Canadian Armed Forces Medical Military-to-Civilian Transition: A Qualitative Investigation of Barriers and Facilitators and Their Perceived Impact on Well-Being

By

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Abstract

Epidemiological monitoring over the past decade has identified a pattern of increasing rates of suicide, financial difficulty, and transition distress in Canadian Armed Forces veterans. Veterans who involuntarily release due to medical reasons experience more challenges than other groups of veterans. While military-to-civilian transition research has increased in recent years, little has been done to examine the experiences of medically releasing personnel. Therefore, there is a dearth of information investigating how barriers and facilitators experienced during the medical release transition process may be contributing to veteran well-being. This study explored the experiences of medically releasing soldiers and medically released veterans to identify perceived barriers and facilitators that occurred during their military-to-civilian transition. These barriers and facilitators were further situated within the seven domains of Veterans Affairs Canada's well-being framework. This study is an extension of a broader veteran research project investigating medical transition experiences of individuals, as well as their current perceptions of personal and relationship health. A pragmatic approach using inductive thematic analysis was used to analyze 40 semi-structured interviews conducted with soldiers and veterans who had experience with the medical military-to-civilian transition process. This investigation yielded four themes: Systemic Complexity, Intersectional Position Considerations for Benefit Effectiveness, Health-Related Limitations, and Sociocultural Disruptions. Implications for future research, policy, benefits, and resources are discussed.

Preface

This thesis is an original work by Cassandra Elliott. The opinions and findings expressed in this publication reflect those of the author and do not represent those of the Canadian Armed Forces or the Department of National Defence. The research project, of which this thesis is a part, received ethics approval from the University of Alberta Research Ethics Board, project name "Soldier and Veteran Experiences of the Medical Release Process", No. Pro00117504, 2022.

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I would also like to thank the Canadian Military Transition Group and the experienced members of CIMVHR who consulted with me so I could have a bird's eye view of transition challenges and how they were being addressed in real-time. As a retired NCM, I was low on the totem pole, but collaborating with so many people as passionate about the same issues was overwhelmingly inspiring.

To the Director General Military Personal Research and Analysis Team members and specifically, Jennifer Lee, the words thank you will never be enough. I am honoured and privileged to have had the opportunity to collaborate with you and your team.

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Finally, to my friends, family, and military family, thank you for all your support. I hope this helps and that I've made you proud.

Chimo & Arte et Marte

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List of Abbreviations

CAF – Canadian Armed Forces

CAF TG – Canadian Armed Forces Transition Group

CBD – Cannabidiol

CM – Case Manager

CoC – Chain of Command

CWA – Collaborative Work Agreement

DGMPRA – Director General of Military Personal Research and Analysis

DND – Department of National Defence

ICF – International Classification of Functioning, Health, and Disability

IPSC – Integrated Personnel Support Centres

IU – Intolerance of Uncertainty

JPSU – Joint Personnel Support Unit

KSAs – Knowledge, Skills, and Abilities

MCT – Military-to-Civilian Transition

MET – Military Employment Transition Program

MST – Military Sexual Trauma

NCM – Non-Commissioned Member

OT – Occupational Transfer

OVO – Office of the Veterans Ombudsman

PCAT – Permanent Category

PTSD – Posttraumatic Stress Disorder

SCAN – Secondary Career Assistance Network

SISIP – Service Income Security Insurance Plan

TCAT – Temporary Category

VAC – Veterans Affairs Canada

VIP – Veteran's Independence Program

Chapter 1: Introduction

Leaving the Canadian military is an inevitability all serving soldiers will encounter. Approximately 5,000 Canadian Armed Forces (CAF) soldiers leave the military and transition to veteran status yearly (National Defence and Canadian Forces Ombudsman, 2016). Although most veterans transition successfully, epidemiological data indicates that a significant portion (32-56%) experience chronic difficulties (Tam-Seto & Dussault, 2022). Moreover, the reported number of adjustment problems has increased in recent years (Sweet et al., 2020; Thompson et al., 2016b). Difficult or failed transitions have been shown to correlate with poor veteran outcomes, such as higher rates of suicide, substance abuse, chronic pain, and financial distress, especially when compared to the Canadian civilian population (Sweet et al., 2020; Thompson et al., 2019).

In recent years, a significant amount of research has been directed toward examining Canadian military-to-civilian transition (MCT) risk factors and outcomes (MacLean et al., 2019; MacLean et al., 2014; Poirier et al., 2021; Rose et al., 2018; Sweet et al., 2020; Tam-Seto & Dussault, 2022; Thompson et al., 2011). Factors such as age, gender, rank, element of service, social connection, and type of release have been identified as the highest risk factors for experiencing a difficult MCT (McCuaig Edge et al., 2022; Rose et al., 2018). However, much of the existing body of MCT research is of quantitative, group-based design, which does not provide a deep understanding of individual experiences within the MCT system (Eichler & Smith-Evans, 2018; Eichler et al., 2021; Tam-Seto & Dussault, 2022). The Canadian MCT has been described as a unique experience as personal, social, and situational factors differ between each person (True Patriot Love Foundation, 2017). Qualitative approaches to understanding Canadian MCT difficulties based on personal factors such as gender and social support are

beginning to emerge (Eichler, 2022). However, little is known of the transition experiences that occur during the Canadian medical MCT process (Eichler, 2022; Lee et al., 2023; Office of the Veterans Ombudsman, 2017).

The Current Study

The body of knowledge exploring Canadian military and veteran phenomena has increased in recent years and continues to expand. However, there is a dearth of literature regarding the medical release experience (Rose et al., 2018). Furthermore, much of what has been investigated is heavily centred around critical population problems such as combat-related PTSD. Many soldiers do not serve specifically in combat roles, deploy, or report an existing psychological disorder but sometimes develop or exhibit worsening psychological symptoms when undergoing an MCT. Nevertheless, reported difficulties during transition continue to increase, suggesting there are more problems unrelated to PTSD and combat that need to be further identified, explored, and addressed.

Study Context

The current study extends a recent project conducted by a Director General Military Personal Research and Analysis (DGMPRA) team. They examined multiple phenomena related to medically releasing or recently released Canadian Armed Forces members. As a result of their work, findings were published to better inform future programs and policies targeted toward helping this population (Williams et al., 2022). However, considering the vast scope of the project, having someone with lived experience re-analyze the data related specifically to barriers and facilitators encountered during the MCT process would be advantageous. The first advantage is that it provides a unique opportunity for building rigour and validity of the original findings through triangulation (Creswell & Poth, 2018). Second, this study provides an opportunity to

examine data using a different theoretical paradigm which may capture a further nuanced understanding of the data. Third, it also allows a member of the target population to provide insights that may not have been otherwise obtained (Berger, 2013; Hemming et al., 2021).

Purpose

Having identified the need to investigate barriers and facilitators associated with the medical MCT process, the current study aimed to contribute to a holistic understanding of the experience for future researchers and MCT policy development. The central question explored in this project was: What are the most prevalent barriers and facilitators facing those who have gone through or are actively navigating the medical MCT process? A secondary question explored was: How are the identified barriers and facilitators potentially affecting the seven domains of well-being as outlined by Veterans Affairs Canada for a successful MCT? Finally, this study explored possible solutions based on identified participant needs.

Overview of Thesis

Chapter 2 of this thesis will be an in-depth review of the literature regarding the characteristics of a successful MCT and the risk factors for experiencing difficulties during the MCT process. In the third chapter, I will describe the design, methodology, and analyses conducted in this project. Chapter four will contain the findings of this project, and finally, chapter five will expand on those findings with an in-depth discussion and conclusion.

Chapter 2: Literature Review

Military-to-Civilian Transition

Canada's National Defence defines military transition as "the period of reintegration from military to life after service and the corresponding process of change that a serving member, Veteran and their family go through when their service is completed" (2022b). This process requires serving members to undergo significant role changes, adjustments, and shifts in identity (Smith-MacDonald et al., 2020). In the CAF, releasing from the military can be voluntary or involuntary (National Defence, 2022a). Voluntary releases occur when a soldier leaves service of their own volition. Involuntary releases, such as medical releases, occur when a soldier is classified as unfit for service. In both cases, a serving member transitions from an actively serving soldier to a retired veteran.

Well-Being Transition Framework

In recent years Veterans Affairs Canada (VAC) identified the need for an updated framework to improve research, programs, and policies directed at supporting veterans' well-being through the transition process and beyond (Thompson et al., 2016a). The resulting published document provides a conceptualization centered on defining and measuring multidimensional well-being as it applies to military members throughout their lives (Thompson et al., 2016a).

Veterans Affairs Canada's framework describes well-being as being *composite,* meaning well-being is the makeup of fluid subjective perceptions and objective observations of how a person is doing (Thompson et al., 2016a). Through extensive research examining the needs of veterans, VAC identified seven domains within composite well-being. These seven domains are *employment or other meaningful activity, finances, health, life skills and preparedness, social*

integration, housing and physical environment, and *cultural and social environment*. Determinant experiences from the past and present within each domain combine and comprise the well-being of that specific domain. Multifaceted challenges and opportunities for growth may arise when determinants within domains influence one another. Achieving good well-being means all domains are considered satisfactory by the veteran and are objectively similar when compared to the general Canadian population. Ensuring veterans achieve and can maintain a high sense of well-being throughout their life is the goal for successful military-to civilian transition. The seven domains of well-being are described next.

Employment or Other Meaningful Activity. The *employment or other meaningful activity* domain highlights the importance for veterans to achieve meaningful activities and/or work after release (Thompson et al., 2016a). Departure from the military does not always mean full retirement, as most CAF members release under the age of 40 (National Defence, 2022b). Job satisfaction, happiness with work, and work-related social relationships are important considerations that have been found to affect an individual's overall quality of life (Weziak-Bialowolska et al., 2020). Achieving meaningful employment has been reported as challenging by many veterans (National Defence, 2022b; Sweet et al., 2020). Findings in American veteran research suggests veterans have difficulty adjusting to civilian workplaces due to differences in social norms, structure, and they sometimes face stigma and discrimination (Shepherd et al., 2021).

Finances. Financial security has been acknowledged in Canadian military transition literature as one of the main contributors to well-being (Rose et al., 2018; Thompson et al., 2016a). Adequate finances facilitate veteran independence, access to health resources, social stability, living arrangements, and desired leisure activities. Military service provides a stable

source of income. That stability can be challenging to find again for some veterans, and reductions in financial security have been reported throughout transition literature (MacLean et al., 2019; Thompson et al., 2016a).

Health. Physical, social, mental, and spiritual dimensions all contribute to a holistic understanding in the *health* domain (National Defence, 2022b). Veterans Affairs Canada utilizes the World Health Organization International Classification of Functioning, Health, and Disability (ICF) model when considering a veteran's disability status. The ICF model describes functioning and disability as multi-dimensional, relating to functional and physical impairment of the body, type of impairment, limitations in activities, participation of others and within society, and facilitators or barriers in the environment (World Health Organization, 2002). To ensure the needs of this domain are appropriately addressed, VAC aims to ensure the following: (a) veterans have access to needed health, rehabilitation, and diagnostic services; (b) there is continuity of care from military to civilian health systems; (c) case managers for veterans are available for support; (d) informal supports are themselves supported; and (e) civilian healthcare givers understand and are familiar with veteran health care issues (Thompson et al., 2016a). Health challenges can lead to lower reported life satisfaction and happiness in veterans as they tend to have fewer personal resources to adjust to external social and physical environments. Veterans who report health challenges are at a higher risk for experiencing difficulties in multiple well-being domains during transition (McCuaig Edge et al., 2022).

Life Skills and Preparedness. The domain of *life skills and preparedness* encompasses the knowledge and understanding soldiers use while navigating the MCT and integrating back into Canadian society (Thompson et al., 2016a). These skills include health management, coping strategies, problem-solving, general knowledge, financial literacy, and employment-seeking

strategies. Preparedness for veterans has also been associated with issues relating to personal identity. Many veterans report complex challenges to their sense of self as they transition from soldier to veteran (Smith-MacDonald et al., 2020). Becoming a member of the CAF involves countless hours of training, conditioning, and enduring hardships, resulting in a high-functioning individual capable of operating in a tightly structured and collectivist environment (Smith-MacDonald et al., 2020). Leaving the CAF requires veterans to re-adjust to an individualistic society with vastly different norms and values. Little has been done to prepare veterans for this inevitable identity shift (Thompson et al., 2016a). However, efforts to understand this phenomenon have increased in recent years (McCuaig Edge et al., 2022; Smith-MacDonald et al., 2020).

Social Integration. Social support and the size of social networks have been identified as protective factors against developing or worsening symptoms of mental health disorders such as PTSD (Hachey et al., 2016; Mota et al., 2021). However, isolation is a common experience for many veterans as they are removed from peers with whom they have a unique bond through shared difficult experiences (Black & Papile, 2010; Rose et al., 2018; Smith-MacDonald et al., 2020). Veterans who feel they do not belong in a social context are more likely to experience significant distress and have an increased risk of suicidal ideation (Thompson et al., 2019). Adapting to new social relationships and networks can be challenging during an MCT, and supportive family connections are especially important (Thompson et al., 2016a). Formal networks such as peer support groups and veteran hobby groups may also help support veterans through an MCT, possibly due to shared connections and reduced stigma encountered compared to civilians (Rose et al., 2018). There is also some evidence to suggest that formal support is more effective when delivered by mentor veterans who have completed their own MCT process.

Unfortunately, many concerns regarding formal groups have been identified in the literature. These problems include a lack of availability to members who are not male and whose primary language is not English (Tam-Seto & Dussault, 2022). Programs that are available to member minorities within the CAF are often more focused on other domains of well-being such as employment and health and are mostly only advertised and accessible through social media.

Housing and Physical Environment. Having access to clean air and drinking water, safe living and work environments, and sufficient infrastructure are all identified by VAC as being important to veteran well-being (Thompson et al., 2016a). Having access to services such as schools, recreation facilities, transportation services, stores, and health care services is recommended by VAC to all transitioning members (National Defence, 2022b). In addition, VAC strives to provide comprehensive services in all domains in an effort to prevent homelessness from becoming an issue for veterans. The latest statistical finding reports 1,905 veterans are currently homeless (Government of Canada, 2022).

Cultural and Social Environment. According to the published report regarding a framework for well-being by VAC, this domain concerns how veteran well-being is affected by the shift in the social and cultural environments they experience when leaving the military (Thompson et al., 2016a). As previously mentioned, this shift is often difficult for veterans and can present significant challenges to their self-identity. This report states that community resources are useful as they can help accommodate veterans and support accessing important necessities like employment. Alternatively, civilian community adversities such as stigmas, stereotypes, and differences in social norms and behaviours can negatively impact veteran identity, well-being, and transition success (Black & Papile, 2010; Thompson et al., 2016a).

In contrast, the language used to communicate the domain's importance to veterans focuses less on environmental factors and more on the veteran's individual responsibility in influencing how they are perceived by Canadian civilians (National Defense, 2022b). The language used on the MCT website encourages veterans to become actively engaged in their surrounding communities. Some offered suggestions include participating as a veteran advocate, mentoring, or engaging with services such as the Legion to gain access to "civilian influencers" (National Defense, 2022b).

The previously listed well-being domains present important areas for measuring subjective and observable determinants for veterans. Efforts have increased in recent years to better understand the rising reports of transition challenges and which domains are most affected (Rose et al., 2018; Sweet et al., 2020). The following section will review important findings identifying correlates between veteran sub-groups and challenges experienced while adjusting to civilian life.

Identifying Risk Factors for MCT Challenges

In 2016, the Office of the Veterans Ombudsman (OVO) commissioned a scoping review to identify the primary factors associated with a successful transition for Canadian Veterans (Rose et al., 2018). Of the 270 publications found, 94 met the inclusion criteria. Quantitative studies were the most common (n = 54), followed by literature reviews (n = 27), and then qualitative studies (n = 13). Of the 94 studies, 18 examined determinants related to successful transition. Only two of the publications included in the review conducted specific investigations of the transition process for medically released veterans. Findings from this review led to the creation of the OVO's Determinant of Successful Transition Model consisting of risk factors

related to personal, service-related, and system and social factors (Rose et al., 2018). These factors are described next.

Personal factors include demographic characteristics related to the individual, such as age, sex and gender, relationship status, health factors, substance abuse history, and employment status (Rose et al., 2018). Identifying as a male, finding satisfying employment, achieving mental and family stability, achieving a high sense of mastery, and releasing during early or late stages of one's career were identified as important facilitators for a successful transition. Low educational attainment was highlighted as a significant risk factor for transition difficulty. Veterans with low educational attainment at the time of their release were more likely to report lower status in employment and less satisfaction with their economic situation.

Type and reason for release, time of release, element of service, and rank achieved were identified as significant service-related factors contributing to MCT success (Rose et al., 2018). Better transition outcomes were reported in veterans who voluntary released at the expected age of retirement, released as a recruit or officer, never deployed, and released from the Air Force. Canadian regular force non-commissioned members (NCMs) and veterans who were involuntarily released medically reported the most challenges. Medically released veterans experienced worse overall transition experiences with lower economic satisfaction, more health-related barriers, and increased sentiments of personal failure and institutional abandonment. These members are also the least likely to have sufficient time for accruing savings or planning for life after service.

System and social factors associated with MCT outcomes include MCT supports provided in the pre-release phase, access to career services, education attainment after service, exposure to stigma, social support from family and friends, and culturally competent care (Rose

et al., 2018). Facilitators for successful transition in this category were utilizing various transition programs and supports, being prepared for retirement, engaging in post-service education, reduced stigma related to medical releases and transition difficulty, accessing professional care services who are knowledgeable on veteran challenges, and having positive family, peer, and social support.

Literature Review Implications

Medically released regular force members are primarily recognized as one of the most at-risk demographics for experiencing difficulties in multiple domains of well-being during the MCT process (Rose et al., 2018). However, information and understanding of this population during the transition is scarce in academic literature. While epidemiological evidence provides insight into which domains of well-being are most challenging for veterans overall, less is known about how problems develop for individual members. Transition difficulties also appear to be steadily increasing in recent years (Sweet et al., 2020). A deeper understanding of the medical MCT process is crucial for improving policy and effectively supporting medically releasing regular force CAF members.

The DGMPRA Study

To address the dearth of literature concerning medically released veterans, the Director General Military Personnel Research and Analysis (DGMPRA) team within the Department of National Defence (DND), investigated the experiences of medically released military personnel throughout an MCT. Specifically, the research questions addressed were: 1) What are the stressors that are experienced by members currently undergoing a medical MCT? 2) What are the stressors that are encountered after the release process has been completed.

Participant eligibility for this study required members to have been medically released within the previous five years or were expected to be medically released within the next two years of their study, which took place during 2017-2018. In total, 45 participant volunteers met DGMPRA's criteria, with 31 veterans having been medically released and 14 still serving but had begun the process. Semi-structured interviews lasting between 40 and 120 minutes were conducted and audio-recorded using an interview protocol involving questions exploring members' transition experiences, health, and well-being. Detailed field notes were taken where audio recordings were not captured due to consent protocols. Each interview was transcribed and then analyzed by two researchers using MaxQDA or NVivo. Questions on the interview protocol included topics about transition experience, services utilized, health, and well-being. Follow-up questions were used at the discretion of the interviewers.

Findings from this study identified the predominant stressors experienced by participants during different stages of the medical MCT process. Important categories described in the study related to uncertainty, systemic challenges, preparation, health management, and main activities. Additionally, this study examined the impact participants' health had on their well-being during their medical MCT.

Identifying the predominant stressors during the different stages of a medical MCT is important for highlighting phenomena which may require a more immediate response. However, this limits the understanding of how determinants in one phase of life may affect well-being during another phase (Thompson et al., 2016a). Furthermore, focusing on specific stressors and their salient effects limits the scope in which experiences are understood. Consideration of facilitating experiences can provide additional insight into practices that could be implemented to improve the medical MCT process in the future.

Justification for Reanalyzing DGMPRA's Data

Hemming et al. (2021) described multiple benefits of including those with lived experience during the data analysis process outlined by Braun and Clark's (2006) methodological framework. The first of these benefits is that contributors with lived experience are more familiar with the language used by the studied population and are more likely to keep that language during the coding process. Themes developed from these codes tend to be more reflective of the language used by participants and can more accurately portray their perceived experiences. Being familiar with the research population's language can also increase the readability of the final report to other members of that population, making findings more accessible to wider audiences. Finally, additional perspectives within data analysis can lead to a richer and more detailed analysis, which in turn can provide a deeper understanding of the data. This may lead to additional insights, considerations, and recommendations for future research and supports designed to help future medically released veterans transition into civilian life. It is important to note that with lived experience comes the need for additional care for managing personal bias. An outline of how bias was considered and managed is provided in the methods chapter of this report.

As a female veteran NCM who has experience navigating medical release, I have an intimate understanding of the process. Having navigated both pre-release and post-release stages, I have a deep understanding of factors that occurred at different stages, how they affected me in the moment, as well as their long-term consequences on my subjective and objective well-being. Additionally, my extensive familiarity of military culture and language means I am able to understand the jargon typically used by CAF members. Due to the personal experience I have

previously identified, I am well positioned to be able to capture nuances in my comrades' experiences.

The Current Study

After much discussion, the DGMPRA team agreed to collaborate with this study's team at the University of Alberta. Specifically, an opportunity existed where an individual with both academic experience and lived experience could analyze the data independently in a timely and fiscally responsible manner. As part of this collaboration, the DGMPRA team provided 40 participant interview transcripts of regular force medically releasing or medically released veterans for this project to analyze.

This study expands on DGMPRA's original study in that it focusses on the understanding of both barriers and facilitators that occur during the process. This study also contributes to highlighting the multidimensional relationships between barriers and facilitators on domains of well-being. Finally, the findings from this study identify the impacts of various barriers and facilitators throughout the different stages of the medical MCT.

This research aims to help address the previously identified dearth of literature on the experience of the medical MCT process for CAF soldiers and veterans. Using a pragmatic approach and inductive thematic analysis, this study aims to provide a rich description of individuals' barrier and facilitator experiences throughout the medical MCT process. Further, these experiences will be situated in VAC's framework of well-being to provide additional context and encourage deeper understanding of the areas in participants' lives that were impacted. Finally, this study aims to provide recommendations based on the findings of this study.

Chapter 3: Methodology

Extensive consideration for the methodological choices in this study was crucial due to the personal experience of the primary researcher. As the purpose of this project was to gain an understanding of the barriers and facilitators medically released veterans face, I was determined to explore unique options to increase study rigour and demonstrate trustworthiness. I endeavoured to choose a research approach and analysis method that would focus on the voices of participants and not my own. The checks and balances used in this study will be described throughout the following section and summarized and expanded on at the end of this chapter. First, I will share my positionality; this transparency will illustrate why minimizing bias was especially important for this project. I will then describe my theoretical paradigms and philosophical assumptions as a researcher. Next, I will discuss the approach of the study, outline ethical considerations, and provide information regarding the participants in this study. Finally, how I conducted the data analysis will be explained, followed by the review of how I addressed quality and rigour in this project.

Positionality

To establish transparency in this study, I will describe my personal experiences, assumptions, and beliefs (Berger, 2013). I served in the CAF army for 10 years as a non-commissioned member working primarily as a Vehicle Technician. Most of my time was spent posted to combat units, where I incurred a spinal injury that would eventually end my career. After the accident, I encountered a significant number of barriers which were preventing me from healing. During this time, many of my peers were also navigating medical transitions. Over a period of just a couple years, I had lost more military and veteran friends to suicide than I did to the War in Afghanistan. When it came time to choose a new path in life, I chose to pursue a

career in psychology, so that I could help address some of the needs of my military family that were not being met. When beginning my medical release to pursue this career I encountered multiple barriers. I went for it anyway. Unfortunately, many of the existing benefits were not accessible to someone in my position and others that would have helped, simply did not exist. The various skills I developed as a soldier to overcome obstacles, along with my inherent stubbornness were instrumental in propelling me through grad school. However, I could not have done this without the support of others. I encountered amazing case managers, accommodating professors, thesis supervisors who went above and beyond, compassionate researchers willing to engage with me, and friends who had the ability to teach me the skills I needed to afford, navigate, and succeed in academia. My journey has been challenging and I can't help but think that it should not have been so hard to get to where I am. Despite numerous systemic barriers I was incredibly lucky to encounter the right people at just the right time. Not everyone in my position has been so lucky. I am doing this study to give them voice.

Theoretical Paradigms and Philosophical Assumptions

My theoretical paradigm for this study is pragmatism. Researchers utilizing the pragmatic paradigm recognize the reciprocal relationship between one's actions and world beliefs. This philosophical understanding of the world is based on the continual interaction of reflecting on one's beliefs and how one's beliefs influence actions, and then in turn reflecting on those actions, which then further influence one's beliefs (Dewey, 1922/2008; Morgan, 2014). A pragmatic theoretical paradigm considers the world and our interpretations as humans are socially influenced as actions and experiences do not exist within a vacuum. This viewpoint recognizes that participants and researchers exist in a world with social, political, and historical contexts (Creswell & Poth, 2018). The goals of pragmatic inquiry are to pursue knowledge that is

actionable, understand how knowledge, acting, and experience interconnect, and determine how differences in precipitating factors of an experience affects outcomes (Morgan, 2014). Thus, pragmatism was determined to be an excellent fit for the purpose of the present study.

Approach and Design

The approach to this study utilizes Dewey's pragmatic systemic approach to inquiry as outlined by Morgan (2014). This approach was designed to solve problems by addressing critical issues identified by participants within a particular context to identify meaningful goals for improvement. This method contains the following five steps: (1) Recognizing a problematic situation; (2) Understanding the nature of the problem; (3) Exploring possible solutions; (4) Considering potential actions and their potential consequences; and (5) Taking (recommending) actions that may help address the problematic situation (Morgan, 2014). It is important to note that similarly to the pragmatic philosophical assumption that experience and action are interconnected, so are the five steps in this methodology. When using this approach, the previously listed steps are not simply a linear outline for guidance, but also a continuous process involving different beliefs and actions requiring significant consideration.

My personal familiarity of the MCT along with exploration of the academic MCT literature accounted for the first step of pragmatic systemic inquiry, *recognizing a problematic situation* (Morgan, 2014). This problem is the increasing difficulty members are experiencing during and beyond medical MCT (Rose et al., 2018).

The second and third steps, *understanding the nature of the problem* and *exploring possible solutions* respectively, were approached using an inductive thematic analysis method as outlined by Braun and Clark (2006; Morgan, 2014). This method of analysis, while flexible, provided specific guidelines to ensure I engaged closely with the data to limit my own bias.

Thematic analysis is a qualitative method used to identify, analyze, and report important themes that convey meaning and experiences of the participants (Braun & Clark, 2006). By using an inductive approach, patterns within the data were developed in a "bottom-up way," ensuring the themes reflected the barriers and facilitators expressed by participants rather than trying to fit their experiences into a pre-existing theoretical framework (Braun & Clark, 2006). To develop a rich understanding of the barriers and facilitators that affected participants during a medical MCT, semantic coding was used to analyze the data. The final themes in this study provide comprehensive summaries describing participants' experiences of barriers and facilitators during their medical MCT. Themes were then situated within VAC's framework for well-being in the discussion chapter to further describe what domains of well-being were being affected by barriers and facilitators. This was important as solutions could not be considered unless the participants' perceived impact of barriers and facilitators were considered and explored (Morgan, 2014).

Finally, within the discussion chapter, I completed the fourth and fifth steps in Dewey's pragmatic systemic approach to inquiry, *considering potential actions and their potential consequences* and *taking (recommending) actions that may help address the problematic situation* (Morgan, 2014). To address the previous steps, I began by considering the nature of barriers and facilitators that affected the participants, along with what I had learned during member checking phases and consultations with the CAF Transition Group (CAF TG). After reflecting on the findings from participants' experiences, members from the community, current literature on the medical MCT, and consultations with CAF TG, I considered various recommendations, and the challenges, consequences, and benefits of implementing them. Various recommendations that best reflected the barriers and facilitators of participants'

experiences with the medical MCT were formulated and then revised with PS. The final recommendations are related to the areas of research, policy, programming, and resources.

Ethical Considerations

The current study received ethics approval by the University of Alberta's Ethics Board 2 (Pro00117504) on September 23, 2022. As the DGMPRA team had already collected participant data under their Social Science Research Review Board, a collaboration work agreement (CWA) was developed between the two institutions to ensure all levels of ethical accountability were agreed upon and met. All parties of the CWA signed the document in September 2022. Additionally, because the military can sometimes be considered a *small world*, the DGMPRA took additional steps to anonymize the data further to minimize the chance that I would recognize any individuals through their responses. A specific code issued by DGMPRA identified participants' transcripts, and data was transferred and stored through secured means.

Participants

Because of the nature of this study, I felt it was important to limit my analysis to regular force members as the medical release process is different between part-time and full-time soldiers. In total, I analyzed 40 participants transcripts provided by DGMPRA for this project. Demographic information was provided for 38 participants. Fourteen participants in this study identified as female and 24 identified as male. The mean age of participants was 43 with ages ranging from 26 to 62. Eleven members were still serving and 29 were veterans. Many of the participants' spouses were present during the interviews but their responses were not included in this report.

Data Analysis

This project aimed to develop a rich understanding of barrier and facilitator experiences during a medical MCT. To achieve this, inductive thematic analysis as outlined by Braun and Clark (2006) was utilized to analyze the data using ATLAS.ti, a qualitative data analysis software. Inductive thematic analysis was chosen to analyze data in this study as it is flexible and met the needs consistent with the theoretical paradigm, pragmatism. Semantic coding was used to capture the explicit language used by participants to ensure themes would accurately represent the barriers and facilitators that were identified throughout the entire data set. This method allowed the final themes of this study to capture what barriers and facilitators were experienced and how the participants were affected, consistent of the goals of pragmatic inquiry (Morgan, 2014).

The first step in this process was familiarizing myself with the data (Braun & Clark, 2006). Five random transcripts were read through a couple of times to begin formulating patterns within the data and engage in reflexive practice to address personal thoughts, feelings, and beliefs. These steps involved taking notes, drawing out mind maps, and reflecting on what I was experiencing in the moment. The same five transcripts were then sent to my supervisor (PS.) to examine. We each developed an initial set of codes to establish inter-relator reliability and ensure I was considering my bias during the coding process. Codes relating to medical MCT determinants within and between transcripts were captured and were primarily semantic, reflecting the language used explicitly by the participants. However, some latent codes were created and noted in my reflexivity journal to monitor my "underlying ideas, assumptions, and conceptualizations" (Braun & Clark, 2006). Moreover, after discussing the findings of initial codes with PS., I began to familiarize myself with the rest of the transcripts by reading and re-reading them. I then proceeded to code the rest of the transcripts while also noting important connections within and between responses that were relating to the codes. During this process, I continued writing down and monitoring my

reflexivity, ideas, and considerations to further discuss with PS. There were times I had to step back from the data analysis because I experienced difficult emotional reactions.

Because of the large number of participants and semantic codes, I created categories to organize barriers and facilitators that were experienced by the participants to help me search for themes. This step was imperative as I made a significant effort to remain faithful to the language used by the individual participants. I then presented the categories and their codes to several military members and veterans known to me. This form of member-checking ensured sentiments were organized in a way that made sense to members of the target population (Creswell & Poth, 2018). After noting feedback and further re-examining the categories, I began sorting them into potential themes that summarized the participants' perceived experiences that inhibited or promoted aspects of their medical MCT. Once I developed my initial theme names I re-examined the transcripts, codes, and my notes to ensure I was capturing all relevant data. To further strengthen the rigour of this study, I randomly selected various categories from each theme and presented them to past and present colleagues. I asked them to sort the categories under the appropriate theme title to establish additional ad-hoc validity with my decisions. Colleagues who partook were civilians or veterans, and feedback was considered during the revision of themes. Most themes remained consistent. However, after further discussions with PS., we decided to revise the final theme into two new themes which better reflected the participants' language and experiences.

The next step involved me summarizing the narratives of codes within to generate definitions. I also re-examined transcripts during this stage to ensure that both the theme names and definitions were capturing the entirety of participants' experiences. I also compared themes to

one another to confirm they all related to barriers and facilitator experiences of the medical MCT but did not overlap in the story they told.

During the final step of the analysis, I finalized writing the themes and sub-themes by utilizing participants' quotes to present vivid narratives which captured the entire data set. The final organization of themes was accomplished with the assistance of PS. The themes generated in this study captured a detailed understanding of participants' experiences of barriers and facilitators throughout a medical MCT.

Trustworthiness

Trustworthiness in qualitative research is crucial as it ensures that the conducted research is accurate and valid (Creswell & Poth, 2018). Within this study, several strategies were used to minimize bias and increase rigour. The first of these strategies was using participant data collected by a recognized, trustworthy, and qualified research group, DGMPRA. While this limits how close I can get to the data, which is important for thematic analysis, it also limited my bias and experience from affecting participant interviews.

The second strategy I utilized was the inductive approach to thematic analysis by using semantic coding for theme generation. Utilizing participant language during data analysis ensured final themes reflected the explicit experiences of participants (Braun & Clark, 2006). The further addition of vivid participant quotes supported theme narratives. The final themes developed from inductive thematic analysis provides readers with a rich and deep understanding of the barriers and facilitators the participants encountered while navigating a medical MCT.

The third strategy I utilized was member checking (Creswell & Poth, 2018). By engaging with people familiar with the medical MCT I was able to ensure my codes, categories, and themes were organized, readable, and understood by the target population. I was also able to gain insight

during these phases into benefit, policy, and program changes which were important for recommendation considerations.

The fourth verification strategy used in this study was the practice of reflexivity. This practice allowed me to address my positionality as both a researcher and someone with lived experience of the study focus (Berger, 2013; Creswell & Poth, 2018). Taking frequent notes and stepping back from the analysis when I felt emotionally connected or noticed transference was able to help me address my bias and resume with a more balanced state of mind. Additionally, consultations with and revisions conducted by my supervisor, PS., provided opportunities to mitigate bias within early drafts of this report.

The final verification strategy was a comparison with DGMPRA's findings once my own had been produced. This step serves as a type of triangulation in that I could ensure my data was accurate, even if the themes captured had different narratives (Creswell & Poth, 2018).

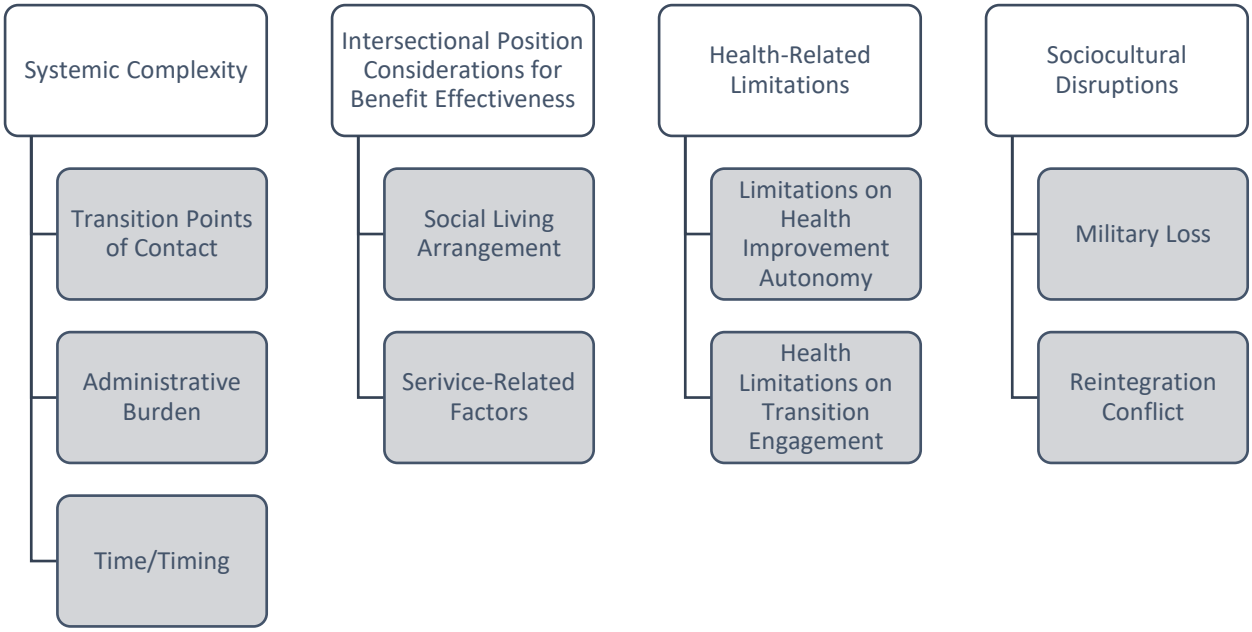
Chapter 4: Findings

The primary purpose of this research project was to develop a rich understanding of perceived barriers and facilitators during a medical MCT. I identified four themes and nine sub-themes, presented in Figure 1. These final themes thoroughly describe the helpful and challenging experiences that participants perceived as making their medical MCT easier or more difficult.

The first theme, *Systemic Complexity*, summarizes what factors inhibited or promoted accessibility to resources that enabled participants to ultimately receive or not receive benefits needed for a successful transition. This theme contains three sub-themes: *Transition Points of Contact, Administrative Burden*, and *Time/Timing*. The second theme explores the *Intersectional Position Considerations for Benefit Effectiveness*. It contains two sub-themes, *Social Living Arrangement* and *Service-Related Factors,* both had commonly perceived benefit challenges or facilitators that were specific to sub-groups within the study sample. The third theme, *Health-Related Limitations,* contains two sub-themes, *Limitations on Health Improvement Autonomy* and *Health Limitations on Transition Engagement.* These sub-themes highlight the barriers and facilitators participants experienced that were uniquely connected to their health. The final theme, *Sociocultural Disruptions,* describes the sociocultural experiences that negatively or positively affected participants well-being as they approached the end of their service and integrated into civilian employment. Participants' experiences in this theme were organized into two sub-themes: *Military Loss* and *Reintegration Conflict*. The following sections, will describe each theme and sub-theme in detail, including participant quotes. A unique number identifies each participant to ensure anonymity. Locations and other identifying information have also been removed.

Figure 1

Visual Depiction of Findings



Theme 1: Systemic Complexity

The theme *Systemic Complexity* comprises three sub-themes: *Transition Points of Contact*, *Administrative Burden*, and *Time/Timing*. Broadly, this theme describes the impact systemic organization and policies had on participants' experiences while accessing information and resources during the medical MCT process. For simplification purposes, all personnel responsible for assisting CAF members during a medical MCT will be referred to *transition staff* unless expressly stated otherwise.

Transition Points of Contact

The sub-theme *Transition Points of Contact* encompasses participants' various experiences and strategies when engaging with transition staff. Participants reported many personnel from a number of distinct offices whom they engaged with during their medical MCT. Engaging with many of these points of contact was required as part of the MCT process. Other transition staff

were considered optional. It was often the case that participants were either unaware of some the optional transition staff available to them or they were unfamiliar with the services and programs they offered. The points of contact typically encountered throughout an MCT are visually presented in Figure 2.

Figure 2

Visual Depiction of Transition Points of Contact Listed by Participants

In addition to the numerous contacts participants needed to engage with, some participants shared frustration over engaging with multiple contacts within one organization due to transition staff turnover or leaves of absence, as reflected by Participant 47 who stated: “I don’t understand

how anyone can even go through this and manage… how many is it now…4 case managers?" Some participants felt overwhelmed and had difficulty while trying to keep track of their appointments. This led to additional stress while they were learning to navigate the medical MCT process, as reflected in the following quote:

> It was pretty difficult for me. I think that, you know, the amount of appointments and the amount of different things that are required of a soldier while going through the transition, it's actually mind boggling because I mean I'm sitting back going, how are young guys or girls getting released keeping track of all this? Because I had a difficult time. (Participant 18)

Having available transition staff that were easy to get a hold of or were close to the participants' unit was helpful for progressing through the MCT. Less accessible transition staff while still serving meant participants were delayed in their ability to prepare for release, as captured in the following quote:

> So I've recently contacted the... my SISIP case manager to say, you know, I'm interested in education, the use of their programs, where do I go from here? And it's been almost two weeks, I haven't heard back from her. So it's me chasing my case managers that are assigned to me. (Participant 49)

For other participants, accessibility of transition supports became more difficult once they had left the military. The lack of preparation for the reduced accessibility of transition staff in the early stages of becoming a veteran was challenging for some participants. An example of this is provided in the following quote:

> And again, IPSC case management, they know the process. They, they're so good. They were... you know, he was there for, for me whenever I needed them. If something

> changed, I would... could just call him, I could stop by at any time, they were always available. And I think maybe that's with my expectation when I released for the SISIP case management, and the VAC case manager, whether he's just unavailable. You don't... it's very challenging to get a hold of them, whereas while I was still serving, very easy to get a hold of transition services and supports and stuff like that. (Participant 49)

For some participants, reduced transition staff accessibility sometimes led to higher feelings of uncertainty and reduced capacity to engage with other aspects of the MCT.

It was often the case that participants were unable to access certain transition staff altogether. The primary example of this was the inability to access needed medications due to the lack of continuity of care as described in the following quote:

> Not being able to get a family doctor. Like we get out, it doesn't matter if you've got a heart condition or what your problem is, you are let loose with your medicines and you're out there on your own. I was in [Location A]. I had to go to [Location B] for a family doctor. (Participant 18)

For participants who were able to access a civilian doctor, some described how they had difficulty accessing their full medical history from the military. Some of these participants stated they were ultimately missing information or had to dig through their files to find the relevant information themselves. The lack of Canadian doctors meant some participants had to utilize walk-in clinics or find and travel to doctors in farther areas. Conversely, participants who had civilian family members were more likely to be successful in accessing timely continuity of care.

Perceptions of the capabilities of transition staff members were sometimes identified by participants as a barrier or facilitator. Staff being perceived as less capable influenced whether participants continued to engage with some formal and informal transition services. Some

participants who identified transition staff capability as problematic believed they lacked the needed experience to support them, as reflected by Participant 44: “I don’t have a whole lot of confidence and, like, I’ve tried to access them for peer support and stuff like that, but they didn’t have anyone in the branches that were even in the military.” Other participants stated that some of the programs they engaged with lacked the resources to support their specific demographic or language ability. Perceived capability variations between transition supports in different geographical locations was also challenging for participants to navigate. An example of this experience is captured in the following quote:

> And one that I was at was amazing, and they were so supportive and they really tried to look outside the box. And the one in [location B] was awful, and they were traumatic. They actually caused more trauma than good. And so by the time I left, you know, it was awful. It was a terrible experience. (Participant 34)

The medical MCT was perceived as easier for participants who felt they had knowledgeable, engaged, and effective transition staff, as the following participant shared:

> So walked me through the TCAT process, how it goes to a PCAT and so on and so forth. So they were with me. It was [case worker], and she was with me through most of the steps. So as far as doing anything on my own, I didn’t really do anything to prepare for the release. (Participant 7)

Perceptions of ease provided by transition staff during the earlier stages of transition meant participants were better able to address navigating the MCT and managing their health. This was partially due the transition staff’s ability to reduce the member’s workload. However, several participants noted that while they felt their transition staff were knowledgeable and personally capable, they still experienced difficulties during their transition. These participants believed that

some of their transition staff were overworked due to staffing shortages, limiting their involvement capacity to help members apply for benefits that would support them after release. In these circumstances, participants perceived that systemic deficiencies inhibited the capability of their transitions staff.

Other systemic issues concerning transition staff also arose. Some members reported that miscommunication or disagreements between different members of their transition staff sometimes resulted in improper or delayed diagnoses, treatments, or access to benefits. An experience of this is illustrated in the following quote:

> So, the bottom line is, when she phoned Blue Cross directly and said, "Look, hey." You know, the Veterans Affairs people who deal with Veterans Affairs Blue Cross, they said "Oh yeah, we pay for that. All we need is the doctor, your doctor to let us know." So the case manager said "No, you can't do it." And the people who actually manage the money said: "Well yes, you can do it." (Participant 39)

Administrative Burden

This sub-theme describes the barrier and facilitator experiences identified with completing administrative requirements or accessing information for the various resources, supports, and benefits needed for a successful medical MCT. Across interviews, participants expressed the overwhelming nature of both the amount of information and amount of paperwork that needed to be completed, with one participant noting the following experience:

> It was, again, when I was doing it I was [early fifties], and all I could say was how are younger people doing this? I'm telling you, I had an agenda that was full. Paperwork and paperwork and this and that. It never ended. (Participant 18)

Transition programs such as Secondary Career Assistance Network (SCAN) seminars, two- to three-day events held on every major base to inform members on release supports and processes, were frequently identified as being helpful for participants. However, many participants expressed multiple challenges with some of these programs, such as incorrect information, too much information, contradicting information, or too generalized information. One participant stated:

> So one of the things that, we first start the process that I find, and I think is common with people I've talked to and stuff like that, is that even attending the SCAN seminars, there's a lot of information but it's not, because it's managed by so many different, I don't know, companies, let's say, it's not very streamlined, and some of the information presented at the SCAN seminars actually contradicts information presented by other presenters. (Participant 44)

Some participants described having significant difficulty with retaining or following the information provided to them because of their particular injury:

> It was good information, I don't know. It may have been my state of mind, but I didn't find that a lot of it was useful. Some of it was very useful, I just don't know… like where I was in my mindset. I also was starting to get very uncomfortable with crowds, so a lot of my time was spent just being stressed out about sitting in a room full of people. (Participant 14).

It was made clear by participants that SCAN seminars were their first step for gaining the information they needed. However, additional information was also received from the numerous transition staff. Having to keep track of the high volume of information related to services and benefits was burdensome for many participants. Participant 37 stated "…right now I'm getting

piecemeal advice from this group, that group, JPSU, VAC, and medical, and so on. So I have to compile it all together myself."

The difficulty of keeping track of information was further exasperated when available policies had changed while participants were navigating the MCT. Changing policies left some members more uncertain about their ability to transition successfully as they believed benefits may be reduced or taken away from them after they were approved. The following participant quote describes having to alter their plans shortly before they released from the CAF:

> A month prior to my releasing from the military there were changes to the regulations on transiting out. One of the things that caused confusion right away was... I had a house over in [Location A] and I was planning on moving in with my fiancée in [Location A] over here and I was entitled to a... to a final move as I was retiring, and I was informed right away by the person that I was dealing with at [Location B] that I wasn't entitled to that anymore because they had changed the regulations. (Participant 38)

In some circumstances, transition staff were able to make the participants aware of the changes, so they were able to adapt their plans relatively easily. Some participants who were still serving delayed their preparations for release in anticipation of new benefits that had been announced but were unsure if they qualified to receive them.

Needing to seek out information was difficult for many participants. It was often the case that self-research was required to determine what benefits and services were applicable to them. One participant describes this in the following quote:

> Again, you have to do your own research and nothing's handed to you. And I don't expect anything to be handed to you, but a little push towards stuff that I should be qualified for, she should be able to tell me about it, I think. (Participant 11)

Conversely, participants who had experience as higher ranks in the chain of command and had previously assisted subordinates in navigating the medical MCT process believed they were more prepared for release. These participants knew what benefits were available to them, how to access them, and how to complete the required administration. An example of this is illustrated in the following quote:

> So I was in a privileged position that I knew the system and I knew how to make it work, which always concerns me because, you know, I'm a major and I know the system. What about the corporal or the master corporal or the lieutenant who doesn't know the system and doesn't have anybody to call? (Participant 28)

Veteran spouses were also sometimes helpful sources of information for participants if they had previously navigated a medical MCT process or had access to capable transition staff. Other informal supports such as peers and social media sites were also identified as being an important source for information. Participant 47 stated: "So we, again, heard through the grapevine about the program that was through and could've accessed through a doctor, but wasn't told about it." However, these supports sometimes provided outdated or irrelevant information which negatively affected some participants preparations and reduced their engagement with some informal supports.

Time/Timing

This sub-theme refers to the various ways time was a significant factor during the medical MCT process. The first challenge encountered in this sub-theme is the duration participants had on the military side of the transition process. Some participants stated they had sufficient time to prepare and plan for their release as captured in the following quote:

> And as an [profession], I was also aware of the fact that there are issues associated with transition that I needed to take care of. So, calling my release is medical, I was also nearing the end of my career, so I actually wound up trying to align everything so my medical career, or my medical release, would happen only after I had attained my 35 years of service so that I would get the full pension. So I was trying to make sure things aligned so I would get the maximum in terms of my postretirement income. I had also, for many years, planned to retire, retire, when I hit 35 years. It's actually at my rank level, my years of service, it's a good enough salary that I can have lived on it. (Participant 33)

However, most of the participants felt they were restricted by either too little time to prepare, or not enough opportunity to effectively utilize the time they had left, as described in the following quote:

> And I even asked JPSU – oh, yes, I remember this now – I even asked JPSU I think two months prior to my release, I was like listen like, you know, can I get, you know, like a few weeks off so I can like do some of the stuff? And they were like, oh well if you have an appointment, you know, like they'll be able to accommodate that. And I said, okay, well it's not always an appointment; it's just like I want to be able to go on the computer and like research some things. I want to be able to, because if you're working full time you can't prepare for a lot of things. (Participant 10)

Additional to the time and opportunity needed for the MCT process, was the timing of benefit accessibility. One important benefit for many of the participants was the Veteran's Independence Program (VIP; Veterans Affairs Canada, 2021). This benefit may be allocated to assist a veteran in housework, lawn maintenance, snow removal, and other laborious activities that an injured veteran may require help with to remain living at home (Veterans Affairs Canada,

2021). The VIP benefit was important in helping veterans conserve and utilize personal resources for other important aspects of their MCT. Participant 18 stated “Yeah. Oh yeah, it’s been good. I mean I wouldn’t be able to manage without it.” However, it was often mentioned that VIP could not be accessed until the member was fully released from the military. Participants shared that the military does offer a similar benefit, however almost none were able to access it.

Benefit delays also caused significant difficulties for some participants. Specifically, long-term disability benefits took up to nine months to arrive for some participants which led to long periods with no financial support. Being required to financially prepare for these benefits and any potential delays led to feelings of uncertainty for the future. The following participant noted:

> I think the worst part, and now I’m thinking like when you were saying what’s the most challenging part? It was not being paid for eight months. That was the most challenging part of the whole transition is not having funds while you’re going through all of this. (Participant 23)

Planning around the accessibility and implementation of the many benefits also caused significant stress for the participants. Systemic policies are in place and outline when members have access to the many different transition supports, such as some employment programs. In other words, the ability to utilize some benefits was contingent on receiving others which significantly impacted participants’ ability to plan and prepare for release, this is highlighted in the following quote:

> Regulatory priority isn't as great, but it's still better than nothing. But neither one of them are you allowed to use until you're actually out. So, and I'm not sure where I want to live.

> I'm actually deciding that I'm going to live wherever I get a job, but I can't use priority hire to get a job until I'm already out. (Participant 6)

The pre-set time for benefit usage that applied to education upgrading was also identified by participants as particularly challenging. Participants stated they were only allotted two-years of education upgrading upon release which was too short to achieve future employment goals. Some participants further expressed that the time requirements to access educational upgrading benefits constrained their ability to focus on attending treatments and improve their health. This is illustrated in the following quote:

> My only issue, and it was part of the reason why I felt like I had to rush to make a decision about a second career, is that SISIP is very clear on the, like, you only have two years, for... you know, for education. So, I don't know, it just feels really rushed, like, you're being pushed into making a decision, on top of the dealing with, like, health and stuff. (Participant 29)

While some of the participants had received previous education, many noted that their education was significantly out of date, never been practically used during their career, or had no relevance to civilian fields of employment.

Challenges associated with strict timelines applied to other benefits and resources as well. Participants' ability to manage their injuries and meet the requirements and expectations of the MCT process was inhibited by the absence of capacity to address their health challenges while in service. The following quote depicts this experience:

> And there's not ... it's not set up to do any of those things, and the military is not set up to allow people to heal period. It never has been. And then I don't think I ever really got the chance to heal before I was making decisions about my career, and then trying to do voc

> rehab, because there's timelines for all these activities that you ... by this time, if you haven't made a decision, then you lose it. By this time, by this time, so I already knew that it would be a long time that I would need to heal. (Participant 13)

Some participants felt some of the problems they had through their transition would have been mitigated if they had access to transition staff such as VAC and SISIP earlier in the MCT process as described in the following quote:

> Yeah, I think that (inaudible) VAC relating to figuring out their timelines for getting these… for getting the compensation packages sorted out because they knew well in advance that I was releasing and what held everything up was that I hadn't received my release message. So I think that the process should be able to start once the member has received… like in my case, it's a three step process, so there's your message saying that you're on a permanent category, and then there's a second message that comes back and says that now you've breached your universality of service. Once you've breached your universality of service, you're gone – you're out of the CM and you're on your way out. The process is now starting. Once you receive that change in your medical (inaudible) limitations, that's when VAC and SISIP should start their process. (Participant 45)

Theme 2: Intersectional Position Considerations for Benefit Effectiveness

The theme *Intersectional Position Considerations for Benefit Effectiveness* comprises of two sub-themes: *Social Living Arrangement* and *Service-Related Factors.* This theme captures various advantages and disadvantages participants had with accessing or receiving various benefits based on individual personal or service-related factor differences. These differences include the available healthy members of a participant's household, the member's rank, or the member's trade. While some differences related to factors concerning gender and language were

noted during data analysis, the amount of information provided by participants was limited and will be addressed in the discussion chapter of this report.

Social Living Arrangement

A significant number of living arrangement concerns were expressed by participants during this project. While some of them related to both, perceived disability severity and if the member lived with another able-bodied adult, a disservice would have been done to separate the two as significant disability challenges added additional stress onto the home unit.

Many participants described how the burden of their care was placed on other adults living in the same residence. While families or roommates were expected to help manage the care of injured veterans, the benefits specifically directed towards helping them to do so were limited, as described in the following quote:

> And I'm, like, I now see how people commit suicide, especially because this is so taxing on the family already. They already have their own personal issues with seeing me and experiencing me die twice, that no ... there's never been any help for them. You know, it's only until recently that I've been fighting for that. And then, yeah, at this case I had VAC look at me when I asked why I couldn't have an OT, because I can get massage, chiro, everything else. I'm like, okay, take that money and pay for my occupational therapist, like. Why is this an issue? Like, you aren't giving me a logical explanation. They told me that they have a lot of people with brain injury and that it's the family's responsibility to manage my care… Nobody ever tested them to see if they were equipped to do my care. Nobody ever helped them, gave them any guidance, instructions or anything else, or even told them up until this moment that that was going to be their responsibility. (Participant 34)

Adults who lived with an injured veteran while they were still in service were also expected to pick up the additional home duties, as highlighted by the following participant:

> That was exactly what I was told – that, if there's somebody – and it doesn't have to be a spouse either, so if you live in an apartment and you have a roommate – they are now expected to do everything for you. Um, because they're fit. And that kind of… there are a lot of issues with that. So my immediate answer – cause I was little bit ticked off about their answer – was that okay, so when my spouse divorces me because of on top of all the other physical, emotional crap that we're going through, now she also has to do all the lawn maintenance, all of the snow removal, all of the house upkeep, renovations – it's just… it's absurd. (Participant 47)

This was identified as problematic by participants as the additional workload became a significant source of stress on their roommates or partners. Some spouses left the workforce due to developing an injury or becoming overwhelmed from caring for, or taking on additional home responsibilities typically completed by the serving member.

Service-Related Factors

This sub-theme describes the various service-related factors that were perceived to help or hinder participants' engagement with their medical MCT. The first of these factors was the participant's trade. Participants who self-identified serving in combat arms trades stated they felt there were less employment options available to them after service due to the lack of transferable skills or physical ability. While employment-related transition programs exist and were sometimes identified as helpful, they offered limited to no perceived options for participants with medical limitations, as highlighted by the following quote:

> So we went to the Canada Company thing, it was just after MET was first created. For us, specifically, I'm being medically released for a physical thing and I only have a high school diploma, it was of no value whatsoever. It, I could see that it could be… it could be very good for other people, but um… but we are not the target audience for that – like for combat arms with medical or physical conditions – it's just… the only jobs that I qualify there was construction company, and I can't do that. (Participant 47)

Some participants in trades with specific skills were also prevented from utilizing or upgrading their skills by transition staff:

> But again, I went to see an assistant coordinator, and I said, "I would like to take training to be an electrician." Since my background is electronics, you know, I'd like to do that. He said "No, I wouldn't support, I won't support anything like that." Why not? "Well you totally won't be able to get a job." That's what he told me. (Participant 39)

Participants' rank at release or amount of time served was another factor found to influence a member's experience with employment-related transition programs. These programs were sometimes perceived to only offer highly specialized jobs, or blue-collar type job opportunities which were not desirable to members of higher ranks who were more accustomed to leadership roles or receiving a higher living wage. Even for public-service sector transfers, older members who had nearly reached a full military pension, were forced to work longer to access their full public service retirement benefits as described by this participant:

> And, but then I'm also missing, you know, seven years of pension that I won't get until I'm 65, from the public service, right? So that means I have to work all the way to 65, or I have to work to 55 and then take a penalty and then be affected by that. So, I think that for people who are medically released and moved to public service, we should be able to

> draw our penalty... our pension; our public service pension with the military, at our 50... at our 35 years of service without being penalized. (Participant 27)

Theme 3: Health-Related Limitations

The theme *Health-Related Limitations* contains two sub-themes: *Limitations on Health Improvement Autonomy* and *Health Limitations on Transition Engagement.* Broadly, this theme captures the unique challenges to personal control or autonomy that were encountered in relation to the participants' health situations.

Limitations on Health Improvement Autonomy

The sub-theme *Limitations on Health Improvement Autonomy* highlights the numerous ways in which personal control over participant injury management was compromised. Many participants described encountering various barriers from within the military institution when trying to improve their own health, such as: indifference to health challenges and physical limitations by chain of command, blocked posting requests, lost paperwork, and untimely administration processing at the unit level. One participant described how part of their health plan was able to be overridden by their chain of command:

> Because they don't go with what the member needs. They go with what they want, so. If the member needs to only work three days a week and the member feels that the three days a week, it would be better to work Monday, Tuesday and Thursday, well that's not… they don't… that's wrong. You have to work Monday, Wednesday, Friday. Why? Because if I need like four days in between my workweek because I need that rest, they come back and say, well it's better for you to do it this way. Your chain of command are not your medical staff and they're not your medical… They have no right to do that. And they come back and say that it's policy, so. (Participant 19)

Accessing certain pain-relieving medications like cannabis was beneficial to several participants. However, some participants shared difficulties or concerns accessing cannabis, as they were informed there would be negative consequences to their transition process and ability to access certain benefits, as highlighted in the following quote:

> So he said if you were prescribed medicinal marijuana you can… basically, you can't be a soldier anymore because you'll be on this medication, so you can't be trusted with weapons, you can't drive vehicles, and that puts you in breach of universality of service. Um… so, he said if you go on this, you will be medically released. Um… but like I said, that's a year and a half ago. And I don't understand how I can take codeine, anti-seizure medication, antidepressants, and all this batch, um, and not be restricted on driving vehicles, but if I take CBD um, I am restricted? (Participant 47)

Other participants stated that health treatments overall were inflexible and limited options were offered to them. One participant stated they were penalized for not following through with a directed medication they were uncomfortable taking:

> So I wouldn't take it. So that wasn't positive. I had a follow-up appointment with him about, probably a month later, and I went in to see him. I simply sat down. He looked at me and he said, so how are you making out with your medication? And I said, I didn't fill the prescription because I said I did some reading into it and discovered that it's not for me. And he said, well, he says, then I don't have anything else for you. (Participant 38)

Some participants had been unsuccessful in accessing certain therapies altogether due to long wait times or limitations on referrals such as was the case with Participant 46, who had been "asking for a year to do the pain clinic."

Health Limitations on Transition Engagement

This sub-theme describes the limitations a participant's health condition put on their coping strategies, well-being, and ability to engage with the MCT process. The most significant limitation injuries had on coping strategies was the limited ability participants had to engage in typical physical activities to reduce stress. Participant 19 stated "Because of the stress and the pain. I can't do the things I used to do and I don't want to do things that I used to do and I'm… frustrated."

Participants also described the impact their injuries had on their social lives. Being exhausted from balancing work and pain, not having the emotional or cognitive resources to socialize, and being prevented to keep up on previously enjoyed activities with social supports were common sentiments across many of the participants. One participant shared:

> I had a three-year-old daughter at the time and she couldn't understand that I couldn't play with her all that much so it was a little complicated for her at the time, but she got over it. With my family, no, that was alright. But with my friends yeah it was a bit more. In the military it is like one big family and we are always doing stuff. Since I could not follow my friends in their activities I lost contact with them quite easily, at least with a lot of them. A few of them stayed true friends but most of them carried on with their lives, I guess. (Participant 50)

Another impact injuries had on participants was their ability to engage with upgrading activities throughout the MCT process. Some participants expressed needing to take time off to recover from doing necessary tasks associated with homelife, the transition process, or education. The following quote describes one participants' struggle:

> Yeah, so, yeah, so I can't... I can't do it. So I can't walk for a long time, and I can't sit for a long time, and I can't drive for a long time, so though I love travel, I can't really travel or I just have... so when I first got out of the military I flew to [Location] for a graduation for my Master's degree and when I arrived there my knee from the flight started to swell. By the time I got back I just couldn't walk for three weeks, it was so swollen I didn't know what to do. The swelling would not go... it was... and painful, and it was horrendous. Then you just can't do anything. That's why I'm afraid to do... so if I went to the mall and I wanted to walk around for an hour, then I have to rest for, like, two days. So I'm not ever going to go to the mall and walk around. (Participant 49)

Limitations to upgrading during the MCT were not only affected by specific injuries, but also by the interpretation of those injuries by transition staff. This experience is thoroughly described in the following quote:

> So I'm in the process right now. I actually just accepted an offer of admission um, but, unfortunately VAC hasn't gotten back to me in time to let me know if they support that endeavour or not. So, my deadline was today, so I decided accept the admission today anyway. Like I don't want to give it up like if they say yup, and if they say no, then I can just decline it. But um, the only complaint I have right now about the process I'm going on right now with the rehab program is that there's this, um, third party company that has been hired by VAC to assess people and their abilities. And I'm not a big fan of it. I've been through it twice now. There's certainly an application for it, um, there's an aptitude test, um, and a physical test, and a couple of other small things that you have to do, but I really don't think that that paints a good picture for everybody. Um, like my biggest thing right now is being diagnosed with PTSD back in January. Um, all of these things are

> called into question about whether I have the capacity to take a four-year degree program, and I was like okay. Like, I've had PTSD then, by your logic, for the past 10 years and I've been a complete functioning human being and I've been able to chase, y'know college diplomas and certificates and stuff without an issue. And now just because I have a diagnosis, all of a sudden that changes everything – which I'm not a big fan of. And I don't like being told I can't do something, um, especially if somebody doesn't know me very well. Like I really don't think that y'know numbers on a piece of paper tells anybody anything about me. So that's my biggest qualm right now with this process. I'm fully capable of doing a four-year business degree, it's just having somebody to determine the rest of my life based off of some numbers is just not uh, not applicable I think. (Participant 26)

Theme 4: Sociocultural Disruptions

The theme *Sociocultural Disruptions* encompasses the social changes and cultural challenges and facilitators that participants described about leaving the military involuntarily and entering into what was seen as a different culture with little preparation.

Military Loss

The sub-theme *Military Loss* describes the difficulty participants experienced with their departure from the military environment and the perceived abandonment because of their medical situation. Some participants reported being pushed out of their home unit to make room for others as captured in the following quote:

> Yeah, they weren't supportive at all because they had some posting slots they wanted to fill so it wasn't convenient for them that I was going through a medical release and I was

> going to affect their optimization of their posting. They have a plan on where people are at. (Participant 32)

Leaving a home unit was particularly difficult when expected military departure rituals were not conducted for the member as the following participant describes:

> But I kind of got left hang out to dry. I didn't get my close of valour, I didn't get any recognition, there was no… usually there's a closing ceremony and you get a certificate of service, your regiment recognizes you, and there's a luncheon and stuff like that, it was just kind of like I dropped off the face of the Earth, in that regard. (Participant 26)

Feelings of abandonment and betrayal by both the chain of command and the institution were common among participants as they felt they were being punished for no fault of their own. One participant shared the following:

> And on my release appointments, my final day of service in the military, it just felt like you were discarded and, you know, it just like, okay, bye. So it was very disheartening and depressing, because you're just thrown away like a piece of garbage in the end, you know. (Participant 29)

The loss of day-to-day support from colleagues and the military collectivist culture was difficult for many participants to accept and led to increased feelings of loneliness, as the following quote captures:

> Well you go from having, you know, you're built up that you're a team, and you work together as a team. In the Army that's what it's all about. And, you know, I was… I had great positions in the Army. Like I worked well. And all of a sudden that's it. Like you're just… you're out there by yourself, and that part I found really difficult. (Participant 18)

Some participants shared that leaving the military environment or not engaging with other veterans facilitated improvements to their well-being. Participant 15 stated: “My stress after I got out of the military went from about 100 down to about a five. I really started losing weight as soon as I got out of the uniform because I didn’t have any stress.” Associating with other veterans or veteran programs was contrasting between participants. Some participants shared that connecting with other veterans was helpful for accessing resources and feeling supported. However, it was sometimes difficult to find veteran peers, as described in the following quote:

> Other than, like, that’s a... finding those peer groups around the area that I’m in, again, [Location B] , it’s hard to find peers that you can relate to, like a Legion, except when you go to the Legion here it’s all civilians. So, like, old civilians that have never been in the military and had nothing to do with it, but those, some of the things that I’ve looked for that I haven’t been able to find. (Participant 44)

Other participants avoided other veterans as to not aggravate their health challenges or would not participate in social events if they were on a military base as the environment was perceived as detrimental to their well-being. This is captured in the following quote:

> And I don't want to go on base, because it is a stress for me. You know, I was volunteering with the swim team on base, but they caused me so much stress, I had to walk away from that. So I do do some things, but it really is away from the military. (Participant 16).

Reintegration Conflict

Working and interacting with civilians after release was often described as challenging for participants who had transitioned into the civilian work force. Participants described having

difficulty adjusting to the individualism typically seen in civilian workplaces. This is described in the following quote:

> Where, when you leave the military mindset and you get into the civilian mindset, the civilian mindset is totally different. They do what they want to do and, where we're team players, a lot of it is individuals out in the civilian world. So that was the hardest par... it's still the hardest part for me, because I'm still working and I'm still every so often I'm butting heads with people to say, "Hey, that's, you know, it's not that difficult to get it done, just get it done." But they don't take direction like you would in the military, right? (Participant 12)

Civilian norms and behaviours in the workplace presented significant challenges to coping strategies for one participant:

> From a personal point of view I would say it's quite a challenge to deal with the behaviour that the civilian world has compared to the military. I did try a short trip to the civilian side to work in a shop as the director of operations there. The mindset of the people there I could not comprehend and I didn't last long. After a month I saw that it wasn't for me to interact with that kind of environment. (Participant 50)

Additionally, one high ranking participant described having difficulty adjusting to differences in ethical principles displayed by their civilian employer. This is presented in the following quote:

> Right, so that whole – the way they apply the ethics and the way that they deal with the civilian side, it's a lot more loose than the military side. So, for me, that transition to going from being on a tight path, to this loose kind of system; that kind of ebbs and flows on depending who's your boss. It has a lot more room for interpretation, I guess. Is a...

> it's something I totally not prepared… to go through, when I transitioned over. (Participant 27)

Another participant further addressed lack of preparation for civilian socialization by expressing a desire for specific training to unlearn the collectivist principles enforced throughout military service:

> So I think there's room for retraining, like, it's hard to say they're not professional in that area but like, there's room for helping people like, when we're in Basic we were all set up and they kind of, they kind of put you under a stress-induced environments and everything else, and reprogrammed you from the civilian mind thought process to more team-orientated sacrifice, self-sacrifice, et cetera, orientated mindset. And I think there's room to take some of that back out of you through mental health programs or whatever else. (Participant 44)

Some participants did experience facilitators during their reintegration into the civilian workforce. Facilitators included feeling supported by their work environment and having accommodations respected by civilian workplaces. Autonomy in the work environment was also a facilitator for some employed participants, as illustrated in the following quote:

> So, if I can control the environment I work in, you know, and the tempo, and the amount of stress, these are all variables that not everybody can always control. So far, I've been afforded a position where I have some autonomy where I can, like, I'm the boss. So I can shape my day better than if I had to work for a company where I'm reporting to someone that has different expectations on how they want me to be working out my day. So it's very subjective. I think if I had to work directly for someone, on a constant basis, that'd be very hard. I'd… yeah. You know, you have good working relationships, and you

> have bad ones, depending on how things go. And if I have a bad working one, I'd probably already be unemployed. Saying I can't, because the stress is triggering too many migraines. (Participant 32)

Positive social experiences in activities outside of the military facilitated integration for participants. Being valued within meaningful employment or volunteering jobs was important for participants to help facilitate improvements to their health and well-being. The following quote supports these finding:

> The job, my belonging to something, being valued for what I'm doing; not sitting at home all day, every day, forever. It made a difference. I mean, it sounds great: get a job, get out, and have fun, but part of the illness is not wanting to get out and do anything, so, you are kind of stuck. I was just very lucky that this is a friend I have known for 40 years actually, hired me on and made me a partner. So, I'm actually doing very well. (Participant 14)

Chapter 5: Discussion and Conclusion

The primary purpose of this study was to understand the barriers and facilitators that impacted military personnel who were either engaged in the medical release process or had completed one recently. Forty participant transcripts were analyzed using thematic analysis; four themes and nine sub-themes were identified. The first theme summarizes the influence of systemic policies and procedures on participants' ability to access needed resources and benefits for their medical MCT. The second theme highlights the unique challenges participants experienced with benefit effectiveness due to personal characteristics and circumstances. Theme three describes the specific challenges to personal control that were directly attributed to a participant's health condition. Finally, theme four explores the social loss of the military network participants experienced and the cultural aspects that emerged for those who moved into or attempted civilian employment.

Despite individual variation in number and intensity of issues, overall, the findings of this study indicate that the medical MCT process had challenging aspects for every participant. Most challenges were attributed to the earlier stages of the medical MCT, including pre-release, and immediately after release. Most facilitators and barriers described by participants were attributed to systemic problems with policy or programs that impacted ability to prepare. For example, experience with the process beforehand, such as in the cases of those who had been involved with subordinates' transition processes, resulted in fewer perceived challenges with the MCT process. However, members with less experience relied more on the transition staff assigned to them to help navigate the many benefits and programs designed to support injured veterans.

The following section will discuss how the findings of this study converge with the seven domains of well-being outlined in the transition framework articulated by Veterans Affairs

Canada (Thompson et al., 2016a). I will then discuss the strengths and limitations of this study, followed by program, research, and policy recommendations based on the barriers and facilitators identified by participants.

Situating the Findings Within the Domains of Well-being

The well-being framework described on the National Defence transition website (2022b) communicates that MCT can be a "positive or negative" experience for members. However, the findings from this study suggest that it is more likely that the medical MCT is an experience with both positive *and* negative aspects, with some members likely to encounter challenges in some domains of well-being more than others.

Employment or Other Meaningful Activity

Civilian work environments that were supportive and could accommodate participant injuries were identified as facilitating job satisfaction and happiness. Having meaningful employment contributed to improvements in the social integration and financial domains of well-being. However, these benefits are not solely related to paid employment. Participants who engaged in volunteering also felt it gave them purpose in life, highlighting the interconnectedness of meaningful activity and social integration. Research in other populations has found that experiencing autonomy and beneficence are critical factors contributing to employment being perceived as meaningful (Bailey et al., 2018; Martela et al., 2021). While the term *meaningful* is subjective, achieving it in one's work can lead to positive well-being (Bailey et al., 2018). Participants in this study who were unable to derive meaning and purpose from employment or lack thereof sometimes struggled with their self-esteem and well-being.

Some participants were limited in attaining employment or meaningful activity due to their health challenges or restrictions placed on them by benefit limitations or transition staff. In

a US study, researchers found that being prepared and having autonomy over post-service employment contributed to motivation in gaining future employment and increasing the meaning and purpose attained from their civilian work (Keeling, 2018). Some transition staff members outside medical professionals were reported to have the authority to deny desired education upgrading for participants in this study. Participants attributed this to stigma towards their injury and personal capabilities, which negatively impacted the perceptions members had of transition staff.

The strict policy allowing for only two years for education upgrading after release also presented challenges for participants, as the transferability of skills was highlighted as a barrier to accessing meaningful future employment. This policy was especially problematic for participants who could no longer use the skills they developed during service because of their health limitations. Participants whose previous educational attainment was military-specific or significantly outdated felt the restricted education policy limited their ability to obtain meaningful employment and achieve the financial level they had while in the military. Members in all ranks from combat trades were particularly impacted by the limitations of skill transferability. Investigations into the correlates of transition challenges for CAF members often prioritizes element of service (army, navy, air), which fails to capture significant differences between the trades (McCuaig Edge et al., 2022; Rose et al., 2018; Sweet et al., 2020). American research has found that some military jobs have clear civilian counterparts, however, there is a dearth of literature concerning the specific knowledge, skills, and abilities (KSAs) of military-specific trades (Gonzalez & Simpson, 2021). A lack of understanding and consensus of trade-specific KSAs in empirical findings limits business organizations from fully exploring the

potential advantages of hiring veterans with different backgrounds. Further, the narrow understanding of KSAs thwarts efforts to address barriers for different groups of veterans.

Managing employment expectations was identified as a barrier for some participants. It was sometimes the case that participants' plans to seek employment were challenged as during the early stages of the medical MCT process they were led to believe that veterans were desirable by many civilian employers. This messaging led to frustration for some participants when they had difficulty securing jobs in the civilian workforce, as they were sometimes no longer able to access some time-gated upgrading benefits. Other research has found that similar veteran employability messaging sometimes results in veterans reducing their effort into developing a competitive resume as they can develop a sense of entitlement (Mael et al., 2022).

Finances

In line with other CAF transition research, financial security was a primary concern for many participants, especially those early in the medical MCT process where uncertainty was more prevalent (Lee et al., 2020). Medically released CAF members experience the greatest drop in post-release income when compared to members who reach retirement age, complete service, or leave voluntarily (Poirier et al., 2021).

The delayed receipt of disability payments was of significant concern as not all participants were able to prepare financially before ending service. Preparations were often challenged by time limitations, complexities in the administration process, unforeseen circumstances, or high financial commitments. The delay of payments meant some participants had to adjust educational or employment plans, miss bill payments, reduce household spending on items like food and other necessities, or accrue a significant amount of debt. Medically

released veterans make less money than they did while serving which may increase the time it takes to financially recover from payment delays (Poirier et al., 2021).

Participants who were not financially secure or were concerned about future financial stability during their pre-release phases, sometimes made major decisions that negatively impacted entitled benefit access due to policy limitations. This sometimes led to missed opportunities for meaningful employment or educational activities post-release. Moreover, financial uncertainty and policy limitations on benefit usage motivated some participants to focus on employment or education upgrading. The sense of urgency, which was partially rooted in fear, reduced engagement in treatments and improvement of their health, ultimately leading to increased problems in the health, social, and cultural domains of well-being. Empirical literature has demonstrated that increased generalized fear can lead to maladaptive avoidance in decision making (Hunt et al., 2019). Other findings on American veterans suggest that veterans with high rates of anxiety are more likely to avoid ambiguous outcomes (Ruderman et al., 2017). Feelings of financial uncertainty in some medically releasing personnel may affect their decision-making ability to plan for the future, resulting in poorer outcomes post-release.

Participants who were close to retirement or reached maximum service were more comfortable with their financial security. This aligns with general CAF veteran data that found members who release closer to retirement age or end of service earn more than those who release earlier in their career (Poirier et al., 2021). Having more knowledge and experience from guiding subordinates through a medical MCT was expressed as a significant facilitator in knowing how to navigate the complexities of the medical MCT system and access financial benefits. Some participants with less experience identified that knowledgeable transition staff were a significant facilitator for accessing critical information and financial benefits, allowing them to achieve

financial stability after release. Another explanation for this finding is that disability benefits often reflect the amount of time the member has served and has been identified as being inequitable for younger and lower ranking members who are medically released (Office of the Veterans Ombudsman, 2020).

Having a spouse who experienced a medical MCT was a facilitating factor in this domain. Spouses not only had experience but sometimes had transition staff that were more knowledgeable and could relay beneficial information for each partner. Spouse employability was also a facilitating factor for financial well-being. However, spousal income is often significantly lower when compared to veteran income (Poirier et al., 2021). Healthy financial situations facilitated extra support for home maintenance and upgrade additions to participants' homes to accommodate their injuries better. The increased support and accommodations facilitated improvements to participants' well-being as they had more personal resources to address needs in other domains. Financial security also facilitated ability to pursue hobbies and interests outside of the military and complementary to their medical limitations.

Health

Several barriers and facilitators affecting this domain were identified to have extensive impacts on well-being. Proper diagnoses, autonomy in medical decisions and treatments, and the opportunity to fully engage with treatments were significant facilitators in this category. When immediate health needs were appropriately met, participants could better engage with the MCT process and focus on improving financial, meaningful activity, social, and preparedness domains of well-being. Examples include increased motivation to find employment or other meaningful activities, seeking upgraded education, improvements to family relationships, and completion of medical MCT administration tasks.

During the earlier stages of the MCT process, access to medical staff was difficult for some participants due to the limited number of medical professionals on bases or long wait times. Moreover, conflict with physicians, lack of communication or consensus between medical professionals, and delays or incorrect diagnoses also negatively impacted participants' health by increasing negative symptomology. Increased negative symptomology was noted by some participants as having a cyclical relationship with other domains of well-being; worsening symptoms would make engaging with the transition process more difficult and vice-versa. Difficult to manage symptoms often resulted in reduced ability to prepare for post-release and contributed to additional stress in the home. Similar findings on the impacts of health distress have been highlighted by other researchers (Kithulegoda et al., 2021; Skomorovsky et al., 2020). Restriction in autonomy regarding health treatments led to some participants becoming less trustful of medical staff. This in turn led some participants to wait until after release to obtain diagnoses or engage with desired treatments. Kithulegoda et al. (2021) noted that some Canadian veterans like to have an active involvement in their health improvements and prefer more holistic approaches to treatment instead of overly relying on pain medications.

Establishing continuity of care was a notable challenge for most participants. Veterans who undergo a medical release have health challenges that impact various aspects of their life (Rose et al., 2018; Thompson et al., 2014). Canadian veterans are also more likely to develop additional chronic health conditions over time (Sweet et al., 2020). The lack of availability of family doctors throughout Canada was identified as a barrier to health improvement and medication access after release. Having civilian family members who were geographically close facilitated medical access to civilian health professionals and treatment. Some participants had to travel long distances or were required to live in a specific area to access health care, which

sometimes negatively impacted their ability to find meaningful employment, sustain financial security, or access desired social and caregiving support.

Life Skills and Preparedness

Preparing for life after release before becoming injured and having knowledgeable transition staff were facilitators for post-release transition success. Sufficient time and opportunity for preparation meant participants could secure their finances, plan for their future, and have fewer burdens while pursuing health improvements. Experience with medical MCTs or having skillful transition staff to advocate for participants also eased the administrative burden associated with the process, resulting in less difficulty with uncertainty and higher well-being for many participants.

Accessing transition programs and supports was a facilitator for some participants. However, participants were rarely aware of all programs and resources, and many found programs varied in usefulness for their specific situations or needs. These barriers limited the effectiveness that programs could provide in facilitating improvements to different domains of well-being. Some participants in this study noted that some programs and services appeared unhelpful for their demographic, while a few were even considered “harmful.” Reviews conducted by Eichler et al. (2021) and Tam-Seto and Dussault, (2022) found that programs targeted towards women were primarily focused on the domains of employment or other meaningful activity and health. Eichler et al. (2021) reported that many existing programs have been built using research from other countries and may not reflect the diverse needs of Canadians. The previous findings align with challenges described by participants with minority genders and language speaking abilities in this study. Furthermore, language used to communicate benefit policies was also a barrier as documents meant to be helpful were

sometimes written at a level that exceeded the understanding of participants. Inability to understand technical administrative processes significantly impaired some participants' ability to access benefits and resources.

Recent efforts have begun to address language communication barriers. For example, an online standardized version of the SCAN seminar has been created so veterans and their support networks can easily access information at their own convenience (National Defence, 2020). Information provided by the online SCAN resource is organized into several short videos on significant topics pertaining to the MCT. Video topics cover general information related to programs and provides contact information so soldiers and veterans may inquire about programs and services most relevant to their needs. The online SCAN videos also break down acronyms used and presents information clearly to minimize confusion and encourage comprehension.

Most participants highlighted the need to "do your own research." Benefits offered to veterans were often overwhelming as they were both overly technical and numerous. It was often difficult for participants to determine what applied to their individual specific situations and what did not. The Veterans Affairs Canada website alone currently offers 178 benefits for veterans to apply to, which led to a significant amount of confusion for some participants (Veterans Affairs Canada, 2019). While it has been noted that the addition of new benefits was intended to improve the lives of veterans, recent findings suggest they have had the opposite effect (Office of the Veterans Ombudsman, 2020). Some participants with less engaged transition staff were told to apply for all the benefits that might apply to their situation. This strategy led to long wait times, limited ability to plan for release, increased uncertainty about future financial security, rejections, or not engaging with the system altogether. Transition staff who were able to direct

members to specific benefits and information, or who were able to assist with administration requirements, were perceived to significantly facilitate MCT success.

Social Integration

Connecting to other veterans with similar experiences and making new civilian friends facilitated improvements in the social integration domain of well-being. Some participants engaged in both formal and informal support programs which helped them build communities outside of the military. Spouses and pets were also identified as strong social supports for many participants in this study. Additionally, undergoing couples counselling and learning to better communicate was identified as an important facilitator for improving the social relationship between participants and their spouses.

Diminished health sometimes increased the burden of care on spouses and family members, as they were expected to become the participants' primary caretaker after injury. Due to the timing at which certain benefits could be accessed or persons living in the household, participants sometimes did not qualify to receive financial support for home responsibilities such as shovelling snow, lawn mowing, cleaning, and food preparation. One participant shared how their spouse had become seriously injured while completing routine home maintenance they were not used to doing. Increased burden of care has been found to increase daily stress experienced by spouses of injured CAF members leading to tension in relationships (Cramm et al., 2020; Lee et al., 2023; Skomorovsky et al., 2020). However, some participants in this study said the challenges they faced made their relationship stronger. Participants whose spouses had undergone a medical MCT themselves highlighted they had an easier time navigating the MCT due to their spouse’s knowledge and support.

Much of the transition research highlights the importance of connecting veterans with other veterans after release and increasing post-release social circles (Black & Papile, 2010; Rose et al., 2018; Smith-MacDonald et al., 2020). It was often the case that participants in this study were unable to find other veterans in their geographical location due to the limited availability or accessibility of informal supports. Conversely, a few participants in this study highlighted that connecting to other veterans was sometimes detrimental to their well-being. These participants sometimes felt like their own healing progress was being hindered by others experiencing similar health problems. This led some participants to disconnect from veteran communities and focus on their own health improvement.

Another barrier in this domain of well-being was the external pressures and heavy demands placed onto participants while navigating a medical MCT. Juggling treatments while working, upgrading education, attending appointments with transitions staff, and dealing with administration left many participants feeling exhausted or overwhelmed, which consequently left them with reduced capabilities to engage with family and friends. Participants reported having compromised physical and mental capabilities due to their injuries. Managing the increased burden that comes with the medical MCT process meant personal resources had to be prioritized, with social engagements usually being let go first. Ogrodniczuk et al. (2021) found that the majority of veterans attending post-secondary education reported feelings of exhaustion, being overwhelmed, and social isolation at similar rates to non-military students. However, differences between medically versus voluntarily released veterans were not explored. It seems likely the additional challenge of balancing health-difficulties with education upgrading and employment responsibilities places an unequitable burden on personnel navigating the medical MCT process, while also serving as a contributor to social isolation.

Housing and Physical Environment

Perceived facilitators and barriers to this domain of well-being were limited in this study's findings. Finding housing near social support, caregivers, and medical professionals was challenging for some participants. Additionally, some participants engaged in demanding medical MCT activities like educational upgrading found it difficult to plan and execute a move during that time. However, the two years given to access their moving benefits was perceived as reasonable and helpful by most participants.

Cultural and Social Environment

This domain encompasses how changes in sociocultural environments affect a veteran's well-being, often through challenges to their personal identity (Thompson et al., 2016a; Thompson et al., 2017). Coping with the significant differences in sociocultural norms between military and civilian workplaces was difficult for some participants in this study. Service within the Canadian military requires the development of a strict moral code, discipline in following orders, desensitization to aggression and violence, and an internalization of an *others before self* attitude (Smith MacDonald et al., 2020). To CAF soldiers, the needs of the group always come before the needs of the self. Behaviours, language, and mannerisms unique to the organization are also internalized. It has been suggested in literature that veterans need to reconcile past military beliefs and norms with new civilian ones to navigate a MCT successfully (Dolan et al., 2022; Lee et al., 2020; Thompson et al., 2017).

In line with other findings, civilian mindset, behaviour, work ethic, and integrity created frustrating situations for veterans as military norms and expectations were often in conflict with civilian ones (Smith-MacDonald et al., 2020). One participant shared that ethical differences with their civilian supervisor led to extended periods of conflict within the workplace and an

inability to develop healthy work relationships. Inability to reconcile the sociocultural differences negatively impacted some participants' well-being and motivation to seek further employment opportunities. These findings align with findings in American literature that negative views towards civilian society increases the difficulty of identity adjustment outside of the military (Orazem et al., 2017). Some participants highlighted they desired to see formal supports put in place so they could 're-learn' Canadian norms and expectations so they could better function in the workplace. Literature on American veteran KSAs have highlighted veterans' adaptability, mission orientation, discipline, work ethic, respect to authority, and decisiveness are valuable to and desired by civilian employers (Mael et al., 2022). However, these KSAs can also challenge developing healthy working relationships if veterans are not able to regulate these qualities as they can come off as being too rigid or impatient. The jargon and harsh language typically associated with military service is also often off-putting for civilian environments.

Findings in this study further suggest that changes in perceptions of the military environment while still in service can also negatively impact well-being in this domain. Abrupt events which occurred near, or at the end of service were perceived by some as abandonment and a betrayal for what participants had given to the institution. Some of these events include: (a) denial of the military ID card; (b) losing access to gym facilities on base; (c) being released before pensions were in place; (d) losing access to needed medical services; (e) poor treatment from leadership, and (f) leadership not confirming if they were ready to leave. Military betrayal has been identified as a *fracturing experience* and has been found to have significant negative impacts on an established military identity and well-being (Smith-MacDonald et al., 2020). A fractured experience can occur when one perceives a violation to social norms, values, and

morals and may result in re-examining one's perception of all that was accomplished during service and the perceptions of the institution itself (Smith-MacDonald et al., 2020). Similar experiences and reflections were described by some of the participants in this study, suggesting that a medical release may be perceived as a fracturing experience. While fracturing experiences have been identified during normal service, their presence has yet to be explored in relation to a medical MCT (Smith-MacDonald et al., 2020).

Conversely, some participants in this study perceived their medical MCT and exit from the military environment as a positive event. Some of these participants had experienced significant difficulties with their chain of command or peers, such as military sexual trauma (MST) prior to medically releasing, others realized after release that simply being in the environment was having a detrimental effect on their well-being. While leaving the military environment was perceived as a facilitator to improvements in well-being, the role of identity in relation to these experiences is unclear. Current understanding of military and veteran identity during MCT suggests not all members are impacted equally and challenges to identity may depend on a wide variety of factors which still require further exploration (Dolan et al., 2022; Thompson et al., 2017).

Comparison with DGMPRA's Findings

The medical MCT barriers identified from this study align with the original DGMPRA study findings published by Williams et al. (2021). However, while the barriers identified were similar between the two studies, final themes conceptualized participants' experiences differently. The differences in analysis and presentation of findings were expected as Hemming et al. (2021) highlighted that researchers from the examined population are likely to interact with data using language congruent with the population. Additionally, the original study's stated

purpose was to examine the stressors participants experienced during and after the medical MCT. Thus, their themes related to challenges and not facilitators, as was the case in the present study. The original study's findings distinguished stressor categories which were salient for participants in the different stages of the MCT process. The final themes presented by Williams et al. (2021) were: 1) Negative impact of illness and injury on well-being (throughout the process); 2) Stressors and challenges while releasing (while still serving), which consisted of stressors related to uncertainty, the transition process, and lack of readiness; and 3) Stressors and challenges post-release (after release from the military), which consisted of stress related to managing health, managing employment or vocational rehabilitation activities, financial benefits, and finding meaning and purpose. The findings presented in the current study further expand understandings of medical MCT barriers and facilitators by: (a) highlighting the role that systemic complexity played in the various barriers and facilitators were experienced by participants; (b) highlighting additional connections between the barriers and facilitators, as well as their effects on the domains of well-being; and (c) describing experiences during one phase of transition that had impacted experiences in another phase**.**

Strengths and Limitations

The similarities in findings with the original study conducted by DGMPRA imply trustworthiness and accuracy across both reports (Creswell & Poth, 2018). The difference in organization and language used in this report is likely attributable to the differences between research questions and further influenced by my experience with the medical MCT and serving as an NCM in the Canadian Army. Hemming et al.'s (2021) findings suggest this perspective may increase readability and relatability for other veterans and provide rich insights for other researchers.

An additional strength of this study is its large number of participants for a qualitative study. Recruiting this number of participants ensured that different personal and service-related factor needs could be explored. While it is true that no two transitions were alike, patterns of shared well-being facilitators and barriers were identified, and the various resulting experiences were described. It is important to note that other demographic data such as ethnicity, race, and sexual orientation were not provided and so it is uncertain if voices belonging to those demographics were included. Limited information regarding these demographics meant minimal findings relevant to specific sub-groups.

Utilizing the interviews conducted by DGMPRA was essential for minimizing my bias. However, I could not use my experience with the medical MCT process to ask specific follow-up questions to peculiar responses, potentially missing valuable information or clarifying contexts. A specific example of this was a caregiver pattern noticed between men and women with school-aged children. Men appeared to be more likely to report being removed from caregiving activities due to their health situation, whereas women appeared to be more focused on their family and household. While this could suggest differing experiences aligned along traditional gender roles which have been noted in other research, it was not possible to explore fully in this secondary analysis (Eichler, 2022).

Another limitation of this study was the lack of awareness or confusion surrounding benefit, program, and resource names by participants and interviewers. It was sometimes the case that participants would speak about their experience with one support when the interviewer was asking about a different one. The lack of follow-up clarification in this regard sometimes prevented the use of data for analysis. This highlights some of the confusion that was described by some participants regarding systemic changes.

Data for this study was collected in 2018. Changes to the transition process have occurred throughout the past decade (National Defence, 2019). New programs and services have been developed while others continue to be altered. Pilot programs have been implemented on some bases to test out new transition supports. Because of the previously listed factors, not all participants interviewed for this study experienced the same MCT process. Significant consulting was done with the CAF Transition Group in the early parts of this study to mitigate reporting on specific challenges that have been addressed through program and benefit changes. However, member checking with personnel currently navigating a medical MCT throughout this process helped ensure the themes identified in this study remain current issues for medically releasing members.

Implications and Recommendations

This study contributes to the understanding of the experience of navigating a medical MCT in the literature. The interconnected nature of facilitators and barriers in domains of well-being within this study's findings indicate the gaps in research, policy, benefits, and resources to consider and address.

Research

This study's findings regarding transition services and programs align with other reviews of programs offered to Canadian veterans (Eichler et al., 2021; Tam-Seto and Dussault, 2022). There were several instances where the individual needs of the participants were not being met due to demographic characteristics. More research is needed to better understand the unique challenges different Canadian military and veteran populations encounter. Further building empirical support in this regard will help inform policies and programs aimed at improving veteran well-being throughout the MCT.

Well-being domains were also affected by various barriers and facilitators to motivation and human needs concepts such as personal safety, security, autonomy, achievement, and personal growth. Little empirical evidence has explored the role these concepts have in relation to Canadian veteran well-being throughout the medical MCT. While well-being in academic literature has no one universally agreed upon definition, research exists supporting the inclusion of concepts relating to human motivation and needs satisfaction when investigating well-being (Nunes et al., 2023; Pincus, 2023; Simmons & Baldwin, 2021; Tang et al., 2019). Future investigations concerning well-being during the medical MCT should consider exploring how motivation and needs concepts contribute to each domain within the VAC framework for well-being.

Uncertainty was a common experience articulated by participants in this study that cut across several specific themes. Uncertainty was less of a concern for participants with skillful and supportive transition staff and those more prepared for life after release. There is some evidence to suggest that low levels of social and professional support and uncertain diagnoses can increase intolerance of uncertainty (IU) and negatively impact behaviour, cognition, and decision-making (Yang et al., 2021). Research in other military and veteran populations has identified correlations between mental health symptomology, suicidal ideation and behaviours, and IU (Hollingsworth et al., 2018; Zerach & Levi-Belz, 2019). Future research investigating the connections between the medical MCT process, IU, and health difficulties in releasing CAF members and veterans may help inform treatments and support for this population.

Policy, Benefits, and Resources

The findings in this study demonstrate discrepancies between the support that medically releasing veterans need and what they are receiving. A pressing problem for participants was the

inconsistency in support received between transition staff and programs. There exists a wide variety of formal and informal supports available to releasing soldiers and released veterans (Eichler et al., 2021). However, how some transition staff, service supports, and programs are monitored and evaluated is unclear. During the early stages of this project, a news article reported on the questionable hiring practices of a program aimed at supporting veteran survivors of military sexual trauma (Burke & Everson, 2021). The program, which various veteran support organizations had funded, had hired an inappropriate peer mentor who caused significant distress for a number of participants. In a similar vein, some participants in the current study also mentioned how some interactions with civilian or reserve transition staff caused them to feel stigmatized, harmed, and alienated. Developing and implementing transparent hiring and evaluation practices within transition support groups and programs is a possible solution. Moreover, independent evaluations of volunteer and peer support organizations can also ensure advertising efforts and financial resources are allocated appropriately.

There are on-going efforts to improve policies and programs targeted at ensuring veterans experience high levels of well-being throughout their life (Veterans Affairs Canada, 2022). However, findings from this study highlight a need to consider the navigation challenges presented by adding new resources or disrupting established processes. Some participants discussed how frequent changes within the transition system created feelings of confusion, uncertainty, and mistrust, which ultimately impacted their ability to make decisions and plan for life after service. Other participants described how difficult it was to access complete and accurate information or be able to understand and retain what was presented to them. The previously listed barrier was further exacerbated if transition support staff communicated conflicting information or if programs and resources differed between geographical locations.

Additionally, the overwhelming amount of available information presented significant challenges, further increasing administrative complexity. The Office of the Veterans Ombudsman has recently called for the harmonization of benefits to improve accessibility for all veterans (2020). The findings from this study further suggest harmonization of programs, as well as clear communication of which domains of well-being they target, should also be considered. Harmonizing benefits and programs would make it easier to report them on one website, making the navigation more accessible. Additionally, one controlled access point may reduce errors associated with miscommunication and reduce feelings of uncertainty.

Another potential solution to reduce difficulties during the medical MCT may be to increase the social support capabilities of the military units. Participants in this study shared facilitating experiences inspiring potential solutions to the previously listed barriers. The first of these is adjusting policy to define and standardize chain of command support for medically releasing members. Clear expectations in policy may ensure individual needs are appropriately supported and members are encouraged to engage with their transition staff. An example of this may be to direct increased levels of collaboration between chain of command and members from the CAF Transition Group to ensure medically releasing member needs are clearly communicated and understood. Home unit support and encouragement may increase motivation for soldiers to interact with the resources available to them. Higher positive engagement with transition staff increases the likelihood that members will develop a sense of mastery over the information and options available to them and ease feelings of uncertainty. Implementing the aforementioned policy will help to improve the standardization between units, which may increase perceptions of social support if soldiers are posted to different units or areas during their MCT. Based on participants' experiences in this study, improving the support a military unit

provides may also help lower feelings of loss and abandonment. During my time with one particular unit that I have the utmost pride in serving with, they had created a unique position specifically for an injured member. This member's job was to develop an intimate understanding and be able to support the units' members with family support, and eventually, transition issues. If a concern came up that member could not assist with, they knew who to contact to resolve the issue. This position helped relieve a lot of stress for members and worked well for several reasons. The first reason is that the member remained consistent over time. Chain of command change frequently and are often either deployed, training, or fulfilling a multitude of other tasks. Having a single member who can stay in a transition assistance role can relieve the burden on CoC while improving the support a medically releasing member gets while trying to plan. The second advantage of this special position is that they can increase the social support a member receives after an injury impacts their career. This is accomplished by helping the releasing member navigate conflicts arising from medical employment limitations with work, as well as encouraging better communication for support with needs. Third, this specialized position can help ensure typical military departure traditions are honoured for releasing members. The final advantage for creating a unique position is that it offers an opportunity to gainfully employ medically releasing personnel who are not ready to leave the military.

Conclusion

This study adds to the dearth of empirical literature concerning existing medical MCT barriers and facilitators affecting the seven domains of well-being. An additional contribution is the expanded understanding of the medical MCT experience and the multidimensional impacts of determinants between well-being domains. Evidence for current supports that have mitigated challenges and promoted positive experiences during the medical MCT have also been

illustrated. The design of this research provided an opportunity to amplify voices of soldiers and veterans with medical MCT experience and increase their presence in academic literature. Findings resulted in the development of considerations to address gaps in research, as well as recommendations for personnel responsible for policy, program, and resource development aimed at enhancing medical MCT success.

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