EMPOWERING SUCCESSFUL CONNECTIONS: A RESOURCE AND STRATEGY GUIDE FOR MEETING THE NEEDS OF U.S. MILITARY VETERANS IN SACRAMENTO, CA AND THE SURROUNDING COMMUNITY

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PROJECT

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EMPOWERING SUCCESSFUL CONNECTIONS: A RESOURCE AND STRATEGY GUIDE FOR MEETING THE NEEDS OF U.S. MILITARY VETERANS IN SACRAMENTO, CA AND THE SURROUNDING COMMUNITY

A Project

by

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Abstract

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Paul D. Flynn
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This project was undertaken to determine whether a need exists for a resource and strategy guide to aid California State University, Sacramento (CSUS) social work students and professionals in Sacramento, CA, and surrounding counties in connecting United States military veterans with needed services. Two researchers collaborated on this study. Each researcher is contributing to the design, data collection, analysis and writing of the project. The research design of this study was exploratory with descriptive statistics used to analyze the data. One hundred and twelve CSUS MSW I and II students participated in a survey, which showed that 77.6% of students lacked knowledge of issues veterans face and 84.9% lacked knowledge of the services available to veterans. This knowledge deficit provides justification for the creation of a resource and strategy guide, which has been created from this project.

__________________________________________________________________________, Committee Chair
Chrystal Ramirez Barranti, PhD, MSW

Date: __________________________
DEDICATION

This study is a dedication to Linda’s father, Frank McElmurry, who is a WWII veteran, to Paul’s stepfather, Carl Richards, who has served in the United States Army, to Paul’s father, Christopher Flynn, who is a veteran of the war in Vietnam, and to Linda’s partner, David Most, who is a Vietnam era veteran. This study is also dedicated to all the men and women who have ever served in the United States military. Thank you all for your service.
ACKNOWLEDGMENTS

I, Paul D. Flynn, want to thank my wife and my family for the love and support they have provided to me during my time in the MSW Program. A special thank you is also in order for my project advisor, Dr. Barranti, whose dedication, compassion and kindness I will never forget. I would also like to thank all of my instructors who have inspired me and encouraged me to continue to grow professionally.

I, Linda Matthews, would like to express my thanks to my partner and my family for their unconditional love and support throughout my education. I want to give special recognition to my project advisor, Dr. Barranti, whose kindness and dedication are an inspiration to me professionally and personally. I would also like to express my gratitude in the order of acquaintance to the professors who have most inspired me including, Bart Phelps, David Nyland, Jude Antoyappan, Janice Gaggerman, Andrew Bein, and Joan Dworkin.
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Chapter 1
PROBLEM STATEMENT

Introduction

“Support Our Troops” has become a well known adage and something that is identifiable in many forms with perhaps the most noticeable, a ribbon shaped magnet affixed to a vehicle. The colors may vary from yellow to red, white and blue, but the message is the same and reminds us to keep vigilant thoughts of the United States military personnel in combat.

The original “Support Our Troops” magnet was produced in April 2003, shortly after which the United States invasion of Iraq had begun. A Christian Bookstore owner from North Carolina, Dwain Gullion, was motivated to create the magnetic ribbon in the spirit of the yellow ribbons that adorned front yards across America commemorating the military personnel engaged in battle (Walker, 2004). Since the origin in 2003, the message continues today. There is no denying the impact and influence of this message; however, the message seems to be directed solely to the service members on active duty and not towards the veterans. Until there is media coverage, or we come face to face with a veteran in need of medical care, mental health service, or housing, the needs of veterans often go unnoticed. There should be no argument against support for veterans being just as important and practical as support for the troops.

Taking a moment to look at how our culture portrays United States military veterans, over the years, what thoughts or feelings come to mind? There may be feelings
of exuberance and triumph over ruthless dictators, highlighted by parades and celebrations, films, stories and personal experience that relay the triumph and tragedy of the battles fought by all the veterans. Yet, our culture often neglects to give account to, or acknowledge, the needs of our soldiers once they separate from the military and become veterans.

The positive images portrayed of veterans in society today may make it difficult to remember a time when veterans were not looked upon in the same light. Recounts of the treatment of veterans coming home from the Vietnam War speak to veterans being spit on and verbally assaulted, if not worse. One Vietnam veteran, a draftee, recalled an encounter with war protestors, when he arrived back from Vietnam. He stated that the war protesters made him feel like someone unwelcomed in the United States, because of the atrocities that some felt had occurred during the Vietnam War, making him guilty by association. The veteran explained that he was issued a new dress uniform, not civilian clothing, upon his departure from Vietnam, and although he was not seeking attention, but rather trying to repress or forget about his experiences from the military, he still received negative attention (Greene, 1989).

The need to examine the services for United States veterans began years ago. However, it still is relevant at this time, especially when one encounters United States veterans who are ‘down on their luck’ mentally, physically and financially. Encountering a veteran holding a sign at a street intersection asking for ‘spare change’ is deplorable. The fault lies not with the veteran, but with the breakdown of the systems that have
placed the veteran in the position of having to ask for change. The images, usually of males with dirty clothing and poor personal hygiene, may make the moment even more surreal and lead to the question, how did the breakdown occur that placed the veteran in these present circumstances?

Perhaps there is not enough thought given to the standards of the systems of care available for United States veterans. To some extent, the military culture may be seen as an entity that takes care of its own. To the outsider then, it would appear that for both service members and veteran alike, there are enough resources and support to alleviate the problems some veterans face that include adjustment problems upon coming back from deployment; family or employment related stressors; or Posttraumatic Stress Disorder (PTSD) (Robb, 2009).

For some veterans the readjustment to coming home from combat or theater of war is successful. Many are able to get back into the routine of home or work life, but for some, coming home and being reunited with family, friends, and loved ones can be stressful and lead to despair, rather than the exhilaration of reuniting with family and loved ones (National Council on Disability, 2009). Reunions can become even more difficult, if the returning service member has been physically or psychologically injured by combat, or if the service member is returning to estranged family dynamics. Another factor that might make coming home difficult is posttraumatic stress disorder. PTSD is a concern that has been coming to light more in recent years. PTSD and other mental health conditions that may go untreated can lead to unpleasant circumstances; which can include
domestic abuse or violence and difficulty in finding or holding a job when the service member returns home (National Center for PTSD, 2009).

The timeliness for the examination of resources and services available for United States military veterans is ideal, given the fact that the United States has had military personnel deployed in Iraq and Afghanistan since the initial invasion of Iraq in 2003, and the beginning of the war in Afghanistan in 2001. In addition, there are Vietnam veterans who are still experiencing trauma from past war related experiences. The relevance of this topic to social work revolves around the physical, emotional, and psychological trauma that United States service members, veterans, and their families are currently facing and struggling with. Research (Franklin, 2009; Jaycox & Tanielian, 2008; Williamson & Mulhall, 2009c) has shown that as a growing number of veterans return from deployment, there will be a greater need for professional social workers to provide services for the veterans. In addition, the increased number of veterans returning home and possibly requiring services may put a strain on a care system that is becoming overextended.

As a social work professional, it is important to remember that service members and veterans may be changed by their experiences in the military, even if deployment to a combat zone does not occur. Judith Herman (1997) wrote, “Traumatic events destroy the sustaining bonds between individual and community” (p. 214). Physical and psychological responses are acquired and utilized by those in the throes of conflict, such as in the wars in Iraq and Afghanistan (Franklin, 2009), which can last upwards to 15
months with shorter rest periods at home, before potential redeployment (Jaycox & Tanielian, 2008). This leads the service member or veteran to remain in a state of ready vigilance and a mindset of exclusion to any forms of physical or mental weakness in order to survive.

The purpose of this study is to develop a resource guide/manual that will help guide the social worker in identifying appropriate resources and services for United States military veterans in Sacramento, CA, and the surrounding counties. It is the belief of the researchers that not all social workers or Masters Level Social Work students have a base of knowledge that could adequately allow them to provide services to veterans. The resource guide will contain information pertaining to services that may compliment or substitute services available from the Veterans Administration Hospital (VHA) or other types of healthcare services that veterans may be eligible to receive. It is the hope of the researchers that such a guide will provide empowerment for area veterans through support from social workers.

Statement of Collaboration

Two researchers collaborated on this study. Each researcher is contributing to the design, data collection, analysis and writing of the project. An agreement was made by both researchers that in the development of this project research will be divided appropriately in order for each researcher to contribute meaningfully to whole of the project. The researchers’ thesis advisor, Dr. Chrystal Barranti, oversaw this study to
ensure each researcher adequately contributed to and gained benefits from this learning experience.

Background of the Problem

At this time, there is a concern about the adequacy of services for meeting the needs of the growing numbers of United States military veterans. Likewise, eligibility processes become a concern. Barriers to identifying and acquiring appropriate services become an issue, especially when there is challenge to obtain services. A resource guide becomes prudent, as it is designed to fill deficits in services for veterans. It is important to examine the barriers in services, prior to addressing the resources available to alleviate the problems.

Starting from the perspective of health care services provided to veterans, it is important to address the misunderstanding about the veteran’s eligibility for health care services from the Veterans Administration Hospital (VA). Woolhandler, Himmelstein, Distajo, Lasser, McCormick, and Bor (2005) found that there is a misconception by the general population that every veteran is eligible for services from the Veterans Administration Hospital. In fact, there are numerous factors that influence the veteran’s eligibility for VA services that include, but are not limited to: the nature of the veteran’s discharge (honorable, other than honorable, dishonorable), length of military service and income restrictions (United States Department of Veterans Affairs, 2008c).

On February 13, 2008, the Chairman of the Committee of Veterans’ Affairs, Daniel K. Akaka, spoke of potential shortcomings of the VA to provide greater care for
those veterans who may have been excluded from services in the past. Chairman Akaka continued by expressing his concerns that veterans who may have developed mental health problems, possibly untreated, or veterans who may be at risk for suicidal ideations need increased support and assistance as well, but budget constraints may not allow for this increased support (Committee on Veterans’ Affairs, 2008).

In 1996, the Veterans Health Care Reform Act was passed, and while the goal was to increase health care coverage for more veterans, the VHA was asked to create eight priority categories for enrollment, and then systematically care was provided to the most urgent (Woolhandler et al., 2005). While the Veterans Health Care Reform Act was monumental, there have been some flaws exposed, especially with the wars in Iraq and Afghanistan and the influx of veterans who required services. On January 23, 2007, Washington State Senator Patty Murray testified before the United States Senate Committee on Veterans’ Affairs and stated that in 2006 the VA planned to see “110,000 veterans from the wars in Iraq and Afghanistan” (p. 6) and ended up seeing 75,000 more veterans than they had budgeted for. Senator Murray also pointed out the oversight of the Bush Administration in not providing more funding for veterans’ healthcare in the overall cost of the war (Committee on Veterans’ Affairs, 2007).

The preceding information was not designed to show fault with the Veterans Administration or the Veterans Administrations Hospital, but rather to illustrate the discrepancies in funding and delivering services to veterans who need support. The Veterans Administration Hospital (VHA) is in fact currently preparing to direct its
services to focus on the long term needs of veterans with psychological wounds, in addition to physical wounds (Welch, 2005). It was reported by Goldstein (2009) that there are over 1,000 VA Hospitals, clinics and Vet Centers, and of the 5.5 million patients the VA has served, 400,000 have been veterans of the wars in Iraq and Afghanistan. There is a concern regarding the increased number of service members returning from combat. On February 27, 2009, in Camp Lejeune, NC, President Barack Obama spoke about the troop withdrawal from Iraq, stating that on August 31, 2010, the combat mission in Iraq would end. Of the approximate 142,000 troops in Iraq, 35,000 to 50,000 remain, but potentially over 100,000 troops may be coming home (Baker, 2009). However, more recently, President Obama declared that he was going to send 30,000 more troops to Afghanistan, with a plan to start bringing troops home by July 2011 (Lockhead, 2009). The concern that lies within is whether the VHA will have the resources to serve all of the veterans who will be in need of services. In addition, with the increased recognition of mental health problems like PTSD, the stigma once placed on receiving assistance for these ailments may lead veterans to turn to the VHA for on-going assistance.

Statement of the Research Problem

On a statewide level California has an estimated 2.2 million Veterans (California Department of Veterans Affairs, 2007); however this number now may be increased. With this large number of veterans a great need for services will also be necessary. Along with other professionals, social workers will play an important role in providing support
to veterans, especially those veterans who may not qualify for services, may be unable to successfully navigate through the process, or require greater care or support due to unique circumstances. It is the researchers’ belief that there is currently a lack of knowledge about the services available to veterans in the Sacramento, CA, and surrounding areas. It is vital that social workers have access to all resources and material that can assist in providing services to veterans, so the development of a resource guide is very practical at this time.

Purpose of the Study

The purpose of this project, “Empowering Successful Connections: A Resource and Strategy Guide for Meeting the Needs of U.S. Military Veterans in Sacramento, CA and the Surrounding Community,” is to develop a resource guide which helps guide the social worker in identifying appropriate resources and services for United States military veterans in the Sacramento, CA, and the surrounding community. The objective is that through the development of the resource guide social work professionals will have information available to better understand the services available relating to medical and mental health needs (including Posttraumatic Stress Disorder), housing, transportation services, employment/vocational training and counseling for United States military veterans, and will feel confident in making a referral to such an agency, if needed.

Research Question

The following research question has been posed in the service of developing a helpful resource and strategy guide for social workers who are serving veterans and their
families. The research question that guided the project development phase of this study was: How knowledgeable are MSW students about resources that serve United States military veterans in Sacramento, California, and its surrounding counties?

Theoretical Framework

The National Association of Social Workers (NASW) (2001) emphasized the importance of the theory of Empowerment and Advocacy because of the responsibility it provides for the social worker to be cognizant of the effect social policies and programs have on client populations, especially populations that face diversity (National Association of Social Workers [NASW], 2001). Payne (2005) also argued that the Empowerment-Advocacy Theory assists people to “overcome barriers” to “gain access to services” (p. 295), thus gaining power. Additionally, Payne stated that when advocacy occurs the person in an oppressed population is given a voice, which he/she did not have before, and, therefore, is more likely to receive assistance commensurate with those in power (Payne, 2005). The caveat to this theory, however, is Payne’s reminder that a person must be actually given the assistance to actually realize the power, it cannot just be handed to the individual.

This theory complements this project well, because the central idea of this project is to empower veterans by providing them with resource information for necessary referrals. The users of this guide are unable to force a recipient to receive a service that he/she does not wish to receive, or would not be willing to follow through. The hope is
that the resource guide will be a tool for social workers to help veterans overcome barriers they might be facing and gain power over a troubling situation.

Definition of Terms

The following terms will be appearing in this project and for better clarification will be defined as follows:

*Active Duty*: Full-time duty in the active military of the United States. This includes the military reserves, but excludes the full-time National Guard (Department of Defense, 2009).

*Deployment*: The relocation of forces and materials to desired operational areas, or the movement of forces within operational areas (Department of Defense, 2009).

*Operation Enduring Freedom (OEF)*: The war in Afghanistan, which began in October 2001 against the Taliban and other insurgents, and is presently ongoing.

*Operation Iraqi Freedom (OIF)*: The war in Iraq which began in March 2003, and is presently ongoing. The forces involved include the United States and Coalition forces from other countries (GlobalSecurity.org, 2009).

*Posttraumatic Stress Disorder (PTSD)*: A mental health disorder as defined by the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (APA, 2000).

*Service Member*: A person appointed, inducted, or enlisted into a branch of military services. Also applies to persons in the military reserves (Department of Defense, 2009).

*Soldier*: Enlisted personnel in the United States Army, Army Reserves, or Army National Guard (Department of Defense, 2009).
Veteran: Any person who served on active duty in any of the branches of the United States Armed Forces, and was discharged on honorable and other than honorable terms (Veteran’s Agent, 2010).

Assumptions

The assumptions for this study include the researchers’ belief that there is not adequate knowledge, known to MSW students at California State University, Sacramento, about issues and services pertaining to United States military veterans, especially services available in Sacramento County and the surrounding counties. It is also the assumption of the researchers’ that veterans in the study area require services and are unable to receive adequate services due to a lack of personal knowledge or support from professionals. There is also an assumption that a resource guide, such as the one that has been developed, does not exist or lacks current information.

Justification

The development of a resource and strategy guide is timely and relevant; especially due to the current number of service members who are engaged in combat in the wars in Iraq or Afghanistan and will become veterans, and the current number of veterans who require services at this time. The resource guide will be a benefit to the profession of social work by increasing the social work professional’s level of awareness, and providing the professional with tangible resources to provide to those requiring services and support.
The resource and strategy guide also complements the *Code of Ethics*, as established by the NASW. The NASW defines the primary mission of social work as the enhancement of the wellbeing of all people, especially vulnerable populations who may be afflicted by poverty. Social work is also a tool designed to create empowerment for all. The social worker’s role is to then focus on the wellbeing of the individual in society (NASW, 2010).

There is a specific set of core values that is embedded within the practice of social work. The core values include, but are not limited to: service, social justice, and competence (NASW, 2010). The social work value of competence speaks to the importance of the professional’s ability to increase his/her professional knowledge and expertise in working with various client populations, as the social worker continues to increase the overall knowledge of the profession. It is believed that the resource and strategy guide will serve as a tool for social workers to increase their professional knowledge and expertise in working with client populations, and in this case the population is United States military veterans who are in need of services.

**Delimitations**

This study is based largely upon existing services available to United States military veterans in the defined target area. This study does not create any new agencies or services, nor does it critique any agencies or services. Rather, it provides information through the literature review of the relevance of the current needs of veterans.
Summary

This chapter introduced the research study and addressed the general needs of United States military veterans. The chapter also introduced the problems some veterans have with readjustment after returning from battle or theater of war that includes, but is not limited to, posttraumatic stress disorder (PTSD) and other social factors. The purpose of the study, theoretical framework, assumptions and justifications of the study were also introduced.

Chapter 2 of this project will be a review of literature that will be divided into twelve areas of interest that help describe relevant information about veteran issues, veterans’ barriers to service acquisition, and the services available to veterans that the researchers feel are important at this time. The subject matter of chapter two will relate directly to the questions asked of the research subjects.

Chapter 3 of this project will explain the design of this project and how the research instrument was administered to research subjects. Chapter 3 will also describe the compilation of the information obtained from the surveys.

Chapter 4 will contain the results of the data gathered from the survey and will present the resource and strategy guide created to be an aid for social workers in supporting United States military veterans.

Chapter 5 will complete the project. In this chapter the researchers will discuss conclusions from the research and provide the benefits of implementing the resources and services presented in the resource guide.
Chapter 2

LITERATURE REVIEW

Introduction

In assessing the needs for United States military veterans, it is important to address the barriers that may be present for some veterans, thus not allowing them to receive services or treatment in a timely fashion or at all. Once the barriers have been addressed, the desired outcome would be that resources are found to fill a void or serve as a bridge allowing the veteran the opportunity to receive the services or treatment that he/she has been unable to receive. The goal of this project is to address some of the military veterans’ barriers to service access through the development of a strategies and resource guide.

To better understand the breadth of issues related to United States military veterans and their access to services, this literature review is divided into 12 areas. 1) Current issues affecting United States Military veterans, 2) Military Culture, 3) Military Sexual Trauma, 4) Mental Health needs, 5) Post Traumatic Stress Disorder (PTSD), 6) Traumatic Brain Injury (TBI), 7) Medical needs for U.S. Military veterans [a. VA Hospital (VHA) [b. TRICARE, 8) Transitional Assistance Program, 9) Employment, 10) Housing for homeless veterans, and 11) Transportation services. The final section of this literature review discusses gaps in the literature.

Due to the complexity of some of the issues mentioned in the review of literature, such as PTSD and medical and mental health services, the focus is placed on how these
services relate to United States military veterans. It should also be known that there are limitations in the services provided by the Veterans Administration Hospital to veterans, which, as a result, exclude some veterans from receiving services from the VHA.

Current Issues Affecting United States Military Veterans

Of concern to health and mental health providers regarding returning veterans are several issues. According to a RAND corporation report released in April 2008, over 1.64 million troops have served in the United States military in Operation Enduring Freedom (OEF) in Afghanistan since 2001 and in Operation Iraqi Freedom (OIF) in Iraq since 2003 (Jaycox & Tanielian, 2008). Due to advances in medical technology and body armor, service members are surviving injuries that would have led to death in prior wars. Because of these new technologies, 15 of 16 seriously wounded service members survive injuries that would have been otherwise fatal (Franklin, 2009). This has created new concerns in that veterans are returning home with medical conditions, mental health conditions, and cognitive health impairments that have not been present in past wars (Franklin, 2009).

Service members’ length of deployments and the numerous redeployments for soldiers present additional concerns (Jaycox & Tanielian, 2008). In Franklin (2009), it is noted that soldiers deployed to Iraq for more than six months or deployed more than once are much more likely to be diagnosed with psychological injuries. The traumatic experiences in combat of service members have created unique mental health needs for our Nation’s veterans. The most prominent mental health issues include PTSD, traumatic
brain injury (TBI), depression, and anxiety (Franklin, 2009). Women veterans present additional concerns as they have the possibility of experiencing sexual harassment, sexual assault or rape, and gender harassment (Mulhall, 2009).

Additional current issues of concern for veterans include homelessness, the increase of unemployed veterans, and veteran suicide rates. Veterans make up 11% of the general population, yet they account for 26% of the homeless population (Williamson & Mulhall, 2009). Women veterans are two to four times more likely than other women to be homeless (Franklin, 2009). The unemployment rate for Iraq and Afghanistan era veterans was 8% in 2007, which was 2% higher than unemployment rates for non-veterans. Suicide rates for veterans are alarming (Williamson & Mulhall, 2009). A 2007 CBS News investigation, “found that veterans were twice as likely to commit suicide as non-veterans, and 120 veterans from all wars kill themselves every week” (Franklin, 2009, p. 164).

Military Culture

Military training can instill idealistic views in soldiers about their capabilities and the meaning of physical and emotional injury. Soldiers are trained to function as a unit, so individual physical or emotional injury can be viewed as a weakness to the entire unit. Following such a line of thinking, most soldiers with minor injuries do not seek medical treatment unless they are physically unable to perform their military duties. The stigmatization of mental illness is even greater as the soldier is not only seen as weak, but
may be considered a risk to the other service members with whom he/she serves (Feczer & Bjorklund, 2009).

In the article “Forever Changed,” Feczer and Bjorklund (2009) cite numerous studies, which indicate that “many Iraq and Afghanistan war veterans do not seek mental health care for their PTSD symptoms” (p. 280), as they are reluctant to acknowledge having such a weakness, are reluctant to consider themselves having a psychiatric disorder, and are fearful of the stigmatization attached to a diagnosis of a psychiatric disorder. Even when sought, veterans often find that treatment within or outside the VA system is unavailable, especially in rural or underserved geographic areas (Feczer & Bjorklund, 2009). In addition, VA disability policies may complicate diagnosis and treatment or existing VA resources like many community mental health resources are simply overwhelmed or have been cut back and are not prepared to serve the number of individuals that need treatment (Feczer & Bjorklund, 2009).

Female military veterans face additional cultural biases in that research suggests there may be gender bias in the diagnosis of PTSD within the VA healthcare system. Pereira (2002) found that male veterans received a PTSD diagnosis 3.4 times more often than female veterans even though the females evidenced more PTSD symptoms than the males. While combat injury in both men and women can almost always guarantee a PTSD diagnosis (90%), “women, who developed PTSD symptoms from sexual assault during their military service, were far less likely to receive a PTSD diagnosis” (Feczer &
Bjorklund, 2009, p. 280). It is especially significant because sexual stress and trauma among female veterans is common (Feczer & Bjorklund, 2009).

In a study of 327 women receiving treatment in a VA women’s clinical program for stress disorders, Fontana and Rosenheck (1998) found that 93% had been exposed to some kind of sexual stress during their military service. Feczer and Bjorklund (2009) inform us that 11.9% of female veterans had direct combat exposure, mortar attacks, enemy fire, etc.; however, 58.4% met criteria for PTSD. These statistics clearly indicate that sexual stress was a more toxic factor in the development of PTSD for female veterans than combat exposure (Feczer & Bjorklund, 2009).

Military Sexual Trauma

Traumatic combat experiences are most closely associated with service in OEF/OIF; however, they are not the only traumatic experiences United States military service members may encounter during military service. Both women and men can experience sexual harassment or sexual assault during their military service. The Veteran’s Administration refers to these experiences as military sexual trauma or MST (United States Department of Veterans Affairs, MST Support Team, n.d.). In FY2008, there were 2,908 reports of some form of sexual assault involving service members overall (Department of Defense, 2008). These reports were up 9% from the previous year (Mulhall, 2009). The most severe sexual stressors for female service members are sexual assault, or experiences of unwanted physical sexual contact that involve some form of
coercion. The encounters can range from gender bias or unwanted touching to attempted or completed rape (Street, Vogt, & Dutra, 2009).

Even in the war zone, troops cannot escape the threat of sexual assault. In Iraq and Afghanistan, 163 sexual assaults were reported in 2008 (Hefling, 2008). While the numbers are alarming, they may be only the tip of the iceberg, as experts estimate that half of all sexual assaults go unreported (Mulhall, 2009). In addition, almost one-third of female service members and 6% of male service members have experienced sexual harassment while serving in the military. It can be devastating to troops’ health and morale (Department of Defense, 2008).

Sexual assault and harassment threaten the individual victim and they undermine military cohesion, morale, and the overall effectiveness of the military unit (Mulhall, 2009). When reporting an incident of sexual assault, some women fear unauthorized repercussions from within their unit, and yet other victims are concerned that in an effort to protect their safety a commander will remove them from their unit rather than remove the perpetrator. Because of their fear of repercussion, many female troops wait until after they leave active duty to receive care and counseling for injuries stemming from sexual assault or harassment (Mulhall, 2009).

Since 1999, the VA has been screening all veterans seeking care at the VA for military sexual trauma (MST) (Mulhall, 2009). Despite congressional hearings, media attention, and the increasing number of women coming forward publically about their trauma, the military has been slow to establish programs to prevent and respond to sexual
assault (Mulhall, 2009). As of May 2007, almost 15% of female Iraq and Afghanistan veterans who have gone to the VA for care have screened positive for (MST) (Hefling, 2008). Veterans of previous generations have reported even higher rates of MST. Almost one-third of female veterans of all generations say they have been sexually assaulted or raped while in the military and more than 70% say they experienced sexual harassment while serving (Benedict, 2008).

Military sexual trauma can lead to the development of major health problems such as depression, eating disorders, miscarriage, and hypertension (Mulhall, 2009). According to the VA, MST can negatively impact a person’s mental and physical health, even many years later. Additional problems associated with MST are disturbing memories or nightmares, difficulty feeling safe, feelings of depression or numbness, problems with alcohol or other drugs, feeling isolated from others, problems with anger or irritability, problems with sleep, and physical health problems (United States Department of Veterans Affairs, MST Support Team, n.d.).

Mental Health Needs

Since October 2001, approximately 1.64 million U.S. troops have been deployed to Afghanistan and Iraq in operations OEF/OIF (Jaycox & Tanielian, 2008). In a study conducted by Rand, early evidence suggests that the psychological toll of the deployments, which have involved prolonged exposure to combat-related stress over multiple rotations, may be disproportionately high (Jaycox & Tanielian, 2008). Unlike the physical wounds of war, posttraumatic stress disorder, major depression, and
Traumatic brain injury are often invisible to the eye, and remain invisible to other service members, family members, and society in general (Jaycox & Tanielian, 2008). All of these conditions affect the thoughts and behaviors of military service members and veterans. Yet, these psychological and cognitive wounds often go unrecognized and unacknowledged. And the effects of TBI remain poorly understood with very little knowledge advising how extensive the problem is or how it can be addressed (Jaycox & Tanielian, 2008). The Rand study also informs that service members who had been in combat and had been wounded had a heightened risk of having a mental health condition, mostly PTSD. Most service members who return from combat are free from any of these conditions. However 5-15% of returning service members may be returning with PTSD and 2-14% may be returning with major depression (Jaycox & Tanielian, 2008). Conditions like PTSD may appear months or even years after exposure to a traumatic event indicating that the need for mental health services for veterans are likely to increase over time.

Hoge, Auchterlonie, and Milliken (2006) explain that only about one-third (23-40%) of military personnel who met criteria after deployment received any professional help, and only about 13-27% received care from a mental health professional. When troops return home, there may be a disincentive for reporting mental health symptoms or accessing services to treat mental health conditions, as service members may worry that acknowledging a mental health problem may delay their return to their family and friends.
or may affect a promotion or their continued advancement in the military (Jaycox & Tanielian, 2008).

In addition, concern about depression is also on the rise as there is an increase of suicide and suicide attempts among returning veterans. According to the Department of Defense in 2003, the rate of suicide across the armed forces was roughly 10-13 per 100,000 (Allen, Cross, & Swanner, 2005), an estimate that is comparable to the general population. However, suicide rates for veterans are alarming (Williamson & Mulhall, 2009). A 2007 CBS News investigation, “found that veterans were twice as likely to commit suicide than non-veterans, and one-hundred-twenty veterans from all wars kill themselves every week” (as cited in Franklin, 2009, p. 164).

Posttraumatic Stress Disorder (PTSD)

Many service members are operating under constant threat of death or injury and seeing the violent death of their comrades and others. Enemies and civilians are often indistinguishable, and service members are asked to play dual roles of warrior and ambassador (National Council on Disability, 2009). Many service members have served multiple deployments with very little down time or leave between deployments (Jaycox & Tanielian, 2008). Because of this constant threat, many service members will develop posttraumatic stress disorder (PTSD), either while they are serving in the military or after their return home. According to current estimates, between 10% and 30% of service members will develop PTSD within a year of leaving combat (Jaycox & Tanielian, 2008).
The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), the publication that defines the criteria used in diagnosing mental disorders, classifies PTSD as an anxiety disorder that arises from “exposure to a traumatic event that involved actual or threatened death or serious injury” (American Psychiatric Association, 2000, p. 463). Symptoms vary considerably from person to person, but the essential features of PTSD are re-experiencing, avoidance/numbing, and hyperarousal/hypervigilance. Re-experiencing which involves flashbacks, nightmares, and intrusive memories of the traumatic event can be the most disruptive of PTSD symptoms. The veteran may be flooded with horrifying images, sounds, and recollections of what happened. He/she may even feel like it is happening again. These symptoms are sometimes referred to as intrusions, since memories of the past intrude on the present. And symptoms can appear at any time, sometimes seemingly out of the blue. At other times, something like an image, certain words, sounds, or a smell can trigger a memory of the original traumatic event (National Council on Disability, 2009). Patients with PTSD often experience avoidance and numbing and may attempt to avoid thoughts or activities that could remind them of the traumatic event. In addition, they may lose their ability to experience pleasure and may seem emotionally “flat” or nonresponsive. They may feel detached or estranged from others. Often, they have a sense of a “foreshortened future” feeling that tomorrow may never exist (National Council on Disability, 2009). Hyperarousal or hypervigilance is another set of symptoms individuals with PTSD experience. They may feel and react as if they are constantly in danger. This increased arousal may disrupt sleep, contribute to
irritability and anger, and impair concentration. Often, individuals will experience the above symptoms as exaggerated startle response (National Council on Disability, 2009).

Jaycox and Tanielian (2008) note that there is a direct correlation between the frequency of exposure (multiple traumatic events), the length of exposure (extended or multiple deployments), and the risk of developing PTSD. Troops deployed as part of OEF/OIF have had longer deployments, redeployment to combat has been common, and breaks between deployments have been infrequent (Jaycox & Tanielian, 2008). Among OEF/OIF veterans rates of PTSD are relatively high. As of October 2007, an estimated 300,000 individuals suffered from PTSD or major depression (Jaycox & Tanielian, 2008).

Military service members with probable PTSD or major depression are not seeking the treatment they need. Recent studies indicated that “about half (53%) of those who met criteria for current PTSD or major depression had sought help from a physician or mental health provider for a mental health problem in the past year” (Jaycox & Tanielian, 2008, p. xxi). Unless treated, the veterans with such conditions face a wide array of negative consequences that affect work, family, and social functioning.

The presence of PTSD can impair the future health, work productivity, and family and social relationships of veterans. Individuals with PTSD are more likely to have other psychiatric diagnosis like substance abuse. They have higher rates of unhealthy behaviors like smoking, overeating, and unsafe sex; higher rates of physical health problems and mortality; and are at increased risk for attempting suicide (Jaycox & Tanielian, 2008).
There is also a possible connection between having PTSD and being homeless (Williamson & Mulhall, 2009). Veterans suffering from PTSD may experience “relationship difficulties, disrupted marriages,” their symptoms may “aggravate the difficulties of parenting and cause problems in children that may extend the consequences of their combat experiences across generations” (Jaycox & Tanielian, 2008, p. 437).

Traumatic Brain Injury (TBI)

Currently, very little is known about the number of veterans who experience a traumatic brain injury or veterans who are currently suffering from problems related to such an injury. The data is scant at present, and estimates range widely (Jaycox & Tanielian, 2008). Traumatic brain injury (TBI) is an injury to the brain that may range in severity from mild (a concussion from exposure to a blast) to severe (a penetrating head wound). TBI is often referred to as the signature wound of OEF/OIF service members, and has created special challenges for the military medical system (Jaycox & Tanielian, 2008).

A person with mild TBI may remain conscious or may experience a loss of consciousness for a few seconds or minutes. Other symptoms of mild TBI include “headache, confusion, light headedness, dizziness, blurred vision or tired eyes, ringing in the ears, bad taste in the mouth, fatigue or lethargy, a change in sleep patterns, behavioral or mood changes and trouble with memory” (National Council on Disability, 2009, p. 20). A person with a moderate or severe TBI may show the same symptoms, but may also have a headache that gets worse or does not go away, “repeated vomiting or nausea,
convulsions or seizures, an inability to awaken from sleep, dilation of one or both pupils, slurred speech, weakness or numbness in the extremities, loss of coordination, increased confusion, and restlessness or agitation” (National Council for Disability, 2007, p. 20).

Of the 35,000 otherwise healthy service members screened for TBI after deployment, 10-20% meet screening criterion for mild TBI (Jaycox & Tanielian, 2008). The data suggest that out of 1.64 million deployed, the number of service members with mild TBI could be as high as 160,000 to 320,000 soldiers (Jaycox & Tanielian, 2008). Mild TBI was not consistently screened for until September 2007 when the Department of Defense (DoD) revised the Post-Deployment Health Assessment (PDHA) and the Post-Deployment Health Reassessment (PDHRA) to include questions related to traumatic brain injury (Jaycox & Tanielian, 2008). The lack of screening before September 2007 indicates there could be thousands of veterans with mild TBI who have not received a diagnosis or treatment for their injury. Therefore, they may not receive a disability rating that would aide them in receiving medical and mental health services for their injury after separation from the military.

The above estimate of 10-20% screening positive for probable TBI does not begin to predict the number of service members who need care, since the majority of mild TBIs do not require medical treatment (Jaycox & Tanielian, 2008). In “Mild Traumatic Brain Injury in U.S. Soldiers Returning from Iraq,” Hoge, McGurk, Thomas, Cox, Engel, and Castro (2008) note that another challenge in identifying and treating TBI among returning service members is that many symptoms, such as anger, difficulty concentrating, and
diminished interest, are characteristic of both TBI and certain mental health conditions such as PTSD and major depression. Of those who screen positive for mild TBI between 60% and 80% will resolve their symptoms without medical attention and are best served by receiving educational materials (Hoge et al., 2008). However, the remaining 20-40% may have significant long-term residual neurological symptoms and will require some form of medical or rehabilitative services (Jaycox & Tanielian, 2008).

Regardless of severity, if a TBI related disability is serious enough that a service member is no longer fit for duty, the individual may be separated or retired from the military (Jaycox & Tanielian, 2008). All service members serving in OEF/OIF are eligible for five years of free care through the VA after separation from the military; however, without a disability rating, the priority for care will be low, and this could potentially create difficulty for the veteran to access health services in a timely manner. Receiving a disability rating enables the separated or retired service member to access VA services beyond the five-year period after their military discharge (Jaycox & Tanielian, 2008).

Medical Needs for United States Military Veterans

The provision of health care to the military population of more than 9.2 million people is an extremely large undertaking. The people who receive health care services include active duty personnel, retirees, other eligible veterans and their families (The Henry J. Kaiser Family Foundation [Kaiser], 2010). There are two major military health care programs that provide services, and those programs are provided through the
Department of Defense (DoD) and the Department of Veterans Affairs. The two programs differ with regard to the eligibility criteria, the benefits offered and how the programs are financed. The Department of Defense’s program is a managed health care program called TRICARE. This is a service for active duty military; active duty service families; retirees and their families and other beneficiaries from any of the seven service branches. The Department of Veterans Affairs provides medical coverage and healthcare to veterans and their families through the Veterans Health Administration (VHA). The VHA is the largest integrated health care system in the United States, and provides care to over 5 million inpatients and outpatients in multiple health care settings (Kaiser, 2010). Both services, TRICARE and the VHA, are invaluable for veterans, as there is a multitude of medical services that are required for veterans, ranging from preventative medical services for ailments that may have developed over time to care for mental and physical trauma and injuries sustained on the battlefield from recent wars (Jaycox & Tanielian, 2008).

To put this into perspective, in 2005 it was estimated that approximately 63,000 of the 300,000 soldiers who left active duty in Iraq or Afghanistan sought health care from the VHA (Starks, 2005). Making the situation even more difficult is that the active military campaigns of Operation Iraqi Freedom and Operation Enduring Freedom are still ongoing. As a result, there will be an increased requirement for medical services as the wars progress.
Additionally, as of March 19, 2008, the fifth anniversary of the United States invasion of Iraq, it was estimated that more than 70,000 service members were wounded in combat or required some type of medical care (Bilmes, 2008). Bilmes (2008) also stated that of the 750,000 troops discharged from the military at the time of his report more than one third have required treatments at medical facilities: 100,000 troops have been diagnosed with mental health conditions and 52,000 troops have been diagnosed with PTSD. Furthermore, the United States Army estimated that 20% of returning soldiers have suffered mild brain injuries, and more than 20,000 troops have received amputations, severe burns or head and spinal cord injuries.

It should not be forgotten that in addition to the medical needs of current veterans, there are still many Vietnam veterans who have specific needs that require medical care. According to Brooks, Laditka, and Laditka (2008a), Vietnam veterans comprise 32% of all military veterans. Brooks et al. (2008a), also suggested that many Vietnam veterans returning from that war described having somatic illnesses: chronic fatigue, headaches, dizziness, and PTSD (Brooks, Laditka & Laditka, 2008a).

In another study, Brooks, Laditka, and Laditka (2008b) also found that the veterans who served in Vietnam are at greater risk of having health problems than those who were deployed elsewhere during the Vietnam War. Now that Vietnam veterans have reached the age of retirement, many veterans have experienced a decline in overall health status and have become more likely to need treatment for chronic health conditions (Brooks, Laditka & Laditka, 2008b).
The following two subsections describe the VHA and TRICARE. These are two very necessary services that are relied upon by many United States military veterans to meet their medical needs.

The VHA

“To care for him who shall have borne the battle and for his widow, and his orphan” is a quote from President Abraham Lincoln’s second inaugural address in 1865 and the motto of the VA. For the VA President Lincoln’s words are a reminder of the quality of care this agency strives to provide to service members who have been injured while in defense of our Nation, and the care provided to the families of the service members who have lost their lives while in military service to the United States (United States Department of Veterans Affairs, 2009b).

The history of the VA dates back to the 1800s during the time of the Revolutionary War, when direct medical and hospital care for veterans was provided by individual states and communities in the forms of domiciliary care and medical facilities. Over the years the services provided by the VA expanded to include benefits and pensions to veterans and their widows and dependents. In the 1930s the VA health care system consisted of 54 hospitals, but now there are 171 medical centers, more than 350 outpatient and community clinics, 126 nursing home care units and 35 domiciliary (United States Department of Veterans Affairs, 2010b).

As previously explained, the VHA is provided through the Department of Veterans Affairs. As the Benefits Fact Sheet website (2010a) explains, the VHA provides
services for veterans and their families that include, but are not limited to: dental care, medical treatment and care, disability compensation, home loans, life insurance and burial benefits. In addition to hospitals and clinics, the VHA also offers outpatient clinics (OPC), readjustment counseling centers, also known as Vet Centers and mental health care facilities (United States Department of Veterans Affairs, 2010a).

The 2009 edition of the Federal Benefits for Veterans, Dependents and Survivors handbook details the eligibility requirements required to receive services from the VHA. Eligibility is based largely upon the type of discharge the veteran received from active duty. If a veteran is discharged from the Army, Navy, Air Force, Marine Corps or Coast Guard with a discharge of other than dishonorable, the veteran becomes eligible for services. Those veterans with dishonorable, bad conduct discharges, which are usually issued through a general court-martial, or veterans or their dependents with an outstanding felony warrant will not be granted services. Additionally, incarcerated veterans or veterans on parole must contact a VA regional office in order to determine eligibility (United States Department of Veterans Affairs, 2009a).

Members of the military Reserves or National Guard may also qualify for benefits from the VHA if they were called to active duty and completed their full period of service time. The minimum duty requirements relate specifically to veterans who enlisted after September 7, 1980 or had entered active duty after October 16, 1981. The service time must be 24 continuous months. For veterans who may have been discharged for hardship,
early out, or having become disabled in the line of duty the minimum duty requirements, as previously listed, may not apply.

The main component in applying for the numerous benefits offered by the VHA is completing the application form known as the VA Form 10-10EZ, Application for Health Benefits. The VA Health Care Eligibility & Enrollment webpage located on the United States Department of Veterans Affairs Website (2008b) provides instructions and advice to assist veterans to complete the application form. This website instructs the user that the enrollment form may be accessed on line at www.va.gov/1010EZ.htm. A veteran may also be able to request a form be mailed to him or her, by calling 1-877-222-VETS (8387). Veterans who may need assistance in completing the application form are able to receive assistance by calling the aforementioned telephone number, speaking with an Enrollment Coordinator at a local VA health care facility, or speaking with a State or County Veterans Service Officer or a Service Officer with a Veteran Service Organization. Certain veterans qualify for priority access. This applies to veterans who require care due to a service-connected disability or have a 50% or greater service-connected condition that requires care.

Once the application is complete, appointments with primary care providers will be established. For those veterans with greater need for service-connected conditions, appointments for evaluations will be scheduled within 30 days of the desired date. For all other veterans, appointments will be scheduled on the basis of availability.
There is a law, the Veterans Claims Act of 2000, which corresponds to obtaining records relating to the veteran’s claim. Under this law, the VA must tell the claimant what evidence is needed in order to support his or her claim, and the VA must make several attempts to collect any of the claimant’s evidence relating to the claim. The VA Health Care Eligibility & Enrollment (2008a) webpage defines the necessary evidence as: statements from the veteran, especially of a combat veteran who is claiming that his or her injury or illness is combat related, statements from friends, relatives, or those with a knowledge of the veteran’s disability and how it is related to his or her service, and medical evidence is also acceptable. Additional information that is considered helpful to reduce process time is as follows: a copy of the discharge papers (DD-214 or “WD” form), military service records that indicate the veteran was a recipient of the Purple Heart Medal, evidence of being in the way of hostile fire, in combat after November 11, 1998, received imminent danger pay, or was the recipient of a combat medal. By submitting this information the process of establishing services may be expedited faster than if the VA was required to search for the information on its own.

Once the VA has received and processed all the necessary information, the veteran is then assigned to one of eight Priority Groups. The groups are as follows:

Priority 1: Veterans with VA-rated service-connected disabilities that are 50% or more disabling, or veterans who are determined by the VA to be unemployable due to service-connected conditions.
Priority 2: Veterans with VA-rated service-connected disabilities that are 30-40% disabling.

Priority 3: Veterans who are former Prisoners of War (POWs), Purple Heart Medal recipients, were discharged with a disability that originated or became aggravated in the line of duty, have a VA-rated service-connect disability that is 10-20% disabling, or have been awarded special eligibility classification under Title 38, U.S.C., § 1151.

Priority 4: Veterans who are receiving aid and attendance or housebound benefits from the VA or who have been determined by the VA to be catastrophically disabled.

Priority 5: Non-service-connected veterans and non-compensable service-connected veterans rated 0% disabled, have an annual income and net worth below the VA National Income Thresholds, receiving VA pension benefits or are eligible for Medicaid programs.

Priority 6: Veterans from World War I, compensable 0% service-connected veterans, veterans who have been exposed to Ionizing Radiation during atmospheric testing or during the occupation of Hiroshima or Nagasaki Japan, were Project 112/SHAD participants, or had served in a theater of combat operations after November 11, 1998 and were discharged from active duty on or after January 28, 2003, or discharged from active duty prior to January 28, 2003, who apply for enrollment on or after January 28, 2008.
Priority 7: Veterans with income and/or net worth above the VA National Income Threshold and below the VA National Geographic Income Thresholds who agree to co-pays.

Priority 8: Veterans with income and/or net worth above the VA National Income Threshold and the VA National Geographic Income Thresholds who agree to co-pays, and have non-compensable service-connected conditions (United States Department of Defense, 2008).

In summary, the focus of the preceding was primarily on the application process: determining the criteria for proof of eligibility to be submitted to the VA and the establishment of a mechanism for assigning one of eight Priority Levels to the veteran seeking service, which would in turn determine the services available to him or her. A listing of the VHA hospitals and service centers can be found in the resource and strategy guide located in Appendix C.

TRICARE

TRICARE benefits are explained in “Your TRICARE Benefits Explained” posted by Military.com (n.d.d). TRICARE is an enormous and very complex health care system regionally managed. The system provides health care services to Active Duty, Activated Guard, Reserves, retirees of the United States military, service members’ families, and their survivors. TRICARE combines the health care resources of the Army, Navy, and Air Force and enhances them with networks of civilian health care professionals. This
system of service provision gives access to high quality medical services, while maintaining the capability to support military operations (Military.com, n.d.d).

Active Duty, National Guard, and Reserve members are automatically enrolled in TRICARE Prime (Military.com, n.d.b). Military dependents, survivors, and retirees must choose one of three TRICARE options, TRICARE Prime, TRICARE Extra, and TRICARE Standard, which can be daunting due to the many coverage options, co-pays, and deductibles of the three options. At best, the system is confusing to navigate for military members and their families, as each choice has limitations and advantages.

In the “TRICARE Prime Overview,” posted by Military.com (n.d.b), members in TRICARE Prime receive their principle health care services at a Military Treatment Facility (MTFs) along with the TRICARE contracted Civilian Medical Providers called Preferred Provider Network (PPN). Members are seen first by a Primary Care Manager who provides and coordinates their care, maintains their health records, and makes referrals to specialists after services are approved. Non-emergency health care can be provided by a TRICARE authorized civilian provider, however, certain requirements apply. In summary, some advantages and requirements of TRICARE Prime are priority for care at military hospitals and clinics; Primary Care Manager provides and guides health care delivery; this is the lowest cost option of the three options; requires enrollment for one year; retirees, their families, and survivors pay an enrollment fee; it is very expensive to receive care outside TRICARE Prime (Point-of-Service Option); and services are not available everywhere (Military.com, n.d.b).
Posted in “TRICARE Extra Overview,” the following is explained: TRICARE Extra provides health care coverage to Active Duty family members and retirees under 65, their family members, and survivors. In summary, TRICARE Extra allows members to choose any doctor in the TRICARE Extra network, is less expensive than the TRICARE Standard plan, enrollment is not required, and members can still seek space-available care in a military hospital, however, they have a low priority to receive health care services. TRICARE Standard is the option that provides the most flexibility to beneficiaries (Military.com, n.d.a).

TRICARE Standard benefits are explained in “TRICARE Standard Overview” as follows. TRICARE Standard covers the family members of Active Duty service members, retirees, their family members, and survivors. The advantages of TRICARE Standard are the broadest choice of providers, services are widely available, there is no enrollment fee, and members may also use TRICARE Extra services. The disadvantages are that there is no Primary Care Manager, the patient pays a deductible and a copayment, as well as the balance if the bill exceeds allowable charges for a non-participating provider, and the member may have to file his or her own claims. In addition, TRICARE Standard beneficiaries have a low priority for access to care in a Military Treatment Facility (Military.com, n.d.c).

To use TRICARE benefits for health care, retirees and their families must navigate a complex system of service requirements, and explanations are confusing at best. Sponsors must be sure family members have an up-to-date uniformed services
identification card and that they are enrolled in the Defense Enrollment Reporting System (DEERS). In their Rand (2008) study, Jaycox and Tanielian explain that TRICARE does not offer specialized PTSD or depression treatment programs. Instead, beneficiaries can use a central referral process to identify locally based providers for treatment of mental health issues. “TRICARE will reimburse for a maximum of two psychotherapy sessions per week in any combination of individual, family, or group sessions. Eight sessions are provided without the need for referral from a primary care provider” (pp. 258-259). In addition, Jaycox and Tanielian (2008) further inform that TRICARE coverage for mental health services has a very low payment reimbursement rate and many providers will not accept TRICARE because the reimbursement for services is so low. This may “limit network participation” of retirees and make it difficult if not almost impossible for beneficiaries to access services from civilian providers (Jaycox & Tanielian, 2008, p. xxvi).

Evidence of such limitations was explained in a recent discussion with Lara Johnson, an insurance benefits verification assistant, at a local mental health facility that provides services to families in El Dorado County. It was found that TRICARE requires mental health service providers to have a state license. In many cases, services could not be provided to many military families and their children using TRICARE benefits, because unlicensed MSW Interns and MFT Interns provide most of the services at this facility. The requirement would be consistent across all counties and could add to the difficulties and confusion of retirees and their families, when mental health services may
make the adjustments military families need to make things a little easier (L. Johnson, personal communication, January 15, 2010).

Transitional Assistance Program

The Department of Defense currently offers a Transitional Assistance Program (TAP) for military service members. Members of the service can plan as much as twelve months in advance and retirees can plan ahead 24 months in advance of their separation from the military. In the information guide, posted on line in, “What Can the VA Do For Me,” by the Department of Veterans Affairs, separating service members can access information that will guide them to services and benefits that will help them with their transition from military service to civilian life. Information can be accessed at the Department of Defense website, TurboTap.org or service members are encouraged to meet with a counselor at their associated Transition Assistance Office. Separation from the various branches of the military may have different procedures so military personnel are advised to meet with a transition counselor to develop their own individual transition plan (ITP) (United States Department of Veterans Affairs-Returning Service Members, 2009). Military service members can access information and assistance about the following areas: transitional assistance, effects of a career change, employment assistance, entrepreneurship, relocation assistance, education and training, health care, life insurance, personal finances, guard and reserve assistance, veterans benefits, disabled veterans benefits and services, retirees benefits, employment restrictions, and leaving the service, through the TAP program as they near the time they will separate from the
military (United States Department of Veterans Affairs-Returning Service Members, 2009).

**Employment**

Each year, approximately 300,000 troops complete their military services. New veterans face an uncertain economic future as they attempt to transition into civilian life and find employment in the struggling American economy (Williamson & Mulhall, 2009). In a report from the Bureau of Labor Statistics in 2008 (United States Department of Labor, 2008), veterans’ unemployment rates were 7.3% overall. The jobless rates for veterans of different age groups vary considerably, as do non-veteran jobless rates. Veterans between the ages of 18 and 24 had an unemployment rate of 14.1%, which was nearly double the rate of veterans ages 25 to 34, who had unemployment rates of 7.3%, and the unemployment rate for that age group is almost three times the rate of veterans age 35 to 44 years old, who’s rates were 4.9%. In general, jobless rates for veterans and non-veterans vary little in the same age groups (United States Department of Labor, 2008).

Williamson and Mulhall (2009) note that as a whole, Iraq and Afghanistan veterans are not statistically more likely to be unemployed than their non-veteran peers, but veterans leaving active-duty do have a higher rate of unemployment. In fact, “the economy is now so tough for troops entering the civilian workforce that some veterans have opted to re-enlist in the military rather than face long-term unemployment” (Williamson & Mulhall, 2009, p. 4). Veterans facing employment challenges find that
many skills developed in the military like “adaptability, teamwork, and mission focus” (Williamson & Mulhall, 2009, p. 2), are skills that every employer should value; however they are not easily translated to civilian employers.

One obstacle returning veterans face in their employment search is simply explaining their military experience to a prospective employer. According to a 2007 survey by Military.com, employers do not believe they have a “complete understanding of the qualifications ex-service members offer” (p. 1). Many prospective employers believe veterans “need additional assistance to make a successful transition into the civilian job market with stronger interviewing skills” (Military.com, 2007, p. 1).

In addition, transitioning service members revealed they did not feel prepared for the process of entering the job market. Those who were surveyed revealed they felt “unprepared to negotiate salary and benefits, had an inability to effectively translate their military skills to civilian terms, and were unsure of how to network professionally” (Military.com, 2007, p. 1). The disconnect between prospective employers and service members leaving active duty has created barriers to employment for veterans.

In USA Today, Joe Davis, National spokesperson for the Veterans of Foreign Wars, advises that issues of mental health “have been a double edged sword” for veterans in that publicity has generated funding and resources for veterans in need of mental health services; however, that same publicity has also made employers cautious about hiring veterans (Study Finds New War Vets, 1998, p. 1). Williamson and Mulhall (2009) note that the National Alliance on Mental Illness, finds that “one in three individuals with
severe mental illness has been turned down for a job for which he or she was qualified because of a psychiatric label’’ (p. 3). It appears that the threat of employment discrimination against veterans has increased as the public’s awareness of troop’s psychological injuries has increased (Williamson & Mulhall, 2009).

Unemployment is only part of the challenge for veterans. In “Employment Histories Report, Final Compilation Report,” a study conducted by Abt Associates, Inc. (2008), veterans earn lower wages and have lower incomes than their nonmilitary peers. Wage gaps for veterans with college degrees are particularly significant as recently separated service members “earn on average $10,000 less per year than their nonveteran counterparts” (p. 9). Results from the 2007 employment history survey verified that recently separated service members (RSS) still face challenges related to employment and career readiness. “Eighteen percent of RSS are currently unemployed and of those employed since separation, 25.0% of RSS earn less than $21,840 a year” (Abt Associates, Inc., 2008, p. 1). Although recently separated service members are taking steps to improve their employability by using various VA and Department of Labor (DOL) assistance programs, there is not a strong indicator that these programs ensure “successful employment outcomes such as high earnings, responsibility in civilian work and placement in senior management positions” (Abt Associates, Inc., 2008, p. 2).

Housing for Homeless Veterans

Veterans are dramatically over represented in the homeless population. According to a report from the United States Department of Veterans Affairs-Homeless Veterans
“Overview of Homelessness,” while veterans make up one-tenth of the adult population, they are approximately one-third of the adult homeless population across the United States. Estimates suggest that about 131,000 veterans (both male and female) are homeless on any given night, and approximately 300,000 veterans experience homelessness at some point during the course of a year (United States Department of Veterans Affairs-Homeless Veterans, 2009). Although homeless veterans are more likely to be educated, more likely to be employed, and more likely to have a stable family background than homeless non-veterans, they are twice as likely to be chronically homeless (United States Department of Veterans Affairs-Homeless Veterans, 2009).

Thousands of Iraq and Afghanistan veterans are joining veterans from other eras on the streets and in shelters. Data from the VA suggests that Iraq and Afghanistan veterans make up 1.8% of the homeless veteran population (United States Department of Veterans Affairs-Project CHALENG, 2008). In an alarming trend, Iraq and Afghanistan veterans are turning up on the streets faster than veterans of other conflicts. Williamson and Mulhall (2009) cite the Director of Homeless Programs at the VA, Pete Dougherty, who reported that there are approximately 70,000 veterans from the Vietnam era who spent anywhere from 5-10 years attempting to readjust to civilian life before becoming homeless. Dougherty states “The veterans of today’s wars, who become homeless, end up with no place to live within 18 months after they return from the war” (Williamson & Mulhall, 2009, p. 4). About 8% of veterans serving since September 11, 2001, are paying more than half their income towards housing. In addition, high rates of PTSD and
traumatic brain injury may also contribute to higher homelessness rates among OEF/OIF veterans (Williamson & Mulhall, 2009).

Rates of mental illness and substance abuse are very high among the homeless population. About 45% of homeless veterans suffer from mental illness and more than 70% suffer from substance abuse (United States Department of Veterans Affairs-Homeless Veterans, 2009). Studies have found that posttraumatic stress disorder increases a veteran’s risk for homelessness and the personal and economic consequences of untreated PTSD, which can include social isolation and violent behavior, further increase the risk of homelessness for veterans. The prevalence of mental health injuries is high among Iraq and Afghanistan veterans and many are not receiving the treatment they need (Jaycox & Tanielian, 2008).

Nearly 20% of military service members, nearly 300,000, who have returned from Iraq and Afghanistan, have reported symptoms of posttraumatic stress disorder or major depression, yet only slightly more than half have sought treatment (Jaycox & Tanielian, 2008). Even among those who do seek help for PTSD or major depression only about half receive treatment that researchers consider minimally adequate for their illness (Jaycox & Tanielian, 2008). If quality mental health care is not provided to such veterans, the consequences of untreated PTSD or major depression could result in additional increases of homelessness in Iraq and Afghanistan veterans (Williamson & Mulhall, 2009).
The number of women serving in the United States military has increased over the past few decades. As a result, the number of homeless female veterans has also increased. In October 2008, the VA estimated there were approximately 7,000 to 8,000 homeless female veterans in the United States. Eleven percent of the homeless Iraq and Afghanistan veterans were women; two times the rate of homeless female veterans in all other generations serving in the United States military combined (Williamson & Mulhall, 2009).

Homeless programs for female veterans, especially for women with children have been slow to materialize and are not sufficient to meet the needs of United States female veterans. There are approximately a dozen female-only facilities nationwide, thus requiring female veterans to travel long distances or out of state to take advantage of these programs. Within the Veteran Administration’s homeless shelter system, “only sixty percent of shelters can accept women and less than five percent have programs that target female veterans specifically, or offer separate housing from men” (Williamson, & Mulhall, 2009, p. 6).

The National Coalition for Homeless Veterans (n.d.) advises that the state of California had approximately 49,724 homeless veterans in 2006, and the Veteran’s Administration has only 1,875 funded beds available to house these veterans. In the 2008 CHALENG survey, (United States Department of Veterans Affairs-Project CHALENG, 2008), the Northern California cities of Martinez, Oakland, and Sacramento had an estimated 3,000 homeless veterans with only 140 transitional housing beds and 50
permanent housing beds to serve them. The number of homeless veterans with minor dependents receiving housing services is 25.

Transportation Services

With respect to the services required for veterans, transportation services may be one of the most crucial, as many of the organizations and agencies providing services for veterans are site based and transportation to the facility is required. An example of this would be the Sacramento VA Medical Center located at Mather Field in Rancho Cordova, CA. The VA Northern California Health Care System website (2010) offers driving directions to the facility and also provides information pertaining to shuttle services from the Sacramento Regional Transit Light Rail station at Mather Field/Mills Station. Additionally, the website offers information pertaining to shuttle service between the Sacramento VA Medical Center and the other outpatient clinics (OPC) between Sacramento and the Bay Area (United States Department of Veterans Affairs, 2010c). The crux of the matter is access to services relies on the patients’ ability to travel to the location of the hospital or OPC or use public transportation to get to their desired destination.

The key components of transportation services relate to the availability of transportation (public or private) and the location of services that serve military veterans. Adding to the challenge is where the veterans reside: urban, suburban, or rural areas, since transportation may become a greater challenge for those who live in rural areas and may not have adequate transportation or the ability or stamina to travel long distances to
receive services. A review of the public transportation systems offered in the counties surrounding Sacramento County (Sutter, Placer, El Dorado, Amador, San Joaquin, and Yolo) shows that all counties have public transportation routes that provide service to Sacramento; however, some of the public transportation routes travel to and from Sacramento at specific times and are unable to deviate from their set schedules.

Even on a National level the need for services for the veterans who live in rural areas has not gone unnoticed. On November 5, 2009, United States Congressman David Wu introduced to Congress, The Rural Veterans Services Outreach and Training Act, H.R. 4028, that sought to increase rural veterans’ access to health care, disability compensation, and transportation benefits. Wu defended his bill by emphasizing the inability of some veterans to access services because they did not live close to a Veterans Affairs Regional Office (Congress of the United States, House of Representatives, 2009). Additionally, it was estimated in 2008 that more than 6 million veterans resided in rural areas, emphasizing the need for transportation services for rural veterans.

A similar bill, The Rural Veterans Health Care Improvement Act, H.R. 2879, was introduced in March 2009 and addressed transportation concerns for veterans living in rural areas. Among other things, this bill proposed that rural veterans be paid 41.5 cents a mile when traveling to receive treatment at facilities of the Department of Veterans Affairs and established a grant program to provide transportation options for veterans in highly rural areas (Library of Congress-Thomas, 2009).
Both bills were referred to the House of Representatives Subcommittee on Health in November and June of 2009 respectively, and unfortunately both bills never proceeded any further. However, this serves as a reminder that there is a present and ongoing need for transportation services for veterans, especially those who live in rural areas.

Gaps in the Literature

In the review of the literature it was found that many of the research studies contained conflicting estimates of the number of individuals diagnosed with PTSD, depression, and TBI. Research studies are being conducted continually, so new information is being introduced often. It is therefore important that the researcher be critically aware of the dates the studies are performed and the research participants’ demographics in the studies. Several studies also mentioned that most participants in their studies were soldiers who had been in combat situations; yet many military personnel are in fact in combat related areas or positions and exposed to traumatic events or even become wounded. Furthermore, women military are not classified to be in combat but in fact they are. Restricting research participants to combat soldiers limits the generalizability of the study to all military personnel and could affect the accuracy of the prevalence of medical, mental, and cognitive injuries. Therefore, there exists a need for studies to include non combat experienced military personnel.

As mentioned in the RAND (2008) study there is very little information about the prevalence of TBI or the severity of cases of TBI; and screening for mild cases of TBI started late in 2007 (Jaycox & Tanielian, 2008). Because of this there is a gap in the
information service providers need to develop effective treatment procedures for veterans with symptoms of TBI. This indicates a need for additional research about the prevalence of TBI and effective treatment measures. In addition, there was a limited amount of information about the success of various models of treatment with veterans suffering with PTSD, depression, and TBI. Each of these concerns indicates the need for future research to better provide veterans with the most effective treatments for these conditions.

Summary

This chapter introduced a review of the literature pertaining to many issues affecting United States military veterans. These issues relate directly to the questions the researchers asked the research subjects in the survey they administered in order to determine the awareness level of the research subjects on these matters. Chapter 3 introduces the research methods used in this study.
Chapter 3

METHODOLOGY

Introduction

The purpose of this project was to develop a resource guide/manual, which will help guide the social worker in identifying appropriate resources and services for military veterans in the Sacramento, CA, and the surrounding community. This chapter introduces the research design of this study and describes the methodology used to implement the research project. This chapter also describes the participant pool, the instrument used to collect the data and how data was to be analyzed. This chapter concludes with information pertaining to the protection of the human subjects used in the research.

Research Question

How knowledgeable are MSW students about resources that serve United States military veterans in Sacramento, California, and its surrounding counties? This research question is posed in the service of developing a resource guide/manual, which helps guide the social worker in identifying appropriate resources and services for military veterans in the Sacramento, CA, and the surrounding community. Data from the MSW student surveys will help inform the development of the resource guide.

Research Design

The research design of this study was exploratory with descriptive statistics used to analyze the data. This type of design was chosen because the objective of this study was to produce a resource guide of services available for United States military veterans.
The resource guide could be utilized by professionals, especially those with an MSW degree to facilitate providing information to veterans who are in need of services. The utilization of an exploratory design was helpful, because it assisted in determining the practicality of performing the research. And it allowed the researchers to assess the basic level of knowledge the research subjects had about the topic. In addition, having descriptive outcomes informed the researchers about the knowledge base the research subjects had about the research topic, and provided a detailed image of the research material (Kreuger & Neuman, 2006). That image was the types of services available to United States military veterans in Sacramento County and the five surrounding counties.

One advantage of an exploratory study was that it placed little to no limitations on the type or number of questions posed to the research subjects. A limitation was imposed, but this was done in order to not deviate from the relevant subject matter. Another advantage to this type of study was that it allowed the researchers to get a better understanding of the research subjects’ general understanding of services available to veterans in Sacramento, CA, and the surrounding area.

A disadvantage of utilizing an exploratory study was that while the research subjects were asked about services for veterans in Sacramento County, and the five surrounding counties, the subjects’ range of knowledge may be limited to Sacramento County and a few surrounding counties. This may result in, inconclusive information about the services available outside of the county(ies) with which the subjects are most familiar.
Study Population/Subjects

The subjects chosen to participate in this study were Master of Social Work (MSW) students at California State University, Sacramento. The researchers believed it was prudent to examine the MSW students’ knowledge about the resources available to United States military veterans in the Sacramento, CA, and surrounding counties because of the growing number of veterans in need of services. Social work professionals should be equipped with knowledge to assist veterans, because the veteran population is growing, and California has one of the largest populations of United States military personnel, veterans and dependents in the United States, and services are not always easy to find (California Department of Veterans Affairs, 2009). Additionally, the researchers also believed in the importance of the social work professional’s abilities to address strategies for working with United States military veterans and to assist in guiding the user in becoming more knowledgeable about the types of issues concerning military veterans. The importance of surveying students was twofold: first to develop an initial understanding of the knowledge level students had and to develop strategies to inform and increase the development of the knowledge level of students.

The subjects were both MSW I and MSW II students, thus providing a greater range of social work field experience and possible exposure to veterans or veterans’ families. Data from the MSW student surveys helped to inform the development of the resource guide, the development of which was the essential goal of this project. The goal for the sample size of the project was 50 respondents. This number was chosen because
of the initial belief that this would provide an adequate cross section of respondents, with
the hope that there would be an equal amount of MSW I and MSW II respondents. It was
discovered that the initial research subjects were primarily MSW II students, so the
researchers sought out subjects in MSW I classes, to develop an equal number of first and
second year MSW students. Surveying more students created the desired balance between
MSW I and MSW II respondents but, the disadvantage was that it made the response
recording more time consuming. A total of 112 MSW I and II students participated in the
research project. Of the 112 students, 42 were MSW I students and 66 were MSW II
students. There were four students who did not indicate their year in the MSW program.

Instrumentation

The survey consisted of a total of 27 questions created by the researchers (see
Appendix A). The questions consisted of scaling, closed and open-ended questions,
designed to assess the research subject’s knowledge of: posttraumatic stress disorder
(PTSD); medical and mental health needs; homelessness among veterans; counseling
services; and military sexual trauma. There were also questions designed to have the
research subjects provide a listing of agencies that provided services to military veterans
in the Sacramento, CA, and surrounding counties (see Appendix A). It was the belief of
the researchers that the questions contained within the survey covered pertinent areas of
concern to United States military veterans. The survey was created in a joint-effort by the
researchers and has not been tested for validity and reliability. The hope was that the data
collected from the survey would enhance the resource guide the researchers created.
Data Gathering Procedures

The researchers’ decision to survey MSW Students at California State University, Sacramento, required the researchers to obtain permission from professors teaching MSW classes at California State University, Sacramento, prior to any research being conducted. The researchers initially contacted the professors from whom the researchers were presently receiving instruction. After that, other professors with whom the researchers had a rapport were contacted to ensure an adequate number of research subjects could be surveyed.

Upon being granted permission to survey MSW students, the researchers negotiated a time with the professors to administer the survey to their classes. Prior to administering the survey to the students, the researchers identified themselves as MSW students completing a research project and informed the research subjects their participation was optional. All participants were provided with a consent form (see Appendix B) and a list of counseling resources (see Appendix B) research subjects could utilize if any unintentional emotional distress was elicited from the survey. During the distribution of the survey, it was discovered that some of the research subjects had already completed the survey in another class. With that knowledge, the researchers did not allow the research subjects to take the survey again. The researchers disclosed to the research subjects in which classes the survey had been administered to ensure subjects were not responding more than once.
To complete this project information about the resources and services available to United States military veterans needed to be gathered and compiled. The researchers utilized multiple sources to obtain this information, including the Veteran’s Resource Book (2009) by the California Department of Veterans Affairs-Division of Veteran Services. The Veteran’s Resource Book (2009) provided information that included, but was not limited to: a directory of County Veteran Service Officers; the locations and contact information for Veterans Administration (VHA) Facilities in California; assistance for homeless veterans, including statewide resources, emergency housing programs and programs for home loans (Cal Vet). The resource book also contained information relating to women veterans and information pertaining to suicide prevention. Another resource that was utilized was Network of Care for Veterans & Service Members (California Department of Veterans Affairs, 2010), a website provided by the County of Sacramento. This website contained contact information relating to local resources: housing and shelters; mental health care and counseling; and crisis and emergency contact information.

Data Analysis

The information collected from the surveys was analyzed by the researchers using descriptive statistics. The data was aggregated and entered into the Statistical Package for the Social Sciences (SPSS, Inc., 2010) and descriptive statistics were run. The use of descriptive statistics allowed the researchers to identify patterns and themes in the information provided by the respondents, in addition to allowing the researchers to
identify the level of knowledge the respondents had about the subject matter. The advantage of utilizing descriptive statistics to interpret and present the data was that it allowed the large quantity of data that was collected to be put into a form, tables, allowing the data to be easily understood. From these tables, reports were created which provided relevant information rather than assumptions (Stocks, 2001).

Protection of Human Subjects

A request for the review of this research project was submitted to the Committee for the Protection of Human Subjects in the Division of Social Work, California State University, Sacramento. The committee approved the study at the “minimal risk” level (approval # 09-10-047).

To reduce the possibility of risk, participants were given a list of referral sources they could contact should they experience any discomfort related to participation in the study. These referral sources were listed in the consent form and in the handout that the participants received at the time of signing the consent form. Participants were informed of the topic ahead of time and only those who were interested in the study topic relating to the services needed for military veterans agreed to participate.

Through the informed consent document and procedure, potential participants were informed of the voluntary nature of their participation. Responses to interview questions were kept confidential. No personally identifying data was collected. Consent forms and data were stored at the researchers’ homes and destroyed when the project was
finished with the intention of destroying all consent forms by July 2010. In addition, consent forms were stored separately from any and all data.

Summary

This chapter described the research study and the methods utilized by the researchers to collect information from the research subjects. The design of the research was exploratory and the research instrument was administered to research subjects with the intention of capturing the subjects’ current knowledge about matters pertaining to United States military veterans. This chapter also described how the researchers compiled the information being placed into the resource guide. In addition, this chapter covered how data was analyzed and how protection of the human subjects was maintained. The results of the data are presented in Chapter 4.
Chapter 4

ANALYSIS OF DATA

Introduction

This chapter presents findings from the survey that was distributed to Master of Social Work (MSW) I & II students at California State University, Sacramento between the dates of November 15, and November 23, 2009. The findings help to justify the need for the resource guide/manual, which helps guide the social worker in developing mindful awareness of the needs of military veterans. In addition, this guide will assist students, community members, social workers, and veterans in their search for support and hopefully lead to the development of successful connections for veterans to resources in their respective communities. This chapter will also include the resource guide/manual, which is the core component of this project.

Overall Findings

There were 112 respondents to the survey distributed by the researchers. The researchers were most interested in finding the research subjects’ knowledge and awareness of issues pertaining to local military veterans and the services available to meet the veteran’s needs. The research subjects were asked to rate their current level of knowledge and awareness of issues pertaining to United States military veterans. In addition, the research subjects were also asked to identify specific resources, if possible, based upon their current knowledge and their level of confidence in providing services to United States military veterans.
The proceeding section will detail the statistical findings from the research subjects. The results were analyzed as a single group, although MSW I and II students were surveyed. All the information was compiled with SPSS 17.0 for Windows.

**Demographics**

*Current Year in Master of Social Work Program (MSW).* The research subjects were all students at California State University, Sacramento and were either in the MSW I or II program. The subjects were asked to indicate their current year, and 108 of the 112 subjects responded (see Table 1). The results found that 58.9% of the subjects were MSW II students, and 37.5% were MSW I students.

**Table 1**

*Current Year in MSW Program*  
<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>MSW I</td>
<td>42</td>
<td>37.5</td>
</tr>
<tr>
<td>MSW II</td>
<td>66</td>
<td>58.9</td>
</tr>
<tr>
<td>No Response</td>
<td>4</td>
<td>3.6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>112</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

*Age ranges.* The age ranges were categorized in ten-year increments, beginning at age 20 through ages 60 and older. The two largest age ranges of the subjects included the range of 20-29 years of age, and this pertained to 45.5 % of the subjects (see Table 2).
The other large age range was 30-39 years old and applied to 31.3 % of the subjects.

There were two subjects who did not provide a response.

Table 2

*Age Ranges*

<table>
<thead>
<tr>
<th>Range</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-29</td>
<td>51</td>
<td>45.5</td>
</tr>
<tr>
<td>30-39</td>
<td>35</td>
<td>31.3</td>
</tr>
<tr>
<td>40-49</td>
<td>12</td>
<td>10.7</td>
</tr>
<tr>
<td>50-59</td>
<td>10</td>
<td>8.9</td>
</tr>
<tr>
<td>60 and over</td>
<td>2</td>
<td>1.8</td>
</tr>
<tr>
<td>No Response</td>
<td>2</td>
<td>1.8</td>
</tr>
<tr>
<td>Total</td>
<td>112</td>
<td>100</td>
</tr>
</tbody>
</table>
Gender. The majority of the respondents were female (87). Twenty respondents identified as male, and three identified as transgender (see Table 3).

Table 3

<table>
<thead>
<tr>
<th>Gender</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>20</td>
<td>17.9</td>
</tr>
<tr>
<td>Female</td>
<td>87</td>
<td>77.7</td>
</tr>
<tr>
<td>Transgender</td>
<td>3</td>
<td>2.7</td>
</tr>
<tr>
<td>No Response</td>
<td>2</td>
<td>1.8</td>
</tr>
<tr>
<td>Total</td>
<td>112</td>
<td>100.0</td>
</tr>
</tbody>
</table>
Ethnicity. The three largest ethnicity groups were: Caucasian (38.4%), Latino(a) (22.3%), and African-American (11.6%). There were eight subjects who did not provide a response (see Table 4).

Table 4

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>African-American</td>
<td>13</td>
<td>11.6</td>
</tr>
<tr>
<td>Asian</td>
<td>11</td>
<td>9.8</td>
</tr>
<tr>
<td>Latino(a)</td>
<td>25</td>
<td>22.3</td>
</tr>
<tr>
<td>Middle Eastern</td>
<td>1</td>
<td>.9</td>
</tr>
<tr>
<td>Native American</td>
<td>2</td>
<td>1.8</td>
</tr>
<tr>
<td>Caucasian</td>
<td>43</td>
<td>38.4</td>
</tr>
<tr>
<td>Other</td>
<td>9</td>
<td>8.0</td>
</tr>
<tr>
<td>No Response</td>
<td>8</td>
<td>7.1</td>
</tr>
<tr>
<td>Total</td>
<td>112</td>
<td>100.0</td>
</tr>
</tbody>
</table>
Number of years of social work experience. The subjects were asked to indicate their years of social work experience. These results are depicted in Table 5. The range extended from zero to 14 years, with one person having 14 years of experience. The majority of the respondents (25.9%) had three years of social work experience.

Table 5

Number of Years of Social Work Experience (Including Internships)

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>4.5</td>
</tr>
<tr>
<td>1</td>
<td>8.0</td>
</tr>
<tr>
<td>2</td>
<td>17.0</td>
</tr>
<tr>
<td>3</td>
<td>25.9</td>
</tr>
<tr>
<td>4</td>
<td>17.9</td>
</tr>
<tr>
<td>5</td>
<td>7.1</td>
</tr>
<tr>
<td>6</td>
<td>2.7</td>
</tr>
<tr>
<td>7</td>
<td>3.6</td>
</tr>
<tr>
<td>8</td>
<td>2.7</td>
</tr>
<tr>
<td>9</td>
<td>2.7</td>
</tr>
<tr>
<td>10</td>
<td>3.6</td>
</tr>
<tr>
<td>11</td>
<td>1.8</td>
</tr>
</tbody>
</table>
Veteran status. Respondents were asked to disclose their veteran status. One respondent indicated that he/she was a United States military veteran (see Table 6). One respondent did not provide a response, and the remaining 110 respondents indicated that they were not United States military veterans.

Table 6

<table>
<thead>
<tr>
<th>Veteran Status</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>110</td>
<td>98.2</td>
</tr>
<tr>
<td>Yes</td>
<td>1</td>
<td>0.9</td>
</tr>
<tr>
<td>No Response</td>
<td>1</td>
<td>0.9</td>
</tr>
<tr>
<td>Total</td>
<td>112</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Demographics summary. The demographics portion of the researchers’ survey helped to provide descriptive information pertaining to the research subjects: level in the MSW Program, age, gender, ethnicity and current number of years of social work
experience. Of these categories 58.9% of the respondents were in the MSW II program; 45.5% of the respondents were in the age range of 20-29; 77.7% of the respondents identified as female; 38.4% of the respondents identified as Caucasian and 25.9% of the respondents indicated they had three years of social work experience.

The researchers were also interested in learning about the veteran status of the participants, and one respondent identified as a veteran. The research subjects were later asked to identify if they personally knew a veteran from a present or prior war. It was the hope of the researchers that, if the research subjects knew military veterans, the subjects would also know about the services and supports pertaining to the veterans. The following tables relate specifically to the subjects’ personal knowledge of veterans from the current wars, Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF), or a previous war, such as the Gulf War (Operation Desert Storm) or the Vietnam War.
Personal Knowledge of a United States Military Veteran

Personal knowledge of a veteran from a current war. More than half of the respondents (59.8 %) stated that they knew a veteran from a current war, OIF or OEF.

Table 7 presents a summary of the results for this question.

Table 7

Personal Knowledge of a Veteran from a Current War

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>45</td>
<td>40.2</td>
</tr>
<tr>
<td>Yes</td>
<td>67</td>
<td>59.8</td>
</tr>
<tr>
<td>Total</td>
<td>112</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Personal knowledge of a veteran from a past war. Almost three quarters (74.1 %) of the research subjects indicated they knew a veteran from a past war (see Table 8). One research subject did not respond. The term “past war” meant a war other than the current wars, OIF and OEF.
Table 8

**Personal Knowledge of a Veteran from a Past War**

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>28</td>
<td>25.0</td>
</tr>
<tr>
<td>Yes</td>
<td>83</td>
<td>74.1</td>
</tr>
<tr>
<td>No Response</td>
<td>1</td>
<td>.9</td>
</tr>
<tr>
<td>Total</td>
<td>112</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Summary of research subjects’ knowledge of veterans from current and past wars.

A majority of the research subjects indicated having knowledge of veterans of a current or past war. This was not a surprising discovery. However, the research subjects’ associations with veterans did not support their competency in providing current veterans with the resources and services needed for veterans to successfully thrive in today’s society.

**Knowledge and Awareness**

Research subjects responded to questions regarding their overall knowledge and awareness of the current issues United States military veterans are experiencing as they transition from combat to civilian life. The survey specifically focused on the research subjects’ knowledge of medical and mental health needs, posttraumatic stress disorder (PTSD), traumatic brain injury (TBI), military sexual trauma (MST), housing needs, and services available for veterans (see Table 9). In general, 45.5% of the research subjects
felt they had a fair level of knowledge and awareness of the current issues experienced by United States military veterans; 32.1% of those surveyed felt their knowledge and awareness was poor; 18.8% felt their overall knowledge was good; only 3.6% of the research subjects felt they had an excellent level of knowledge and awareness pertaining to current issues experienced by transitioning military service personnel.

Table 9

*Overall Knowledge and Awareness of Issues Experienced by United States Military Veterans*

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent</td>
<td>4</td>
<td>3.6</td>
</tr>
<tr>
<td>Good</td>
<td>21</td>
<td>18.8</td>
</tr>
<tr>
<td>Fair</td>
<td>51</td>
<td>45.5</td>
</tr>
<tr>
<td>Poor</td>
<td>36</td>
<td>32.1</td>
</tr>
<tr>
<td>Total</td>
<td>112</td>
<td>100.0</td>
</tr>
</tbody>
</table>

*Knowledge and awareness of medical and mental health needs.* The research subjects indicated that their knowledge and awareness of medical and mental health needs of United States military veterans primarily in the fair (39.3%) and poor (30.4%) categories (see Table 10). However, 23.2% of the respondents felt they had a good level
of knowledge and awareness and 7.1% felt they had an excellent understanding of the medical and mental health needs of military veterans.

Table 10

*Knowledge and Awareness of Medical and Mental Health Needs*

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent</td>
<td>8</td>
<td>7.1</td>
</tr>
<tr>
<td>Good</td>
<td>26</td>
<td>23.2</td>
</tr>
<tr>
<td>Fair</td>
<td>44</td>
<td>39.3</td>
</tr>
<tr>
<td>Poor</td>
<td>34</td>
<td>30.4</td>
</tr>
<tr>
<td>Total</td>
<td>112</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Knowledge and awareness of PTSD. The research subjects’ level of knowledge and awareness of PTSD, as it relates to military veterans was: 41.1% good, and 37.5% indicated they had a fair level of knowledge. 15.2% of the respondents felt their level of knowledge was poor as it related to PTSD and United States military veterans. The results are detailed in Table 11.
Table 11

Knowledge and Awareness of PTSD

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent</td>
<td>7</td>
</tr>
<tr>
<td>Good</td>
<td>46</td>
</tr>
<tr>
<td>Fair</td>
<td>42</td>
</tr>
<tr>
<td>Poor</td>
<td>17</td>
</tr>
<tr>
<td>Total</td>
<td>112</td>
</tr>
</tbody>
</table>

Knowledge and awareness of TBI. Knowledge and awareness of traumatic brain injury TBI of the research subjects was in general poor (50.0%). The next highest percentage, 31.3% was the fair level of understanding. One survey respondent did not answer this question (see Table 12).
Table 12

*Knowledge and Awareness of TBI*

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent</td>
<td>6</td>
<td>5.4</td>
</tr>
<tr>
<td>Good</td>
<td>14</td>
<td>12.5</td>
</tr>
<tr>
<td>Fair</td>
<td>35</td>
<td>31.3</td>
</tr>
<tr>
<td>Poor</td>
<td>56</td>
<td>50.0</td>
</tr>
<tr>
<td>No Response</td>
<td>1</td>
<td>.9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>112</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

*Knowledge and awareness of MST.* Overall 65.2% of the research subjects felt they had a poor understanding of military sexual trauma; this was followed by 24.2% listing their knowledge as fair. Table 13 illustrates the findings in detail.
Table 13

Knowledge and Awareness of MST

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent</td>
<td>2</td>
</tr>
<tr>
<td>Good</td>
<td>10</td>
</tr>
<tr>
<td>Fair</td>
<td>27</td>
</tr>
<tr>
<td>Poor</td>
<td>73</td>
</tr>
<tr>
<td>Total</td>
<td>112</td>
</tr>
</tbody>
</table>

Knowledge and awareness of housing needs. Research subjects’ knowledge and awareness of the housing needs of veterans was 42.0% poor, 35.7% fair, and 20.5% good (see Table 14). Only 1.8% felt they have an excellent level of knowledge and awareness of the housing needs of United States military veterans.
Table 14

*Knowledge and Awareness of Housing Needs*

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent</td>
<td>2</td>
<td>1.8</td>
</tr>
<tr>
<td>Good</td>
<td>23</td>
<td>20.5</td>
</tr>
<tr>
<td>Fair</td>
<td>40</td>
<td>35.7</td>
</tr>
<tr>
<td>Poor</td>
<td>47</td>
<td>42.0</td>
</tr>
<tr>
<td>Total</td>
<td>112</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Knowledge and awareness of services needed for United States military veterans.

Overall, the current level of research subjects’ knowledge of services, as they pertain to United States military veterans was poor, (41.4%), fair (43.8%), good (9.8%), and excellent (3.6%). As depicted in Table 15, two surveys had no response to this question. In the next section of the survey research subjects were also asked to identify their knowledge of specific agencies that provide services to veterans.
Table 15

Knowledge and Awareness of Services Needed for United States Military Veterans

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent</td>
<td>4</td>
<td>3.6</td>
</tr>
<tr>
<td>Good</td>
<td>11</td>
<td>9.8</td>
</tr>
<tr>
<td>Fair</td>
<td>49</td>
<td>43.8</td>
</tr>
<tr>
<td>Poor</td>
<td>46</td>
<td>41.1</td>
</tr>
<tr>
<td>No Response</td>
<td>2</td>
<td>1.8</td>
</tr>
<tr>
<td>Total</td>
<td>112</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Summary of knowledge and awareness. In a review of the data the researchers found that a small number of research subjects felt they had an excellent and good (4.23% and 19.26% respectively) knowledge and awareness of the current issues and needs of veterans and the services available to them. More importantly, a large number of the research subjects felt they had a fair and poor (36.74% and 39.43% respectively) knowledge and awareness of the current issues and needs of veterans and services for United States military veterans. Overall, the majority of research subjects (76.17%) felt their knowledge and awareness of issues, needs, and services for United States military veterans was lacking competency to successfully support veterans and connect them to the services they need.
Knowledge of Services and Service Centers Available to Veterans

Transportation services for veterans. The research subjects were asked to identify their knowledge of transportation services for disabled or homeless United States military veterans who require transportation to access medical, mental health or employment services. The research subjects were given a possible response of “yes,” “no,” or “don’t know.” Slightly more than half (55.4%) of the 112 who responded answered “yes” to this question indicating the ability to identify transportation services for veterans. As depicted in Table 16, 33.9% responded “no” and 10.7% responded “don’t know.”

Table 16

<table>
<thead>
<tr>
<th>Transportation Services for Veterans</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>62</td>
<td>55.4</td>
</tr>
<tr>
<td>No</td>
<td>38</td>
<td>33.9</td>
</tr>
<tr>
<td>Don’t Know</td>
<td>12</td>
<td>10.7</td>
</tr>
<tr>
<td>Total</td>
<td>112</td>
<td>100.0</td>
</tr>
</tbody>
</table>

County Veteran Services Divisions. The research subjects were asked whether they knew if there were Veteran Services Divisions in Sacramento and surrounding counties. More than half (58.9%) of the research subjects replied “no,” indicating that they thought that Sacramento and surrounding counties do not have Veteran Service Divisions. Only 42 (38.4%) of the 112 respondents indicated that they knew that
Sacramento and the surrounding counties have Veteran Services Divisions (see Table 17).

Table 17

*County Veteran Services Divisions*

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>43</td>
<td>38.4</td>
</tr>
<tr>
<td>No</td>
<td>66</td>
<td>58.9</td>
</tr>
<tr>
<td>Don’t Know</td>
<td>2</td>
<td>1.8</td>
</tr>
<tr>
<td>No Response</td>
<td>1</td>
<td>0.9</td>
</tr>
<tr>
<td>Total</td>
<td>112</td>
<td>100.0</td>
</tr>
</tbody>
</table>

*Knowledge and Awareness of VHA and TRICARE Benefits*

_Awareness of the services provided by the Veterans Administration Hospital._

When the research subjects were asked about their awareness of the services provided by the Veterans Administration Hospital 55.4% responded “no.” As indicated in Table 18, 44.6% of the respondents indicated that they were aware of the services provided by the Veterans Administration Hospital.
Table 18

*Awareness of the Services Provided by the Veterans Administration Hospital*

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>50</td>
<td>44.6</td>
</tr>
<tr>
<td>No</td>
<td>62</td>
<td>55.4</td>
</tr>
<tr>
<td>Total</td>
<td>112</td>
<td>100.0</td>
</tr>
</tbody>
</table>

*Awareness of the services provided by TRICARE.* Most of the research subjects (84.8%) indicated that they were not aware of the services that TRICARE provides to veterans (see Table 19). This was an overwhelming majority compared to the 15.2% of the respondents who answered “yes.”

Table 19

*Awareness of the Services Provided by TRICARE*

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>17</td>
<td>15.2</td>
</tr>
<tr>
<td>No</td>
<td>95</td>
<td>84.8</td>
</tr>
<tr>
<td>Total</td>
<td>112</td>
<td>100.0</td>
</tr>
</tbody>
</table>

*Summary of findings.* Overall, it was found that many of the respondents did not have a strong knowledge of the resources available or an understanding of the issues
currently pertaining to military veterans. As a result, the researchers perceived a need to develop a resource and strategy guide for current and future MSW students at California State University, Sacramento. Additionally, it is the belief of the researchers’ that the resource and strategy guide will also target other community workers and veterans. It is the researchers’ hope that the resource and strategy guide, located in Appendix C, will increase the social worker’s success in connecting veterans to resources and services now and in the future.

The next chapter, Chapter 5, provides a summary of the research and draws conclusions. Additionally, limitations of the project are discussed along with suggestions for the use of the resource and strategy guide by social work professionals, veterans, and other community members.
Chapter 5
SUMMARY AND CONCLUSIONS

Introduction

This chapter provides a summary of the project that lead to the development of our resource and strategy guide, “Empowering Successful Connections: A Resource and Strategy Guide for Meeting the Needs of U.S. Military Veterans in Sacramento, CA and the Surrounding Community.” In addition, this chapter will examine the conclusions that were drawn from the research conducted to complete this project. In this chapter the researchers will also discuss the implications for the social work and other professions, and review the probable limitations of the resource and strategy guide, which has been developed.

Summary

This study introduced the idea that current cultural tendencies often extol the role of the soldier in this society. Yet, generally, society tends to overlook or does not have a clear understanding of the medical and mental health needs of veterans, the services and treatments available to address veterans’ needs, or the barriers veterans experience when they attempt to access services. While media coverage of soldiers’ combat experiences has enlightened the public to some degree, many people do not clearly understand the combat experiences that lead to the veteran’s needs. Additionally, there are others that do not understand the barriers that prevent veterans from receiving the services and
treatments they need to transition successfully back to the lives they left before their service to the United States military.

In review of the current issues facing United States military veterans it was found that due to new technologies, 15 of 16 seriously wounded service members survive injuries that would have been fatal in past wars (Franklin, 2009). This has created new concerns in that veterans are returning home with physical medical conditions, mental health conditions, and cognitive health impairments that have not been present in past wars (Franklin, 2009). The length of deployments and the numerous redeployments for soldiers present additional concerns (Jaycox & Tanielian, 2008), as soldiers deployed to Iraq for more than six months or deployed more than once are much more likely to be diagnosed with psychological injuries (Franklin, 2009). The most prominent psychological injuries include posttraumatic stress disorder (PTSD), traumatic brain injury (TBI), depression, and anxiety (Franklin, 2009). And men and women veterans may also have experienced sexual harassment, sexual assault or rape, and gender harassment (Mulhall, 2009). All of which leads to the concern for effective assessments and service provision for the soldiers leaving the combat arena and returning home.

Additional issues for veterans include homelessness, the increase of unemployed veterans, and veteran suicide rates. Veterans make up 11% of the general population, yet they account for 26% of the homeless population (Williamson & Mulhall, 2009). Women veterans are two to four times more likely than other women to be homeless (Franklin, 2009). The unemployment rate for Iraq and Afghanistan era veterans was 8% in 2007,
which was 2% higher than unemployment rates for non-veterans. Suicide rates for veterans are alarming (Williamson & Mulhall, 2009): a 2007 CBS News investigation “found that veterans were twice as likely to commit suicide as non-veterans, and 120 veterans from all wars kill themselves every week” (Franklin, 2009, p. 164).

Combat training and military culture can instill the view that physical and emotional injuries are signs of weakness. These views have helped to create a stigma for soldiers and veterans in accessing treatment and services for PTSD, TBI, depression and anxiety. In addition, the lack of assessments for these conditions as soldiers transition out of the military has created barriers for veterans seeking services in the future. Larger cultural attitudes about the mental health of veterans, and a lack of employer understanding of veterans’ training and employable skills have limited veterans access to employment and intensified the problems military personnel experience as they transition back to non-military status. The unmet needs of veterans have lead to prolonged medical and mental health problems for veterans, added to the numbers of homeless veterans and increased the number of veterans that commit suicide.

Veterans are entitled to services, treatments, and resources to address their medical and mental health, employment, housing, and other transitional needs. The lack of proper assessments, help with transition, and guidance to adequate treatment and services for the growing numbers of United States military veterans have created problems that need to be addressed. These issues create a challenge for social workers and service providers of all venues to meet the needs of veterans.
The creation of a resource guide becomes prudent, as it has been designed to inform and aid the social work professional to efficiently provide services to veterans in a timely manner. The development of the resource and strategy guide is timely and relevant, especially due to the current number of service members who are engaged in combat in the wars in Iraq or Afghanistan who will become veterans and the current number of veterans who require services at this time. This resource guide will be of benefit to the profession of social work by increasing the social work professional’s level of awareness, and provide the professional with tangible resources to guide those requiring services and support.

Conclusions

Based upon the survey of 112 MSW students at California State University, Sacramento, it was found that a large percentage of the students (77.6%) had a fair to poor level of knowledge and awareness of the current issues that United States military veterans may be experiencing that include, but are not limited to: medical and mental health services, posttraumatic stress disorder (PTSD); traumatic brain injury (TBI); military sexual trauma (MST), and employment and housing needs.

The same group of students were asked to indicate their level of knowledge relating to specific services, such as: transportation services and Veterans Health Administration (VHA) and TRICARE services, in addition to veterans’ service centers in Sacramento and surrounding counties. It was found that a large percentage of students
(84.9%) did not have knowledge or awareness of the services and service organizations designed specifically to assist veterans.

These findings are worthy of note based upon the number of respondents who indicated a personal knowledge of a veteran from a current war (59.8%) and the number of respondents who indicated they personally knew a veteran from a past war (74.1%). The research in this project shows that there is a discrepancy between the respondent’s knowledge of veterans and the needs and services available for veterans at the current time.

The MSW student research subjects are a wide and diverse group of individuals who come from numerous counties and communities, not only from Sacramento County but from the greater population of the state of California. Therefore, an assumption has been made that the large percent of students who lack knowledge and awareness of veterans’ issues, needs for service, and resources available to veterans can be generalized to the greater population of California. The lack of knowledge and awareness found in our study indicate that social work students need competency in providing professional services to veterans and educating the greater population of California about the needs of veterans. The lack of competency and knowledge of social work students regarding veterans prohibits the provision of advocacy and the empowerment of a population of vulnerable and oppressed individuals and further prohibits the assurance of the individual wellbeing of veterans and the wellbeing of society as a whole.
Implications

It could be inferred from this study that there should be offerings in the MSW program at CSUS to educate future social work providers; those course offerings should focus on military culture, the need for treatment and services, barriers to service acquisition, and resources for United States military veterans. There is also a need for the development of a greater understanding of veterans’ issues among social workers already providing professional service in the community. It is the recommendation of these researchers that the Sacramento branch of the National Association of Social Workers (NASW) assist in the development of a course offering that informs students, interns, professional social workers, and the community about military culture and the current and upcoming needs of veterans. The *NASW Code of Ethics* (NASW, 2010) lists the value of service that directs the ethical principle that the social worker’s primary goal is to help people in need and to address social problems.

This research project indicates that there is a social problem in the community in that the current group of MSW students and interns are in need of education and experience that would help them develop competency with the veteran population. Offering a curriculum that educates students about the resources and strategies needed to help veterans with successful transitions into the community is prudent. The resource and strategy guide is a tool that could be used by any level of social work professional in the beginning phase of filling the knowledge gap that exists about veterans’ needs.
Limitations

Whereas this guide is comprehensive in providing current information pertaining to veterans in the Sacramento County and surrounding counties, there is a likelihood the information may become outdated, so further revisions may be necessary to provide the most current information.

Although the researchers assume that the research results can be generalized to the greater population, there were no specific questions in the research that allowed the researchers to make the correlation between the student population and the greater population. Further, a non-probability sampling method was used in this study, further limiting the generalizability of the findings from the survey. In addition, practicing social workers and other helping professionals were not surveyed regarding their knowledge of veterans’ issues and available resources. Therefore this could indicate a need for further research, because the findings in this study may be germane only to the specific study population.

Summary/Conclusion

The purpose of this project was to determine whether there was a need for a resource and strategy guide that could be utilized by numerous professionals in Sacramento, CA, and the surrounding counties in connecting veterans with needed services. That such a need exists is demonstrated by the data from the study. One population of professionals who have been identified as candidates for the resource and strategy guide developed from this study are MSW students at California State
University, Sacramento. Based upon the research findings, the overall knowledge of MSW students pertaining to the current issues United States military veterans experience transitioning from military service to civilian life was found to be fair rather than good or excellent. Additionally, the research conducted in this project provided conclusions that many of the MSW students did not have a strong understanding of the needs of United States military veterans or the resources currently available for military veterans in Sacramento, CA, and the surrounding counties.

In addition to MSW students, other professionals that may also benefit from the resource and strategy guide include other medical and mental health providers and community workers providing employment services and housing resources to veterans. Veterans may also benefit from the resource and strategy guide finding it helpful in navigating through a system that can be overwhelming and frustrating.

The resource and strategy guide resulting from this project has been designed as a tangible product not only to serve as a learning tool, but also to raise awareness of the difficulties returning veterans face and to allow professionals to provide timely and effective support to those in need. It is the hope of the researchers that having the information pertaining to veterans in Sacramento, CA, and surrounding counties presented in a single entity will enable professionals to spend less time searching for available resources, thus expediting the successful connection of veterans with the services they need.
APPENDIX A

Survey


Survey for MSW Students

To the best of your knowledge, please answer the following questions

<table>
<thead>
<tr>
<th></th>
<th>Question</th>
<th>Rating Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I would rate my current level of knowledge and awareness of issues pertaining to U.S. Military Veterans as:</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>I would rate my current level of knowledge of Posttraumatic Stress Disorder (PTSD) as related to U.S. Military Veterans as:</td>
<td>1</td>
</tr>
<tr>
<td>3</td>
<td>I would rate my current level of knowledge pertaining to services available for U.S. Military Veterans as:</td>
<td>1</td>
</tr>
<tr>
<td>4</td>
<td>I would rate my current level of knowledge and awareness of medical needs and mental health needs of U.S. Military Veterans as:</td>
<td>1</td>
</tr>
<tr>
<td>5</td>
<td>I would rate my current level of knowledge and awareness of housing issues for homeless U.S. Military Veterans as:</td>
<td>1</td>
</tr>
<tr>
<td>6</td>
<td>I would rate my current level of knowledge of military sexual trauma as:</td>
<td>1</td>
</tr>
<tr>
<td>7</td>
<td>I would rate my current level of knowledge of Traumatic Brain Injury (TBI) as:</td>
<td>1</td>
</tr>
<tr>
<td>8</td>
<td>I personally know a U.S. Military Veteran from the current wars in Iraq and Afghanistan (Operation Iraqi Freedom &amp; Operation Enduring Freedom):</td>
<td>Yes</td>
</tr>
<tr>
<td>9</td>
<td>I personally know a U.S. Military Veteran from a previous war:</td>
<td>Yes</td>
</tr>
<tr>
<td>10</td>
<td>Are there transportation services for disabled or homeless Veterans to access the medical, mental health or employment services they might need?:</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Question</td>
<td>Yes</td>
</tr>
<tr>
<td>---</td>
<td>---------------------------------------------------------------------------------------------------</td>
<td>-----</td>
</tr>
<tr>
<td>11.</td>
<td>Do counties in the Sacramento, CA, and surrounding areas have Veteran’s services divisions?:</td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>I am aware of the services the Veterans Administration Hospital provides to veterans?:</td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td>I am aware of the services TRICARE provides to military veterans?:</td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td>I can identify agencies that provide healthcare to U.S. Military Veterans?:</td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td>I can identify agencies that provide mental health services to U.S. Military Veterans?:</td>
<td></td>
</tr>
<tr>
<td>16.</td>
<td>I can identify agencies that provide addiction treatment and recovery services to U.S. Military Veterans?:</td>
<td></td>
</tr>
<tr>
<td>17.</td>
<td>I can identify agencies that provide housing services to U.S. Military Veterans?:</td>
<td></td>
</tr>
<tr>
<td>18.</td>
<td>I can identify agencies that provide employment/vocational training services to U.S. Military Veterans?:</td>
<td></td>
</tr>
<tr>
<td>19.</td>
<td>I can identify services that provide family counseling services to veterans?:</td>
<td></td>
</tr>
</tbody>
</table>
20. A newly discharged U.S. Military Veteran needs to set up services with the Veteran’s Administration Hospital (VAH) to get a VA Card. What is the first step the Veteran should take?

| A.) Meet with an Armed Forces Recruiter. |
| B.) Nothing. The military will do it for you. |
| C.) Go to a Vet Center or VA Hospital to apply for services. |
| D.) Wait for notification from the VA Hospital. |

21. Please read the following scenario and answer the question that follows:

Rachel is a fifty-four year old female Navy Veteran, who has recently become homeless. Prior to becoming homeless, she had permanent housing and was employed as an In Home Support Service (IHSS) chore worker for an elderly woman who was receiving IHSS. Due to recent cuts in the IHSS program, the elderly woman has a share of cost for her medical expenses and has not been able to pay Rachel for the past two months.

How confident are you in that you have the knowledge and awareness to help Rachel regain permanent housing and overcome homelessness?

| 1 | Not at all confident |
| 2 | Somewhat confident |
| 3 | Very confident |
| 4 | Extremely confident |
## Demographics

<table>
<thead>
<tr>
<th></th>
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<th>20-29</th>
<th>30-39</th>
<th>40-49</th>
<th>50-59</th>
<th>60+</th>
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<td>2.</td>
<td>Gender</td>
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<td>___Female</td>
<td>___Transgender</td>
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<td>4.</td>
<td>I am a U.S. Military Veteran:</td>
<td>___Yes</td>
<td>___No</td>
<td></td>
<td></td>
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<tr>
<td>5.</td>
<td>Current year in MSW Program</td>
<td>___1. MSW I</td>
<td>___2. MSW II</td>
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<td></td>
<td></td>
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<tr>
<td>6.</td>
<td>Number of years of Social Work experience (including internships):</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
APPENDIX B

Consent Form


I hereby agree to participate in research which will be conducted by Paul D. Flynn and Linda Matthews, MSW II students at California State University, Sacramento. Paul and Linda are working under the direction of Dr. Chrystal Barranti, Associate Professor as their thesis advisor.

The purpose of this project is to:
The purpose of this project is to develop a resource guide/manual which helps guide the social worker in identifying appropriate resources and services for military veterans in the Sacramento, CA, and surrounding community. Data from the MSW student surveys will help inform the development of the resource guide.

Procedure:
You are being asked to complete 27-item survey that explores your knowledge of resources available for U.S. military veterans in the Sacramento area and 5 surrounding counties. Those who wish to participate will complete a consent form first which will be collected in a large envelope separately from any completed survey. For those participants whose professors have granted class time to complete the survey, the survey will be passed out and completed at the time of the researchers visit. For those participants whose professors have not granted class time to complete the survey, they are asked to drop the completed surveys in a drop box outside of Dr. Barranti’s office (4006 Mariposa Hall). The survey should take approximately 15 minutes to complete.

Risks:
You will not be asked questions of a personal nature, but rather questions about your knowledge levels regarding resources for U.S. military veterans in the Sacramento area and surrounding community. However if you should become distressed as a result of participating in this study you can access the following services. This list is also provided on the handout attached to this consent form.

I understand that this research may have the following benefits:
Data gathered from this study will help in the preparation of a resource and strategy guide developed for social workers who may work with U.S. military veterans in Sacramento.
and the surrounding community. Such a resource guide may lead to more timely and successful acquisition of needed resources for military veterans.

**Alternatives/Rights to Refuse or Withdraw:**
Your participation in this research is entirely voluntary. If you decide to participate in this study, you may decline to answer any questions and you may discontinue your participation at any point without risk or consequences.

**Confidentiality:**
Your identity will be kept confidential. No personally identifying information will be collected or used in the study. During the analysis of the data all information will be kept in lock boxes to ensure confidentiality. The consent form will be stored separately from any and all data. All information collected will be appropriately destroyed after the Master’s thesis project has been filed with California State University of Sacramento and no later than July, 2010.

**Compensation:**
There will be no inducements offered to the participants other than the appreciation given from the researchers, for the participant’s assistance.

**Contact Information:**
If you have any questions about this research project or would like to inquire about the findings from this research project, you may contact Paul D. Flynn at 916-342-0476 or by email at flynn.paul@gmail.com, or you may contact Linda Matthews at 530-622-4195 or by email at beautifulsong60@hotmail.com. In addition you may contact this researcher’s thesis advisor, Dr. Chrystal Barranti at 916 278-4161 or cbarranti@csus.edu.

**I understand:**
I understand that my participation in this research is entirely voluntary. I may decline to participate at any time without risk.

Your signature below indicates that you have read this page and agree to participate in the research project.

______________________________  ____________________________
Signature                      Date
APPENDIX C

EMPOWERING SUCCESSFUL CONNECTIONS: A RESOURCE AND STRATEGY GUIDE FOR MEETING THE NEEDS OF U.S. MILITARY VETERANS IN SACRAMENTO, CA AND THE SURROUNDING COMMUNITY

Paul D. Flynn & Linda Matthews
Introduction

This is a guide designed to assist with the provision of services to United States Military Veterans in the Sacramento, CA, and surrounding counties. It has been designed to help fulfill any lack of knowledge or voids in understanding regarding the issues that are pertinent to veterans in Sacramento, CA, and the surrounding counties of Amador, El Dorado, Placer, San Joaquin, and Yolo.

While the focus of this guide will be on the needs of veterans, this guide will also provide strategies for professionals to practice thoughtfulness towards veterans, especially as it relates to the transition home from military service or battle. The topic of Posttraumatic Stress Disorder (PTSD), a condition that is becoming increasingly prevalent among military veterans, will also be discussed. The guide will conclude with a listing of helpful services that include directions for getting signed up for benefits from the Veterans Administration Hospital, a listing of the county veterans service officers, employment and vocational training services, support for veterans who are or may become homeless and information pertaining to the Sacramento Veterans Resource Center.
Homecoming: Perceptions, Feelings and Readjustment

Veterans returning home may require time for readjustment. It may take time for the veteran to readjust to family life and daily life, such as a career and interacting with others again. Some veterans may appear to have changed, for example displaying a greater sense of pride due to accomplishments made in extreme circumstances, such as on the battlefield. Veterans may also experience support and personal acknowledgements from the public, as thanks for the veteran’s service. Additionally, the veteran may experience an emotional bond between fellow service members that may be difficult to describe to others.

Other, more difficult changes that may be experienced by some veterans, such as feelings that friends or loved ones no longer understand the veteran in ways they have done so in the past. Also, the veteran may feel that the daily problems experienced with life at home are inconsequential compared to the problems experienced on the battlefield. A veteran may also begin to form an opinion that society, or the world in general, is more complicated than it used to be.

Additional experiences that may affect veterans are: problems with sleep; feelings of exhaustion; difficulty with trusting other people; feeling edgy, angry, sad or numb; difficulty concentrating or remembering things; increased use of drugs or alcohol and pain or physical limitations as a result of an injury ("Coming Home: Have Things Changed?", 2009).

With regards to families, a veteran may experience the feeling that his or her place in the family has changed.
since returning from service or deployment. One reason for the change may be a result of the veteran, or the veteran's family member, feeling a sense of denial that there are any problems present. The willingness of the veteran to talk about these problems may be difficult. However, it is important to establish a safe environment allowing open communication when the time is right to discuss these matters (Scurfield, 2009).

Friends and other people in the community also play an important role in assisting the veteran to transition successfully back home. Something to be cognizant of is that the power of words can be potentially devastating for the veteran: “Was it cool over there?”, “Did you get shot at?”, “Do you have emotional problems now?” Comments such as these may reinforce the idea that the general population, those who have never served in the armed forces, do not or never will understand the experiences a veteran has witnessed or experienced firsthand. A more thoughtful approach people may take when speaking to a veteran is “Thank you for serving.” Conversation may continue, especially if a rapport can be established. This can be done by asking questions with factual answers. Examples of these types of questions may include: “How long have you been home?” or “What branch of the military were you with?” (Swords to Plowshares, n.d.)
Cultural Competency and Awareness

For the individual who may not have any direct experience with the military, military culture may be difficult to understand and veterans may not be willing to share information with people without military experience. Many military personnel and veterans, especially males, have received training in self-sufficiency, thus equating asking for help or assistance as a sign of weakness. Additionally, a veteran may also feel embarrassed by the problem or problems he or she is experiencing, so he or she may just assume the problem will go away on its own and not seek help. As a result, some veterans may express and display a need for distance and choose not to engage with the professional. It is also important for the professional to be cognizant of triggers that may cause veterans to experience emotional or behavioral difficulties. These triggers include holidays such as the Fourth of July and Memorial or Veterans Day. The emotions veterans experience may be related directly to past service or perceptions on how the government or society has treated them personally or their comrades.

Awareness, on the part of the professional, that veterans may have experienced stressful situations and may not wish to talk about the stressful situations or personal stress they are feeling is also crucial in the establishment of trust of the professional. While the veteran may not be able or willing to talk about the stress he or she is feeling, there are some warning signs that veterans may be experiencing and dealing with stress in their own way. These warning signs include, but are not limited to: the increased use of drugs or alcohol; increased isolation or withdrawal from daily activities; increased emotional outbursts; increased
family problems (conflicts, lack of communication and failure to meet family obligations) and performance issues at work or school that include tardiness or excessive absences and the inability to complete assignments or meet deadlines (National Center for PTSD, 2009).

**Building Professional Relationships**

In order to help bridge the gap between the veteran and professional, building trust may be the first and most important step in doing so. There are many methods to building trust and a good first method is to be sensitive to the needs of the veteran as an individual. This includes professionals being aware of and able to offer high-quality services to veterans. It may also be helpful for the professional to be knowledgeable and versed in military jargon and to have the awareness of when and how to use the jargon appropriately. These can be done in both informal and formal situations and may be a helpful first step in bridging the gap between the veteran and the professional (O’Niel, 2008).

Another helpful skill that plays a role in establishing and cultivating a professional relationship is communication skills. Three major components of communication include verbal, non-verbal, and listening skills. Having already discussed the importance of being aware of the power of words, non-verbal communication skills, such as reading the veteran’s body language to key in on signs of distress, anger or fear, is also a crucial tool the professional needs to use when interacting with a veteran. Practicing active listening, which allows the veteran to be heard and to have his or her experiences validated, along with responding empathically, not only allows the veteran to feel like he or she has a voice but also
facilitates further communication between the veteran and the professional (O'Neill, 2006).

Posttraumatic Stress Disorder (PTSD)

The current wars in Iraq and Afghanistan have required many service members to serve multiple deployments with very little downtime or leave between deployments (Jaycox & Tanielian, 2008). As a result, an increased number of service members may develop posttraumatic stress disorder (PTSD), either while they are serving in the military or after their return home. According to current estimates, as many as 10 to 30 percent of service members will develop PTSD within a year of leaving combat, and as of October 2007 it was estimated that 300,000 individuals currently are diagnosed with PTSD or major depression (Jaycox & Tanielian, 2008). The difficulty with PTSD is that often times there may be no visible symptoms; rather there are feelings of avoidance, numbing, hyperarousal or hypervigilance. Additionally, flashbacks to frightening events (being in combat, for example), nightmares, unpleasant memories of images or sounds may also be symptoms of PTSD. Most frightening is that these experiences may appear at any given time or may result from certain words, sounds or smells (National Council on Disability, 2009). A person experiencing PTSD may also begin to feel sad and have the feelings that things are never going to improve, rather than having an optimistic view on his or her life; the person may lose interest in a preferred activity or hobby; and the person may become overly tired or lethargic (National Center for PTSD, 2009). What makes PTSD so frightening and frustrating for so many is the fact that visible symptoms are not always present, thus making it more difficult to
describe the problem the veteran is experiencing. Other psychiatric disorders may accompany PTSD, such as depression, substance abuse and problems with memory.

The good news is that PTSD is becoming an issue that more people are beginning to discuss, and as a result, there are treatments for PTSD that can be matched to the person’s need. For example, cognitive behavioral therapy (CBT) has been shown as an effective treatment for PTSD. There are other components to CBT that include exposure therapy, where the patient and the professional talk repeatedly about the memories of the stressful or frightening situations until the memories become less upsetting. Cognitive therapy is also a component of CBT, and through cognitive therapy a patient receives assistance to help him or her identify the trauma-related thoughts and ways to change the thoughts so they become less distressing (National Center for PTSD, 2009). The additional attention being given to PTSD also allows the professional, family member, or support team member the opportunity to learn about this condition and continue to discuss it in order to eliminate any negative connotations or feelings of shame or embarrassment associated with this condition. The following portion of this guide will focus on the resources available to veterans in the Sacramento, CA, and surrounding counties.
Transitional Assistance Program

The Department of Defense currently offers a Transitional Assistance Program (TAP) for military service members. Members of the service can plan as much as twelve months in advance, and retirees can plan ahead twenty-four months in advance of their separation from the military. In the information guide posted on line in “What Can the VA Do For Me?” (http://www.esof.va.gov) by the Department of Veterans Affairs, separating service members can access information that will guide them to services and benefits that will help them with their transition from military service to civilian life. Information can be accessed at the Department of Defense website, TurboTap.org or service members are encouraged to meet with a counselor at their associated Transition Assistance Office. Separation from the various branches of the military may have different procedures, so military personnel are advised to meet with a transition counselor to develop their own individual transition plan (ITP) (United States Department of Veterans Affairs, 2009).

California Transition Assistance Advisor

The California Transition Assistance Advisor (TAA) is the first line of support for returning veterans to help troubleshoot concerns surrounding their benefits, education assistance, employment and any other issues they may encounter. For further information contact:

Horst Laube  
Transitional Assistance Advisor  
Joint Forces Headquarters  
9800 Goethe Rd (Box37)  
Sacramento, CA 95826  
(916) 854-3315  
(916) 854-3439 (Fax)  
horst.laube@us.army.mil
### California County Veterans Service Officers

The California Association of County Veterans Service Officers (CACVSO) is an organization of professional advocates for veterans. This association plays a critical role in the veteran's advocacy system and is often the initial contact in the community for veterans. A Veteran Service Office can assist you, if you are a veteran, widow of a veteran, child of a deceased or disabled veteran or parent who lost a son or daughter in military service.

#### Service contacts and locations:

<table>
<thead>
<tr>
<th>Location</th>
<th>County Veterans Service Officer</th>
<th>Address</th>
<th>Phone Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amador</td>
<td>Floyd Martin</td>
<td>800 Court St, Jackson, CA 95642</td>
<td>(209) 267-5764, (209) 267-0419 (Fax)</td>
</tr>
<tr>
<td>El Dorado</td>
<td>Ed Swanson</td>
<td>30 Placerville Dr., Ste. B, Placerville, CA 95667</td>
<td></td>
</tr>
<tr>
<td>Placer</td>
<td>Rick Buckman</td>
<td>1000 Sunset Blvd., Ste. 115, Rocklin, CA 95665</td>
<td>(530) 621-5892, (530) 621-2218 (Fax)</td>
</tr>
<tr>
<td>Sacramento</td>
<td>Carrie Clark</td>
<td>2007 19th St, Sacramento, CA 95818</td>
<td>(916) 874-6811, (916) 974-8868 (Fax)</td>
</tr>
<tr>
<td>San Joaquin</td>
<td>Ron Green</td>
<td>105 S. San Joaquin St, Stockton, CA 95202</td>
<td>(209) 468-2916, (209) 468-0291 (Fax)</td>
</tr>
<tr>
<td>Yolo</td>
<td>Billy Wagesler</td>
<td>120 West Main St., Ste. A, Woodland, CA 95695</td>
<td>(530) 464-4850</td>
</tr>
</tbody>
</table>
VA Health Care

The Veterans Administration (VA) operates the nation’s largest integrated health care system with more than 1400 sites of care, including hospitals, community clinics, nursing homes, domiciliaries, readjustment counseling centers, and various other facilities. For additional information on VA health care, visit: www.va.gov/health

The VA will provide health care and more to our newest veterans returning from the armed services. Here are some of the benefits the VA provides:

Five Years of Enhanced Health Care: You are eligible to receive enhanced VA health care benefits for 5 years following your military separation date. Whether or not you choose to use VA health care after separation, you must enroll with VA within 5 years to get health care benefits later on.

Dental Benefits: You may be eligible for one-time dental care, but you must apply for a dental exam within 180 days of your separation date.

OEF/OIF Program: Every VA Medical Center has a team ready to welcome Operation Enduring Freedom (OEF)/Operation Iraqi Freedom (OIF) service members and help coordinate their care. Information is on the home page of your local VA Medical Center.

Primary Health Care for Veterans: The VA provides general and specialized health care services to meet the unique needs of veterans returning from combat deployments.

Vet Center Benefits: The VA provides individual, group, and family counseling to all veterans who served in any combat zone. Services are also available for their family members. Veterans have earned these benefits through their combat service and are provided at no cost to the veteran or family.

Non-Health Benefits: Other benefits available from the Veterans Benefits Administration may include: financial benefits, home loans, vocational rehabilitation, education, and more.
Basic Eligibility

A person who served in the active military, naval, or air service and who was discharged or released under conditions other than dishonorable may qualify for VA health care benefits. Reservists and National Guard members may also qualify for VA health care benefits, if they were called to active duty (other than training only) by a Federal order and completed the full period for which they were called or ordered to active duty.

Enrollment

For most veterans entry into the VA health care system begins by applying for enrollment. To apply, complete VA form 10-10EZ, Application for Health Benefits, which may be obtained from any VA health care facility or regional benefits office online at www.1010ez.med.va.gov, by calling (877) 222-VETS (8387), or by visiting your County Veterans Service Office online at www.ca.vsc.org. Once enrolled, veterans can receive health care at VA health care facilities anywhere in the country.

Veterans Benefits Administration-Regional Offices

Oakland Regional Office, Sacramento
10365 Old Placeville Rd.
Sacramento, CA 95827

VA Medical Centers

Sacramento VA Medical Center
10535 Hospital Way
Sacramento, CA 95655
(916) 841-7000
(916) 843-9001 (Fax)
Hours: Mon – Fri, 8:00am-4:30pm
24 hours Emergency Care Available

Services: The Sacramento VA Medical Center is a 50-bed inpatient facility that offers comprehensive health care services, including emergency services, primary care, surgical, and medical health care. In addition, on-site staff...
can assist veterans with disability claims and service referrals. Patient advocates are also on-site to help the veteran make appointments and obtain necessary services.

Sacramento Mental Health Clinic at Mather
19535 Hospital Way
Building 649
Sacramento, CA 95655
(916) 366-5420
Or (800) 382-8387
(510) 366-5328 (Fax)
Hours: Mon – Fri, 8:00am-4:30pm

Services: The Sacramento Mental Health Clinic provides a full range of psychiatric and psychological assessments and interventions, including individual and group psychotherapy, medication management, substance abuse treatment and a Post traumatic Stress disorder (PTSD) treatment program. All mental health outpatient visits are facilitated at this location.

McClellan Outpatient Clinic
5342 Dudley Blvd.
McClellan, CA 55652
(916) 561-7400
(916) 561-7513 (Fax)
Hours: Mon – Fri, 8:00am-4:30pm

Services: The McClellan Outpatient Clinic provides a wide range of medical and secondary services and programs, including primary care, audiology, compensation and pension exams, Home Based Primary Care, laboratory, mammography, optometry, pharmacy, physical therapy, prosthetics, radiology, special program exams, and women’s health services.

McClellan Dental Clinic
5401 Arnold Ave.
McClellan, CA 55652
(916) 561-7800
or 1 (800) 382-8187
(916) 561-7835 (F)
Hours: Mon – Fri, 8:00am-4:30pm
Services: VA outpatient dental treatment, including the full spectrum of diagnostic, surgical, restorative, and preventive procedures are offered.

Vet Center (Free Counseling)
The goal of the Vet Center program is to provide a broad range of counseling outreach and referral services to eligible veterans in order to help them make a satisfying post-war readjustment to civilian life. Services are available to eligible veterans and their families.

Sacramento Vet Center
111 Howe Ave., Ste 390
Sacramento, CA, 95825
(516) 566-7430
(516) 566-7433 (Fax)
http://www.vetcenter.va.gov

Services: Readjustment counseling services are available, which include: individual counseling, group counseling, marital and family counseling, bereavement counseling, medical referrals, assistance in applying for VA benefits, employment counseling, guidance and referral, alcohol and drug assessment, information and referral to community resources, sexual trauma counseling & referral and community education.

24 hour toll free service provided by the VA Mental Health Care
Suicide Hotline 1-800-273-TALK (8255)
Employment Development Department (EDD)

The California Employment Development Department (EDD) Workforce Services Offices and One-Stop Career Centers have specially-trained staff to ensure veterans of the U.S. Armed forces receive maximum employment and training opportunities. Services can include counseling, labor market information, job referrals, job search workshops, and job development with potential employers. All veterans are eligible for the Veterans Intensive program. Special assistance is available for veterans with service-connected disabilities. Veterans may qualify for assistance under the Workforce Investment Act. Services can include: Alternative school services, follow-up services, guidance counseling, leadership development, mentoring, occupational skills training, paid and unpaid work experience (such as internships, apprenticeships, and job shadowing), supportive services, tutoring, study skills training, and instruction leading to completion of secondary school.

Employment Development Department
Job Service Office
2901 50th street
Sacramento, CA 95817
(916) 227-0301
Hours: Mon. - Fri, 8:00am-5:00pm
www.edd.ca.gov

Career Center Locations

El Dorado County/Placerville
Veteran Employment Representative
Tim Whalen,
(530) 642-7143

Placerville/One-Stop Resource Career Center
3047 Braw Road
Placerville, Ca. 55667
**Placer County/Roseville**  
Veteran Employment Representatives  
Edward Alexander  
(510) 774-4063  
Chuck Carter  
(510) 774-4058  
Dennis Pearson  
(510) 774-4018  
Gary McKenzie  
(510) 774-4013  

Roseville/One-Stop Career Center  
1180 Sierra Gardens Dr., Ste. 100  
Roseville, CA 95661  

**Sacramento County/Sacramento**  
Veteran Employment Representatives  
Randy Hadley  
(510) 227-0314  
Carol Katalbas  
(510) 227-0315  
David Most  
(510) 227-0320  

National Guard Reps.  
Roderick McKe  
Carlos Gill  
(510) 227-0213  
Mark Sanders Career Center  
2901 50th St.  
Sacramento, CA 95817  

**Rancho Cordova**  
Mather Career Center  
Veteran Representative  
10638 Shrir Ave.  
Mather, CA 95655  
(916) 228-3136  

**Sacramento Veteran Resource Center**  
Veteran Representative  
7270 E. Southgate Dr.  
Sacramento, CA 95823  
(916) 393-8387  

**Yolo County/Woodland & W. Sacramento**  
Veteran Employment Representative  
Robert Schloas  
(530) 661-2618  

Dept. of Employment & Social Services  
25 N. Cottonwood St.  
Woodland, CA 95696
Programs for Homeless Veterans

Some of the factors that have affected homelessness have been a shortage of affordable housing, a livable income, and access to healthcare. Also, there is a large number of displaced and at-risk veterans living with lingering effects of Post Traumatic Stress Disorder (PTSD) and substance abuse, compounded by a lack of family and social support networks.

The Continuum of Care (COC) website below contains all the homeless assistance coordinators’ contact information for Northern California.

www.hud.gov/local/california/continuumcare/realcocc

El Dorado County
Joyce Aldrich,
Human Services Department
3957 Brin RD.
Placerville, CA 95667
(530) 642-7276

Placer County
Janice Critchlow, Coordinator
Placer Greater Collaboration
P.O. Box 215156
Sacramento, CA 95821

Sacramento County
Suzanne Hamner,
Program Manager
Sacramento County Department of Human Assistance
Sacramento City & county
1590 North A St
Sacramento, CA 95814
(916) 874-4323

San Joaquin County
Ms. Chris Becerra
Community Development Department
1810 Hazelton Ave.
Stockton, CA 95205
(209) 468-3157

Yolo County
Anara Pickens
Yolo County Department of Employment and Social Services
25 North Cottonwood St
Woodland, CA 95695
(530) 661-2934
California Veterans Assistance Foundation (CVAF)

The California Veterans Assistance Foundation (CVAF) is a nonprofit tax exempt corporation established in 2003 to operate transitional housing programs for military veterans who are homeless or at risk of becoming homeless. You can also visit their website at www.cvaof.org. For further information call (611) 695-3626, or to make referrals for admission call (866) 225-8387.

U.S. Department of Veterans Affairs (USDVA)

Every VA Medical Center has a Health Care for Homeless Veterans (HCHV) coordinator who is responsible for helping homeless veterans access VA and community-based care. Contact your local VA for assistance or the homeless outreach coordinator at the locations below:

California VA Medical Center Homeless Coordinator

Sacramento YAMC
10535 Hospital Way
Mather, CA 95655
(916) 366-5366
(916) 841-7000
(809) 382-8387

VA Homeless Coordinators:
Reed Walker
(916) 843-9090
Maureen Gallagher
(916) 843-7094

Northern California
Roberta L. Rosenthal, Chief
Social Work Service VA Medical Center-662
4150 Clement St.
San Francisco, CA 94121
(415) 551-7338
Roberta.Rosenthal@med.va.gov

VA Headquarters
Pete Dougherty, Director
Homeless Programs VA Central Office-07D
810 Vermont Ave. N.W.
Washington, DC 20420
Pete.Dougherty@mail.va.gov
Vietnam Veterans of California (VVC)
www.vvvetts.org

Established in 1980, the Vietnam Veterans of California (VVC) offers community-based services for veterans and their families. VVC has several programs located in Sacramento, Eureka, Santa Rosa, and Menlo Park. Their focus is on employment and training support, transitional housing, and alcohol & drug recovery, with four locations throughout California.

Sacramento Veteran Resource Center (SVRC)
7170 E. Southgate Dr.
Sacramento, CA 95821
(510) 393-8387
(510) 393-8389 (F)
vrcsvac@vvetts.org
www.vvetts.org/svrc.htm

The Sacramento Veteran Resource Center (SVRC) is a multi-function campus with the most comprehensive mix of services for veterans in Northern California.

Some of the services offered:

Employment Counseling & Training: The Sacramento Veterans resource Center (SVRC) originated in 1989 as the first and now longest employment assistance service offered to veterans. The SVRC has a long tradition of helping veterans obtain career training and self-sustaining employment opportunities.

Supportive Housing: The SVRC offers fifty-two onsite and eight offsite beds for homeless veterans, including female veterans with children. Their supportive housing programs offer up to twenty-four months of stable living, combined with comprehensive supportive services to effectively end the cycle of homelessness and assist veterans in the acquisition of permanent housing and sustainable-wage jobs. The Jon Obeg Center is a state licensed, twenty-two bed transitional housing program for
veterans and non-veterans alike who are in need of
drug/alcohol recovery services.

The Veterans Business Outreach Center (VBOC) is
one of only four Small Business Administration funded
business centers in the nation for veterans who own or are
interested in starting a small business.
References


REFERENCES


Herman, J. (1997). *Trauma and recovery: The aftermath of violence from domestic abuse and political terror*. New York: Basic Books


