the civilian systems" (p. 119). One participant stated, "I didn't even know how to find a doctor, how to go to a doctor, how to make an appointment, how to find a dentist, nothing because all that stuff in the military is completely different" (Burkhart & Hogan,

2015, p.119). Additionally, female veterans had to contend with being diagnosed with PTSD and MST. For instance, those who suffered from PTSD symptoms including anxiety attacks, anger, aggression and depression indicated this disorder was an additional stressor they had to endure during their transition (Burkhart & Hogan, 2015).

Information gained from Burkhart and Hogan's (2015) study provided a better understanding of how to assess, treat and refer veterans to health care and social services. Burkhart and Hogan (2015) did not explore existing resources to determine whether the respondents would utilize the services currently available through the VA for eligible participants. The current study sought to fill this void by assessing the availability of resources and support for transitioning veterans that would complement the last three phases of Burkhart and Hogan's (2015) model by adding a pre-departure phase and coping with transition resources.

The Military Transition Theory: Rejoining Civilian Life. Castro and Kintzle (2016) theorized that military transition entails three phases: Phase 1- Approaching the Military Transition; Phase 2-Managing the Transition; and Phase 3-Assessing the Transition. The theory encompasses the transitions service members are likely to encounter during the lifecycle of their careers. Transitioning from the military culture to civilian culture involves changes in relationships, assumptions, employment as well as both personal and social identity; such changes appear to be commonalities between different transition theories and models. Castro and Kintzle's (2016) Military Transition Theory goes beyond previous theories and models however by focusing on how transition occurs in response to a gap they perceived in existing theories. The purpose of their theory was to identify factors which promote or impede transition as well as operational outcomes that were associated with successful transitions.

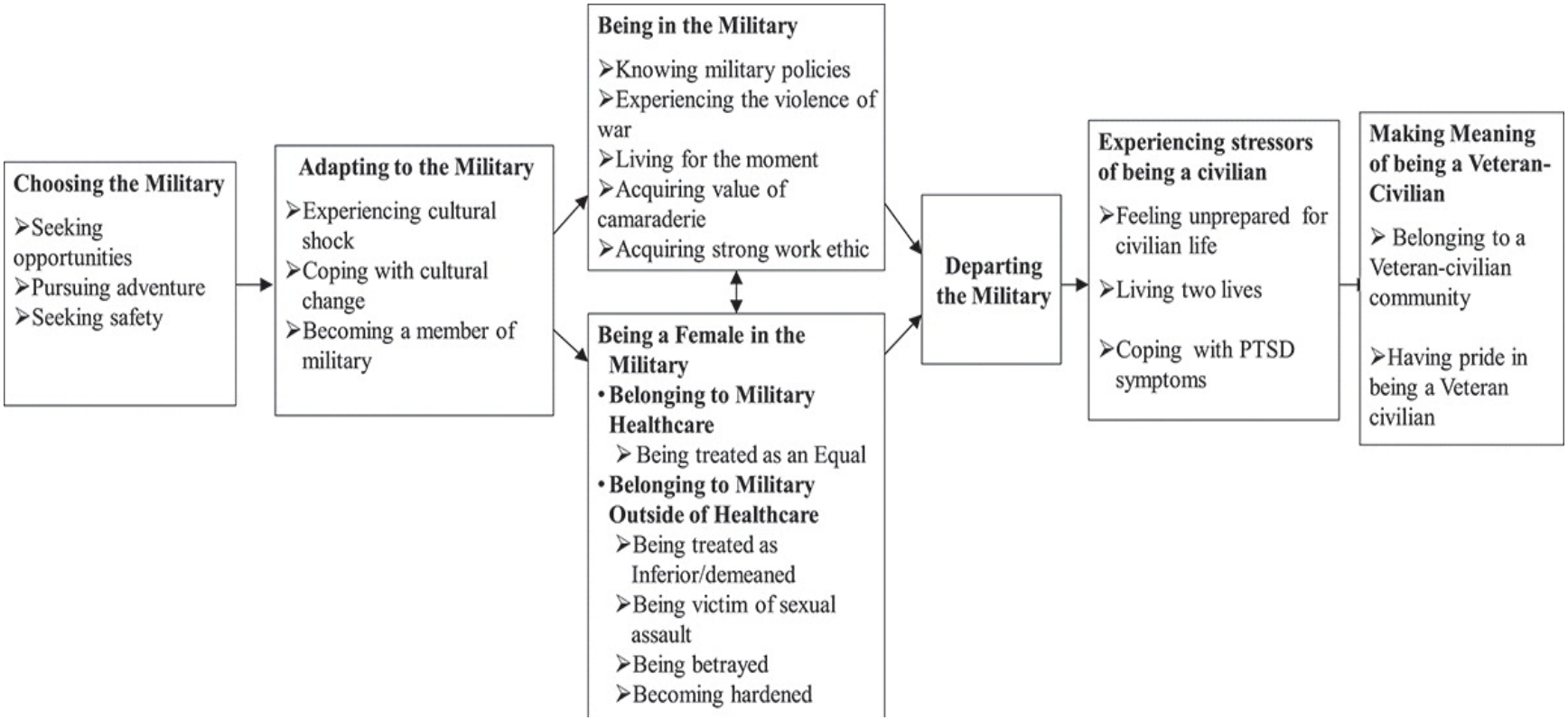

Figure 2.3. Coping with transition from civilian to veteran-civilian status. From Burkhart, L.,and Hogan, N. (2015). Being a female veteran: A grounded theory of coping with transitions. *Social Work in Mental Health*, *13*(2), 108-127.

Table 2.2

Types of Military Discharges and Associated Benefits

Type of Discharge	Definition	Veteran's Benefits
Honorable Discharge	Met or exceeded military conduct and performance standards.	All
General Discharge under Honorable Conditions	Satisfactory performance.	Includes disability compensation, education assistance (except for GI bills), survivor pensions, VA health care, and TRICARE.
Other than Honorable (OTH) Discharge	Most severe administrative discharge that indicates a serious departure from the conduct and performance expected of a service member (infractions may include security violations and personnel endangerment).	Not likely to receive benefits but the VA will determine eligibility based on circumstances.
Bad Conduct Discharge	A punitive discharged imposed by court-martial (i.e., a criminal trial).	If discharge is determined based on results of a special court-martial, VA makes the determination. If convicted during a general-court-martial there is no entitlement to benefits.
Dishonorable Discharge	The most serious of all aforementioned categories. Infers a serious offense (e.g., desertion, rape or murder).	All veteran and military benefits are forfeited.
Entry-level Separation	Not suitable for military service and can only be given in the first 180 days.	No benefits are earned at this juncture unless there was an injury or illness involved as a result of service.

Note: Labor and employment: Discharges and their effect on veterans' benefits (Retrieved from: https://www.lawyers.com/legal-info/labor-employment-law/discharge and their effect-on-veteran benefits.html). Beginning July 5, 2018, veterans with an other-than-honorable (OTH) administrative discharge can apply and receive emergency mental health care at all Veterans Health Administration (VHA) medical centers. This is the first time a U.S. Department of Veterans Affairs Secretary has started an initiative focused on OTH service members who are in mental health distress (Retrieved from: http://connectingvets.com/articles/veterans-other-honorable - discharge-now-able-get-va-mental-help.

Phase one. Phase one of Castro and Kintzle's (2016) theory focuses on the approach to an impending military transition. This phase includes what they refer to as the base of the transition trajectory including the veteran's type of discharge, combat history, mental and physical health, expectations and most importantly, personal preparedness. According to Castro and Kintzle (2016), this variable will impact the veteran's attitude and disposition thus, phase one is important because it establishes the foundation from which veterans are able to navigate their transition.

In relation to type of discharge, there are six possible outcomes to one's military career; the different types of discharges and the VA benefits that accompany each discharge type are shown in Table 2.2. The type of discharge received determines a veteran's entitlement to health care and benefits. The implication that the type of discharge impacts the trajectory of transition is further reinforced by Darehshori (2016) who asserted that the impact of bad papers, in other words an "other than honorable discharge," is really impossible to overstate. It makes it hard for veterans to get the kind of care they need, but also to move on with their lives.

Furthermore, the impact of deployments and combat history may be contributing factors to the veteran's mental and physical health. Based on the circumstances, the veteran may experience difficulty integrating into the civilian sector as a result of sustaining immobilizing injuries, PTSD, MST, or other unpronounced mental disabilities.

Phase two. Phase two occurs while a veteran is in the midst of the transition process. During this phase, the veteran may feel as though everything is in flux. It is crucial that veterans are knowledgeable about the resources that are available to them and are able to navigate through the various systems of support. During this phase, civilian and community support resources and the proximity of such resources become highly salient.

Phase three. In the third phase, a veteran assesses her transition from the military. Transition outcomes and success are measured through interconnecting categories of overall wellness including: work, family, health, general well-being and community. The outcomes are not mutually exclusive, however, as wellness, or lack thereof, in one category affects wellness in other categories.

The three phases of the Castro and Kintzle's (2016) theory frame how various elements affect a veteran's transition. The expectations of female veterans specifically, are that they will be received as veterans with access to the support and resources required to meet their specific needs.

SECTION THREE: METHODOLOGY

The current study is seeks to expand upon the last three stages of Burkhart and Hogan's (2015) model, departing the military, experiencing stressors of being a civilian and making meaning of being a veteran-civilian, specifically in regards to the availability or lack of resources and support for female veterans transitioning to civilian-veteran status. The goal of the present study is to identify resources that facilitate or impede the transition of women veterans to civilian status using a mixed-methods approach as approved by the University of Oklahoma's IRB (see Appendix K). A qualitative approach is used for this inquiry.

Research Questions

The current study seeks to address the overarching question "What role do support resources play in female veterans' transition from military to civilian life?" Specifically, the study will examine:

RQ1: What resources do female veterans use to help them transition to civilian status?

RQ2: What resources do female veterans believe are most useful for helping them manage the transition prior to departure from the military, in the first 6 months to a year after departure, and long-term?

RQ3: What, if any, resources do female veterans believe are still needed to help servicewomen successfully transition between military and civilian life?

RQ4: How do women make meaning of their veteran status and develop a sense of membership in the veteran-civilian community?

A two-part study will be used in the conduct of this study. As shown in Figure 3.1, qualitative data will be collected concurrently, but separately, for the two parts of the study so that the researcher may best address the research questions (Cresswell & Cresswell, 2018).

Part One-Online Survey

Rationale. An online survey was developed in order to gather basic information from study participants regarding their military service. The questions were formulated to obtain background data on the volunteers who were completing the survey. Additionally, with respect to the purpose of this study, the objective of the survey was to ascertain what benefits and resources the larger sample of veterans used or currently use in their transition to veteran-civilian status. The questions were formulated in order to obtain basic information from a larger sample that could supplement more in-depth information obtained in the interviews conducted in part two of the study. Information including the number of years served in the military, the branch of the military, number of deployments, type of discharge and disability status was collected given that these are all factors that might dictate the tone of participants' transition experiences either negatively or positively. Similarly, information regarding their marital situation and spousal military service was collected in order to obtain information about personal resources available to participants during their transition to veteran-civilian status. The online survey also served as a means for recruiting participants for the interview portion of the study.

Items. Questions for the online survey were developed, in part, from field-tested interviews and survey questionnaires (see Bradley, 2017, p. 10; Burkhart & Hogan, 2015, p. 114). The survey questions included both open- and closed-ended questions but did not request individually-identifying information. The survey contained a total of 21 questions, 17 of which asked basic demographic and military service information. The last 4 questions were used to recruit potential participants for the more in-depth interview portion of the study and to obtain contact information and preferred times for interviews for willing participants (see Table 3.1 and 3.2).

Table 3.1

Qualtrics Online Survey Questions

1.	Did you serve on active duty in the U.S. military?
2.	In what branch of the military did you serve?
3.	How many years did you serve?
4.	What were the inclusive dates of your service (month/year)?
5.	What was your career field (please do not use the number designations)?
6.	What grade/rank were you at the time of your discharge?
7.	What type of discharge were you awarded?
8.	Did you deploy during your time in the military?
9.	How many times did you deploy?
10.	Are you classified as a disabled vet?
11.	What percentage is your compensation?
12.	What is your current marital status?
13.	My spouse is/was: (a) currently serving in the military, (b) a veteran, or (c) a civilian
14.	Do you have children living in the home?
15.	As a veteran, what entitlements do you use or have used? (a) Pre-discharge, (b) Disability, (c) Veteran's Pension Supplemental Income for Wartime Veterans, (d) Veterans Government Life Insurance, (e) Education, Training, and Certifications, (f) Home Loans, (g) Vocational Rehabilitation, (h) Veterans Benefits Health Care Benefits, (i) Veterans Choice (AKA Community Care Program, (j) Veterans Homeless Program
16.	What city and state are your home of record (location where you first enlisted)?
17.	In what city and state did you settle following your separation from the military?
18.	Would you consent to a telephone interview? The interview process will provide a more in-depth personal perspective on your individual transition experience to enhance the research.

Table 3.2

Contact Information Survey for Interview Participants

Please provide your preferred contact information.
What is the most convenient time for you to be interviewed?
(a) 0900-1200 (b) 1201-1700 (c) 1701-1900
During the interview, how would you like me to address you?

Procedure. To solicit participants for the survey, the researcher provided a formal letter of request to social media and website administrators to post a flyer (see Appendix L) on their respective social media page or site. Specific women's veteran sites were targeted because they are closed groups and frequented by women veterans. The sites included: Women Veterans of Colorado (1,175 followers), Military Women in Transition Alliance (website), Women Veterans Business and Shopping (website), and Women's Veterans Benefits Assistance Group (15,603 members). The information regarding the survey gained traction through reposts and word of mouth which resulted in propagation to: Beauties in Boots 2.0 (3,642 members) and Beauties in Boots-The Remix (2,260 followers), along with individual posts linking friends to the posted flyers that contained the link to the survey.

The survey was administered online through the Qualtrics Data Collection Application in order to reach a geographically-dispersed sample of female veterans as well as to maintain anonymity of survey responses. Potential participants were first directed to an online consent screen; individuals had to consent to participate prior to viewing the online survey. After consenting to participate, respondents were immediately administered the survey online via Qualtrics. The first question in the survey acted as a screening question; women who responded no regarding having served on active duty in the military were directed out of the survey and were not eligible to participate in the interview portion of the study. Survey participants who volunteered to be interviewed were asked four final questions which requested their contact information and preferred interview times (see Table 3.2).

Participants. The criteria for selection of participants were that they served on active duty in the U.S. military, were female, and had transitioned out of the military to the civilian sector. A total of 155 responses were received to the survey; however, 24 responses were

deemed invalid resulting from duplicate and incomplete surveys yielding an effective sample of 131 responses.

Part Two-Telephone Interviews

Rationale. Telephone interviews were conducted to obtain more detailed information regarding resources used and needed during the veteran-civilian transition process. The person-to-person telephone exchange provided the ability to ascertain the tone and emotions associated with participants' responses to certain questions and allowed the researcher to follow-up as needed for clarification of responses. According to Bevan (2014), the interview is the most common data collection method by phenomenological researchers but "there is very little instruction as to how it should be undertaken" (Bevan, 2014, p. 137).

Items. The questions posed to the participants were open-ended to afford them the opportunity to share their personal transition experiences and perspective on the resources they used during, before and after their transition to veteran-civilian status. Each participant was asked a total of 13 questions during the phone interviews (see Table 3.3).

Participants. Pietkiewicz and Smith (2012) asserted there is no rule regarding how many participants should be included during the data gathering process in phenomenological research; instead they advise researchers to consider the depth, richness, restrictions and purpose of the research in determining an appropriate sample size. While Guest, Bunce and Johnson (2006) proposed that studies similar to the current study interview at least 12 participants, Pietkiewicz and Smith's (2012) indicated a good goal would be to interview 15 to 25 participants. For this study, the sample was determined by those who volunteered to be interviewed through the survey. The researcher contacted each prospective participant by text message or email. Using a script (see Appendix M), the researcher thanked them for their participation and requested a date and time

that was convenient for them to be interviewed. Seventy female veterans consented to be interviewed but only 52 of the 70 responded to initial and subsequent attempts to schedule the interview.

Table 3.3

Telephone Interview Questions

1.	Why did you join the military?
2.	Why did you decide to leave the military?
3.	How far in advance did you plan your departure from the military?
4.	Please describe what your transition plans were once you decided to separate or retire from the military?
5.	Please identify the three agencies or people you found to be most helpful or supportive during your transition to veteran civilian. Please provide at least 3 specific ways they supported or helped in your transition to civilian life.
6.	What were the top three challenges you faced that affected your transition from military service reintegration into the civilian environment?
7.	Please provide details regarding your experiences whether positive or negative with using government or civilian employment resources to help secure a job following your departure from the military.
8.	Please provide details regarding your experience whether positive or negative with using government or civilian resources to help secure housing following your departure from the military.
9.	How would you describe the level of support received from your community as you transitioned and reintegrated into the community?
10.	How long did it take for you to feel fully integrated back into civilian life as a veteran-civilian?
11.	What were the challenges you faced, other than securing a job and housing that were unforeseeable during your transition back to civilian life? In other words, did any events occur during this time that you did not include in your transition plan?
12.	Is there anything you would like to add so that your journey could be better understood?
13.	As a result of your participation in the online survey and interview, I plan to make a $10.00 donation to The Women in Military Service for America Memorial or to a verified women's veteran organization of your choice. Are you satisfied with the selected organization or would you like to choose another women veteran's organization? If so, please specify the name and address of the organization?

Procedure. The interviews were scheduled based on the availability of the participants and their respective time zones. Timeframe preference options were included on the survey and included: 0900-1200, 1201-1500, 1501-1700, 1701-1900. Although appointments to be interviewed were coordinated with each individual, some scheduled interviews could not be conducted due to lack of participant responses to the researcher's call, participants experiencing personal or family illness, their inability to receive text messages (e.g., landline) to schedule interviews, and the use of phone call blocking features by participants.

Those who volunteered and consented to participate in the interviews provided a name of their choosing to be used during the interview to protect their anonymity. For instance, one individual wanted to be addressed as "Cathy is fine." Prior to conducting each interview, the researcher read the IRB-approved script to inform the participants of the purpose of the survey, the right of the participant to conclude the interview at any time, the benefits and application of the survey results and safeguards for data protection. In one case, a potential participant became upset during the reading of the consent script, insisting she felt that the researcher had misrepresented OU by referring to it as the University of Oklahoma rather than Oklahoma University. The researcher tried to explain the difference to the veteran, but the veteran would not proceed with the interview. All other consent processes proceeded as expected before each call. Upon receiving verbal consent from all other interviewees, the researcher started the recording device. No one responded negatively to being recorded. Interviews lasted between 8 and 54 minutes depending on the length of participants responses. On average, 3.63 interviews were conducted per day between September 1, 2018 and October 4, 2018.

Coding. The coding process used was in accordance with the methods recommended by Saldana (2016), specifically, "If it moves, code it" (p. 43). While the researcher was recording

the interview, the interviewer also took notes as a back up just in case the comments were not audible on the tape. The information from each participant was transcribed by the researcher. Initially the interviews were transcribed verbatim to include pause fillers; however, that contributed to the tedium of the process. The interviewer subsequently elected to continue the transcription, deliberately omitting the pause fillers but capturing the data.

Saldana (2016) explained that a theme can be a by-product of coding. An example contained in this study would be better quality of life which describes an explicit segment of the data and leave environment as being more subtle and can be considered the theme. Saldana (2016) cited the aspects of coding include: cognitive aspects or meanings, emotional aspects or feelings and hierarchical aspects or inequalities (p. 44). Every unrelated commentary was not coded; however, each response to the questions asked was looked at for connectivity to other questions.

The researcher employed the splitter, a precise process where dissection is used to create more categories and lumping, a broader approach method (Saldana, 2016) to capture the coding. Some responses did not warrant lumping. More detailed responses required splitting because there was relevant data contained in the response. In response to the question "Please describe what your transition plans were once you decided to separate or retire from the military?" one respondent indicated:

> Of course, I went through mandatory transition assistance. I did TAP program the Navy ran it for us [AF] and then just, it was planning between me and my husband. We were looking at finances. We were looking at where we were going to live next. So specifically, I would say just doing TAP, looking at jobs, seeing what's out there and getting ready financially.

The underscored phrases indicate splitting which created additional emerging themes from the broader category of transition planning. Although this participant summarized her transition plan, the elements for coding emerged throughout her response.

Saldana (2016) cited seven personal attributes that are complimentary when conducting solo coding: be organized, exercise perseverance, deal with ambiguity, be flexible, be creative, be rigorously ethical and have an extensive vocabulary (p. 79). The researcher used a manual process to conduct coding using the following sequential process: (1) transcribed the recorded interviews, (2) took copious notes simultaneously during the interviews, (3) read the transcription of each participant's responses, (4) highlighted relevant comments contained in the responses, (5) created an Excel workbook containing separate sheets for each question with each respondent listed in alphabetical order on each sheet, (6) re-read each response while including it on the respective spread sheet, (7) created a separate sheet to document notable responses, (8) created columns for each unique response, (9) reviewed the coded responses for commonalities, (10) subjectively aligned the emergent themes under the consolidated coding using color identifiers, (11) counted one response for each code although the respondent may have indicated two to three responses under that particular code, and (12) reviewed the interviews again in conjunction with the responses on the spreadsheet

SECTION FOUR: RESULTS

Part One-Online Survey

Branch of military service. Individuals who enter the military must be 17 years of age. Federal law established 42 years old as the maximum age a person can join the military; however, each branch of the military established policy for their particular service which is required to be less than the maximum. The standard maximum enlistment age policy for each branch of service are: Air Force (39), Army (35), Coast Guard (27), Marine Corps (29) and the Navy (34). Participants in the study represented all branches of the military although the Air Force (53.4%) was most strongly represented, followed by the Army (22.1%), the Navy (21.4%), multiple branches (1.5%), the Marines (0.8%) and Coast Guard (0.8%).

Number of years served. The participating veterans served from less than 1 year to 37 years in the military. The mean tenure was 14.5 years (*SD*=10.34); the distribution was bimodal with peaks at 4 and 20 years. It is worth noting that when a civilian enlists into the military, the minimum time required to serve is 2 years for the Army and the Navy and 4 years for the Marine Corps, Navy and Air Force. Commissioned Officers are required to serve a minimum of 3 to 9 years with consideration given to their status, rated or non-rated, source of accession, Reserve Officer Training Corps (ROTC), military academy or officer training school (Enlistment, Appointment, and Induction, 2015). Those who separated prior to serving the minimum required commitment most likely were separated for cause.

There were several female veteran participants who exited the military so their spouses could stay in; however, not one participant indicated the reverse of that scenario. Their reasons for getting out were they had made a promise to their spouses that they would get out after they achieved a certain rank, to raise their family, to get married, or to be a military spouse. Participants

also did not reenlist because they were married to an active duty member and did not want to entertain the possibility of a dual deployment.

Eras participants entered the military. The U.S. ended the draft in 1973 and as a result, the number of female recruits surged (Patten & Parker, 2011). Upon termination of the draft, women represented 2% of enlisted members and 8% of officers (Reynolds & Shendruk, 2018). A majority (65%), of the survey participants entered the military during one of the two peacetimes following the Vietnam War (see Figure 4.1).

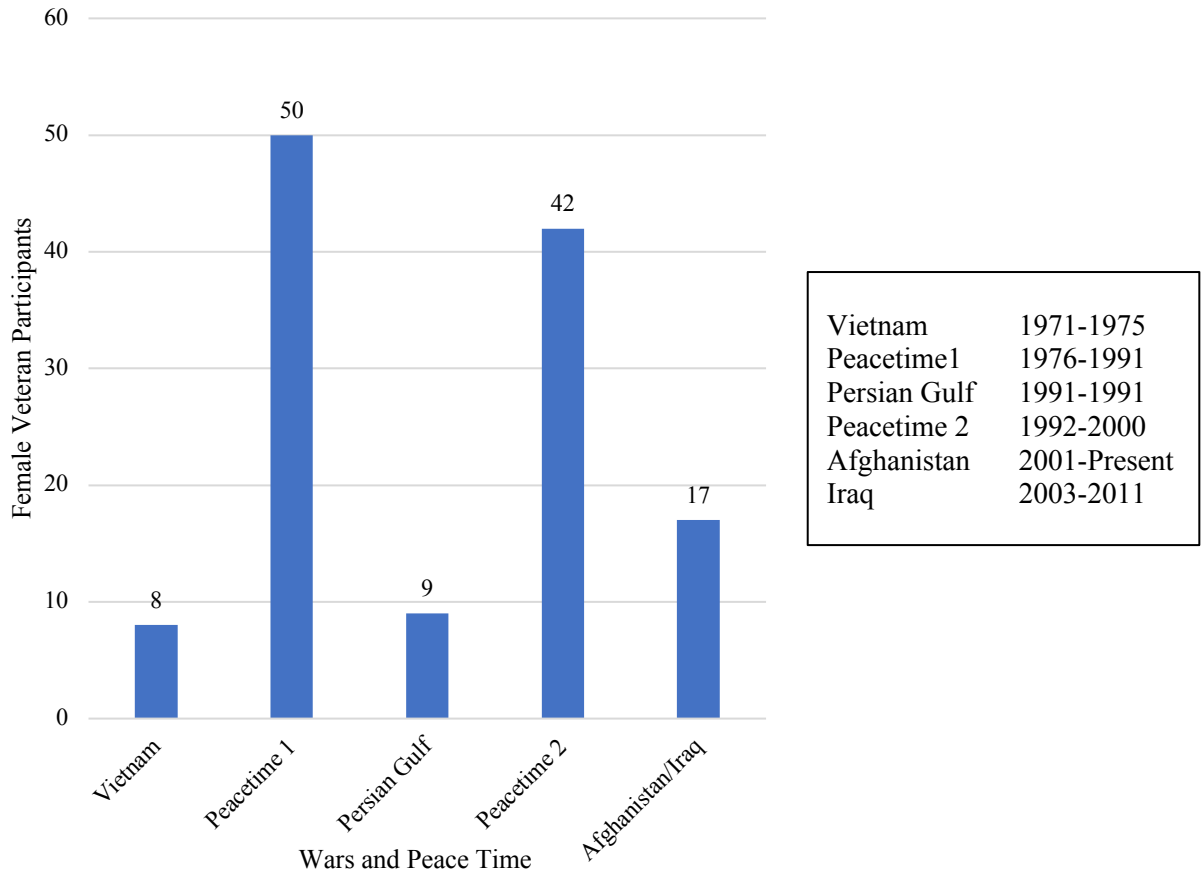

Figure 4.1. War and peacetime eras during which participants joined the military.

Grade/rank and type of discharge. Participants' ranks varied from enlisted grade E-2 to officer O-6. Almost all respondents (91.6%) received an Honorable Discharge, with the

remaining respondents receiving a Medical Discharge (7.6%) or a General Discharge Under Honorable Conditions (.8%).

Type of Discharge Awarded. There were 120 female veterans who received an honorable discharge, 10 received a medical discharge and 1 received a general discharge under honorable conditions. The types of discharges indicate the participants eligibility to receive VA benefits. The results may indicate unintentional bias as there were no respondents who received less than an under honorable conditions discharge. The VA would have to evaluate individual situations of veterans who did not receive some type of honorable discharge to determine eligibility to receive certain benefits.

Disability compensation. Of the respondents, 74% (*N*=97) indicated receiving compensation for illness or injuries sustained during their military service. Of those receiving compensation, 40.2% receive 81-100% compensation; 35.1% receive 51-80% compensation; 16.5% receive 26-50% compensation, and 8.2% receive 10-25% compensation. There were 34 participants who indicated they did not receive any disability compensation indicating that they either did not receive a disability rating following their exit medical evaluation or they did not apply for disability benefits.

According to the Rural Veterans Health Care Atlas, the VA is the largest health care system in the U.S. and those with compensable disabilities have access to VA facilities located across the country. As of FY 15, the Veterans Health Administration had jurisdiction over 1,241 active medical facilities to include 167 VA medical centers, 568 primary care community-based outpatient clinics (PCCBOC), 188 multi-specialty community based outpatient clinics (MSCBOC), 9 mental health or domiciliary residential rehab treatment programs (DRRTP), 2

community living centers (CLC), 276 other outpatient services (OOS), 14 health care centers (HCC), and 17 that do not have site classifications (see Appendix N).

Deployments. Participants indicated deploying anywhere from 1 time to more than 5 times during their time in the service; 36 participants indicated they did not deploy. Data on the duration of the deployments was not collected.

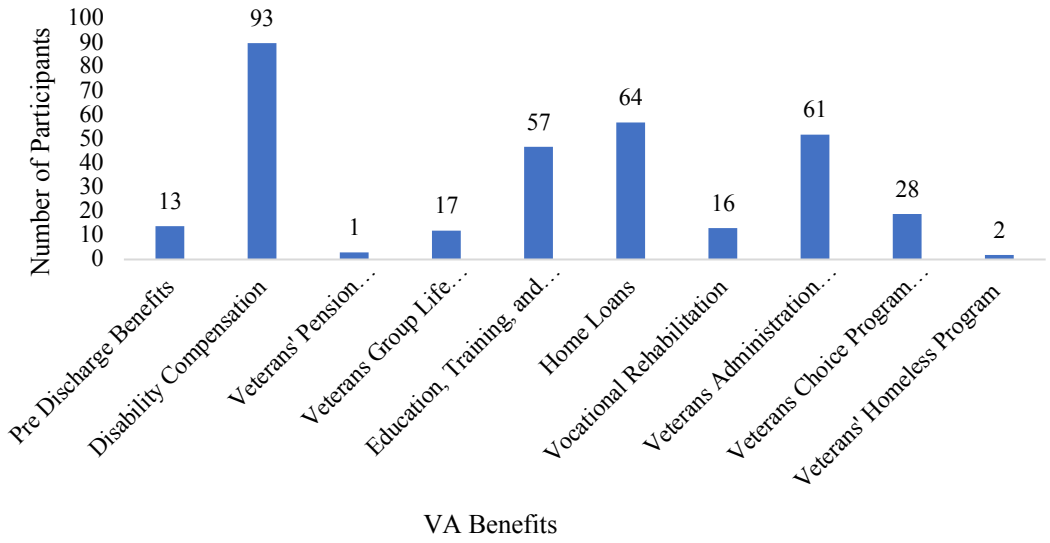

Figure 4.2. Participant utilization of VA benefits. This figure depicts the benefits used presently and in the past by the survey participants.

Marital status and spousal military involvement. Participants predominately indicated they were married (52.7%), followed by divorced (24.4%), never married (17.6%), widowed (4.6%), or separated (0.8%). Of the 100 participants that responded regarding their spouse's military status, 79% indicated having a spouse, ex-spouse or late spouse who was currently serving in the military or is a veteran, while 21% reported being married to civilians.

VA benefits. As shown in Figure 4.2 the female veterans surveyed took advantage of the benefits afforded to them as veterans (see Appendix N).

Geographic location. Participants were situated in 32 of the 50 states. Within the four regions classified by the VA, 29 were located in the Northeast, 41 in the Southeast, and 22 in each of the Continental and Pacific regions, respectively. Of the remaining participants, two were located in Germany, five were married and still relocating with their military spouses, one was still looking and one was located in the District of Columbia. There were eight non-respondents, two of which responded where they entered the military but did not identify the area in which they decided to settle. In 2017, the highest concentration of female veterans was located in Texas, California, Florida, Virginia and Georgia. The states with the highest percentages of female veterans were located in the District of Columbia, Virginia, Alaska, Maryland and Georgia (VA, 2017a). The geographical representation of the participants in the current study do not coincide with the concentration of female veterans located in the states with the highest populations or percentages.

Part Two-Telephone Interviews

Prior to conducting any analysis, the researcher transcribed the recorded data verbatim. For questions that required a quantitative response (e.g., How far in advance did you plan your departure from the military?), the lower bound of open-ended ranges (e.g., "at least one year" was coded as "1") or the midpoint of defined ranges (e.g., "one to two years" was coded as "1.5") was used for computations. Upon completion of the transcription, the researcher reviewed the data to determine if there were themes across responses using the coding process which is the transitional process between data collection and more extensive data analysis (Wicks, 2017). In many cases, responses included multiple themes. In those cases, the response was counted once for each major theme represented in the response. The coding process is not exact and is based on the comments of the participants and interpretation and translation of the comments by the

researcher. In some instances, it was a challenge to determine the overarching themes because of the fragmented responses (one response to a two-part question). In addition, some participants responded after a question was asked but did not actually answer the question presented.

Reason for joining the military. Four major themes emerged in participants' answers regarding why they joined the military including: to have a better quality of life (*N*=30), to serve the country/maintain family tradition (*N*=17), to develop as a person (*N*=5), and to seek out adventure (*N*=14). Responses may have included more than one of the major themes and thus the sum of responses across categories is greater than the total number of respondents. The modal theme in responses was to have a better quality of life which was reflected in answers including to attain money for college, to become financially independent, and to escape one's current environment. For instance, one respondent stated

> I joined because I wanted to find a new environment and just kind of get away from my whole life of a little cow town that I knew. Because I knew eventually, I'd end up with my current boyfriend then and be pregnant at least within the next two years and I didn't want that for my life so I set out other ways and I wasn't ready for college yet.

Another veteran indicated,

> I joined on my 17th birthday. We were very poor. My father had gotten cancer. My parents were divorced. My dad had gotten cancer and we were in financial dire straits and I had to become financially independent and at 17, it was the only way I knew to do that.

A number of participants indicated they wanted to serve their country or maintain their family's tradition of service. Such comments included:

> I initially joined the military because I came from a military background so I understood what I would be getting into as far as the sacrifices I would have to make. But secondary, they offered me a ROTC (Reserve Officer Training Corps) scholarship and it was a way for me to pay for college.

Another veteran stated, "I joined because I was born into a military family and I needed money for college to be a lab tech which I could do in the military so I joined the Air Force." Based on the responses, it seems that most respondents had multiple motives for joining the military.

Reason for leaving the military. A myriad of reasons was given for leaving the military. Some respondents were quite ready to leave the military when they did while others did not want to leave but various circumstances beyond their control compelled them to depart from the military. One major theme was a growing incompatibility between the veteran and the military whether due to conflicting politics, fear, or incompatibility with the military culture. When asked why she left the military, one veteran's response was,

> I left the military because I was frustrated with the Iraq War beginning. I didn't understand. You know, I understood Afghanistan but I didn't understand why we were going into Iraq and I had some frustrations with the politics at the time and not being able to express my opinion.

Another female veteran's response was

> Well I was in trouble in my head and in my body. I had been assaulted. I knew I was going down a spiral tube. I knew that I couldn't keep up my façade of being okay. I was a Sergeant when I left. I had a good record and everything like that but I knew that I couldn't hold it together. It was my time; my time was up and it was either reenlist or get out and I was afraid to reenlist and so I got out.

One veteran felt the same reason why she joined, was the same reason she got out. She expressed this in her response, “I got the benefits and the military just wasn't for me. I'm not very good at following rules and the military is the worse. So, the same reason that got me in, got me out.”

Another major theme was that respondents left the military due to family issues. A common family issue that lead respondents to separate from the military was having a military spouse. The veterans whose spouses were serving on active duty either got out to avoid mission-related separations or to support their spouses’ careers which they felt took priority over their own military careers. After serving in the military for a period of time, taking care of their families became a priority as indicated in statements such as: “I got out, I was about to get married and my husband at that time was active duty and instead of us being in two separate locations I sacrificed my career to help promote his” and “I retired after 20 years to focus on taking care of my children,” as well as

> I retired: 20 years, 6 months and 6 days. It was time for me to retire. I have two young daughters at home, not that young, they’re 15 and 13. My family was very important to me to be available to my children.

The majority of respondents (54%) retired with 20 or more years of service. Some of the women felt it was just time to get out, some felt they needed to get out due to their age and several others had to retire as a result of meeting the maximum time allotted relative to their rank which is referred to as *high year tenure* or *retention control point*.

Advanced planning for transition. For this question, most respondents gave a specific number or range of time during which they started planning their transition out of the military. On average, interviewees said that they spent 1.67 years preparing to depart the military. The median and modal responses were 1 year with a standard deviation of 2.09 years. The

distribution was skewed because two individuals stated they spent 10 years planning their departure.

Description of transition plans. Based on the responses, in order of representation, the veterans wanted to get everything in order which meant attending TAP and TGPS, accumulating savings and eliminating debt and ensuring their financial situation was in order, as well as addressing any medical concerns. One veteran stated,

> My plan was to not work for a year after I got out of the military. We looked at a few locations that we wanted to transition. We looked at cost of living. We made sure our bills had zero balances, our cars were paid off, so we wouldn't have any financial issues when we got out. I thought it would be relatively easy to find employment after separating.

They felt like finding a job after the military was important in order to assimilate back into the civilian sector and to be independent. Twenty-four percent of the 84 respondents did not have any plans. Those who did not have plans, did not see the need to make any plans because they were either married to an active duty servicemember, or anticipated their departure from the military and decided in advance with their spouse that the female veteran would be a stay-at-home spouse and mother. Unfortunate career-related circumstances or administrative processes precluded some veterans from having enough time to plan prior to their departure from the military. Finding a home following separation was important to the veterans to facilitate their transition in addition to enrolling their children in school.

Identified support agencies. This was a two-part question and some participants experienced some difficulty trying to recall who assisted with their transition or how they were most helpful. In some instances, the researcher was remiss in not following up with the

interviewee to elicit information to complete their response to the entire question. A majority of the respondents received support which they deemed to be most helpful from federal and non-profit veteran organizations such as the DAV, VA, TAP, TGPS, DOL, Order of the Purple Heart, local military base, USO Pathfinder Program, AMVET, the respective bases civilian personnel offices, the Airmen and Family Readiness Centers and Fleet and Family Service Centers. Organizations were deemed helpful because they assisted veterans in completing paperwork to file disability claims, provided useful referral services and made resources available to assist veterans with pre-transition and post-transition needs. The veterans also felt attending the training provided specifically by the TAP, TGPS and DOL, although mandatory, was imperative. One veteran asserted,

> I really did very little with any organization or agency. I've done a lot more transitioning in the last year than I did the year prior or after actually separating. I got a VSO, Veterans Services Officer, who has been very good. I utilize the veterans' health care system. I use the veterans' support organizations. When I was struggling financially, they've helped me from small local organizations which you know whatever, paid an overdue electric bill to you know to other organizations. I am also now part of the online community of support, you know, in a couple of different groups where I never was originally.

A number of participants felt that personal and professional support from their spouses and family members, supervisors, and other veterans (peers and mentors) enabled them to obtain pertinent information about out processing the military, employment resources, support agencies, medical and VA claims processing. They also found that being able to converse with fellow veterans and military members was beneficial resulting from their military-service connections.

In some instances, respondents indicated their family was not only supportive, but provided a permanent or temporary domicile for the veteran and their immediate family members. Unfortunately, the perception of some veterans was that they received no support at all (*N*=11). As briefly stated by one veteran, "No. No one. I was in, and then I was out."

There were three types of civilian agencies that participants indicated as being helpful in the transition process: universities, state employment agencies and company-sponsored job fairs. Additionally, one veteran sought counseling from a civilian agency she felt provided the appropriate care for the psychological symptoms she endured over a significant time of period, while another veteran indicated she relied on her faith.

Transition challenges. The challenges of the transitioning veterans were varied. The question asked each respondent to provide three challenges they experienced that might have impacted their transition. Some participants, however, did not have any challenges they perceived while others reported multiple issues they perceived as challenges. Twenty percent perceived seeking employment and being employed as challenging. Of those respondents, some felt that leaving the military with a certain skill set would make finding a job easier, while others underestimated their training and capabilities. Recounting her experience, one veteran said,

> Not realizing my skill sets. So, I guess I felt of less than because it was male dominated so getting out, I thought we, you know, I really don't have skills that would be taken seriously and I think probably I didn't take them seriously either.

Furthermore, this veteran stated,

> I think ability to translate what I had learned and become proficient or expert in, into what was available on the outside, essentially both. Another one was how to dress for success in a comfortable manner, so I wasn't missing my combat boots

> too much. So, communication, dress and availability. Finding out what was available on the outside, what the opportunities were. That was an interesting experience, trying to figure out what else was available and how to get there was challenging.

Eighteen percent of the respondents felt the military separation process was onerous. Advancements in technology was a challenge for an Air Force veteran who was trying to out process, "the transition is automated, so everything is automated, the assumption is that you knew where to find everything and that wasn't always the case." While deployed, one veteran was put in the stop loss program, a program that extended her service contract. Subsequent to her deployment, she had put in her retirement paperwork.

Transitioning out of the workplace was difficult. One veteran stated, "I would say that the workplace didn't have a great transition plan. They, it's just not something they're concerned with, they try to get as much work out of you before you go so, they can get things stable." Another respondent reported experiencing guilt. She had a lot of exit medical appointments and was unable to fulfill her responsibilities as the ranking sailor in her unit. Not having a replacement for position turnover presented a challenge for another veteran. That veteran also got the impression that, due to the work demand, the leadership within her unit did not care about her transitioning out or the appointments she had that were associated with her departure from the military. It was difficult for some veterans (14%) to abandon the military ethos to which they were accustomed. Woman veterans indicated that "not being a part of that military community anymore" made transitioning difficult. They reported that in civilian life "you don't have the same comradery." One veteran conveyed her difficulty in transitioning by stating "My inability

to relate to anyone around me. I found that I had nothing in common with civilian women." This veteran realized her dependence on the military's parenting indicating:

> the military tells you what time to be at work, this is what you need to do, this is where you eat, you know, this is what you wear those kinds of things…I wasn't prepared for how that was going to look.

In trying to reconcile their newfound independence and re-integration, some female veterans (11%) thought important information was not communicated or was communicated insufficiently. A veteran retiring from an overseas location stated,

> Returning back to the states from overseas as somebody that's retiring, most people didn't know how to, what to do with me. I can't possibly have been the first person to, male or female, to ever have retired in those circumstances but nobody had answers.

The biggest challenge for one veteran was "understanding the transition for being taken care of medically and dental wise." Similarly, another veteran stated,

> There wasn't like a women's house program. I didn't really understand like what my health benefits were at all. I didn't think I, I didn't really understand the whole VA healthcare system. I don't even think there was a women's health at the time and just knowing there were resources available, that there were agencies to help. I didn't know any of that.

In addition to financial challenges, a number of veterans (13%) had to cope with psychological and physical medical conditions. The reduction in pay was financially challenging, especially for one veteran who was 5 months pregnant when she got out and who stated that at

the time "work was beyond her capacities." That veteran also reported suffering from PTSD. Another veteran expressed the following challenge,

> My leg was partially paralyzed and I could not move anything below the knee. I couldn't move my ankle, my toes, nothing and I had to learn to do that. It took two years to wiggle a toe. So that was a challenge.

One participant shared that going back to live with her mother was a challenge after being in the military for 4 years. Another veteran summed up her biggest challenge as finding a new sense of purpose. She said:

> Probably a sense of purpose is something I think that everyone deals with whether you have this really great, grand plan or whether you're just really unsure. I think having a sense of purpose is the number one challenge that I think a lot of us face. Also, sort of how would I build my network, how do I build my community now that I am no longer in the military.

A few veterans (7.5 %) expressed that they did not experience any challenges. These veterans attributed their uneventful transitions with good planning or being married to an active duty service member.

Government and civilian employment experience. There were 73 distinct responses regarding the veterans' employment experiences because some participants provided multiple responses. Out of distinct responses, major themes included: resume completion and conversion of skills from military descriptors to equate to the civilian job market (8%), utilization of federal and state employment resources (18%), understanding employment and application processes (11%), adapting one's military demeanor and to the civilian work ethic (5%); employment

challenges and lack of support and information (33%), and other (25%). One individual summed up her employment challenge as,

> The biggest challenge is figuring out which type of resume format to use because you know, coming out of the military, and even going through the transition assistance program they don't really teach you how to write a federal resume. So that was the negative. It's overwhelming to find job opportunities because they're so all over the place I mean they are everywhere. So that was probably a negative. The positive experience was that I had people who I knew who were already like in the system, the federal system who could help and who could give advice.

Other veterans associated their negative experiences with: the hiring process being too lengthy, timely feedback following an interview, difficulty of finding work, overseas employment requirements, lack of information on where to go to find employment resources, adjusting to perceived civilian work ethics, lack of consideration of additional duties that extend beyond military career designation, being a great worker but not fitting in, and not feeling understood during the interview process. The positive experiences veterans noted included job referrals from friends, the ease of which they got a job, having a job prior to exiting the military, getting a job commensurate with their job in the military, and searching for jobs on USA Jobs. Further, 4% of participants reported owning their own business, 3% collected unemployment and 11% did not seek assistance or did not plan to work once they left the military.

Utilization of government and civilian housing resource. The percentage of veterans who owned their homes was 54% (*N*=51). Included in that percentage are those who decided to settle at the location where they were and already owned a home, those who relocated back to where they already had a home, and those who purchased a home during their transition. Several

participants (15%) reported being married to active duty member and living on base. Several other participants (10%), indicated that securing housing was not a problem. In regards to living with family, one veteran stated the following,

> When I got out, I first moved in with my child's father and that pretty quickly became untenable and then I took my daughter and moved across country and stayed for a couple of years and then after that actually my daughter's father purchased a home, you know, invested in a home in my area for us to live in sort of in lieu of child support. So since then, I've been housed that way. I've never been actually homeless like not having a roof over my head, but I've always, since getting out I've always been housing insecure. I've always been dependent upon the goodwill of people that may or may not want to extend that to me.

A few respondents (6%) indicated having issues with temporary housing and encountering obstacles in the process of securing housing. For instance, one veteran had a service dog and found it to be difficult to get an apartment because her dog was classified as a comfort companion when he was actually a service dog. Another respondent receiving temporary housing 30 years after transitioning. She stated, "I paid $16.00 dollars a month but I was only there for like two years and then I bought me, I bought my own house."

Community support. Half of the participants (*N*=26) felt that the community in which they decided to settle was supportive of the military and the area was military-centric which was beneficial during their transition period. Some veterans (*N*=8) reported moving back home to be around family, friends and fellow veterans. One such respondent indicated,

> I moved back home and live where I grew up so everybody around here is very supportive of the military. So, it's a very small town and when I moved back

> home, everybody was like wanting to know about everything. When I actually graduated from boot camp, they posted it in the paper. When I got deployed overseas, it was posted in the paper.

Regarding asking for or receiving support from within their communities, about a third (*N*=18) of respondents felt they did not need nor did they ask for support. Almost a quarter of the veterans (*N*=12) received community support from military liaisons at universities, the Airmen and Family Readiness Center, the local base installation, the VA, the Chief Petty Officers Community (Facebook), and the American Legion. A few responses (*N*=4) could not easily be grouped with other responses. One veteran respondent stated, "So here when I transitioned, you have to almost, you've got to be the one that takes the initiative. Folks are really leery about getting to know new people and we're always accustomed to that." Two veterans reported living in areas that did not support the military or perceived them as outsiders. One such participant indicated,

> We moved into a nonmilitary community. My husband was a recruiter and the closest base was two and a half hours away and we moved into what I would call stereotypical backwoods, okay. It was in a part of the country where the military was frowned upon.

Thus, respondents experienced a range of reactions from the communities in which they settled. While many veterans reported receiving community support, such experiences were not shared by all respondents. Some had very negative and unwelcoming reactions from community members.

Reintegration period. The respondents had varied reasons for the timeframe in which they reintegrated into the civilian sector. Of the 52 participants almost half (*N*=25) reported

being fully integrated into their respective communities while another quarter (*N*=13) indicated they were not there yet. The remaining participants indicated transition took no time at all (*N*=8), they were living in the same community during their transition as they did while on active duty (*N*=3), they lived on base with their active duty spouse (*N*=1), or they did not provide a numerical response to the question (*N*=2). Responses by those who did not give a numerical estimate of time to transition indicated the importance of having a sense of purpose and identity whether as a member of the military or in a new role. One stated:

> After I had a job and I had a reason to get up and a reason to keep on going and not let it just eat me up and let depression and let the woes of everything get to me.

The other respondent held onto her military-based identity indicating "You're never fully a civilian, you're always a veteran, right. I mean I'll always be a veteran, I'll always be a, it's never fully, but yes."

Conversely, respondents who felt like they had not yet integrated, indicated they were depressed, felt alone and had little in common with members of their communities. A response from one participant stated,

> There is no community here unless you ice skate, snow mobile or hunt. I've been here for 5 years and for the last three years I've had no contact with my family and there's nowhere to go to meet people unless I want to drive a minimum of an hour. So, I have no friends and no family, wonderful. This is the most isolated I have felt in my whole entire life.

Additionally, a veteran-civilian-spouse did not experience the military to civilian transition because she continued to reside on a military installation with her active duty spouse. The

veterans who integrated into their communities quickly indicated they were previously stationed in their communities and thus still had friends and contacts in the area. For many, they had returned home, purchased a home with the intention of relocating to that location, got involved within the community by volunteering, joining a church or situated themselves within a military community.

Additional transition challenges. This category encompassed the challenges the veterans experienced aside from housing and employment. Approximately a third of respondents (*N*=18) reported not experiencing any challenges. In fact, one respondent wanted to talk about the positive experiences she had with transition. She said, "there is a positive impact that I want to put on there is the education benefits for vets. I forgot to tell you that. They have a great GI program so people should use it."

Another third (*N*=17) reported experiencing mental and physical problems, problems with access to VA facilities, and VA claims. Medical concerns were a notable challenge for veterans. For instance, one participant reported having to travel 1 hour and 20 minutes to receive medical care. Some participants had trouble figuring out the process for post-military medical care. Participants also commented about medical records being lost or being diagnosed with existing untreated health issues during their exit physicals. They felt it was also a challenge to file VA disability claims.

Other problems reported included problems with finances and benefits (*N*=1); relocation (*N*=5); adjustment and feelings of uncertainty (*N*=9); family issues (*N*=3); and employment issues including disability ratings and working with civilians (*N*=5). For instance, one respondent said,

> You know, interesting enough, the biggest thing is and I actually still have a little problem with this is recognizing that people that have not been in the military do not have that sense of duty and commitment and you know that there is not a choice, or there shouldn't be a choice to follow some of the rules that we have to, that are governed for us to follow.

A few participants indicated they were not diagnosed with PTSD or MST until years after transitioning out of the military. One participant stated,

> The spiraling out of control and the MST and everything. I couldn't have seen all that coming but if I think if they had like, if somebody had, like through the VA or with putting me with the VA with health screening or mental health screening or something like that. Like some sort of touching base with a mental health screening. Maybe like you know, maybe a couple times or something like that. Just maybe like a mental health umbrella or something like that probably would have been useful or could have saved me a lot of pain and destruction.

Participants also noted they were confronted, post-transition, by the need for self-care and the realization that they were no longer in the military.

Advice based on their personal journey. When veterans were asked to share the experiences of their journey, the themes that emerged were: taking advantage of benefits (20), planning early (17), getting medical issues documented (18), mentally preparing for transition (9), developing a community network (21), evolving to the civilian career sector (13), relocating to a supportive area (9), and other (4). Again, most veterans' responses contained several themes thus the compilation of responses across topics summed to more than the number of participants. Some themes were multi-faceted. For instance, planning early included attending TAP briefing

and getting one's finances in order while getting medical issues documented included obtaining a pre-separation medical exam, having one's medical history documented and securing a copy of the records. Responses that involved developing a community network included advice such as consulting with mentors, establishing a network, and getting involved in the community. One respondent commented that when departing from the military, veterans need to:

> Get connected, you know even if you don't think you need it. I mean get connected to the community your support systems possibly. Have a network of people who are or aren't veterans but who understand what you, you know that understand and are supportive of you landing on your feet.

Advice regarding evolving to the civilian employment sector included having one's resume reviewed, determining how to convert skills to the civilian market, just getting a job, furthering one's education through a degree or some type of certification, or starting one's own business. Advice regarding relocation focused on relocating near the vicinity of a VA or military hospital or at a location where the veteran has connections. Overall, participants recommended veterans start early in preparing for transition, start with VA services, seek out a community of other veterans, especially female veterans, make mental health appointments, be prepared to live on half of their current military salary, get out of the military mindset and not be afraid to self-identify as a veteran.

SECTION FIVE: DISCUSSION

Women have participated in American wars since 1775. The documentation of their service was sparse and the benefits and compensation afforded to females were few. The enactment of the Women's Integration Act of 1948 gave women permanent status in all branches of the military. As official members of the military, upon departure from the military, they were entitled to utilize veterans benefits subsequent to an eligibility determination. The current study seeks to address the overarching question, "What role do support resources play in female veterans' transition from military to civilian life with the intent to also expand the research model of Burkhart and Hogan (2015)?"

Research Questions

Research Question 1. What resources do female veterans use to help them transition to civilian status?

The participants attended mandatory TAP also referred to as Transition, Goals, Plans and Success (TGPS) prior to their separation or retirement from the military. The program is geared to extend the lifecycle of the military member's career and build her skills so she is career ready upon her departure from the military (Kime, 2019b). The DD did not collect data on female members' satisfaction or outcomes resulting from their participation in the program prior to 2018 which makes it difficult to determine whether DD and VA are sufficiently preparing women servicemembers for possible hardships and challenges encountered during and after their return to civilian life. Currently, the program's curriculum is relative to all servicemembers but an initiative has been introduced to extend the program an additional day for training specific to women departing the military (DAV, 2018). Another pre-departure resource used by the participants was the ability to file a pre-discharge claim 90 to 180 days prior to leaving military

service if they sustained an illness or injury resulting from active duty service (VA, "Center for Women Veterans," n.d.).

Following their departure from the military, the participants used the benefits available to both male and female veterans with no acknowledgement of gender distinction in delivery of service relative to education and training, home loans, vocational rehabilitation, veterans group life insurance, veterans' pension, veterans' choice program (community of care) or the veterans' homeless program. There was some indication of inequality and exclusion related to VA healthcare which may impact disability compensation. Some of the veteran participants were not aware of their benefits and did not receive a diagnosis of PTSD or MST until a substantial time period had elapsed following their transition. The lack of a diagnosis impacts female veterans' entitlement to appropriate care and disability compensation commensurate with their psychological or physical service-connected illnesses. It appears the VA is becoming increasingly aware of this issue, as it recently launched an awareness campaign to increase the frequency of female veterans' use of VA facilities (Kime, 2019a). For this campaign, the VA contacted 1.2 million female veterans to glean information on their benefits and available health care services for women (Kime, 2019a).

Research Question 2. What resources do female veterans believe are most useful for helping them manage the transition prior to departure from the military, in the first 6 months to a year after departure, and long-term?

The benefit utilization rates indicate female veteran participants attended the TAP program prior to their departure from the military and also filed pre-departure VA claims, as previously stated. In addition, the participants believed the exit physical was an important element to the transition process. The diagnoses obtained during the exit physical facilitated the

treatment of service-related illnesses that had gone unattended. Additionally, such information was to be included in their medical records and thus was instrumental in filing disability claims. Unit support was needed to make the transition from the immediate work environment. In some instances, the participants felt their unit was not supportive of the time needed to out process. They indicated their units/duty sections did not have an internal transition plan for departing members to enable them to attend appointments associated with their exit from the military. The participants recommended that all medical conditions be included in their medical records as the documented medical diagnoses will be instrumental in filing disability claims. Unit support was needed to make the transition from the immediate work environment. In some instances, the participants felt their unit was not supportive of the time needed to out process. Some felt the support received from peers within their units was positive in regards to the assistance provided in planning retirement ceremonies and meeting their need for provisional housing.

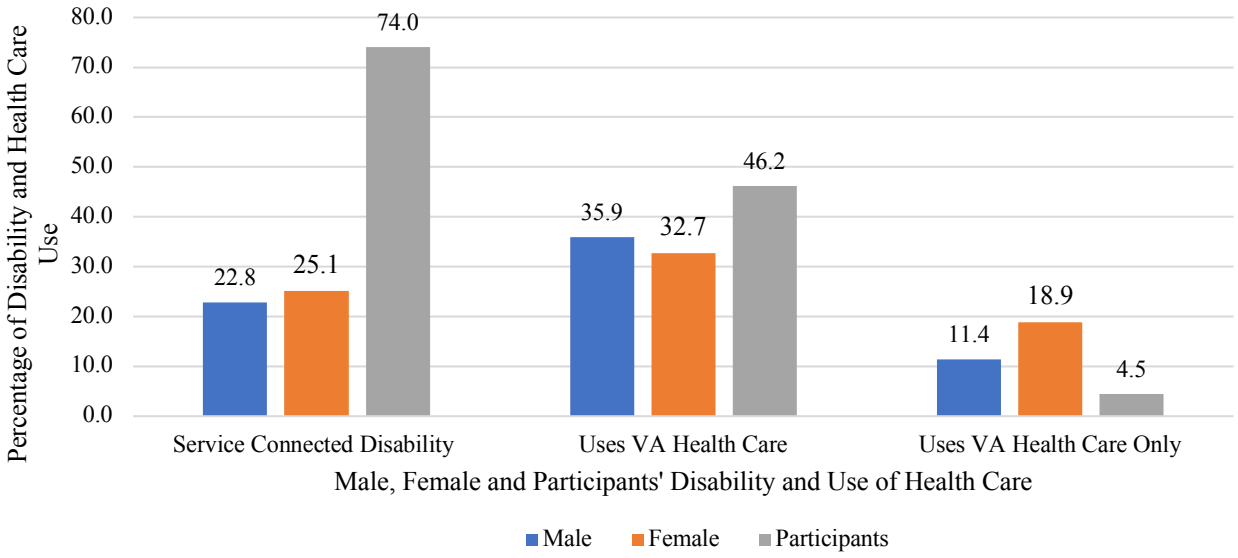

Figure 5.1. Male, female and participants' disability and use of health care. The figure is demonstrative of a comparison of the male and female veteran population and the participants in the study in regard to service-connected disabilities and utilization of VA Health Care benefits.

The resources needed or utilized at the time of the participant's departure from the military are relative to their status at the time of discharge. The utilization of non-profit and federal resources such as the DAV, VFW, DOL, VBA, federal and state employment resources and home loans/housing assistance appeared to fall within the support resources needed to assist with filing VA claims, securing employment, and filing for benefits and compensation. The use of the VA home loans and housing programs were used for those participants who wished to buy a home. The VA housing program provided assistance to participants who needed relocation support. VA assisted with initial rent costs and paid for certain bills related to back rent or utilities. Following relocation and settlement, education and training, and vocational rehabilitation resources as well as community support were beneficial resources following their satisfaction with their progress in meeting physiological and safety needs. In some instances, participants managed the transition without the use of VA benefits or resources; however, females who did not take advantage of the resources available to them at the time of their transition, are currently registered with the VA and using the health care services to which they are entitled to receive. The utilization of benefits, resources and support, is not cyclic but based on the awareness and psychological and physical needs of the female veteran at a particular juncture in their transition journey and life.

Research Question 3. What, if any, resources do female veterans believe are still needed to help servicewomen successfully transition between military and civilian life?

Advice to service women. The participants offered the following advice to service women based on their own transition journey: utilize VA benefits, plan early, attend TAP more than once if possible, manage finances, get a pre-separation medical exam and they also emphasized the need to maintain copies of all medical documentation. They also recommended veterans

prepare themselves mentally for the change in culture and possible feelings of loneliness and abandonment, consult with civilian and military mentors and welcome the support from family and friends, establish new formal and informal networks to distance themselves from the military mindset. They advocated for future female veterans to get involved in their respective communities through church, their children's sports and school activities and to volunteer within the community. In reference to employment, the participants recommended veterans get a degree or obtain some type of certification, review their resumes and ensure their skills are converted to the civilian equivalent, find a job to fit their skill set or start their own businesses. Relocating in the vicinity of a VA facility (see Appendix O) or military hospital was important to veterans who suffered from any type of illness or disability.

Accordingly access to medical care is an imperative for female veterans. The impact of PTSD associated with MST is a pervasive influence in the behaviors and lives of female veterans and can manifest itself years later as experienced by female study participants. The counseling received through the VA health care system may be long-term and is needed to help females cope and be able to manage their everyday existence. Additionally, females can receive MST related care from the VA notwithstanding their eligibility to receive other VA benefits.

Advice to military leadership. Some of the female veterans departed the military because they perceived their opportunities for progression within their respective career fields was limited. Leadership has a responsibility to ensure each member of the military feels valued and are provided with opportunities for growth. They should enable them to utilize training resources to supplement their knowledge base. This would be career enhancing and benefit the mission as well as provide them with additional tools to facilitate their preparedness for transitioning out of the military. The challenges experienced while still in the military follows the veterans through

their transition to the civilian sector. Commanders at all levels should implement policy to ensure victims of sexual harassment and assault receive counseling and coping strategies prior to their exit from the military. They should also provide referral information so the veteran can continue treatment as needed. Currently, there is no follow up with veterans who separated from the military prior to retirement. There should be collaboration between DD, VA and DOL to follow up with female veterans within 60 days following their departure from the military to inquire about their transition experience and to determine if the information presented during their attendance to TAP was applicable. Information is a powerful tool for veterans. Leadership should ensure veterans have the information they need to make the transition from the military to the civilian sector. Contact with veterans through email or regular mail should become a standard practice to keep them informed of their benefits and resources that are veteran friendly.

Research Question 4. How do women make meaning of their veteran status and develop a sense of membership in the veteran-civilian community?

Many participants felt connected to their communities because they relocated near family or within a familiar area or they moved into a military community. Some participants did not have to make a full transition adjustment to civilian life because they were married to a military member and lived on a military installation. Participants felt they had to take the initiative to engage their neighbors. Because of their military experiences or psychological disposition, there were participants who isolated themselves from the outside world and were comfortable with living in isolation because it was conducive to their emotional health. It was easier for some female veterans to "fit in" by not mentioning their status as a veteran because it would lead to questions and possibly hard, uncomfortable conversations about their military experiences. The ability to find a renewed sense of purpose also helped the female veterans feel connected within

their respective communities. Participants achieved this new sense of purpose by volunteering and involvement in veteran organizations.

Results of a survey conducted by the Service Women's Action Network (SWAN, 2016) showed that when participants were asked about building a stronger community, 71% indicated they did not have membership in a veteran service organization, whereby, the participants in this study were active members or have an association with organizations such as the VFW, DAV, Military Order of the Purple Heart, VA, AMVETS, and the American Legion. One third of the participants in the SWAN survey (2016) felt they did not feel welcome in existing veteran service organizations, while 51% did not hear of opportunities to become members. Additionally, 97% indicated they would welcome an organization dedicated to the issues of service women and women veterans. Fifty-three percent of the participants in the SWAN study indicated that an organization dedicated to women should provide resources tailored to service women and women veterans, and create a stronger sense of community (SWAN, 2016). In this study, veterans' organizations appeared to be strong allies for the participants in their attempt to understand the nuances of reintegrating back into the civilian sector.

A comparison of the utilization of VA benefits by male and female veterans would appear to be practical if all factors were equal; however, women face barriers that are incomparable to males. Male veterans may be shrouded with a different set of obstacles, but the structure of the VA was founded on the soldier, airman, marine, coast guardsman or sailor being a male as indicated by the VA motto. Female veterans are not only seeking gender-specific care but also general veteran's care as indicated by research conducted by the VA Office of the Inspector General (VA, 2017c). In 2014, 414,804 female veterans visited a VA facility; of that total, 195,100 of those visits were for gender specific care. The remaining 53% visits were not

specifically related to gender-specific care (VA, 2017c). Similarly, the veterans face homelessness, PTSD, MST and suicide; however, each situation or medical condition has gender-discerning elements.

The Burkhart and Hogan (2015) study started with a female making the decision to enter the military. Their study addressed the lifecycle of a female veteran who considered joining the military, joined, served commitment, served as a female, and departed the military. Throughout the military life cycle, the veteran experienced positive and unfortunate situations as indicated in the model that might have remained with them up to and likely through their departure from the military; however, Burkhart and Hogan (2015), terminated their coping with transition model at a crucial point in the process. They reported a limited amount of resources; however, they did not address them as viable tools in the transition process. Burkhart and Hogan (2015) posited their research will provide insight into the experiences and needs of female veterans and will enable them to assess, diagnose and refer individuals to the appropriate social and health care services. By extending the existing model to include pre-departure and transition coping resources, it is possible to determine what resources are needed, or will be utilized to facilitate the transition as well as provide more expedient care.

Burkhart and Hogan (2015) asked four questions regarding the participants' transition (Departing the Military):

> Tell me your story about when you finished your military service and returned to civilian life?
>
> What were the most challenging aspects of returning to civilian life?
>
> What helped you when returning to civilian life?
>
> What would have helped you during this transition?

(Burkhart & Hogan, 2015, p.112)

The responses to these questions were categorized under Departing the Military that contained two subcategories: experiencing stressors of being a civilian and making meaning of being a civilian.

The primary objective of Burkhart and Hogan's (2015) study was to supplement existing literature to provide descriptors used to identify the stressors females experience prior to and throughout their military career and through the transition points of considering the military, entering the military being in the military and departing the military. Previously, tested strategies to alleviate PTSD and promote well-being involved intervention, telephone monitoring, a self-defense program, PTSD educational treatment sessions, mind-body intervention and massage treatments and case management of homelessness were employed with limited success (Burkhart & Hogan, 2015).

There are experiences that female veterans face that happened prior to their separation from the military that transposes to their military to civilian transition. Sexual assault and the feeling of inferiority were traumatizing experiences in addition to physical and visual impressions of war. The participants reportedly adapted to their transition by hiding their military experiences, withdrawing into alcohol abuse, and seclusion. In order to cope with the impact of transition, the participants found solace in the pride of being in the military and belonging to a veteran-civilian community. Although Burkhart and Hogan (2015) advocated the implementation of coping strategies, they also indicated that women used a limited number of coping mechanisms, such as avoidance, which contributed to their PTSD.

During a summit sponsored by the Center for Women Veterans in 2011, women veteran's issues were examined and an initiative to provide benefits and resources information to female

veterans was implemented (Burkhart & Hogan, 2015). This study aligns with that initiative to append the coping with transition model to include pre-departure, transition resources and support. The participants in this researcher's study used the VA benefits afforded to them to facilitate their transition along with family and friends, military mentors, and military affiliated organizations. The success of incorporating resources before and during the transition process is undetermined; however, utilization can alleviate some of the stressors and provide a central point through the VA to address the issues of employment, education, relocation, and most importantly mental and physical health issues. If the pre-departure and transition resources element was inserted prior to experiencing the stressors of being a civilian, feeling unprepared for civilian life, living two lives or coping with PTSD symptoms, indicated in the model, the effects of transition might be better understood and help would be provided, in advance, to alleviate some of the implications of transitioning from the military to the civilian sector. Figure 4.1 represents the enhanced coping with transitions model. The military pre-departure encompasses medical separation screening, a psychological intake, assignment of a dedicated transition specialist, attending TAP and filing pre-departure VA claim if applicable. The present system requires attendance to the TAP; however, solutions independent of the week-long training have not been explored. Additionally, veterans indicated a need for someone to assist with their transition on a more intimate level such as an outplacement counselor. Having a dedicated person familiar with the process and the needs of the veteran would help to alleviate some of the unforeseen circumstances and assist veterans in maneuvering the sometimes-challenging out-processing system. This addition would also help to ensure all requirements are completed prior to separation. It is more difficult to correct matters once the member has left the military. There were 13 (10%) pre-departure claims filed by the participants. There is a distinct possibility that if

this process was incorporated in the model, the opportunity to increase awareness would possibly increase the usage. The psychological intake and medical screening would identify health care issues experienced by the member. Currently, there is an exit exam in place for military members; however, standards need to be incorporated to make sure the psychological and physical exams are not robotic in nature. These steps are important to identify trauma and other untreated medical issues. Participants indicated they did not take care of themselves while on active duty which resulted in additional appointments and aftercare or they lacked awareness of psychological symptoms related to PTSD or MST.

Following departure from the military, prior to experiencing the feelings of unpreparedness for civilian life, living two lives and experiencing the symptoms of PTSD, female veterans should take advantage of the transition resources to alleviate some of the stressors that may be associated with their transition. When confronted with getting out, finding a job, managing finances, relocation and working with the VA, the challenges seem insurmountable; however, the participants used the resources relevant to their situation. Working with the VA was sometimes difficult, but some of the veterans used the services of veterans' organizations to assist them in filing their claims for disability compensation. They also used the counseling services at the VA for mental health and to learn positive coping strategies to manage their veteran-civilian status.

Implications

This study identified the participants' use of their earned benefits, but it also identified the continued diminished respect for female veterans. Time, education and awareness are the only solutions to make known the contributions of female veterans who actually did go to war to support the U.S. Based on the data from the participants, future female veterans and leaders can

be instrumental in posting landmarks along the journey of female veterans exiting the military in the future.

Future female veterans. A perceived consequence of departing the military is the loss of structure. Although it appears to be elementary, prior to transition, female veterans should be reacquainted with basic life skills and given a list of referral agencies that accommodate veterans. Some of the veterans entered the military directly following their graduation from high school and transitioned from their parents' home to the military without the need to independently manage their daily lives. A training specifically targeting the 21 to 25-years old age range of female military members transitioning out of the military might assist those individuals struggling with what is perceived to be a basic foundation. The training series would encompass seminars on managing daily finances, how to build a network, the apartment search, building their community of caregivers to include doctors, dentists, and other specialty physicians, what to look for in trying to secure daycare, transportation challenges in certain geographical areas and familiarizing them with local veterans' organizations. This knowledge is sometimes assumed to be an already learned skill set. Participants mentioned the fact that they would like to have remained in the military, wanted to go back into the military, or did not want to exit the military. The Palace Chase Program offers an alternative for military members who have completed two-thirds of a 4-year term to apply to join the guard or reserves. To avoid completely severing ties with the military, servicemembers should seek information from military career advisors on the reserve units of the Army, Navy, Marine Corps, Coast Guard or Air Force (part-time) their state's Army or Air National Guard unit, Active Guard or Reserve units (full-time) or the Individual Ready Reserve, if they are indecisive about getting out of the military or to determine if this is a viable option for them. Part-time or full-time reserve duty is

conducive to the transition process as it affords the elements of both the military and civilian cultures.

Advanced planning played a critical role in the transition process. Participants believed that female veterans should start the planning process a minimum of 18 months in advance of departure based on the data. Prospective veterans should ensure their finances are in order and have enough savings to sustain them until they can find employment. They recommend saving enough money to cover three to six months of living expenses prior to departure. Additionally, the participants recommend getting the exit physical and securing copies of their medical records for safekeeping and to file VA claims. If future veterans plan to work, they need to have an adaptive resume prepared for the employment search. They also encouraged veterans to make sure their DD 214 is accurate and to take advantage of all of their VA benefits and resources.

Leadership. When individuals transition from one location to another, they are provided a dedicated introduction sponsor. Assigning an exit sponsor would facilitate a female military member's departure from the military. The concern of the veterans from this study indicated they did not have a checklist and there was not enough information on the sequential order of what had to be done to complete out processing. Some out-processing tasks were electronic, and the participants were not trained to use the application. The requirements to out-process from an installation should be standard across all military services. The information required on forms should also be propagated to all electronic system stakeholders to improve the efficiency of the process and alleviate the frustration and doubt of whether all required tasks were completed.

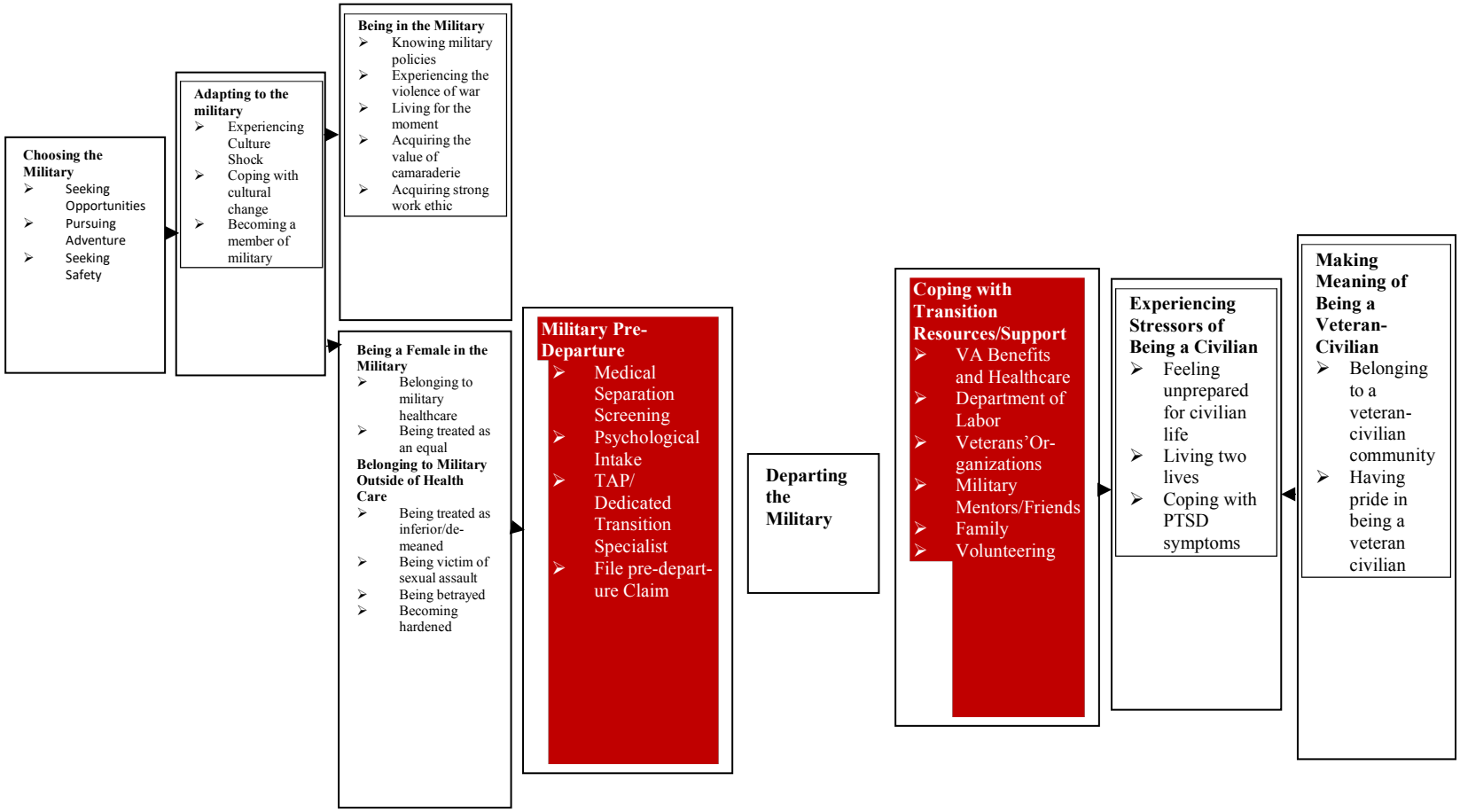

Figure 5.2. Adapted Coping with Transitions Model. The military pre-departure and coping with transition resources/support phases were added to close the gap in Burkhart and Hogan's (2015) original model.

The practice of releasing individuals in transition from their units/section responsibilities should also be a standard practice throughout all services and incorporated into a unit transition plan. This will allow military members the opportunity to fulfill their appointment commitments prior to their transition as most of them are time sensitive. Approximately 90 days prior to exiting the military, departees should be assigned to a transition unit outside of their designated duty locations. Participants were stressed because they tried to continue the same operations tempo at work which was sometimes hectic while trying to manage appointments and briefings associated with their transition.

It is recommended that leadership, at the level of the transitioning member devise and conduct a transition survey assessment in accordance with DD Instruction 1100.13 (DD, 2017). Most individuals tend to provide a more accurate assessment of their experiences when departing a particular environment. The feedback will be beneficial to those who will be transitioning in the future and enlighten prospective departees on the positive and negative aspects of out processing and also provide input to maintain the currency of information provided to enhance out processing procedures.

Additionally, military administrators should develop a series of presentations for the command to reinforce the command culture of respect and reiterate policies on zero tolerance for any form of sexual harassment or assault to be presented at commander's calls. Commanders have to develop trust and commit to conducting thorough reviews of incidents and take appropriate disciplinary action when warranted. Individual participants in this study did not report instances of sexual harassment and abuse for fear of retaliation and re-victimization. This practice may be exercised in some units but it needs continued emphasis based on the detrimental impact to military members and veterans.

First-hand experiences and accounts often provide the most credible assessment of a situation. During TAP, facilitators should solicit volunteers who will remain in the area to provide feedback about their experience with using resources during their transition. Veterans who departed the immediate area can also volunteer at their local installation or selected gathering points to share their experiences with transitioning from another state. The participants stated they gleaned information from persons who just went through the transition process or who had done so previously. A central point to share collective experiences would offer different perspectives on challenges and personal successes, and what resources were most useful.

The female veteran participants in this study are taking advantage of the benefits they earned and the resources available to them; however, they need support from leadership to pave the way for more females to feel comfortable and welcome in VA facilities. The VA motto should be modified to encapsulate all veterans, not just the male veterans. Women don't feel respected and the VA motto reinforces disregard for women veterans' contributions to the U.S. war effort.

Limitations of the Study

The online survey was conducted using social media. Although it was accessible 24 hours a day, access to the survey was limited to those who frequented the websites which included recruitment postings. Surveys such as this, attract individuals who are looking for a platform. Additionally, individuals were able to take the survey multiple times which required additional time to screen and analyze the data. Online surveys are inexpensive, independent and can offer an expanded coverage depending on how it is distributed; however, it can omit certain populations, such as homeless veterans and those not tied to any of the organizations used for recruitment.

The online survey and the telephone interview questionnaire, did not ask the participants how their transition experience and use of benefits and resources differed from that of their male counterparts. Although this study was focused on the support and resources for female veterans, data on their experiences and observed differences in treatment and customer service received by female veterans compared to their male counterparts, would have highlighted possible disparities in non-specific care.

Telephone interviews provided a means to speak with participants; however, scheduling, considering time zones was a challenge, blocked phone numbers and disregard for scheduled telephone interviews presented a challenge. Additionally, it consumed a lot of time, calling individuals back or anticipating their callback.

Future Research

Vogt (2018) suggested veteran research is siloed which imposes limitations on findings that may help veterans. Future research should therefore include a collaborative study comprising stakeholders from varied disciplines would help to understand root problems that may contribute to a veteran's overall success in reintegrating back into the civilian sector, specifically female veterans. Additionally, the DD commission should form an independent firm to track female veterans' transition from the military 3 months prior and 3 months after the transition for the purpose of studying their behaviors, obstacles and challenges. This would require sponsors or representatives to be on-site to provide advice and service to departing members prior to their departure from the military. It would also require a continued relationship following the member's departure from the military. The data will be used to detect any trends that may or may not impact the female veteran's transition and contribute to process improvement. Finally, future research should aim to determine the use of civilian healthcare providers contracted by the VA to

alleviate backlog and to assist with veteran care, specifically, for females. The study would encompass cost comparisons, credibility, quality of care and access, and follow up care as well as a comparison of the treatment provided to civilian and veteran patients, as well as veteran male patients. Female veterans transition from the military to civilian life utilizing the benefits available to them; however, further research can determine if there is a correlation between the type of benefit or resource used and long term success and mental wellness.

Summary

Results from the study indicate that female veterans are using the services provided by the VA. The umbrella of care has been long term for some participants. There appears to be a number of issues with receiving information regarding benefits and access to healthcare, which is getting better; however, participants felt they were still not respected as female veterans in some VA facilities and expressed concern regarding the quality of care received or available. The VA Mission Act was signed into law on June 6, 2018. The Act implements the Community Care Program to ensure veterans receive easy and reliable access to care when needed, form partnerships within communities to build trust and ensure veterans and their families are healthy (VA, 2018b). Female veterans have a choice as to where they want to obtain female-specific health care if it is unavailable in their facility or at their location. There is also a women's' veterans help line that is monitored by female veterans (1-855-VA-women). The data from this research mirrored findings in the extant literature. The supplement of the pre-departure phase and coping with transition resources to Burkhart and Hogan's (2015) coping with transition model demonstrates how exploring existing research can help produce a viable tool that will helpfully benefit female military and veterans, military care providers, leadership at all levels and the civilian sector who cater to military members.

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Appendix A

Women Veterans Issues a Historical Perspective

Women Veterans were the best-kept secret for many years. The 1980 Census was the first time that American women were asked if they had ever served in the Armed Forces, and an astonishing 1.2 million said "yes." Because very few of these newly identified Veterans used VA services, Congress and VA began a concerted effort to recognize and inform them of their benefits and entitlements. Activities were initiated to increase public awareness about services for women in the military and women Veterans.

Soon after the 1980 census, Congress granted veteran status to women who had served in the Women's Army Auxiliary Corps (WAAC) during World War II.

In 1982, at the request of Senator Daniel Inouye, the General Accounting Office (GAO), conducted a study and issued a report entitled: "Actions needed to ensure that female veterans have equal access to VA benefits."

- Women did not have equal access to VA benefits.
- Women treated in VA facilities did not receive complete physical examinations.
- VA was not providing gynecological care.
- Women Veterans were not adequately informed of their benefits under the law.

At the same time, VA commissioned Louis Harris and Associates to conduct a "Survey of Female Veterans: A Study of the Needs, Attitudes and Experiences of Women Veterans," published in August 1985, to determine the needs and experiences of this population. This survey found that 57 percent of the women did not know they were eligible for VA services, benefits, and programs. Another particularly troublesome finding was that women Veterans reported twice the rates of cancer as compared to the women in the general adult population, with gynecological cancers being the most common.

The results of the Census and the Harris survey raised many questions concerning women Veterans, but one conclusion was inescapable: the system was failing them. In April 1983, Harry Walters, Administrator of the Veterans Administration, began to remedy this situation by establishing a National Advisory Committee on Women Veterans.

In November 1983, following the first meeting of the VA Advisory Committee, Congress passed Public Law 98-160, "Veterans' Health Care Amendments of 1983," mandating VA to establish an Advisory Committee on Women Veterans. The charge to the Committee was broad. Not only were they tasked with assessing the needs of women Veterans with respect to adequate access to VA programs and services, but they were also empowered to make recommendations for change.

Under the leadership of Dr. Susan H. Mather, Chief Officer, Public Health and Environmental Hazards, the Committee was entrusted with the responsibility to follow-up on these activities and to report their progress to Congress in a biennial report.

The following events are historical markers since the establishment of the Advisory Committee on Women Veterans.

1984	First report of the Advisory Committee identified the need for strong outreach, and the lack of adequate privacy and gender-specific treatment for women at VA facilities as the most pressing areas of concern.
	Pamphlets, posters and publications about the service of women Veterans and their eligibility for VA services were developed.
	President Reagan proclaimed the first "Women Veterans Recognition Week." The states of New Jersey, California and Washington declared 1984 as "Women Veterans Year."
1985	As a result of the Advisory Committee's recommendations, VA appointed the first Women Veterans Coordinators.
	"The National Vietnam Veterans Readjustment Study," commissioned Congress, was the first national study on Veterans that included women.
1986	The Advisory Committee report focused on health care needs. Recommendations were made to expand VA health care to include osteoporosis, gynecological and hormonal care, research, mammography, Agent Orange exposure diseases and smoking cessation.
	Women Veterans Coordinators were appointed in VA regional offices.
1987	Congress revisited the issue of women Veterans in an oversight hearing. Women Veterans testified to noted progress but expressed concern about the consistency of the quality of health care provided to women Veterans at VA facilities.
1988	A Veterans Health Administration office to address women's health issues was first created, led by Dr. Susan H. Mather.
1989	The Advisory Committee on Women Veterans began site visits.
1991	GAO was tasked by Congress to do a follow-up study on VA health care for women. Their 1992 report was entitled, "VA Health Care for Women - Despite Progress, Improvement Needed."
1992	The 1991 GAO report, along with Congressional hearings related to sexual harassment and assault, led to the enactment of Public Law 102-585, "Veterans Health Care Act of 1992." It provided specific provisions for women's health

and broadened the context of Post-Traumatic Stress Disorder (PTSD) to include care for the aftermath of sexual trauma associated with military duty.

1993 Dedication of the Vietnam Women's Memorial.

1994 Secretary Jesse Brown established the Women Veterans Program Office within the Office of the Assistant Secretary for Policy and Planning. Joan Furey was appointed Executive Director of the Women Veterans Program Office.

The Center for Women Veterans was created by Congress under Public Law 103-446, "Veterans' Benefits Improvements Act of 1994."

The National Center for Post-Traumatic Stress Disorder created a Women's Health Sciences Division at the Boston VA Medical Center.

Three research projects were proposed by VA as an alternative to a comprehensive epidemiologic study of the long-term health effects experienced by women who served in the Armed Forces in Vietnam, as mandated by Public Law 99-272, "Veterans' Health-Care Amendments of 1986." The original study was determined not scientifically feasible. The three research projects included:

- a study of post-service mortality (results were published in 1995);
- the re-analysis of psychological health outcome data collected for women in "The National Vietnam Veterans Readjustment Study" (completed in 1988); and,
- a study of reproductive outcomes among women Vietnam Veterans.

VA funds the first national study on the quality of life of women Veterans who use VA health care services.

1995 Joan Furey was appointed as the first Director of the Center for Women Veterans. members increased communication with women Veterans, increased individual site visits to VA facilities, and provided briefings to Congressional members and staff.

1996 The first "National Summit on Women Veterans Issues" was held in Washington, DC, marking the first time women Veterans from across the Nation had the opportunity to come together with policy makers and VA officials.

1997 Kathy Zeiler was appointed as the first full-time Director for the Women Veterans Health Program.
The Women in Military Service for America Memorial was dedicated.

The First National Conference of VA Women Veterans Coordinators was held in San Antonio, Texas.

1998 VA completed the "Women Vietnam Veterans Reproductive Outcome Study," and published its findings.
The 50th Anniversary of the Women's Armed Forces Integration Act.

1999 Carole Turner was appointed as the second Director for the Women Veterans Health Program.

Results of the 1998 VA study indicated that children of women who served in Vietnam had a higher rate of birth defects. This prompted a Congressional hearing.

For the first time, the Subcommittee on Minority Women Veterans was established within the Advisory Committee.

VA's decision to provide prenatal and obstetrical care to eligible women Veterans signaled a new era in VA gender-specific services.

The Second National Conference of VA Women Veterans Coordinators was held in Chicago, Illinois.

2000 VA allocated funds for the first time ($3 million) to support programs specifically for women Veterans who are homeless. Three-year demonstration programs were designed at 11 locations across the country.

The Veterans Benefits and Health Care Improvement Act of 2000, PL 106-419, authorized special monthly compensation for women Veterans with a service-connected mastectomy. Additionally, it provided benefits for children with birth defects born to women Vietnam Veterans.

The Sunset Provision for sexual trauma counseling in VA was extended to December 31, 2004.

VA convened two task forces to study the necessity for inpatient psychiatric units for women in each VISN, and the need to extend sexual trauma counseling to Reservists and National Guard who have been victimized while on inactive duty training days.

The second "National Women Veterans - Summit 2000" was held in Washington, DC.

VHA Women Veterans Health Program was selected as the Bronze Winner of the Wyth-Ayerst HERA Award. Awards are presented to those demonstrating leadership in women and children's health.

2001 Women's Health National Strategic Work Group convened to develop progressive, state-of-the-art programs to provide high-quality comprehensive health care for FY 2002 through FY 2007. The Group commissioned Dr. Katherine M. Skinner to study the role of Women Veterans Coordinators.

September 11, 2001, changed the battlefield. Women in the Pentagon are now as vulnerable as those directly on the front lines. The likelihood of women casualties increases commensurately.

Dr. Irene Trowell-Harris was appointed as the second Director of the Center for Women Veterans.

The Charter for VA Advisory Committee on Women Veterans was renewed.

Appointments of the first minority women Veterans in leadership were made on the VA Advisory Committee on Women Veterans, in the positions of an African American as Chair, and an American Indian as Vice-Chair.

2002 The Third National Conference of VA Women Veterans Coordinators was held in Las Vegas, Nevada.

The population of women Veterans as a percentage of all Veterans is expected to increase as the number of former military service women continues to grow.

Dr. Irene Trowell-Harris testified before the Subcommittee on Health, House Committee on Veterans' Affairs on services in VA for women Veterans.

2003 According to VA's Office of Policy, Planning & Preparedness VetPro program (based on the 2000 Census) of the 25.6 million Veterans, 1.7 million are women Veterans. In 2002, the 1.7 million women Veterans constituted 6.5 percent of all Veterans living in the United States, Puerto Rico, and overseas.

VA has seen a significant increase in the number of women Veterans who receive benefits and health care services from the Department. The number of women Veterans enrolled in VA's health care system grew from approximately 226,000 in FY 2000 to nearly 305,000 in FY 2002, an increase of approximately 35 percent. Women Veterans enrolled in VA in Fiscal Year (FY) 2003 were 331,000 (up 8.6 percent from FY 2002) and of those enrolled in FY 2003, 195,516 (up 7.2 percent from FY 2002) actually used the system.

VA celebrated the 20th Anniversary of the Advisory Committee on Women Veterans on September 15, 2003, at the Women in Military Service for America Memorial (WIMSA) with Senator Daniel K. Inouye presenting the keynote address. Committee past and present chairs, co-chairs and members were honored at the ceremony.

2004 The Charter for VA Advisory Committee on Women Veterans was renewed.

The Fourth National Conference of VA Women Veterans Coordinators was held in Las Vegas, Nevada.

The third "National Summit on Women Veterans Issues - Summit 2004" was held in Washington, DC.

The Sunset Provision for sexual trauma counseling in VA was extended permanently.

2005 The Charter for VA Advisory Committee on Women Veterans was renewed.

2006 Dr. Susan Mather retired from the Department of Veterans Affairs on January 3. Dr. Mather served as the Designated Federal Official (DFO) for the Advisory Committee on Women Veterans from 1983 until 1995. She continued to serve as an ex officio member on the Committee from 1995 until her retirement in 2006.

The Fifth National Conference of VA Women Veterans Program Managers was held in Orlando, Florida.

The entire Journal of General Internal Medicine for March 2006 was dedicated to research on women Veterans. There were 16 articles, covering various issues, to include VA health care utilization, health and mental health issues among women Veterans.

2007 The Charter for VA Advisory Committee on Women Veterans was renewed. Carole Turner, the second Director for the Women Veterans Health Program, retired from VA January 2007

Dr. Betty Moseley Brown testified before the House Veterans' Affairs Committee Subcommittee on Health to highlight VA services available for women Veterans.

2008 Women's Veterans Health Program Office was elevated to the Women Veterans Health Strategic Health Care Group, effective March 2008. Dr. Patricia M. Hayes
was appointed Chief Consultant April 13, 2008. The Advisory Committee recommended the realignment of the Women Veterans Health Program Office to the status of a Strategic Healthcare Group and the Program Director position be designated as a Chief Consultant in the 2006 report.

The fourth "National Summit on Women Veterans' Issues - Summit 2008" was held in Washington, DC. Members of the Advisory Committee on Women

Veterans served as facilitators for the various workshop sessions and the town hall meeting.

Dr. Paula Schnurr, Deputy Executive Director for VA's National Center for Post-Traumatic Stress Disorder (PTSD), received the 3rd annual Ladies Home Journal "Health Breakthrough Award" for her work with PTSD and women Veterans.

Memo signed July 8, 2008 regarding the hiring of a full-time Women Veterans Program Manager at each medical center. The establishment of a full-time Women Veterans Program Manager position at VA medical centers had been recommended by the Advisory Committee in the 2006 report.

There are 1.7 million women Veterans comprising 7 percent of the total veteran population. As the number of women in the military increases, it is estimated that 10 percent of all Veterans will be women by the year 2020.

As of July 2008, there are currently over 27 research projects funded by VA's Health Services Research & Development Service addressing women Veterans' issues.

Versions of the "Women Veterans Health Care Improvement Act of 2008" introduced in both the House (H.R. 4107) and the Senate (S. 2799); some aspects related to improving health care services for women Veterans have passed.

Public Law 110-387 "Women Veterans Health Care Improvement Act of 2008" establishes a permanent requirement for the Advisory Committee on Women Veterans' biennial report.

In November 2008, the Director of the Center for women Veterans, representing the Secretary of Veterans Affairs, briefed the Fédération Mondiale des Anciens Combattants, World Veterans Federation, Standing Committee on Women on VA's initiatives, benefits and services for women Veterans in Paris, France.

2009 Charter for the Advisory Committee on Women Veterans approved by Secretary, Veterans Affairs.

Director of the Center for Women Veterans is designated to represent the Department on the White House Interagency Council on Women and Girls, which was created to ensure that American women and girls are treated fairly in all matters of public policy.

The Government Accountability Office (GAO) released its report, "VA Health Care: VA Has Taken Steps to Make Services Available to Women Veterans, but Needs to Revise Key Policies and Improve Oversight Processes," detailing its

findings on VA's health services for women Veterans gathered from several to VA medical centers.

On May 20, the Center Director, Advisory Committee chair, and others women Veterans' advocates participated in a roundtable discussion with the House Committee on Veterans' Affairs regarding the Department's current services for women Veterans, as well as developing an implementation plan to enhance services for women Veterans.

On July 1, President Barack Obama signed S.614, a bill awarding the Congressional Gold Medal to women who served in the Women Airforce Service Pilots (WASP) program, which was established during World War II; 1,102 women volunteered and 38 women pilots died during service to their country.
On Nov. 19, Secretary of Veterans Affairs Eric K. Shinseki announced that the Department would launch a comprehensive study of women Veterans who served in the military during the Vietnam War, to explore the effects of their military service upon their mental and physical health.

2010 The Center for Women Veterans initiates the "Her Story" campaign during Women's History Month, highlighting the many accomplishments of women who are serving and women Veterans.

The Department of Veterans Affairs launched in March 2010 a yearlong campaign, "Her Story," in an effort to nationally recognize the contributions of women Veterans employees at each VA facility, highlighting their military service and their continued commitment to the service of our great nation.

PL 111-163, the "Caregivers and Veterans Omnibus Health Services Act of 2010," authorizes VA to carry out a 2-year pilot program to assess the feasibility and advisability of childcare for "qualified Veterans who are the primary caretaker of a child." It also authorizes VA to provide health care to newborn children of qualifying women Veterans for up to seven days, and increases focus on research for women Veterans.

July 14 -16, 2010, VA hosted a Women's Health Services Research Conference. The Theme was, "Using Research to Build the Evidence Base for Improving the Quality of Care for Women Veterans." This important VA research conference bought together investigators interested in pursuing research on women Veterans and women in the military with leaders in women's health care delivery and policy, within and outside the VA, to significantly advance the state and potential impact of VA women's health research.

On July 28, 2010, at the Women's Memorial, VA sponsored a daylong forum for women Veterans' advocates and Veterans service organizations (VSO). The purpose of the Forum was to highlight enhancements in VA services and

benefits for women Veterans. Members of the Advisory Committee on Women Veterans attended as part of their site visit to Washington, DC.

There are 1.8 million women Veterans comprising 7.7 percent of the total Veterans population. As the number of women in the military increases, it is estimated that 10 percent of all Veterans will be women by the year 2020.

There are currently over 35 research projects funded by VA's Health Services Research & Development Service addressing women Veterans' issues.

2011 In March, the Veterans Benefits Administration (VBA) instituted staff training for staff processing claims on personal assault related PTSD claims, and initiated the development of an electronic tracking and reporting system to identify and track claims involving personal assault trauma.
VHA's women Veterans call center launched in June 2011, to solicit input on ways to enhance the health care services VA provides to women Veterans, determine why they are not using VA and whether they are aware of the gender specific services we offer, and inquire about additional services women Veterans would like to see VA offer.

During the fifth National Training Summit on Women Veterans, held in Washington, DC on July 15-17, members of the Advisory Committee on Women Veterans (ACWV) served as facilitators for the various workshop sessions. Secretary Shinseki announced to Summit participants that VA would establish a Women Veterans Task Force (WVTF), with the charge of developing a comprehensive VA action plan for resolving unmet gaps in service and how VA serves women Veterans.

In July, VA announced its child care pilot initiatives for Veterans--a continuing effort to improve access to health care for eligible Veterans, particularly the growing number of women Veterans. The three sites selected are in Northport, NY; Tacoma, WA; and Buffalo, NY.

A special supplement of the journal Women's Health Issues, published July 13, highlighted VA's tremendous growth and diversity in VA women's health research.

Charter for the Advisory Committee on Women Veterans was renewed.

VA begins to implement components of the Caregivers and Veterans Omnibus Health Services Act of 2010, Section 205 (Public Law 111-163:

- In October, the 2-year child care pilot program began in Buffalo, NY (VISN 2).

- Newborn care provided for 7 days for women Veterans receiving VA maternity care.

Rural mobile health clinic pilot hires staff to ensure that women Veterans can receive comprehensive primary care according to VHA standardized protocols for women Veterans.

By November, nearly 1.9 million, or 8 percent of the 22.2 million total Veterans population, are women.

In response to recommendation # 6 of the 2010 ACWV report, which recommended that VA provides full-time women Veterans coordinators in regional offices serving a catchment area of at least 14,000 women Veterans, VBA identified 14 regional offices that will begin to offer a full-time women Veterans coordinator.

2012 On May 14, The Women Veterans Task Force draft report was published in the Federal Register and announced by VA news release for Veterans, stakeholders and the public to review and comment.
VA Learning University (VALU), in partnership with Booz Allen Hamilton, is developing a training module, "Serving Women Veterans e-Learning Course" for VA employee new hires and current VA employees, to raise awareness of their responsibility to treat women Veterans with dignity and respect.

Newly created child care pilot program offered in Dayton, Ohio (VISN 2). VA's Women Veterans Program was established and officially transferred to the Center for Women Veterans in September 2012.

2013 Women Veteran VA health care users doubled, from 159,000 in 2000 to 390,000 in 2013.

VA's grant rates on disability claims for PTSD based on MST achieved parity with grant rates for all other PTSD claims, through an extensive claims staff training program, updated policies, and the efforts of specially-trained coordinators deployed throughout the country.

The quality of care provided to women Veterans through VA was significantly higher than in the private sector, based on both gender-specific measures (e.g., screening for cervical and breast cancer) and for gender-neutral measures (e.g., management of hypertension and diabetes, treatment of elevated cholesterol, and screening for colorectal cancer).

VA expanded its outreach to women Veterans through a new hotline (1-855VA-WOMEN) to respond to questions from Veterans, their families, and caregivers about the many VA services and resources available to women Veterans.

VA Research invested more than $16.5 million in 86 studies on women Veterans' health. This research investment greatly expands VA's network of sites conducting women Veterans' health research from 4 in 2010 to 37 in 2013.

VA also funded Women's Health Collaborative Research to Enhance and Advance Transformation and Excellence (CREATE), a research initiative aimed at better meeting the needs of women Veterans.

Elisa Basnight, Esq., was appointed Director of the Department of Veterans Affairs (VA) Center for Women Veterans, in October 2013, where assumed the roles of primary advisor to the Secretary of Veterans Affairs on programs and issues related to women Veterans, the designated federal official for VA's Advisory Committee on Women Veterans, ex-officio member on the Defense Advisory Committee on Women in the Services (DACOWITS), and VA's representative on the White House Council on Women and Girls.

The Public Service and Community Engagement link was activated on the Center for Women Veterans' Web site in December 2013, to provide information and resources for women Veterans and their advocates that will facilitate greater awareness around opportunities for them to lead and engage within their communities.

VA created dedicated claims processing teams within each VA regional office for exclusive handling of MST-related PTSD claims.

Charter for the Advisory Committee on Women Veterans was renewed.

2014 VA designed mini-residency training programs to train primary care providers and nurses as well as emergency care clinicians to meet the needs of increasing numbers of women Veterans and trained over 2000 primary care providers and 350 primary care nurses to date.

VA developing Information Technology solutions (the Breast Care Registry and the System for Mammography results tracking) to improve coordination of breast care services for Women Veterans.

VA partnered with the American Heart Association to raise awareness of heart disease in women Veterans.

VA pilots mobile applications for women's health providers, Caring4 Women Veterans and Preconception Care.

VA Women's Health Services has expanded Telehealth services for women Veterans by supporting over 26 Women's Health Telehealth programs nationally.

In February, the Center for Women Veterans facilitated the creation of a VA led interagency Women Veterans Working Group, which includes members from various Federal agencies/members of the White House Council on Women and Girls.

In March, the Center for Women Veterans, VBA, and VHA conduct a Twitter town hall to address women Veterans benefits and health care.

Director of Center for Women Veterans moderated a panel for the White House's Champions of Change event for women Veteran industry leaders. The Advisory Committee on Women Veterans participated, as part of their March 2014 meeting. The purpose of the event was to highlight women Veterans' incredible contributions to our nation's business, public and community service sectors.

In June, Director of the Center for Women Veterans and the Chief Consultant of Women's Health Services participated in a roundtable discussion sponsored by the Senate Veterans' Affairs Committee. The roundtable focused on the needs of women Veterans.

In July, the Center for Women Veterans launched an interactive online women Veterans' cyber community to pilot innovative ways to conduct outreach activities to impact a women Veteran at different phases in the lifecycle of homelessness and to provide access to Federal, State and local programs and services to which she may be entitled.

In August, VA hosted a Women's Health Research Conference, which bought together investigators interested in pursuing research on women Veterans and women in the military, to significantly advance the state and potential impact of VA women's health research.

In October, the Center for Women Veterans entered into a memorandum of agreement (MoA) with the Center for American Women and Politics (CAWP), a unit of the Eagleton Institute of Politics at Rutgers, the State University of New Jersey, to increase women Veterans' leadership and careers opportunities, to leverage existing resources, and to increase coordination of activities in an effort to help women Veterans develop public service and community engagement skill sets and prepare for public and community service opportunities.

In November, the Center for Women Veterans celebrated the 20th anniversary of its establishment.

Source: Department of Veterans Affairs (2014). *Women veterans issues: A historical perspective*. Retrieved from https://www.va.gov/womenvet/docs/20yearsHistorical Perspective.pdf

Appendix B

Legislation Related to Women

f	Date	Title
P.L. 106-419 Title III Subtitle A § 302	November 1, 2000	Veterans Benefits and Healthcare Improvement Act of 2000
Intent: Authorized special monthly compensation for women veterans with a service-connected mastectomy and benefits to children born of mothers who served in Vietnam and who have certain types of birth defects.		
P.L. 107-330 Title 1 § 1114(k)	December 6, 2002	Veterans Benefits Act of 2002
Intent: Authorized special monthly compensation for women veterans for women veterans who lost 25% or more of tissues from a single breast or both breasts in combination (including loss of mastectomy or partial mastectomy) or has received radiation or breast tissues.		
P.L. 108-422 Title III § 301	November 30, 2004	Veterans' Health Programs Improvement Act of 2004
Intent: Authority permanently to extend military sexual trauma counseling and treatment to active duty service members or active duty for training.		
P.L. 110-186 § 104(e)	February 14, 2008	Military Reservist and Veteran Small Business Reauthorization and Opportunity Act of 2008
Intent: Established a women veteran's business training resource program.		
P.L. 111-163 Title II § 201-201	May 5, 2010§	Caregivers and Veterans Omnibus Health Services Act of 2010
Intent: Provides study of barriers for women veterans to health care from the Department of Veterans Affairs. Training and certification for mental health care providers of the Department of Veterans Affairs on care for veterans suffering from sexual trauma and post-traumatic stress disorder. Pilot program on counseling in retreat setting for women veterans newly separated from service in the Armed Forces. Service on certain advisory committees of women recently separated from service in the Armed Forces. Pilot program on assistance for childcare for certain veterans receiving health care. Care for newborn children of women veterans receiving maternity care.		

Appendix C

Living Women Veterans by Age Group

Actual and Projected Totals by Year

	Actual			Projected		
Age Groups	2016	2017	2018	2019	2020	2021
<20	2,648	2,522	2,349	2,225	2,164	2,064
20-24	59,633	60,079	57,757	55.774	54,686	53,668
25-29	136,964	136,493	135,665	133,147	130,028	127,697
30-34	180,221	175,742	173,597	172,925	172,296	170,868
35-39	188,983	196,292	200,781	201,223	198,631	193,791
40-44	167,274	171,201	183,050	191,425	199,429	206,860
45-49	194,129	190,132	185,164	180,555	173,961	173,072
50-54	209,132	201,345	196,757	195,037	197,060	195,315
55-59	226,544	228,976	228,259	223,541	215,100	205,809
60-64	180,745	192,859	201,766	208,684	214,638	219,916
65-69	103,128	114,379	127,168	142,029	158,101	172,325
70-74	67,462	70,962	74,740	81,248	88,210	95,237
75-79	43,170	44,460	48,909	51,138	53,869	59,358
80-84	38,063	38,185	35,833	34,709	35,010	34,991
85-89	62,421	59,221	57,213	55,681	53,446	51,691

Note. Numbers should be interpreted to the nearest 1,000.
Note. Adapted from Veteran Population-National Center for Veterans Analysis and Statistics (October 20). Retrieved from https://www.va.gov/vetdata/Veteran_Population.asp

Appendix D

Number of Women Veterans by State of Residence

Alabama	39,317	Missouri	35,883
Alaska	9,465	Montana	8,512
Arizona	46,399	Nebraska	11,863
Arkansas	19,212	Nevada	21,715
California	143,211	New Hampshire	8,541
Colorado	45,279	New Jersey	25,550
Connecticut	13,645	New Mexico	16,354
Delaware	6,945	New York	58,855
District of Columbia	3,905	North Carolina	82,582
Florida	144,229	Ohio	61,697
Georgia	88,735	Oklahoma	29,100
Hawaii	11,906	Oregon	25,498
Idaho	10,611	Pennsylvania	60,021
Illinois	49,534	Puerto Rico	4,396
Indiana	31,169	Rhode Island	5,039
Iowa	15,140	South Carolina	42,965
Island Areas & Foreign	10,528	South Dakota	6,515
Kansas	17,972	Tennessee	44,405
Kentucky	24,415	Texas	177,507
Louisiana	28,754	Utah	10,438
Maine	9,103	Vermont	3,784
Maryland	51,974	Virginia	103,918
Massachusetts	22,391	Washington	56,867
Michigan	43,095	West Virginia	10,218
Minnesota	23,789	Wisconsin	28,907
Mississippi	20,385	Wyoming	4,672

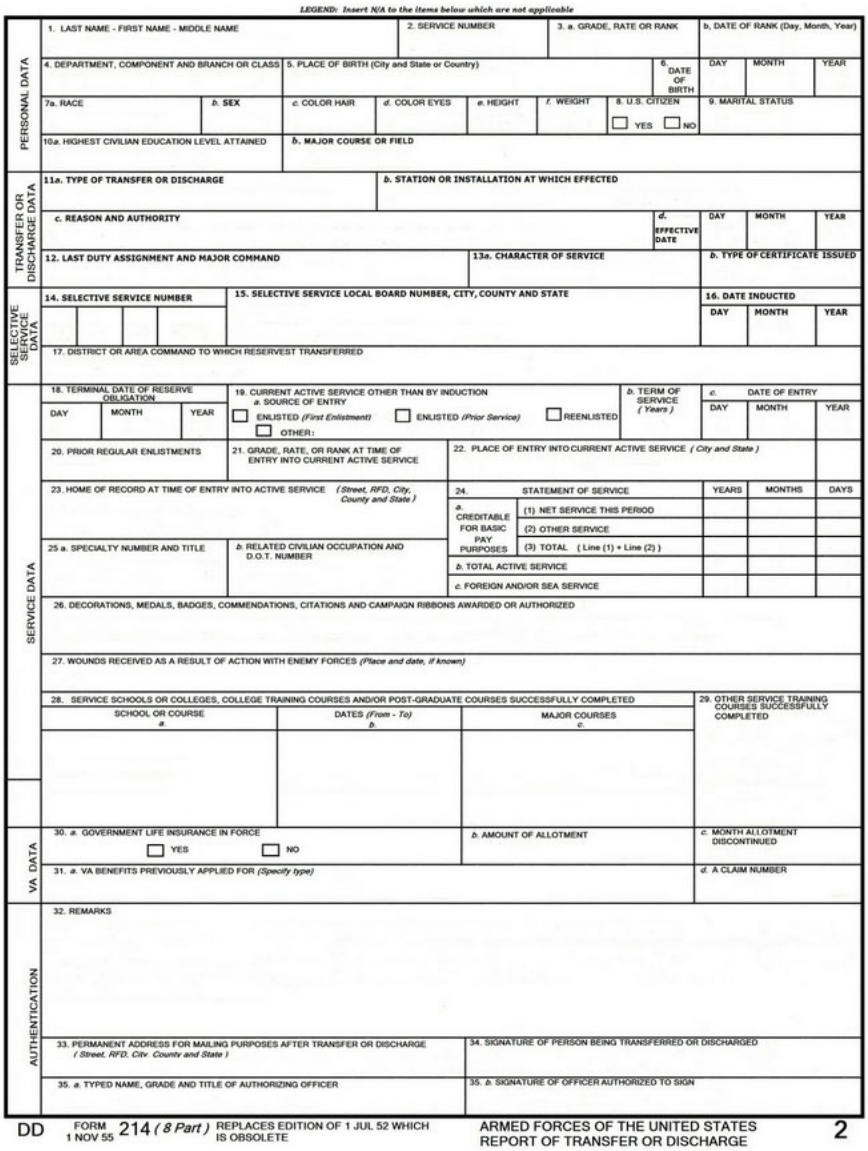
Note: Adapted from Table 6L: Vetpop2016 Living Veterans by State, Age Group, Gender, 2015-2045 (September 30, 2017).

Retrieved from: https://www.va.gov/vetdata/veteran_population.asp.

Appendix E

DD Form 214, Armed Forces of the United States
Report of Transfer or Discharge (Report of Separation)

The DD Form 214 (1955) is a document provided by the military prior to retirement, separation, or discharge that provides a reflective record of military service (Air Force Personnel Center, n.d.). The completed form is used to register at the VA as well as serves as verification of the veteran's military commitment and determines their eligibility to receive benefits, compensation, special employment consideration, membership in veterans' organizations and most importantly medical care. The form contains information regarding home of record, military job certification and education, combat and deployment experience, decorations and campaign medals and honors, total military service to include reserve time if applicable, and type of discharge.



LEGEND: Insert N/A to the items below which are not applicable

PERSONAL DATA

1. LAST NAME - FIRST NAME - MIDDLE NAME | 2. SERVICE NUMBER | 3. a. GRADE, RATE OR RANK | b. DATE OF RANK (Day, Month, Year)
4. DEPARTMENT, COMPONENT AND BRANCH OR CLASS | 5. PLACE OF BIRTH (City and State or Country) | 6. DATE OF BIRTH (DAY, MONTH, YEAR)
7a. RACE | b. SEX | c. COLOR HAIR | d. COLOR EYES | e. HEIGHT | f. WEIGHT | 8. U.S. CITIZEN ☐ YES ☐ NO | 9. MARITAL STATUS
10a. HIGHEST CIVILIAN EDUCATION LEVEL ATTAINED | b. MAJOR COURSE OR FIELD

TRANSFER OR DISCHARGE DATA

11a. TYPE OF TRANSFER OR DISCHARGE | b. STATION OR INSTALLATION AT WHICH EFFECTED
c. REASON AND AUTHORITY | d. EFFECTIVE DATE (DAY, MONTH, YEAR)
12. LAST DUTY ASSIGNMENT AND MAJOR COMMAND | 13a. CHARACTER OF SERVICE | b. TYPE OF CERTIFICATE ISSUED

SELECTIVE SERVICE DATA

14. SELECTIVE SERVICE NUMBER | 15. SELECTIVE SERVICE LOCAL BOARD NUMBER, CITY, COUNTY AND STATE | 16. DATE INDUCTED (DAY, MONTH, YEAR)
17. DISTRICT OR AREA COMMAND TO WHICH RESERVIST TRANSFERRED

SERVICE DATA

18. TERMINAL DATE OF RESERVE OBLIGATION (DAY, MONTH, YEAR) | 19. CURRENT ACTIVE SERVICE OTHER THAN BY INDUCTION a. SOURCE OF ENTRY ☐ ENLISTED (First Enlistment) ☐ ENLISTED (Prior Service) ☐ REENLISTED ☐ OTHER: | b. TERM OF SERVICE (Years) | c. DATE OF ENTRY (DAY, MONTH, YEAR)
20. PRIOR REGULAR ENLISTMENTS | 21. GRADE, RATE, OR RANK AT TIME OF ENTRY INTO CURRENT ACTIVE SERVICE | 22. PLACE OF ENTRY INTO CURRENT ACTIVE SERVICE (City and State)
23. HOME OF RECORD AT TIME OF ENTRY INTO ACTIVE SERVICE (Street, RFD, City, County and State)

24. STATEMENT OF SERVICE		YEARS	MONTHS	DAYS
a. CREDITABLE FOR BASIC PAY PURPOSES	(1) NET SERVICE THIS PERIOD			
	(2) OTHER SERVICE			
	(3) TOTAL (Line (1) + Line (2))			
b. TOTAL ACTIVE SERVICE				
c. FOREIGN AND/OR SEA SERVICE				

25 a. SPECIALTY NUMBER AND TITLE | b. RELATED CIVILIAN OCCUPATION AND D.O.T. NUMBER
26. DECORATIONS, MEDALS, BADGES, COMMENDATIONS, CITATIONS AND CAMPAIGN RIBBONS AWARDED OR AUTHORIZED
27. WOUNDS RECEIVED AS A RESULT OF ACTION WITH ENEMY FORCES (Place and date, if known)
28. SERVICE SCHOOLS OR COLLEGES, COLLEGE TRAINING COURSES AND/OR POST-GRADUATE COURSES SUCCESSFULLY COMPLETED

SCHOOL OR COURSE a.	DATES (From - To) b.	MAJOR COURSES c.	29. OTHER SERVICE TRAINING COURSES SUCCESSFULLY COMPLETED

VA DATA

30. a. GOVERNMENT LIFE INSURANCE IN FORCE ☐ YES ☐ NO | b. AMOUNT OF ALLOTMENT | c. MONTH ALLOTMENT DISCONTINUED
31. a. VA BENEFITS PREVIOUSLY APPLIED FOR (Specify type) | d. A CLAIM NUMBER

AUTHENTICATION

32. REMARKS
33. PERMANENT ADDRESS FOR MAILING PURPOSES AFTER TRANSFER OR DISCHARGE (Street, RFD, City, County and State) | 34. SIGNATURE OF PERSON BEING TRANSFERRED OR DISCHARGED
35. a. TYPED NAME, GRADE AND TITLE OF AUTHORIZING OFFICER | b. SIGNATURE OF OFFICER AUTHORIZED TO SIGN

DD FORM 1 NOV 55 214 (8 Part) REPLACES EDITION OF 1 JUL 52 WHICH IS OBSOLETE — ARMED FORCES OF THE UNITED STATES REPORT OF TRANSFER OR DISCHARGE — 2

Appendix F

Explanation of Veterans Administration Benefits

Pre-Discharge-Benefits Delivery at Discharge
The Benefits Delivery at Discharge program allows Service members to submit a claim for disability compensation between 180 to 90 days prior to separation, retirement, or release from active duty or demobilization. We need a minimum of 90 days to complete the medical exam process (which may involve multiple specialty clinics) prior to your separation from service.

Disability Compensation
Disability compensation is a monthly tax-free benefit paid to Veterans who are at least 10% disabled because of injuries or diseases that were incurred in or aggravated during active duty, active duty for training, or inactive duty training. A disability can apply to physical conditions, such as a chronic knee condition, as well as a mental health conditions, such as post-traumatic stress disorder (PTSD).

Veterans Pension Supplemental Income for Wartime Veterans
VA helps Veterans and their families cope with financial challenges by providing supplemental income through the Veterans Pension benefit. Veterans Pension is a tax-free monetary benefit payable to low-income wartime Veterans. Generally, a Veteran must have at least 90 days of active duty service, with at least one day during a wartime period to qualify for a VA Pension. If you entered active duty after September 7, 1980, generally you must have served at least 24 months or the full period for which you were called or ordered to active duty (with some exceptions), with at least one day during a wartime period.

Veteran's Group Life Insurance (VGLI)
VGLI provides for the conversion of servicemembers' Group Life Insurance (SGLI) to a renewable term life insurance policy. This policy is renewable every five years, regardless of health, and can be retained for life.

Veterans Mortgage Life Insurance (VMLI) is an insurance program that provides insurance coverage on the home mortgages of certain severely disabled servicemembers and veterans.

Disabled Veterans Insurance (S-DVI) is life insurance for veterans who have received a service-connected disability rating by the Department of Veterans Affairs. The basic S-DVI program, insures eligible veterans for up to $10,000 of coverage. Veterans who have the basic S-DVI coverage and are totally disabled are eligible to have their premiums waived.

Servicemember Group Life Insurance Traumatic Injury Protection (TSGLI) program provides short-term financial assistance to severely injured servicemembers and veterans to assist them in their recovery from traumatic injuries. The coverage is automatic for all members of the uniformed services covered under the Servicemembers' Group Life Insurance (SGLI) program.

Education, Training and Certification

The Harry W. Colmery Veterans Education Assistance Act of 2017, commonly referred to as the "Forever GI Bill," was signed into law on August 16, 2017. It made several changes to GI Bill benefits, one of which was an extension of the time limit to use the Post-9/11 GI Bill. Under the provisions of the new GI Bill, assistance will be provided to students affected by school closures and certain program disapprovals; the use of the Post-9/11 GI Bill Program 15-year limitation will be eliminated; VA will look at schools with priority enrollment for veterans to inform potential students; the Reserve Education Assistance Program (REAP) eligibility will be credited towards the Post-9/11 GI Bill Program; the GI Bill can be used at technical schools and non-Institutions of Higher Learning (IHL) and the law removes the expiration date of June 30, 2022, for certain qualifying work-study activities. These changes became effective immediately. Other revisions will be implemented in the Fall of 2018.

Home Loans

The VA will provide a home loan guaranty benefit and other housing-related programs to help veterans buy, build, repair, retain, or adapt a home for personal occupancy. VA Home Loans are provided by private lenders, such as banks and mortgage companies. VA guarantees a portion of the loan, enabling the lender to provide veterans with more favorable terms.

Vocational Rehabilitation

Veterans may receive Vocational Rehabilitation and Employment (VR&E) services to help with job training, employment accommodations, resume development, and job seeking skills coaching. Other services may be provided to assist Veterans in starting their own businesses or independent living services for those who are severely disabled and unable to work in traditional employment.

Veteran Employment Resources supports veterans in all stages of the job search—from returning to work with a service-connected disability, to getting more training for new job opportunities, to starting or growing a business. In addition, the VA connects veterans to the Department of Labor (DOL) for more resources and career advice. The DOL assists with resume writing and facilitates connections to employers who want to hire veterans and military spouses.

VetSuccess on Campus (VSOC) program helps veterans, servicemembers, and their qualified dependents through a coordinated delivery of on-campus benefits assistance and counseling, leading to completion of their education and preparing them to enter the labor market in viable careers. The VSOC program provides a VA Vocational Rehabilitation Counselor (VRC) to each VSOC school. These VRCs are called VetSuccess on Campus (VSOC) Counselors. A VA Vet Center Outreach Coordinator is also provided, and co-located on many campuses, to provide peer-to-peer counseling and referral services.

Burial Allowances

VA burial allowances are flat rate monetary benefits that are generally paid at the maximum amount authorized by law for an eligible Veteran's burial and funeral costs. A VA regulation change in 2014 simplified the program to pay eligible survivors quickly and efficiently. Eligible surviving spouses of record are paid automatically upon notification of the Veteran's death,

without the need to submit a claim. VA may grant additional benefits, including the plot or interment allowance and transportation allowance, if it receives a claim for these benefits.

Veterans Administration Health Care Benefits

Veterans are most likely to receive medical care benefits if one of the following conditions are met: (1) receives financial compensation (payments) for a service-connected disability; (2) were discharged for a disability resulting from something that happened in the line of duty; (3) were discharged for a disability that got worse in the line of duty; (4) are a recently discharged combat veteran; (5) get a VA pension; (6) are a former Prisoner of War (POW); (7) received a Purple Heart (8) get or qualify for Medicaid benefits; (9) served in Vietnam between January 9, 1962, and May 7, 1975; (10) served in Southwest Asia during the Gulf War between August 2, 1990, and November 11, 1998; (11) served at least 30 days at Camp Lejeune between August 1, 1953, and December 31, 1987. If none of the aforementioned qualifiers apply, veterans may apply based on their income.

U.S. Department of Veterans Affairs, Veterans Benefits Administration, n.d., Retrieved from https://www.benefits.va.gov/vocrehab/index.asp.

Appendix G

Results for the Study of Barriers to Care for Women Veterans 2015

Below are highlights of results/findings for the nine established barriers (in the order addressed in the survey and report).

Barrier 1: Comprehension of Eligibility Requirement and Scope of Services

Not surprisingly, a significantly higher percentage of system users reported having received information related to VA services than did non-users. Only 51% of non-users felt that they had enough information on eligibility for VA services. As a source of information, brochures are most preferred by users and non- users alike. Talking to a VA representative and getting information from family and friends were also popular sources. The overall preference for hard copy versus electronic communication is also re-enforced by the fact that women indicated a preference for postal mail (46%) by a significant margin and email (26%) for future communications from VA. Disability level, however, seems to alter the preferred mode of communication considerably. As disability level increases, the preference for telephone use increases. Timing of information delivery seems to support the concept of "early and often". Women would like to receive information both before they separate from service and repeatedly after separation/return from deployment.

Barrier 2: Effect of outreach specifically addressing women's health services

There is a disparity between system users and non-users when assessing receipt of information about Women's Health Services. Most system users (67%) report having received information on Women's Health Services, compared to only 21% of non-users. The percentage of women who received this information (for both groups) is lower than the percent having received general VA information. Women from all Service eras reported seeing this information, with pre-Vietnam Veterans reporting the most at 46%, with a declining percentage for each later era. Across Veteran Integrated Service Networks (VISNs) there is significant disparity with the percentage reporting having seen information specific to women's care. For users, the range is 56%-83%, and for non-users it is 31%-52%. The lowest VISNs in the user groups do not necessarily correspond to the lowest scoring VISNs in the non-user groups. This may reflect variances within each VISN population, but may also be attributed to VISNs having disparate programs for communicating to women Veterans within their boundaries. It would be useful to explore the methods of those VISNs with high levels of awareness and determine if similar methods would be applicable to other VISNs.

Barrier 3: Effect of driving distance on access to care

The majority of women, whether in urban or rural settings, indicated that finding transportation was not problematic. Overall, only 10% indicated that finding transportation is either very hard or somewhat hard. However, there is an additional burden on those Veterans with higher disability ratings. For women with a 70-100% disability rating, 12% indicate having a very hard or somewhat hard time finding transportation. Ease of finding transportation was a moderate-strength

significant predictor for VA use among current users. Those for whom finding transportation is easy use VA more frequently. Driving themselves was the clearly preferred mode of transportation across all user groups (80%). The second preferred mode was to have family or friends drive them (14%). There is no significant difference between the transportation preferences of women Veterans living in rural versus urban locations.

Non-users report less difficulty finding transportation (to non-VA sites of care); however, this may be because they select their provider based upon proximity to either home or work, which may mitigate transportation problems. The limited number of VA sites of care (compared to available providers outside the federal system) makes this dynamic an inherent structural component of system design.

Barrier 4: Location and hours

Of all women who report using the VA system, 72% indicate that they do not utilize the nearest VA facility for Primary Care. This high number of women who bypass their nearest VA for care is likely indicative of the fact that many women who use VA care also utilize non-VA (non-federal) care (64%) and the location of their alternate sites of care have little relationship to the VA location. Of those women who indicate they use VA care for their primary care, only 10% indicate that they bypass their nearest VA site of care to go to another VA facility. The most common reasons for bypassing the nearest VA were the women's services I need are not available (16%), and I do not feel the providers are good (12%). The point made by responses to this question is that perception of quality of providers and availability of needed services are the dominant reasons for selecting one VA facility over another, even if it is further away. The scores are generally very good for women receiving an appointment in the timeframe needed. Availability of Primary Care appointments (typically needed more urgently than routine or mental health appointments) is scored lowest compared to appointing for other types of health care appointments. Percent scored as outstanding (a 5 on a 5-point scale) by appointment type is 36% for primary care, 47% for routine women's services, and 46% for mental health care. Combined 4 and 5 ratings (top-two on the 5-point scale) are 60%, 71% and 70%, respectively. Analysis showed that Convenience of Appointments at VA was a moderate- strength significant predictor. Women who report that VA has convenient appointment times use VA more frequently. Data indicate that morning appointments are most preferred, not necessarily because of a personal scheduling convenience, but rather because as the day goes on, appointments run further and further behind schedule (prevalent theme in respondent comments related to appointing).

Concerns and recommendations about appointing was one of the top three categories for all the respondent comments (receiving thousands of comments). One theme among the appointing comments was that communication and coordination about appointment times were a challenge. The communication about appointing may be a barrier that needs more attention. Even if satisfactory appointment times are available, if the communication and confirmation of appointments is not handled effectively, patients will be highly dissatisfied and this could discourage use of the VA system.

Barrier 5: Childcare

More users than non-users report that finding childcare to attend medical appointments is somewhat hard or very hard (42% for users, 30% for non-users). Women who are not married also have more difficulty finding childcare (39% find it hard/very hard to find childcare versus 29% for married women). Finding care is easier as women get older, and it is slightly easier for women in rural settings. Data show significant variation in ease of finding childcare across VISNs. Statistically, however, ease with which women can find childcare is not associated with user status. When queried about the possibility of on-site childcare, three out of five women (62% overall) indicated that they would find on-site childcare very helpful. Otherwise, more non-users than users reported that on-site child care would be somewhat helpful (22% non-users vs. 16% users) and more users than non-users reported that on-site child care would be not helpful (22% users vs. 17% non-users). In general, many women would like on-site childcare, but this is not a significant factor in whether they choose to utilize VA care.

Barrier 6: Acceptability of integrated care

This study assessed preferences for gender integrated Comprehensive Primary Care versus Comprehensive Primary Care provided in Clinics for Women only. For this research, Comprehensive Primary Care was defined as one provider who provides all general medical care and routine women's health care such as Pap smears, contraception, and menopause care. When asked about the importance of receiving care from a clinic just for women, users placed a greater importance on having clinics for women only (60% for users, 47% for non-users). While women throughout all demographic categories show a preference for women-only settings, some subsets of the women Veteran population may be particularly sensitive to mixed-gender settings. Women who reported previous unwanted sexual attention preferred women-only clinics slightly more than those who did not have that experience (52% to 48%). Women who had previously experienced threat or force of sex felt more strongly, with 57% stating it was very important or somewhat important to have women-only clinics (versus 47% who did not have that experience). Additional comprehensive care features were assessed including having one provider for primary care and women's services and having a female provider for women's specific services. With regard to having one single provider for all care, 75% of respondents rated this as very important or somewhat important. The importance of having a female provider for women's services may be less important than the other integration of care metrics with 65% of women rating it as very important and somewhat important but, even though the preference is lower, this is still a strong satisfier for women. Open-ended comments from respondents noted that women's clinics often had only one female provider and that appointments with that provider frequently backed up. This would indicate a possible shortage of female providers available to provide women-specific care.

The final metric related to integrated care was whether women Veterans agree with the statement that "At VA sites of care, women may see a female provider if they want to." Because this question is asked of both users and non-users, the answers are based as much (if not more) on perception than actual experience. Women who are not using the system reported lower rates of agreement with the statement (59% of non-users vs. 72% of users somewhat or strongly agree). This finding indicates that perception can be a real barrier for non-users. Twenty- eight percent of users do not agree with the statement that they may see a female provider if they want to. There are significant differences across VISNs, indicating that some locations may have more or fewer female providers available. For non-users, the perception of the ability to choose a female provider is widespread and not location specific.

Barrier 7: Gender sensitivity (users only)

The changing demographic of the VA population makes it imperative that the culture evolve not to simply accommodate women Veterans, but to actively embrace their needs and respond accordingly. To evaluate this, the study included questions about satisfaction on relationships with providers and clinic staff, and with whether women felt respected. Satisfaction with provider for women receiving comprehensive care is good and is fairly consistent across VISNs regardless of whether it is delivered in a women's specific clinic or in a general primary care clinic. However, within some VISN ratings for satisfaction with provider outside of the comprehensive care setting does differ based on type of care and location in which the care is received. This may indicate that VA is generally performing well in the provision of gender sensitive care, but some VISNs have primary care clinics which are lagging behind other care settings (comprehensive and women only) in this regard. This may reflect staffing or staff training challenges, and the unique culture of a women's clinic within VA. As may be expected, regression analysis found that women who report greater satisfaction with their primary care provider use the VA system more frequently. The women Veterans using the VA system who are most satisfied with their primary care provider are those who receive comprehensive care in a women's clinic. As age increases, satisfaction increases. As disability rating increases, satisfaction decreases. Women reported the highest level of respect from their primary care provider, and increasingly less respect by other providers and office staff, with office staff showing the least amount of respect. Women receiving comprehensive care in a women's clinic report the highest level of respect from all staff; this may indicate the success of dedicated women's clinics within VA, offering a more women-friendly and respectful environment than that of other setting. Older age groups report being treated with more respect than younger age groups. Those with no disability rating report being treated with more respect than those with higher disability ratings. The staff respect composite shows significant differences by VISN for women receiving primary care, but not comprehensive care, and women receiving comprehensive care received outside of a women's clinic. This indicates that some VISNs have a greater focus on patient-staff interaction than others, whether or not that is related to respect shown to women veterans.

Barrier 8: Mental health stigma

It is imperative that women Veterans in need of behavioral health services can locate the care they need, and are willing to enter the system to access it. Data from this study show that women who use the VA system are 1.85 times more likely (an increased "risk" of 85%) to report depression and 3.63 times more likely to report PTSD than non-users of VA health care (this shows association, not causation). More than half of women Veterans (52%) indicate they have needed mental health care. Of the system users who self-reported a need for mental health services, 49% indicated they had received mental health care from a Vet Center, and 64% reported they received mental health care from VHA sites of care (questions were not mutually exclusive). Overall, 24% of women indicated that they were hesitant to seek care for mental health issues, with more users than non-users feeling hesitant (35% of users vs. 21% of non-users). Differences in levels of hesitancy among users and non-users were also found by service era, those with self-reported traumatic brain injury (TBI), self-reported depression, and unwanted sexual attention or threat or force of sex. Reasons for hesitancy to seek care (from any source), in decreasing order, include I'm worried about medicines used (62%), It could negatively affect my job (54%), Others would think less of me (47%), I prefer spiritual/religious counseling (40%), I'm not sure it would help me (36%), I would think less of myself (32%), and It could affect my relationship with family/spouse (31%).

Current social pressures are not the only reason women are hesitant to seek mental health care. A significantly higher proportion of users, compared to non-users, reported avoiding VA because of past sexual trauma (19% of users vs. 8% of non-users). Given the historically male dominated culture and patient base in VA facilities, women who already have misgivings about seeking care may be even more hesitant when faced with barriers of both mental health stigma and gender sensitivity issues.

Barrier 9: Safety and comfort (users only)

Women from all demographic categories expressed agreement that the safety and comfort factors in VA facilities were adequate. But women from earlier Service eras had stronger agreement than more recent eras; those with no disability or lower disability ratings showed higher agreement than those with higher disability rating; and those with no experience of unwanted sexual attention/threat or force of sex showed stronger agreement that VA has adequate safety and comfort. By service era, more recent Veterans (OEF/OIF-present era) felt that facilities were less safe and comfortable overall. By disability rating, satisfaction with safety and comfort steadily decrease as disability level increases. As may be expected, women with experiences of unwanted sexual attention or threat or force of sex feel less safe and comfortable in VA facilities than women who did not have these experiences. Overall, the more comfortable women are with the safety and comfort of a facility, the more likely they are to use VA services. Only 9% of VA healthcare users indicated they had an inpatient experience at VA within the last 24 months. Women from the OEF/OIF-present era reported significantly less satisfaction with safety and comfort compared to women from other eras. The least satisfying experience for this group was with the admissions process. By disability, those with higher disability ratings (70-100%) felt significantly the least safe and comfortable with the ease and speed of the admissions process. Women with previous experiences of unwanted sexual attention or threat or force of sex felt

significantly less safe and comfortable than women veterans without those experiences (for almost all measures). The inpatient measure with which they felt the least comfortable was the ability to secure the door to their room at night. There were significant differences by VISN. Additionally, only 3% of women VA healthcare users reported an inpatient mental health stay in the previous 24 months. The number of women reporting a mental health inpatient stay is too low to assess differences in safety and comfort by VISN, and too low for regression analysis. However, top concerns identified include the inability to secure the door to their room at night, having access to a private bathroom, showering during their stay, and the speed of the admissions process.

Source: Department of Veterans Affairs. (2015). *Study of barriers for women veterans to VA health care: Final report*. Retrieved from: https://www.womenshealth.va.gov/docs/Womens%20Health%20Services_Barriers%20to%20Care%20Final%20Report_April2015.pdf.

Appendix H

Department of Defense Mandated Transition Briefing Topics

Effects of Career Change
Reserve Affiliation and Reserve Component Counselor at Installations
Verification of Military Experience and Training (VMET) – DD Form 2587
Civilian Occupation Corresponding to Military Occupations/*ONET
Licensing, Certification, and Apprenticeship Information
Military Occupational Code Crosswalk
U.S. Army Credentialing Online (Army COOL)
U.S. Navy Credentialing Online (Navy COOL)
U.S. Air Force Credentialing Online (Air Force COOL)
U.S. Marine Corps Credentialing Online (MC COOL)
United Services Military Apprenticeship Program (USMAP)
DoD Skill Bridge
Defense Activity for Non-Traditional Education Support (DANTES)
DoD Tap Web Portal
American Job Centers – Priority of Service
DOL Website
DOLEW and Service-Sponsored Transition Workshops/Seminars
Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)
State Employment Agencies
State Job Boards
Public and Community Service Opportunities (PACS)
AmeriCorps and Volunteering
Federal Employment Opportunities
USAJOBS
Go-Defense
Veterans' Preference in Federal Government
Veterans Federal Procurement Opportunities
Office of Personnel Management (OPM) Special Hiring Authorities
Veterans Recruitment Appointment (VRA)

Appendix H continued

Department of Defense Mandated Transition Briefing Topics

Hiring Preference for Non-Appropriated Fund (NAF) Jobs
Workforce Innovation and Opportunity Act (WOIA)
Small Business Administration Entrepreneurship Track – Boots to Business
Permissive Temporary Duty (PTDY) and Excess Leave
Travel and Transportation Allowances
Contact Information for Housing Counseling Assistance
U.S. Department of Education Federal Aid Programs
Other Federal, State, or Local Education/Training Programs and Options
Information on Availability of Healthcare and Mental Health Services
Separation History and Physical Examination (SHPE)
Transitional Healthcare Benefit/TRICARE
Financial Management
Separation Pay
Unemployment Compensation
General Money Management
Personal Savings and Investment
State Veteran Benefits
Two-year Commissary and Post Exchange Privileges (Eligible Involuntary Separatees)
Voting Assistance
Legal Assistance
Post Government (Military) Service Employment Restriction Counseling

Note. Mandatory briefing topics are in accordance with Title 10, United States Code (USC), Chapter 58, Section 1142 and Department of Defense Instruction (DoDI) 1332.35, February 29, 2016. Department of Defense Transition Assistance Program, Service Member Pre-Separation/Transition Counseling-Executive Summary Sheet.

Appendix I

State Benefits

State	Veterans Homes/ Home Loans	Tax Exemption/ Credit		Vehicle Registration	BusinessLicense	State Employment Points/ Preference	Education Benefits	Burial	Recreation Discounts			
		Property	State						Fishing	Hunting	State Park Entry	Gun Permits
AL	x	x	x	x		x	x	x	x	x		x
AK	x	x				x					x	
AZ		x	x			x	x	x	x	x	x	
AR	x	x	x			x	x	x	x	x	x	
CA	x	x		x	x	x		x	x	x	x	
CO		x	x			x		x			x	
CT	x	x	x			x	x				x	
DE	x		x	x		x	x	x				
DC	x	x				x						
FL	x	x				x	x		x	x	x	
GA	x			x	x			x	x	x	x	
HI	x	x				x		x				
ID	x					x		x	x	x	x	
IL	x		x				x				x	
IN	x	x	x			x			x	x	x	
IA		x	x			x		x	x	x		
KS			x			x		x	x	x	x	
KY	x	x	x			x	x	x	x	x		
LA	x	x	x			x	x	x	x	x	x	
ME	x	x	x			x	x	x	x	x	x	
MD	x	x	x		x			x	x	x	x	
MA	x	x	x	x		x	x					
MI	x	x	x	x		x		x	x	x	x	
MN	x	x			x		x	x	x	x	x	x
MS	x	x	x			x		x	x	x		x

Appendix I Continued

State	Veterans Homes/ Home Loans	Tax Exemption/ Credit		Vehicle Registration	Business License	State Employment Points/ Preference	Education Benefits	Burial	Recreation Discounts			
		Property	State						Fishing	Hunting	State Park Entry	Gun Permits
MO	x	x	x			x		x	x	x		
MT		x			x	x	x	x	x	x		
NE	x	x	x			x	x	x	x	x		
NV	x	x	x			x		x	x	x	x	
NH	x	x				x		x	x	x	x	
NJ	x	x	x			x		x	x	x		
NM	x	x		x		x	x	x	x	x		
NY	x	x	x	x	x	x	x	x	x	x	x	
NC	x	x				x		x	x	x		
ND	x	x				x	x	x	x	x	x	
OH	x	x	x			x	x		x	x	x	
OK	x	x	x			x			x	x	x	
OR	x	x	x			x			x	x	x	
PA	x	x	x			x	x		x	x		
RI	x	x		x			x	x	x	x	x	
SC	x		x			x		x	x	x	x	
SD	x	x				x	x	x	x	x	x	
TN	x	x			x	x		x	x	x	x	
TX	x	x			x	x	x	x	x	x	x	
UT	x	x				x	x	x	x		x	
VT	x	x			x	x			x	x	x	
VA	x	x				x	x	x	x	x	x	
WA	x	x		x	x	x	x	x	x	x	x	

Appendix I Continued

State	Veterans Homes/ Home Loans	Tax Exemption/ Credit		Vehicle Registration	BusinessLicense	State Employment Points/ Preference	Education Benefits	Burial	Recreation Discounts			
		Property	State						Fishing	Hunting	State Park Entry	Gun Permits
WV	x	x	x			x	x	x	x			
WI	x	x	x			x	x	x	x	x	x	
WY	x	x				x	x	x	x	x	x	
GU												
MP												
PR		x	x			x	x					
VI		x		x		x	x					

Note. Data Compiled from Veterans State Benefits. https://www.military.com/benefits/veteran-state-benefits/state-veterans-benefits-directory.html (2018)

Appendix I continued

Special State Veteran Benefits

State	Benefits
Delaware	Provides a paraplegic pension benefit totaling $3,000 per year.
Idaho	Grants financial assistance up to a $1,000 for emergencies.
Illinois	Offers a $100 survivor bonus for certain periods of war to include: Korean, Vietnam, Persian Gulf, and the Global War on Terrorism.
Iowa	Grants up to $10,000 for serious combat injuries sustained after September 11, 2001.
Louisiana	Provides professional licensure for corresponding military training.
Massachusetts	Offers a $2,000 annuity ($1,000 biannually, August 1 and February 1) for 100% disabled veterans and a welcome home bonus.
Nebraska	Offers emergency funds for veterans' families in distress.
New Hampshire	Provides a $100 bonus, activiated on September 11, 2001. One criteria is the receipt of the Global War on Terrorism Medal.
New Jersey	Offers a catastrophic entitlement of $62.50 for severely disabled veterans.
New York	Authorizes a blindness annuity, EZ pass for the New York for free travel anywhere on the thruway.
North Dakota	Offers a hardship grant for the purchase of a PTSD service dog.
Ohio	Has a veterans bonus program for veterans who served on or after October 2001. They provide $100 per month for service in Afghanistan, and $50 per month for service elsewhere up to a max of $1,500. They also offer financial assistance to veterans in need in 88 counties.
Oklahoma	Veterans who are 100% permanently and totally disabled are exempt from paying state sales tax.
Oregon	Offers veterans emergency assistance.
Pennsylvania	Awards a $525 Persian Gulf War veterans' bonus. The offer expires on August 31, 2018. They also offer a blind veterans' pension of $150 and a paralyzed veterans' pension of $150 per month.
South Dakota	Provides a veteran's bonus of $500 for the starting period of August 1990 through a date to be determined.
Utah	Purple Heart recipients are exempt from motor vehicle license, registration, and associated fees.
Vermont	The state Veterans' Affairs Office provides emergency financial assistance to help veterans.
Washington	Assists in translating military training and experience to qualify for Washington State licensure and credentialling. Grants recently employed or unemployed veterans up to $3,000 per year for a maximum of 2 years if they have a financial need while being retrained for employment.
Virgin Islands	Free emergency ambulance service and reimbursement for medical travel.

Note. Benefits are awarded based on meeting prescribed state criteria. To receive some benefits, there may be an associated application process to determine eligibility and are subject to approval. State Veterans Benefits (2018). Retrieved from https://www.military.com/benefits/veteran-state-benefits/state-veterans-benefits-directory.html.

Appendix J

Facebook Support Resources
(not all inclusive)

Page/Group	Members/Followers
American Women Veterans	108,280 Followers
BiBs (Beauties in Boots) The Remix	2,264 Members
BiBs (Beauties in Boots 2.0	3,695 Members
Center for Women Veterans, U.S. Department of Veterans Affairs	3,361 Followers
Disabled American Veterans	2,460 Followers
Disabled Female American Veterans	2,578 Members
Female Veterans Journaling Project	70 Followers
Female Veterans Helping Each Other	469 Members
Female Vet Connect	723 Members
Female Veterans of America	9,031 followers
Female Veterans Network	255 Followers
Joining Forces for Women Veteran Sisters	797 Followers
Military Women	16,524 Followers
Proud Women Veterans	34,458 Followers
Retired Military Women	513 Members
Service Women's Action Network	15,612 Followers
Sisterhood of the Traveling Veterans	639 Members
Supporting Our Veterans	2,367,188 Followers
Szu-Moy Toves Female Veteran Advocate	694 Followers
The Veterans Site	3,360,321 Followers
U.S. Department of Veterans Affairs	1,167,254 Followers
VA Claims – Veterans Helping Veterans	9,475 Members
VA Comp & Pension Claims	74,000 Members
VA Disability Chatter that Matters	21,842 Members
Veteran 2 Veteran	459,962 Members
Veterans Advantage	1,178,371 Followers
Veteran Benefits Network	5,510 Followers
Veteran Benefit Resources	1,142 Followers
Veterans Benefits Administration (VBA), U.S. Department of Veterans Affairs	565,164 Followers
Veterans Claims Assistance	569 Members
Veterans Claims Assistance Group	17,155 Members
Vets Disability Guide	17,047 Followers
Vets Helping Vets	15,139 Followers
Veterans' Health Administration (VHA) U.S. Department of Veterans Affairs	247,013 Followers
Veterans Helping Veterans	3,792 Members
Veterans United Network	1,261,553 Followers
Veteran Women Rock	171 Followers
Women Veterans	28,518 Members
Women Veterans Alliance	6,239 Followers
Women R Veterans Too	3,910 Followers
Women Veterans Rock	3,810 Followers
Wounded Warrior Project	3,112,353 Followers

Appendix K

IRB Approval Letter

The UNIVERSITY of OKLAHOMA

Institutional Review Board for the Protection of Human Subjects

Approval of Initial Submission – Expedited Review – AP01

Date: August 16, 2018 **IRB#:** 9557

Principal Investigator: Hester Jackson-Roberts **Approval Date:** 08/16/2018 **Expiration Date: 07/31/2019**

Study Title: DEPARTING THE UNITED STATES MILITARY: TRANSITION OF FEMALES TO VETERAN-CIVILIAN STATUS: AVAILABILITY AND EFFECTIVENESS OF DEDICATED SUPPORT SERVICES TO FACILITATE REINTEGRATION TO THE CIVILIAN SECTOR

Expedited Category: 6 & 7

Collection/Use of PHI: No

On behalf of the Institutional Review Board (IRB), I have reviewed and granted expedited approval of the above-referenced research study. To view the documents approved for this submission, open this study from the *My Studies* option, go to *Submission History*, go to *Completed Submissions* tab and then click the *Details* icon.

As principal investigator of this research study, you are responsible to:

- Conduct the research study in a manner consistent with the requirements of the IRB and federal regulations 45 CFR 46.
- Obtain informed consent and research privacy authorization using the currently approved, stamped forms and retain all original, signed forms, if applicable.
- Request approval from the IRB prior to implementing any/all modifications.
- Promptly report to the IRB any harm experienced by a participant that is both unanticipated and related per IRB policy.
- Maintain accurate and complete study records for evaluation by the HRPP Quality Improvement Program and, if applicable, inspection by regulatory agencies and/or the study sponsor.
- Promptly submit continuing review documents to the IRB upon notification approximately 60 days prior to the expiration date indicated above.
- Submit a final closure report at the completion of the project.

If you have questions about this notification or using iRIS, contact the IRB @ 405-325-8110 or irb@ou.edu.

Cordially,

Ioana Clonea, Ph.D.
Vice Chair, Institutional Review Board

Appendix L

Solicitation Flyer for Volunteer Participants

Vietnam Women's Memorial

ATTENTION ALL FEMALE VETERANS

Are you a female veteran who transitioned from active duty military to civilian life who would like to share your transition experience?

I am a retired Air Force veteran and a doctoral student at the University of Oklahoma. I am researching the availability of resources for female veterans. I am also interested in individual perspectives on what resources are needed but are currently unavailable that might help facilitate the military to veteran-civilian transition.

If you are a willing participant, please click on the following link to take the survey. At the end of the survey, you will also be asked if you want to participate in a follow-up interview.

Click here to take the survey

If you have any questions, you may contact me via email at jackson-roberts-1@ou.edu. The survey will be available through 30 September 2018.

For the completion of both the survey and interview, I will donate $10.00 to The Women in Military Service for America Memorial or to a verified women's veteran organization of each participant's choice.

IRB NUMBER: 9557

IRB APPROVAL DATE: 08/16/2018

Appendix M

Text Message Script to Prospective Interview Participants

Hi, my name is Denise and I would like to thank you for your support with the women's veterans' transition survey. Throughout this process, I found it to be more efficient if you provide me with a specific date and time to conduct our interview. I don't want to be a bother so if you've changed your mind about participating in the interview, please let me know. Thanks again and have a great weekend. V/R

Appendix N

Participant Benefits' Utilization

Veteran	Pre-Discharge Benefits	Disability Compensation	Veterans Pension Supplement	Veterans Group Life Insurance	Education, Training and Certification	Home Loans/ Housing	Vocational Rehabilitation	Veterans Administration Health Care	Veterans Choice Program	Veterans Homeless Program
FV1		x		x						
FV2	x	x		x	x	x		x		
FV3		x						x		
FV4		x						x	x	
FV5						x				
FV6		x								
FV7		x								
FV8		x			x	x		x		
FV9					x	x				
FV10		x			x		x	x	x	x
FVx1		x			x	x		x		
FV12		x								
FV13	x				x	x				
FV14		x				x		x		
FV15								x		
FV16		x								
FV17	x				x	x				
FV18		x			x	x	x	x		
FV19				x		x				
FV20		x		x	x		x	x		
FV21		x			x	x		x		
FV22		x					x			
FV23						x				
FV24		x				x		x	x	
FV25										
FV26						x				
FV27		x				x		x		

Appendix N continued

Participant Benefits' Utilization continued

Veteran	Pre-Discharge Benefits	Disability Compensation	Veterans Pension Supplement	Veterans Group Life Insurance	Education, Training and Certification	Home Loans/ Housing	Vocational Rehabilitation	Veterans Administration Health	Veterans Choice Program	Veterans Homeless Program
FV28		x				x		x		
FV29		x								
FV30		x				x				
FV31										x
FV32	x	x		x	x	x		x	x	
FV33	x			x	x	x		x	x	
FV34		x								
FV35		x							x	
FV36		x			x		x	x		
FV37		x								
FV38					x	x				
FV39		x		x	x	x	x	x	x	
FV40		x			x	x	x			
FV41		x			x					
FV42					x	x			x	
FV43						x				
FV44		x						x		
FV45		x								
FV46		x		x		x		x	x	
FV47		x						x		
FV48		x				x				
FV49		x		x	x			x	x	
FV50	x				x	x				
FV51		x			x					

Appendix N continued

Participant Benefits Utilization continued

Veteran	Pre-Discharge Benefits	Disability Compensation	Veterans Pension Supplement	Veterans Group Life Insurance	Education, Training and Certification	Home Loans/ Housing	Vocational Rehabilitation	Veterans Administration Health	Veterans Choice Program	Veterans Homeless Program
FV52						x				
FV53		x								
FV54	x					x				
FV55								x		
FV56		x		x	x			x	x	
FV57	x				x	x				
FV58		x			x					
FV59						x				
FV60		x								
FV61	x					x				
FV62								x		
FV63		x			x	x				
FV64		x			x			x		
FV65		x			x			x		
FV66		x		x	x	x		x		
FV67		x			x			x		
FV68	x					x				
FV69		x		x	x		x	x		
FV70		x				x		x		
FV71		x					x			
FV72		x						x		
FV73					x					
FV74		x					x			
FV75		x			x	x				

Appendix N continued

Participant Benefits Utilization continued

Veteran	Pre-Discharge Benefits	Disability Compensation	Veterans Pension Supplement	Veterans Group Life Insurance	Education, Training and Certification	Home Loans/ Housing	Vocational Rehabilitation	Veterans Administration Health	Veterans Choice Program	Veterans Homeless Program
FV76		x								
FV77	x	x	x	x	x	x		x	x	
FV78		x								
FV79								x		
FV80						x				
FV81		x								
FV82		x			x	x				
FV83						x		x		
FV84						x				
FV85		x			x					
FV86		x			x	x		x	x	
FV87		x						x		
FV88					x					
FV89		x			x			x	x	
FV90		x			x			x	x	
FV91					x	x		x		
FV92		x								
FV93		x		x	x	x		x	x	
FV94		x			x		x	x	x	
FV95						x				
FV96								x		
FV97		x					x			
FV98		x				x		x		

Appendix N continued

Participant Benefits Utilization continued

Veteran	Pre-Discharge Benefits	Disability Compensation	Veterans Pension Supplement	Veterans Group Life Insurance	Education, Training and Certification	Home Loans/ Housing	Vocational Rehabilitation	Veterans Administration Health	Veterans Choice Program	Veterans Homeless Program
FV99		x			x			x	x	
FV100		x		x				x		
FV101								x	x	
FV102		x						x		
FV103		x			x	x	x	x	x	
FV104		x			x	x			x	
FV105						x				
FV106		x				x		x	x	
FV107		x		x		x			x	
FV108		x				x		x	x	
FV109		x			x	x	x	x		
FV110		x			x			x		
FV111		x						x	x	
FV112								x		
FV113		x			x			x	x	
FV114		x					x			
FV115		x				x		x		
FV116		x			x		x	x		
FV117		x								
FV118		x								
FV119		x								
FV120	x	x			x	x				
FV121		x						x	x	
FV122		x							x	
FV123		x			x	x		x		

Appendix N continued

Participant Benefits Utilization continued

Veteran	Pre-Discharge Benefits	Disability Compensation	Veterans Pension Supplement	Veterans Group Life Insurance	Education, Training and Certification	Home Loans/ Housing	Vocational Rehabilitation	Veterans Administration Health	Veterans Choice Program	Veterans Homeless Program
FV124		x		x	x	x				
FV125		x				x				
FV126					x	x		x		
FV127		x			x	x				
FV128		x			x	x				
FV129						x				
FV130		x			x	x				
FV131	x	x			x			x		
FV132						x				

Note. Table represents the survey participants' (*N*=132) utilization of VA benefits: Pre-discharge benefits *N*=13 (10%), Disability Compensation *N*=93 (70%), Veterans Pension Supplement *N*=1 (.8%), Veterans Group Life Insurance *N*=17 (13%), Education, Training and Certification *N*=57 (43%), Home Loans/Housing *N*=64 (48%), Vocational Rehabilitation *N*=16 (12%), Veterans Administration Health Care *N*=61 (46%), Veterans Choice Program *N*=28 (21%) and Veterans Homeless Program *N*=2 (2%).

Appendix O

VA Facilities by State

According to the Rural Veterans Health Care Atlas, the VA is the largest health care system in the U.S. As of FY 15, the Veterans Health Administration had jurisdiction over 1,241 active medical facilities to include 167 VA medical centers, 568 primary care community-based outpatient clinics (PCCBOC), 188 multi-specialty community based outpatient clinics (MSCBOC), 9 mental health or domiciliary residential rehab treatment programs (DRRTP), 2 community living centers (CLC), 276 other outpatient services (OOS), 14 health care centers (HCC), and 17 that do not have site classifications.

State	VA Medical Center w/o hospital service	VA Medical Center w/hospital service	Vet Center	Cemetery	Regional Office	VA Clinic	Clinic Types	HCC	CLC	DRRTP
Alabama		4	4	4	Montgomery	17	MSCBOC - 3, OOS-3, PCCBOC-11			
Alaska		1	3	2	Anchorage	5	PCCBOC-5			
American Samoa			1		Phoenix	1	PCCBOC-1			
Arizona		3	7	7		28	MSCBOC-7, PCCBOC-11, OOS-10			
Arkansas		3	2	5	Little Rock	20	MSCBOC-2, PCCBOC-14, OOS-4			
California	3	6	30	15	Los Angeles, Oakland & San Diego	60	MSCBOC-16, PCCBOC-34, OOS-8	2	1	

Appendix O continued

VA Facilities by State

State	VA Medical Center w/o hospital service	VA Medical Center w/hospital service	Vet Center	Cemetery	Regional Office	VA Clinic	Clinic Types	HCC	CLC	DRRTP
Colorado		2	6	3	Denver	17	MSCBOC-5, PCCBOC-6, OOS-6		1	1
Connecticut	1	1	4	1	Hartford	7	PCCBOC-6, OOS-1			
Delaware		1	2	2	Wilmington	3	PCCBOC-2, OOS-1			
District of Columbia		1	1			2	PCCBOC-1, OOS-1			
Florida	1	6	24	9	St. Petersburg	74	MSCBOC-12, PCCBOC-29, OOS-29	4		1
Georgia		4	7	4	Atlanta	29	MSCBOC-3, PCCBOC-19, OOS-7			
Guam			1	1		1	PCCBOC-1			
Hawaii			6	9	Honolulu	7	PCCBOC-5, OOS-2			
Idaho		1	2	2	Boise	10	PCCBOC-7, OOS-3			

Appendix O continued

VA Facilities by State

State	VA Medical Center w/o hospital service	VA Medical Center w/hospital service	Vet Center	Cemetery	Regional Office	VA Clinic	Clinic Types	HCC	CLC	DRRTP
Illinois		5	11	9	Chicago	33	MSCBOC-5, PCCBOC-20, OOS-8			
Indiana		3	5	3	Indianapolis	21	MSCBOC-5, PCCBOC-12, OOS-4			1
Iowa		2	3	2	Des Moines	19	MSCBOC-4, PCCBOC-11, OOS-4			
Kansas		3	2	7	Wichita	19	PCCBOC-11, OOS-8			
Kentucky	2	2	2	11	Louisville	20	MSCBOC-2, PCCBOC-16, OOS-2			
Louisiana		2	4	8	New Orleans	16	MSCBOC-3, PCCBOC-9, OOS-3	1		
Maine		1	5	6	Togus	11	MSCBOC-1, PCCBOC-7, OOS-3			
Maryland		2	6	8	Baltimore	10	MSCBOC-7, PCCBOC-3			

Appendix O continued

VA Facilities by State

State	VA Medical Center w/o hospital service	VA Medical Center w/hospital service	Vet Center	Cemetery	Regional Office	VA Clinic	Clinic Types	HCC	CLC	DRRTP
Massachusetts	1	4	7	3	Boston	16	MSCBOC-4, PCCBOC-9, OOS-3			
Michigan		5	8	2	Detroit	28	MSCBOC-3, PCCBOC-20, OOS-5			1
Minnesota		2	3	3	St. Paul	15	MSCBOC-2, PCCBOC-11, OOS-2			
Mississippi		2	2	5	Jackson	10	PCCBOC-8, OOS-2			1
Missouri		5	4	8	St. Louis	31	MSCBOC-3, PCCBOC-22, OOS-6			
Montana		2	4	5	Ft. Harrison	16	PCCBOC-7, OOS-7	2		
Nebraska	1	1	2	3	Lincoln	10	MSCBOC-1, PCCBOC-5, OOS-4			
Nevada		2	3	3	Reno	16	PCCBOC-9, OOS-7			

Appendix O continued

VA Facilities by State

State	VA Medical Center w/o hospital service	VA Medical Center w/hospital service	Vet Center	Cemetery	Regional Office	VA Clinic	Clinic Types	HCC	CLC	DRRTP
New Hampshire	1		2	1	Manchester	6	PCCBOC-5, OOS-1			
New Jersey		2	5	3	Newark	16	MSCBOC-4, PCCBOC-11, OOS-1			
New Mexico		1	4	3	Albuquerque	15	PCCBOC-14, OOS-1			1
New York	3	10	16	7	Buffalo & New York	64	MSCBOC-12, PCCBOC-30, OOS-22			
North Carolina		4	6	8	Winston Salem	26	MSCBOC-5, PCCBOC-16, OOS-4	1		
North Dakota		1	3	2	Fargo	8	PCCBOC-7, OOS-1			
North Marianas				1		1	OOS-1			
Ohio		4	7	3	Cleveland	50	MSCBOC-26, PCCBOC-8, OOS-15	1		

Appendix O continued

VA Facilities by State

State	VA Medical Center w/o hospital service	VA Medical Center w/hospital service	Vet Center	Cemetery	Regional Office	VA Clinic	Clinic Types	HCC	CLC	DRRTP
Oklahoma		2	3	4	Muskogee	14	MSCBOC-2, PCCBOC-8, OOS-4			
Oregon	1	2	5	4	Portland	19	MSCBOC-4, PCCBOC-12, OOS-3			
Pennsylvania	2	7	12	5	Philadelphia & Pittsburg	38	MSCBOC-11, PCCBOC-16, OOS-11			
Puerto Rico		1	3	2	San Juan	8	MSCBOC-2, PCCBOC-3, OOS-3			
Rhode Island		1	1	1	Providence	2	PCCBOC-1, OOS-1			
South Carolina		2	4	4	Columbia	16	MSCBOC-2, PCCBOC-10, OOS-4			
South Dakota		3	2	5	Sioux Falls	11	MSCBOC-1, PCCBOC-4, OOS-6			

Appendix O continued

VA Facilities by State

State	VA Medical Center w/o hospital service	VA Medical Center w/hospital service	Vet Center	Cemetery	Regional Office	VA Clinic	Clinic Types	HCC	CLC	DRRTP
Tennessee		4	5	9	Nashville	23	MSCBOC-3, PCCBOC-12, OOS-8			
Texas	3	6	20	10	Houston & Waco	60	MSCBOC-17, PCCBOC-24, OOS-16	3		1
Utah		1	3	1	St. Lake City	7	PCCBOC-4, OOS-3			
Vermont		1	2	1	White River	6	MSCBOC-1, PCCBOC-3, OOS-2			
Virgin Islands						2	OOS-2			
Virginia		3	5	18	Roanoke	22	MSCBOC-2, PCCBOC-15, OOS-5			
Washington	2	3	8	2	Seattle	13	MSCBOC-2, PCCBOC-6, OOS-5			
West Virginia		4	7	3	Huntington	12	MSCBOC-1, PCCBOC-6, OOS-5			

Appendix O continued

VA Facilities by State

State	VA Medical Center w/o hospital service	VA Medical Center w/hospital service	Vet Center	Cemetery	Regional Office	VA Clinic	Clinic Types	HCC	CLC	DRRTP
Wisconsin		3	4	5	Milwaukee	19	MSCBOC-4, PCCBOC-14, OOS-1			
Wyoming		2	2	2		12	PCCBOC-5, OOS-7			