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2023 Veterans’ Well-being Community Health Needs Assessment

UNDERSTANDING CANADIAN VETERANS’ HEALTH AND WELL-BEING

Health Professionals and Policy and Research Divisions, Veterans Affairs Canada

Veterans Affairs Canada
Anciens Combattants Canada

Canada

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We respectfully acknowledge that this assessment and research was conducted on and across the traditional lands of the Indigenous Peoples (Inuit, First Nations, Métis) of Canada. We honour the heritage and ancestry of the Indigenous Peoples and give thanks to them.

Executive summary

Introduction The 2023 Veterans' Well-being Community Health Needs Assessment (CHNA) is a tool to support the health and well-being of Canadian Veterans. It can be used by Veterans and stakeholders to increase understanding of Veterans' strengths and needs and prioritize action. The CHNA's objectives were to highlight priorities for Canadian Veterans' health and well-being, inform decision-makers, and support the allocation of resources. Using a mixed-methods approach, we combined evidence from existing Veteran research with new data we collected through Veteran and stakeholder engagement, and Veteran interviews and focus groups.

The Veteran community The Veteran community is inclusive of all Canadian Veterans, their families, and other stakeholders who have a role to play in health and well-being. For the purposes of the CHNA, the term 'Veteran' includes any person who served in the Canadian Armed Forces.

Community strengths Veterans' strengths positively impact their health and well-being. Veterans draw on a range of strengths connected to their personal characteristics and military experiences (e.g., resilience, camaraderie, discipline, adaptability, resourcefulness, and self-awareness). Veterans empower and advocate for other Veterans and gain a sense of purpose and satisfaction from giving back to their peers and engaging in their communities. Many Veterans express a sense of ownership over their health and well-being.

Community needs Veterans' health and well-being are holistic and interconnected. The needs and resources they use are contextual, complex, and influenced by their military service and intersecting identities. Their needs span individual, interpersonal, community, organizational, structural, and historical levels. Veterans need recognition and appreciation for their military service; access to trauma-informed and culturally relevant resources; and for military and Veteran organizations to acknowledge and be accountable for past and present harms.

Conclusion The CHNA, in partnership with Veterans, highlighted many strengths and priorities to address barriers and improve health equity. Veterans must be active participants in decision-making, policy development and research concerning their health and well-being. Listening to Veterans enables us to build trust, develop meaningful partnerships, and act at the community, provincial/territorial, and federal levels. To achieve this, collaboration with and among the entire Veteran community is essential.

Acknowledgment Thank-you to all Canadian Veterans and Veteran families for your service to this country. We are sincerely appreciative to the Veterans who participated in this CHNA – your stories, time, and insights were integral to completing this assessment. This includes those who participated in engagements, interviews and focus groups, and Veterans who contributed, in any way, to the existing research incorporated in this work.

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We are grateful to all stakeholders who provided support throughout the project. Your expertise related to Veterans' experiences was invaluable to guiding our research approach.

To Dr. Cyd Courchesne, Director General of Health Professionals Division, Veterans Affairs Canada (VAC); Mitch Freeman, Director General of Policy and Research Division, VAC; Nathan Svenson; and Jonathan O'Keefe, thank you for your belief in our vision and support from day one.

Finally, we would like to acknowledge the countless others who hopped on the bus[a] of perseverance to see this work through.

Our story

This work is the result of a genuine desire to have the information we need to better serve Veterans. Our research question was simple:

"What are the health and well-being strengths and needs of Canadian Veterans?"

While we acknowledge the wealth of existing research on Veterans' health and well-being, there has never been a CHNA of the overall health and well-being of ALL Canadian Veterans. The decision to take this approach was based on our professional knowledge and previous experiences, as Registered Nurses, using CHNAs at the community and provincial level to improve health outcomes. While the CHNA approach is a well-established and proven method, we knew that conducting a CHNA on a national scale with a diverse population would not be easy. Our first step was to get buy-in from the community by consulting Veterans and

[a]Special mention is also warranted for the metaphorical bus that kept us in humour and on course for what otherwise may have been an impossible journey – navigating detours, maneuvering through barricades, spike strips, and snow squalls. The bus took us where we were going, together, and in one piece.

stakeholders in early planning stages to earn their trust and introduce them to the CHNA process.

Our team was built with individuals who shared our passion. Team members were recruited specifically for their diverse skills, expert knowledge, professional, and life experience. Team members came from multiple professional backgrounds including, Canadian Armed Forces, Nursing, Research, Public Health, Academia, Political Science, Medicine, and public and non-public sectors, and were diverse in gender, ethnicity, sexual orientation, age, language, and spiritual beliefs. In taking an interdisciplinary and intersectional approach to team development, we embraced each other's uniqueness while sharing a common vision. By creating a safe space to challenge our unconscious biases, we thrived from our collective strengths and our work was elevated beyond our expectations. So, this is what we did…

Key terms

Anti-oppressive refers to individual, cultural, and societal practices that seek to counter the effects of discrimination, prejudice, and inequality, and equalize power imbalances between people.[1]

Barrier refers to factors that prevent and hinder access and use of resources, and/or attainment of health and well-being needs (CHNA's working definition).

Community encompasses a group of individuals with common interests or characteristics; specific to geography or social context.[2]

Decolonial theories and approaches critically challenge and seek to dismantle the ongoing legacies of colonialization while supporting the perspectives, knowledge, self-determination, and strength of non-dominant groups and Indigenous nations.[3,4]

Discrimination refers to the intentional or unintentional differentiation of individuals or groups based on legally protected characteristics, such as sex, gender, race or disability. Occurring at personal, interpersonal, community, organizational, and institutional levels, it creates barriers that limit participation in society, including reduced access to essential services and supports, which impedes health and well-being.[5,6]

Facilitator refers to factors that enable and improve the attainment of health and well-being, including those that improve access and use of resources (CHNA's working definition).

Family includes single parents, couples, skip-generation families, chosen families, blended families, friends, pets, and/or caregivers (CHNA's working definition).

Equity-deserving groups are any subgroups of the population who, collectively, face substantial barriers to participate in society, including gender, ability, sexual orientation, race, or other social, physical, and environmental barriers.[5]

Gender refers to the socially constructed expressions, behaviors, roles, and identities of women, men, and gender diverse people; a continuum which can change overtime.[6]

Functional difficulties refer to restrictions in an individual's functioning that impede their ability to engage in tasks without accommodations. Understanding functional difficulties has particular importance for Veterans with disabilities (CVHS, 2022).

Hard-to-reach groups are sub-populations who have been historically difficult to identify or connect with due to physical or social limitations.[7]

Health equity refers to the principle of creating a fair opportunity for everyone to meet their health potential by identifying and removing obstacles to health for marginalized groups.[8]

Health and well-being are subjective, localized, and dynamic states that go beyond the absence of disease or illness, and include the holistic combination of physical, mental, emotional, spiritual, social, community, cultural, economic, and environmental factors.[9]

Holistic concepts recognize interconnectedness and holism of something or someone, and not just separate parts.[10]

Intersectionality refers to social-justice theories and approaches that seek to uproot structural and systemic discrimination and inequities by recognizing that identities are multifaceted and overlapping; influenced by time, societal levels, and place.[11]

Life course approaches are analytical and consider life experience in understanding health and well-being as dynamic, contextual and cumulative, evolving from childhood to older adulthood.[12]

Lived-experience comes from personal knowledge and insight gathered and born out of an individual's multiple and overlapping identities, circumstances, and histories.[13]

Needs are shaped by lived-experiences, political, economic, and social contexts. Needs relate to subjective desires, concerns and demands of individuals, communities, or societies.[14]

Participatory approaches engage individuals and stakeholders in the research process, including problem identification, method design, recruitment, and knowledge translation.[15,16]

Positionality refers to an iterative reflexive process in which individuals examine their social identities and location and explore how the intersection of these identities and contexts shape one's engagement and understanding of the world.[17,18]

Protective factors are variables associated with higher likelihood of positive outcomes or that reduce and/or mitigate risk factors. Protective factors may or may not vary over time.[19]

Resources refer to skills, relations, networks, benefits, materials, programs, and services that individuals rely on to support their needs (CHNA's working definition).

Risk factors are variables associated with higher likelihood of negative outcomes. Risk factors may or may not vary over time.[19]

Sex refers to biological attributes that are primarily associated with physical and physiological features, including reproductive anatomy, hormone levels and function, gene expression, and chromosomes. Sex is normally categorized as female or male.[6]

Sex-and Gender-Based Analysis Plus (SGBA+) is an analytical approach that assesses how different sociodemographic factors (such as gender, age, disability, race, indigeneity, etc.) impact experiences of policies, programs, services, and other initiatives.[20]

Social-ecological model considers how the interaction of individual, interpersonal, community, organizational, structural, and historical factors impact health and well-being.[21]

Social identity and identities refer to markers of sub-groups defined along social constructs and categories of differences (e.g., gender, sexual orientation, race, ethnicity).[22]

Social justice theories have a goal to foster equity across policies, relationships, and/or structures by addressing the roots or origins of disparities.[22]

Social location refers to the unique and complex intersection of an individual's multiple identities within broader power structures. It is shaped through processes of privilege and oppression and depends on the historic or situational context.[23]

Strengths are the knowledge, skills, behaviours, and other attributes that enable an individual or community to address their needs and cope with challenges (CHNA's working definition).

Transition is the time-period and the dynamic process of re-integrating into civilian life following military service.[12]

Trauma-informed approaches acknowledge the varied impacts of trauma to prioritize the safety, agency, and well-being of individuals during delivery of service.[24,25]

NOTE: The CHNA Team is aware of the psychosocial and biological roots of the words "woman" and "female"— and their importance to health equity. The term "woman" is used to represent a broad psychosocial exploration of experience, unrelated to the biology of the individual. The term "female" refers to sex-specific information which may describe biological events and conditions encountered by some females (e.g., menstruation, female reproductive organ-related conditions). Where the terms were conflated in current published literature, a conscious decision was made by the CHNA Team to employ the term used in the original work which may or may not recognize the psychosocial and biological distinctions.

Introduction

The aim of the 2023 Veterans' Well-being Community Health Needs Assessment (CHNA) was to identify the health and well-being-related strengths and needs of the Canadian Veteran population and to report findings in an accessible way. The primary objectives of the CHNA were to highlight priorities for Canadian Veterans' health and well-being, inform decision-makers, and support the allocation of resources.

This CHNA is the first of its kind for Canadian Veterans. As this population grows more diverse,[26] deliberate effort is needed to close gaps that have resulted from the underrepresentation of equity-deserving and hard-to-reach Veterans in Canadian military and Veteran research. Equity-deserving groups include communities who collectively, face substantial barriers to participate in society, including gender, ability, sexual orientation, race, or other social, physical, and environmental barriers.[5] For the purposes of the CHNA, women, 2SLGBTQI+, Indigenous, Black and racialized Veterans, and Veterans with disabilities, were identified as equity-deserving groups. This is in keeping with equity-deserving groups as identified by VAC and in line with terminology used by the Government of Canada.[7] The term "hard-to-reach" refers to sub-populations who have been historically difficult to identify or connect with due to physical or social limitations. This includes Veterans experiencing homelessness or living in remote and isolated areas.

This symbol will appear throughout this report where implications for health equity are discussed.

The CHNA has implications for health equity as it identifies health disparities, and inequities in accessing and using supports and resources. According to the World Health Organization (2023),[8] discriminatory practices are often embedded in institutional and systems processes. However unintentional this may be, these practices can result in under-representation of individuals and groups in research, policies, or decision-making. This can lead to individuals and groups being under-served or excluded. Health equity is achieved when individuals have fair opportunities to reach their fullest health potential.[8] For Veterans, this means identifying and reducing unfair and unjust disparities.

This report provides a comprehensive overview of the CHNA project (see Appendix A for Project Governance), including background, research methodology, findings and discussion, priority strengths and needs, and opportunities for change, which marks the point from which knowledge mobilization must begin. Furthermore, we will describe how the CHNA applied a population health lens to:

- Engage with Veterans, service providers, policy makers and researchers, to understand from a Veterans' perspective, the complex and multiple factors that influence their health and well-being experiences.
- Collect new and existing data to identify the individual, community, and systemic gaps, barriers, and facilitators that impact Veterans' health and well-being outcomes.
- Identify priorities in collaboration with the Veteran community.

We seek to honour Veterans who have served Canada by promoting their health and well-being and telling Veterans' stories well.

Background

The Veteran community is inclusive of all Canadian Veterans, their families, and other stakeholders in Veterans' health and well-being. For the purposes of this assessment, the term 'Veteran' includes any person who served in the Canadian Armed Forces (CAF). This is different from the definition used by Veterans Affairs Canada (VAC) which is, "any former member of the CAF who successfully underwent basic training and is honourably discharged."[27]

Across the life course, Veterans look to themselves, their families, friends, one another, community and online networks, health systems, and organizations for health promotion, disease and illness prevention, treatment and care, and support to maintain their health status. Throughout the CHNA, we identified more than 250 Veteran stakeholders from multiple sectors

across community, provincial, territorial, and federal levels that have a stake in Veterans' health and well-being. This included Veteran-led organizations, Veteran service organizations, and provincial and territorial health authorities. VAC is the Federal government department "responsible for supporting the well-being of Veterans and their families, and for promoting recognition and remembrance of the achievements and sacrifices of those who served Canada in times of war, military conflict and peace."[27] As such, VAC is also identified as an important Veteran stakeholder while acknowledging that Veterans are the owners of their health and well-being.

What is unique about Veterans' health and well-being? Health and well-being are interconnected concepts that extend beyond the absence of illness or injury. These concepts, which are often defined contextually and socially, have different meanings for individuals and populations. From Veterans, we heard that health and well-being are holistic and cannot be separated or distinguished. Veterans' health and well-being are often impacted by their military service and transition experiences, and further influenced by their individual, demographic, social, and geographical factors. Physical, mental, spiritual, emotional health, life satisfaction, social connections, community engagement, a sense of purpose, meaningful employment, financial stability, stable and safe housing, and access to essential health and social resources are among the many factors that Veterans told us impact their overall health and well-being.

While enrolled in the CAF, members (aged 36.1 years old on average)[28] receive comprehensive medical and dental services under a patient-partnered model through the CAF Spectrum of Care until release. The Spectrum of Care consists of six parts: Comprehensive Medical Care; Supplemental Healthcare; Occupational Healthcare; Preventive Medicine; Health Promotion; and Comprehensive Dental Care.[29]

Having access to free, comprehensive health services while serving in the CAF is considered a protective factor for overall health. However, the nature of transition often leaves Veterans experiencing a lack of continuity of care. Upon release (aged 44.7 years old on average),[28] Veterans return to their provincial and territorial health systems as governed by the Canada Health Act[30] and, those with service-related injuries or illnesses, may also be eligible for supports and services from VAC.[31] As Veterans enter life after service, understanding available benefits and navigating a civilian/public healthcare system poses difficulties for some, irrespective of release type.[32]

Veterans' perceptions of health and well-being also evolve over their life course. This evolution is accompanied by changing strengths and needs, as well as context-specific facilitators and barriers that enable a Veteran to access and effectively use resources. It is crucial for researchers, program planners, and policymakers to seek out and understand what Veterans identify as important for their health and well-being, and to consider how this may vary across Veteran sub-populations, such as women, 2SLGBTQI+, Indigenous, Black and racialized Veterans, and Veterans with disabilities. An integrated approach to the development of policies, programs, services, and interventions that align with Veterans' unique strengths and needs, will

more holistically impact their health and well-being. This CHNA has applied this approach to explore and identify with Canadian Veterans, how they experience and perceive their health and well-being.

Veteran well-being surveillance framework

Based on the Public Health Agency of Canada's determinants of health, VAC developed the Veteran Well-being Surveillance Framework in 2017 to help support Veterans' well-being. It emphasized seven domains with 21 measurement indicators.[33]

This framework marked a beginning point for longitudinal measurement and reporting on the health and well-being of Canadian Veterans across the life course. While it remains a strong framework, it may not adequately address all dimensions of health and well-being for all Veterans as the nature and perception of their health and well-being evolve.[33] This work is meant to be iterative, with the framework, itself, stating that "departmental investments and resources will need to be directed to expanding the surveillance system and larger data collection strategy, if it is to become more comprehensive."[33] This assessment has been very helpful for continuing efforts to conduct research and collect information that may be used to inform future well-being indicators. Furthermore, the Veteran community can benefit from opportunities to assess comparative data between the Veteran and Canadian civilian populations to identify areas where Veterans are doing well and where they are at risk.

Embracing complexity

More than just monitoring indicators, this assessment emphasizes the need to consider health and well-being as part of a holistic, interactive, evolving, and complex process – one that is shaped by various actors, factors, and structures that go beyond the Veteran.

To better understand the strengths and needs of Veterans, the CHNA Team used the social-ecological model to frame health and well-being as an ecosystem that connects the individual, interpersonal, community, organizational, structural, and historical levels of being.[21,34] Such an ecological view enables us to identify and trace inequities within larger power structures and socioeconomic conditions.[22,34]

Individual refers to a Veteran's biological and sociodemographic factors and social roles such as health status and medical history, gender, age, education, income, military service experiences, friend, employee, etc.

Interpersonal refers to the close relationships influencing Veterans' Day experiences, behaviors, and attitudes, such as their families including those not blood relatives, friends, caregivers, pets, etc.

Community (civilian and Veteran) refers to the settings in which a Veterans' social relationships occur. These can be formal or informal; civilian or Veteran; in-person or virtual.

Organizational refers to broader organizations such as provincial health authorities, insurance agencies, VAC, CAF/Department of National Defence (DND), and their formal operational regulations and processes.

Structural refers to the overarching structures that govern the individual to the organizational levels and their patterns, norms, behaviors, rules, and attitudes. This includes broader governmental policies and legislation, and societal and cultural norms.

Historical refers to the narratives and often hidden or unsaid historical experiences that are relevant to some Veterans' circumstances, and how that history has impacted both the Veteran and collective Veteran Community. Factors can include past legacies of organizational and system's harm, oppression, and lack of accountability.

Each of these levels overlap and influence one another. It is their interaction that shapes overall health and well-being experience.[22,34] Understanding Veterans' health and well-being experiences therefore requires a multidimensional, collective, and simultaneous examination to work with and support sustainable improvements for their health and well-being outcomes.

To fundamentally address health inequities, it means not shying away but rather embracing complexity.

Gaps in Veteran research

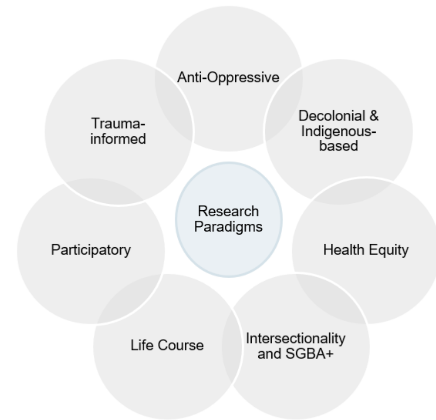
When scanning the literature, global progress in Veterans' health research falls short, especially in areas like home care, caregiving, spiritual health, women's health, reproductive and sexual health, oral health, and rural health. A recent scoping review revealed substantial research gaps in understanding the experiences of women Veterans.[35] Gender and sexually diverse Veterans are underrepresented in data and policy considerations, with a limited understanding and contextualization of their health and well-being under a socioeconomic lens.[36–44] When compared to countries such as the United States, there are knowledge gaps concerning Canadian military and Veteran experiences, as well as the health and well-being indicators, of Indigenous, Black and racialized, and disabled Veterans.[41,42,45–48] Insufficient available data and a lack of consistent definitions of sex, gender, race, and ethnicity across data collection tools, research, and policy products, contribute to these gaps.[37,42] Moreover, there is a gap in applying research to practice in a culturally competent and trauma-informed way. Capturing quantitative and qualitative data that considers power dynamics, social norms, and sociodemographic variables as analytical components is fundamental to understanding where research, policy, and services, fall short for these equity-deserving Veteran populations.

Without understanding how race, gender, sexual orientation, ability, military culture, and other identity-related characteristics intersect to shape Veterans' health, it is impossible to achieve equitable decision-making. Therefore, it is important to acknowledge that culturally sensitive means sensitive to military experience,[49,50] as well as other life experiences. Achieving health equity requires the development of policies and services that are responsive to these considerations. For instance, policies specifying eligibility for health services from 'accredited' or 'recognized' institutions may exclude those seeking traditional or cultural approaches. Existing policy frameworks and programs lack the flexibility and responsiveness required to address the distinct needs of equity-deserving groups, contributing to persistent barriers to good health and well-being for Veterans.

Canada

Methods

The CHNA process was used to gather, analyze, and synthesize evidence on the Veteran population. Within this framework, we used a mixed-methods research approach that was guided by seven paradigms, including intersectionality and sex and gender based analysis plus (SGBA+), which aligned with our values and enabled the research to remain grounded in lived-experience of Veterans. Together, these diverse but symbiotic paradigms promoted reflexivity, critical evaluation, accountability, and methodological coherence.



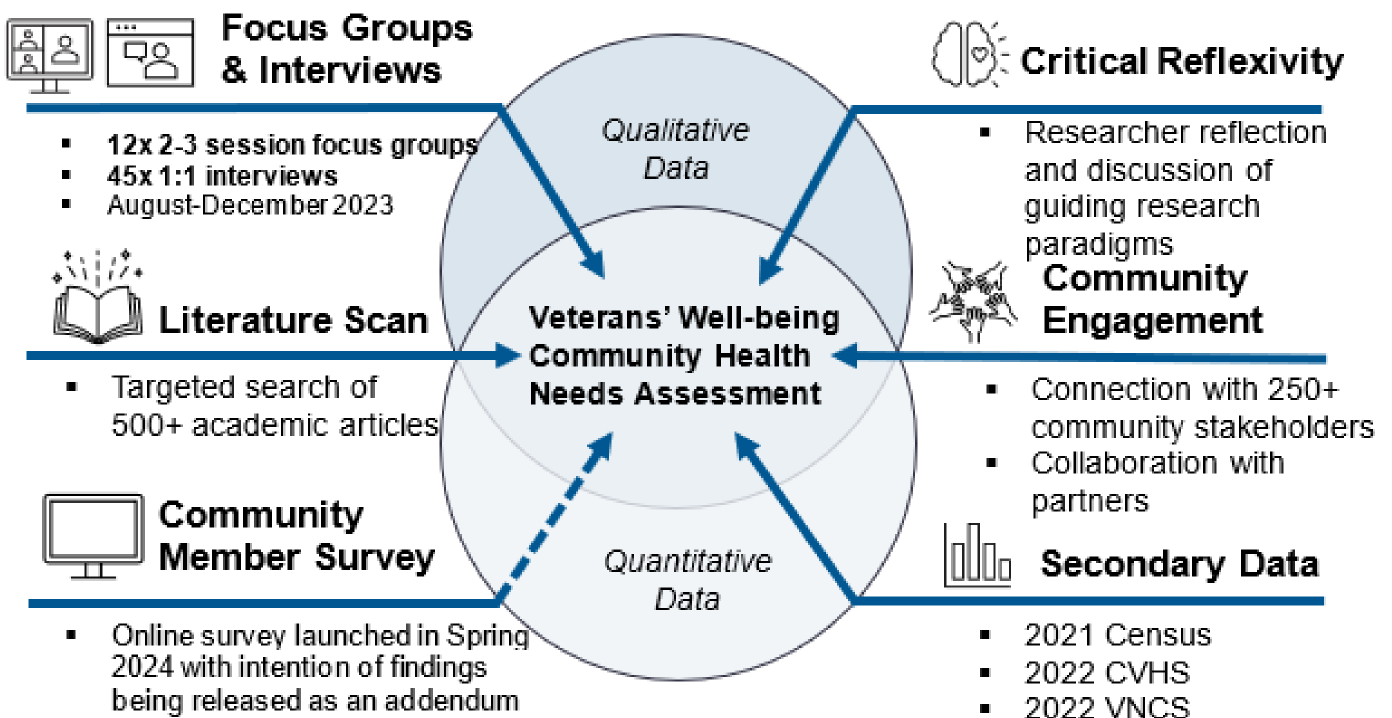
Our overarching research question was “What are the health and well-being strengths and needs of Canadian Veterans?

How did our paradigms guide the research?

Health equity	Explored the root causes of inequities at the individual, interpersonal, community, organizational, structural, and historical levels using holistic frameworks of health and well-being indicators.
Intersectionality and SGBA+	Investigated the impact of intersecting social identities and social locations on Veterans' health and well-being, including gender, sexual orientation, race, ethnicity, ability, military service, and sex.
Life course	Considered how the military-to-Veteran life course shapes current and future health and well-being trajectories (including pre-military, in-service, transition-to-civilian, and life after service experience)
Participatory	Collaborated with Veterans and stakeholders to inform research design, data collection, recruitment, and knowledge translation; incorporated feedback to support improvements and validity of findings.
Trauma-informed	Completed comprehensive training with attention to military context; applied approaches throughout planning and implementation to ensure Veterans could participate in safe and supportive environments.

Anti-oppressive	Identified and engaged with equity-deserving Veterans and stakeholders to understand strengths and experiences of Veterans who have traditionally been left out of research; avoided stigmatization and 'othering.'
Decolonial and Indigenous based	Expanded studies beyond colonial methods by using participatory approaches, centering lived-experiences, and exploring other knowledge sources such as oral histories.

Our mixed-methods approach included critical reflexivity, community engagement, literature scan, secondary data analysis, interviews and focus groups, and an online survey (see Appendix B Logic Model for details). This approach allowed us to leverage the contextualized insights of qualitative data as well as the generalizable, externally valid insights of quantitative data.



Critical reflexivity

To guide and inform our research decisions and processes, we built a critical reflexivity practice that enabled us to continuously revisit our guiding research paradigms. Activities included education on paradigms, discussing application of research paradigms to processes, reflection on researcher positionality, and journalling throughout data collection and analysis phases to identify power imbalances, privilege, systemic oppressive practices, unconscious biases, and stereotypes. We used reflexivity as a *practice* of doing research rather than as a source of authority over knowledge.

The CHNA Team committed to ensuring Veteran safety and ethical research practices. All team members completed: training on Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (2022); Gender Based Analysis Plus; VAC's online modules on trauma-informed support and CAF 101 for Civilians; instruction on qualitative research methods, data collection and storage; mock trials for interviews and focus groups; and instruction on VAC's Suicide Awareness Intervention Protocol. In addition, we developed the CHNA Participant Well-Being Protocol which was applied to all engagements with Veterans.

Community engagement

To include Veterans and stakeholders in the planning, implementation, and evaluation of the CHNA, we met with over 40 key stakeholders and engaged with over 250 organizations. These efforts built trust with the Veteran community, spread awareness of goals and objectives, supported the research design, promoted participant recruitment efforts (specifically for equity-deserving and difficult to reach Veterans), and supported knowledge translation activities (see Appendix C and Appendix D for Carillon articles used to support Knowledge Translation within VAC). Stakeholders included community-level organizations, Veteran Service Organizations, and provincial/territorial and federal government departments. Information about our work was made available through a VAC webpage with updates shared via social media and stakeholders were invited to provide their input and feedback with the CHNA Team (see Appendix E for Stakeholder Engagement Evaluation).

> We don't know it all. In fact, we don't know much.
> We will get some of it right but most of it wrong.
> We probably need our [participants] more than they need us.[51]
>
> Jennifer Esposito, 2022

Literature scan

To identify the breadth and depth of Canadian and international evidence on Veteran health and well-being, we conducted a comprehensive literature scan of over 500 peer-reviewed articles and grey literature. Remaining grounded in our research paradigms enabled us to influence the choice of evidence sources and search terms. For example, the use of traditional academic published literature was not considered the only credible source of evidence for Veteran health and well-being. We used PubMed, EBSCOhost (Ageline, CINAHL), the VAC Library, Google Scholar, and Google to search the topics of demographics, life course, purpose, finances, social status, health, risk behaviours, disability, health and social services, health inequity, life skills, social integration, housing, adverse childhood experiences, and discrimination. Key search terms included health needs, strengths, challenges, influences, resources, priorities, gaps, lived-experiences, inequity barriers, well-being, access, social-health determinants. Synonymous and related terms were used as applicable.

Terms used to search for Veteran related sources included armed force, military, navy, reservist, national guard, and Veterans Affairs. Relevant articles were identified using the following inclusion criteria; academic and grey literature, credible source, Five Eyes partnering countries (CAN, AUS, NZ, UK, USA), English and French language, publishing date year 2000 or after, Veteran-specific, equity-deserving Veteran sub-groups. All sources were screened and assessed for methodological quality using the Mixed Methods Appraisal Tool (MMAT)[52] and the AACODS tool.[53]

Secondary data analysis

To use existing Veteran population data, secondary analysis of the 2021 Census[28] (Statistics Canada) and 2022 Canadian Veteran Health Survey[54] (CVHS) (Statistics Canada) was completed to include results on sociodemographic data of the Canadian Veteran population, as well as Veteran health, social, and well-being indicators. Data analysis was completed using R and relevant figures were created or adapted using Excel.

2021 Census: Census data was presented in counts and percentages of population, with some disaggregation of gender (men+, women+), Indigenous, and racialized Veteran subgroups.

2022 CVHS: 2022 CVHS variables included indicators of socioeconomic determinants of health and were identified through in-depth literature review. Variables were chosen based on Veteran and stakeholder consultations, organizational priorities, and in consideration of gaps in current Veteran evidence and knowledge. Selected 2022 CVHS variables were analyzed to provide frequency tables with further disaggregation following an intersectional framework that allowed the CHNA Team to identify trends within and between groups of Veterans (e.g., total Veteran

sample included women+ and men+; totals and gender, men+ and women+, breakdown of: Indigenous, Black and racialized, functional difficulties, sexual orientation). This approach highlighted gaps, areas of strength and inequities in Veteran population health outcomes. Confidence intervals (95%) were used to determine areas of significant differences and identify gaps, areas of strength and highlight inequities.

The 2022 VAC National Client Survey (VNCS): 2022 VNCS data was used conservatively to analyze data that was not otherwise available in the 2022 CVHS or 2021 Census to prevent an over-representation of VAC clients.

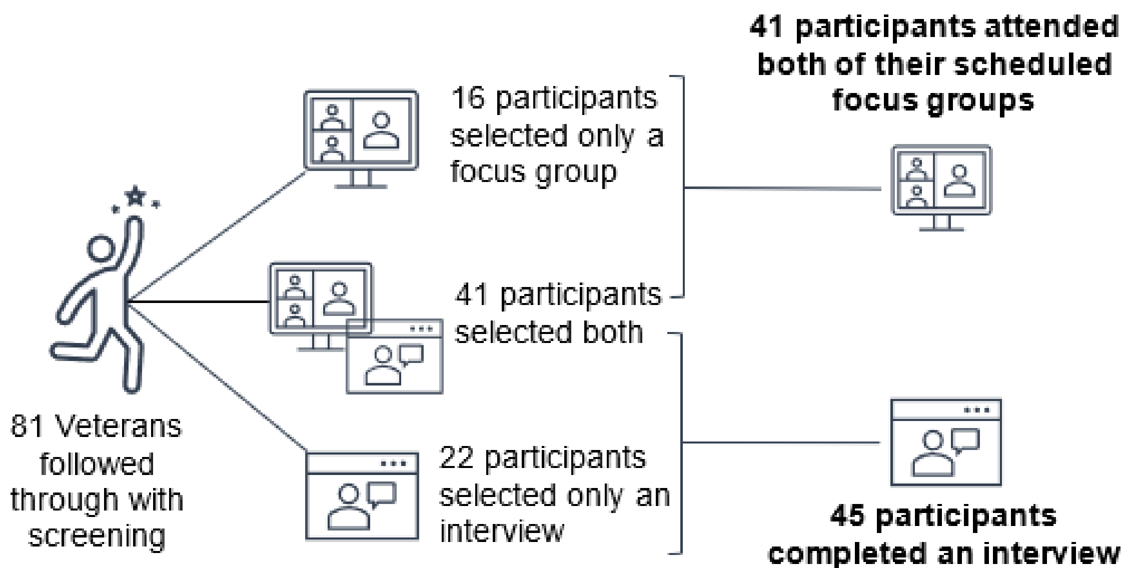
Interviews and focus groups

We conducted qualitative semi-structured interviews and focus groups between August and November 2023. The purpose was to collect data that was otherwise missing from existing sources, provide context to existing quantitative data, ensure the representation of equity-deserving Veterans, and enable intersectional analysis of findings.

Leveraging our engagement strategy, Veteran participants were recruited through word of mouth, social media, and a VAC webpage. Participation was voluntary and Veterans were invited to express their interest to the CHNA Team by voicemail or email. Potential participants were emailed a research information package, including interview and focus group semi-structured guide questions, Veteran oriented emergency phone number/resources, and a pre-interview time was scheduled (see Appendix F for Interview and Focus Group Research Information Letter and informed Consent). Pre-interview sessions were conducted by CHNA Team members via phone to explain benefits and risks of participating in the research, obtain informed verbal consent, and collect participants' sociodemographic characteristics. This gave Veterans the opportunity to ask questions and choose if they would like to participate in an interview, focus group, both, or not at all. These interactions ranged from 15 to 35 minutes. The only exclusion criteria for participation was if a potential participant reported not having previous military experience.

Prior to qualitative data collection, the research team developed a well-being protocol that included step by step guidance for interviewers and focus group moderators/co-facilitators to offer immediate support to a participant during or after research data collection activities.

Semi-structured interviews and focus group sessions were conducted with a sample of 75 participants with varying sociodemographic and identity characteristics, including gender, age, race, sexual orientation, military service characteristics, marital status, language, rural/urban, etc. (see Appendix G for Participant Socio-demographic Variables). Data saturation was achieved enhancing the validity and trustworthiness of the qualitative findings.[55]



Forty-five semi-structured interviews were conducted virtually using Microsoft Teams, with each interview lasting approximately 60 minutes. Semi-structured interviews were characterized by open-ended questions and an interview guide to capture Veterans' descriptions of their health and well-being experiences, including their strengths, needs, and facilitators and barriers to resources (Appendix H for Interview and Focus Group Discussion Guides).

Twelve focus groups, with three to five participants each, were conducted virtually using Microsoft Teams. Each focus group met for two sessions, with each session lasting approximately 60 minutes. One focus group met for a third session at the participants' request to allow additional time to answer questions. Focus group sessions were led by a moderator and supported by a co-facilitator. Focus groups were characterized by open-ended questions and used a semi-structured guide to elicit an understanding of Veterans' well-being, factors that facilitate or complicate healthcare access, health priorities, relevant information of military experience, and transition to life after service. Participants were given the option to participate in homogeneous or heterogeneous focus groups to enhance their comfort and safety in a group setting. All requests were accommodated and resulted in segmentation by gender (four women Veteran groups, six men Veteran groups), race (one Black Veteran group), and language (one Francophone Veteran group).

At the end of each interview and focus group, participants were invited to complete a brief evaluation of their interview or focus group experience (see Appendix I Interview and Focus Group Evaluation Questions).

The interviews and focus groups were recorded using Microsoft Teams which generated videos and transcripts. All data was saved and stored on the GCdocs platform in a restricted access folder which only the CHNA Team had access to. All team members used Government of

Canada password protected laptops. NVivo 14 was used for storing and coding transcripts, which were the units of analysis.

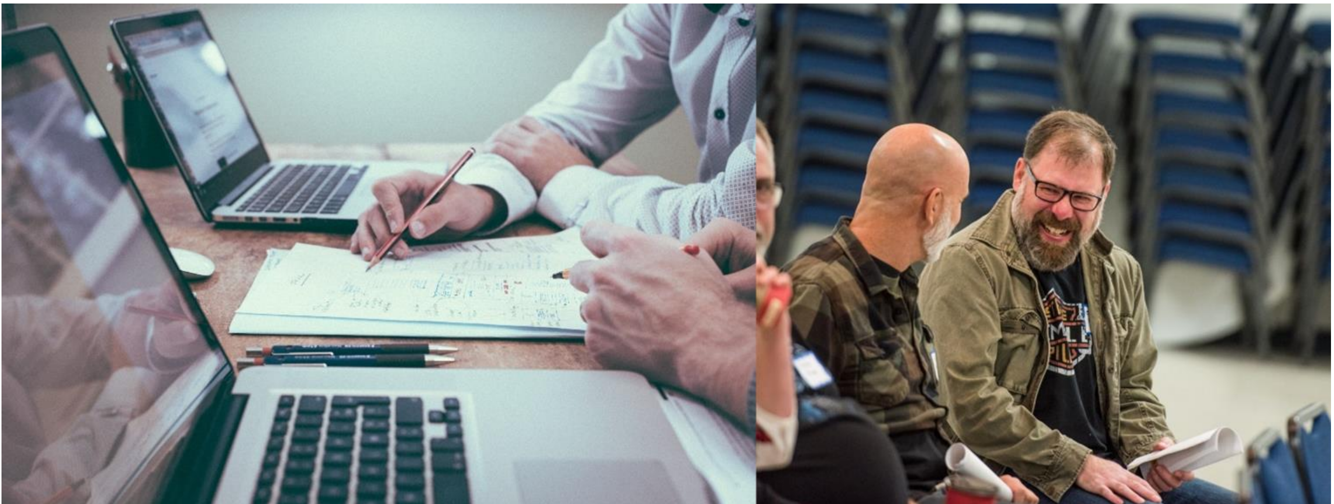
Thematic analysis[56] was carried out using an intersectional framework that emphasized SGBA+ to ensure diverse identities and multifaceted experiences of Veterans' health and well-being were centered.

Transcripts were reviewed to achieve data familiarization and validated using the recorded interviews to ensure accuracy of transcripts. CHNA Team researchers completed three rounds of inductive and deductive coding with constant comparison between researchers to ensure consistency. Next, codes were combined to identify subcodes and categories to identify patterns and relationships in the data. Finally, abstract interpretation was applied to create final themes.

Qualitative data validation, using member checking, was completed with interview and focus group participants. Qualtrics was used to share a summary of findings and themes with participants ranked their level of agreement using a Likert scale ranging from strongly agree to strongly disagree (see Appendix J for Data Validation).

Community member survey

A community member online survey was developed with input from Veterans and stakeholders (e.g., VAC, CAF/DND, Office of the Veterans Ombud) to enable collection of anonymized quantitative data using Qualtrics software. A convenience sample of Veteran participants will be targeted to allow for the disaggregation of intersectional characteristics. While the community member survey was not completed within the project timeline, results will be communicated as an addendum to this report and encourage ongoing conversations.



Limitations and risks

This section highlights identified research limitations and risks to effectively mobilizing CHNA findings to knowledge users.

Military identity

Noting that the project scope only included CAF Veterans, there were limitations in the availability of Canadian military and Veteran research literature with inclusion of members from the Special Forces, Canadian Rangers, and other categorizations such as "purple trades." The 2022 CVHS did not capture key military service characteristics such as branch and length of service which limited insights on how Veterans' military experiences and intersectional identities impacted their health and well-being strengths, needs, barriers, and facilitators to resources. This was mitigated using international military and Veteran research literature, and exploration of Veterans' military characteristics and intersectional identities via semi-structured interviews and focus groups.

Recommendations:

- ✓ Veteran population surveys should prioritize collection of military service variables such as branch of service, rank, military occupations, length of service, type of release, etc. to better contextualize Veterans' health and well-being outcomes. Future CHNAs could consider including RCMP members/former members to explore and identify differences in health and well-being outcomes of these similar, but unique populations.

Under-represented Veteran groups

There was a dearth of Canadian military and Veteran literature that included adequate representation of equity-deserving and hard-to-reach Veterans, such as Veterans who have experienced homelessness. Challenges with data collection arose from the proportionally smaller numbers of equity-deserving individuals within the overall Veteran population. Without oversampling strategies, Veteran population research results in small unreportable sample sizes of equity-deserving groups. This under-representation of equity-deserving populations limits the identification and understanding of the unique strengths, needs, and health and well-being outcomes for women, 2SLGBTQI+, Indigenous, and Black and racialized Veterans.

The CHNA's intersectional analysis of available data represents a progressive step in national research that will support the development of health policies and programs. A strength of the CHNA is the inclusion of 2022 CVHS data, a key secondary source that provides Veteran health and well-being outcomes and applies health equity, SGBA+, and intersectionality to fill gaps in the current health and well-being research landscape for Veterans. Furthermore, the CHNA Team's collaboration with the VAC Research Directorate demonstrates a proactive and responsive approach to enhancing the comprehensiveness and relevance of health and well-being data for the Veteran community.

Recommendations:

- ✓ Design mixed-methods and/or qualitative research studies to explore the context of Veterans' lived-experiences and target equity-deserving and hard-to-reach Veterans. Ensure application of SAGER principles, SGBA+, and intersectionality in quantitative and qualitative research designs.
- ✓ Support the collection of intersectional identity indicators in assessment tools and emerging research fostering an environment where Veterans can fully embrace their identity and receive support and care based on their unique needs.
- ✓ Continue efforts to identify and address data gaps in Veteran health and well-being, particularly in areas such as women's health, sexual and reproductive health, oral health, spiritual health, emotional well-being, and other under-researched areas, through collaboration with relevant stakeholders.
- ✓ Cultivate ongoing cross-departmental and cross-organizational communication and collaboration with analysis teams of key secondary data sources, like CVHS, to ensure a proactive approach in improving the comprehensiveness and relevance of health data for the Veteran community.

Recruitment

The recruitment of Veterans who were not currently receiving VAC benefits or services, equity-deserving, and hard-to-reach Veterans, was identified as a potential challenge during the initial stages of project planning. To address this, the CHNA Team engaged the Veteran community and stakeholders to build trust and reach participants through word-of-mouth across various Veteran networks. While these strategies were effective in recruiting women Veterans and Veterans who were not currently receiving VAC benefits or services, further efforts were needed for 2SLGBTQI+, Indigenous, Black and racialized Veterans. Lower-than-expected turnout from these groups may be attributed to a lack of community connections, distrust, and disinterest in the study's relevance. Furthermore, limited time and funds created additional challenges and barriers with recruitment. These factors narrowed the project's scope in developing a comprehensive portrait of Veterans' needs, strengths, and resources.

To mitigate this, the recruitment approach included the use of online and print resources to spread awareness; promotion at multiple Veteran community events (with a focus on equity-deserving Veteran events); and implementation of a segmentation strategy for focus groups. Participants were asked to self-identify using sociodemographic characteristics, and if interested in a focus group, were offered the opportunity to participate in a group of peers of the same race, gender, language, ability, or lived-experience. The team was responsive and accommodating to Veterans' requests for placement in different focus groups based on preference (and some elected to not be segmented in any way). This segmentation strategy empowered Veteran participants to select the group which they felt most safe and comfortable with and aimed to encourage the participation of equity-deserving Veterans.

Recommendations:

- ✓ Actively engage and include the Veteran community in the design, implementation and delivery of initiatives, benefits, and services to foster trust and inclusivity.
- ✓ Expand outreach efforts to non-VAC clients, as well as equity-deserving and hard-to-reach Veterans through various resources, including Veteran and non-Veteran networks.
- ✓ Expand outreach efforts to non-VAC clients, as well as equity-deserving and hard-to-reach Veterans using various resources, including Veteran and non-Veteran networks. It is particularly important to understand and apply preferred engagement methods for hard-to-reach and equity-deserving Veterans.
- ✓ Promote partnerships and co-leadership in both governmental and non-governmental projects, emphasizing participatory, trauma-informed, anti-oppressive, de-colonial, intersectional and SGBA+, life course and healthy equity focused research approaches.

- ✓ Use diverse and adaptable participation methods in future research endeavors, including virtual, in-person, and asynchronous options, to ensure effective engagement while catering to the diverse needs of Veterans and promoting their autonomy.

Approach and cultural implications

The readiness (or lack thereof) of the Veteran community to accept the CHNA findings and implement recommendations poses a risk to knowledge translation. While the assessment is intended to be anti-oppressive, existing systems and systemic issues prevent fulsome application of the principles of mixed-methods research approaches. These principles, particularly those related to intersectionality and health equity, are new to the Veteran community and not well understood.

Acknowledging this risk, one of the CHNA's strengths lies in the team's commitment to incorporate their guiding paradigms in research activities. Critical reflexivity was maintained throughout the assessment by journalling and meeting together to actively reflect on the research process and to identify power imbalances, privilege, oppressive practices, conscious and unconscious biases, stereotypes, and systemic racism. This resulted in a more comprehensive and inclusive understanding of health needs and priorities, leading to contextualized strategies and outcomes for the Veteran community.

Recommendations:

- ✓ Continue to foster an inclusive culture within the Veteran community that recognizes and supports the diverse backgrounds and experiences of Veterans, including those with intersectional identities such as disabled and transgender individuals. This includes cultures within the CAF and VAC.
- ✓ Active efforts should be taken to identify and address the inherent biases and power imbalances within military and government organizations. These dynamics contribute to hierarchies within the Veteran community, amplifying challenges to Veteran health and well-being.
- ✓ Although it may take time for research to reach equity-deserving Veterans who are still in the process of understanding or accepting their intersectional identities, Veteran stakeholders must acknowledge and adapt to ongoing cultural changes within the CAF.

Findings and discussion

Data from the 2022 CVHS, 2021 Census, and the 2022 Canadian Community Health Survey (2022 CCHS) are included in the following section. These data have classifications and definitions that aid in interpretation of findings and discussion.

- **Regarding gender:** In the following findings and discussions, the concept of "women+" is derived from a gender variable based on three categories: women (including transgender women and cisgender women) and some non-binary persons. The concept of "men+" is derived from a gender variable based on three categories: men (including transgender men and cisgender men), and some non-binary persons. These categories are used in 2022 CVHS and 2021 Census products.

- **Regarding race/ethnicity:** In the following findings and discussions, the concept of "Black and racialized" groups is based and derived directly from the concept of "visible minority" groups in the 2021 Census. While the text of the document refers to "Black and racialized" groups; charts, tables and graphs use the derived variable of "visible minority." The Employment Equity Act defines visible minorities as "persons, other than Aboriginal peoples, who are non-Caucasian in race or non-white in colour."[57] These categories are used in 2022 CVHS, and 2021 Census products. Statistics Canada is currently reviewing the visible minority concept. For details, see Visible minority concept consultative engagement.
    - "Black and racialized" / "visible minority" in this report consists of the following groups: South Asian, Chinese, Black, Filipino, Arab, Latin American, Southeast Asian, West Asian, Korean, and Japanese.
    - "Not Black and racialized" / "not a visible minority" in this report consists of the following groups: white and Indigenous (including First Nations, Métis, and Inuk [Inuit]). For more information on specific category inclusions, see the Statistics Canada standard.

- **Regarding Indigenous identity (Indigeneity):** In the following findings and discussions, results presented as being part of the Indigenous subgroup are derived from a question where a person may indicate they identify as Indigenous (including First Nations, Métis, and Inuk [Inuit]) or not.

- **Regarding sexual orientation:** In the following findings and discussions, the concept of sexual orientation is derived from the variable in the 2022 CVHS where a person may describe their sexuality as heterosexual, lesbian, gay, bisexual, or "other – please specify" representing any other sexual orientation that is not heterosexual. This group has been identified throughout this document as **LGB+.** These categories are used in 2022 CVHS products. For more information see the Statistics Canada standard.

- **Regarding functional difficulty and disability:** Functional health difficulties refer to restrictions in an individual's functioning that impede their abilities to engage in tasks without accommodations. The 2022 CVHS asked if respondents had difficulty with any of the six functional health areas including: seeing, hearing, mobility (i.e., walking or climbing steps), cognition (i.e., memory and concentration), self-care (i.e., such as washing all over or dressing), and communication (i.e., difficulty understanding or being understood when using one's usual language). Respondents could answer on a scale of "no difficulty," to "cannot do at all" with each of the six health areas. While a "functional limitation" or "functional difficulty" is the result of having some difficulty across any domain of functional health, "disability" is the result of a person with a functional difficulty interacting with an unaccommodating environment.[58,59] These categories are used in 2022 CVHS products.

Qualitative findings in the form of participants' direct quotes from semi-structured interviews and focus groups are also included in the following sections. Selected quotes may include participants' characteristics to aid in the interpretation of findings and implications.

- **Intersectional identifiers:** Intersectional identifiers (such as gender, Indigeneity, sexual orientation, etc.) are included with quotes when participants' describe how their identity characteristics impact their contextual lived-experiences. This practice aligns with the research's goal of exploring and identifying the multiplicity of lived experiences of equity-deserving Veterans, including women, Indigenous, 2SLGBTQI+, Black and racialized, and disabled Veterans. This approach is integral to the application of the project's guiding research paradigms of intersectionality and GBA Plus, health equity, participatory and decolonial practices, anti-oppressive, and trauma-informed within all phases of the research project, including reporting of findings. Acknowledging and naming participants' intersectional identities helps to uncover power dynamics, stigma, oppression, etc. that some participants' face (past and present) as a direct result of their equity-deserving Veteran identities.

Sociodemographic profile

Data from the 2022 CVHS and 2021 Census[28] shed light on the demographics and social characteristics of Canadian Veterans. Key findings include:

- According to the 2021 Census, there were 461,240 Veterans in Canada, representing 1.5% of the Canadian general population over the age of 17.[60]
- The Veteran population was 83.8% men+ and 16.2% women+ (Census 2021),[60] this was a much higher share of men to women than in the Canadian general population.[61]
- Over 4 in 10 Veterans were 65 years or older (41.8%), with men+ Veterans on average being older (61.7 years old) than their women+ Veteran counterparts (59.1 years old).[60]
- Half (52.8%) of all Veterans served in the Regular Force, 36.1% served in the Reserve Force, and 11.0% of Veterans had multiple service types (CVHS, 2022).
- The majority of Veterans (18.7%) released from service 30-39 years ago; 18.3% released over 50 years ago and those Veterans were more likely to experience functional difficulties than those who released sooner (CVHS, 2022).
- Veterans who released more recently fell into two groups: 15.9% of Veterans released less than 10 years ago, and 14.6% of Veterans released between 10 and 19 years ago (CVHS, 2022).

As Canada's serving population continues to grow in diversity, so does its Veteran population.[26] Throughout this report, the experiences and outcomes of equity-deserving Veteran groups are outlined, supported by findings from the 2021 Census.[28]

- One in twenty Veterans identified as Indigenous (5.2% or 23,075).[26,62] Most of these Veterans identified as a single Indigenous identity, where 47.5% of Indigenous Veterans identified as First Nations, 45.2% identified as Métis, and 3.3% identified as Inuk (Inuit).[33,63]
- Most Veterans (95.7% or 425,380) did not identify as a visible minority[b].[64] The largest racialized population of Veterans were those that identified as Black (5080 or 1.1% of Veterans), followed by South Asian (3,400 or 0.8% of Veterans) and Chinese (3,150 or 0.7% of Veterans).[64]
- The share of Veterans who identified as transgender (0.1% transgender men, 0.1% transgender women) and non-binary (0.1%) was similar to that of the total population.[26]

[b]For more information on this category, see the Statistics Canada standard.

Health indicators

Data from the 2022 CVHS and 2021 Census, along with our new qualitative findings, are used in the following sections to examine health and well-being indicators. Data from the 2022 CCHS are used, where applicable, for comparable data of the general Canadian population. Data from the 2022 VNCS, which represents a sample of VAC clients, are used conservatively to prevent an over-representation of these Veterans.

Definition: Health indicators are summary measures designed to provide comparable and actionable information about priority topics related to population health or health system performance.[65]

Physical health

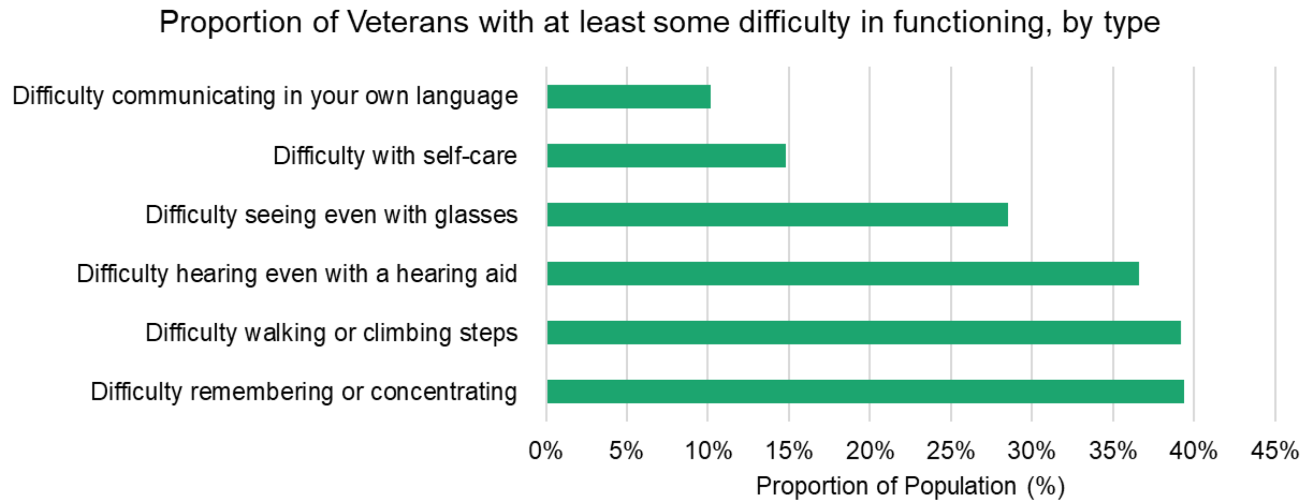
What you need to know:

- A Veteran's physical health can influence, and be influenced by, other domains of well-being.
- Some physical health disparities reflect longstanding inequities rooted in discrimination, affecting Veterans' overall well-being.
- A Veteran's understanding of their physical health is personal and shaped by their general and military lived-experiences.

Definition: Physical health refers to the fluidity of an individual's biological, physiological, and overall functioning, and how they may reach optimal capacities within an everchanging social and environmental landscape.[66]

Veterans' domains of well-being: The implications of physical health on overall health and well-being extend across all the domains of well-being measured by the existing surveillance framework.[33]

Figure 1: proportion of Veterans experiencing at least some difficulty in functioning, by type



Difficulty type	Proportion of Veterans (%)
Difficulty remembering or concentrating	39.4%
Difficulty walking or climbing steps	39.2%
Difficulty hearing even with a hearing aid	36.6%
Difficulty seeing even with glasses	28.5%
Difficulty with self-care	14.8%
Difficulty communicating in your own language	10.2%

Figure 1: proportion of Veterans experiencing at least some difficulty in functioning by type (Source: CVHS, 2022)

Research has found that, when compared to the general Canadian population, Veterans have a higher prevalence of physical health conditions, particularly musculoskeletal disorders and chronic pain.[67] For Canadian Veterans, physical health problems and anxiety disorders can manifest together, with impacts on physical health-related quality of life and activity limitations.[68]

- Veterans with functional difficulties reported difficulty **with at least one** of six functional health components (CVHS, 2022).

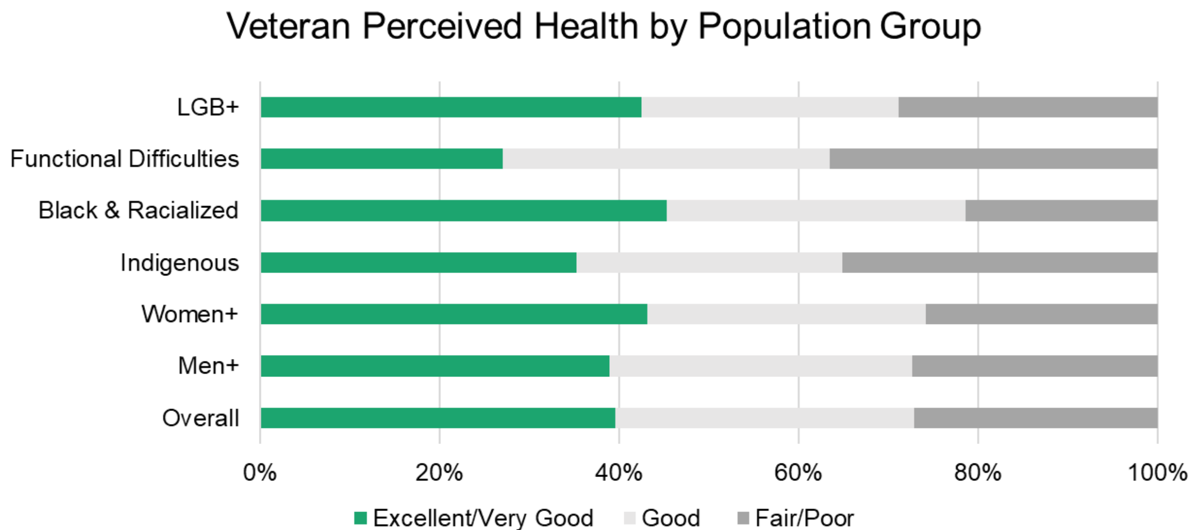
The 2022 CVHS findings highlighted that a proportion of Veterans experienced difficulties in their daily activities, including difficulty communicating in your own language, difficulty with self-care, difficulty remembering or concentrating, difficulty walking or climbing steps, difficulty hearing even with a hearing aid, and difficulty seeing even with glasses (see Figure 1).

Physical and mental health and well-being

CHNA participants spoke at length about the relationship between physical health and mental health. Many shared personal definitions which showed that physical health played an instrumental role in mental, social, and spiritual health. In turn, each aspect of health had the

ability to impact their physical health. Some participants said physical health was not only the absence of disease, but that it needed to be regarded as an interconnected web of factors for Veterans to achieve overall positive health and well-being outcomes.

Figure 2: Veteran perceived health by population group



Perceived health	Overall	Men+	Women+	Indigenous	Black and racialized	Functional difficulties	LGB+
Excellent/Very good	39.6%	39.0%	43.2%	35.3%	45.3%	27.0%	42.6%
Good	33.3%	33.7%	31.0%	29.6%	33.3%	36.4%	28.6%
Fair/Poor	27.1%	27.3%	25.8%	35.1%	21.4%	36.6%	28.8%

Figure 2: Veteran perceived health by population group
Note: Health includes "the absence of disease or injury, and also physical, mental and social well-being (Source: CVHS, 2022)

The 2022 CVHS asked Veterans about their satisfaction with their perceived health (see Figure 2), which was intended to reflect “aspects of health not captured in other measures, such as: incipient disease, disease severity, aspects of positive health status, physiological and psychological reserves and social and mental function.”[69] The 2022 CVHS instructions asked Veteran participants to consider “not only the absence of disease or injury but also physical, mental and social well-being.”[54]

- Veterans rated their overall health less positively than the Canadian adult population: only 39.6% of Veterans rated their health as excellent or very good (CVHS, 2022); compared to 53.8% of the Canadian population (Census, 2021).[70]

Health is interconnected

Many CHNA participants identified that their ability to feel physically healthy was dependent on several factors, including: access to health providers (including specialized services for women and Indigenous Veterans); financial health (e.g., ability to afford medication, housing, food, counseling, and provide themselves with a sense of security); bodily health and well-being needs (related to aging, sleep, stress and pain management, nutrition, and being able to engage in physical activity); and spiritual and community health needs (e.g., feeling spiritually, culturally, and socially supported and understood).

The influence of bias on Veterans' care

Many equity-deserving CHNA participants mentioned that notions of physical health were different for them. Women CHNA participants shared that biases around women in service being 'soft' influence their future support seeking behaviours, access to healthcare resources, and the understanding of symptomology in Veterans. Research demonstrates that there are known sex differences for physical health observed between female and male Veterans; for instance, male Veterans are more likely to have cardiovascular issues.[71]

- While women+ Veteran respondents in the 2022 CVHS had similar perceptions of their overall health to their men+ counterparts, research has found that Veterans who experienced military discrimination report having poorer physical health.[72]
- 2022 CVHS data showed that health ratings differed significantly between Veterans with functional difficulties and those that did not. Veterans with functional difficulties rated their health much poorer (27.0%) than Veterans with no functional difficulties (67.7%) (CVHS, 2022).

> "So, when it comes to me struggling with cognitive function or physical function, you know it's a lot different than if a man is struggling with it."
>
> Racialized Veteran Woman

"Healthy behaviours" are activities that promote short and long-term health and prevent disease.[73] Engaging in healthy behaviours can include participating in physical activity, eating well, and engaging in routine immunizations. Immunizations are safe and effective interventions that help people stay healthy and prevent disease and premature death.[74]

- Half of Veterans (52.6%) reported having received the seasonal flu vaccine in the past year (CVHS, 2022).
- There was no significant difference in the proportion of men+ and women+ Veterans reporting that they received the seasonal flu vaccine (CVHS, 2022).
- Indigenous Veterans reported lower uptake rates of the seasonal flu vaccine (43.7%) than non-Indigenous Veterans (52.9%) (CVHS, 2022).
- Black and racialized Veterans reported lower uptake rates of the seasonal flu vaccine (38.8%) than Veterans who were not Black and racialized (53.2%) (CVHS, 2022).

Chronic conditions

What you need to know:

- A Veteran's experience living with chronic conditions can be influenced by their military experience, gender, age, and access to supports.
- Support for chronic conditions requires trauma-informed and intersectional approaches with culturally safe interventions.
- Different populations of Veterans report differences in the top five conditions they experience.

Definition: Chronic conditions can refer to recurring, prolonged or persistent illnesses or impairments lasting at least a few months, and while often treatable, are not curable once acquired.[75–77]

Veterans' domains of well-being: Chronic conditions can impact multiple aspects of a Veterans' well-being, including their overall health, purpose and employment, social integration, and life skills.[33]

Figure 3: chronic conditions by total Veteran population

Chronic condition	Proportion of Veterans (%)	Chronic condition	Proportion of Veterans (%)
Diabetes	14.2%	**Arthritis**	40.8%
Cancer in lifetime	15.3%	**Back problems**	43.2%
Heart disease	12.8%	**Mood disorder**	17.9%
Heart attack	8.2%	**Anxiety**	18.4%
High blood pressure	34.5%	**PTSD**	16.3%
High blood cholesterol	37.2%	**Alzheimer's or other dementia**	2.1%
Stroke	3.5%	**Chronic fatigue syndrome**	2.4%
Osteoporosis	7.3%	**Multiple chemical sensitivities**	2.2%
Fibromyalgia	2.3%		

Figure 3: The reported variables were those available from the Statistics Canada CCHS Chronic Conditions module and are not reflective of all chronic conditions that Veterans may experience. Obesity and pain are detailed in other sections of this report.

Figure 4: Top five common chronic conditions by population group

Indigenous Veterans

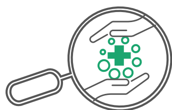
Condition	%
Back problems	46.5%
Arthritis	39.4%
High cholesterol	34.8%
High blood pressure	31.8%
Anxiety	26.5%

Black and racialized Veterans

Condition	%
Back problems	34.2%
High cholesterol	29.1%
Arthritis	23.6%
High blood pressure	22.6%
Anxiety	20.9%

LGB+ Veterans

Condition	%
Back problems	42.1%
Arthritis	35.5%
High cholesterol	28.6%
Mood disorder	28.3%
Anxiety	26.8%



Men+ Veterans

Condition	%
Back problems	44.0%
Arthritis	40.4%
High cholesterol	38.8%
High blood pressure	36.0%
Anxiety	17.4%

Women+ Veterans

Condition	%
Arthritis	43.0%
Back problems	38.5%
High cholesterol	27.8%
High blood pressure	25.9%
Anxiety	24.1%

Figure 4: The reported variables were those available from the Statistics Canada CCHS Chronic Conditions module and are not reflective of all chronic conditions that Veterans may experience. Obesity and pain are detailed in other sections of this report.

For Veterans, many factors play a role in the diagnosis, management, and treatment of a chronic condition, including demographic characteristics (e.g., gender, SES status, race and ethnicity, sexual orientation, geography/rurality); healthcare factors (e.g., availability, access, clinical cultural sensitivity, prejudice/bias/discrimination); institutional and organizational factors; military factors; and military cultural competency.[70,71,78–80] Figure 3 shows some of the chronic conditions reported by all Canadian Veterans according to the 2022 CVHS; Figure 4 highlights the top five common chronic conditions reported by population group of Veterans according to 2022 CVHS.

Did you know?

In the Canadian population, arthritis and high blood pressure were among the most common chronic conditions in 2021.[82]

Sex, gender, and chronic conditions

- Men+ Veterans were significantly more likely to report diabetes, high blood pressure, and high blood cholesterol than women+ Veterans (CVHS, 2022).
- Men+ Veterans were also more than twice as likely to report cases of heart disease, and nearly four times as likely to report heart attacks than women+ Veterans (CVHS, 2022).
- Women+ Veterans were more than twice as likely to report fibromyalgia and osteoporosis (CVHS, 2022).
- Women+ Veterans were also significantly more likely to report mood disorder and anxiety than men+ Veterans (CVHS 2022). (*See also Mental Health and Well-Being section*)

For comparison, 2022 CCHS data on Canadians 18+ showed similar trends as those observed in Veterans, with a greater share of males reporting diabetes and high blood pressure than females, and a greater share of females reporting mood disorder and anxiety disorder than males.[70]

Indigenous, racialized, and LGB+ groups and chronic conditions

In the 2022 CVHS, there were statistically significant differences in chronic condition reporting, which may point to inequities in access and care.

- Indigenous Veterans, especially men+, were significantly less likely to report cancer in their lifetime (9.2%) than non-Indigenous Veterans (15.6%) (CVHS, 2022).
- There was not a statistically significant difference when comparing Indigenous and non-Indigenous Veterans regarding proportions of those reporting diabetes, heart disease, heart attack, high blood pressure, stroke, osteoporosis, fibromyalgia, arthritis, back problems, mood disorder (including depression), Alzheimer's or other dementia, chronic fatigue syndrome, and multiple chemical sensitivities (CVHS, 2022).

- When factoring in gender, Indigenous men+ Veterans were five times more likely than Indigenous women+ Veterans to report heart disease, and 12 times more likely to report heart attack than Indigenous women+ Veterans (CVHS, 2022).
- Indigenous Veterans (54.4%) primarily served in the Regular Force compared to other service types (CVHS, 2022).

Culturally appropriate care for chronic conditions

Indigenous CHNA participants expressed a desire to manage their chronic conditions with Indigenous cultural knowledge, incorporating and valuing Indigenous medicines and healing practices along with Western healthcare approaches.

- Black and racialized Veterans, compared to Veterans who were not Black or racialized, were significantly less likely to report cancer in lifetime (4.4% vs 15.8%), heart disease (3.4% vs 13.3%), heart attack (2.0% vs 8.4%), high blood pressure (22.6% vs 35.0%), stroke (0.6% vs 3.6%), arthritis (23.6% vs 41.6%), and back problems (34.2% vs 43.5%) (CVHS, 2022).
- There was not a statistically significant difference in the reporting of diabetes, high blood cholesterol, osteoporosis, fibromyalgia, mood disorder, anxiety, Post Traumatic Stress Disorder (PTSD), Alzheimer's or other dementia, chronic fatigue syndrome, and multiple chemical sensitivities, between Black and racialized Veterans overall, and those who were not Black or racialized (CVHS, 2022).
- When factoring in gender, Black and racialized men+ Veterans were significantly less likely to report diabetes, heart attack, high blood pressure, high blood cholesterol, stroke, osteoporosis, arthritis, and Alzheimer's or other dementia, than men+ Veterans who were not Black or racialized (CVHS, 2022).

Discrimination and chronic conditions

Black and racialized CHNA participants spoke about the compounding nature and challenges effects of structural racism on diagnosis, prevention, and management of chronic conditions.

- LGB+ Veterans did not differ significantly from heterosexual Veterans across the majority of chronic conditions (CVHS, 2022).
- LGB+ Veterans significantly reported lower rates of chronic fatigue syndrome (0.1%) and multiple chemical sensitivities (0.2%) (CVHS, 2022).

Barriers to diagnosis and support

2SLGBTQI+ CHNA participants expressed concern for their quality of healthcare, noting a lack of trauma-informed approaches and knowledge of their unique health needs. Two-Spirit participants said that barriers to accessing medical diagnoses are compounded by colonialism, racism, and cultural insensitivity, along with homophobia and heterosexism.

Veterans with functional difficulties and chronic conditions

- Veterans with functional difficulties were significantly more likely to report diabetes (16.2%), high blood pressure (38.6%), high blood cholesterol (41.6%), and osteoporosis (9.3%), than Veterans with no functional difficulty (CVHS, 2022).
- Veterans with functional difficulties reported cancer in lifetime (18.2%), heart disease (15.4%), heart attack (10.6%), stroke (4.7%), fibromyalgia (3.2%), arthritis (50.8%), back problems (51.3%), mood disorder (23.8%), anxiety (23.3%), and PTSD (22%), at more than twice the proportion of Veterans with no functional difficulties (CVHS, 2022).
- Men+ Veterans with functional difficulties were significantly more likely to report heart disease, heart attack, and high blood pressure, than women+ Veterans with functional difficulties, as well as men+ Veterans with no functional difficulties (CVHS, 2022).
- Women+ Veterans with functional difficulties were significantly more likely to report osteoporosis, fibromyalgia, mood disorder, and anxiety, than their men+ counterparts (CVHS, 2022).
- There was no statistically significant difference in Alzheimer's or other dementia, chronic fatigue syndrome, and multiple chemical sensitivities reporting between those with functional difficulties and those without (CVHS, 2022).
- Women+ Veterans with functional difficulties were significantly more likely to report chronic fatigue syndrome and multiple chemical sensitivities than women+ Veterans with no functional difficulties (CVHS, 2022).

Disability and chronic conditions

CHNA participants mentioned the impact that functional difficulties had on their ability to manage their chronic illness, including their abilities to engage confidently in social settings and to advocate for their health needs. Some expressed mobility challenges, which in turn impacted their overall mental and physical well-being.

- Veterans with functional difficulties were significantly more likely to serve in the Regular Force (55.7% vs 45.8%) and significantly less likely to serve in the Reserves (31.7% vs 46.1%) than those without difficulties (CVHS, 2022).

> "Health cannot fit into these little boxes of how VAC has been set up. You know that you have to be chronic. You have to be medically diagnosed. It has to have a service relationship. We spend so much time and energy and effort and pretzeling ourselves to fit into the boxes."
>
> Veteran Woman

Range of chronic conditions

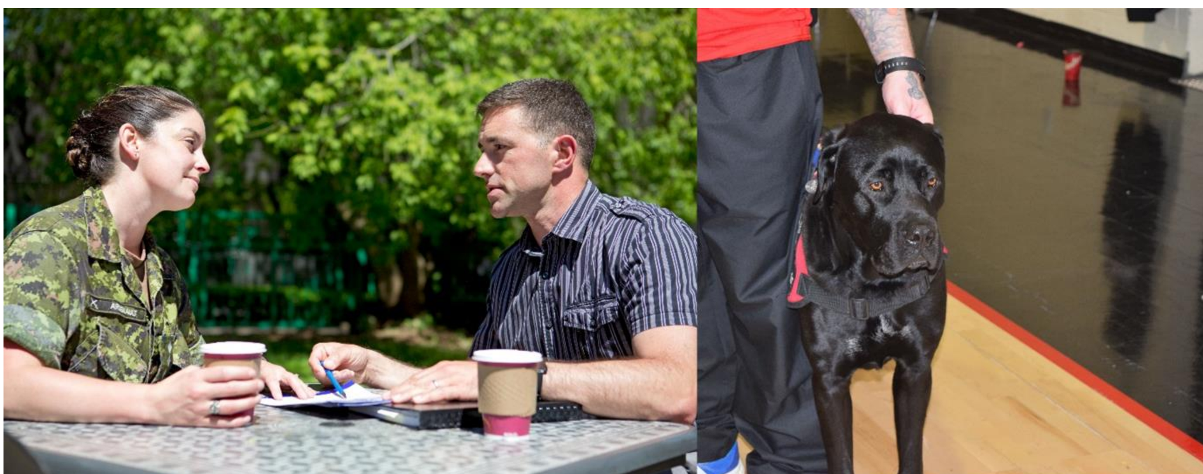
Some CHNA participants spoke of chronic conditions as a constant companion, while others identified unexpected, often acute, flare-ups.

> "To have the yard work done that would take somebody a weekend to do. It takes you a month to do when you're limited with health, because you have to spread it out, you have to wait, rest, you have to brace up, you have to prepare. It takes a long time. Just quite an ordeal when you're trying to do a simple job."
>
> Veteran Man

Veterans experiences of chronic conditions

CHNA participants described their experiences of development, diagnosis, and treatment with one or more chronic conditions and shared how living with chronic conditions is personal.

Management of chronic conditions is an important topic for Veterans, who identify that a network of support and a sense of belonging can positively impact quality of life. Findings speak to the need for a holistic approach that involves delving into Veterans' histories to adequately address the burdens associated with the daily management of chronic condition. Further research is recommended to explore how life course trends and contextual factors shape chronic conditions in the Veteran population, including age, income, and military characteristics.



Mental health and well-being

What you need to know:

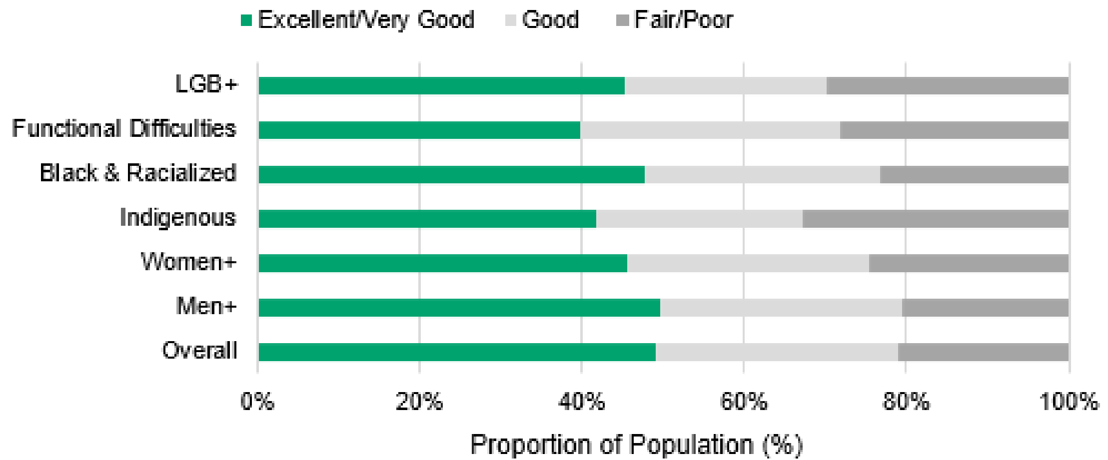
- There is a connection between mental health and all other domains of well-being, including physical, financial, social, and spiritual health.
- Veterans' mental health is influenced by military service, as well as personal, cultural, historical, and community contexts.
- Equity-deserving Veterans may disproportionately experience mental health issues and require personal, culturally relevant, trauma-informed interventions.

Definition: Mental health is the state of one's "psychological and emotional well-being",[81] and is a fundamental component of overall health and well-being.

Veterans' Domains of Well-Being: Mental health is connected to all aspects of health and well-being, including physical health, housing, financial security, life skills, and social integration.[33]

For Veterans, special attention to mental health is required given the dynamic nature of military service and increased risk of exposure to moral injury and traumatic events.[71,82–85] Many factors impact the mental health of Veterans. Individual factors such as resilience can improve mental health and well-being for a Veteran, while other factors such as obesity and smoking can contribute to poorer mental health outcomes.[84,86] External factors such as social, economic, geopolitical, and environmental circumstances can also increase the risk of experiencing mental health conditions.[84,87–93] Figure 5 highlights Veterans' perceptions of their mental health by population group.

Figure 5: Perceived mental health by Veteran population group



Perceived mental health	Overall	Men+	Women+	Indigenous	Black and racialized	Functional difficulties	LGB+
Excellent/Very good	49.2%	49.8%	45.6%	41.7%	47.6%	39.9%	45.3%
Good	29.7%	29.7%	29.8%	25.4%	29.0%	32.1%	24.8%
Fair/Poor	21.1%	20.5%	24.7%	32.9%	23.3%	28.1%	29.9%

Figure 5: perceived mental health by Veteran population group (Source: CVHS, 2022)

Perceptions of mental health

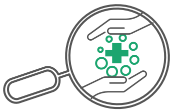
- Half (49.2%) of the total Veteran population reported excellent or very good perceived mental health (CVHS, 2022), which is slightly lower than the adult (18+) Canadian population (54.8%).[70]
- There was no statistically significant difference between perceptions of mental health between men+ and women+ Veterans; or Black and racialized Veterans and Veterans who were not Black and racialized; or LGB+ and heterosexual Veterans; or men+ and women+ Veterans with functional difficulties (CVHS, 2022).
- A significantly lower proportion of Indigenous women+ Veterans (29.3%) rated their mental health as excellent or very good compared to non-Indigenous women+ Veterans (46.7%) (CVHS, 2022).

- Black and racialized women+ Veterans were more than twice as likely to report PTSD (34.6%) than Black and racialized men+ (13.1%) or women+ Veterans who were not Black and racialized (16.7%) (CVHS, 2022).
- Indigenous Veterans, compared to non-Indigenous Veterans, were significantly more likely to report anxiety (26.5% vs 18.0%) and PTSD (24.3% vs 16.0%) (CVHS, 2022).
- Almost half of Veterans with no functional difficulties (69.4%) rated their mental health as excellent or very good compared to Veterans with functional difficulties (39.9%) (CVHS, 2022).

Did you know?

Recent efforts made by VAC to increase the availability of mental health supports include the VAC Assistance Service (1-800-268-7708) and the 2022 Mental Health Benefits initiative that makes benefits immediately available for any former CAF member who has submitted a disability benefit application for certain mental health disorders.

For more information, visit: Mental Health Benefits



The 2022 CVHS indicated a higher incidence of PTSD among Black and racialized women+ Veterans, highlighting the intersectional impact of race and gender on health outcomes.

Intersectionality in mental health

CHNA participants shared their experiences on a wide range of mental health topics. Conversations detailed the impact of military service on mental health, as well as the compounding factors of personal, cultural, historical, and community contexts on well-being.

> "Well-being, I suppose to me it is the net result of the interaction of those two things: my health and my mental health. And how well they are meshing together determines what my well-being is going to be."
>
> Veteran Man

Factors such as age, time since release, and path to diagnosis can impact demand for specialized mental health services. Research demonstrates that younger Veterans in Ontario accessed mental health services more frequently, and at a higher use intensity, following release from the CAF than their older counterparts.[94]

Impact of isolation on mental health

CHNA participants identified factors such as their sense of belonging or feelings of isolation as influencing overall mental health and vice versa.

These are important factors to consider when challenges like the COVID-19 pandemic may have contributed to the development of, or exacerbated mental health functioning for many Veterans.[95] According to research on the well-being of Canadian Veterans during the COVID-19 pandemic, over half of survey respondents reported worsened mental health after the pandemic—38.6% to 53.1% of respondents attributed their symptoms to a direct result of, or worsened by, the pandemic.[95]

All mental health stories are different

In addition to experiences with anxiety, PTSD, and mood disorders, CHNA participants shared other issues related to mental health: trouble concentrating, connections between mental health and physical health, as well as positive and negative coping strategies. Some Veterans said resources that took into consideration their gender, sexual orientation, age, cultural context, and inclusion of family and friends, were critical to achieving 'good' mental health.

Military sexual trauma

In a 2022 study using data from the 2018 CAF Members and Veterans Mental Health Follow-up Survey, military sexual trauma (MST) was reported as an ongoing problem for serving members and Veterans, where the overall prevalence was reported as 44.6% in females and 4.8% in males.[89] Research shows correlations between military sexual trauma and mental health conditions, including PTSD, anxiety, and depression. Furthermore, military sexual trauma survivors have also reported eating disorders, chronic physical health problems, chronic pain, poorer sexual satisfaction and function, and increased risk of suicide attempt.[96]

The lasting impact of military sexual trauma

Several women CHNA participants spoke candidly about their experiences with military sexual misconduct and how military sexual trauma led to mental and physical health difficulties which impacted their ability to engage with others, including intimate and social relationships. While military sexual trauma is not a women-only issue, men CHNA participants did not discuss lived-experience of military sexual trauma, which may speak to the stigma associated with sexual assault of men.

Suicide and self-directed harm

- Overall, 0.7% of Veterans reported suicide attempt in the past 12 months (CVHS, 2022).
- 5.8% of Veterans reported suicidal ideation in the past 12 months. The proportion was similar between genders (CVHS, 2022).

- Black and racialized women+ Veterans had a higher proportion (6.6%) reporting suicidal attempt in the last 12 months than women+ Veterans who were not Black and racialized (0.4%) (CVHS, 2022).
- Veterans with functional difficulties were significantly more likely to report suicidal ideation (8.0% vs 1.1%) and suicidal attempt (0% vs 1.0%) in the past 12 months than those with no functional difficulty (CVHS, 2022).

The issue of self-directed harm, including suicide, is well documented within the Canadian Veteran population.[12,97–99] Although Veterans have an overall lower risk of all-cause mortality, Canadian Veterans are at a higher risk of death by suicide compared to Canadians in the general population.[97,98]

Veterans' exposure to suicide and self-directed harm

Some CHNA participants shared their experiences with suicide and thoughts of self-directed harm, including loss of family and/or friends to suicide and exposure to suicides as part of military and post-military working environments. They noted the traumatic nature of being a survivor of suicide loss, and of being exposed to suicides as part of military and post-service transition environments. These participants spoke about the complex nature of suicide and self-harm, pointing to traumatic incidences as causal factors (e.g., the LGBT Purge, military sexual trauma). They also discussed cumulative or compounding experiences as risk factors (e.g., sociodemographic, economic, health, military lived-experiences, and transition).

> "I was struggling with my mental health. My physical health was not as good anymore because of my mental health, and then my mental health deteriorated, where tried to commit suicide. So, I was still in the military then, and so I guess I still struggle with that a lot."
>
> Veteran Woman

Suicide interventions: gaps and facilitators

CHNA participants called attention to the lack of insights into how many Veterans die by suicide, identifying a need for timely, culturally competent care that considers Veterans' mental health needs. The Legion and peers were among the factors identified as helping Veterans off the pathway to suicide. Some participants noted that gender, culture, and military experience can impact a Veteran's suicide risk and their access to care.

Suicide causation is multifactorial, complex, and varies individually such that factors interact rather than lie along linear causal chains.[12]

Women's health

What you need to know:

- Women's health has historically been under-served, under-researched, and under-resourced, leading to sex and gender-based health disparities.
- Women Veterans' health is broader than reproductive health and has gender-based differences in physical, mental, financial, employment, and social health.
- Women Veterans are not all the same. Personalized care must address health equity gaps that are informed by military experience and personal identity factors.

Definition: Women's health encompasses a broad spectrum of health aspects beyond sex-specific conditions and reproductive functions, such as menstruation, endometriosis, pregnancy, and menopause.[100,101] It embraces various aspects of women's well-being, such as physical, emotional, social or spiritual,[102] while also addressing their health conditions that vary between individuals or with a disproportionate impact (e.g., diabetes or heart disease).[100,101]

Expanded definitions of women's health allows for the inclusion and support of people who have female biology but don't identify as women, as well as those that may not have female reproductive organs but experience discrimination and oppression due to their gender identity.[103,104] Further, intersectional perspectives highlight the importance of considering women's health within the context of other social identities and broader power structures. Disparities in socioeconomic status, access to healthcare, treatment approaches, and knowledge exist not only between women and men, but also among different groups of women.[103,104]

Veterans' domains of well-being: Women's health is directly connected to the health domain of well-being,[33] and impacted by socioeconomic factors such as income, education, employment, and housing conditions.[33]

> "Women's injuries are completely different than men! Many of us have back, knee, feet issues from wearing equipment that was way too big for us, or boots that were too big for us."
>
> Veteran Woman

Research points to the unique health risks and chronic conditions faced by women Veterans due to their service, including higher rates of chronic pain and the necessity for healthcare providers to adopt a military cultural competence to adequately address these needs.[105,106] The 2022 CVHS presented an excellent opportunity to compare women+ Veterans with both men+ Veteran respondents, and the Canadian general population.

- Women+ Veterans were more likely to report a range of chronic conditions compared to men+ Veterans (CVHS, 2022). (See also Chronic Conditions section)
- Specifically, women+ Veterans reported higher rates of mood disorders such as depression (23.7% vs 16.8% in men+ Veterans) and anxiety (24.1% vs 17.4% in men+ Veterans); were twice as likely to report osteoporosis; and nearly four times as likely to report fibromyalgia (CVHS, 2022).

According to the 2022 CCHS, females in the Canadian general population also reported higher rates of mood disorders (14.4% vs 8.9% in Canadian general population of males), as well as higher rates of anxiety disorders (19.2% vs 10.3% in Canadian general population of males).[70] While certain chronic conditions were reported with similar frequency between women+ and men+ Veterans (including cancer in lifetime, stroke, arthritis, back problems, PTSD, Alzheimer's or other dementia, chronic fatigue syndrome, and multiple chemical sensitivities), the experience of managing chronic conditions can have specific gender-based implications on health and well-being.[70]

Reproductive factors, including menarche and pregnancy,[107] have been linked to risk factors for some diseases such as breast and cervical cancer,[108] cardiovascular disease,[109] Alzheimer's or other dementia[110] as well as some mental health disorders.[111] Research has also identified links between menopause and the rates of rheumatoid arthritis, chronic fatigue syndrome,[112] diabetes, chronic pain, heart disease, and stroke.[113]

Bias and discrimination in service and beyond

Many women CHNA participants described experiences in military service, and as a Veteran, marked by sexism, racism, and homophobia. Women participants perceived inequities in their interactions with organizations when applying for benefits and recognition for their military service, and healthcare providers when seeking diagnosis and support. They noted that services were slower, less comprehensive, and less respectful of their status as Veterans in comparison to men.

International research on women serving members and Veterans has primarily examined gender integration into the military, as well as Veteran and serving women's experiences of well-being, physical health, mental health, sleep health, pregnancy and reproductive health, healthcare access, and sexual trauma.[114] Women Veterans encounter challenges in accessing healthcare as a result of issues with childcare, personal, and family responsibilities.[115,116] However, overall Canadian literature on women Veterans is limited. The impact of gender bias

on diagnosis, treatment, and health outcomes for women Veterans, as well as other domains of well-being, remains understudied.[35,36,40,114] Additional intersectional and SGBA+ studies are long overdue.[35,37,45,117]

Oral health

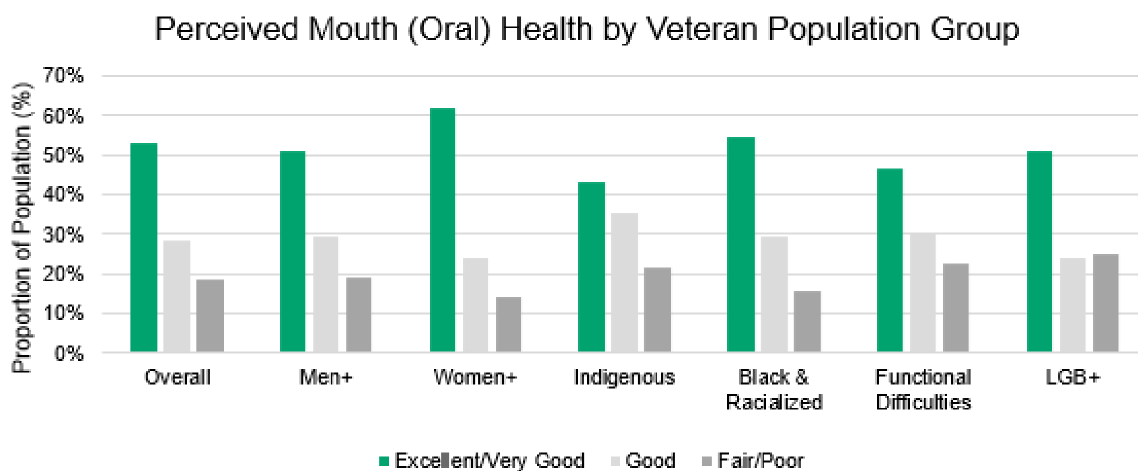
What you need to know:

- Oral health, which can impact a Veteran's quality of life, can influence, and be influenced by, mental, physical, and financial health.
- Equity-deserving Veterans may be at risk of poor oral health due to lack of access to dental services.

Definition: Oral health is the state of one's oral-facial system (i.e., mouth, teeth, gums, etc.), facilitating essential functions like eating and breathing, as well as enabling us to work and socialize.[118,119]

Veterans' domains of well-being: Oral health is intertwined with a number of domains of well-being, including health, social integration, and finances.[33]

Figure 6: perceived mouth (oral) health by Veteran population group



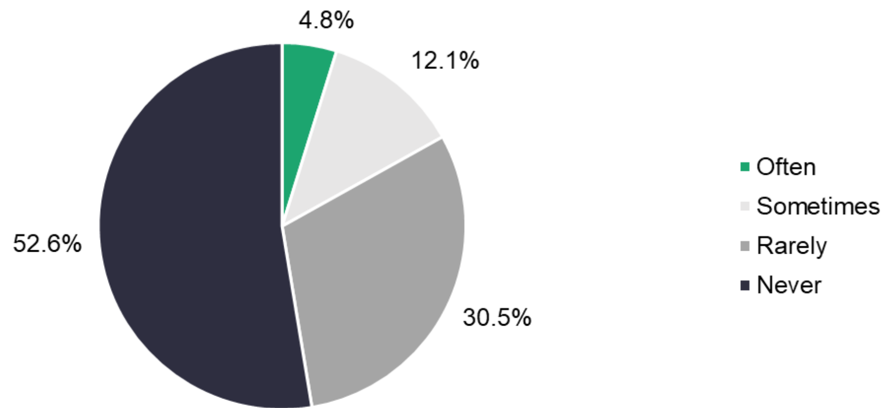
Perceived health of mouth	Overall	Men+	Women+	Indigenous	Black and racialized	Functional difficulties	LGB+
Excellent/Very good	52.9%	51.3%	61.7%	43.3%	54.7%	46.7%	50.9%
Good	28.5%	29.3%	23.9%	35.4%	29.6%	30.5%	24.1%
Fair/Poor	18.6%	19.3%	14.4%	21.4%	15.7%	22.7%	25.0%

Figure 6: self-perceived mouth (oral) health by Veteran population group (Source: CVHS, 2022)

Maintaining good oral health is linked to broader health and social outcomes and prevents common dental issues such as cavities and gum disease, as well as other oral/mouth diseases, including cancers, infections, decay or loss.[118–122] Poor oral health is associated with cardiovascular disease, diabetes, and respiratory infections,[120,123] and is exacerbated by lifestyle factors (e.g., alcohol, poor diet, smoking, etc.) and frailty.[120,123–126]

- Overall, 18.6% of Veterans reported their oral/mouth health as fair or poor (see Figure 6) (CVHS, 2022).
- Only 52.9% of Veterans self-reported having excellent or very good oral/mouth health (CVHS, 2022).
- Women+ Veterans were significantly more likely to report excellent or very good oral/mouth health than men+ Veterans (61.7% vs 51.3%) (CVHS, 2022).
- Indigenous Veterans, as well as Veterans with functional difficulties, were significantly less likely to report excellent or very good oral health compared to non-Indigenous Veterans and Veterans without functional difficulties, respectively (CVHS, 2022).
- In particular, Veterans with functional difficulties were more than twice as likely to report fair or poor oral health (22.7%) than those with no functional difficulty (9.3%) (CVHS, 2022).

Figure 7: frequency of persistent or ongoing mouth pain in past 12 months for Veterans



Frequency of persistent or ongoing mouth pain in the past 12 months	Overall
Often	4.8%
Sometimes	12.1%
Rarely	30.5%
Never	52.6%

Figure 7: frequency of persistent or ongoing mouth pain in past 12 months for Veterans (Source: CVHS, 2022)

- Among all Veterans, 12.1% reported persistent mouth pain while 4.8% reported having mouth pain "often" (see Figure 7). These results were comparable between men+ and women+ Veterans (CVHS, 2022).

LGB+ Veterans and Veterans with functional difficulties were significantly more likely to report sometimes having mouth pain than their respective counterparts. In healthcare settings, including dental healthcare, 2SLGBTQI+ populations[127] and populations with special needs often face discrimination, leading to differences in levels of access, care, and treatment.[128]

The connection between mental health and dental health

CHNA participants shared their experiences with oral health impacting other areas of health and well-being. Participants noted that dental issues impacted their personal confidence and ability to engage in their communities.

Research has shown that oral health can be influenced by pregnancy, the menstrual cycle, and menopause, which can result in differences in dental disease and pain.[129] However, women may be more incentivized to engage in good oral healthcare due to gender standards regarding facial aesthetics that may impact their ability to engage socially and economically.[130,131]

According to the literature, PTSD and life stress can exacerbate bruxism and other oral and periodontal conditions.[132,133]

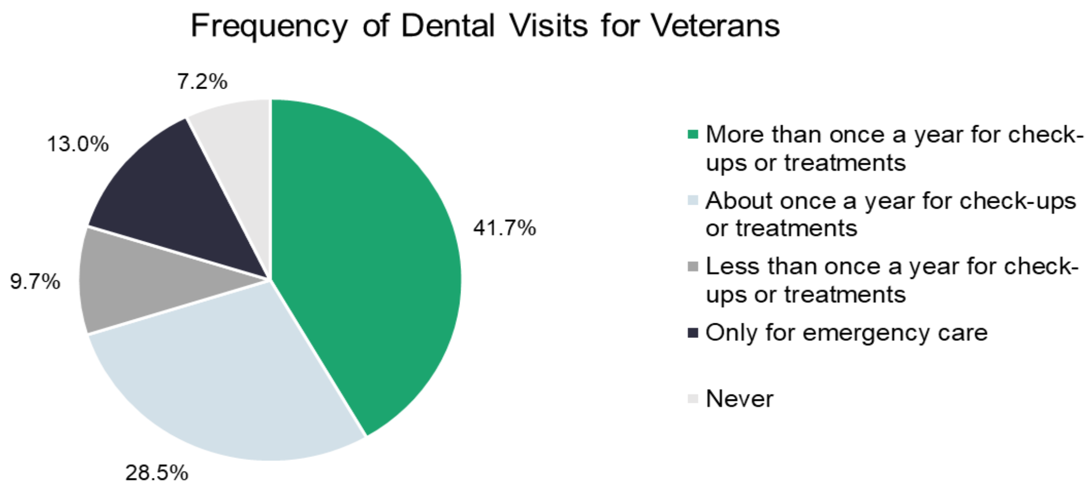
Chronic conditions and oral health

CHNA participants described oral health issues including bruxism, as well as chronic illnesses that led to oral health issues.

"When I got really sick and started to lose weight (…) my teeth started to fall out."

Veteran Woman

Figure 8: frequency of dental visits for Veterans



Frequency of Veteran dental visits	% of respondents	
More than once a year for check-ups or treatments	41.7%	
About once a year for check-ups or treatments	28.5%	
Less than once a year for check-ups or treatments	9.7%	
Only for emergency care	13.0%	
Never	7.2%	

Figure 8: frequency of dental visits for Veterans (Source: CVHS, 2022)

- More than 4 in 10 (41.7%) Veterans visit a dental professional over once a year for check-ups or treatments, 3 in 10 (28.5%) see a professional about once a year, and 1 in 10 (9.7%) see them less than once a year. Further, 13.0% of Veterans only see a dental professional for emergency purposes, and 7.2% never visit a dental professional (see Figure 8) (CVHS 2022). Comparatively, recent CCHS data showed that nearly two-thirds (65%) of Canadians, aged 12 or older and excluding people from the territories, reported visiting a dental professional in the last 12 months.[134]
- Women+ Veterans were significantly more likely to see a dental professional more than once a year (48.1%) than men+ Veterans (40.5%) (CVHS, 2022).
- Men+ Veterans with functional difficulties were significantly less likely to report seeing a dental professional about once a year than men+ Veterans with no functional difficulties (CVHS, 2022).
- When asked about the reasoning behind their dental care seeking behaviours, about 1 in 5 Veterans reported avoiding dental care in the past 12 months due to cost (21.4%) and avoiding recommended dental treatment in the past 12 months due to cost (19.7%). These findings were comparable between men+ and women+ Veterans (CVHS, 2022).
- Nearly a third of Veterans (29.4%) did not have any expenses covered, while 67.9% of Veterans had their dental expenses covered by insurance or a government program (CVHS, 2022). Canadian rates (of those 12+) were similar, with more than one in three (35%) reporting no dental coverage, whether private or public.[134] Furthermore, insurance coverage varied by age and geography, where over half of older Canadians (58%), nearly half of Quebec residents (49%), and 41% of rural-dwelling Canadians, did not have any dental insurance coverage.[134]
- Indigenous women+ Veterans were significantly less likely to not have expenses covered than their non-Indigenous women+ counterparts (CVHS, 2022).

While 2022 CVHS results for Indigenous Veterans and Veterans with functional difficulties may be similar, the root of the reasons behind these gaps are informed by distinct histories. Literature demonstrates that Indigenous people in Canada face obstacles to healthcare provision and use informed by the affordability, availability, and accessibility of oral health services, as well as the accommodations, acceptability and policy surrounding services.[125,135,136]

The high cost of oral health

CHNA participants shared challenges navigating and securing insurance support for dental and other healthcare needs. Other participants shared further concerns regarding costs and access to dental health providers.

> "I hate going out in public because you can see the tooth is gone, right. So, all my teeth need to be pulled, and I need false teeth. That's very expensive. So, as long as I'm on income support, when I get my appointment with a specialist, [my teeth] will be removed in the hospital, and it'll be covered. If I go back to work, that's it. I'll have no coverage, and I can't afford this."
>
> Veteran Woman

Disparities in oral health

CHNA participants from equity-deserving groups noted that they faced age and gender discrimination when securing insurance and healthcare support, resulting in different health and well-being outcomes.

Access to regular dental care and preventive measures are integral components of promoting overall health and ensuring a higher quality of life.[120,122,125,128,137] Understanding Veterans' oral health in the context of their health conditions (including mental health), lifestyle factors, socioeconomic circumstances, and broader structural inequities to accessing essential dental care, is important for a comprehensive view of their health and well-being.

Aging

What you need to know:

- The proportion of older Veterans in Canada is increasing. By 2026, one-third of the Veteran population will be over 70 years of age.
- Veterans' experiences in military service can create health challenges as they age, including their physical, mental, financial, and social health.

Definition: Aging is a natural and universal process, characterized by the progressive decline of various physiological functions essential for fertility and survival—although the rate and effect of aging varies person to person; aging can affect change in physical appearances, functional and cognitive abilities, susceptibility to health conditions, and independence and autonomy.[52,138,139]

Veterans' domains of well-being: Although aging is not distinctly categorized in the existing well-being framework, it impacts all seven domains.[33,63]

The exploration of aging as an indicator in Veterans' health and well-being is imperative considering the increasing proportion of older Veterans in Canada, with 41.8% of Canadian Veterans aged 65 or older in 2021—34.6% are between 65-84 years, and 7.2% are 85 years or older.[28,60] Research findings indicate differences between aging Veterans and the general Canadian population, such as limitations in performing various activities and potential impacts on mental health.[28,140]

Aging experiences

Links between aging, military service and life experiences

CHNA participants commented on the impact age had on their health and well-being. They shared their perceptions of aging and accompanying needs, which were particularly influenced by their military service as well as other life experiences. Many participants shared how injuries, which were previously less impactful on their lives, become cumulative, compounding, overlapping, and hard to disentangle. They further described how this makes the process of finding support harder.

> "When I talked about being proactive, you know, my health is not gonna increase as I get older, I'm gonna have things that happen (…) I don't think we do enough discussion with people, what it means to age, and what you can expect, and what's realistic, and what you can do to plan, to be proactive as you age."
>
> Older Veteran Woman

- Literature on aging Canadians supports findings indicating that characteristics and health outcomes of younger seniors aged 65 to 74 were, in many cases, dramatically different than those of persons aged 85 and over.[141–143]
- Veterans with functional difficulties were disproportionately older than Veterans with no functional difficulties and released 50+ years ago (CVHS, 2022).
- Veterans with functional difficulties were also significantly more likely to be 80+ (16.2% vs 6.0%), and significantly less likely to be under 35 (12.8% vs 2.6%), than those with no functional difficulties (CVHS, 2022). This is especially important to note considering that by 2026, one-third of the Veteran population will be over 70 years of age.[140]
- LGB+ Veterans were significantly less likely to be older (65-79 and 80+) than heterosexual Veterans (CVHS, 2022).
- Generally, there were more Indigenous and Black and racialized Veterans who were younger than older, coinciding with statistics on years since release (CVHS, 2022).

Life age and stage-related health changes

Older CHNA participants, spoke about how their health and well-being needs evolved across their life course, and how the resources they used at an earlier stage of life changed as they aged.

Finances

Financial health and aging

CHNA participants called attention to their need to be prepared and aware of the financial impacts of aging. Some Veterans expressed concern that their financial resources may not be sufficient to support them as they aged, potentially impacting their access to transportation; their ability to address acute, complex, and evolving care needs; and their [financial] ability to remain in their own homes or access community and/or long-term care facilities.

Intersectionality in aging

While CHNA participants shared their anxieties regarding the unaffordability of supports, resources, and care as they age, aging has distinct concerns for equity-deserving Veteran groups. Some participants from equity-deserving groups noted they may be at higher risk due to compounding factors such as race and sexual orientation. Women CHNA participants specifically noted that gender discrimination, which had prohibited them from achieving a higher rank or longer period of service, influenced their ability to afford retirement and care.

Isolation

As Veterans age, many experience feelings of isolation and loneliness, which can shape their health and well-being outcomes.[144] Although older male Veterans were found more likely to be socially isolated than female Veterans,[144] women CHNA participants shared that single, older women Veterans experience a unique kind of social isolation compared to their counterparts, as they feel denied access to Veteran spaces based on their gender.

Loneliness and social isolation in older Veterans

CHNA participants found that their feelings of isolation came as a surprise. Older Veterans noted that interacting with friends, community, and family, traveling, and working became more challenging as they aged when unexpected barriers arose (e.g., insurance not covering travel and challenges socializing due to managing overlapping ailments).

Managing aging

- 95% of VAC clients between 65 and 84 who received Veterans Independence Program (VIP) benefits reported that the program helped them remain in their own homes and communities.[145]
- Use of home care services was rare for the Veteran community, with 85.2% of Veterans identifying they did not have home care service (CVHS, 2022).

Aging and chronic conditions

CHNA participants noted that as they aged, managing various treatments for comorbid chronic conditions had implications on their overall well-being. Some participants felt the need to become more knowledgeable regarding their conditions, treatments, tests, and the impacts of care decisions. In addition, Women participants shared the personal responsibility they felt to understand gender-based reproductive health needs and the impact of menopause.

The care and support needs of older Veterans

CHNA participants spoke to some of the expected experiences of aging – a feeling of "slowing down," needing more time and effort to complete activities, and requiring more support in their day-to-day lives.

Increased burden of health

CHNA participants noted increased burden from managing their health and care (e.g., coordinating tests for conditions during specific periods of life, appointments, and advocating for health and well-being needs), securing required special equipment (e.g., wheelchairs, walkers, canes, and accessible spaces), and arranging home care supports (e.g., housekeeping, personal care, grounds maintenance) to allow them to age in place.

Gender based discrimination for older Veterans

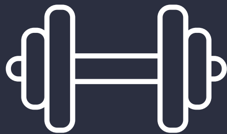
Women CHNA participants noted that they had experienced discrimination when previously securing support for home care because some of the tasks were seen as gendered.

Understanding the nuances of aging among Canadian Veterans is crucial for developing targeted interventions and support mechanisms that address their unique health needs and ensure a higher quality of life throughout their extended lifespan.

Healthy behaviours

Physical activity

What you need to know:

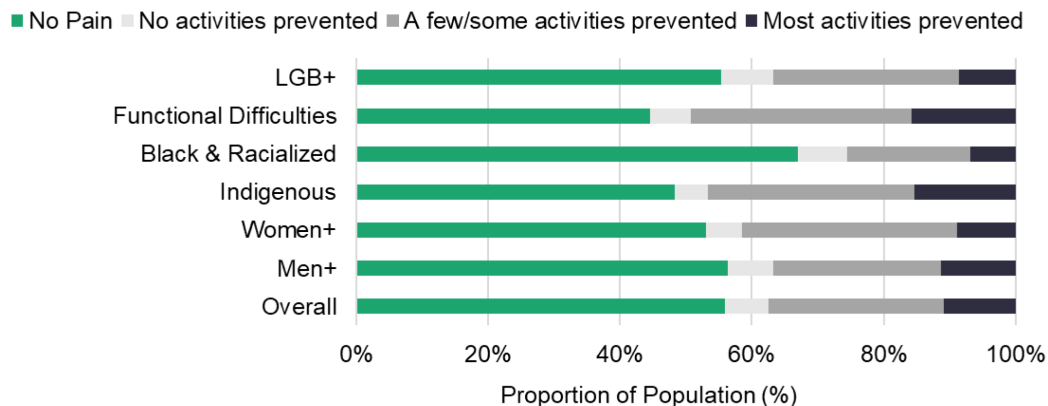


- Veterans' ability to engage in physical activity is informed by personal, social, environmental, cultural, and historical factors which can change over time.
- Chronic pain is one of the highest causes of disability or activity limitation for Veterans.

Definition: Physical activity describes the means of moving the body in a variety of ways, achieved by engaging skeletal muscles and burning energy— and extends beyond exercise or fitness to include leisurely activities, household or occupational work, transportation, or other activities.[146,147]

Veterans' domains of well-being: Physical activity can contribute to improved physical and mental health, prevention and management of noncommunicable diseases, multimorbidity and mortality, and a fostered sense of community belonging.[148–153]

Figure 9: number of activities prevented by pain by Veteran population group



Pain limiting activities	Overall	Men+	Women+	Indigenous	Black and racialized	Functional difficulties	LGB+
No pain	55.9%	56.4%	53.0%	48.3%	67.0%	44.5%	55.4%
No activities prevented	6.6%	6.8%	5.5%	5.0%	7.4%	6.3%	7.9%
A few/some activities prevented	26.6%	25.5%	32.7%	31.4%	18.7%	33.4%	28.1%
Most activities prevented	10.9%	11.3%	8.8%	15.3%	6.9%	15.9%	8.6%

Figure 9: number of activities prevented by pain by Veteran population group (Source: CVHS, 2022)

Veterans are more active than non-Veterans; however, the amount of activity reduction over time is higher among Veterans compared to the general population.[105,154] As a result, more Veterans need assistance with at least one daily activity compared to other Canadians of comparable age.[154,155]

- According to the 2022 VNCS, less than half of respondents surveyed agreed that they were physically active (41%). For respondents under 40, only 56% identified as physically active.[145]

Veterans versus in-service identities

CHNA participants did not often compare their physical activities and abilities to non-Veterans. Instead, many compared their ability to engage in physical activity with their past selves, both during service and in earlier years of life.

- 29.7% of Veterans were obese (CVHS, 2022).

Hidden causes of weight gain

Some CHNA participants shared their experiences with weight gain. For some, weight gain was as a consequence of taking medication for chronic conditions. Other participants associated their weight gain with an inability to exercise due to chronic pain or disability.

When the recent CVHS asked Veterans about their usual pain or discomfort, they could indicate "yes" or "no" to experiencing pain or discomfort, indicate the severity of their usual pain, as well as indicate if it had an impact on preventing them from doing activities (see Figure 9).

- Overall, half of Veterans (55.8%) stated they were usually free of pain or discomfort. For the 44.2% of Veterans that experienced regular pain or discomfort, incorporating physical activity required an individualized approach that factored in overall states of health and well-being (CVHS, 2022).

- Most Veterans (55.9%) reported their level of pain as no pain, those that experienced pain described their regular pain with great variety (CVHS, 2022).
- Among Veterans experiencing some level of pain, their pain was most often reported as being "moderate" (24.0%); whereas 13.2% of Veterans reported their pain as mild, and 7.0% reported their pain level as severe (CVHS, 2022).
- For one quarter of Veterans experiencing pain (26.6%), their pain prevented them from engaging in some activities, while 10.9% reported that most activities were prevented by pain (CVHS, 2022).

Chronic pain is one of the highest causes of disability or activity limitation for Veterans. Some common conditions that lead to chronic pain among Veterans include arthritis, back problems, and gastrointestinal problems.[155] Other personal and environmental factors that have a correlation with activity limitation for Veterans include older age, low income, not having a post-secondary degree, being a non-commissioned member, deployment, low social support, high life stress, and having a weak sense of community belonging.[154–156] In the 2019 Life After Service Survey, over half of Canadian Veterans reported experiencing chronic pain (50.7%); female Veterans were more likely to report chronic pain, as well as Veterans who had disabilities, health-related activity limitations, and served longer in the military.[156] Class C Reserve Force Veterans were seen to have a higher prevalence of chronic pain compared with Class A and B Reserve Force Veterans.[88]

Physical activity and connection

Some CHNA participants shared that activity helped to mitigate and manage their pain. They also mentioned that activity provided opportunities to engage with their families and their communities. For many participants, pets and service animals were an important element to achieve physical activity.

> "It's aggravating when we can't necessarily do things with your kids. I can't run and play soccer, that sort of thing, kicking the soccer ball, just you name it, right. When my kids want me to lift them up or do something and it's like, 'no, sorry I can't,' because I have to avoid that activity because I don't want to cause my wrist flare up or have more pain. So, then there's the whole mental health, the anxiety."

Veteran Man

Physical activity has distinct health equity-based considerations for Veterans.

- Women+ Veterans were significantly more likely than men+ Veterans to report that pain prevented them from engaging in some activities (25.5% vs 32.7%) (CVHS, 2022).

Gender, culture, and activity

Women CHNA participants traced activity limitations to a lack of gender-specific accommodations during military service. Some noted that treatments for chronic pain required gender and culturally aware approaches to achieve future physical activity goals.

- Black and racialized Veterans were more likely to report having no pain (66.8%) compared to their counterparts who were not Black and racialized (55.4%) (CVHS, 2022).
- One in five Black and racialized Veterans stated their pain prevented some of their activities (18.7%), while 6.9% reported that it prevented most activities (CVHS, 2022).

Discrimination in healthcare

Black and racialized CHNA participants who shared experiences of discrimination noted that there was a pattern of dismissal, disbelief, or lack of support regarding their health and well-being.

- Veterans with functional difficulties were more likely to report usually being in pain or discomfort (55.5%), compared to those with no functional difficulties (19.2%) (CVHS, 2022).
- A larger proportion of Veterans with functional difficulties reported having moderate or severe pain levels (31.6%, 10.1%) versus those with no functional difficulties (7.1%, 0.2%) (CVHS, 2022).
- Among Veterans with functional difficulties, over half identified that they experienced regular pain. Of those Veterans, the majority had some (33.4%) or most (15.9%) of their activities prevented by pain. These proportions were significantly higher than those reported by Veterans with no functional difficulties, where 11.6% had some activities prevented by pain, and under 1% had most activities prevented by pain (CVHS, 2022).

Veterans with mental health conditions, particularly PTSD[157,158] and bipolar disorders, are more likely to have decreased physical activity and hence obesity compared to those with no mental health condition.[157] Moreover, the combination of a mental health disorder, particularly PTSD with chronic pain leads to greater pain-related disability among Veterans compared to those with chronic pain only.[159]

Healthy behaviours and disability

CHNA participants noted that many types of exercise were impossible for them to participate in safely due to their functional limitations, mental health conditions, or financial situation.

Understanding physical activity as a healthy behaviour is particularly important to consider in the health and well-being of Veterans. This is related to their increased risk of functional

difficulties, chronic pain, activity limitations, and chronic conditions, with additional considerations for their other health behaviours, finances, and aspects of life, that can contribute to and/or be exacerbated by their physical (in)activity.[71,156,88,157,160]

Nutrition and food security

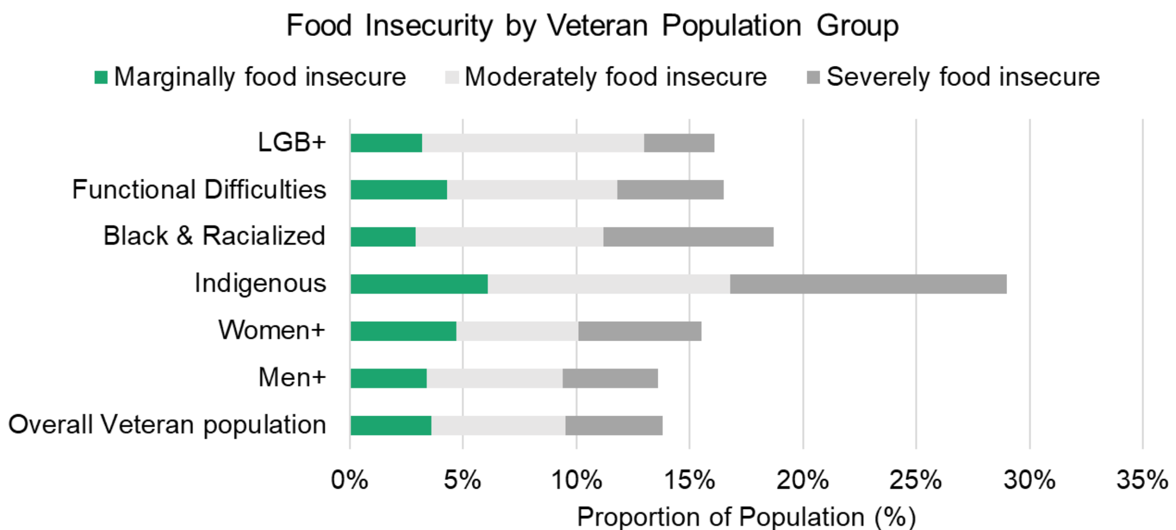
What you need to know:

- Veterans' access to nutritious foods is influenced by their financial health and personal identity characteristics.
- Food insecurity is an indication of a health inequity and is linked to poor physical, mental, and social health outcomes.

Definition: Nutrition and access to adequate food is essential for proper health, growth, and development, pertaining to the intake of food and other nourishing substances by the body.[161]

Veterans' domains of well-being: Nutrition has important implications for a Veteran's ability to achieve overall health and well-being.[33] Following a healthy dietary pattern is linked to injury prevention, physical health, and cognitive performance forming a foundation for bodily function, disease prevention, and sustained energy levels.[161–164] Conversely, food insecurity is associated with various adverse physical and mental health outcomes, including chronic conditions, infectious diseases, comorbidities, premature mortality, and increased healthcare service utilization.[165–175]

Figure 10: food insecurity of household in the past 12 months by Veteran population group



Veteran population group	Marginally food insecure	Moderately food insecure	Severely food insecure
Overall Veteran population	3.6%	5.9%	4.3%
Men+	3.4%	6.0%	4.2%
Women+	4.7%	5.4%	5.4%
Indigenous	6.1%	10.7%	12.2%
Black and racialized	2.9%	8.3%	7.5%
Functional difficulties	4.3%	7.5%	4.7%
LGB+	3.2%	9.8%	3.1%

Figure 10: food insecurity of household in the past 12 months by Veteran Population Group (source: CVHS, 2022)

There is limited literature on nutrition related to Canadian military members, Veterans, and their households.[176] However, evidence shows that food insecurity is closely linked to mental health challenges among Canadian Veterans and first responders, leading to increased stress, anxiety, and even depression and further exacerbating existing mental health issues, particularly PTSD.[92] In the context of the COVID-19 pandemic, 10% of Veterans who responded to the Canadian COVID-19 Coping Study (aged 55+) from May to June 2020 noted that they were worried about basic necessities such as getting food.[177] Beyond this, recent available data on Canadian Veteran nutrition largely examined their household food (in)security, as seen through the 2022 CVHS.

- The majority of Veterans' households were food secure in the past 12 months (86.2%) (see Figure 10) (CVHS, 2022).
- Of the Veterans that were food insecure (13.8%), 3.6% were marginally food insecure (which was comparable across all equity-deserving groups), 5.9% were moderately food insecure, and 4.3% were severely food insecure (CVHS, 2022).
- Men+ and women+ Veterans were comparable in food insecurity levels (13.6% and 15.5% respectively) (CVHS, 2022).

For general comparison, 2021 Canadian Income Survey (CIS) results showed that 18.4% of people in the provinces were living in a food insecure household.[178,179] Like the 2022 CVHS, the CIS data showed a similar sex-based trend where males and females were generally comparable in household food insecurity (18.2% and 18.7%),[179] although Veterans overall had less household food insecurity than the general population.

Impacts of food security for Veterans

CHNA participants shared that access to adequate amounts of acceptable, culturally relevant, nutritious food for themselves and their families was important for their health and well-being. Participants also identified that nutrition requirements could change after their military release to account for changing levels of physical activity and symptom management, which sometimes posed unique challenges during their transition.

"There's a direct correlation of nutrition to the brain and the impact that nutrition has on other aspects of my physical body and my psychological [state] (…) It took me a long time to realize that nutritional key is paramount to good health."

LGBT Purge survivor Veteran Woman

Equity-deserving populations, including Indigenous people, Black and racialized people, and those with disabilities, as well as individuals affected by various social determinants of health (e.g., low-income, temporary and precarious housing, migration, etc.), disproportionately face food insecurity in Canada.[180,181,179,178,175] When looking at 2022 CVHS data on household food (in)security, Indigenous Veterans are disproportionately food insecure compared to non-Indigenous Veterans.

- Indigenous Veterans were significantly less likely to report their household being food secure than non-Indigenous Veterans (CVHS, 2022).
- 3 in 10 Indigenous Veterans (29%) experienced being food insecure (CVHS, 2022).
- Specifically, Indigenous Veterans were significantly more likely to be moderately food insecure than their non-Indigenous counterparts (CVHS, 2022).
- Indigenous Veterans were also more than three times as likely to be **severely** food insecure than non-Indigenous Veterans (12.2% vs 4%) (CVHS, 2022).
- Rates of household food security and insecurity for Black and racialized Veterans and LGB+ Veterans were not significantly different from Veterans who were not Black and racialized, and heterosexual, respectively. However, Black and racialized men+ Veterans were significantly more likely to report household food insecurity than men+ Veterans who were not Black and racialized (CVHS, 2022).

Comparatively, the recent CIS data showed that 33.4% of Indigenous people and 39.2% of Black people lived in food insecure households.[179] This was compared to just 15.3% of people who were neither visible minority or Indigenous—the lowest prevalence of food insecurity among population groups by racial or cultural identity and 63,.[178,179]

Canadian data shows that food security is influenced by physical disabilities.[182]

- Veterans with functional difficulties were significantly less likely to live in a household that was food secure, and significantly more likely to have experienced moderate household food insecurity, than Veterans with no functional difficulties (CVHS, 2022).

Future 2022 CVHS analyses and research should provide contextual data by geographical region, income, and age to better understand the food security and related circumstances of Veterans and their families.

Risk behaviours

What you need to know:

- Veterans' individual experiences with substance use are informed by the interplay between personal history and genetics, exposure to trauma, military experience, and socioeconomic influences, and can occur along a spectrum.
- Substance abuse can impact other areas of health and well-being and can impact a Veteran's ability to cope with stress.

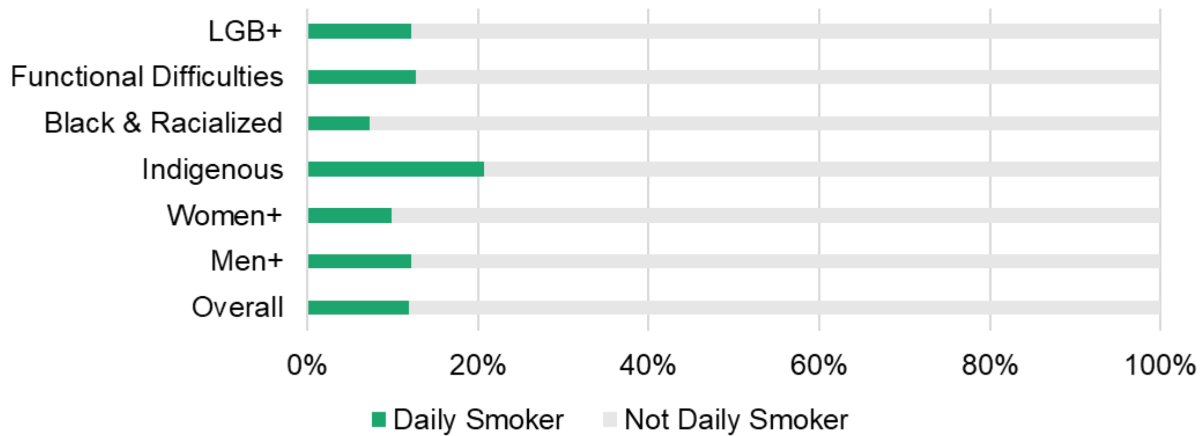
Definition: Risk behaviors refer to actions or behaviours that may (un)intentionally increase an individual's susceptibility to disease, impairment, injury, social difficulties, and premature death.[183]

Veterans' domains of well-being: Risk behaviours intersect several domains of well-being, including health, life skills, cultural and social environment, and financial security.[33]

Substance use, as a risk behaviour, poses direct health risks through the potential for physical harm (particularly cardiovascular disease and other organ failure), as well as psychological and social well-being effects,[184,185] and can be used to cope with stress, trauma, or pain, for medical purposes, religious or ceremonial purposes, or for personal enjoyment.[184] Substance use can exacerbate mental health conditions such as PTSD, depression, and anxiety, which are disproportionately prevalent among Veterans compared to the civilian population.[186,187]

Cigarette and vaping use

Figure 11: Veteran cigarette smoking habits in the past 12 months by Veteran population group



Veteran smoking habits	Overall	Men+	Women+	Indigenous	Black and racialized	Functional difficulties	LGB+
Daily Smoker	11.9%	12.2%	9.9%	20.7%	7.2%	12.7%	12.1%
Not Daily Smoker	88.1%	87.8%	90.1%	79.3%	92.8%	87.3%	87.9%

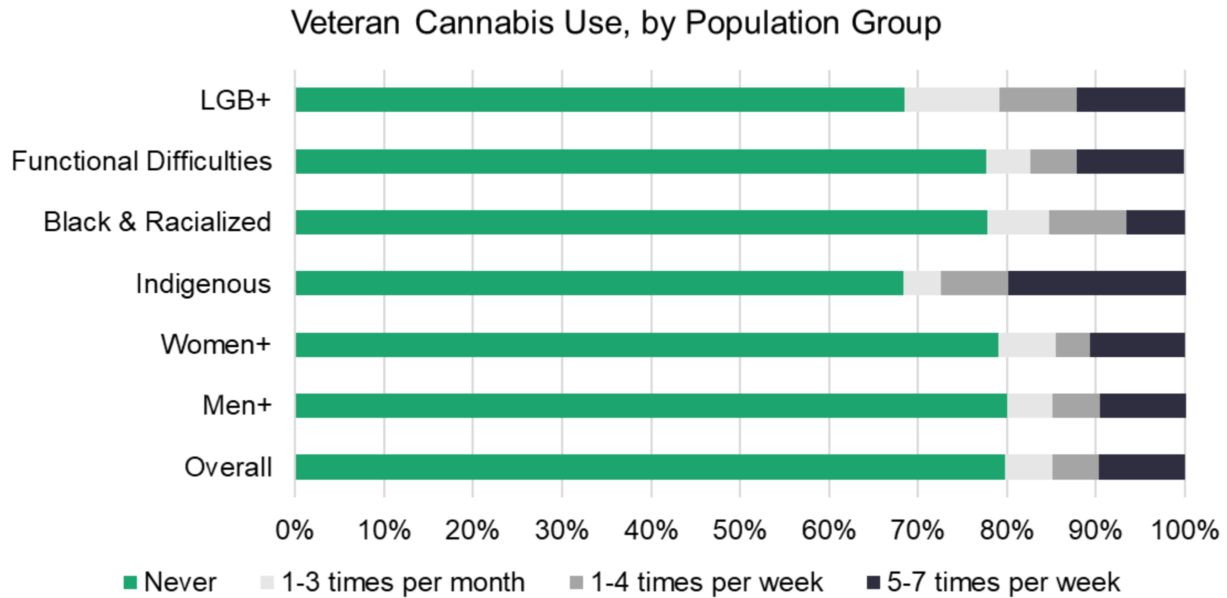
Figure 11: Veteran cigarette smoking habits in the past 12 months by Veteran population group (source: CVHS, 2022)

- 11.9% of Veterans reported daily smoking (CVHS, 2022) (see Figure 11), a rate similar to that of Canadians aged 15 and older who were surveyed in the 2022 CCHS (12%).[188]
- Indigenous Veterans, especially women+, were nearly twice as likely, to report daily smoking than non-Indigenous Veterans (20.7% vs 11.5%) (CVHS, 2022).
- Black and racialized men+ Veterans were about half as likely to report daily smoking than Veterans who were not Black and racialized (6.5% vs 12.4%) (CVHS, 2022).

Research found that Veterans smoke at higher rates than their non-Veteran counterparts,[187] and that military combat exposure is associated with smoking.[189] The Canadian Tobacco and Nicotine Survey from 2022 showed that 6% of Canadians aged 15 and older had reported vaping in the past 30 days.[190] Canadians aged 25 and older were less likely to have vaped in the past 30 days compared to their younger counterparts.[190] This finding may be important to younger Veterans and Veterans using e-cigarettes as a method of smoking cessation.

Cannabis use

Figure 12: Veteran cannabis use in the past month by population group



Cannabis use over the past 30 days	Overall	Men+	Women+	Indigenous	Black and racialized	Functional difficulties	LGB+
Never	79.8%	80.0%	79.0%	68.3%	77.8%	77.7%	68.5%
1-3 times per month	5.3%	5.1%	6.5%	4.3%	7.0%	4.9%	10.7%
1-4 times per week	5.2%	5.4%	3.9%	7.6%	8.6%	5.3%	8.6%
5-7 times per week	9.7%	9.6%	10.6%	19.9%	6.6%	12.0%	12.2%

Figure 12: Veteran cannabis use over the past 30 days, by population group (Source: CVHS, 2022)

- Overall, 14.9% of Veterans reported using cannabis at least once a week in the past month, and further, 9.7% of Veterans reported using cannabis 5-7 times a week (see Figure 12) (CVHS, 2022).
- Only 6.5% of Veterans had documentation from a health professional to use cannabis for medical purposes (CVHS, 2022).
- Indigenous Veterans were significantly more likely to use cannabis 5-7 times a week, compared to non-Indigenous Veterans, although they are also more likely to have medical documentation for cannabis use from a health professional than non-Indigenous Veterans (CVHS, 2022). Disaggregating further by gender, Indigenous women+ Veterans were

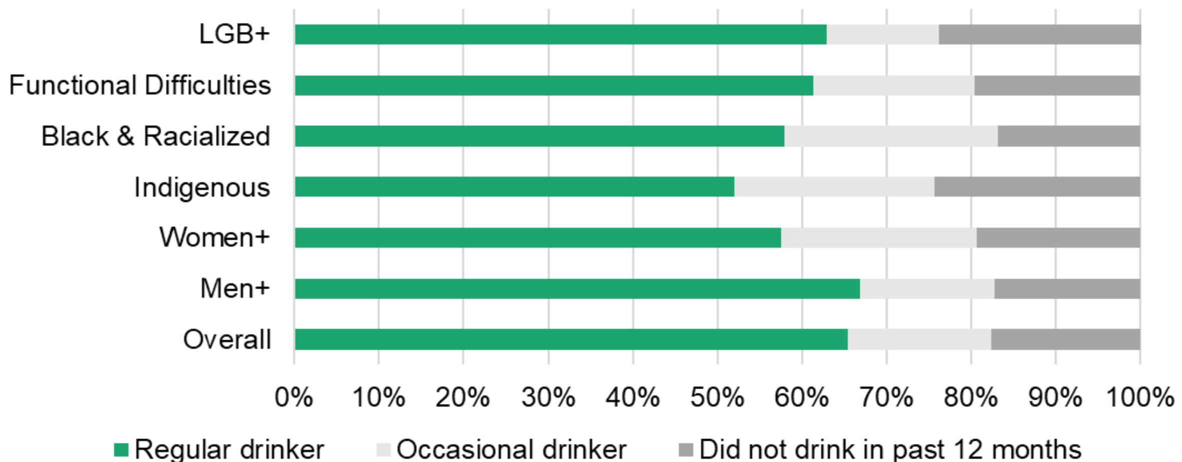
significantly more likely to use cannabis, with over twice the proportion using cannabis 5-7 times per week when compared to their non-Indigenous counterparts (24% vs 9.7%) (CVHS, 2022).

- Veterans with functional difficulties were over twice as likely to report using cannabis 5-7 times a week in the past month than their counterparts with no functional difficulties (12% vs 4.7%). Disaggregating further by gender, women+ Veterans with functional difficulties were six times more likely to report using cannabis as their women+ counterparts with no functional difficulties. Men+ Veterans with functional difficulties were twice as likely to report this level of cannabis use as their counterparts with no functional difficulties (CVHS, 2022).
- Veterans with functional difficulties were more likely than their counterparts to have medical documentation from a health professional to use cannabis for medical purposes (8.9% vs 1.4%) (CVHS, 2022).

A recent qualitative study with Canadian Veterans revealed that despite some negative side effects, most Veterans reported improvements in quality of life, relationships, mood, and pain in using cannabis for medical purposes.[191] However, findings from broader literature indicate that the benefit to harm ratio of cannabis for medical purposes is uncertain.[191]

Alcohol use

Figure 13: Veteran alcohol consumption habits, by population group



Consumption habits	Overall	Men+	Women+	Indigenous	Black and racialized	Functional difficulties	LGB+
Regular drinker	65.4%	66.8%	57.5%	52.0%	57.9%	61.3%	62.9%
Occasional drinker	17.0%	15.9%	23.1%	23.6%	25.2%	19.1%	13.3%
Did not drink in past 12 months	17.6%	17.3%	19.4%	24.4%	16.8%	19.6%	23.9%

Figure 13: Veteran alcohol consumption habits by population group (Source: CVHS, 2022)

- Overall, 65.4% of Veterans drank regularly, 17% drinking occasionally (see Figure 13) (CVHS, 2022).

In the USA, alcohol use disorder is more common among Veterans than civilians, and approximately 40% of US Veterans had a lifetime score of alcohol use disorder.[185]

Alcohol and the military

CHNA participants shared that previous experience with potentially hazardous substance use, specifically alcohol drinking habits, was often tied to military cultural norms, including developing and maintaining a sense of camaraderie while serving and coping with stress and transition after release.

- Men+ Veterans were significantly more likely than women+ Veterans to report regular drinking (66.8% vs 57.5%) (CVHS, 2022).
- Women+ Veterans were significantly more likely to report occasional drinking than their men+ counterparts (23.1% vs 15.9%) (CVHS, 2022).
- Indigenous Veterans, especially men+, were significantly less likely to report regular drinking than non-Indigenous Veterans (52.0% vs 66.0%) (CVHS, 2022).
- Black and racialized Veterans were significantly more likely to report occasional drinking than their counterparts who are not Black and racialized (25.2% vs 16.6%) (CVHS, 2022). Research from Public Health Canada in 2020 found that Black Canadians have lower rates of heavy alcohol use.[192]
- Veterans with functional difficulties were significantly less likely to report regular drinking than Veterans without functional difficulties (61.3% vs 74.7%); however, Veterans with functional difficulties were significantly more likely to report occasional drinking than their counterparts (19.1% vs 12.1%) (CVHS, 2022).

Alcohol has played a harmful role in the colonial history of Indigenous peoples in Canada, and research has shown a large stigma and health impacts of substance use.[193,194]

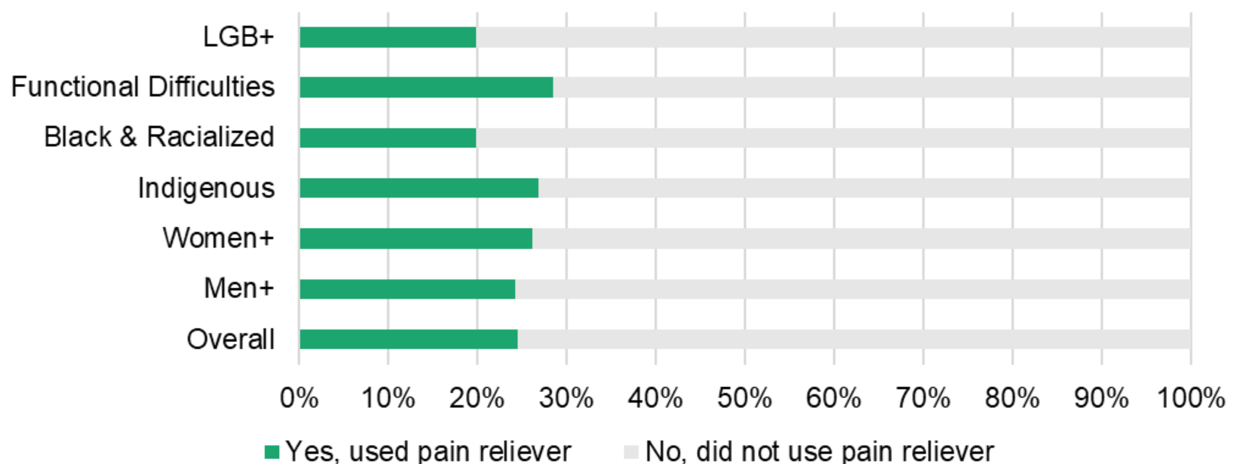
Alcohol and mental health

CHNA participants shared they used alcohol to cope with physical and mental health, including PTSD, trauma, and stress. They discussed that PTSD had an impact on their substance use, emphasizing the importance of further investigation into how PTSD can influence the substance use experience for Veterans. Alcohol use had cross-cutting impacts across all realms of health and well-being, often impacting interpersonal and community relationships.

> "I began self-medicating. I was drunk every night (…) My life was a shitshow for a decade (…) I managed to keep my life together enough to still take my kids to soccer and hockey. And but every night I was self-medicating. And then I would get up in the morning and do whatever I had to do."
>
> Veteran Man

Pain reliever use

Figure 14: Veteran pain relief medication, by population group



Use of pain relief medication in past 12 months	Overall	Men+	Women+	Indigenous	Black and racialized	Functional difficulties	LGB+
Yes, used pain reliever	24.5%	24.2%	26.2%	26.9%	19.9%	28.5%	19.9%
No, did not use pain reliever	75.5%	75.8%	73.8%	73.1%	80.1%	71.5%	80.1%

Figure 14: Veteran pain relief medication, by population group (Source: CVHS, 2022)

The 2022 CVHS measured pain reliever use (see Figure 14) with self-reported use of codeine, oxycodone, fentanyl, opioid, or other related products with or without a prescription.

- Overall, 24.5% of Veterans reported using pain relief medication in the past 12 months (CVHS, 2022).
- Veterans with functional difficulties were significantly more likely to report using pain relief medication in the past month than their counterparts (28.5% vs 15.7%) (CVHS, 2022).

Other risk behaviours

Research on the risk behaviours of Veterans has often focused on substance use (such as alcohol, nicotine/smoking, cannabis, and prescription drugs for non-medical uses); however violence, gambling, and risky sexual behaviors have also shown a profound effect on health and well-being for Veterans.[195,196]

> "I was on sick leave for three to four months. It's fun to just stay alone gaming. I point my TV there and play games all day. But at some point, when I tell my kids, go to school, study for a job, then I look at myself, 'yeah, you're not doing that. Preach by example!' If my wife asks me, 'can you at least just mow the lawn today?' And I don't want to do it, but it creates overtime a lot of conflicts in the relationship."
>
> Francophone Veteran Man

Education and literacy

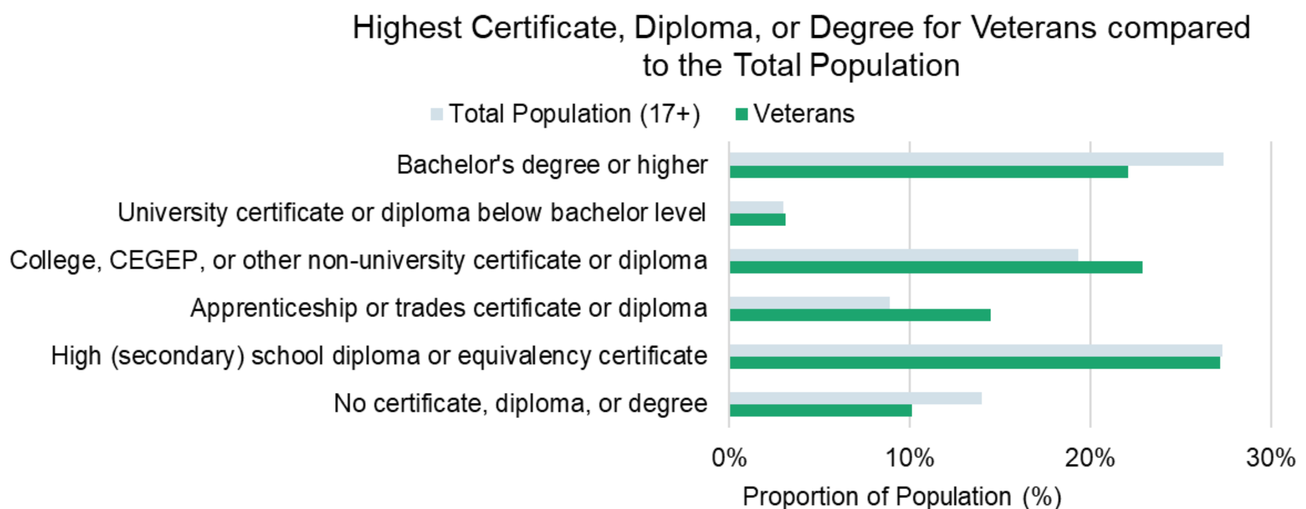
What you need to know:

- Veterans' paths to education and literacy are informed by their lived-experiences, including opportunities for training and learning while in the military.
- Veterans' literacy includes financial and administrative literacy, foundational skills that impact their transition and their overall health and well-being.

Definition: Education, whether formal or informal, includes the development of knowledge and/or the mastery of skills.[197–199] Literacy can include many facets such as: reading literacy, mathematic literacy and scientific literacy, data literacy—a person would be considered to have literacy with ability to understand and engage in one of these facets.[200]

Veterans' domains of well-being: Education and literacy influence multiple aspects of a Veterans' well-being through their ability to problem solve, secure stable and equitable employment and income, comprehend health messaging (e.g., health literacy), and their ability and willingness to access health and social services.[33,201–204]

Figure 15: highest certificate, diploma, or degree for Veterans compared to the total population



Highest certificate, diploma or degree attained	Veterans	Total population (17+)
No certificate, diploma, or degree	10.1%	14.0%
High (secondary) school diploma or equivalency certificate	27.2%	27.3%
Apprenticeship or trades certificate or diploma	14.5%	8.9%
College, CEGEP, or other non-university certificate or diploma	22.9%	19.3%
University certificate or diploma below bachelor level	3.1%	3.0%
Bachelor's degree or higher	22.1%	27.4%

Figure 15: highest certificate, diploma, or degree for Veterans compared to the total population (Source: Census, 2021)

Military and Veteran experiences can enhance access to educational opportunities and career progression. 2021 Census data revealed that 3 in 5 Veterans (62.7%) had more than a high school education.[28] More Veterans had apprenticeships or trades certificates than the Canadian population (14.5% vs 8.9%).[28] However, less Veterans had university degrees than the Canadian population (22.1% vs 27.4%).[28]

The 2022 CVHS data demonstrated both positive and negative differences in educational attainment between equity-deserving Veterans and their counterparts (see Figure 15).

- The majority of Black and racialized Veterans completed at least a bachelor's degree (42.4%), and they were significantly more likely to report this level of education than Veterans who were not Black and racialized (CVHS, 2022).
- Black and racialized Veterans were also less likely than Veterans who were not Black and Racialized to not have completed high school (CVHS, 2022).
- Indigenous Veterans most commonly completed some post-secondary education but less than a bachelor's degree (42.2%) (CVHS, 2022).This is relatively consistent with 2021 Census data which indicated that completion of a post-secondary certificate, degree, or diploma was most common among Indigenous people aged 25-64 (49.2%).[205]
- Indigenous men+ Veterans were significantly less likely than non-Indigenous men+ Veterans to have a bachelor's degree or higher education (CVHS, 2022). Likewise, 2021 Census data demonstrated a lower proportion of Indigenous men+ with at least a bachelor's degree than non-Indigenous men+.[205]

Did you know?

VAC has an Education Training Benefit that is available to eligible Veterans to help pay for the education required to reach their career or personal goals.

- Further, Veterans with functional difficulties most commonly reported completion of some post-secondary education but less than a bachelor's degree (40.9%) (CVHS, 2022).
- Compared to Veterans with no functional difficulties, Veterans with functional difficulties were significantly more likely to not have completed high school and significantly less likely to have at least a bachelor's degree (CVHS, 2022).

Men+ and women+ Veterans differ in their educational pursuits. 2021 Census data indicated that women+ Veterans exceeded men+ Veterans in obtaining higher education, where they were more likely to have at least some level of post-secondary education and at least a bachelor's degree than men+ Veterans.[28] This trend was relatively consistent with 2022 data from the working Canadian population (aged 25-64), where 69% of females had tertiary education (college or university qualification) compared to 56% of males. Conversely, men+ Veterans were more likely to have an apprenticeship or trades certificate/diploma than women+ Veterans, and were more likely to have a high school diploma or equivalent.[28] There were also more men+ Veterans with no certificate/diploma/degree than women+ Veterans.[28] This was consistent with 2022 data from the working general population where males were more likely to be educated below an upper secondary level than females (8% vs 6%).[206]

Service impacts on education

CHNA participants highlighted how their service provided them with entry to higher education, such as pursuing MBAs. Additionally, others mentioned that educational reimbursements enabled them to access higher education that would have been challenging otherwise, empowering them to advocate for their peers. However, participants shared that during transition, education and literacy gaps became clearer; and that resources were required for both the Veteran and their families to fill those gaps.

Higher education among Veterans positively impacts transition experiences and life after service, as education level can impact earning potential, employment status, financial stability, and financial satisfaction.[202,207] However, Veterans experience transition challenges in pursuing education post-release, such as differences in thought processes and approaches compared to their civilian peers due to varied life stages, experiences, and age.[208,209] Furthermore, Veterans with lower educational levels are prone to reporting poor self-rated health and mental health conditions.[84,157,210,211]

Education impacts on health

CHNA participants viewed education as a component of their health and well-being, allowing them to advocate for themselves, access resources and supports, and acquire meaningful, financially stable employment. Many identified that having an undergraduate, master's degree, or other higher education is a strength.

> "Internally, I mean there's no doubt my level of education helps. I have two master's degrees. I did my undergrad thesis on sexual assault because the more you learn about it and read about it, the more you can understand. You learn what things can trigger you. So, my own education has been a strength for me."
>
> Veteran Woman

Financial, administrative, and policy literacy

CHNA participants distinguished between having higher education and literacy, citing the importance of specialized literacy such as 'financial literacy' and 'policy literacy.' They emphasized that literacy, especially in understanding government and healthcare forms and administration, is distinct from formal education. Participants also noted that having Indigenous cultural competency, military cultural competency, and even civilian cultural competency, is important for recognizing and addressing differences in need, norms, and experiences.

Military training recognition

CHNA participants expressed frustration at civilian workplaces' lack of recognition for their military-acquired experience and training, causing them to pursue additional education.

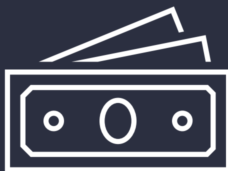
Education and self advocacy

Many CHNA participants spoke about needing to educate themselves about their health and well-being in order to advocate for themselves with government and healthcare providers. Recognizing this need, they also acknowledged the importance of advocates to assist those with lower health, finance, and process literacy in engaging effectively with support systems.

Education and literacy, spanning pre-military, military service, and post-release influence Veterans' health and well-being and that of their families. Opportunities for improvement exist in formal vocational rehabilitation programs, educational/skills training, and with informal opportunities to better understand how to navigate government processes, interpret health-related information, and promote financial literacy.[212]

Financial security and wellness

What you need to know:

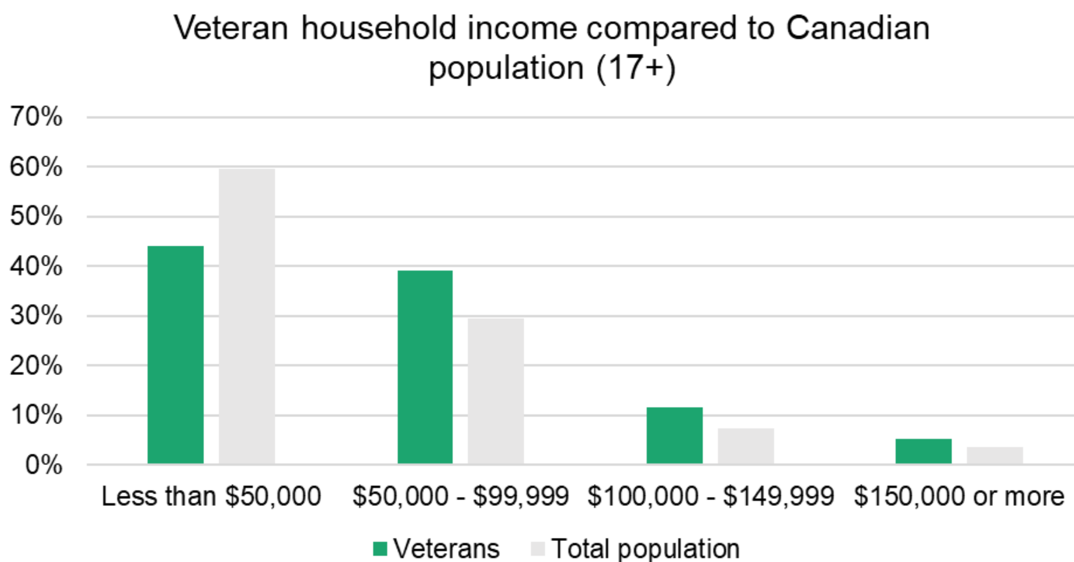


- Veterans from equity-deserving groups may experience financial difficulties as a result of economic barriers to equitable pay, both while in military service and post-service.
- Financial security can influence, and be influenced by, other domains of well-being, including mental health, physical health, social health, and well-being.

Definition: Income refers to the earnings (i.e., value or money) of an entity,[213] while socioeconomic status includes factors which influence quality-of-life beyond income; such as perception of class, education, and type of job.[214]

Veterans' Domains of Well-Being: Incomes, expenses, and socioeconomic status are fundamental to Veterans' well-being and are currently measured by the existing Veteran Well-Being Surveillance Framework.[33]

Figure 16: Veteran household income compared to Canadian population 17+



Household income	Less than $50,000	$50,000 - $99,999	$100,000 - $149,999	$150,000 or more
Veterans	44.0%	39.0%	11.6%	5.3%
Total population	59.5%	29.5%	7.3%	3.7%

Figure 16: Veteran household income compared to Canadian population 17+ (Source: Census, 2021)

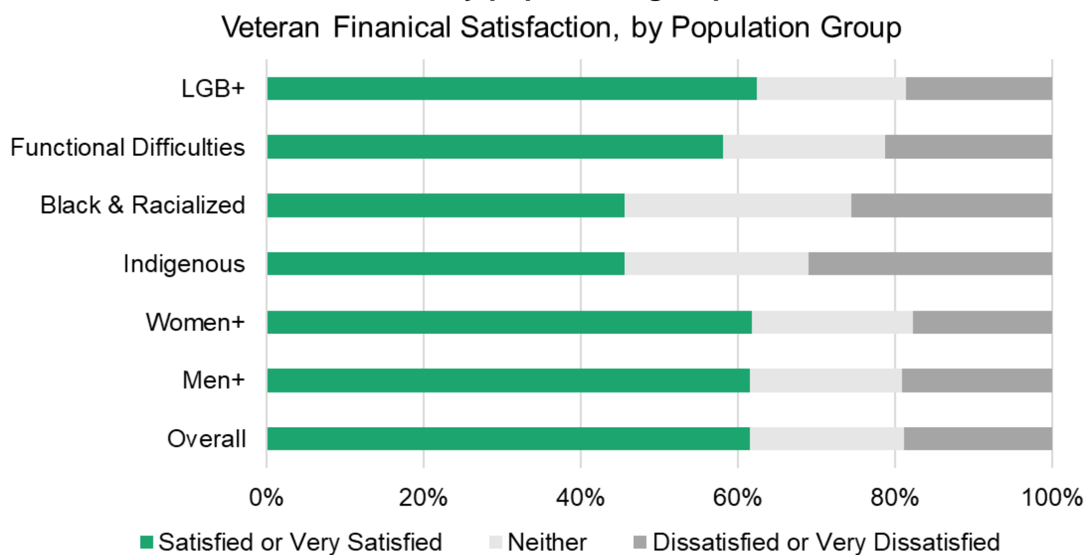
In 2021, 7.4% of Canadians were below the official poverty line in Canada, as per the market basket measure.[215] In the Veteran population, 5.1% of Veterans were in poverty according to the Census' market basket measure.[28] (See Figure 16 for Veteran household income compared to Canadian population 17+).

Discrimination and financial health

Some CHNA participants shared that they were prevented from achieving the rank or service duration they desired, in some cases due to discrimination. For a small number of participants, staying in service past aged fifty-five was important, both for securing their financial security and for their sense of self. Some older CHNA participants noted that finances were the domain of their partner or spouse, and that it would be challenging if they had to manage their finances alone.

> "What if I don't make money? (…) I need a job to put food in my belly, to put a roof over my head, to be able to kind of live my life, to pay my bills, to drive my car, to do all of this stuff right?"
>
> Older Veteran Man

Figure 17: Veteran financial satisfaction by population group



Financial Satisfaction	Overall	Men+	Women+	Indigenous	Black and Racialized	Functional Difficulties	LGB+
Satisfied or Very Satisfied	61.5%	61.5%	61.8%	45.5%	45.6%	58.1%	62.5%
Neither	19.5%	19.4%	20.5%	23.5%	28.8%	20.6%	19.0%
Dissatisfied or Very Dissatisfied	18.9%	19.1%	17.7%	31.0%	25.6%	21.3%	18.6%

Figure 17: Veteran financial satisfaction by population group (Source: CVHS, 2022)

A Veteran's age and rank at release, release type, and service duration can impact their labour market participation, post-release income, and satisfaction with finances.[106,216,217] Certain factors, including being age 60-64 at retirement, or having a medical release, or being female have been associated with a larger decline in income post-release.[216] (See Figure 17 for details about Veteran financial satisfaction by population group according to 2022 CVHS).

Financial health and its impacts

Some CHNA participants noted that their worries about finances, income, and employment increased their stress, anxiety, and mental health issues. Participants spoke of finances being influenced by military experience and financial literacy.

- 61.5% of Veterans responded they were satisfied or very satisfied with their financial situation; however, 18.9% of Veterans identified they were dissatisfied or very dissatisfied with their financial situation (CVHS, 2022).
- Indigenous Veterans were less satisfied with their financial situation than non-Indigenous Veterans. Nearly half (45.5%) of Indigenous Veterans stated they were satisfied or very satisfied with their financial situation, compared to 62.3% of non-Indigenous Veterans (CVHS, 2022).
- Black and racialized Veterans were less likely to be satisfied or very satisfied (45.6%) with their financial situation than Veterans who were not Black and racialized (62.1%) (CVHS, 2022).

Costs of being a Veteran

Some CHNA participants spoke about additional expenses associated with claiming benefits for service-related conditions, undergoing preventative care and treatment, and accessing supports for which they had no benefits.

Purpose and day-to-day activities

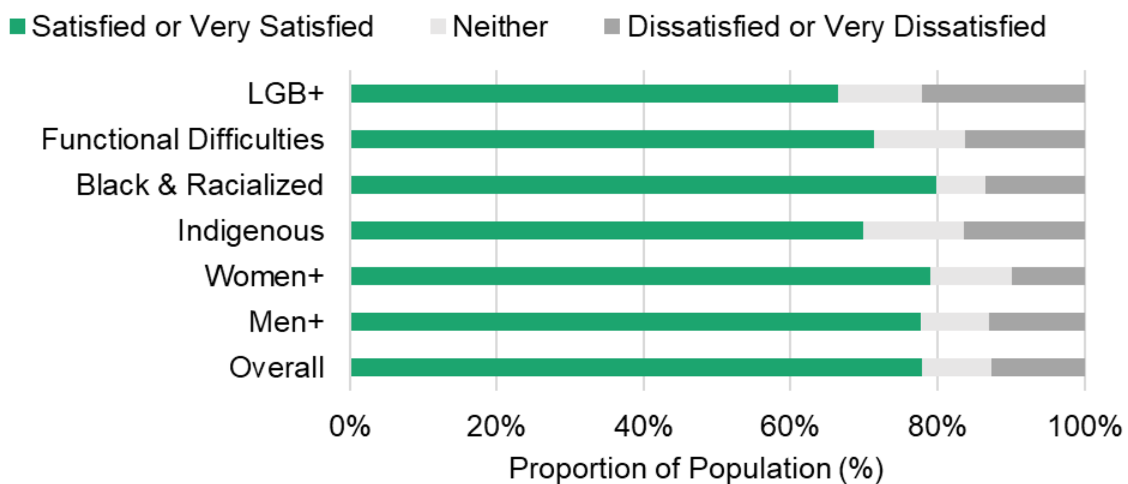
What you need to know:

- A Veteran's sense of purpose is personal, linked to their values, and can change over time.
- A Veterans' sense of purpose can impact all domains of health and well-being, and influences mental, physical, financial, and social health.

Definition: The concept of a sense of purpose is unique to each individual, extending beyond employment to include meaningful activities like volunteering, hobbies, and education.[33,63,67]

Veterans' Domains of Well-Being: A Veteran's sense of purpose influences overall health and well-being and is recognized as one of the seven domains of well-being in the existing framework.[33]

Figure 18: life satisfaction by Veteran population group



Canada

Life satisfaction	Overall	Men+	Women+	Indigenous	Black and racialized	Functional difficulties	LGB+
Satisfied or very satisfied	77.9%	77.7%	79.1%	70.0%	79.9%	71.3%	66.5%
Dissatisfied or very dissatisfied	12.6%	13.0%	9.9%	16.5%	13.5%	16.3%	22.1%
Neither	9.5%	9.2%	11.0%	13.6%	6.6%	12.4%	11.4%

Figure 18: life satisfaction by Veteran population group (Source: CVHS, 2022)

The 2022 CVHS life satisfaction measure asked Veterans to report their feelings of satisfaction on a scale of 0 to 10—those who responded with a value of 6 or greater were interpreted as being satisfied or very satisfied with their lives in general (see Figure 18).

- Overall, 78.0% of Veterans rated their life satisfaction as satisfied or very satisfied (CVHS, 2022), slightly lower than the Canadian adult population (18+) (86.9%).[70]
- Considering life satisfaction rating by gender, we saw no significant differences between men+ (77.7%) and women+ (79.1%) (CVHS, 2022), which is slightly lower than Canadians 18+, where males (87.0%) and females (86.8%) also had similar ratings of life satisfaction.[70]

Changes in purpose over time

CHNA participants shared that their interests developed, changed, and evolved due to a number of factors including their age, social connections, geography, and lived-experiences.

> "We know that a lot of what we need to be healthy includes those social relationships (…) It's that sense of purpose, right? And that sense of purpose is more than just 'I'm physically, mentally OK.' (…) Whether it's with groups or whether it's as a parent, a grandmother, a mother, it can be a variety of things, but people focus different ways than that."
>
> Veteran Woman

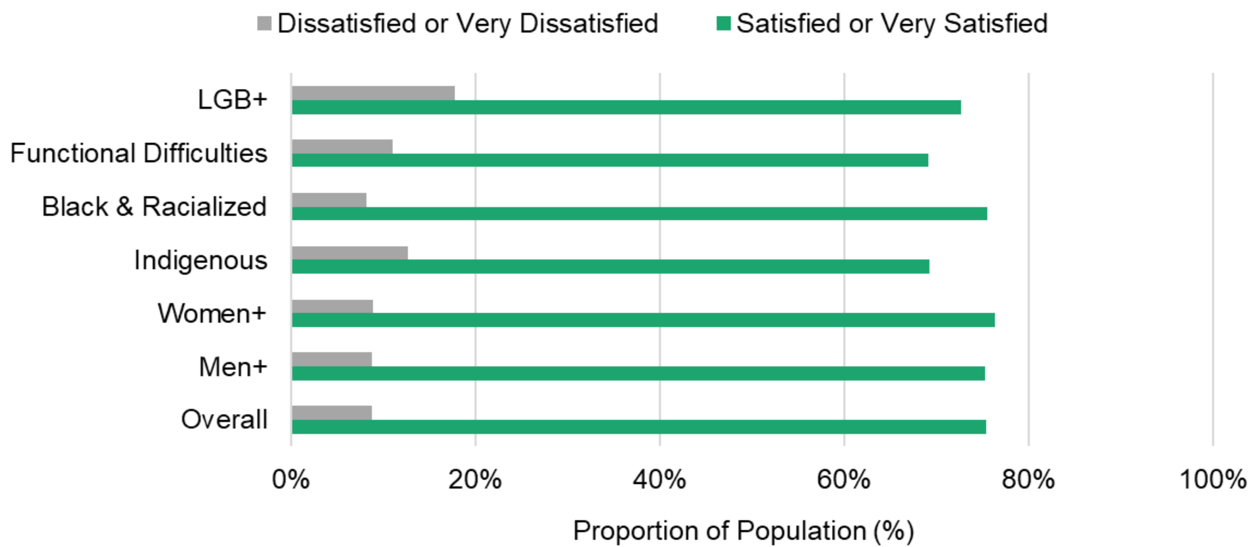
Some equity-deserving Veteran groups in the 2022 CVHS rated their overall life satisfaction lower than their counterparts.

- Veterans with no functional difficulties were more likely to rate their life satisfaction as satisfied or very satisfied (93.0%) than their counterparts with functional difficulties (71.3%) (CVHS, 2022).

- Non-Indigenous Veterans were significantly more likely to report that they were satisfied or very satisfied with their life (78.3%) than Indigenous Veterans (70.0%) (CVHS, 2022).

Recent research pointed to a relationship between experiences of discrimination and sense of purpose,[218] as well as the impacts of that relationship on an individual's health outcomes.[219]

Figure 19: satisfaction with main activity in past 12 months by Veteran population group



Satisfaction with main activity in past 12 months	Overall	Men+	Women+	Indigenous	Black and racialized	Functional difficulties	LGB+
Satisfied or Very Satisfied	75.4%	75.3%	76.3%	69.2%	75.5%	69.1%	72.7%
Dissatisfied or Very Dissatisfied	8.8%	8.8%	8.9%	12.7%	8.2%	11.0%	17.8%

Figure 19: satisfaction with main activity in past 12 months by Veteran population group (Source: CVHS, 2022)

Veterans can find purpose and meaning in their main activity, which can include employment, retirement, or providing care for themselves or others—the 2022 CVHS allowed for an examination of these facets, and their reported satisfaction levels (see Figure 19).

- The majority of Veterans (45.3%) identified that working was their main activity in the past 12 months (CVHS, 2022).

- Veterans that were not employed as their main activity most frequently identified as retired or not looking for work (43.6%) (CVHS, 2022).
- The remaining Veterans identified their main activities as managing a long-term illness (5.3%); providing caregiving, household work, or volunteering (2.9%); looking for work (1.0%); receiving an education (0.9%); or other activities (0.9%) (CVHS, 2022).

Many factors may influence these results, including the availability of employment and transferability of skills, as well as the impact of ageism, sexism, racism, and discrimination on income and retirement options.[220]

Purpose outside of employment

CHNA participants spoke candidly about the activities that gave them a sense of purpose. While employment and volunteering were mentioned, participants also found meaning in connecting with community, nature, and family.

> "If you can find meaningful, purposeful employment then you've nailed it. Most people will just find employment to keep eating and the lights on. And that will lead to all those other health consequences kind of being amplified, good or bad."
>
> Veteran Man

According to the 2022 VNCS, five in eight (64%) respondents agreed that they have a purpose in life. However, case-managed respondents under 65 (44%) were much less likely to agree compared to other strata, and three in ten (29%) disagree. Additionally, Indigenous respondents (54%) are less likely to agree than non-Indigenous respondents (65%).[145]

Discrimination may influence the main activities available to some Veterans.

- Indigenous Veterans and Veterans with functional difficulties were significantly less likely to report satisfaction with their life, than non-Indigenous Veterans and Veterans with no functional difficulties, respectively (CVHS, 2022).
- Three-quarters (74.1%) of Black and racialized Veterans reported working as their main activity, which was statistically more than Veterans who were not Black and racialized (44.2%) (CVHS, 2022).
- Fewer than two in five Veterans with functional difficulties (37.9%) reported working, compared to three in five of their counterparts (61.9%) (CVHS, 2022).

For equity-deserving groups, the ability to work may be influenced by systemic, institutional, or historical biases and factors.[221–223]

- Comparing Veterans who reported their main activity as retirement or not looking for work, men+ Veterans were significantly more likely to report this as their main activity (44.7%) than women+ Veterans (37.6%) (CVHS, 2022).
- Indigenous Veterans, Black and racialized Veterans, and lesbian, gay, bisexual and other sexually diverse (LGB+) Veterans were found to be less likely to be retired or not looking for work than their respective counterparts (CVHS, 2022).
- Indigenous men+ Veterans were more than twice as likely as Indigenous women+ Veterans to be retired or not looking for work (CVHS, 2022).
- Veterans with functional difficulties were also more likely to be retired or not looking for work (48.7%) than their counterparts (32.2%) (CVHS, 2022).

Equity-deserving Veterans who identified their main activity as having a long-term illness may experience compounding and overlapping challenges to their mental and physical health that can affect their sense of purpose and vice versa.

- Indigenous Veterans were more likely to report a long-term illness as their main activity (9.1%) than non-Indigenous Veterans (5.2%) (CVHS, 2022).
- Other Veterans who were more likely to report long term illness than their respective counterparts include Veterans with functional difficulties, at 12 times the reporting rate as those without functional difficulties (7.4% vs 0.6%), and LGB+ Veterans, who reported long-term illness twice the amount as heterosexual Veterans (10.5% vs 5.0%) (CVHS, 2022).

These Veteran groups may have additional challenges with establishing and maintaining a sense of purpose, as they may not have the resources or availability to participate in social interaction and other meaningful activities.[224]

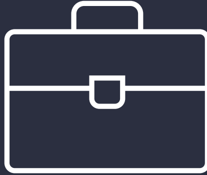
Purpose and advocacy

For many of the equity-deserving CHNA participants, advocating for other Veterans provided a sense of purpose. However, they also reported that doing so can be difficult when they, personally, are experiencing financial difficulties, lacking appropriate treatment benefits, and navigating a difficult transition.

While purpose and intentionality has previously been linked to employment and volunteering activities, new CHNA findings demonstrated that a Veteran's ability to find meaning, fulfilment, and direction can be related to many factors—cultural, personal, environmental, historical, and organizational—which can change over time.

Employment and working conditions

What you need to know:

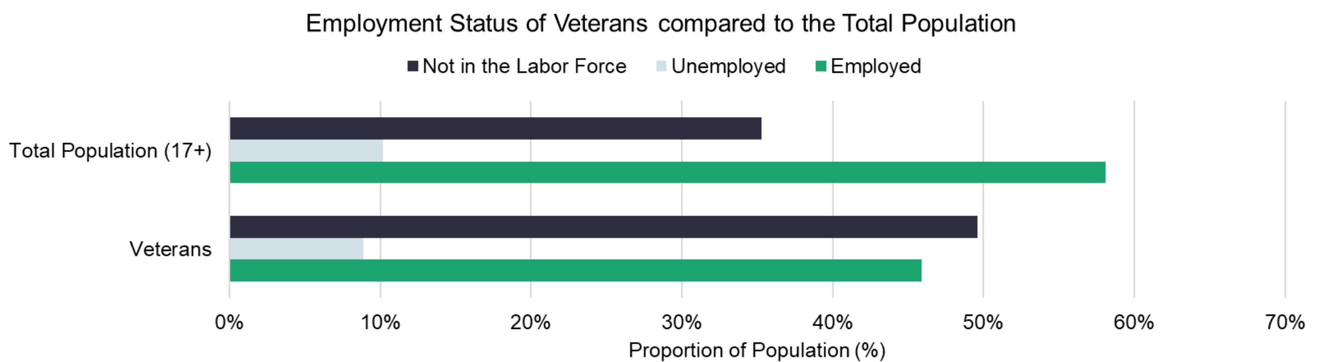


- Veterans' satisfaction with their employment can influence, and be influenced by, their mental health, financial health, social health, and well-being.
- A Veteran's employment options can be influenced by inequities rooted in discrimination or a lack of trauma-informed, accessible, militarily competent options.

Definition: An employed person is someone who does any paid work at a job or business—this could be in the context of an employer-employee relationship or as self-employment.[225] Working conditions refer to the physical or mental demands of an individual's employment, as well as factors such as their schedule, pay, and/or breaks.[226,227]

Veterans' Domains of Well-Being: For Veterans, having fewer job-related concerns and greater control over working conditions has been associated with better health and higher longevity.[33]

Figure 20: employment status of Veterans compared to the total population



Labour force status	Veterans	Total population (17+)
Employment rate*	45.9%	58.1%
Unemployment rate**	8.9%	10.2%
Not in the labour force	49.6%	35.3%

The proportions in this table do not sum to 100% due to the following notes:
*Employment Rate is calculated as the number of employed Veterans out of the total number of Veterans in the population.
**Unemployment Rate is calculated as the number of unemployed Veterans out of the total number of Veterans in the labour force.
Figure 20: employment status of Veterans compared to the total population (Source: Census, 2021)[28]

At the time of the 2021 Census, unemployment rates for Veterans (8.90%) were lower than for the Canadian public aged 17 years or older (10.2%); however, employment rates were also lower among Veterans than Canadians 17+ (45.9% vs 58.1%) (see Figure 20).[28]

- Women+ Veterans were more likely to have full-time work than men+ Veterans (12.8% vs 6.7%) (CVHS, 2022).
- Among Veterans with functional difficulties, women+ Veterans were more than twice as likely to have full time work than their men+ Veteran counterparts (CVHS, 2022).
- Black and racialized Veterans were more likely than not Black and racialized Veterans to be employed (66.6% vs 45.0%); statistics show that two-thirds of Black and racialized Veterans were employed.[28]

The 2021 Census found that employment rates were comparable across genders within the Veteran community, as well as between Indigenous and non-Indigenous Veterans. This suggested that employment challenges and opportunities did not significantly differ within these subgroups. Despite this, Black and racialized Veterans and Indigenous Veterans faced a greater likelihood of unemployment, indicating that being employed does not uniformly shield these groups from labor market vulnerabilities.[28]

Did you know?

Veterans who are older, female,[231] released for a medical reason,[232] and live with a disability or functional limitation,[233] more often reported lower employment rates than their counterparts.

Pressures on employment

CHNA participants shared that they felt pressured to get a job upon release to maintain access to their benefits (e.g., Income Replacement Benefits, Diminished Earning Capacities, Canada Pension Plan) even when they struggled with their health and well-being or did not feel ready to return to the workforce. Several expressed frustrations or fears over losing their benefits if they pursued volunteer opportunities.

According to the 2021 Census, the top five occupation groups for Veterans (ages 25 to 64) to find employment in were occupations related to trades, transport, and equipment operators (19.7%); occupations in education, law, and social, community, and government services (13.0%); occupations in sales and service (11.7%); occupations in business, finance, and administration (11.2%) and natural and applied sciences occupations (9.8%).[28] Notably, the most common Veteran employer immediately following release was the public service.[216]

Precarious employment

CHNA participants offered that employment can be precarious when they have to balance financial health with other health related concerns.

> "Without a doubt, I would say that my current employment pays me money in the bank, as well as I have a good private benefits package for things like medications, my dental care, my vision care. I believe there's also counseling services available. So those intangible benefits from my current employment wouldn't be there if I was unemployed or if I was solely relying on Veterans Affairs for my healthcare."
>
> Veteran Man

Military and civilian working conditions

For some CHNA participants, seeking purpose in their post-service employment led them to workplaces where commitment, selflessness, sacrifice, and esprit de corps were important aspects of working conditions. These roles, often in public service, military contractors, or trades related their military-acquired skills, offered CHNA participants a sense of seamlessness in their transition, where taking off the uniform did not mean losing their mission. Some participants expressed greater dissatisfaction with their working environment than other participants. Many of these participants commented on the difference in civilian working conditions, often pointing to feelings of mismatched values, where civilians were less dedicated.

> "My sense of purpose went completely out the window. I am not adapting well to not being in the military, even though I had loads of time to prepare. I had literally years to prepare. But I wandered around my house aimlessly for a couple of years (…) Unless I'm working, I have no purpose."
>
> Veteran Woman

Some Veteran subpopulations experience greater barriers to accessing the labour market than others.[106] Younger Veterans,[228] Veterans with fewer years of service,[229] Veterans with combat experience,[230] and women Veterans often experience higher rates of unemployment.

Barriers to post-service employment

CHNA participants shared that having a clear post-service plan and confidence in their skills were key to finding fulfilling employment post-service. They shared the importance of having an employer that understood military culture and a workplace that made accommodations for mental or physical health needs. Women participants who struggled to secure or maintain fulfilling employment pointed to several barriers, including challenges coordinating mental and physical health conditions. These participants also described a prevailing sense that the value of their military-acquired skills was unclear to themselves, their employers, and their colleagues.

The impact of military service and release can be long-lasting and unique to Veterans' lived-experiences. Women Veterans who experienced military sexual trauma are less likely to be employed in civilian jobs and may experience more functional and interpersonal challenges in their civilian careers compared to those who did not experience military sexual trauma.[38]

Military sexual trauma (MST) and employment

CHNA participants shared that military sexual trauma experiences negatively impacted post-service employment and led to challenges with engaging in interpersonal relationships and community roles.

Housing and physical environment

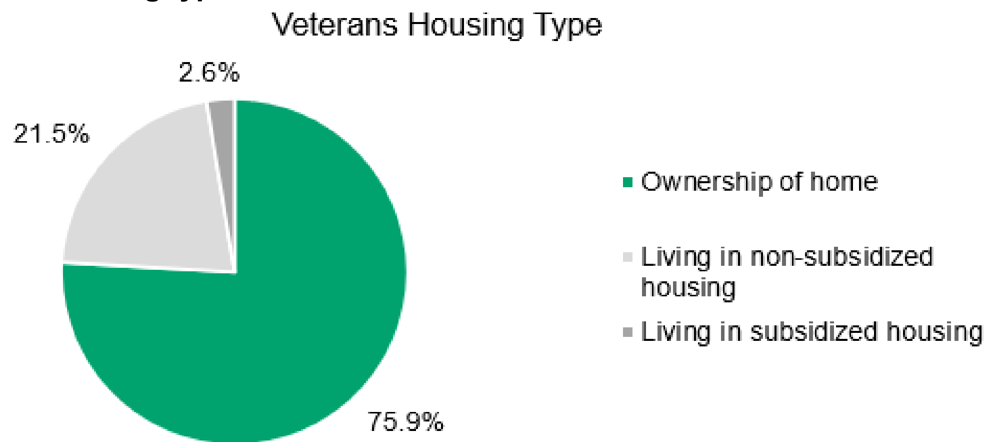
What you need to know:

- Veterans identify that housing adequacy, affordability, and suitability are critical to their health and well-being.
- Veterans' housing needs can be influenced by factors such as marital status, geography, and availability of healthcare resources.
- Participants who experienced homelessness note that intersectionality, as well as personal, military, and post-service experiences, influence the risk for homelessness.

Definition: Housing is discussed in terms of its safety, accessibility, state of repair, suitability for number of residents, availability of safe drinking water, and more; while physical environment encompasses the location of the house, the safety of the community, and the proximity for access to schools, healthcare facilities, and shopping.[231,232]

Veterans' domains of well-being: Housing and physical environment play an important role in Veterans' overall health and well-being, noting that pollutants in the air, water, food and soil can lead to a range of harmful health consequences.[33]

Figure 21: Veterans housing type



Veteran Housing Types	Proportion (%)
Ownership of home	75.9%
Living in non-subsidized housing	21.5%
Living in subsidized housing	2.6%

Figure 21: Veteran housing type (Source: Census, 2021)

The 2021 Census measured the core housing need for Veterans, an indicator based on adequacy, affordability and suitability of housing (see Figure 21 for more information).[28,233]

- According to the 2021 Census, fewer Veterans live in households that are unaffordable and fall below housing standards (core housing need) (5.4%; 24,105 Veterans) than the general population (7.1%).[28]

Veterans housing

CHNA participants identified that housing adequacy, affordability, and suitability were critical to their health and well-being. Many participants noted that finding stable housing was their priority upon transition from military service. This provided them with a sense of security to effectively address their other health and well-being needs.

- Of the one or more Veterans who lived in the same household at the time of the 2021 Census, three-quarters (75.9%) of Veterans owned their own home, 21.5% lived in non-subsidized housing, and 2.6% of Veterans lived in subsidized housing.[28]
- According to the 2021 Census, most Veterans lived in single-detached homes (63.7%) compared to other private dwellings (36.3%).[234] In addition, 3.6% of Veterans (16,750 Veterans) lived in collective dwellings (such as long-term care homes).[28]

Impact of military service on housing needs

CHNA participants discussed their personal and military housing experiences. Some participants found prior experience with campus style living was a positive one, which helped them develop a sense of community and belonging; while others shared that base housing exposed them to risks of feeling isolated and exposed to harassment, often without support or recourse.

- The 2022 VNCS revealed that the majority of respondents were satisfied with their housing (81%) however this figure has declined since 2020 (90%).[145]

The 2022 VNCS found that while case-managed Veterans under 65 were the least satisfied with their housing (68%), Black and racialized Veterans were more likely to be unsatisfied with their housing (74%) than their not Black and racialized counterparts (83%).[145]

Housing security and health

CHNA participants noted that stress related to housing security (e.g., finding secure housing, maintaining housing and physical surroundings, and evolving housing standards with health, well-being, and aging needs) had intersectional considerations and often impacted other areas of health and well-being.

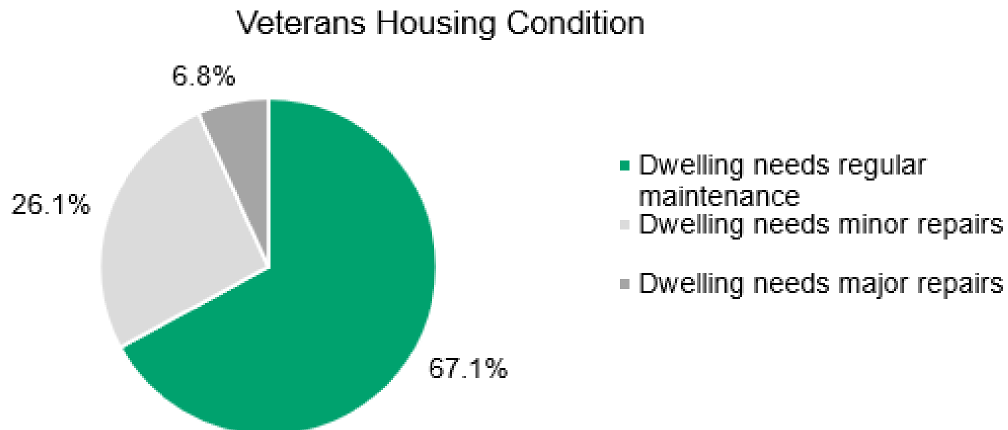
- A higher share of Veterans (23.1%) lived alone than the Canadian general population (15.8%), while 63.9% of Veterans lived with their married or common law partner (men+ 65.8%, women+ 53.9%).[28]

Intersectional housing considerations

Single CHNA participants who lived alone spoke about feelings of isolation and lack of supports for Veterans of all genders. Women participants with partners identified that homelife instability influenced housing security if their partners had addictions or if they experienced, or were at risk for, intimate partner violence.

The link between housing and health is an important consideration for Veterans, especially equity-deserving Veterans, as it has been found that housing insecurity exacerbates various health issues.[235]

Figure 22: housing conditions for Veterans



Veterans housing condition	Proportion (%)
Dwelling needs regular maintenance	67.1%
Dwelling needs minor repairs	26.1%
Dwelling needs major repairs	6.8%

Figure 22: Veterans housing condition (Source: Census, 2021)

- According to the 2021 Census, more than two-thirds of dwellings that Veterans lived in required regular maintenance (67.1%), with 26.1% requiring minor repairs and 6.8% requiring major repairs (see Figure 22).[28]

Home and housing supports

CHNA participants expressed feeling overwhelmed when managing household maintenance and repairs alongside mental and physical health challenges. Some participants spoke about the home as a secure and comfortable place and noted that home supports (e.g., maintenance support, housekeeping, and home modifications to improve accessibility), ensured security, health and well-being. Participants also shared that the availability of housing and community involvement can play a critical role in ensuring health and well-being for Veterans living alone.

Homelessness

The lack of adequate, quality housing can have negative impacts on a Veterans' health and well-being. Homelessness refers to the status of individuals, families, or communities that do not have access to consistent, safe, long-term, and adequate shelter, or the means or capacity to secure housing in the near future. The issue of homelessness can often be the result of systemic or societal barriers. These barriers include lack of available, affordable and appropriate housing in a particular geographical area, racism and discrimination, and/or the individual/household's financial, mental, cognitive, behavioral or physical challenges. Canadian Veterans at risk for homelessness were found to have physical health conditions such as dental problems, head injuries, musculoskeletal injuries, and foot problems. Similar results were found for both the Veterans and a matched comparison group of non-Veterans.[235]

- The prevalence of Veterans experiencing homelessness was recently reported as approximately 1.6% of emergency shelter users.[236] However, this estimate may be lower than the actual number of Veterans affected by homelessness, as 1 in 5 Veterans reported not using emergency shelters.[237]
- Veterans using shelters were reported to be majority male (84.4%), and male Veterans using shelters were typically older (48 years on average) than female Veterans (38 years on average) using the shelter.[237]

Homelessness and housing precarity

A few CHNA participants shared stories of their experiences with housing precarity and/or homelessness. Additionally, they noted that an intersectional analysis of the risks and experiences of homelessness was important to understanding the impact on their health and well-being. They shared that their identity factors, as well as personal, military, and post-service experiences, influenced their risk for homelessness.

> "Not being homeless is huge to our personal health and our family health. So that I think that word security (…) makes sense."
>
> Veteran Man

Risk factors associated with homelessness appear to have specific gender dimensions. Female Veterans who experienced adverse childhood events, abuse, family upheaval, military sexual trauma, intimate partner violence, substance use, physical and mental health issues, race and racism, and gender discrimination, were at higher risk for homelessness across their life course.[238] CHNA participants also identified a decreased sense of community belonging as a potential risk for homelessness.

According to a recent report, women Veterans and gender diverse Veterans were more likely to experience hidden homelessness (such as couch surfing) and exchanging sex for material support, which put their health and well-being at greater risk.[239] This is important to consider as housing programs generally do not address the unique challenges faced by women during post-service transition.[240]

Resources and intersectionality

CHNA participants shared that homelessness resources for the Veteran population tended to be fragmented and relied heavily on emergency shelters that don't meet their intersectional needs (e.g., awareness of military culture and experiences, trauma informed approach, substance use resources, etc.).

Veterans with substance use disorder, mental health concerns, and income related factors, are at greater risk for homelessness.[241] A pilot study demonstrated that Veterans who were provided housing were found to rely less on emergency shelters, drop-in-centers, and hospital-based services. Being in stable housing improved these Veteran's access to mental health, addiction, medical, and income supports, resulting in a significant reduction in homelessness.[242]

Physical environment

A Veteran's physical environment, including access to civilian and Veteran resources, is also a key factor for health and well-being.

Community-based resources

CHNA participants shared the community they lived in, including healthcare resources and supports, schools, recreation areas, and Veteran services, had an impact on their sense of belonging, support, and overall health.

Majority of respondents (82%) to the 2022 VCNS reported being satisfied with their neighbourhood.[145] However, Indigenous Veterans, who were more likely to face discrimination in their communities, were found to be less satisfied with their community (71%), than their non-Indigenous counterparts (83%).[145]

Belonging in communities

Some CHNA participants described a decreased sense of belonging, specifically in civilian communities. Participants who reported challenging post-service transitions were more likely to share feelings of isolation. This was often amplified by their experiences with resources, supports, and institutions who lacked military cultural competency or an understanding of military history, or did not use a gender, culture, or trauma-informed lens in their interactions with Veterans.

- The 2022 VNCS also found that nine in ten (91%) respondents who were in receipt of VIP benefits agreed that they relied on VIP to help them remain in their home and community.[145]
- Recipients of VIP who were 50 or older were more likely to say they rely on VIP to keep them in their home and community (92%) than respondents under 40 (74%).[145]

Establishing networks of care and belonging

CHNA participants described challenges encountered during their transition from military service (e.g., establishing new networks of healthcare, community, and Veteran supports that met or partially met their needs). Some discussed these as factors that could influence their desire to stay or leave their community. 2SLGBTQI+ and Indigenous participants stressed the importance of local communities having culturally relevant connections. A few CHNA participants shared that despite not having completely satisfactory healthcare and community supports in their geographic region (e.g., lacking military, gender-based, cultural competency) the burden of moving was too high to start again in a new community.

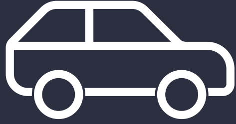
- This sentiment is not consistent for all Veterans. The 2022 VNCS found that the majority of Veterans would not move to a better home even if they could (58%),[145] This may speak to them having strong connections to geographic locations and community networks.
- The 2022 VNCS also found that 42% of Indigenous Veterans and 44% of Black and racialized Veterans responded that if they were able to move to a better home they would.[145]

Cost of participation

CHNA participants noted that participating in their physical environment and cultivating a sense of belonging required financial stability to participate, physical health to access, and mental health to engage meaningfully. For participants with chronic pain and conditions, as well as those living in rural spaces where resources require transportation, the ability to engage with their physical environment created additional stressors.

Transportation

What you need to know:



- Having access to dependable, affordable, accessible transportation is essential for accessing health services as well as meeting basic needs.
- More attention is needed to understand and recognize transportation as an indicator of Veterans' health and well-being.

Definition: Transportation involves the movement of individuals or goods from one location to another, and the various means by which such movement is accomplished, including walking, cycling, public transit , personal vehicle, ferry, rail, and air.[243] Transportation accessibility gauges how effectively individuals can reach essential services, considering factors such as public transit availability, proximity of facilities, and ease of travel.[244,245]

Veterans' domains of well-being: Transportation impacts the domain of physical environment, as well as having individual, organizational, and broader population-level implications for health, social integration, and employment domains.[33]

Transportation and access to needs

CHNA participants shared that access to personal and public transportation is a relevant factor that influences their health and well-being. They emphasized that transportation is not only important to attend healthcare and medical appointments but also to meet daily needs (groceries, pharmacy, etc.).

> "I have means of transportation, which allows you to go to the gym, go to the library, go to the grocery store and go to your appointment."
>
> Veteran Woman

Despite limited Veteran-specific literature, broader research indicates that inadequate transportation can hinder healthcare access, disproportionately affecting vulnerable populations in Canada.[244,246–248] Closure of public transportation has been shown to prevent people from accessing essential health services in a timely manner, predominantly impacting equity-deserving groups and those experiencing disabilities or with functional difficulties.[246] Veterans are especially implicated here as they have a disproportionate risk of, and/or already live with, functional difficulties and disabilities.[71,80,140,249]

Furthermore, it is important to note that transportation challenges associated with living in rural areas disproportionately affect Indigenous communities and other vulnerable populations.[70,71,78–80,244,246–248] Canada's rural population has the highest rate of growth among G7 countries.[250] This is interesting to consider because rural communities encounter distinct challenges, as their healthcare models are often based on urban settings which often do not account for the nuanced health needs of these predominantly older, low-income, and unwell communities.[251]

Geographic and financial transportation considerations

Some CHNA participants emphasized that limited access to transportation in both urban and rural settings is a barrier to meeting their health and well-being needs, especially those requiring specialist services that entail costly travel.

> "I think for some people, just even like a lack of transport, like sometimes even in a big city, some Veterans I know can't drive across the city or it's too hard for them to take the bus to go to the food bank or something like that. What do you do with eight bags of groceries, you know, on the bus. So, I think transport can be a huge, huge issue too."
>
> Veteran Woman

Transportation also plays a role in maintaining social connections.[252] The absence of adequate transportation can contribute to social isolation and loneliness, which CHNA participants identified as a health and well-being challenge they faced. Older Veterans face heightened challenges with mobility and social interactions, which can make using transportation increasingly difficult and further exacerbate their sense of isolation.[253,144]

Collectively, these findings demonstrate the importance of transportation in accessing healthcare services and resources and social interactions. The lack of Veteran-specific research in this area emphasizes the need for increased understanding of how transportation influences Veterans' health and well-being. Given the aging population Veterans,[28] efforts should be taken to assess and address transportation challenges that older Veterans may face to support them in accessing resources and stay meaningfully connected to their communities.

Community belonging and life skills

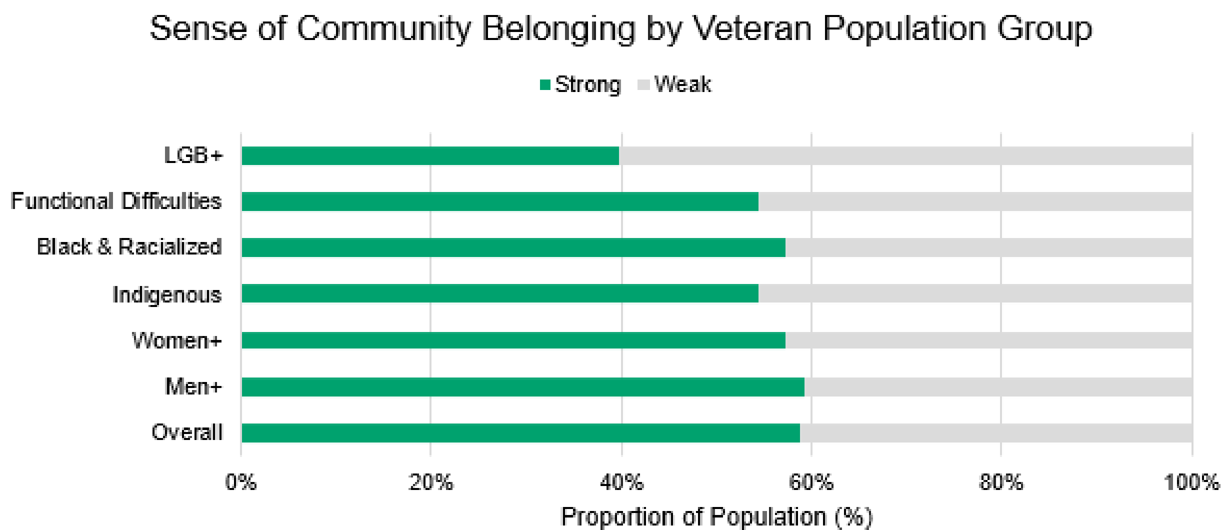
What you need to know:

- A Veteran's ability to feel a sense of connection with a broader group can influence, and be influenced by, other health domains.
- Veterans may find belonging within number of communities based on lived-experience, military background, and identity components; however, not all communities may fulfill or consider a Veteran's intersectional needs.

Definition: According to the 2022 CVHS, community belonging refers to the proportion of the population that reports a strong sense of belonging to their local community.

Veterans' domains of well-being: Community belonging and life skills have direct connection to social integration, cultural and social environment, and life skills and preparedness.[33]

Figure 23: sense of community belonging by Veteran population group



Community belonging	Overall	Men+	Women+	Indigenous	Black and racialized	Functional difficulties	LGB+
Strong	58.9%	59.2%	57.3%	54.5%	57.2%	54.4%	39.8%
Weak	41.1%	40.8%	42.7%	45.5%	42.8%	45.6%	60.2%

Figure 23: Sense of community belonging by Veteran population group (Source: CVHS, 2022)

- Overall, 58.9% of the Veteran community reported a strong sense of community belonging (CVHS, 2022), similar to the 63.5% reported by the Canadian population (18+).[70] (See Figure 23 for sense of community belonging reported by Veteran population group.)

Earlier research showed that Veterans had a weaker sense of community belonging compared to Canadians.[249] This has previously been explained as Veterans perceiving barriers in their ability to connect with civilians due to a lack of shared experiences.[254]

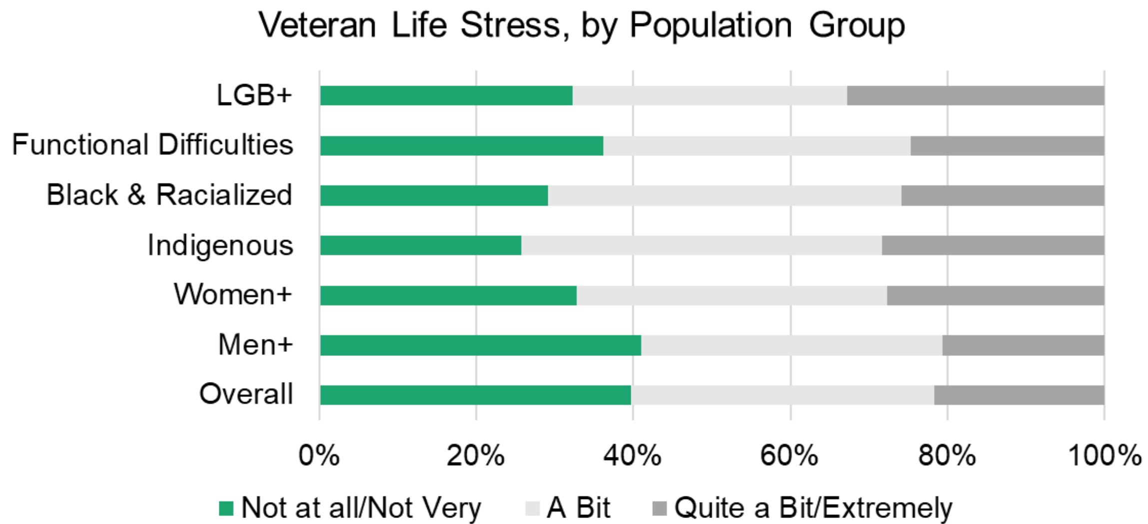
- While there was no significant difference between men+ and women+ Veterans within any subpopulation, strong sense of community belonging was significantly higher in both men+ Veterans (69.3%) and women+ Veterans (68.4%) with no functional difficulties, compared to their respective counterparts with functional difficulties (54.9% for men+ and 51.6% for women+) (CVHS, 2022).
- Only 39.8% of LGB+ Veterans reported having a strong sense of community belonging, a far lower proportion than the 59.9% of heterosexual Veterans that reported a strong sense of community belonging (CVHS, 2022).

> "I think from a wellness and well-being perspective, the biggest gap I've noted in dealing with my own and other Veterans is that there is a loss of community and connection. Many of the guys I've come across who are most at risk are feeling isolated and completely cut off from losing their military community and not connecting to a new or remote civilian community."
>
> Veteran Man

Perceptions of families and home

For some CHNA participants, family was a vital element in their social support network. Some participants described their families as critical supports – standing beside them through military service and beyond, often making sacrifices to support the Veteran in their career. Several participants specifically mentioned their spouses as significant supports. However, not all participants identified family as a positive influence on their health and well-being. Some participants shared that their family could magnify feelings of being misunderstood and isolated by the broader civilian community.

Figure 24: Veteran life stress by population group



Life stress	Overall	Men+	Women+	Indigenous	Black and racialized	Functional difficulties	LGB+
Not at all/Not Very	39.7%	41.0%	32.8%	25.7%	29.1%	36.2%	32.2%
A Bit	38.6%	38.4%	39.6%	46.0%	45.0%	39.2%	35.0%
Quite a Bit/Extremely	21.7%	20.6%	27.6%	28.3%	25.9%	24.6%	32.8%

Figure 24: Veteran life stress, by population group (Source: CVHS, 2022)

The 2022 CVHS measured Veteran life stress, by population group (see Figure 24), with perceived life stress defined as the amount of stress in a person's life, on most days, as perceived by the person responding.

- Canadian Veterans reported perceiving that most days were quite a bit or extremely stressful (21.7%) (CVHS, 2022); similar to the Canadian adult population (22.3%).[70]
- Women+ Veterans reported their life stress as quite a bit or extremely stressful (28%) more than men+ Veterans (21%) (CVHS, 2022). A similar pattern was observed between genders within equity-deserving groups in the general Canadian population, where women+ Canadians reported their life stress being fair or poor more often than men+.[255]
- When looking across equity-deserving groups there was no significant differences in life stress ratings (CVHS, 2022).

The literature found that Regular Force Veterans were less likely to identify a high stress level than the general Canadian population.[256]

Intersectional needs

Equity-deserving CHNA participants discussed intersectional considerations for coping with stress, including supports that target gender, cultural, and age-based needs.

Stress, resilience, and support

CHNA participants who experienced higher life stress relied on intricate networks of support. Others expressed that life stress and overlapping mental and physical health issues made them feel isolated from help. For those who noted decreased daily stress following transition, some made a conscious effort to limit exposure to stressful situations in their lives. The causes of life stress were numerous and personal, influenced by life and military experiences, health, support networks, and sociodemographic characteristics of each Veteran.

An important factor in a Veteran's well-being is their confidence in their ability to adapt, belong, and manage following transition, where "those able to access relevant information, plan in advance, enjoy a sense of identity apart from military life, and seek social support as needed reported a sense of feeling well-prepared to transition."[257]

Research has found that Veterans who were unfamiliar with civilian life, experienced low institutional support, lacked appropriate time to prepare for release, or struggled to let go of military life, often had more challenging release processes and experiences.[257]

Perception of skills and transitioning

CHNA participants who saw their skills as valuable and transferrable before military release shared that their transition experience felt easier than participants who did not.

Research has demonstrated the value of peer support, stating that membership in various social groups and the value that they attach to those memberships is a key factor in their sense of belonging.[254]

Spectrums of social supports

Many CHNA participants identified establishing strong social supports as a factor in good health and well-being. When discussing social supports, participants mentioned a range of relationships – families, friends, peers, and neighbours, as well as informal networks, online and digital spaces, community members, organizations, and institutions.

Adverse childhood experiences

What you need to know:

- Research has found a high proportion of Veterans reported adverse childhood experiences, which are linked to poor health outcomes across the domains of well-being.
- More research is required to understand the full extent of how adverse childhood experiences impacts Veterans' health and well-being across all domains.

Definition: Adverse childhood experiences are distressing events that occur before a person reaches the age of 18,[19] including abuse (e.g., physical, emotional, sexual, etc.), neglect (physical and emotional), and/or parental or caregiver-related issues (e.g., alcohol or substance abuse, incarceration, intimate partner violence, divorce, etc.).[258,259]

Veterans' domains of well-being: Adverse childhood experiences are not currently monitored under the Veteran Well-being Surveillance framework;[33] however, there is evidence to suggest that adverse childhood experiences can have developmental impacts on the physical, psychological and social health of the individual well into adulthood.[260,261]

Adverse childhood experiences are particularly important to consider when studying the health and well-being of Veterans. Research indicates that Veterans often have higher levels of childhood adversity than their civilian counterparts, with one study finding that 85.0% of Veteran participants experienced at least one category of adverse childhood experiences.[262] These findings were comparable to another study in which 83% of participants reported a history of at least one adverse childhood experience, and 42% reported four or more adverse childhood experiences.[263] These studies are part of a growing body of research on the impact of childhood trauma. Adverse childhood experience scores have been associated with adult experiences of depression, anxiety, stress, and memory impairment,[244] chronic disease, functional limitations, PTSD,[264,265] low self-rated health, increases in social isolation, and low resiliency and stress

management skills[261] as well as premature death.[266]

> "So, the complex PTSD I was diagnosed with, according to my psychologist, was a result of shitty parents. They were basically nonexistent. So, all the stuff that happened in the military kind of just was exacerbated because of that."
>
> Veteran Man

Adverse and traumatic experiences

CHNA participants who discussed potentially traumatic or stressful events in their childhood referred to verbal abuse, sexual and/or physical assault, a lack of loving homes, poverty, periods of homelessness in childhood, and witnessing domestic violence, excessive substance or alcohol use, and stressful separations or divorces. Participants shared that, in many cases, their adverse childhood experiences were motivating factors to join the military and that service was a way to escape or detach themselves from difficult home lives.

> "I kind of ran away from home when I was 16 years old and the military seemed like a good option for, I guess, food, shelter and the job."
>
> Racialized Veteran Woman

While adverse childhood experiences can affect anyone regardless of gender, race, culture, sexual orientation, income or education background, evidence shows that children from Black and racialized populations are at greater risk than their counterparts.[258] Women are also more likely to report adverse experiences (including emotional and physical abuse, sexual abuse, and neglect) than their men counterparts.[267]

Impossible choices

Some CHNA participants noted that their decisions to stay in the military was also informed by their concerns of returning to an adverse family environment. For a few participants, traumatic military experiences and history of childhood trauma left them with an impossible choice between two abusive and unsafe environments. Participants identified unsafe military environments as ones where they experienced military sexual misconduct, racial or gender discrimination, and persecution as 2SLGBTQI+ serving members during the LGBT Purge.

Access and use of resources

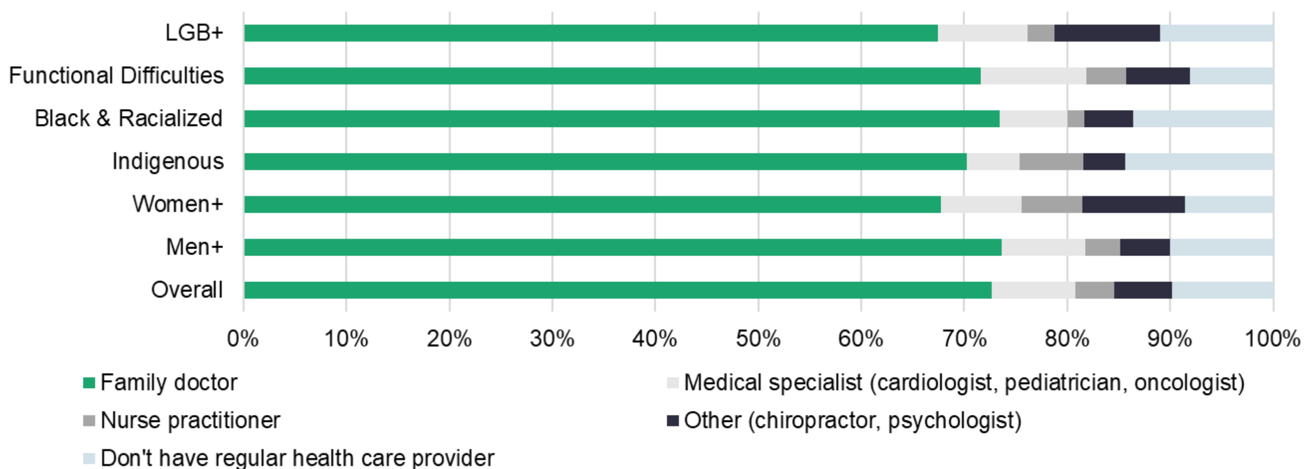
What you need to know:

- A Veteran's access to culturally relevant, trauma-informed resources who understand military culture is a key factor in their ability to survive and thrive.
- A Veteran's access and use of resources is dependent on many factors, including their health and well-being, their identity factors, and where they live.

Definition: Accessing resources involves the ability to actively seek, use, and benefit from a spectrum of resources, including those related to health, social, economic, educational, material, and political aspects, across individual, community, organizational, or institutional levels.[268–273]

Veterans' domains of well-being: The ability to access and use resources but is not specifically named as a domain of well-being under the current framework, but influences all aspects of health and well-being.[33]

Figure 25: healthcare provider Veterans regularly consult with by population group



Healthcare provider you regularly consult with	Overall	Men+	Women+	Indigenous	Black and racialized	Functional difficulties	LGB+
Primary care provider	72.7%	73.6%	67.7%	70.2%	73.4%	71.5%	67.4%
Medical specialist (cardiologist, pediatrician, oncologist)	8.1%	8.1%	7.8%	5.2%	6.6%	10.3%	8.7%
Nurse practitioner	3.8%	3.4%	5.9%	6.2%	1.7%	3.8%	2.7%
Other (chiropractor, psychologist)	5.6%	4.8%	9.9%	4.0%	4.7%	6.2%	10.2%
Don't have regular healthcare provider	9.8%	10.0%	8.6%	14.4%	13.6%	8.1%	11.0%

Figure 25: healthcare provider Veterans regularly consult with, by population group (Source: CVHS, 2022)

Access to resources and health

CHNA participants shared how the ability to access and use resources enabled them to better understand their health, manage their conditions, and regain and maintain independence.

> "I'm very lucky to have a GP here in my city. I also live very close to a community hospital, and I have found that combination with the occasional visit to a specialist suits my needs (…) The only complaint that I have there is the long wait times."
>
> Older Veteran Man

The 2022 CVHS assessed the type of healthcare provider that Veterans most often consulted (see Figure 25).

- Overall, 9.8% of Veterans indicated that they do not have a regular healthcare provider, with 90.2% reporting that they regularly consulted some type of healthcare provider (CVHS, 2022). In comparison, 85.8% of Canadians (18+) in 2022 reported having a regular healthcare provider, a slightly lower proportion of the population than Veterans.[70]
- The majority of Veterans indicated that their regular provider was a primary care provider (72.7%), while 8.1% regularly consulted a medical specialist, 3.8% regularly consulted a nurse practitioner, and 5.6% consulted some other type of provider (CVHS, 2022).
- There was no statistically significant difference in men+ and women+ Veterans' access to regular healthcare provider consultations (CVHS, 2022).This however contradicts findings from previous studies reporting that female Veterans were more likely to access all types of health services, particularly primary care doctors, than male Veterans.[80,274] In line with this, Canadian data of those 18+ also showed a similar trend with a larger proportion of females having a regular healthcare provider (89.8%) than males (81.7%).[70]

- The proportions of other equity-deserving Veterans who regularly consulted any healthcare provider were not notably different from their counterparts (Indigenous and non-Indigenous Veterans, Black and racialized and Veterans who were not Black and racialized, Veterans with functional difficulties and those without, heterosexual and LGB+ Veterans) (CVHS, 2022).
- This also applied to comparisons between equity-deserving Veterans and their counterparts among those who reported not having a regular healthcare provider (CVHS, 2022).

In Canada, studies have also shown that the consultation rate for mental healthcare was higher for Veterans than the Canadian general population.[80,275] Moreover, research showed that family physicians often served as a primary source of mental healthcare for Veterans post-release.[94]

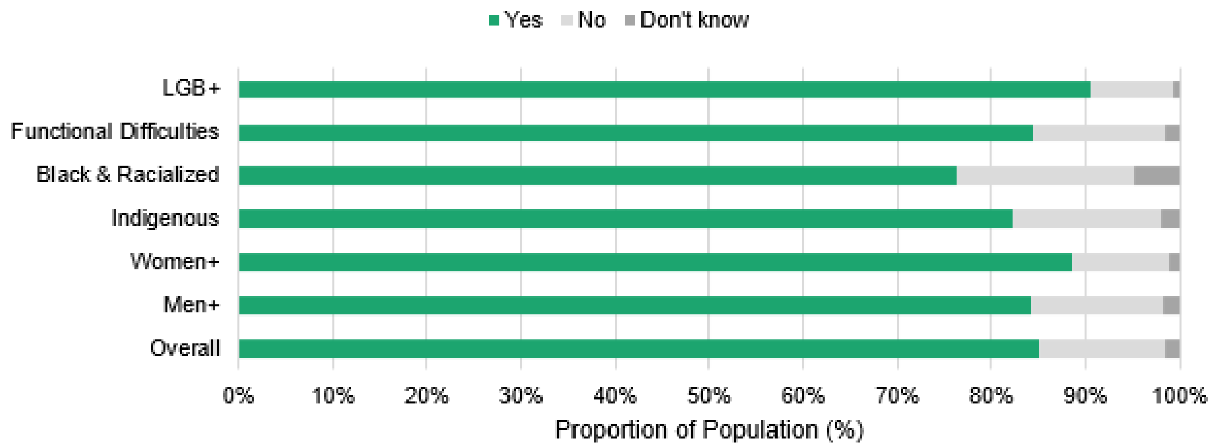
Intersectional challenges finding resources

Some CHNA participants discussed challenges caused by limited knowledge about how to locate resources in their communities, including finance and insurance resources.

> "Without my job specific training, I would not be aware of any support services available in the community or from Veterans Affairs Canada to help with physical or emotional health concerns, whether they relate to service or not."
>
> Métis Veteran Man

To appropriately serve and benefit equity-deserving groups, resources and services must be inclusive, intersectional, culturally safe, trauma-informed, anti-oppressive, and community-oriented.[248,251,276–284] This is particularly relevant to consider in Veterans' health and well-being, as they additionally require such resources and services to be military culturally competent.[49,285]

Figure 26: insurance for prescription by Veteran population group



Insurance for prescriptions	Overall	Men+	Women+	Indigenous	Black and racialized	Functional difficulties	LGB+
Yes	85.0%	84.4%	88.5%	82.3%	76.3%	84.4%	90.6%
No	13.4%	14.0%	10.3%	15.6%	18.8%	14.0%	8.7%
Don't know	1.6%	1.7%	1.2%	2.1%	4.9%	1.6%	0.7%

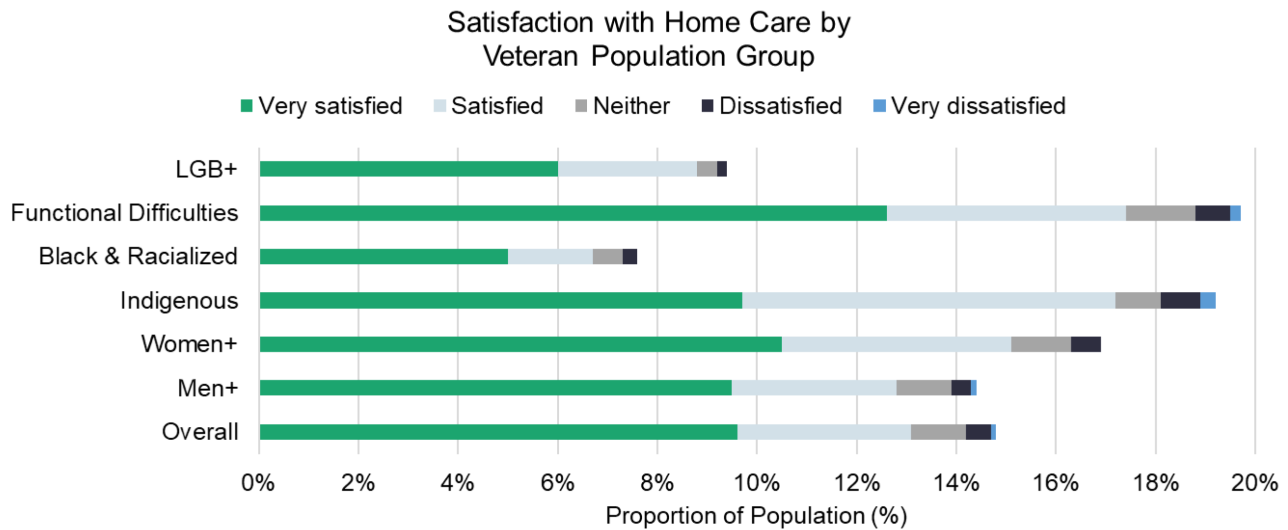
Figure 26: insurance for prescriptions by Veteran population group (Source: CVHS, 2022)

The 2022 CVHS data allowed us to examine Veterans' access to prescription insurance to better understand their healthcare access (see Figure 26).

- Of the total Veteran population, 85.0% reported having insurance for prescriptions, with no significant difference reported between men+ (84.4%) and women+ (88.5%) Veterans (CVHS, 2022). For comparison, men and women in the Canadian population (aged 25-64, and 65+) previously reported slightly lower rates of having any drug insurance plan (data inclusive of 2015, 2016, and 2019).[286]
- Black and racialized Veterans had a lower proportion of having insurance for prescriptions (76.3%) than Veterans who were not Black and racialized (85.4%) (CVHS, 2022). Likewise,
- data from the Canadian population (2015, 2016, and 2019 inclusive) showed that a lower proportion of people from a racialized group (male or female) reported any drug insurance coverage than their non-racialized counterparts.[287]

Home care and community care are helpful for Veterans who are regaining or maintaining their independence, autonomy, and control over their health and well-being.[288,289] These services offer comprehensive support for managing functional limitations, chronic conditions, and complex health needs. Being able to stay at home, avoiding prolonged stays at hospitals or care facilities, contributes to a higher standard of living and overall well-being.[288,289]

Figure 27: satisfaction with home care by Veteran population group



Satisfaction with home care	Overall	Men+	Women+	Indigenous	Black and Racialized	Functional Difficulties	LGB+
Very satisfied	9.6%	9.5%	10.5%	9.7%	5.0%	12.6%	6%
Satisfied	3.5%	3.3%	4.6%	7.5%	1.7%	4.8%	2.8%
Neither	1.1%	1.1%	1.2%	0.9%	0.6%	1.4%	0.4%
Dissatisfied	0.5%	0.4%	0.6%	0.8%	0.3%	0.7%	0.2%
Very dissatisfied	0.1%	0.1%	X	0.3%	X	0.2%	X
No home care	85.2%	85.6%	83.1%	80.9%	92.4%	80.4%	90.7%

Figure 27: satisfaction with home care by Veteran population group (Source: CVHS, 2022)

- Most Veterans (85.2%) did not have home care services (CVHS, 2022).
- Of the 14.8% of Veterans with home care services, the majority (88.5%) reported being very satisfied or satisfied with services, and over 75% agreed that the services helped them stay in their homes—this was observed across Veteran subgroups (see Figure 27) (CVHS, 2022).

- There were no notable differences in home care use and satisfaction between men+ and women+ Veterans (CVHS, 2022).
- Black and racialized Veterans were less likely to report having home care services than Veterans who were not Black and racialized (CVHS, 2022).
- Veterans with functional difficulties were more likely to have home care services than those with no functional difficulties (CVHS, 2022).

Spiritual and cultural health

What you need to know:

- Veterans' spiritual, religious, and/or cultural health have impacts on overall health and well-being.
- Veterans' spiritual and cultural health needs change over time and are influenced by their military experience and personal identity components.

Definition: Spirituality, which is often personal and may overlap with religious practices, is regarded as an emerging property characterized by feelings of interconnectedness with oneself, others, communities, nature, and higher beings, and can help provide a sense of purpose.[290] Cultural health involves a profound understanding of one's own cultural background and life experiences, acknowledging their impact on personal values, perspectives and behaviors.[291]

Veterans' domains of well-being: While spiritual and cultural health are directly linked to cultural and social environment, they also impact multiple aspects of a Veterans' well-being, including their overall health, purpose and employment, social integration, and life skills[33] as well as other realms not captured by the domains of well-being.

Did you know?

Colonial history profoundly impacted First Nations, Métis and Inuit Veterans, families, communities and culture: it is important not to unjustly oversimplify cultural needs associated with "106, ."[296]

According to the 2021 Census, half (53.3%) of the Canadian population reported affiliation with a Christian religion, 34.6% identified no religious affiliation, and the proportion of Canada's population who reported being Muslim (4.9%), Hindu (2.3%) or Sikh (2.1%) continued to grow.[292,293] There was no specific data regarding the religious and spiritual affiliation of Veterans or serving members.

Intersectional religious considerations

Some CHNA participants noted that religious organizations can offer community benefit through exercise and activity programs, and some Black CHNA participants specifically noted that church can play a role in their social well-being. A few participants shared concerns of religious bias in VAC supports, noting they may not consider the interconnected spiritual and physical health needs of non-Christian Veterans.

> "For me well-being is: 'I have been optimized to be as good as I can be, mind, body and spirit holistically.' So, it is looking at physical health, emotional health, mental health, social health, financial health, environmental health, spiritual health, all of those different things to me are part of health."
>
> Veteran Woman

> "Well-being is being happy, being content, having goals that you're, you know that you've set in life like short-term, long-term goals, a positive outlook on life and just feeling spiritually, and emotionally in a good place."
>
> Veteran Man

Spirituality and culture

Many CHNA participants identified as 'spiritual.' They described spiritual and cultural health as linked, layered and evolving. Many participants discussed the lack of benefits or coverage available for spiritual services and cultural retreats.

Varying definitions of spiritual and cultural health

For some CHNA participants, spiritual and cultural health were not one and the same. While many used the same sentiments – a deep sense of personal connection to something beyond themselves – some expressed connection as being rooted in cultural communities with shared traditions, while others sought a sense of personal alignment with individual or societal values, nature, and themselves.

> "I find that connection with culture really helped my mental health and find that identity again."
>
> First Nations Veteran Man

Gender, religion, spirituality and culture

CHNA participants spoke about feeling invisible or feeling caught someplace between dominant gender norms. Two-spirit and women participants spoke about the impact of gender on spiritual and cultural health, reflecting a dissonance between restrictive definitions of gender norms in the dominant military culture and their personal or cultural norms. More specifically, some women participants with ties to organized religion felt their gender-based needs were seen as a threat to the culture, tradition, and beliefs of organized religion that otherwise could have provided them a sense of community.

Shifts towards diversity and inclusion can enhance the quality of life for individuals and address a restrictive dominant culture to support well-being.[294] The emphasis on cultural competency among healthcare providers calls for a trauma-informed approach, empathy, flexibility, and support to improve Veterans' well-being.[49]

Health and well-being themes

Findings from our CHNA interviews and focus groups are presented in the following sections to explore unique, yet complimentary insights to the indicators presented above. These themes offer contextual, in-depth descriptions and understanding of Veterans' strengths, needs, identities, attitudes, interactions, and social processes that contribute to their lived-experiences of health and well-being.

Every individual who served in the military has a unique story to tell about their journey to becoming a Veteran. To those we spoke with, being a Veteran may mean having a sense of pride in serving their country. It may also be a feeling that they are part of a bigger family or community that shares an understanding of what it means to willingly choose to make the ultimate sacrifice. We have learned that for most, becoming a Veteran involves coming to terms with their transition from military service to civilian life.[c] Participants told us that navigating this transition often includes learning to reconcile their military identity and their 'old life' with their Veteran identity and a search for purpose in their 'new life.'

Did you know?

Whereas quantitative approaches often provide us with the 'what' of a research question, qualitative approaches offer us an in-depth explanation of 'why' and 'how.'

> "Pride of service that I put my country first before anybody, anything else to my fellow citizens, for my family, for everybody."
>
> Veteran Man

> "It's a very important part of who I was and what I did."
>
> Veteran Woman

> "A Veteran is a Veteran no matter the experience, you served your country (…) We're all Veterans together, but I think that it's important that we have that intersectionality and that we recognize that experiences are different for different people."
>
> 2SLGBTQI+ Métis Veteran

However, we also learned that not all Veterans identify themselves as a 'Veteran.' For some, this depends on their military experiences, including but not limited to length of service, where they were posted, occupations held, if they deployed domestically or internationally, and the type of military release they had (e.g., voluntary or unvoluntary). For those who do not call

[c] In CHNA interviews and focus groups, Veterans were more likely to use the term "transition to civilian life' rather than 'life after service.'

Canada

themselves a Veteran (i.e., especially women and 2SLGBTQI+ Veterans), they shared that their sense of belonging to the Veteran community can be further shaped by how civilians and other Veterans perceive them. Preconceived notions and stereotypes about who a Veteran is, what a Veteran looks like, or how long or where they have served creates challenges for those who do not 'fit' into these expectations. In addition, evolving and divergent organizational definitions of 'Veteran' can add to this complexity.

> "I remember telling Veterans that I didn't feel like I belonged because I hadn't been deployed and they were the first ones that were like, 'No, you absolutely belong!'"
>
> 2SLGBTQI+ Veteran Woman

> "I don't believe that in the concept of how society defines the word that I meet that definition from my experiences, my length of service, and a lack of an overseas deployment opportunity."
>
> Métis Veteran Man

For certain themes, we've used the social-ecological model,[21] along with intersectionality,[11,22,51] to frame their descriptions of health and well-being as an ecosystem that connects the individual, interpersonal, community, organizational, structural, and historical levels of being.

This enables us to better understand how Veterans define their own health and well-being, what they identify as their needs, strengths, and resources they access and use, the barriers, and facilitators they can encounter, and the gaps in Veteran support and service they experience.

Did you know?

75 Veterans participated in CHNA interviews and focus groups between August and December 2023.

We achieved data saturation in our new qualitative findings, ensuring validity and trustworthiness of this research.

Veterans' definitions of health and well-being

What **Veterans** need you to know:

- Veterans describe their health and well-being as holistic and interconnected.
- Veterans' health and well-being evolve and are shaped by their contextual lived-experiences.
- Veterans' health and well-being are influenced by their military service experiences.

Veterans describe their health and well-being as holistic and interconnected

Veterans described their health and well-being as holistic and interconnected. They explained that their health and well-being go beyond the absence of having a disease or illness; instead, these include a combination of physical, mental, emotional, spiritual, social, community, cultural, economic, and environmental factors that are interconnected. Some Veterans emphasized that it is difficult for them to separate these factors into individual domains. Vitality, stability, and happiness frequently overlap with the co-morbidity of injuries, illnesses, and daily pain – blurring the distinction between a state of positive or negative health and well-being. Several Veterans explained that life satisfaction and overall quality of life are influenced by a 'holistic balance' between factors.

> "We need balance in our life, but it doesn't mean everything is perfect. You know you can still have those pain days, but maybe it can be offset, by going for a walk in the beautiful 30-degree weather or hanging out with your best friend going for coffee (…) It's just that overall balance of health, family, yourself, your supports."
>
> Veteran Woman

> "Being healthy is getting up in the morning, going downstairs, eat what the Navy/Air Force would feed, have lunch, be able to eat all my meals properly, and having my kids phone me up is very important."
>
> Older Veteran Man

Veterans' physical, mental, emotional, spiritual, social, community, cultural, economic, and environmental factors may hold greater significance for some than it does for others. Some Veterans agreed all factors were essential to positive health and well-being, whereas for others, they weren't as relevant.

Most Veterans identified overall quality of life was paramount for their health and well-being. This included meeting basic needs of financial security, housing, nutrition, sleep, safety, and transportation.

> "It's mental, physical, just having all my needs met, safety, security, food, shelter, the basic needs."
>
> Racialized Veteran Woman

Many Veterans strongly affiliated their health and well-being with notions of a sense of community belonging, both with their Veteran and civilian communities.

> "A lot of it has to do with your social interactions, your relationships, whether they're fulfilling, how you're understood and viewed in a group and treated in society. You want to belong!"
>
> Veteran Woman

Many linked health and well-being to their physical and mental fitness, mobility, independence, autonomy, pain management, and acceptance of their limitations.

> "Being healthy is being able to wake up in the morning with no aches or pains."
>
> Black Veteran Man

Some Veterans highlighted that their connections to nature, pets, and spirituality were vital aspects of their health and well-being.

> "Health is not just physical, it's also about the spiritual aspect, whether you are religious or not, you may have a connection to a higher spirit or just a spirit by being out in nature. It's a connection to more than just yourself. […] The beauty of the world."
>
> Veteran Man

> "My dog saves my life every day. I wouldn't be here if he didn't exist."
>
> Veteran Man

Others emphasized purposefulness, positivity, contentment, and inner peace.

> "It's not just the health of the body, it's the health of the mind, and the (…) soul, but the sense of self-worth, the inner sense, if you will."
>
> Veteran Man

Some women Veterans emphasized that recognition of their service, experiences, and sacrifices was important to them.

> "What we need as women Veterans is the recognition that we did the same job, and not only did we do the same job, but we had to work harder to get the same recognition as the guys, and that is still going on today within Veterans Affairs."
>
> Veteran Woman

Veterans' health and well-being evolve and are shaped by their contextual lived-experiences

Veterans lived-experiences, individual characteristics (e.g., gender, age, ethnicity, sexual orientation, marital status, etc.), and the contexts where they intersect strongly influence their health and well-being over time. Some Veterans described self-acceptance and adapting to changes in mobility and independence as they age.

> "At my age, I'd say it's about being able to look forward to all those things - being healthy enough that I expect to continue to be healthy and eventually come to a peaceful end. Health is without fear for the future, or with a positive expectation of the future."
>
> Older Veteran Man

Veterans emphasized that their different experiences are not congruent with the notion of a "one-size-fits-all" definition or approach for policies and programs available for Veterans. This includes differences with income and social status, employment and activities, education and literacy, physical environments, healthy behaviors, social support, life stressors, and access to health services, etc.

> "It's very important to know what health means to that individual because you can't have a cookie cutter approach. You have to really look at individuals and provide them [what they need]."
>
> Veteran Woman

> "I think really, it's if the person is happy, you know. If the cake tastes good, you don't need to change the recipe, right? So, whatever the ingredients are for that individual person, then that's what it is. There's no one size fits all!"
>
> Veteran Man

Veterans also described contexts (i.e., life course, cultural, organizational, and structural environments) that they felt influenced their health and well-being.

Life course context

Veterans described how their health and well-being evolves as their physical and cognitive functions, identity, and social roles change throughout their life course. They shared their experiences during early years, adulthood, and older adulthood influenced their past, current, and potentially future health and well-being strengths, needs, and resource requirements.

Early years:

Veterans described a variety of positive and negative childhood and pre-military experiences. Some Veterans highlighted that adverse childhood experiences (e.g., poverty, food insecurity, violence, abuse, neglect, abuse, or bullying) had influenced or had enduring effects on their health and well-being during their military service and transition.

> "I had a very rough childhood when I was being brought up and it was a relief for me, when I was 18 years old, to join the Army."
>
> Veteran Man

Discrimination at an early age, such as sexism, racism, and homophobia, could also cause a variety of negative impacts. For several of these Veterans, these impacts were hard to pinpoint.

> "My sexual orientation probably played a big role. I joined the military in hopes that it would un-gay me because it's such a masculine environment."
>
> LGBT Purge Survivor Veteran Man

Some Veterans explained that enlisting in the military provided an escape from these unsafe environments and challenging experiences.

> "It wasn't a good place to be, and I felt that the military was better than staying home."
>
> Veteran Woman

Others joined the military to follow in their family's footsteps, or because they had positive experiences as a youth in the cadets.

> "My father was military; he was high ranking. We lived a blessed life travelling the world. I had a great childhood!"
>
> Veteran Woman

Adulthood:

Veterans described their adulthoods through the lenses of their relationships, military service, post-service employment, or attainment of new skills and hobbies.

> "I do a lot of work, doing research and history which is something that I enjoy and love. It's something I do every day (…) It has to do with Veterans or Black Canadian history."
>
> Black Veteran Woman

Women Veterans noted how their reproductive needs evolved over adulthood, from managing menstruation to pregnancy and/or menopause. This was often accompanied by challenges within and outside of military service, especially when there was a lack of reproductive care or supportive services available to them (e.g., gynecological care unavailable on military bases or during deployments).

> "There are things that I've had to look for specifically because I'm a woman. I also am aware of the fact that because I'm 47, if not already in perimenopause, I'm certainly heading that way. So that's going to be another sort of, you know thing I'm going to have to navigate soon."
>
> 2SLGBTQI+ Veteran Woman

Men and women alike talked about balancing caregiving duties for their children and/or elderly parents with employment and other responsibilities. They described how this could 'take a toll' on them, affecting their overall health and well-being.

> "I live life for my kids. I live to provide for them, provide a future for them. I don't really have much enjoyment life in myself. Do what I need to do. I work. I take care of the kids. There is little enjoyment in what I do, it burns me out."
>
> Veteran Man

> "Owning a business, you just don't shut the doors at 5 and forget about it till the next morning. It's rewarding owning your own business, but it's also very demanding. And I'm also the primary caregiver for my mom."
>
> Veteran Woman

Older adulthood:

Older Veterans expressed that an important feature of good health and well-being was having confidence in the future – knowing that, as they aged, they would be able to meet their overall needs and have access to the resources they needed to remain independent.

> "The state of well-being for me is that I adapt as I age, and that I have a quality of life. So, I may have health issues, but I have resources to help me deal with those as I age in place."
>
> Older Veteran Woman

They shared concerns about financial security in retirement and their ability to provide financial support to their children and/or grandchildren. For both men and women, ageism was a barrier to finding employment.

> "I think maybe if there's one big worry in my life, it's being able to afford to retire. Because I'm not sure I could support myself as I grow older."
>
> Older Veteran Man

Several mentioned the importance of social connections and community involvement, which diminished with age due to decreasing independence, chronic pain, loss of loved ones, or living far away from family.

> "I'm just an old guy living in the country, wishing he had more friends and was closer to his family. I'm not asking for a lot you know."
>
> Older Veteran Man

They also emphasized how their health and well-being was further shaped by their various social roles such as becoming caregiver for their spouse, affecting their overall life satisfaction.

> "The only time I really feel that it gets sort of rocking and rolling my life is if my spouse has a bad day with the dementia side. That becomes a problem, and it causes a lot of stress."
>
> Older First Nations Veteran Man

Cultural context

A few Veterans discussed how notions of health and well-being may be intimately connected to their culture and ethnicity. Métis and First Nations Veterans noted health and well-being was intrinsically connected to the environment, nature, spirituality. Having access to culturally appropriate healing options such as Elders, traditional gatherings, smudging, and sweat lodges was essential to positive health and well-being outcomes.

> "Culturally, I believe to be healthy I need better access to cultural supports in terms of Indigenous perspective. From a Métis perspective, that's having access to Elders, traditional gatherings, traditional medicines, especially for smudging and sweats, and things like that to help not only maintain a cultural identity, but to access traditional and culturally appropriate healing options. In the case of Indigenous people, Métis, First Nations, Inuit, that could be access to Elders, access to knowledge keepers, as well as to the community as a whole."
>
> Métis Veteran Man

> "I focus a lot on spirituality. When I find myself in a First Nations spiritual ceremony, the sound of the drum hits me, and it feels good. It really does me good!"
>
> First Nations Veteran Woman

Organizational context

A few Veterans who released over ten years ago, shared they had a limited awareness of available transition resources before transition, with limited access to resources while adapting to civilian life; whereas some Veterans, who released more recently, acknowledged the organizational efforts of CAF and VAC to increase collaborative approaches and resources to assist with their transition experience.

> "I was the old school, so I had a very harsh transition, and I definitely went much deeper into unwellness post my release because I could not find help in support of what I needed."
>
> Veteran Woman

> "When you left the military, you didn't have any assistance. It was not the same military that they have today. I never knew there was any help available to me. When you're put out through the door, you're put out through the door!"
>
> Veteran Woman

Structural context

Several Veterans explained how sexism, racism, homophobia, and colonialism, both in the military and civilian contexts, could lead to a range of injuries, illnesses, and traumas. These experiences significantly impacted them individually, as well as their families, and communities in a variety of ways.

> "It's been identified, for example, that there's racism in the military, and people are saying: 'Oh no, there is not, there isn't!.' Well, I'm here to tell you I was on the receiving end of it all the time whether it's racism, whether it's systemic barriers, or what not. It was all presented to me numerous times, and of course the higher up and rank I go, the more I would see of it. Now that's affecting me in a huge way, and to find somebody, a therapist for example, which would understand the needs and concerns of a Black Veteran is next to impossible!"
>
> Black Veteran Man

Many equity-deserving Veterans described how these larger systems and structures of power overlapped, shaping which types of knowledge and experiences were valued and included in healthcare practices, research, and policymaking. In turn, this influenced the quality, distribution, and access of resources. For example, women, 2SLGBTQI+, Indigenous, Black and racialized Veterans described an unequal distribution of and access to resources. Many recounted that they felt invalidated, misunderstood, and misdiagnosed by their healthcare providers.

> "Every psychologist will tell you the same thing. If [women] are always assessed with the same directive [as men], we are going to fall through the cracks. Because assessments are designed for the male mental structure and how males think."
>
> Veteran Woman

Veterans' health and well-being are influenced by their military service experiences

Veterans health and well-being was strongly influenced by their military service experiences. Veterans described repetitive injuries and harmful exposures while serving, and how the onset

of symptoms was difficult to recall or trace to a specific instance or event. Veterans shared that injuries, disorders, illnesses, conditions, and traumas related to military service could, and often did, emerge at various stages of their life.

> "As I get older, things that I used to do casually take a lot more work and things that are cumulative are a lot worse than what I expected them to be at my age (…) It's almost like as soon as you stop all those aches and pains catch up."
>
> Veteran Man

Some Veterans also described their physical and mental disabilities, illnesses, and pain as fluctuating and unpredictable, which in turn, made managing these very challenging. Veterans shared how this impacted many aspects of their life (e.g., their sense of autonomy, interactions with family members and friends, participation in community activities, and employment, etc.).

> "Some days it's high, like when I feel I've accomplished many things. Some days, I try to deal with it. Other days, I must be a little lower key because mentally or physically I'm not capable. I have to accept that being gentle with yourself is useful."
>
> 2SLGBTQI+ Veteran Woman

> "I blame the divorce on my physical and mental health greatly. I have the shared custody of the kids and I feel like I'm a bad dad a lot of time when I have them because I can't do a lot of the activities with them or I have such great fatigue that I can't, you know, I just feel like I'm constantly letting them down. I'm not able to be the father that I want to be, like the father that I had. So that's, that's hard. So, it's, it's affecting me physically and I guess [my] well-being."
>
> Veteran Man

> "When I'm suffering, it's very difficult. I have a very close family and we like to make plans and we like to do things together, and I like to socialize with my friends, and we plan dinners. But when I suffer from bouts of vertigo and, and vomiting, I'm not up to anything and I always feel like I'm letting my family and my friends down."
>
> Veteran Woman

Many Veterans shared that specific aspects of their service were especially impactful on the health and well-being, including length of time they served, occupations and deployments, military culture and norms, and adverse events and traumas.

Length of military service

Several Veterans discussed the experiences, occupations, skills, travels, and educational opportunities from which they benefited due to their military service. These Veterans described having a positive, fulfilling military career that they looked back on fondly and with pride.

> "Mostly positive. In fact, it was all positive. I did quite well professionally. I was promoted many times. I did five different tours. I wore the uniform to do something. I didn't wanna sit in Canada behind the desk. I wanted to go see the world."
>
> Veteran Man

> "It's been a hell of a ride! I don't regret joining the military and doing the things. As I love to say, it was a suit of clothes that fit!"
>
> Veteran Man

For Veterans who joined the military young and served many years, their health and well-being were influenced by feelings of grief and loss for their military life and community of peers. They spoke of adjusting to civilian life and a new civilian community while searching for a new purpose. They questioned who they were and where they fit-in outside the military.

> "I think the longer you spend in the military, the longer the transition period should be. When, when you focus your whole life and energy and, and you've got a whole career and all that time (…) It's kind of hard to imagine doing something else. Whereas if you're young, and you've done a few years, and it's not really an adapted lifestyle, it might be, you know, maybe just because you're younger, it's easier to pick up and start over."
>
> Veteran Woman

Additionally, Veterans expressed adjusting to civilian life included 'not knowing how to be normal,' needing to 'deprogram,' feeling misunderstood by those who had not served, and adjusting to what they called the 'disorganization and chaos of the civilian world.'

> "I had a hard time transitioning out just cause life was just not the same. You no longer have the chain of command, and you no longer have the support of your fellow soldiers."
>
> Veteran Man

> "You join the army, you get reprogrammed, you go do crazy stuff and then, you got a handshake and you're gone. We need to un-program the army out of us so that we can function properly in society."
>
> First Nations Veteran Man

Military occupations and deployments

Veterans' occupational risk factors and deployments experienced during service, ranged from carrying heavy equipment, working in high noise and stress environments, to traumatic physical and mental experiences. Often, risk factors varied depending on the occupations or roles they held. However, women Veterans noted these were often exacerbated by their sex and gender. They described how equipment (e.g., rucksacks, boots, etc.), medical care, and deployment length were designed for men, without consideration of women's' sex and gender differences or needs. A few men and women Veterans discussed how these negative impacts led to their medical release, created challenges in their transition, and had long-term impacts on their health and well-being.

> "I think a lot of my ailments are absolutely related to my gender. Have no doubt about it! VAC has agreed because it was in my disability claim, my hips are completely related to my gender and my size having to been in the army for years during rucksack marches at the pace of a six-foot man all the time, you know, every rucksack march."
>
> Veteran Woman

> "As a young recruit or young soldier, we spent a lot of time marching or running around with heavy boots on the asphalt and cement and jumping out of trucks and doing all the physical stuff. I think it played a role in my knees. Certainly, the fact that we underwent most of our daily activities without hearing protection contributed to my hearing loss."
>
> Veteran Man

> "Just living in a tent in Afghanistan. In the sweltering heat, breathing in all the dirt and dry fecal matter, which blows around in the dust everywhere. Just, it being a terrible place to be surrounded by death and not being safe at all - just constantly being on edge and you're working really long days, you're having no downtime. It's aggravating injuries or sustaining new ones."
>
> Veteran Man

For many Veterans, chronic pain was described as a constant companion, requiring them to adapt their lifestyles and learn to live with the constraints pain imposed on their day-to-day functioning. Changes in physical and mental health prompted individuals to mourn their former selves, both before and during their time in military service. Thus, the notion of self-acceptance became important aspects of a Veteran's health and well-being.

> "If you live with pain for so long, you become more tolerable of it. And it just becomes day in, day out. It just becomes something you're used to, and you live with it. You just live within your capabilities and the means that you can. That's what you do day to day, you know."
>
> Veteran Man

> "You just wanna go back to that person again and that's never gonna happen. So, I'm just gonna try to be the person I am now and deal with everything. That's the hard part right there."
>
> Veteran Woman

Military culture and norms

Veterans often described the military as a 'unique way of life,' 'a core identity,' and 'a shared family' with its own set of norms and culture. Several described the military as an 'autonomous,' 'self-sustaining,' '24/7' organization that structured and supported parts of their whole adult life from personal, medical, housing, financial, legal, to social needs.

> "Veterans are a unique society. I just don't feel that the civilian side of the world realizes how much of a unique society we are (…) When we get out of the military, it's basically about re-integrating us back into civvy life. So, if you have to integrate us back into the civvy life, then we obviously have a unique career and we are unique."
>
> Veteran Man

> "They don't understand that being a Veteran isn't just another job. It's, you join, they indoctrinate you, they change you, right. You become a Veteran and it doesn't leave you when you quit the military."
>
> Veteran Woman

Some Veterans described specific personal attitudes, values, skills, and behaviors ingrained in them by the military as having both positive and negative effects on their health and well-being. A few Veterans described how the military's emphasis on physical fitness led to struggles with their self-image during transition.

> "When you're in the military, you're very fit and healthy. And then you get out of the military. And then for me I started to raise our family like the kids, and then your health gets put on the back burner. All the focus is on the kids. You let your body go to crap! And then it's just you can't do what you used to do and then pain sets in."
>
> Veteran Woman

Veterans shared that teamwork, discipline, routine, and commitment fostered pride, structure, adaptability, fortitude, and created enduring military friendships.

> "You can't take the military out of the out of the girl, but you can take the girl out of the military. During our military time, we all work as a group. Even if you are not always supported fully in it, you are part of the same boat, and everybody paddles on the same side together."
>
> Francophone Veteran Woman

A few Veterans said they developed a rigid 'my way or the highway' mindset that put strain relationships with family and friends.

> "When you get into the military it is about the discipline. You're in a routine, there's a discipline, you do things certain ways, and there's a method to and why. That spills into your non-military career, the civilian side of things, and the interactions with people I know are there with you know become a little different, because that's just the way it is. For a long time, that was a struggle, because it was my way - my way needs to be my way."
>
> Veteran Man

Others shared they remained influenced by the 'suck-it up buttercup' military culture, which discourages admitting when they needed help and stopped them from seeking support for both physical and mental issues.

> "I never sought help while I was in the service. Because in the service you're told to, you know, suffer in silence. That was a big motto of my unit was to suffer in silence. So, with that kind of mentality, you're not gonna go seek help. It wasn't until I was released for quite a few years, that I felt, it was OK to go get help."
>
> First Nations Veteran Man

Adverse experiences and traumas

Some Veterans vividly described multiple instances of poor leadership, abuses of power, harassment, bullying, and physical, emotional, and sexual assaults while serving. This led to overwhelming feelings of fear, guilt, shame, sense of failure, and even suicidal ideation. Women, 2SLGBTQI+, Indigenous, Black and racialized Veterans described experiencing discrimination, racism, homophobia, military sexual trauma, or being a victim of the LGBT Purge. Some described feeling dismissed, overlooked for career promotion, or involuntarily released from service.

> "The good parts were amazing, but there was a lot of negativity and a lot of toxicity. It was a really hyper-sexualized environment."
>
> 2SLGBTQI+ Veteran Woman

> "So, when I left, I was told that my security clearance was going to be taken away. I was told that, I was not a Veteran and that I would never qualify to be a Veteran."
>
> LGBT Purge Survivor Veteran Man

A few Veterans who were medically discharged described feeling discarded, 'pushed out,' or betrayed by their organization, which negatively impacting their self-worth. This disrupted their identity and sense of belonging within the Veteran community. Overall, adverse experiences reduced some Veterans' trust in the organizations and institutions in place to support them.

> "I was kind of forced out. I didn't want to leave. And then I just had to kind of pick up the pieces."
>
> Veteran Woman

> "You are released, and you are nothing (…) It's like 'thanks for the time you gave us, see you later,' and that was the end of it."
>
> Veteran Woman

Veterans' needs

What **Veterans** need you to know:

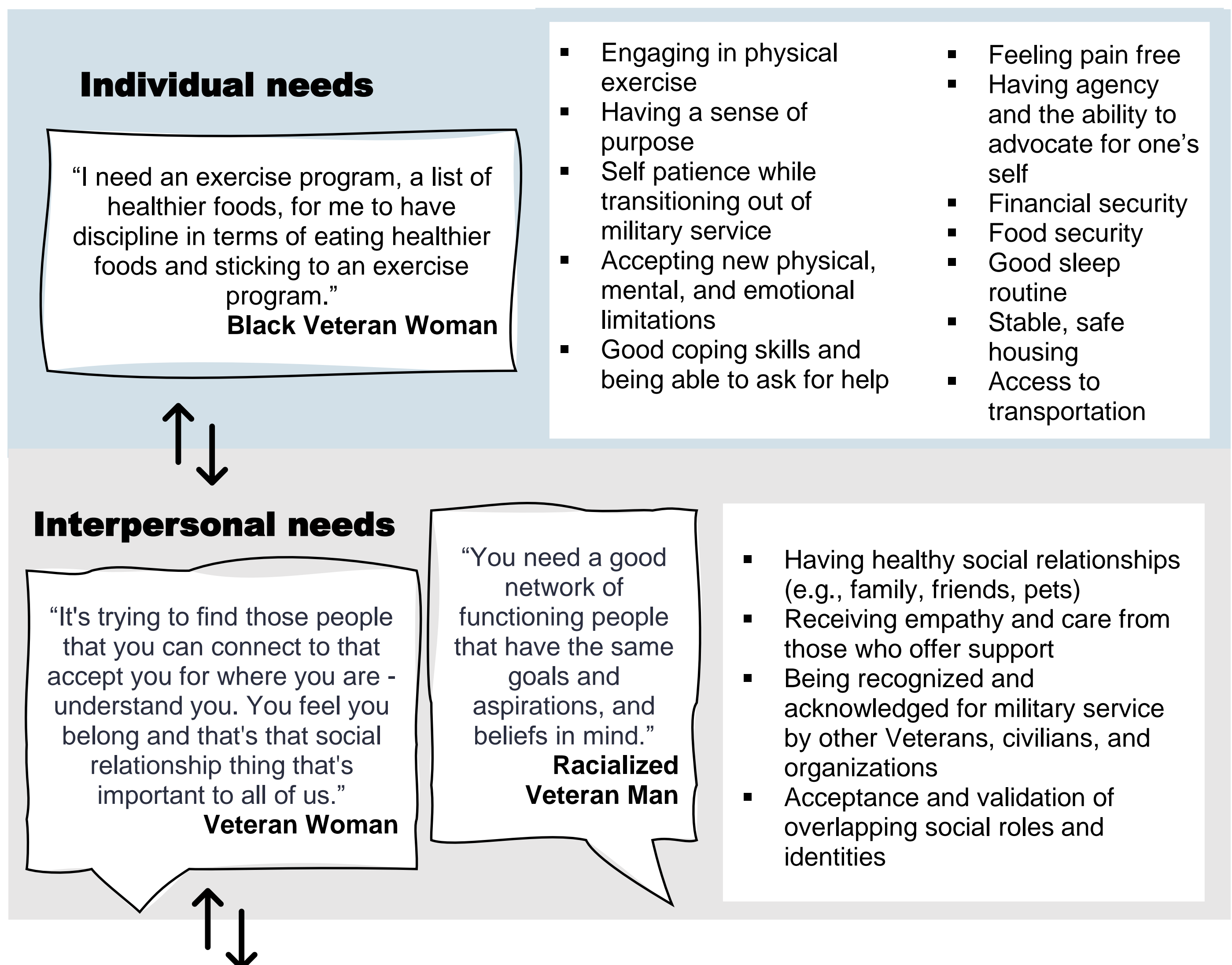
- Veterans' needs are diverse and span individual, interpersonal, community, organizational, structural, and historical levels.
- Veterans need to feel empowered and supported in their transition from military service to civilian life.
- Veterans need person-centered and streamlined bureaucratic processes.
- Veterans need community resources and organizations that have military-cultural competency and trauma-informed approaches.
- Veterans need recognition and appreciation for their sacrifices and selflessness.
- Veterans need acceptance and validation of their multiple identities.
- Veterans need organizational acknowledgement and accountability of past and current harms.

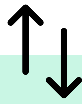
Veterans' needs are diverse and span individual, interpersonal, community, organizational, structural, and historical levels

Veterans identified a range of health and well-being needs influenced by their sex and gender, lived-experiences, family and peer relationships, communities, and organizational and societal values and structures. Veterans shared their needs were unique, but interconnected, and cumulatively contributed to their overall health and well-being outcomes.

> "Women's health is very unique, and approach is very unique, and I think again that one size fits all does not work. I think policies have to be around the unique needs of women. Men's health is unique, and then also 2SLGBTQI+ group (…) policies have to be around that."
>
> Veteran Woman

A Veteran's sense of purpose, which is often thought of as individually determined and attained, requires broader facilitators such as availability of employment, community engagement, and organizational support to be achieved. For Veterans to meet their individual needs, a number of elements (i.e., interpersonal, community, institutional, and historical) need to be considered and included.





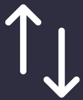
Community needs

"The feeling that you belong somewhere right when you're in the military, these are your brothers and sisters, right? When you get out, you're kind of this outsider, and then you're like, well, where do I fit into all of this?"
Veteran Woman

"I need someone who understands me. My family doctor and I talk about all kinds of stuff when I go for an appointment. It's not just about my health, it's about all kinds of stuff. And like he gets me."
Veteran Man

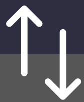
- Sense of belonging to Veteran communities
- Sense of belonging to civilian and cultural communities
- Veteran peer support
- Access to primary care providers (e.g., physician, nurse practitioner) and other healthcare providers with military cultural competency, who use trauma-informed approaches
- Employers that understand military skills can be adapted to civilian workplaces

Organizational needs



"I need to receive care that is aligned with my health problems, without needing to fight, having to explain, fill in 66 different types of papers, and to be told contradictory information from one case manager to another."
Francophone Veteran Man

- Positive interactions and support from institutions such as VAC or CAF/DND
- Simplified administrative guidelines and processes
- Transparency and accountability from organizations
- Flexible access to healthcare services and other resources (e.g., virtual care, cultural and spiritual resources)



Structural needs

- Anti-discriminatory approaches, attitudes, and policies

"It's about not having to constantly fight (…) My husband released two years ago, and I released in March and the amount of fighting for resources I have to do, versus all he had to do is say he needs a doctor. There was a doctor! Says he needs a medication. He got the medication! Whereas with me, it's like every single step of the road there's a fight. He can't believe it, and I'm sitting there like, 'yeah, I'm not surprised' (…) and I feel like it just goes back to how, whether it's Veterans Affairs, whether it's healthcare providers, whether it's the Army itself, I don't know what it is! Is it because I'm a girl? Is it because I'm not white? (…) And you know what, it's like I would have dealt with it if I didn't see how unequal it was, because I can see how my husband is treated versus how I'm treated and it's very different."
Racialized Veteran Woman

Historical needs

- Organizational acknowledgement of past and current harms, including inequities and systemic discrimination
- Organizational efforts to build trust with Veterans (including healthcare systems, communities, VAC, CAF/DND, etc.)

"If you don't have trust, you've got nothing. There's no well-being without trust."
Racialized Veteran Man

"We have to have a voice that is actually meaningfully heard with accountability from VAC for our voice. The entire system has been set up to silence us and punish us if we speak out too much. Especially on the women Veteran side. We're an inconvenient truth. We don't fit into the paradigm. We tend to whistle blow. We tend to say we want better and so we are systemically, institutionally silenced. We're not given a way to give feedback. We're not given a way to coordinate ourselves. We're not given a way to have our voice heard collectively. For me, the fact that after everything that we've been doing for as long as we have (…) We're done already. Our voice is the 15%, the 85% will always wash us out."
Veteran Woman

Veterans need to feel empowered and supported in their transition from military service to civilian life

Veterans need a sense of agency and empowerment over their health and well-being experiences, especially during transition from military service to civilian life. Some Veterans described their transition as more difficult than they expected. They recalled struggling with their sense of identity, belonging and purpose, mentioned feeling misunderstood by others and lacking community support. Several explained the challenges they had building new civilian community networks, such as finding and accessing dentists, primary care providers, massage therapists, and physiotherapists, etc.

> "There's a lot of programs out there and members getting out and Veterans are pretty much babes in the woods when it comes to like, 'well, how do I do this? Where do I go?' Almost as if you have to relearn, you have to, you know, you have to do a civilian boot camp. How to become a civilian again."
>
> Veteran Man

Many Veterans disclosed feeling unsupported and even forgotten by key organizations such as VAC and CAF/DND during their transition.

> "When I left the military, I started my release within a couple months of getting back from Afghanistan. I knew I had suffered a psychological kind of stress injury from over there from different experiences I had. But because I was being released, there was no counseling or anything available as I hadn't been diagnosed with PTSD yet. They said that I either had to be back from the tour for six months or it had to be six months after the traumatic incident to be diagnosed with PTSD. So, because I wasn't diagnosed there was no counselling available from the military or through Veterans Affairs. I really needed counselling but couldn't get it because I hadn't been diagnosed with something that was recognized."
>
> Veteran Man

Veterans who were still serving, those who had released since 2023, and those who had transitioned many years ago described not receiving adequate information and support about available civilian and VAC-related resources upon release.

> "I feel like I was dropped in the middle of the forest and there was nobody else to help me. There was no military support whatsoever, so I was by myself trying to find solutions for my mental health. I have no primary care provider anymore either. I know the military needs to shut their file, but I wish it would be a follow up."
>
> Veteran Woman

Some Veterans, especially women, saw their medication, treatment plans, and care programs interrupted after their release due to bureaucratic delays. They also reported being unable to receive diagnosis before release and/or requiring additional confirmation of diagnosis by civilian primary care providers. This meant having to wait up to a year to have their prescriptions paid for or their care plan reinstated.

> "It's been months, and I still don't have a rehab plan (…) I did have my psychologist and OT before I released from the military, and they were civilian providers. So, my VAC case manager was able to keep them on as my providers. However, there's other stuff like physical physiotherapy that I can't do until the [PCVRS] assessments are done, and they've been done for a few months and there's still no plan."
>
> Racialized Veteran Woman

By contrast, successful transitions were possible when Veterans felt empowered, both personally and with VAC and CAF/DND's support, to strategically plan their transition. Veterans described a positive experience when they transitioned without disruption to the care they received during service, had easy access to VAC coverage, and their holistic health and well-being needs were taken into consideration and supported.

> "I have had a lot of success in meeting with one of the [VAC] case managers at the Transition Center (…) I had a bit of a breakdown one day, and I was near the base. I went

to the Transition Center and talked to that person. So even just having a VAC connection somewhere on a base, is a positive thing. I'd love to see it more robust. It's a really good in-person resource."

Veteran Man

"So, when I released, I had a release interview with VAC, and it was just 10 minutes in an office before the pandemic! But they made sure I knew about my VAC account and other things. It was very worthwhile. You should get a release interview as part of your transition process from the Regular Force or Reserve Force. That VAC release interview was quite worthwhile."

Veteran Man

Many Veterans noted how important their family and friend connections were for locating resources, feeling a sense of belonging, and re-adjusting to civilian life at the time of their transition. Further, Veterans described how using their transferrable military skills for a new job/activity/volunteer/hobby improved their sense of belonging, identity, and purpose. Recently released Veterans described how VAC, and CAF/DND helped them prepare them for release through seminars and classes.

"The social aspects are all things you need to establish before you leave [service]. Strong social support net is critical (...) They [Veterans] might not have enough network to be successful in their transition."

LGBT Purge Survivor Veteran Woman

"When I released, I remember having an interview with a VAC client service agent looking at if I have any needs and those sorts of things. I did attend the [CAF] retirement session, the SCAN and those sorts of things. But I went from being in uniform to civilian within 24 hours, but I was in the same office. So, I was surrounded by a lot of resources. So, mine [release] was very seamless. I was able to get a family doc because my husband and son were civilians, and their family doc took me on. I knew the city, and we didn't move. So, it was an easy transition."

Veteran Woman

Veterans need person-centered and streamlined bureaucratic processes

Veterans need simplified and person-centric guidelines and processes that consider their holistic health and well-being. Federal and provincial government processes can be particularly hard to navigate especially for Veterans who have little to no experience dealing with administrative procedures or are facing health and well-being challenges.

> "When you come out of the military, you come from a completely self-contained ecosystem that takes care of your every need. They clothe you and tell you what to wear. They can feed you, they can house you, they pay you, they take care of your medical. They take care of your pension. They take care of your family. They take care of all your needs. Great! When you are now a civilian you have to figure out pretty much all of them."
>
> Veteran Man

Several Veterans shared feeling overwhelmed and ill-equipped dealing with multiple organizations to apply for and access their benefits.

> "When you're out, it's like, 'OK, who am I talking to? Am I talking to Blue Cross? Am I talking to my case manager?' (…) I literally don't even know where to start. There's no one person to talk to who can be like 'Oh, yeah I can help.' At the same time, having to be like 'well, who the hell do I talk to figure this form out?'"
>
> Veteran Man

Veterans suggested clarifying VAC's and insurance agencies' roles and processes, and offering automatic eligibility to benefits and programs based on service experience, thereby reducing the burden of proof on Veterans.

> "It can be really discouraging for people who are, you know, either still serving and just recently injured or people who are getting out and starting to do all the claims at the tail end of their career. It's really discouraging for people to put in claims to a system that is notorious, that compounds, and gets worse at every layer of outsourcing of resources and claims and paperwork, whether it's Blue Cross, PCVRS, Canada Life, you know, whoever the hell the next contractor is gonna be."
>
> Veteran Man

Veterans described how excessive paperwork, long processing times, and confusing language left them feeling disempowered, overwhelmed, frustrated, stressed, misunderstood, and reluctant to access care. Such feelings were typically magnified if their military release was not voluntary, and/or if they had negative service experiences, and if they were coping with chronic pain, illnesses, or traumas. Some Veterans suggested organizations adopt personable and

accessible language when communicating, and a consistent person to explain available services, and assisting with completing paperwork.

> "I'm just burned out from filling out bureaucratic forms."
>
> Veteran Man

> "New applicants with a medical issue may take months or even years to get all the paperwork required for the approval by the department because of the backlogs and slowdowns in the civilian system."
>
> Veteran Man

Several Veterans criticized over-reliance of primary care providers to support their VAC claims. Many shared experiences with healthcare providers who were unable or unwilling to complete forms. For some, this led to delays in accessing care. Some even had to pay their primary care provider out of pocket.

> "The access to a doctor [impacts] access to everything else you need for Veterans Affairs. You need, 'yes' from your doctor to go get blood pressure, or whatever checked (…) you need a doctor to have everything. So, if you don't have one, then you don't have access to medication. You don't have access to specialists, or to a psychiatrist because you can't see a psychiatrist without a referral. So, you need a doctor first."
>
> Veteran Woman

> "I know my physician will charge $250, because he's already said that's what he charges for filling out any forms."
>
> Veteran Woman

> "I have a family doctor, but he refuses to write prescriptions. Or he doesn't believe in Veterans Affairs. He's had too many issues with Veterans Affairs demanding this, demanding that, that he's basically said, if you are Veterans Affairs client, don't ask me for a massage therapy or chiropractic or anything like that."
>
> Veteran Woman

A compartmentalized approach to health and well-being created gaps in care for Veterans' holistic needs. Veterans spoke of VAC's inflexibility when their illness or condition did not conform to what they called, the 'VAC boxes.' Incomplete or missing military medical records, undocumented injuries, or symptoms that emerged years after service complicated the eligibility process, resulting in time-delays, additional costs, and denial of claims.

> “In my 12 years of service, I never got a new pair of boots of combat boots, work boots. They were always second hand and so I have severe feet issues and ankle issues to this day. But because none of it's reported, and because they didn't document all the times that I've plantar fasciitis or whatever, I can't get a claim with VAC.”
>
> Veteran Woman

Implicit bias and systemic discrimination (e.g., gender, race, age) within the military, healthcare systems, organizations, and research were reproduced through bureaucratic and/or administrative processes Veterans needed to navigate. As a result, the health and well-being of Veterans' who ‘fit’ the heteronormative image of a Veteran, were more easily accommodated than others. A few equity-deserving Veterans expressed feeling unrecognized and discriminated against while applying for or appealing disability claim decisions.

> "I was diagnosed prior to leaving by a gynecologist, and so I have applied to Veterans Affairs saying, I believe this is related to my service and I believe is directly related to my military sexual trauma (...) The UTI's I believe, is directly related to years and years of living in austere conditions, having to hold urine in, in austere conditions, you know, as a woman in the field, we couldn't just pee behind a bush (…) I applied [to] Veterans Affairs (…) They [VAC] asked me to go to my family physician to see if that physician believed that there was the correlation that I was making. But I didn't have a family doctor. And I went to a walk-in clinic and I had a doctor go, ‘I don't know you. I can't make any determinations’.”
>
> Veteran Woman

Several described their interactions and communication with VAC as confrontational, paternalistic, cold, impersonal, even punitive. The language was often described as formal and too bureaucratic, with information hard to find and at times contradictory.

> “The one aspect of dealing with VAC that I understand why, but it strips your dignity, and it's also coercive and a barrier, is almost every VAC letter, VAC form, basically goes into the penalties if you don't comply. If you don't do it [comply], you're told you'll get kicked off IRB, or your claim won't be processed, or whatever. There's always that hanging out of a punishment of some type to the Veteran, which, to be completely honest, even if you understand why, it's there, sometimes that's a little bit of a bitter pill to swallow, because you're just asking for help.”
>
> Veteran Man

> “I don't trust that if I went to Veterans Affairs with an issue that I am going to get a satisfactory outcome. I feel like when you sit down to fill out the initial piece of paper with Veterans Affairs, you have to be in the mindset for a fight.”

Veteran Man

Veterans suggested that to improve their health and well-being, organizations need to build person-centric relationships with them. Veterans suggested setting clear expectations between Veterans and organizations, adopting personable and open communication approaches, encouraging proactivity and adaptability, and improving organizational transparency. Central to this, Veterans need be active contributors to organizational strategies to improve administration, policy, and decision-making processes.

> "I got a phone call from a case manager, and she just said, 'Was thinking of you, did everything go okay? How are you going?' And that phone call, lifted my spirits up like you wouldn't believe it, it was magical. Someone took the time to ask how I was!"

Veteran Man

> "When they start a file, the case worker could explain to the Veteran 'we've got ground rules that we're gonna share. You're gonna tell me what you expect, and I'm gonna tell you what I expect.' I don't remember a conversation ever starting that way with anyone, but I wonder if that would be a huge step forward in dealing with Veterans. Just having that first conversation of what are the ground rules. [For example], 'do we understand each other?' 'I'm here to help you,' 'I'm gonna give you recommendations,' and 'If you don't take my recommendations, there's nothing I can do for you."

Veteran Man

Veterans need community resources and organizations that have military-cultural competency and trauma-informed approaches

Veterans' military experiences are unique and distinct from the experiences of most civilians. This includes combat and other traumas, injuries, and illnesses caused by military occupational hazards, attitudes and behaviors resulting from military culture and norms, or adverse experiences while serving (e.g., bullying, discrimination, military sexual trauma, LGBT Purge, etc.). Because of this, Veterans need to feel understood, validated, supported, safe and believed. For many Veterans this is achieved by engaging with healthcare providers and organizations that possess military-cultural competency and use trauma-informed approaches to care. Veterans shared that they felt greater confidence and trust in the care and support offered to them when primary care providers, healthcare providers, and organizations were empathetic and understood the nature of their military experiences and traumas.

> "I need someone who's gonna understand what I'm going through. Someone that understands that you're hurting. Somebody acknowledging that, I find, is one of the more grounding effects of my well-being."
>
> Black Veteran Woman

However, Veterans reported that many primary care and other healthcare providers do not understand Veterans unique needs, eligibility and claims processes, or how to provide trauma-informed care. Veterans felt tired of re-telling their stories, being misunderstood, and feeling stressed out, even re-traumatized from these interactions. Some Veterans described how lack of military competency led to misdiagnosis and/or delayed diagnosis, which compromised their access to benefits, treatment, and care.

> "I'm tired of having to explain this every single time. How many times do I have to relive my trauma to explain to somebody?"
>
> Veteran Woman

> "I have had to go through a lot of therapists that have actually probably caused more trauma than they have helped (…) They are not equipped to deal with women or men with military sexual trauma."
>
> Veteran Woman

Many highlighted how organizational guidelines and processes for benefit applications and reassessment are not designed or adapted for Veterans struggling with trauma, injuries, illnesses, and chronic pain. Negative encounters with staff, benefit denials, feeling like they needed to fight for their benefits, and long wait times created fear, undue stress, distrust, and often reluctance to seek and access the care and support Veterans needed.

> "If that Veteran has issues, physical, mental issues, or maybe anger issues or whatever, it would be really hard for them to navigate the system successfully because it's very complicated."
>
> Veteran Man

> "It doesn't help when you're dealing with a system that as soon as I see Veterans Affairs calling me, I almost wanna get sick to my stomach. I'm like, what are they gonna take away from me now or what are they gonna do to me now or, it might be positive. They might actually be calling to tell me something good. But the minute I see that number, I just, seriously, the bile goes right into my throat, and I want to throw up. And you get that brown envelope, right? It's like now I don't open any of my mail because of Veterans Affairs because it's like, what is it gonna say? Is it gonna say something bad? Is it a denial?"

Veteran Woman"I don't want any extra rewards or recognition. I just want to be able to access the services that I need when I need them, as a form of repayment and recognition for our services. I don't want to have to fight the system."

Veteran Man

Women Veterans highlighted the need for primary care and other healthcare providers to contextualize their symptoms, injuries, and pain to their military experience but not to forget that sex and gender factors are equally important to consider. Failure to account for a Veterans' comprehensive identities coupled with systemic discrimination increased barriers to care, misdiagnosis, ineffective treatment, and harm. Military-cultural competency and trauma-informed care must intersect with anti-oppressive approaches that counter unconscious bias, discrimination, sexism, racism, and homophobia. Competent, inclusive, and trauma-informed care are required for Veterans to access effective care and feel safe and validated.

> "They called me schizophrenic and they gave me every diagnosis in the military because they had no understanding of how PTSD in women manifest differently than PTSD in men."
>
> Veteran Woman

> "It's been very hard for the women I've talked to, to walk into an OSI clinic and discuss their military sexual trauma because they just can't connect at the same level as the men that are sitting around the circle discussing, you know, being blown up in Afghanistan or whatever. Like it's, just it's a different level of PTSD."
>
> Veteran Woman

> "I find that a lot of the support here is male dominated and you try to get help with them, but you are an outsider."
>
> Veteran Woman

> "There is a lack of culturally appropriate treatments and supports from Veterans Affairs for Métis. None exist within the current framework of the treatment benefits or any of the supports."
>
> Métis Veteran Man

Veterans need recognition and appreciation for their sacrifices and selflessness

Veterans identified a unique necessity for their health and well-being - the importance of 'recognition,' feeling appreciated for their military service, and remembrance of what their service contributed to Canadian society, historically and currently.

> "When you're a Veteran (…) you gave up certain rights when you joined to serve your country. That service needs to be recognized. It's also important to be representing those of the past, the Veterans who services in World War I and World War II to keep their legacy alive so people remember the sacrifice."
>
> Veteran Woman

Many Veterans joined the military knowing it could put their life at risk. While their service brought positive experiences, they spoke of long-lasting impacts on their health and well-being, including chronic pain or strained family relationships. Some Veterans expressed that this self-sacrifice, and what it cost them, was not well understood by civilians.

> "We generally feel as a community that we're not totally understood by the general public, and [are] under recognized for what we did and the impact it had on our lives."
>
> Veteran Man

These feelings of underappreciation, combined with disappointing release experiences and feeling unsupported by VAC and CAF/DND, could result in a sense of institutional betrayal. This was further exacerbated if a Veteran's access to care post-service was difficult.

> "I did elect to serve our country and risked my life many times. I did that thinking that perhaps maybe a decade from now, if I had problem, I would be helped."
>
> Veteran Man

Veterans need acceptance and validation of their multiple identities

Veterans need their multiple and overlapping identities to be acknowledged and validated in their interactions with families, civilians, Veteran communities, healthcare providers, and organizations.

Veterans discussed being misunderstood and facing stereotypes and stigma from civilians, other military members, and Veterans about their military experiences. These misconceptions ranged from civilians picturing Veterans as elderly white men from World War I, II, and Korea, to military members qualifying that be a "real Veteran" included being deployed to a combat zone. Women Veterans, in particular, frequently faced skepticism and comments suggesting

they were not Veterans. Additionally, equity-deserving, younger Veterans, Veterans from purple trades, and reservists also mentioned feeling marginalized within Veteran communities. This forced many Veterans to repeatedly explain and validate their military identity.

> "As a female Veteran, people don't see you (…) It can be sort of demoralizing to constantly having to reassert yourself as a Veteran."
>
> 2SLGBTQI+ Veteran Woman

> "The last time I went to mental health on the base, they said, 'oh, I'm sorry, we're busy with real Veterans that went to Afghanistan, you'll have to wait.'"
>
> Veteran Man

Women, 2SLGBTQI+, Indigenous, and Black and racialized Veterans also discussed the insufficient support and care from primary care and other healthcare providers when they didn't consider and respect their complex and intersecting identities. For some, the fear of facing denial or discrimination based on their identities led to reluctance in seeking care until it became absolutely necessary.

> "When I have gone to therapists in the past, they're either missing the Veteran perspective, they're missing the Indigenous perspective, or they're missing the LGBT perspective."
>
> 2SLGBTQI+ Métis Veteran

Veterans need organizational acknowledgement and accountability of past and current harms

Several Veterans emphasized feeling betrayed by organizations like VAC, CAF/DND. They cited a lack of support or protection during or after service as well as their role in perpetuating harassment, inequities, and systemic discrimination. For women, 2SLGBTQI+, Indigenous, Black and racialized Veterans who experienced military sexual trauma, racism, and/or the LGBT Purge, organizational acknowledgement of past and current harms would demonstrate accountability.

> "I signed a dotted line that could potentially include my life and I was willing to do that and I'm still willing to do that (…) but you guys screwed us over, betrayed us, abandoned us, rejected us and then we are left on our own to figure things out."
>
> Veteran Woman

> "Where is the compensation for the hardships that we go through as women, from not having kit that fits us, destroying our feet and back, and the sexual harassment?"

Black Veteran Woman

Many Veterans emphasized that accountability from organizations could take many forms, including formal apologies, financial compensation, commitment to ongoing change and reparation, efforts that acknowledge and honor Veterans strengths, and openly commemorating past injustices. For some Veterans, accountability included increasing research and evaluation efforts to better understand current and past harms and inequities. Veterans also suggested including Veterans in decision and policy-making processes, offering military cultural competency and trauma-informed education to healthcare providers, and simplifying service delivery processes as appropriate actions. Some Veterans identified having access to feedback mechanisms for community-based courses or Veteran programming would enable them to identify potential issues or problems to prevent perpetuation of harm.

> "It's important that we look at where inequities exist in services, whether that be through direct services from VAC or services from other organizations that are supporting Veterans."

2SLGBTQI+ Métis Veteran

> "All you do [VAC] on your report is say what we sent one hundred Veterans on this course - check mark, and yet you hurt me. There's no way for me to give feedback that you [VAC] hurt me, and you did not help me. And you keep sending more people on the course because all you do is the numbers. You're [VAC] not doing the qualitative evidence-based review. There's no accountability!"

Veteran Woman

As several Veterans mentioned, such efforts can be profoundly important for the healing of survivors, their ability to trust others, and their reconciliation or renewal of relationships with organizations.

Veterans' strengths and resources

What **Veterans** need you to know:

- Veterans' strengths positively impact their health and well-being.
- Veterans advocate for and empower their Veteran peers.
- Veterans use a variety of resources to meet their health and well-being needs.

Veterans' strengths positively impact their health and well-being

Veterans draw from a range of strengths connected to their personal and military service experiences. Veterans identified many strengths that positively impact their health and well-being. Among these were a powerful sense of duty, adaptability, resilience, fortitude, discipline, strong work ethic, camaraderie, compassion, curiosity, resourcefulness, and self-awareness.

> "I think we all joined the military because we're strong individuals and for what I stand up and fight for what I believe in!"
>
> Veteran Woman

> "My resilience is my strength. It's not because I'm 80% banged up that it stops me from working."
>
> Francophone Veteran Man

Some Veterans felt their strengths resulted from recognizing the unique value of their differences, including their military skills. They described how their unique experiences across various military occupations, coupled with their strong work ethic, made them resourceful and valuable assets in both the civilian workplace and within community organizations. Some highlighted the professional skills they gained during their military career and their ability to transfer them to civilian employment.

> "Regardless of your age or rank, you will leave the military with a higher caliber of professional skills when compared to your peers (…) I can lead people, direct a meeting, be on time. I'm a good teacher, manager and I understand complex systems of people more. How they function and how we can sort of separate and compartmentalize the way information flows around an organization, but also how the personalities affect it."
>
> Veteran Man

Other Veterans drew upon adverse or traumatic military experiences to harness change for themselves and improve their health and well-being.

> "I refuse to be dismissed. I refuse to be talked to like somebody's door mat, and especially when it comes to healthcare professionals, Veterans Affairs, or different people in government (…) I've kind of gone from in the military where, I just had to obey all their commands and take it and not push back. So now, when I see a wrong, I wanna fix it!"
>
> Veteran Woman

Many also explained how the occupational experience, military courses, and education they received while serving provided the skills and knowledge required to navigate bureaucracies, access healthcare resources, and advocate for themselves. In this way, many Veterans felt a

sense of ownership over their health and well-being. Several shared their journey of becoming their own advocate, where they found pride in their story, overcame stigma, and asked for help.

> "When you're active in an occupation, it's very difficult to advocate for yourself, especially in terms of mental health, because the stigma is real. Now that I've accepted where my pain is coming from and how to best deal with myself on the mental health side, I now have the strength, because I decided not to care anymore about that stigma, to ask for what I need. I know what I need, I just don't always know where to get it."
>
> Veteran Man

Veterans advocate for and empower their Veteran peers

Many Veterans shared that a strength they are particularly proud of is advocating for and empowering their peers with their health and well-being needs. For example, many shared they have supported peers who were experiencing a challenging transition, were vulnerable, needed assistance with day-to-day living, or struggled with administrative processes like filing taxes, applying for VAC benefits or other program resources.

> "A couple years after I was out of uniform, a dear friend of mine who we were privates together, she was being released medically with severe PTSD. I ended up flying to [where she was] for a week to physically help her through the release process, because she was that incapacitated, she couldn't have done it on her own."
>
> LGBT Purge Survivor Veteran Woman

For many Veterans, organizing and participating in grassroot initiatives became a key strength in their health and well-being. These initiatives provided purpose and built capacity in the community sector; providing other Veterans with resources and solutions that were more tailored, personable, and adaptable than those offered by larger Veterans organizations. A few Veterans explained that involvement in these initiatives gave them a sense of satisfaction, purpose, and a positive feeling by giving back. For some it also provided a sense of justice (e.g., feeling heard, recognized, validated) and self-efficacy, which in turn activated feelings of empowerment and collective agency.

> "It became my way of giving back to society and keeping me busy and giving me a reason to get up and out the house."
>
> Veteran Man

> "I built a whole new kind of community support for myself out of other Veterans that were kind of doing the same thing. It's founded by MST survivors and then we have other survivors and allies that are all working together. So, I think overall it was very positive and I think that it's, it's very powerful."

2SLGBTQI+ Veteran Woman

Some Veterans created their own community programs, and peer support networks to support their transition, feelings of isolation, and improve access to appropriate care. This included pet therapy organizations, buddy programs, military sexual trauma peer support groups, suicide-support lines, and 2SLGBTQI+ advocacy groups. These grass roots efforts helped address unmet needs within the Veteran community and fill organizational gaps in support or care.

> "We have a program here that we've set up ourselves and I have two people that come to me that got out of the military and I helped them transition through everything and I've trained them how to do the same thing."

Veteran Woman

Several women Veterans described their activism in policymaking efforts to improve overall health and well-being of Veterans. Their advocacy efforts led to building social movements directed at policy change and the development of resources for other women Veterans.

> "I have tried to be advocating in the last few years at a strategic level. I have been involved with things like the Veterans Affairs Parliamentary Committee, which is doing a study right now on the experiences of women Veterans."

Veteran Woman

Veterans also formed advocacy groups to petition for organizational accountability, compensation, enhance understanding of past and current harms, and promote wider-system-level changes. This included initiating class-action lawsuits for the survivors and victims of the LGBT Purge and military sexual trauma and seeking recognition and formal apologies for the Black Veterans who served in the No. 2 Construction Battalion. These pursuits of justice were integral aspects of healing.

> "We realized that there was no organization representing LGBT Veterans in Canada. We've formed our own group called the Rainbow Veterans of Canada, where we do education and advocacy around LGBT Veterans. We've since been engaged with a number of departments within VAC to improve the experiences of 2SLGBTQI+ Veterans."

2SLGBTQI+ Metis Veteran Man

> "The [MST] class action lawsuit really helped, and the restorative engagement piece with the Chief of Defence Staff has made such a difference. I don't want to use the word closure, but just validation."

Veteran Woman

Many Veterans expressed a desire to continue sharing their skills and insights by collaborating with military and Veteran organizations to improve the health and well-being of those who come behind them.

> "Can we be participatory? We just want to fix the problems for the people behind us. Let us help you!"
>
> Veteran Woman

Veterans use a variety of resources to meet their health and well-being needs.

Veterans rely on a variety of resources, such as networks, activities, services, and programs to meet their unique health and well-being needs. One Veteran likened the management of health and well-being to creating a roadmap. This process involved identifying and connecting with various resources and supports along the way.

Veterans shared how the resources they depended on and valued were tied to their lived-experiences, identities, and contexts. Not all Veterans relied on the same resources. Some turned to the Legion, family members, peers, primary care providers, and VAC for support; while others preferred peer support groups, alternative treatments, spiritual leaders, and pets.

> "I need a doctor, a dentist, and access to my audiologist. I also use a chiropodist for footcare, that's about it health-wise. At this point I'm not using any mental health services, I have in the past. So, I know how to access them (…) but at this point I mean, I'm not in any need of those."
>
> Veteran Woman

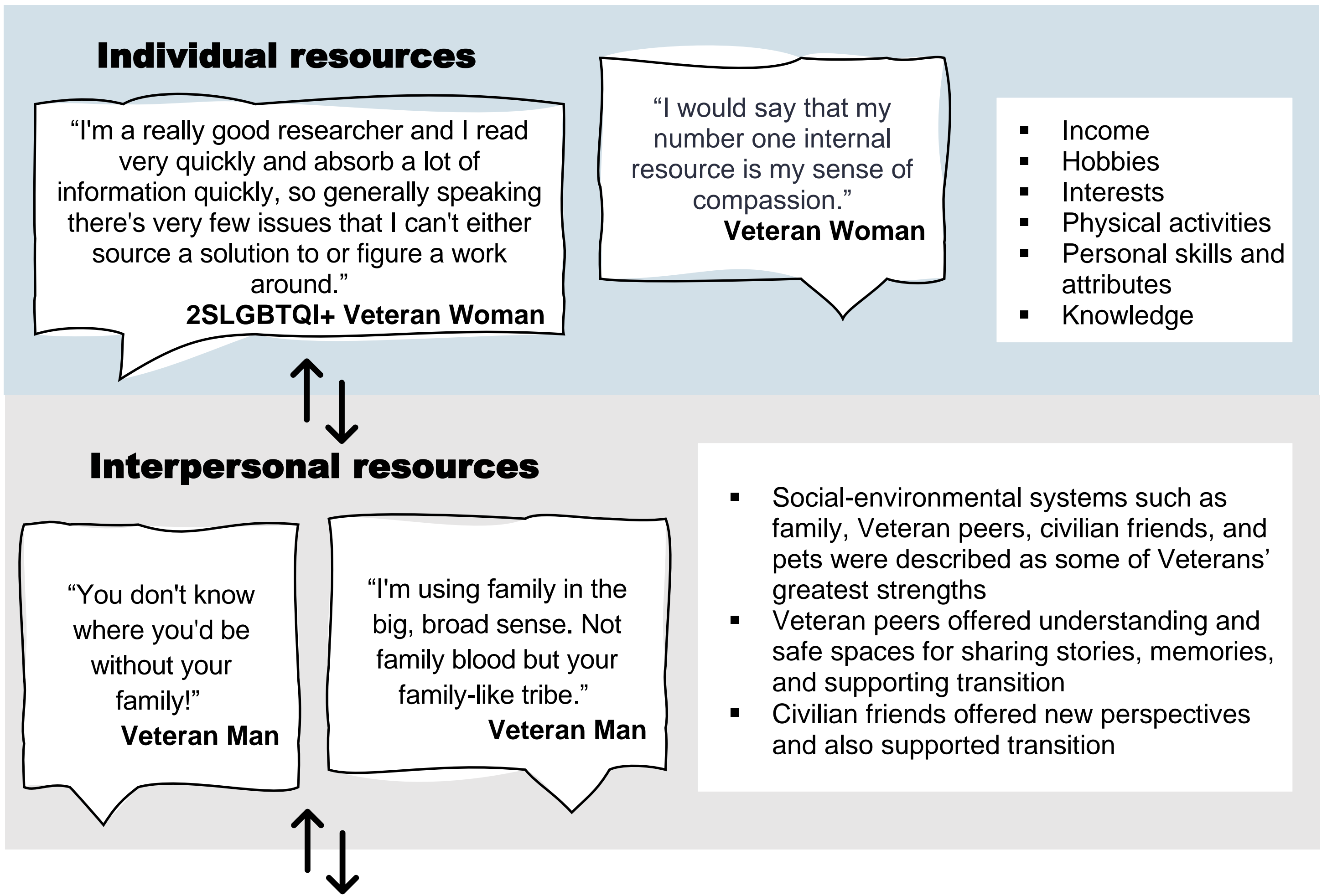
> "I try to go to different social [settings] for example, I go to the Veteran social areas like the Veterans Food Bank (…) For physical activity, I use the gym, I work out at the gym, the pool, yoga, track."
>
> Veteran Woman

Women, 2SLGBTQI+, Indigenous, and Black and racialized Veterans were seeking culturally safe resources where they could freely express their multiple and overlapping identities without denial of who they are and what they need. Having access to specialized and tailored groups such as Veteran-led military sexual trauma networks, a Black Veteran support group, and a 2SLGBTQI+ Veteran community, enabled them to feel safe, understood, and validated.

"Just having services available for people who have experienced [similar experiences]. I always had an old white man who had no idea what it was like to be a marginalized person, let alone a woman. I can talk to my military friends who are of color. And even if I didn't say the words, they knew what I was going through because they had shared experiences."

Black Veteran Woman

Veterans need, and must have, access to resources at the individual, interpersonal, community, and organizational levels that take into account their military experiences and understand the various contexts that affect their needs.

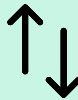


Community resources

"The biggest strength that I see and that is important to me is having access to a good supportive doctor who understands me."
Black Veteran Man

"Having connections to cultural supports post-release is really important, and that's specific to First Nation Veterans. If you connect folks with those cultural supports, then that solves a lot of problems. It helps with isolationism, and it helps with finding support within your own community."
First Nations Veteran Man

- Neighborhoods
- Local churches
- Indigenous ceremonies
- Volunteer opportunities
- Local parks
- Research and educational institutions
- Community services (e.g., libraries, grocery stores, gyms, transportation, food programs)
- Cultural and spiritual communities
- Therapeutic programs (e.g., arts-based, retreats, animal therapy)
- Advocacy networks
- Social media groups
- Primary care and other healthcare providers



Organizational resources

"If Veterans Affairs is not on board with me, then I'm not going to be successful."
LGBT Purge Survivor Veteran Woman

"The competency of those providing the resources to understand, what it is to be a Veteran, what it is to be a woman Veteran, those types of things certainly makes it easier."
Veteran Woman

- VAC
- CAF
- DND
- RCMP
- Medical insurance programs
- Provincial/Territorial healthcare systems

Several Veterans emphasized the importance of coordinating and strengthening linkages and partnerships across resources within these levels, as each have distinct functions and assets to leverage and optimize. For Veterans, increasing partnership, collaboration, and coordination requires streamlining processes, increasing awareness of supports, and clarifying roles and responsibilities. Central to this is improving knowledge exchange (e.g., user experience and military cultural competency) between Veterans, communities, and organizations. Above all, inclusion of Veterans' perspectives and lived-experiences is essential.

Facilitators and barriers

What **Veterans** need you to know:

- Veterans' access and use of resources are impacted by a variety of facilitators and barriers.
- Facilitators and barriers are dynamic, overlapping and highly contextual.

Veterans' access and use of resources are impacted by a variety of facilitators and barriers

When examining the health and well-being of Veterans, it is important to consider both facilitators and barriers to accessing and using resources. Veterans face diverse health and well-being issues that arise from their military service experiences. This means that accessible and appropriate health and support services are crucial for a successful transition to civilian life and their overall well-being.

Veterans described multiple facilitators and barriers that impacted their interactions with resources at the individual, interpersonal, community, organizational, structural, and historical levels.

Individual facilitators and barriers

Barrier: "The biggest barrier was [my] functional capacity (…) because I was very broken. By the time I got out of the uniform, I worked as a civilian for two years and I could not even answer a phone. I couldn't face people. I would just seclude myself in a part of the house (…) That took years for me to be able to pick up the phone again."
2SLGBTQI+ Veteran Woman

- Physical and cognitive abilities
- Awareness and knowledge of services, personal safety and security, personal skills (e.g., self-advocacy, coping, technology, and literacy skills)
- Employment
- Finances
- Chronic illness and pain
- Benefit and service eligibility
- Life stressors (e.g., caregiver burden)
- Military experiences

Interpersonal facilitators and barriers

- Interaction with and support from family, friends, and social networks, including Veteran communities

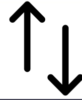
Facilitator: "My partner was a big support system. When I was struggling mentally, she was the one that contacted VAC mental health support line. She actually called them on my behalf and got me connected. So, that was a real help because I was going through a mental health crisis, and her giving me the push to ask for help, was very beneficial - and it got me on the right path."
First Nations Veteran Man

Community facilitators and barriers

Facilitator: "I'm in the city, so pretty much everything I need is around. I'm not in some remote community in the middle of nowhere. If I move back to backwoods, where I'm from, I wouldn't have the physiatrists, the physiotherapist, the shockwave therapy, the counselors available and everything else that I know is at my doorstep. So that's huge, like where I live."
Veteran Man

- Geographical residence
- Availability of personal and public transportation
- Technology (e.g., Wi-Fi)
- Healthcare providers, programs, and services – specifically flexible appointments, knowledge of military culture and trauma-informed care

Facilitator: "When your medical team actually understands the terminology and the acronyms. I know guys that have actually went and switched psychologists or social workers or psychiatrists because their session is just explaining all the different acronyms (…) If your healthcare provider knows the terminology, like my psychologist is ex-military, and he's actually sat down with all the therapists in the office that he works in and explained [the acronyms] in civilianized terms. And now they're getting past it and these guys are actually getting better help."
Veteran Man



Organizational facilitators and barriers

"Proactivity and active engagement, like if someone [at VAC] were to phone me up or send me an email once a month and check in and say how are you doing."
Veteran Man

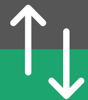
- Provincial healthcare systems
- Coordination between resources and organizations
- Increase awareness of VAC's programs, benefits, and services
- Person-centered communication and interactions with VAC and other organizations
- Streamlined bureaucratic processes

Barrier: "More transparency in the application process for Veterans to streamline and make it less of a headache, cause the application processes right now are very vague (…) I've seen Veterans say, 'you know what, I don't qualify. So, I'm not gonna bother to apply,' even though they probably do fall in within that parameter. It's just the wording on the application!"
Veteran Man

Structural facilitators and barriers

Barrier: "For women, it is really challenging to access resources because there's just not the right resources for their unique health needs."
Veteran Man

- Presence and/or absence of oppressive and discriminatory practices, military culture, and systems (e.g., homophobia, racism, colonialism, sexism, ablism, etc.)



Historical facilitators and barriers

Facilitator: "It would be conducive to the betterment of our mental and physical well-being, if we felt like somebody had our back. When you get medically released, you feel like the organization you put your heart and soul into turned their backs on you, right? So, it's not a good feeling (…) I think a lot of Veterans' health and well-being would be better off if they knew somebody had their backs."
Racialized Veteran Woman

- Organizational recognition and accountability for current and past harms
- Veterans' ability to trust others, community resources, and organizations

Canada

Improving access to primary care and other healthcare providers was identified as one of Veterans' main priorities. Depending on Veterans' strengths, needs, and context, they consistently identified a range of compounding factors that could function as a facilitator or a barrier. Descriptions of the current challenges in accessing primary care and other healthcare providers underscores the crucial need for cross-sectoral coordination among Veterans, their families, communities, and organizations. The following example demonstrates the facilitators and barriers Veterans noted when accessing a primary care provider.

Veterans identified facilitators to accessing and using primary care and other healthcare providers:

- Primary care and other healthcare providers who are familiar with military culture and employ trauma-informed and anti-oppressive approaches provided effective care.
- Availability of flexible and/or virtual healthcare options facilitated and simplified healthcare appointments.
- Consistent healthcare teams contribute to improved outcomes and streamline care experiences.
- Referrals from case managers, family members, and/or healthcare providers can assist Veterans to find a suitable primary care provider.
- Trusting healthcare services, help-seeking behavior, awareness, and knowledge of available services, coupled with self-advocacy skills and navigation of bureaucratic processes can empower Veterans to access care and support.
- Communicating health needs in their language of choice helps ensure Veterans' concerns are fully understood and addressed by primary care and other healthcare providers.

Facilitator: "For me, it was hard to find a doctor in the community that's close to us. So just out of desperation, I asked my great case manager at VAC, and she goes 'We have a list of doctors who put Veterans at the front of the line.' So, it took me two phone calls in a little town of about 15,000 people and I got a doctor right away!"

First Nations Veteran Man

Facilitator: "Right now, I have an occupational therapist and psychologist through Veterans Affairs, and have the ability to go virtual on the days that I have really low energy. So, I'm not missing an appointment. I can just go virtual and be like, I'm not wasting the physician's or the specialist's time. It's just, this is where my energy levels at and today I can't go out and make the 40-minute drive to their office. So, I really appreciate being able to have virtual services."

Racialized Veteran Woman

Veterans identified barriers to accessing and using primary care and other healthcare providers:

- Inability to find a primary care and/or healthcare provider willing to accept new patients, or who had military cultural competency and understanding of equity-deserving Veterans' unique needs.
- Lack of ability to guarantee continuity of care, even if a primary care provider was found. Veterans without a consistent healthcare team felt frustrated and fatigued when repeatedly recounting their medical history to different providers.
- Conflicts between personal schedules and clinic hours made it challenging to schedule appointments. Extensive wait times for appointments further exacerbated these challenges.
- Experiences from chronic pain, illnesses and disabilities could make it discouraging for Veterans to seek help, due to the energy required and fear that seeking help would not yield tangible benefits.
- Cumbersome administrative processes make it difficult to apply for and access benefits and services (i.e., completing paperwork and obtaining medical records from VAC/CAF/DND complicated accessing care). Providers were discouraged from accepting Veterans as patients due to the lack of financial compensation. In some cases, primary care providers requested additional financial compensation from Veterans themselves, which added to the financial burden of accessing care. VAC does not recognize all providers, resulting in Veterans having to pay-out-of-pocket.
- Increased burdens related to accessing healthcare services from rural areas, including higher transportation costs and longer travel times. The shortage of primary care providers in rural areas compared to urban settings could make it even more challenging for Veterans to find appropriate care.
- Decreased sense of trust and propensity to access resources (by Veterans) due to past adverse experiences of discrimination and racism with healthcare providers.

Barrier: "When I'm out in public with people, I don't really like people getting too close, touching me type of thing, which again makes it difficult (…) just because of the injuries. It took me 12 years to go see my family doctor for my pap smears and stuff like that because I just couldn't bring myself to do it."

Veteran Woman

Barrier: "I am obliged to always go to private resources for getting documents signed, or when I need a new prescription. I don't have financial problems, so it doesn't make me as uneasy, but I still have to pay 250 dollars for a 10-minute doctor's appointment just for him to sign my papers."

Francophone Veteran Man

Facilitators and barriers are dynamic, overlapping and highly contextual

Understanding facilitators and barriers requires a comprehensive, contextual, and interactive perspective. Veterans are uniquely positioned to offer this dynamic and grounded knowledge.

Veterans emphasized that the facilitators and barriers they encountered were dynamic, evolving over time, and influenced by their identities, personal circumstances, and lived-experiences. Organizational and structural facilitators and barriers also created challenges, such as the availability of programs and policies that incorporate an intersectional lens. Veterans' interactions in society are diverse, and some Veterans may have access to more resources than others. For example, Indigenous, Black and racialized Veterans and Veterans with multiple intersectional identities spoke of more challenges finding services to address their unique cultural needs.

> "If an individual asked to speak to an Elder and for health-related travel in order to access that, there's none available. If they are looking for a mental health provider that understands or has a greater education on Indigenous issues and how military service may have affected them, it doesn't exist. If someone wishes to be able to have support with smudging because, they do not feel they are in the position to do it through their culture themselves, there is no supports available through Veterans Affairs."
>
> Métis Veteran Man

In context, influencing factors have the ability to act as both a facilitator and a barrier at the same time. Veterans brought forward many barriers and facilitators that were interconnected and mirrored each other.

The three examples below demonstrate how the relationship between facilitators and barriers is contextual and overlaps, affecting Veterans' ability to access resources and meet their health and well-being needs.

Veterans identified how social networks could act as a facilitator or a barrier to meeting their health and well-being needs:

- **Facilitator:** Veteran social networks, such as the Legion are often regarded as a valuable resource for many Veterans, offering vital community and administrative support. Some Veterans reported that the Legion assisted them in navigating their transition and complex bureaucratic procedures with VAC. Other benefits included reduced isolation, maintaining a sense of belonging and identity, instilling pride, and offering space for talking through hardships with peers who understand.

> "When we get together once a month, like we're back on course again, and one guy says, you know, 'I got a problem with, or VAC gave me this letter. What do I do about it?' (…) We'll sit down, and we'll talk about what those problems are and how to get over those hurdles, because someone else around that table has been there and they said, 'here's what I had to do to turn it into a positive.' So, we're creating our own little network that way."
>
> Veteran Man

- **Barrier:** However, for women Veterans, the Legion was frequently perceived as exclusionary, with many reports of feeling unwelcome, and even facing skepticism about their Veteran status from certain members. Similarly, for younger Veterans, the perception of the Legion varies depending on its geographical location and financial resources. In certain instances, it may be perceived as an 'old-boys club' that potentially alienates younger generations. For some, the Legions and other Veteran networks may be overwhelming, becoming spaces of 'trauma-bonding.'

> "We would go to Legion events and right away they're assuming you know, my husband is the Veteran alone. It's frustrating when you had to constantly explain that, and then people give you these weird looks of 'what do you mean you're in the military?' It's like, 'yes, believe it or not, women can serve in the military too.'"
>
> Veteran Woman

Veterans identified how military service experiences could act as a facilitator or a barrier to meeting their health and well-being needs:

- **Facilitator:** Veterans who had a high rank upon release or who had medical or administrative occupations explained that they had a good understanding of their own health and well-being needs. These Veterans had the ability to use their bureaucratic knowledge and skills to navigate complicated organizational processes, such as VAC and insurance agencies.

  "I was a Medic in the Army, so I have my own knowledge that helps me understand some of my signs and symptoms. I also have a good knowledge of IT because I took the programmer analyst course with the rehabilitation program."

  Francophone Veteran Man

  "For example, you leave the military as a Colonel, who has been working as staff job at National Defence for a decade [versus], you're from [rural province]. You're not a High School graduate. You leave after years of honorable service for whatever reason. You both leave and your skill sets are different. You're talking about keyword indicators in an application, the ability to fill out the paperwork, navigate a bureaucracy, deal with certain kinds of people a certain way over the phone. You know what? I'm gonna say, right now, that Colonel probably got an advantage route."

  Veteran Man

- **Barrier:** For some Veterans, military cultural norms and self-perceptions of needing to be an 'ideal soldier' prevented them from seeking help and support from healthcare providers. Veterans who encountered discrimination, racism, sexism, and homophobia in service also avoided seeking help because of these negative experiences.

  "I'm quiet don't say anything, so I just keep it all down, then I don't get help even though I know I should (…) I can't go into the pharmacy to go get it [my medication]. So, I have to wait for the occupational therapist to come with me [because] I can't do it. I had a problem with the pharmacy with the K number and it just went downhill from there. So yeah (…) I was quiet and just like said, 'OK, forget it', and didn't take my medication for two months because I didn't wanna bother anybody."

  Racialized Veteran Woman

Veterans identified how VAC could act as a facilitator or a barrier to meeting their health and well-being needs:

- **Facilitator:** Several Veterans reported having positive experiences with VAC. This included helpful employee interactions, access to services and programs, and policies that enabled them to work towards meeting their health and well-being needs. Veterans described: assistance with complex application processes; friendly and easy communication via MyVAC Account; engaged and empathetic case managers; direct billing; and streamlined administrative processes. VAC employees demonstrated accessibility, compassion, understanding of military culture, and utilization of trauma-informed approaches in care provision.

    > "VAC's support. VAC's Rehab Programs and all that's available for Veterans. It has been tremendous for me; I don't think I would have survived; I think I'd be homeless if it weren't for them to be honest. I think I'd be struggling a lot."
    >
    > Racialized Veteran Woman

- **Barrier:** Veterans also provided specific examples of bureaucratic gatekeeping, such as lengthy wait times for benefits, complex eligibility criteria and administrative procedures, and lack of integration with other insurers and service providers leading to out-of-pocket expenses or gaps in service-related coverage. Veterans reported poor communication, inconsistent support, inadequate information on available benefits, and inflexibility. Negative administrative processes were also highlighted, with reports of harm from repeatedly re-telling traumatic experiences (e.g., for benefit application or reassessment processes). Veterans explicitly expressed dissatisfaction with VAC's failure to address their needs holistically, including a lack of focus on preventative care options or complementary forms of medicine like animal therapy, Indigenous medicine, or healing retreats. Lastly, Veterans emphasized discrimination and inequities within VAC; particularly concerning wait times, funding, quality of care, and resource availability to support racialized trauma, Indigenous medicine, and reproductive health.

    > "I got out and it was the worst time in my life. I was not leaving under my own terms; I was suicidal at the time, and I'm being given this stack of paperwork that I really don't understand how to fill out and a catalogue of all these injuries that I've accumulated over 20 years. At the same time, I have to figure out these forms out, but who the hell do I talk to? There was no one available."
    >
    > Veteran Man

Gaps in support and care

What **Veterans** need you to know:

- Organizations have a narrow understanding of Veterans' health and well-being.
- Gaps in organizational support burdens Veterans and the community sector.
- Equity-deserving Veterans experience inequities and discrimination when accessing care and support.
- Gaps in information about support and care leave Veterans feeling unaware of available resources.
- Gaps in coordination and continuity of support between Veterans' military release and transition to civilian life.

Organizations have a narrow understanding of Veterans' health and well-being

Veterans described discrepancies between VAC's conception of health and well-being and their own, which they perceive as multifactorial, holistic, and extending beyond their physical and mental health or the absence of disease.

They described requiring their needs to be met in a way that acknowledges the intertwined nature of their physical, mental, emotional, spiritual, social, and cultural health and well-being. Veterans felt frustrated by repeatedly having to prove eligibility for benefits, rather than automatic decision making for certain service-related conditions. This process felt exhausting and futile, particularly because Veterans know their health and well-being can not be compartmentalized.

> "VAC has to look at us as a holistic, comprehensive person, and that everything matters. It isn't just our blood pressures and cholesterols, it is our sense of loneliness, our social isolation, and all those other areas (…) I know that VAC uses the paradigm of the seven domains of well-being, but I will challenge that it needs to be updated."
>
> Veteran Woman

Veterans noted that social prescribing, preventative care, and/or complementary forms of medicine (e.g., animal therapy, service pets, or cultural healing retreats) were not VAC-approved resources or treatments. They also emphasized the lack of support for their social, reproductive, oral, financial, and spiritual health and well-being, which they felt should include support for their families (including blood relation and chosen family). Several Veterans shared that they would welcome VAC's involvement to help reduce Veterans' social isolation by engaging in solutions to strengthen a sense of belonging in their communities.

VAC's eligibility criteria are not flexible, holistic, or adaptable to Veterans' evolving needs. As previously stated, a Veteran's injuries, illness, and chronic pain may emerge or accelerate several years after their military service. Some Veterans found it challenging to apply for service-related benefits if injuries and conditions had not been reported or documented on their health record during service or upon release. Benefit claim denials often left Veterans feeling invalidated, unrecognized for their service, and betrayed.

> "I personally I think the default is to deny the claim right off the bat because most claims do get denied. Then the Veteran has to start through on the appeal process."
>
> Veteran Man

Gaps in organizational support burdens Veterans and the community sector

When Veterans identify a deficiency in resources or services within the Veteran community, they often attempt to address this gap themselves, through advocacy and support initiatives. While participation in those initiatives can be empowering, it can also be disempowering. Constant barriers, denials, and challenges from various organizations and communities can lead to activism burnout. Several women Veterans voiced ongoing fear and safety concerns about being in public and virtual spaces (e.g., death threats). This resulted from them speaking out to express their needs, share their gendered stories, and denounce the sexual discrimination and misogyny they experienced while serving, and as Veterans.

> "I was harassed. I've been stalked. I've been threatened. I've had, you know, death threats. I've been online harassed, to have to get lawyers."
>
> Veteran Woman

Veteran advocacy groups and grassroots community supports have limited financial and human capacity. They can easily be overwhelmed by an increase in demand from Veterans who are in need. This demand has created bottlenecks in service, where individual Veterans or small groups will step in to close the gap. This puts an emotional and financial burden on Veterans whose health and well-being may already be taxed. These gaps stem from systemic problems

and inequities, making them unrealistic for any single individual or small group to solve. This underscores the need for integrated and collaborative systemic change.

> "It's embarrassing. We have Veterans being called to help Veterans instead of having a medical organization or Veterans Affairs having these services."
>
> Veteran Woman

This lack of organizational support and resources requires some Veterans to access third party agencies. While many groups are well-established, some Veterans were concerned with the lack of evaluation processes in place for them to provide feedback on their experiences with third party agencies. Without feedback mechanisms, Veterans may be at risk for potential harm due to a lack of oversight and regulation.

> "You've got all these programs being thrown out there, but they're just cash grabs, and so the Veterans get caught up in these and not everybody knows how to research if this program is truly a Veteran funded group. People keep going to these [third party] groups and they get more and more injured because there are people out there that are not qualified in our area."
>
> Veteran Woman

Equity-deserving Veterans experience inequities and discrimination when accessing care and support

Historic and ongoing systemic discrimination in civilian healthcare systems, military organizations, and Veteran organizations can contribute to an unequal distribution of resources. Women, 2SLGBTQI+, Indigenous, Black and racialized Veterans can be impacted more than others.

Some Veterans shared that they experienced discrimination and inequities in their interpersonal relations, interactions with health and social programs and services, and through implicit biases within research and policymaking frameworks. As a result, these equity-deserving Veterans described a lack of community and organizational resources to meet their various health and well-being needs.

> "There are no resources for me, and every time I go some places, they're like, 'you know what? I've never dealt with someone like you.'"
>
> Black Veteran Woman

Veteran-based community resources and networks were often described as exclusionary and uncomfortable. Some Veterans said these experiences left them feeling invalidated, misunderstood, silenced, and dismissed.

> "Like if you go to a Legion, it's not really friendly for me. You know it's more friendly for my husband. Umm, so your kind of an outcast, and then you're kind of an outcast in women's groups as well because they're not catered towards military women. So, you just end up kind of isolated?"
>
> Racialized Veteran Woman

When accessing care, equity-deserving Veterans shared negative medical experiences. Women, Indigenous, Black and racialized Veterans described having their concerns minimized by healthcare providers. This led to delayed diagnosis and/or misdiagnosis and these Veterans feeling invalidated, and constantly having to re-tell their story. They also discussed insufficient support from healthcare providers in comprehending and delivering appropriate care that aligns with their complex and intersecting identities.

> "I know that other Black Veterans that have been in service for a long time (…) they're saying sometimes they feel that they are not heard or understood as well as they could be because, because they are, because they're Black. I know from a health perspective I find that sometimes the treatment has been given to members of our community, is different from members of the other communities (…) Listening to what other Black Veterans are saying, they find sometimes that when they go into healthcare, that they're somewhat dismissive."
>
> Black Veteran Woman

Equity-deserving Veterans also emphasized unequal treatment by VAC as compared to their white, hetero, cis-male counterparts. Veterans, regardless of time since release, noted longer wait times, discriminatory comments, and inadequate cultural understanding. Veterans said that the lack of support for Indigenous healing approaches, resources to address colonial and racialized traumas, and women's reproductive health, made them hesitant to seek assistance from VAC (e.g., applying for benefits). This gap in trauma-informed, culturally sensitive, and inclusive resources, exacerbated Veterans' health and well-being disparities.

> "I'm afraid to ask because I always fear getting rejected, but you know, that's just how I am. So, I just let it go and think, let's see. That's it. It's the fear, the fear of being rejected, you know."
>
> Francophone First Nations Veteran Woman

Gaps in information about support and care leave Veterans feeling unaware of available resources

Veterans highlighted a pervasive lack of knowledge and awareness regarding available resources. They often described the process of searching for support and resource information as overwhelming, challenging, and confusing.

> "Not enough information out there! I didn't know what I was entitled to being at one hundred percent (…) I don't know what all the benefits are, and they say, 'grid A,' 'grid B' and it's mind boggling!"
>
> Veteran Man

Many Veterans emphasized the need for accessible information about their eligibility for VAC benefits and insurance coverage. Many Veterans expressed uncertainty about entitlements, benefit application, and reimbursement procedures. They found language and information about services to be confusing, and inconsistent.

> "I still am not entirely sure what my VAC Blue Cross card does, no matter how many times I've gone to a website, no matter how many times I've talked to somebody, I still don't know!"
>
> Veteran Man

Both recently and long released Veterans described transitioning from military service without adequate support or information about available Veteran community and organizational resources. They said the information they were provided upon release was not necessarily tailored to their needs.

> "The knowledge available to military members, even considering leaving the military is grossly inadequate."
>
> Métis Veteran Man

Several Veterans shared that they often relied on social media (e.g., Facebook groups), web searches, peers, and Veteran community groups to find information. However, a few shared concerns about misinformation, scams, and distrust when using these networks. Older Veterans highlighted difficulties with using technology and social media.

> "There's only like a couple different ways to get the knowledge of the resources, and that's either through one of a few niche organizations like the Legion or VTN, or by other Vets who have been through it. We don't have a big influencer network (…) there's like a couple Facebook groups, and one Reddit."
>
> Veteran Man

Gaps in coordination and continuity of support between Veterans' military release and transition to civilian life

Veterans called attention to poor or non-existent organizational coordination as they transitioned from service to civilian life, especially those who had pre-existing chronic physical and mental health issues. Finding a primary care provider following release to ensure continuity of care and access to medication was a key challenge for these Veterans.

Policies restricting the sharing of Veterans' personal information and a lack of official communication channels between healthcare providers, insurance agencies, CAF, and VAC resulted in breaks in care and treatment for some Veterans.

> "There are some incredible delays for decisions to be made about your rights, especially when you've just come out, many people complain about waiting six months, seven months, and even me, for nine months. I stopped psychotherapy treatments because VAC took ages to decide whether I was entitled to it or not."
>
> Francophone Veteran Man

Many Veterans described the gaps in organizational coordination as one of their greatest challenges during their transition. It created uncertainty, stress, and frustration that negatively impacted their health and well-being. Numerous Veterans highlighted difficulties in coordinating with CAF/DND to transfer their medical records, and with VAC and insurers for reimbursements.

> "If I need mental health and I have to pay out of pocket for it, I have to go back and claim it with VAC. And VAC says you only have XYZ number of dollars per year for mental health resources. For a psychiatrist, for example, the initial appointment free could be like 250 dollars. Then you only have minimum 75 dollars for every visit after that and that doesn't cover the whole thing (…) Or VAC will say, after you've seen the doctor, 'oh he's not recognized as one of our service providers.' And I've seen that over and over again. But to get that doctor who just moved to nowhere land, because that's where I live, to get identified and recognized with Veterans Affairs, is a challenge."
>
> Inuk Veteran Woman

Some Veterans were reluctant to access support due to a lack of knowledge and clarity of the roles and responsibilities between organizations, programs, services, and networks.

> VAC, Blue Cross and PCVRS are meant to be working together. However, they often contradict each other. The lack of centralization, streamlining and coordination when dealing with VAC becomes a major obstacle. Even for me, and I'm used to working with bureaucracies. It becomes a mad house!"
>
> Francophone Veteran Man

Many Veterans struggled to find support that met their health and well-being needs as they transitioned. Some Veterans expressed feeling unsupported or forgotten by VAC and CAF/DND.

> "We need detailed coordination between DND and Veterans Affairs for a seamless transition from CAF to Veterans Affairs Services, meaning every single benefit and service that a member is receiving in the military must be set up through Veterans Affairs before the release date."
>
> Veteran Man

Some Veterans felt that more education and preparation for transition years prior to military release was needed. Several regretted attending the SCAN seminar right before their release, finding it challenging to assimilate new information all at once or learning they could have been better prepared for transition. Some Veterans also asked for courses about how to navigate bureaucracies and administrative procedures.

> "I was frustrated because when I went to my scan seminar, I was like, I could have been going to school this whole time? I didn't know that (…) So, I released and I was just out on my own. There's no one on the receiving end to help me. Yeah, it was a culture shock."
>
> Veteran Man

Consistently Veterans emphasized the importance of involving their families and friends in the development of transition strategies and post-release plans. Several Veterans also stressed the necessity to integrate civilian actors, networks, and organizations early in the release process to help them "deprogram" from the military world and "reprogram" into the civilian world.

> "We purposefully stayed [here] because [my partner and I] knew that's where all our friends were (…) We took to heart the SCAN seminar and went through the questionnaires and really analyzed where we wanted to be and for now that's here, because we wanna be close to friends. Because that is part of our network."
>
> Veteran Woman

Wrap-up of findings

Organizations, such as VAC and CAF/DND, have traditionally relied on Veteran population level findings (e.g., Statistics Canada surveys, large Veteran data sets) to inform service delivery and policy development to meet Veterans health and well-being needs. The CHNA embraced complexity and use a mixed-methods approach to identify what Veterans' health and well-being outcomes are, and why and how Veteran's conceptualize and understand their health and well-being.

Veterans told us that they loved participating in this research, and we have received positive messages of support and constructive feedback from them about their engagement in the CHNA.

“I'd like to thank you deeply for giving us the right to speak, but above all I'm grateful to see that what has been said is already bearing fruit and is being recognized for what it is, rather than being interpreted.”

“I loved the welcome and understanding of the person who questioned me. I could feel all her consideration for Veterans like me!"

“The Community Health Needs Assessment sounds great, and this is an approach that is long overdue to understand Veterans' health and well-being.”

Strengths, needs, and opportunities

In the following sections, findings from all our mixed-methods are brought together to highlight key strengths, needs, and opportunities for change.

Strengths

- Veterans have a good understanding of their health and well-being needs and what works for them.
- Veterans embrace their lived-experiences and personal skills to harness change.
- Veterans feel a sense of ownership over their health and well-being, while being aware of their abilities and limits to influence change for themselves.
- Veterans display many attributes that promote and protect their overall health and well-being, including managing life stressors and navigating bureaucracies, financial security, technical literacy, and help-seeking behaviours.
- Veterans advocate for and empower fellow Veterans.
- Veterans benefit from interaction with and support from their families, friends (civilian and military), and other social networks.
- Veterans lean on close interpersonal relationships to help navigate transition; maintain a sense of belonging, identity, purpose, and pride; and overcome hardship.
- Veterans have a strong sense of duty towards their community and desire for community belonging (especially compared to civilians).
- Veterans self-organize through support networks to address unmet needs and fill-in for organizational gaps.
- Veterans' networks can provide prompt and personalized support for Veterans, involving governmental and community-based supports.
- Veterans benefit from having had access to comprehensive medical care (including dental) while serving in the CAF.
- Veterans benefit from the education they received while serving in the CAF, including informal and formal training.
- Veterans have access to an array of supports through VAC, including education, employment, financial, and treatment benefits (dependent upon eligibility criteria).

Needs

- Veterans need a sense of purpose, belonging, and connection in their community that decreases their overall sense of isolation.
- Veterans need recognition that their health and well-being needs are holistic and evolving.
- Veterans need to be able to include their families and/or support networks in communication, approaches, and efforts concerning their health and well-being.
- Veterans need improved access to a wide range or primary care providers, beyond primary care providers, who understand military/Veteran culture.
- Veterans need to be heard and to feel understood by those involved in supporting their health and well-being.
- Veterans need to feel empowered and supported in a transition process that connects them with the broader Veteran community and ensures continuity of care.
- Veterans need recognition for their service through commemorative initiatives that increase public awareness of their diverse identities and experiences.
- Veterans need better coordination among organizations, including CAF, VAC, provincial/territorial healthcare systems, and insurance agencies to promote continuity in meeting needs across the life course.
- Veterans need access to up-to-date information about benefits and community resources that is easy to understand and is readily available.
- Veterans need services and support that are person-centric, trauma-informed, culturally sensitive, easily understood, streamlined, flexible, transparent, and accountable.
- Veterans need to understand their health and well-being through access to research and results that adequately represent the uniqueness and diversity of the community.
- Veterans need to be engaged in the development of policies to ensure their diverse strengths and unique needs are reflected.
- Veterans need organizations to acknowledge their role in current and past harms.

Opportunities for change

Level	Opportunities
Individual	• Involve families/support systems in health and well-being journey. • Participate in research and/or opportunities to advise on policy. • Share history and experiences with healthcare providers to assist their understanding and ability to support. • Begin planning for healthy aging at transition.
Interpersonal	• Increase self-awareness of resources and services available for families and Veterans. • Share knowledge of community/provincial/territorial resources. • Participate in programs available for Veteran families. • Seek opportunities to be involved in Veteran communities.
Community	• Increase efforts to collaborate with other community stakeholders to create awareness and identify synergies. • Commit to creating safe and inclusive environments that support health equity. • Regardless of mandate, consider use of holistic assessments to accurately understand needs and set goals. • Communicate with Veterans and other stakeholders in an open, honest, and transparent manner.
Organizational	• Where bureaucratic processes cannot be eliminated, transfer the burden from Veterans and their families to the organization to increase usability. • Evaluate programs and initiatives using pre-identified measures and indicators based on evidence. • Provide education and training to organizations, primary care and other healthcare providers on Veterans' health and well-being including military culture and trauma-informed approach. • Introduce models to support aging in the right place for all Veterans beginning with transition.
Structural	• Reduce reliance on primary care providers for application processes and healthcare access. • Implement participatory approaches in research, policy development and program planning. • Increase ability to understand Veterans' strengths and needs compared to the Canadian population. • Investigate comprehensive care approach that includes input from interdisciplinary professionals/providers to support Veterans' needs.
Historical	• Acknowledge past and ongoing institutional harms and systemic discrimination. • Increase efforts to evolve Canadians' understanding and recognition of Veterans' diversity and contributions.

Conclusion and next steps

The Veterans' Well-Being Community Health Needs Assessment answered, "What are the health and well-being strengths and needs of Canadian Veterans?" and employed a new approach to highlight priorities, inform decision-makers, and support the allocation of resources. The Veteran community **identified many strengths and offered insight into the priorities required to overcome barriers and challenges to address their needs**.

The Veteran community is growing increasingly diverse, and Veterans from equity-deserving groups face unique challenges that may result from lived-experiences, military service, or from broader social injustices. This speaks to the need **to identify and reach equity-deserving Veterans** now to ensure the provision of culturally sensitive and safe services and to promote health equity for all.

For Veterans, health and well-being are holistic and include a combination of physical, mental, emotional, spiritual, social, community, cultural, economic, and environmental factors that interconnect and evolve across their life course. Health and well-being also include notions belonging and isolation within Veteran and civilian communities. This understanding is important **to inform the development of new health and well-being measurement indicators** and points to the need to embrace frameworks that include a multilevel conceptualization of health and well-being.

Veterans told us that health and well-being cannot be regarded, assessed, or addressed using a one-size-fits-all strategy; instead, tailored approaches that are flexible, responsive, and contextual to Veterans are required. Listening to Veterans enables us to uncover their real needs, leverage and build on their many strengths, and **to develop and strengthen partnerships at the community, provincial/territorial, and federal levels** to **improve service, programs, and policies**. To achieve this, collaboration with and among the Veteran community is fundamental.

Next steps

Moving forward, it is vital to communicate the CHNA results and support knowledge translation to Veterans and stakeholders. This will promote the understanding of findings and support the ability to act on priorities. Importantly, ongoing evaluation of the CHNA's intended outcomes is required, including identification of new well-being indicators, and assessments and methods for measuring Veterans' health equity (e.g., health equity impact assessment).

It is imperative that Veterans are active participants in research, policy development, and decision-making concerning their health and well-being. These efforts will benefit from approaches that center Veterans' lived-experiences, intersectionality, and enable comparative analysis to advance a holistic view of Veteran health and well-being.

The Veteran community, including Veterans and stakeholders, must continue to work together…we cannot do this alone.

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Technical appendices

Appendix A – Project governance

The 2021 Minister of Veterans Affairs and Associate Minister of National Defense Mandate Letter identified that a priority for VAC was to provide services and benefits necessary for the physical, mental, and economic well-being of Veterans and their families that are easily accessible, responsive, and available in a timely manner.

To contribute to the Minister's Mandate, the CHNA, a grassroots initiative led and designed by two nursing leaders, aimed to identify, and better understand the health and well-being strengths and needs of Canadian Veterans, including equity-deserving Veterans. This assessment was a joint initiative between the Health Professionals, and Research and Policy Divisions at VAC. Planning began in November 2022 with final reporting in March 2024. The project was funded through an investment proposal that enabled the onboarding of research team members.

Project status was awarded to the CHNA through VAC's Departmental Project Management Committee, and was subject to the Government of Canada Directive on the Management of Projects and Programmes and conducted under legal authority from Section 7 of the Financial Administration Act for Public Opinion Research (non-contracted). Applicable standards set out by Appendix C of the Government of Canada Directive on the Management of Communications and Government of Canada standards for conducting contracted public opinion research were applied throughout all phases of the project. Notice of plans for public consultation was posted on the Consulting with Canadians webpage.

A departmental project charter approved and monitored the CHNA's scope of work, including the activities and resources required for implementation. These included project planning, engagement of the Veteran community, data collection and analysis, summary of findings, recommendations, and reporting results to Veterans and stakeholders.

Project objectives and outcomes

The CHNA had three objectives relevant to all Veteran stakeholders:

1. Highlight priorities for Canadian Veterans' health and well-being
2. Inform decision-makers
3. Support the equitable allocation of resources

We achieved our objectives by establishing clear outcomes in the CHNA pre-planning phase and by evaluating progress throughout implementation. While a full evaluation was not within the scope of this project, a process evaluation was conducted. Indicators associated with each process outcome are listed below.

Outcome 1: Identification of the health and well-being strengths and needs of Veterans

- ✓ A comprehensive CHNA report.
- ✓ Tailored summaries of the CHNA results that are accessible to Veterans, service providers, decision-makers, policy makers, researchers, and stakeholders.

Outcome 2: Partnership development with Veterans by providing safe spaces to be heard and understood, and with stakeholders to promote health and well-being

- ✓ Acknowledgement that Veterans own their own health and well-being.
- ✓ A trauma-informed, person-centric, participatory approach.
- ✓ Active engagement with key Veteran stakeholders to build trust, seek expert advice, and facilitate implementation of best-practices.

Outcome 3: Inclusion of equity-deserving and hard-to-reach Veterans' experiences, perspectives, and language

- ✓ An innovative mixed-methods research approach informed by research paradigms rooted in social justice.
- ✓ Collaboration with community partners to create awareness, facilitate targeted outreach, and promote recruitment of equity-deserving Veterans.
- ✓ Establishing relationships with Veterans from equity-deserving groups that have historically been underrepresented or are hard-to-reach.

Outcome 4: Better informed policies, research, programs, and services

- ✓ To report findings in an accessible way.
- ✓ A comprehensive overview of resources available for or used by Veterans to support their health and well-being.
- ✓ A knowledge translation plan to support the dissemination of findings, promote understanding of evidence, and mobilization of recommendations.

Outcome 5: Consideration of evolving health and well-being measurement indicators for Veterans

- ✓ Review of the existing frameworks used to measure or support Veteran health and well-being.
- ✓ Reflection on how Veteran health and well-being is conceptualized, understood, and approached holistically.
- ✓ Reflection on evolving strengths, needs, and priorities of Veterans, supporting CHNA to be conducted on a cyclical basis.

Process evaluation

A participatory approach has been highlighted in the literature as key to creating a comprehensive and inclusive assessment of community health and well-being.[127] Throughout the CHNA, we engaged the Veteran community to foster partnerships and include Veterans and stakeholders in the design, implementation, and evaluation of our research. Furthermore, we encouraged and welcomed input from Veterans and stakeholders which allowed us to evaluate our processes and make modifications, as necessary. When asked to share their thoughts on participating in data collections and engagement efforts, Veterans and stakeholders responded with countless messages of support and positive feedback.

'"I'd like to thank you deeply for giving us the right to speak, but above all I'm grateful to see that what has been said is already bearing fruit and is **being recognized for what it is, rather than being interpreted**. I loved the welcome and **understanding of the person who questioned me**. I could feel all her consideration for Veterans like me!"

"The Community Health Needs Assessment sounds great, and this is an approach that is long overdue to understand Veterans' health and well-being."

Lessons learned

This section outlines lessons learned by the CHNA Team during the planning and implementation phases of the CHNA. While not exhaustive, here we highlight challenges encountered with project and bureaucratic processes, provide a brief analysis of the nature of these challenges, and offer suggestions to better facilitate and support participatory work in the future.

Bureaucratic processes and risk aversion can hinder the implementation of grass-roots initiatives and novel research approaches.

- Complex and lengthy internal processes delayed initiation of Veteran engagement and research activities which significantly impacted project timelines. Examples include establishment of appropriate authorities for quantitative and qualitative data collection and communication with Veterans and stakeholders, and research software procurement.
- Clear and documented approval process activities and timelines, increased accountability, and coordination between project and departmental teams could have mitigated these delays.

➢ To effectively implement grass-roots initiatives and novel research approaches with the Veteran population, organizational leadership needs to increase trust in evidence-based methods, adapt existing processes to achieve agile project implementation and management, communicate and clarify expectations of employees' roles and

responsibilities in this change. Implications include improving service delivery and impacting health and well-being outcomes for Veterans.

The CHNA's impact may be limited by the project's scope, in that temporary resources were used to conduct the assessment and communicate results.

- Early in the project planning phase, an investment proposal was approved to fund the project's temporary staff salaries and limited operational expenses.
- Costs for in-person data collection, research software and student resources, and knowledge translation activities were not included in the investment proposal. Instead, approved communication tools (i.e., MS Teams) were used to collect data virtually. This resulted in unanticipated benefits for the Veteran participants and recruitment efforts. For example, Veterans participated in interviews and focus groups at their choice of location and did not have to travel to an unfamiliar environment. Virtual participation also enabled Veteran recruitment to be national in scope. Software and student term costs were mitigated through divisional budgets. However, knowledge translation activities for the Veteran community and stakeholders will be limited to electronic distribution, which limits the mobilization of findings.

➢ To effectively budget for future CHNA projects, a detailed expense report recorded during project implementation should be used. In addition, best practice for CHNAs recommends a cyclical approach (i.e., repeated every three years) to allow sufficient time for planning and partnering with the community, implementation, and knowledge translation activities. Assessment of Veteran's health and well-being on an ongoing basis enables VAC to leverage Veterans strengths and support their needs.

Availability and access to current and relevant data is critical to successfully complete a CHNA.

- Through VAC and Statistics Canada's data sharing agreements, publicly available 2021 Census data tables and the 2022 CVHS data file were used to analyze and paint fulsome picture of the sociodemographic health, and well-being status of the Veteran population, including women, 2SLGBTQI+, Indigenous, Black and racialized Veterans.
- The CHNA Team's access to these data sets occurred later during implementation than was anticipated, reducing time for analysis and interpretation.

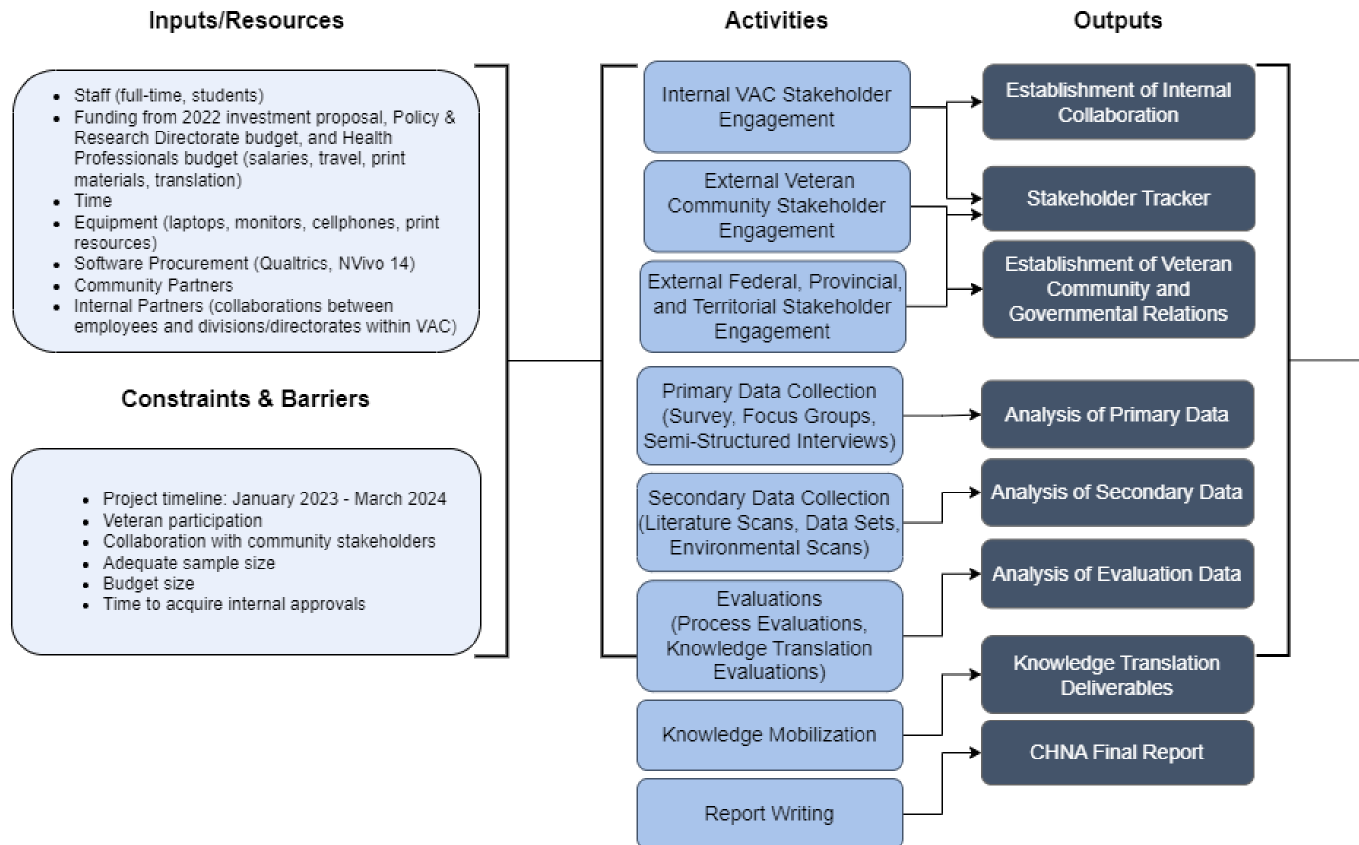
➢ To ensure availability and timely access to Veteran population data, future iterations of the CHNA should account for Census and CVHS research cycles.

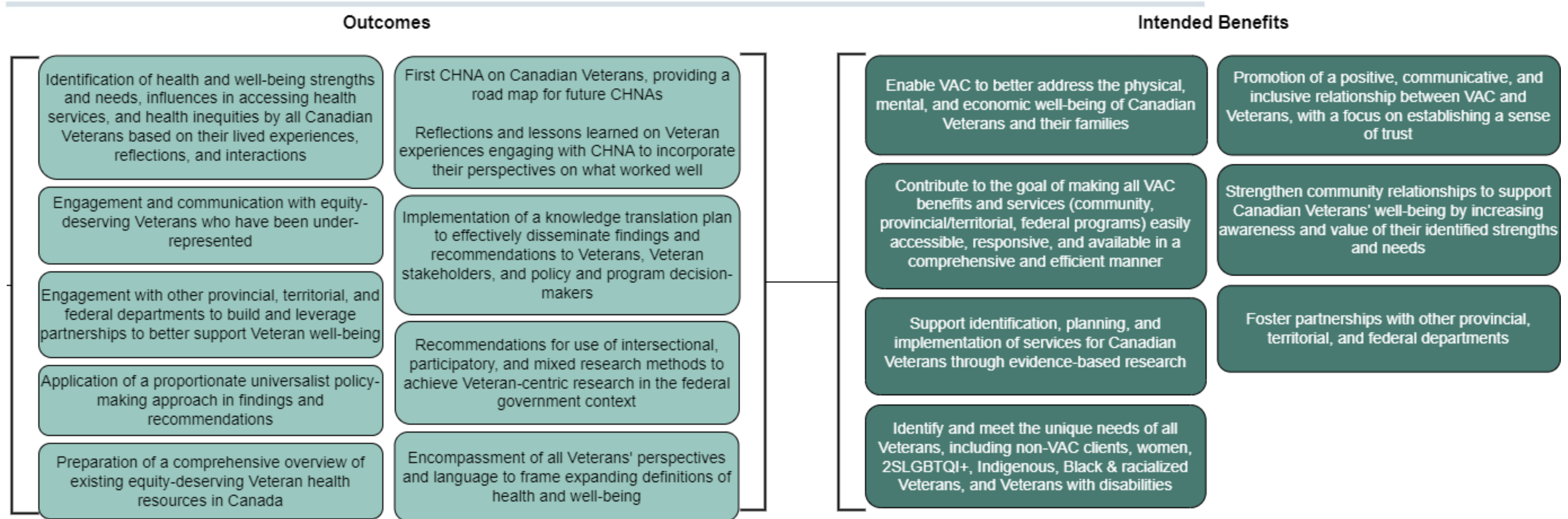
Commitment to the CHNA process and mixed-methods research approach facilitated a successful initial VAC needs assessment completion and enabled partnership building with Veterans and stakeholders.

- The original 12-month project timeline accounted for the planning, implementation (including mixed-methods research processes), and reporting of findings for a CHNA process. However, the workflows, approvals, resources, and partnerships required to achieve this were in many cases lacking or did not exist. To facilitate Veteran, internal and external stakeholder buy-in, navigation of workflow and approval processes, and to procure essential research software, a three-month project extension was approved.
- Despite these collective challenges, the first ever Canadian Veterans CHNA was completed, and Veterans and stakeholders reported having positive experiences during engagement and in the participatory, intersectional, SGBA+ research process. Mitigation of the identified challenges for a future CHNA would enable a one-year project timeline.

➢ To facilitate and promote partnership and trust building with Veterans, the Veteran community, and stakeholders, a commitment to inclusive Veteran engagement, intersectional and SGBA+ research methods, and the CHNA process is essential.

Appendix B – Logic model




Outcomes
Identification of health and well-being strengths and needs, influences in accessing health services, and health inequities by all Canadian Veterans based on their lived experiences, reflections, and interactions
Engagement and communication with equity-deserving Veterans who have been under-represented
Engagement with other provincial, territorial, and federal departments to build and leverage partnerships to better support Veteran well-being
Application of a proportionate universalist policy-making approach in findings and recommendations
Preparation of a comprehensive overview of existing equity-deserving Veteran health resources in Canada
First CHNA on Canadian Veterans, providing a road map for future CHNAs
Reflections and lessons learned on Veteran experiences engaging with CHNA to incorporate their perspectives on what worked well
Implementation of a knowledge translation plan to effectively disseminate findings and recommendations to Veterans, Veteran stakeholders, and policy and program decision-makers
Recommendations for use of intersectional, participatory, and mixed research methods to achieve Veteran-centric research in the federal government context
Encompassment of all Veterans' perspectives and language to frame expanding definitions of health and well-being
Intended Benefits
Enable VAC to better address the physical, mental, and economic well-being of Canadian Veterans and their families
Contribute to the goal of making all VAC benefits and services (community, provincial/territorial, federal programs) easily accessible, responsive, and available in a comprehensive and efficient manner
Support identification, planning, and implementation of services for Canadian Veterans through evidence-based research
Identify and meet the unique needs of all Veterans, including non-VAC clients, women, 2SLGBTQI+, Indigenous, Black & racialized Veterans, and Veterans with disabilities
Promotion of a positive, communicative, and inclusive relationship between VAC and Veterans, with a focus on establishing a sense of trust
Strengthen community relationships to support Canadian Veterans' well-being by increasing awareness and value of their identified strengths and needs
Foster partnerships with other provincial, territorial, and federal departments

Objectives

- Highlight priorities for Canadian Veterans' health and well-being
- Support the allocation of resources
- Inform decision-makers

Resources

- Staff
    - Project initiatives manager
    - Lead researcher
    - Data collector/analyst (x3)
    - Students (x6)
    - Executive assistant
- Funding (salaries, travel, software subscriptions)
    - 2022 Investment Proposal
    - Policy and Research Directory Budget
    - Health Professionals Budget
- Time (*See Constraints and Barriers*)
- Equipment (laptops, monitors, cellphones, print resources)
- Software Procurement (Qualtrics, NVivo 14)
- Community partners (Veterans, Veteran organizations, provincial/territorial health departments, federal departments)
- Internal Partners (collaborations within VAC branches/divisions/directorates/units)

Constraints and barriers

- Project timeline: January 2023 – December 2023 (with extension for March 2024 granted in October 2023)
    - Due to project method, scope and staffing resources, the project timeline is January 2023 – December 2023. CHNAs are most effective when repeated on a two-to-three-year cycle so trends in health data can be observed and analyzed. Project recommendations will include identification of gaps in population data and relevant topic areas requiring additional research
- Collection of existing data for the project is constrained by availability and access to equity-deserving Veteran health and well-being data, including:
    - Survey data available through Statistics Canada (e.g., 2022 CVHS)
    - Secondary data (limited research on Veteran health and well-being within Canada, particularly within equity-deserving populations)
- Limitations with direct communication with Veterans
    - Privacy department regulations restrict how research information is shared with Veterans, who can be a point of contact (e.g., general CHNA email address), and the method of communication (e.g., we must be contacted first in order to respond via email)

- Collaboration with community stakeholders
  - Collection of new data for the project is constrained by the participation of Canadian Veterans and key stakeholders
- Adequate sample size
  - Validity of findings for equity-deserving groups is constrained by obtaining an adequate sample to represent unique experience
- Budget size restrictions, for example:
  - Unable to compensate Veterans for their time participating in interviews, focus groups, or surveys
  - Unable to allocate funding for in-person focus groups (i.e., travel costs, room-booking, accommodations, etc.)
  - Restricted team travel opportunities
  - Hiring new staff/students
- Time to acquire internal approvals resulted in months-long delays
  - Concerns from the Privacy department regarding handling of personal Veteran data
    - Conducting interviews and focus groups
    - Use of software such as NVivo and Qualtrics
    - Collecting survey data
  - Approval for distribution of recruitment and general CHNA information

Activities

- Internal VAC stakeholder engagement
  - Established relationships with various internal teams at VAC, including Communications, Privacy, Information Technology/Security, Policy and Research, Knowledge Centre for Inclusion (KCII)
- External Veteran community stakeholder engagement
  - More than 250 external Veteran community stakeholder groups were consulted for the CHNA project in varying capacities (e.g., generating awareness, recruitment, POR tool review, knowledge translation)
  - Consultations with numerous external stakeholders, including Veteran Service Organizations, Provincial/Territorial Health Departments, and Federal Departments were held during initial engagement and reporting back phases: Army, Navy, and Air Force Veterans in Canada (ANAVETS); Atlas Institute for Veterans and Families; Assembly of First Nations; Built for Zero Canada - Veteran Homelessness (The Canadian Alliance to End Homelessness); CAF Transition Group; CAF/DND Defence Advisory Groups; Canadian Forces Health Services; Canadian Institute for Military and Veteran Health Research (CIMVHR); Canadian Women's Wellness Initiative - Veterans Population; Chronic Pain Center of Excellence for Canadian Veterans; Fondation québécoise des vétérans; Indigenous Services Canada; It's Not Just 20K; LGBT Purge Fund; Minister's Advisory Groups – to the Minister of Veterans Affairs;

Mood Disorders Society of Canada; Operational Stress Injury Clinic Network; Public Service Commission of Canada – Priority Entitlements; Rainbow Veterans; Respect Forum – Campagne Respect (Respect Canada); Royal Canadian Legion National Headquarters; Service Women's Salute; Sexual Misconduct Support and Resource Centre (SMSRC); True Patriot Love Foundation Head Office; Veteran Transition Network; Veterans House Canada; Veterans Task Force; Women and Gender Equality – Canada; Wounded Warriors; Manitoba Department of Health, Seniors and Long-Term Care; Newfoundland and Labrador Department of Health and Community Services; Northwest Territories Health and Social Services; Saskatchewan Ministry of Health; The Government of Nunavut – Department of Health

- Primary data collection (survey, focus groups, semi-structured interviews)
  - A goal of 40-60 interviews and 11-22 focus groups (5-7 participants each) to acquire an adequate amount of data for analysis and stakeholder recommendations.
- Secondary data collection (Literature Scans, Data Sets, Environmental Scans)
  - Used to justify project rationale and methodology by comparing, evaluating, and triangulating our collected primary data with findings from existing literature
- Evaluations (process evaluations, knowledge translation evaluations)
  - Process and knowledge translation evaluations were created and conducted after interviews/focus groups and final knowledge mobilization meetings to gauge participant and stakeholder experience during the CHNA project.
- Report writing
  - Overview of the Veterans' CHNA, background, project objectives and outcomes, scope, limitations, research paradigms, introduction to VAC framework + SDOH categories + other, methodological approach, defining a Veteran
  - Sociodemographic profile of Veteran sample, Veteran health outcomes and health and well-being status, Veterans' access and utilization of resources, gaps in themes, ranked list of health priorities as provided by Veterans
  - Validity of VAC well-being framework and social-health determinants
  - Evaluation, research tools, lessons learned, key findings, areas for further research, and recommendations
- Knowledge mobilization, for example:
  - Tailored meetings, presentations, and other deliverables for internal VAC stakeholders, external stakeholders that service the Veteran community, and the general Canadian Veteran population (see Outputs for more information)
  - Podium presentation and workshop at the 2023 Canadian Institute for Military and Veteran Health Research (CIMVHR) conference

Outputs

- Establishment of internal collaboration
  - Significant relations with teams we knew we had to work with (Comms, Privacy, IT)

  - Ideally internal and external engagement would occur at the same time (brought into a large group) but in our research it ended up being separate
- Stakeholder tracker
  - Developed to document this collaboration across the project. It will include information including, but not limited to:
    - Name of stakeholders identified
    - Basic information about the stakeholder or group (i.e., which hard-to-reach and/or equity-deserving group or community they represent, or their mission)
    - Contact information
    - Logistical details of any meetings
    - Relevant feedback provided from stakeholders (e.g., information about how to reach Veterans or promote interest in participation)
- Establishment of Veteran community and governmental relations
- Analysis of primary data
- Analysis of secondary data
- Analysis of evaluation data
- Knowledge translation deliverables
  - For internal and external stakeholders who indicate interest, key findings will be summarized in a presentation that demonstrates the unique context of each Veteran and stakeholder group. The CHNA Team will be noting Veterans' and stakeholder's needs for data and areas of interest throughout ongoing engagements to frame these deliverables. Types of key stakeholders for which these **CHNA Knowledge Translation Presentations** will be developed are:
    - The Canadian Veteran community
    - VAC directorates and units
    - Health professionals that serve Veterans
    - Other governmental stakeholders that serve Veterans
    - Community (non-governmental) stakeholders that serve Veterans
- CHNA Final Report
  - Key stakeholders will receive the CHNA Final Report with the information that they require to better serve the Canadian Veteran population. Ideally, the information highlighted in the CHNA will be used to guide informed decisions about the allocation of resources for supports and services related to Canadian Veterans' health.

Audience

- Veterans Affairs Canada (Policy, Programs and Services, Research)
- All Canadian Veterans (including VAC clients and non-VAC clients)
- Governmental institutions (federal, provincial, territorial)
- Government institutions (federal, territorial, Indigenous-based, or provincial)
- Researchers

- Veteran-centered community organizations, activistic groups, and other non-governmental organizations
- Other individuals, groups, and organizations with an interest in Veteran health and well-being and/or CHNAs
-

Outcomes

- Identification of health and well-being strengths and needs, influences in accessing health services, and health inequities by all Canadian Veterans based on their lived-experiences, reflections, and interactions
- Engagement and communication with equity-deserving Veterans who have been under-represented; fostering community relations and a safe space for Veterans to share their opinions and be heard
- Engagement with provincial, territorial, and federal departments to build and leverage partnerships to better support Veteran well-being
- Application of a proportionate universalist policy-making approach in findings and recommendations
  - Defined by Marmot and Bell (2012), a proportionate universalist policy making approach involves considering "both the people at the bottom of the health gradient and the gradient as a whole, ensuring that their impact [of policy] is proportionately greater at the bottom end of the gradient" (p.S10) where the need is greatest
- Preparation of a comprehensive overview of existing equity-deserving Veteran health resources in Canada to highlight resource accessibility and where gaps may exist
- Introduction of the first CHNA on the Canadian Veteran population, which provides a road map for future CHNAs
- Implementation of a knowledge translation plan to effectively disseminate findings and recommendations to Veterans, Veteran stakeholders, and policy and program decision-makers
- Recommendations for use of intersectional, participatory, and mixed research methods to achieve Veteran-centric research in the federal government context
- Inclusion of equity-deserving Veterans' experiences, perspectives and language to frame expanding definitions of health and well-being

Intended benefits

- Will enable VAC to better address the physical, mental, and economic well-being of Canadian Veterans and their families
- Contribute to the goal of making all VAC benefits and services (community, provincial/territorial, federal programs) easily accessible, responsive, and available in a comprehensive and efficient manner
- Support identification, planning, and implementation of services for Canadian Veterans through evidence-based research

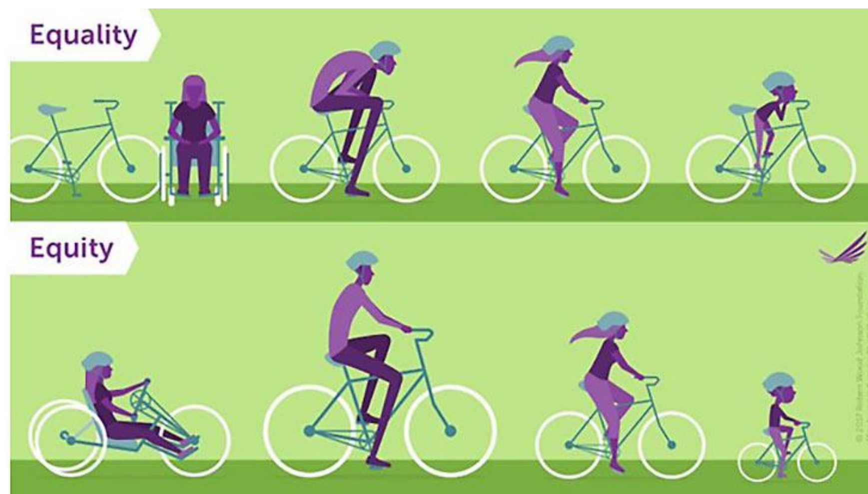
- Identify the unique strengths and needs of all Veterans, including non-VAC clients, women, 2SLGBTQI+, Indigenous, Black and racialized Veterans, and Veterans with disabilities
- Promotion of a positive, communicative, and inclusive relationship between VAC and Veterans, with a focus on fostering trust
- Increase awareness of Veteran health and well-being strengths and needs among a diverse array of stakeholders
- Advancement of partnerships with provincial, territorial, and federal departments

External factors

- A Canadian federal worker strike occurred between April 19, 2023, and May 3, 2023, causing a disruption to the processes of the project and onboarding for students

Appendix C – Knowledge translation tool: health equity

VAC Carillon Article: Health Equity – Why are we talking about this?
Published 15 November 2023
Peggy Fry, National Nursing Officer and Lisa Garland-Baird, Senior Researcher



Health equity is created when individuals have the fair opportunity to reach their fullest health potential – and that matters for Veterans. All of us at Veterans Affairs Canada (VAC) ought to be talking about it!

Supporting the well-being of Veterans and their families is central to our mandate at VAC. While **health** and **well-being** are not the same thing, the two are intimately connected – we cannot achieve one without the other. Health can be affected by many social, environmental, and biological factors beyond one's control. These factors include things such as race, gender, sexual orientation, sex, age, income, social status, education, physical environment, and life experience. For Veterans, achieving health equity requires identifying and reducing avoidable differences which are unfair and unjust.

Let's break it down.

According to the World Health Organization (2023), discriminatory practices are often embedded in institutional and systems processes. However unintentional this may be, these practices can result in certain groups being under-represented in research, policies, or decision-making. Furthermore, this discrimination can lead to groups and individuals being left out or under-served.

Many of us have seen some version of the picture above. In the context of what we do at VAC, health equality would mean ensuring that every Veteran, regardless of their background or differences, would have the same access to VAC services so long as they meet eligibility requirements. While that may sound good enough, without considering the social, environmental, and biological factors of individual Veterans, many of them would be distinctly disadvantaged and unable to achieve their optimal state of health and well-being. Therefore, in the context of what we do here at VAC, health equity means considering the different factors (and how they intersect) of the Veterans we serve to identify and reduce unnecessary barriers or differences.

In terms of Veterans, we must think about and consider **military indicators** such as rank and service history. It is also important to think about how health and well-being is influenced by **gender**, **sexual orientation**, **race**, **ability**, **age**, **sex**, **physical environment where they live**, **education**, etc.

It's not necessarily about changing what we do – it's about changing how we do it.

Advances in health equity require complementary interventions at behavioural, organizational, and systemic/societal levels. No matter our position, at VAC we all have a role to play in promoting health equity for Veterans.

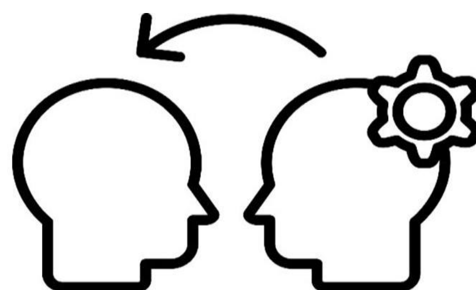
Here are five things you can start now to contribute to health equity for Veterans:

- **Self-reflect.** Reflect on your awareness of individual and system biases, and readiness to change.
- **Assessment.** Make a list or brainstorm with a team to assess your knowledge about how social, environmental, and biological factors impact Veterans' health.
- **Prioritize.** Identify the most important health inequities that must be addressed now and outline the longer-term health inequities to be addressed later.
- **Lead and inspire.** Act now on what is in your power or area of responsibility. Advocate or collaborate on what is out of your scope or may require engagement from other areas or senior leadership.
- **Commit.** Stay up-to-date and informed about topics related to health equity and intersectionality including the Veterans' Well-being Community Health Needs Assessment.

"If you don't have a seat at the table, bring a chair or create a new table."
-Rear Admiral Aisha K. Mix, DNP, MPH, RN, Chief Nurse Officer and Assistant Surgeon General, U.S. Public Health Service

Appendix D – Knowledge translation tool: knowledge translation

VAC Carillon Article: Knowledge Translation - Putting evidence into action
Published 7 February 2024
Peggy Fry, National Nursing Officer (HPD) and Jacinta Keough, Senior Project Officer (PRD)



Knowledge translation is vital to the work we all do at Veterans Affairs Canada (VAC). **From research to policy development to service delivery, effective knowledge translation can help promote high-quality Veteran-centric care**. Veterans count on us to get it right so we can apply what we know to what we do.

But what exactly is it?
Put simply, knowledge translation (KT) is getting the right information to the right people, at the right time, in the right format (i.e., user-friendly and accessible). When done well, KT is on a constant loop of Identify, Learn, Share, and Apply.

To be effective, **everyone has a role to play** in KT so that we, as a department, can determine:

1. what knowledge we need to support our decision-making;
2. the best way to get that information; and
3. how to interpret and use new information to better support Veterans and their families.

Here are some steps **you can take now** to promote KT within VAC:

- **Identify.** Identify the information gaps that cause roadblocks or hinder decision-making. Prioritize these needs and work with colleagues to determine the best way to get the knowledge required to move forward.
- **Learn.** Become familiar with available information about Veterans and use it to inform your work including:
  - Facts & Figures and Veteran Population dashboards
  - Research and Reports

  Keep an eye out for new reports that are coming soon including:

    - 2022 Canadian Veteran Health Survey
    - Veterans' Well-being Community Health Needs Assessment
- **Share.** Share project details or interesting findings with others across VAC. Sharing can be formal or informal - connect with colleagues and partners, participate in working groups, attend presentations, or write a Carillon article!
    - Tip: using plain language will help ensure information is understood and used!
- **Apply.** Apply what you learn to the work you do. Support Veterans by implementing improvements directly into the areas within your control and advocate for the changes that require higher-level or outside approval.

Appendix E – Stakeholder engagement evaluation questions

Thank you for your attendance at the Veterans' well-being community health needs assessment (CHNA) preliminary findings presentation!

The goal of our presentation was to introduce preliminary findings about Canadian Veterans health strengths, needs, and priorities from the CHNA research. Please provide your feedback on our presentation. We will use your input to develop our knowledge mobilization plan to share final CHNA findings within VAC, with our stakeholder partners, and with Veteran communities.

Your responses will remain confidential and anonymous.

1. With which organization do you primarily work?
2. The preliminary findings from the Veterans' well-being community health needs assessment are applicable to my area of work...
   a. Strongly agree
   b. Agree
   c. Unsure
   d. Disagree
   e. Strongly disagree
3. I will be able to use the Veterans' well-being community health needs assessment findings (both preliminary, and the final results) to advance and/or improve my work...
   a. Strongly agree
   b. Agree
   c. Unsure
   d. Disagree
   e. Strongly disagree
4. How would you rate your knowledge of the health strengths and needs (including resources used) of Canadian Veterans before this presentation?
   a. Extremely knowledgeable
   b. Very knowledgeable
   c. Moderately knowledgeable
   d. Somewhat knowledgeable
   e. Not knowledgeable at all
5. How would you rate your knowledge of the health strengths and needs (including resources used) of Canadian Veterans after this presentation?
   a. Extremely knowledgeable

   b. Very knowledgeable
   c. Moderately knowledgeable
   d. Somewhat knowledgeable
   e. Not knowledgeable at all
6. Which preliminary findings were most useful and/or interesting to you? (Check all that apply)
   a. Research paradigms and approach (i.e., critical reflexivity, SGBA+, intersectionality, health equity, anti-oppression, decolonialism, life course, participatory, and trauma-informed)
   b. Unique perspectives and experiences of equity-deserving Veterans (such as Black and racialized, 2SLGBTQI+, Indigenous, women, Veterans with disabilities, Francophone, Veterans who have experienced homelessness, etc.)
   c. Theme 1: Veterans see their health and well-being as holistic and interconnected
   d. Theme 2: Veterans needs and resources are complex and unique
   e. Theme 3: A greater understanding of the multiple factors that influence Veterans use and access to resources is needed
   f. Theme 4: Pivot towards trauma-informed approaches, culturally sensitive, and person-centric services
   g. Theme 5: Veterans are seeking a more meaningful relationship with VAC
   h. Theme 6: VAC needs to collaborate with Veterans and stakeholders to tackle the complex problems Veterans face
   i. Other (please specify):
7. Which preliminary findings are you interested in learning more about? (check all that apply)
   a. Research paradigms and approach (i.e., critical reflexivity, SGBA+, intersectionality, health equity, anti-oppression, decolonialism, life course, participatory, and trauma-informed)
   b. Unique perspectives and experiences of equity-deserving Veterans (such as Black and racialized, 2SLGBTQI+, Indigenous, women, Veterans with disabilities, Francophone, Veterans who have experienced homelessness, etc.)
   c. Theme 1: Veterans see their health and well-being as holistic and interconnected
   d. Theme 2: Veterans needs and resources are complex and unique
   e. Theme 3: A greater understanding of the multiple factors that influence Veterans use and access to resources is needed
   f. Theme 4: Pivot towards trauma-informed approaches, culturally sensitive, and person-centric services
   g. Theme 5: Veterans are seeking a more meaningful relationship with VAC
   h. Theme 6: VAC needs to collaborate with Veterans and stakeholders to tackle the complex problems Veterans face
   i. Other (please specify):
8. Is there anything else you would like to share with the research team? Note: It can be a general comment and/or related to your response to any question.

Appendix F – Interview and focus group research information letter and informed consent

Objectives

- ✓ **Establish participant eligibility** criteria to participate in the focus groups and/or interviews
- ✓ **Provide information to participants** about the focus groups and semi-structured interviews
- ✓ **Participants** choose either a focus group (in their desired segment) and/or a semi-structured interview, or both
- ✓ Accommodate any **accessibility requirements** that participants may have
- ✓ Obtain **informed consent** to participate in the research project

Participants will email (CHNA email address here) or call the CHNA project telephone number and leave a voice message to indicate interest in being contacted regarding the focus groups and/or the semi-structured interviews.

Guide script

CHNA team members will call participants using the following script:

Introduction

Hello/Bonjour,

May I speak with_______________? Hello, my name is __________ and I am a researcher with Veterans Affairs Canada. I am calling today because you have indicated interest in this research. We invite you to participate in VAC's Veterans' Well-Being Community Health Needs Assessment project. This includes the opportunity to participate in a survey, a focus group, and/or a one-on-one interview.

If leaving a voicemail message:

Hello/Bonjour, my name is____________. I am researcher with Veterans Affairs Canada. We are seeking people to interview for a research project with Canadian Veterans We will call you back at another time to see if you are interested in participating. If you would like to learn more about this research, you can call the National Client Contact Center at 1-866-522-2122. Thank you and have a wonderful day.

If someone other than the Veteran answers the phone and the Veteran is not available:

Hello/Bonjour, May I speak with___________? My name is ___________ and I am a researcher with Veterans Affairs Canada. We are seeking people to interview for a research project with Canadian Veterans. We will call back at another time when ____________is available. To learn more about this research, you can call the National Client Contact Center at 1-866-522-2122. Thank you and have a wonderful day.

Language of choice

Would you prefer that I continue in English or in French? Préférez-vous continuer en français ou en anglais?
If French, continue in French or arrange call back with French interviewer French interviewer : Nous vous rappellerons pour mener cette entrevue de recherche en français. Merci. Au revoir.
If English, continue

Eligibility questions

Veterans Affairs Canada (VAC) is currently seeking Canadian Veterans to participate in a research study called the Veterans' Well-Being Community Health Needs Assessment.
Have you ever served in the Canadian military? (Canadian military service includes service with the Regular Force or Primary Reserve Force)
If yes, continue
If no, thanks and terminate call

If unsure:
Are you interested in hearing more information about the study?

Yes **Continue reading below**
No **Thank and Terminate**

Purpose

The purpose of the study is to learn more about Canadian Veterans' health and well-being strengths and needs. The findings of the study will be used to help VAC ensure that policies, programs, and services provide appropriate support for all Veterans in Canada.
This research project is led by a research team within VAC and operates at an arm's length from areas of the Department who manage decisions about eligibility to VAC's benefits, programs, or services. Your participation is completely voluntary, and the information you share will not affect your current benefits or programs/services with VAC, or your eligibility for future benefits, programs/services.

Benefits and risks

The benefits of participating in this research project include increasing your knowledge and awareness on personal and other Veteran's health realities, experiences, needs and

wellbeing; and contributing to scientific knowledge and sharing expertise with researchers and other participants can elicit feelings of pride, 'making a difference,' and sense of purpose.

The risks of participating in this research project are minimal. You will be asked questions related to your well-being and health, which may feel uncomfortable. You have the right to refuse to answer any interview question by saying pass without consequences. You also have the right to withdraw from this study at any time during, or up to 2 days after the focus group, or interview. If you choose to withdraw from the study, you can send an email to the CHNA project indicating your wishes. We can also provide you with the contact information for a telephone counselling/crisis line should you need support.

The focus group consists of two sessions that are each 60-90 minutes long, and the interview will be 45-60 minutes.

Are you interested in participating in a focus group, interview, or both?
Yes: **Continue with informed consent and schedule focus group/interview times**
No: **Thank and Terminate**

If the participant asks to validate the study: You can contact the CHNA project leader_________ at Veterans Affairs Canada by phone [phone number] or email [email], or you can call the VAC National Contact Centre Network (NCCN) at 1-866-522-2122 to verify the validity of the study.

Schedule and call back to continue with screener before ending the call.

Informed consent

Now that you have agreed to take part, I will read you the formal invitation to participate in the study.
The focus group sessions and/or interview will be conducted online using a secure platform called Microsoft Teams, or over the telephone at a time that best suits your schedule in the next two weeks. The focus group consists of two sessions each 60-90 minutes long, and the interview will last 45-60 minutes.

The information we are interested in includes: your age, sex, gender, marital status, if you live in a rural or urban setting, type of military service, year of release, rank, military occupation, etc.

Your participation is completely voluntary, and the information you share will not affect your current benefits or programs/services with VAC, or your eligibility for future benefits, programs/services.

The information you share will be stored on secure, password protected laptops that only the CHNA team members have access to. Information will be summarized, made anonymous, and will remain confidential. This means that individuals will not be identified in the final research reports and only the CHNA team members will have access to this information. VAC will not share information related to this study with other organizations.

The focus groups and interviews will be digitally recorded to generate transcripts. All recordings and data collected will be used for research purposes only. Again, your personal information will remain anonymous and confidential, and protected and managed according to the Privacy Act of Canada and Government of Canada laws for information management.

Are you comfortable with the discussion being recorded? Yes_____ No_____
Yes 1
No 2

Focus groups and interviews will be conducted from XXX- XXXX. Is this the best phone number to reach you?
Additional Phone number ____
What time and date would be most convenient to call you back for your interview?

Check schedule/record time and zone/date
*Public Opinion Research guidelines state that calls are made between 9am to 9pm local time M-F, Sat 10am to 9pm, and Sun noon to 9pm.

Conclusion

We are conducting focus groups and interviews with a limited number of individuals, so the success of the study will be affected by no shows. Once you have decided to participate in the focus group and/or interview, please make every effort to attend. If you are unable to take part in the study, please email the CHNA project at X or call project manager _________. as soon as possible so a replacement may be found.
Following the study, if you wish to receive a summary of the final report, please email your mailing address to the CHNA project email (insert email address here) and we will send you a copy.
Thank you for your interest in our study.

Provide as needed: Additional information on the safeguarding of personal data
Personal data will be anonymized and stored in accordance with government security policy following completion of the study with VAC guidance and approval.

Appendix G – Participant sociodemographic variables

1. Total # of participants = 75

2. Province or territory

Alberta	11
British Columbia	3
Manitoba	5
New Brunswick	3
Newfoundland and Labrador	3
Nova Scotia	5
Ontario	38
Québec	5
Saskatchewan	1
Other (temporarily living in US)	1

3. Language of choice (for participation)

English	68
French	7

4. All languages spoken

English and French	13
English and Other	3
Other Languages	15
Not multilingual	44

5. Age

Average Age	58
Minimum Age	32
Maximum Age	89

6. Sex assigned at birth

Male	47
Female	28

7. Gender

Man	47
Woman	28
Other	0

8. Cultural or ethnic background

White	62
South Asian	1
East Asian	1
Black/African	2
Caribbean	1
First Nation	2
White and Peruvian	1
White, Black/Caribbean, Inuk	1
White and First Nation	1
White and Métis	2
Métis and First Nation	1

9. Perceived race

East Asian / Southeast Asian	1
South Asian	1
Black	3
European / White	65
Hispanic	1
Indigenous	1
European / White and Indigenous	3

10. Indian status

Yes	2
No	73

11. Spirituality

Not Spiritual	8
Slightly Spiritual	22
Moderately Spiritual	29
Very Spiritual	15
Prefer not to answer	1

12. Religion

Not Religious	29
Slightly Religious	24
Moderately Religious	18
Very Religious	4

13. Disabilities

Yes	62
No	13

14. Main activity over past 12 months

Worked	24
Retired	16
Looked for work	4
Unable to work	6
School / Training	1
Caregiver	2
Other	6
Worked, Retired	1
Worked, School / Training	5
Worked, Caregiver	1
Retired, Unable to work	3
Retired, Caregiver	1
Retired, Caregiver, Other	1
Retired, Other	1
Looked for work, Caregiver	1
Looked for work, other	1
Unable to work, School / Training	1

15. Level of education

No High School	1
High School Diploma	5
Apprenticeship / Trades	2
College, CEGEP, non-university certificate	19
University, below bachelor's degree	7
Bachelor's Degree	21
Post-Graduate Degree	20

16. Sexual orientation

Heterosexual	67
Lesbian	3
Gay	2
Bisexual	1
Other	1
Two-Spirit and Gay	1

17. Type of neighbourhood of main residence

Remote Setting	3
Rural Setting	20
Suburban Setting	26
City Setting	26

18. Relationship status

Long-Term Relationship	1
Married	41
Living Common-Law	4
Widowed	6
Separated	3
Divorced	5
Single	13
Other	1
Divorced and Single	1

19. Household income

<$25,000	1
$25,000 - $50,000	5
$50,000 - $75,000	15
$75,000 - $100,000	18
>$100,000	34
Prefer not to answer	2

Sufficient income – Yes	63
Sufficient income – No	12

20. Housing security

Currently experiencing homelessness	1
Previously experienced homelessness	11
Never experienced homelessness	63

Steady place to live	65
Place to live today, unsure tomorrow	9
No steady place to live	1

21. Service type and branch

Regular Force	34
Reserve Force	7
Both	34

Canadian Army (CA)	39
Royal Canadian Navy (RCN)	4
Royal Canadian Air Force (RCAF)	13
CA and RCN	7
CA and RCAF	7
RCN and RCAF	2
CA and RCA and RCAF	3

22. Terms and year of release

Voluntary	27
Compulsory	7
Medical	34
Other	6
Voluntary and Compulsory	1

Earliest Year of Last Release	1966
Latest Year of Last Release	2024

Average Length of Service (years)	20
Min Length of Service (years)	1
Maximum length of Service (years)	48

23. Rank upon release

Officer	29
Senior Non-Commissioned Officer	15
Junior Non-Commissioned Officer	31

24. Domestic and international deployments

International Deployments	10
Domestic Deployments	9
Both	36
Neither	20

Average # of International Deployment	2
Average # of Domestic Deployment	3

25. LGBT Purge survivor = 6

Appendix H – Interview and focus group discussion guides

Semi-structured interview questions

1. What does being healthy mean to you?
2. What does having good well-being mean to you?
3. How would you describe your overall health and well-being?
4. What are your current health and well-being challenges?
5. What are your health and well-being needs?
6. Do you feel any of those health and well-being needs as being due to being Veteran or other identity factors?
7. What are some of the resources you use to help you fulfill those needs?
8. Can you name some factors, whether positive or negative, that influence your ability to fulfill these needs?
9. What are your unmet health and well-being needs?
10. What additional health and well-being resources would you want?
11. Are there some health and well-being challenges you currently face due to your life prior to your military service?
12. Can you tell me about your life during your military service?
13. Can you tell me about your experience transitioning from military service?
14. How would you describe your level of satisfaction with your current life?
15. Do you identify as a Veteran?

Focus group questions

1. What does health mean to you?
2. What does well-being mean to you?
3. What would your ideal well-being and health look like?
4. What are your health and well-being needs?
5. What are some of your health and well-being strengths?
6. What resources do you use to address those needs?

7. What are your unmet health and well-being needs?
8. What additional health and well-being resources do you need?
9. What are some factors, whether positive or negative, that influence your decision and/or ability to access these resources?
10. Do you feel you and other Veterans have experienced similar challenges fulfilling your health and well-being needs?
11. Do you feel some Veterans experience greater advantages than you in meeting their health and well-being needs?
12. What are some of your health and well-being priorities?

Appendix I – Interview and focus group evaluation questions

Interview evaluation questions

Question 1: (Multiple choice) Reflecting on your interview experience, how would you rate your overall level of satisfaction?

- Excellent / Great / Good / Fair / Poor / Not Applicable

Question 2: (Word cloud) If you feel comfortable, please explain why you chose this rating.

Question 3: (Multiple choice) How would you rate your level of comfort sharing your lived experiences with your interviewer?

- Excellent / Great / Good / Fair / Poor / Not Applicable

Question 4: (Word cloud) If you feel comfortable, please explain why you chose this rating.

Question 5: (Multiple choice – multiple selections) Which interview topics did you feel were the most useful for you to share your experiences?

- Questions about health and well-being strengths and needs, and health challenges, etc.
- Mapping out health and well-being strengths and needs
- Questions about facilitators and barriers in seeking and accessing health and well-being resources
- Questions about pre-military experiences
- Questions about military service
- Questions about life after leaving and/or retiring from the military
- Questions about defining and identifying what it means to be a Veteran

Question 6: (Multiple choice – multiple selections) Which interview topics did you feel were the least useful for you to share your experiences?

- Questions about health and well-being strengths and needs, and health challenges, etc.
- Mapping out health and well-being strengths and needs
- Questions about facilitators and barriers in seeking and accessing health and well-being resources

- Questions about pre-military experiences
- Questions about military service
- Questions about life after leaving and/or retiring from the military
- Questions about defining and identifying what it means to be a Veteran

Question 7: (Word cloud) Are there other areas of health and well-being that you feel would be important to include in the interviews to explore with other Veterans?

Question 8: (Word cloud) Do you have any suggestions for our team to improve the interview experience for future participants?

Focus group evaluation questions

Question 1: (Multiple choice) Reflecting on your Focus Group experience, how would you rate your overall level of satisfaction?

- Excellent / Great / Good / Fair / Poor / Not Applicable

Question 2: (Word cloud) If you feel comfortable, please explain why you chose this rating.

Question 3: (Multiple choice) How would you rate your level of comfort sharing your lived experiences during the Focus Group?

- Excellent / Great / Good / Fair / Poor / Not Applicable

Question 4: (Word cloud) If you feel comfortable, please explain why you chose this rating.

Question 5: (Multiple choice – multiple selections) Which interview topics did you feel were the most useful for you to share your experiences?

- Defining health and well-being
- Identification of health and well-being strengths and needs
- Mapping out health and well-being resources
- Identifying gaps in health well-being needs
- Exploring influences for health and well-being experience: enablers and barriers
- Exploring perceptions of inequities
- Health and well-being priorities and recommendations

Question 6: (Multiple choice – multiple selections) Which interview topics did you feel were the least useful for you to share your experiences?

- Defining health and well-being

- Identification of health and well-being strengths and needs
- Mapping out health and well-being resources
- Identifying gaps in health and well-being needs
- Exploring influences for health and well-being experience: enablers and barriers
- Exploring perceptions of inequities
- Health and well-being priorities and recommendations

Question 7: (Word cloud) Are there other areas of health and well-being that you feel would be important to include in the focus groups to explore with other Veterans?

Question 8: (Word cloud) Do you have any suggestions for our team to improve the focus group experience for future participants?

Appendix J – Data validation

Introduction

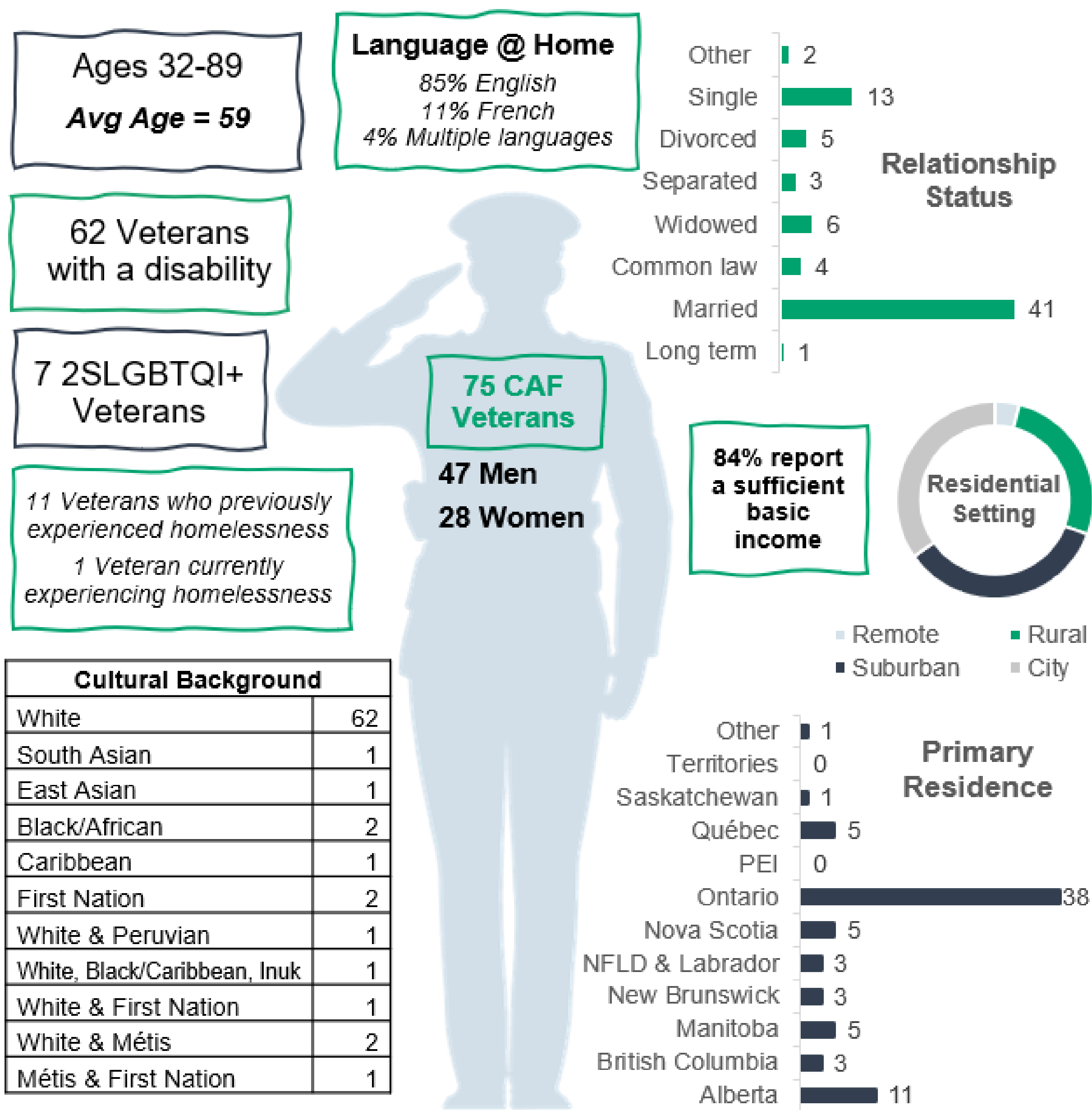
The Veterans Community Health Needs Assessment (CHNA) research project was conducted to help better understand Veterans' health and well-being strengths and needs. Between August and November 2023, our CHNA Team had the privilege hearing your diverse perspectives on what factors you feel influence your and other Veterans' health and well-being in Canada. Our CHNA Team offers our sincerest gratitude for your time and for sharing your important stories.

Before we finalize the study results, we want to hear your feedback on a summary of the study's themes, select examples, and quotes. Please note that this summary is not exhaustive, rather it provides an overall picture of what Veterans shared collectively. The CHNA final report will be available in Spring 2024 on the VAC webpage.

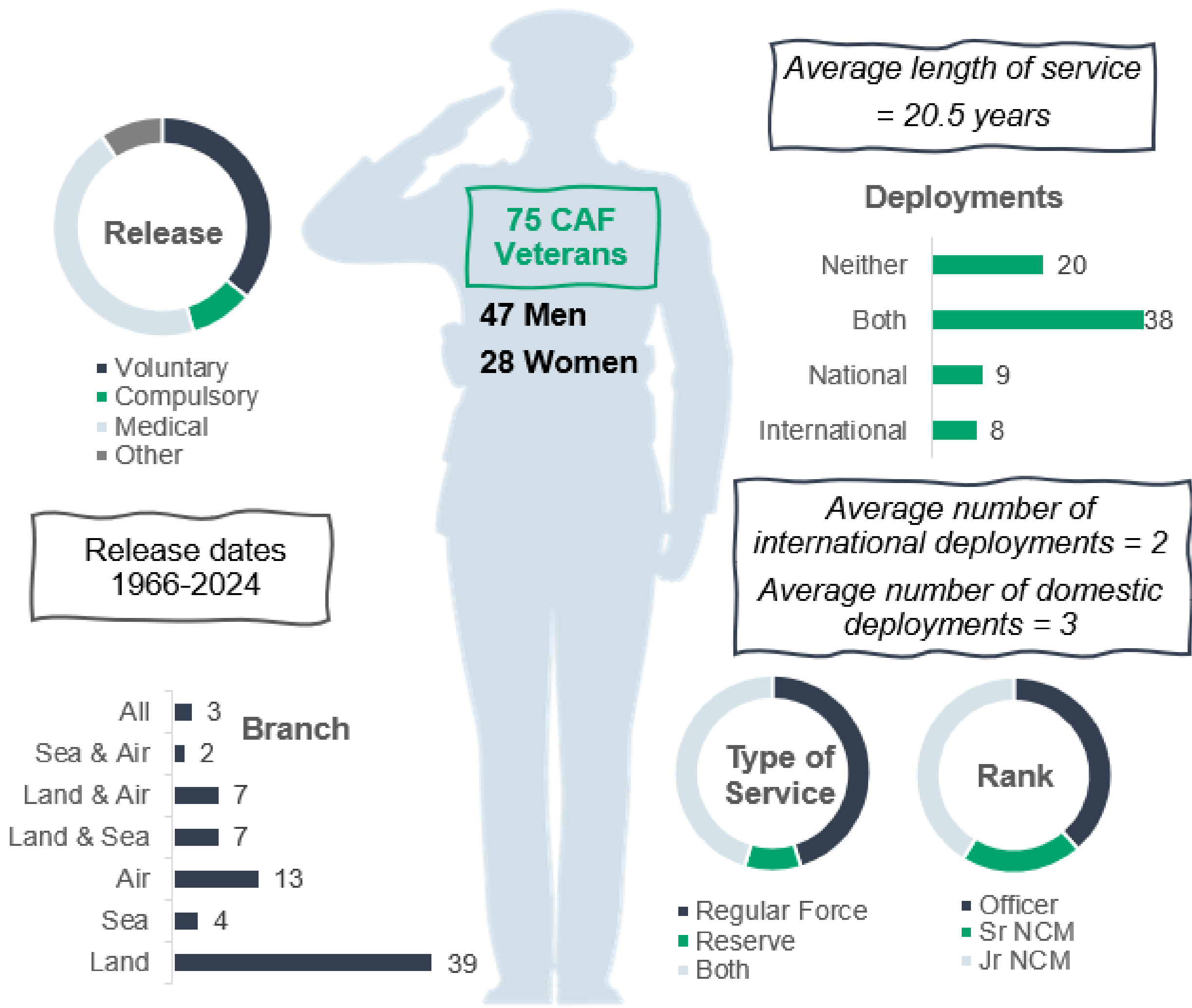
Your participation is completely voluntary and will not affect your current and/or future eligibility for VAC or Government of Canada benefits, programs, and services. Your responses will be completely anonymous and will not be linked to any of your personal identifying information. It will take approximately 15 minutes to provide your feedback.

Who did we talk to?

It was important that we talked to Veterans from all walks of life. Here is a snapshot of the unique characteristic of those who participated in the interviews and/or focus groups.



Cultural Background	
White	62
South Asian	1
East Asian	1
Black/African	2
Caribbean	1
First Nation	2
White & Peruvian	1
White, Black/Caribbean, Inuk	1
White & First Nation	1
White & Métis	2
Métis & First Nation	1



SECTION 1 – Veterans' health and well-being

In the interviews and focus groups, we asked you - "What does health and well-being mean to you?"

You answered:

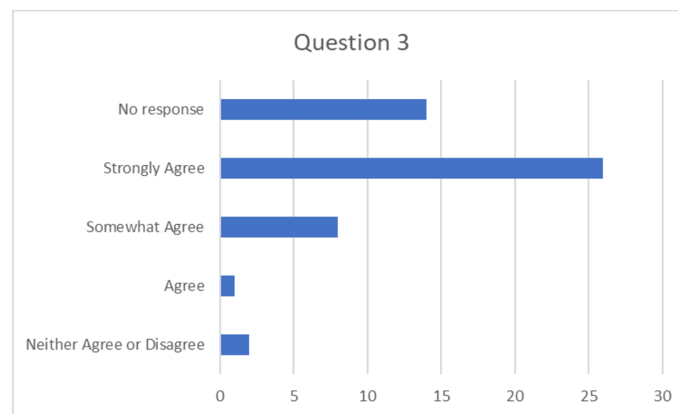
Health and well-being are multifactorial, interconnected, and holistic in nature.

You said that health and well-being go beyond the absence of having a disease or illness; instead, it includes a combination of physical, mental, emotional, spiritual, social, community,

cultural, economic, and environmental factors that are closely intertwined. You also described life satisfaction and quality of life as a "holistic balance" between these factors.

Quote: "It's mental, physical, just having all my needs met, safety, security, food, shelter, the basic needs."

How much do you agree?



Health and well-being are highly contextual and impacted by a Veterans' lived-experiences.

In the interviews and focus groups, you emphasized the contextual nature of health and well-being, and rejected the notion of a "one-size-fits-all" definition or approach.

Quote: "It's different for everybody!... For example, women's injuries are completely different than men!"

Quote: "Men's health is unique, women's health is unique, and then also 2SLGBTQ+ group. Everyone has very unique needs and policies have to be around that."

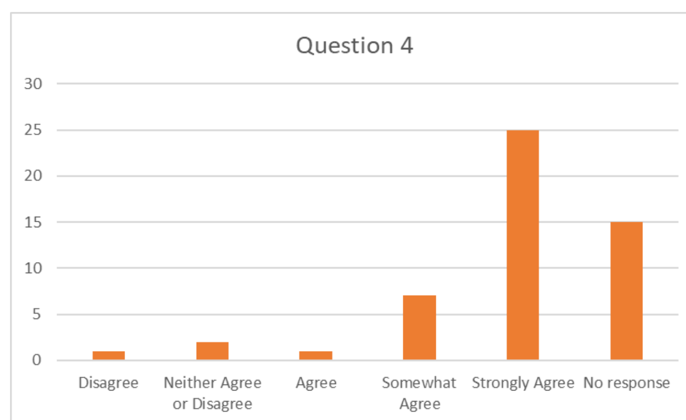
- You also told us that physical, mental, emotional, spiritual, social, community, cultural, economic, and environmental factors have various levels of significance for different individuals. Some of these factors are essential to health and well-being, while others are considered less relevant or insignificant. Several of you noted that health and well-being are influenced by your multiple and overlapping identities (i.e., gender, sex, race, ethnicity, age, sexual orientation, etc.), personal circumstances, and life histories. The different contexts you identified included:

- **Military context**: You highlighted the importance of considering your military context (i.e., military rank, trades, tours, training, courses, type of release, years of service,

etc.) and your broader military, transition, and post-military experiences. This included impactful experiences such as military sexual trauma, the LGBT Purge, discrimination, homophobia, etc. and how these experiences impacted your health and well-being.

- **Cultural context**: You discussed how notions of health and well-being may be intimately connected to your culture and ethnicity. For instance, Métis and First Nations Veterans noted that health and well-being may be viewed as intrinsically connected to their culture, spirituality, and having access to "traditional and culturally appropriate healing options."
- **Life course context**: You explained how your experience and understanding of health and well-being varied across your life course - from childhood to adulthood. You noted that age-related biological changes in physical, cognitive, and reproductive functions, Aging Veterans expressed that an important feature of good health and well-being is having confidence in the future, knowing that, as you age, you will be able to meet your overall needs and have access to the resources you require to help you remain independent.
- **Structural context:** Many of you explained that sexism, racism, homophobia, and colonialism, both in the military and civilian contexts, can lead to a range of injuries, illnesses, traumas, and conditions that significantly affect Veterans' health and well-being for themselves, their families, and their communities in a variety of ways.

How much do you agree?



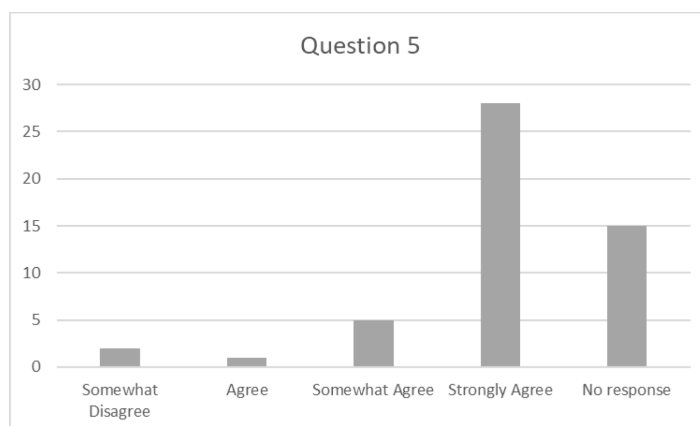
Health and well-being are fluid, dynamic, unpredictable, and often impacted by your military service.

You shared that injuries, disorders, illnesses, conditions, and traumas related to military service can and often emerge at various stages of life. The period between exposure and

appearance can vary, with physical and mental pain and symptoms often being unpredictable 'like a rollercoaster' and therefore difficult to manage. Some Veterans may experience these challenges during their military service, leading to potential early or unexpected release from service. For others, these issues may gradually emerge and 'take a toll later in life' or become apparent long after discharge from service.

Quote: "Most don't understand is. Just how hard it is on your body. You don't even know this when you're in your twenties, early thirties, then running around and you know out every day because you're in a combat arms situation. It takes a toll on your body, but you don't start paying the price until you're sixty."

How much do you agree?

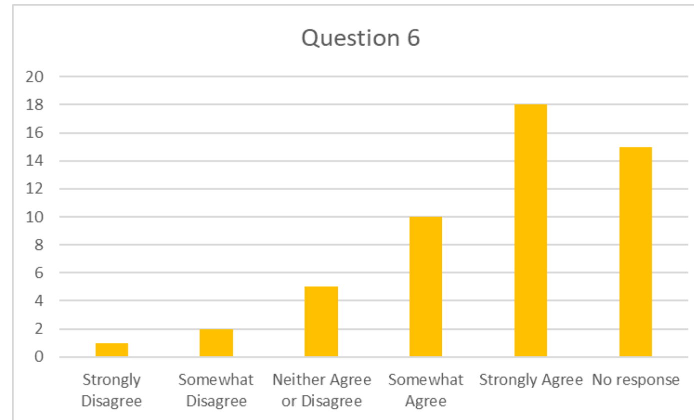


Health and well-being evolve and changes along with your social identity.

You highlighted how your health and well-being evolves as your social roles and identity changes over your life. You shared that becoming a parent, having caregiving responsibilities, being a serving member, releasing or retiring from service, being a civilian employee, etc. exposes Veterans to different health and well-being strengths, opportunities, risks, stressors, needs, and resource requirements. Once again these vary depending on your identity, personal histories, and life contexts.

Quote: "When you're in the military, you're very fit and healthy. And then you get out of the military. And then for me I started to raise our family like kids, and then your health gets put on the back burner. All the focus is on the kids. You let your body go to crap! And then it's just you can't do what you used to do and then pain sets in."

How much do you agree?



SECTION 2 – Veterans' health and well-being needs

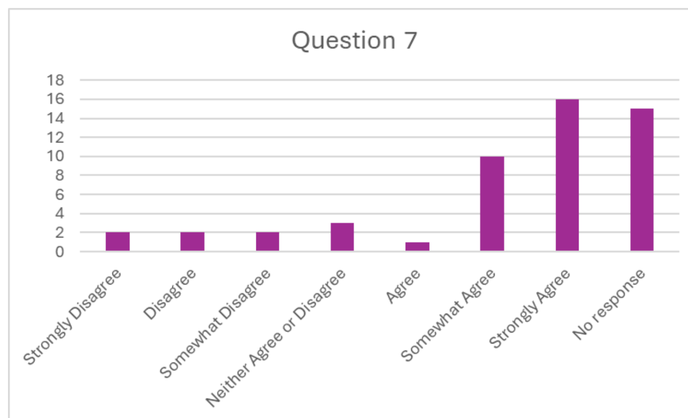
In the interviews and focus groups, we asked you - "What are your Health and Well-being needs?"

You told us that your health and well-being needs vary across your intersecting characteristics such as sex, gender, race, age, etc. and your lived-experiences. You also identified that Veterans' needs were often dependent on your military service experiences, ranks, trades, deployments, years of service, etc.

Quote: "The other factor that I think is important is not all the GBA intersectionality's that are commonly used within public service are enough for the military. I think there is a GBA things like you know what rank you were because the NCM versus officer. Huge difference about you knows how operational you were."

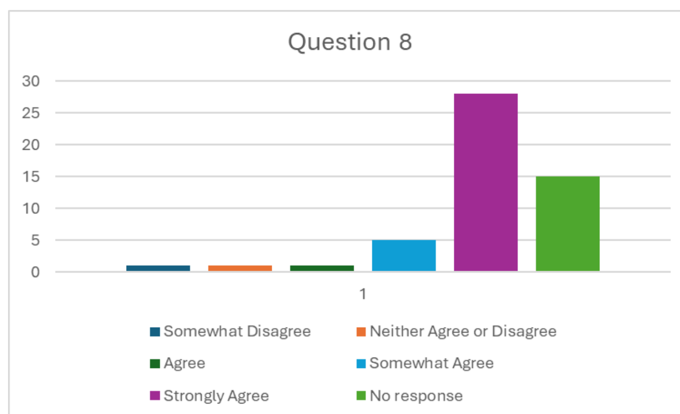
Quote: "It was really rewarding, but also, came with a lot of trauma as well. I found joining the military got me out of poverty and it made me proud. It made me proud to wear the uniform because a lot of people, like you, get a lot of, admiration or respect because you're in the Forces and that was something I hadn't experienced before. So that was really a good feeling. It made me feel good. But I also dealt with a lot of racism and harassment while I was in the Forces."

How much do you agree?



A few examples of your identified needs include:
Healthy social relationships (i.e., family, friends, pets); Engaging in physical exercise; Purpose (i.e., work, hobbies, volunteering); Sense of belonging to your community; Patience for yourself while transitioning out of military service; Accepting new physical, mental, emotional, etc. limitations; Ability to advocate for yourself; Recognition and acknowledgment of your service by other Veterans and civilians; Recognition and validation of your multiple and overlapping identities; Safety; Financial security; Food security; Stable, safe housing; Access to transportation; Veteran peer support; Access to primary care providers (i.e., physician, nurse practitioner) and other healthcare providers with military cultural competency, who use trauma-informed approaches; Flexible access to healthcare and other resources (i.e., virtual and in-person); Positive interactions and support from institutions such as VAC, CAF and DND; Simple bureaucratic guidelines and processes

How much do you agree?



SECTION 3 – Veterans' strengths and resources

In the interviews and focus groups, we asked you to identify your strengths (i.e., personal attributes, skills, knowledge, attitudes, and behaviors) and the resources (i.e., activities, programs, and services) that you rely on to support your health and well-being needs.
You answered:

Veterans have many strengths that contribute to and maintain their health and well-being.

You identified a wide range of strengths that influence your health and well-being positively. This includes a strong sense of duty, desire to help other Veterans, adaptability, resilience, fortitude, discipline, strong work ethic, camaraderie, compassion, curiosity, resourcefulness, and self-awareness.

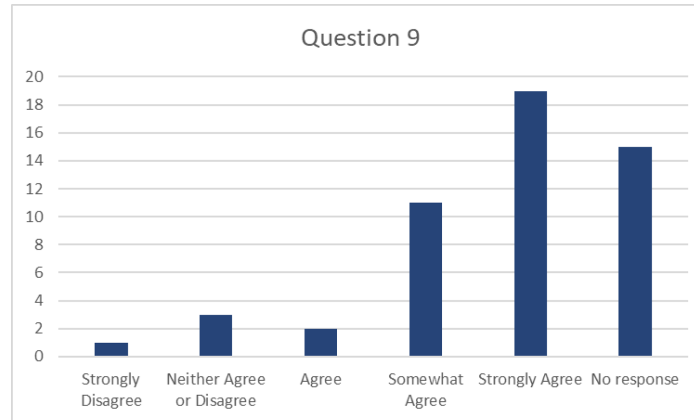
We heard from many of you that a strength you are proud of is your ability to advocate for and empower other Veterans to meet their health and well-being needs. Several of you described your involvement in community initiatives, activism, and influencing policymaking efforts to help improve the overall health and well-being of Veterans. Many of you expressed a desire to continue sharing these skills and insights, as well as collaborating with other Veterans, communities, and organizations to improve the health and well-being of Veterans who come behind you.

Quote: "If somebody else who's a Veteran or spouse of a Veteran needs to reach out, if they see my plate, at least they can, they can approach. I may not be able to know the answer or help you know, but I'll know where to get it."

Quote: "I met a number of people over the years that got involved in creating a report on what had happened with people in the military with gay and lesbian people in the military. And then started a class action lawsuit against the federal government."

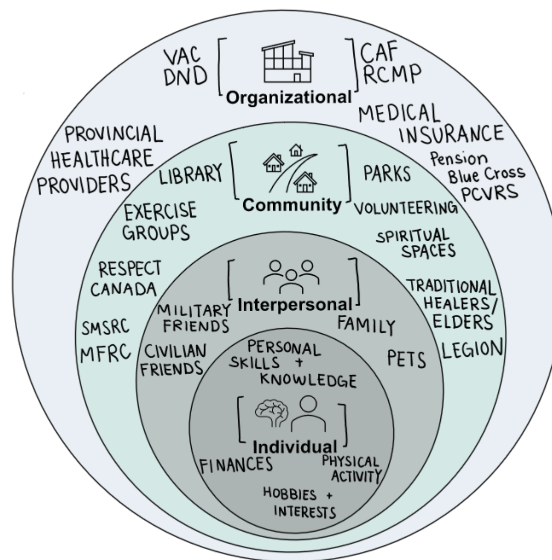
Quote: "When we get together once a month and one guy says, you know, 'I got a problem with, or VAC gave me this letter. What do I do about it?' […] We'll sit down, and we'll talk about what those problems are and how to get over those hurdles because someone else around that table has been there, and they say, 'Here's what I had to do to turn it into a positive.' So, we're creating our own little network that way."

How much do you agree?

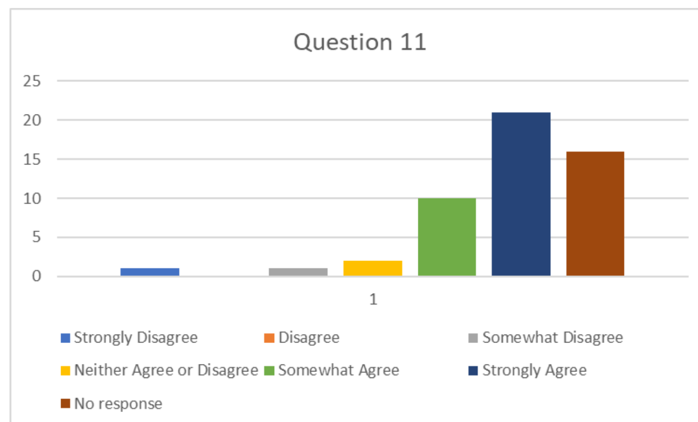


Veterans rely on a variety of resources (i.e., networks, activities, services, and programs) to meet their unique health and well-being needs.

The diagram below highlights examples of the many resources you identified. We present these resources at the individual, interpersonal, community and organizational levels:



How much do you agree?



SECTION 4 – Veterans' barriers and facilitators

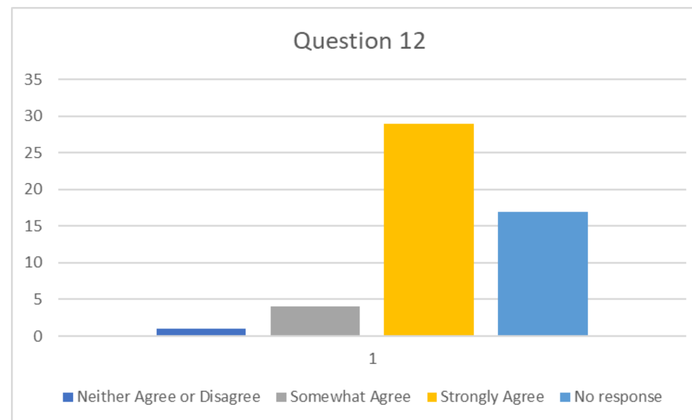
In the interviews and focus groups, you told us about the barriers and facilitators to meeting your needs, access, or use of health and well-being resources. Again, you shared that the factors that influence this are varied and dynamic, and influenced by your social identities, individual circumstances, and lived-experiences.

Examples of barriers and facilitators include:

- Physical, mental, emotional health status
- Coping skills
- Self-advocacy abilities
- Personal safety and security
- Life stressors and responsibilities (i.e., caregiving burden, employment)
- Capacity to access knowledge and information about available resources
- Veteran and military networks and supports
- Social connections with friends, family, and community
- Residential location (i.e., urban, rural, or remote)
- Access to transportation
- Employment
- Financial security
- Access to a primary care provider (i.e., doctor, nurse practitioner) and healthcare providers
- Communication and coordination between healthcare and social providers, organizations, and systems
- Eligibility for health and social benefits, programs, and services
- Bureaucratic institutions and processes

- Discrimination, racism, sexism, homophobia, etc.
- Time

How much do you agree?

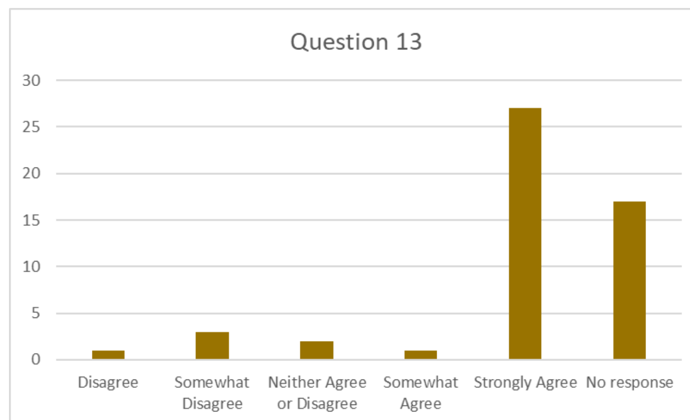


Military service experiences can function as a facilitator or barrier for a Veteran to meet their health and well-being needs.

Some of you told us that Veterans with who had a higher rank, or who were in medical or administrative occupations while in military service could use their past administrative knowledge, experiences, and skills to better understand and navigate the complex bureaucratic processes of organizations such as VAC or insurance agencies. This functioned as a facilitator because these Veterans were able to use the 'right words' or 'medical language' to successfully filling out an application or reassessment form.

However, some of you also said that the military cultural norms you were exposed to and experienced while in service deterred or even prevented you from seeking out military healthcare and well-being supports and resources despite experiencing physical, mental, emotional, etc. injury or illness. Pressures to uphold the image of an 'ideal soldier,' mental health stigma, fear of repercussions to your career or deployment readiness, discouragement from military healthcare providers or leaders, and experiences of discrimination, racism, sexism, homophobia frequently deterred you from seeking treatment during service.

How much do you agree?



VAC can function as a facilitator or barrier for a Veteran to meet their health and well-being needs.

Many of you identified that VAC could function as either a facilitator or barrier for a Veteran to meet their health and well-being needs. Some of you shared that when certain conditions are met, VAC employees, services, programs, and policies enable Veterans to access support for and work towards meeting health and well-being needs. Examples include when your primary care provider assists you with your required application/reassessment paperwork; engaged, empathetic and proactive case managers; and healthcare providers that are accessible, understand military culture, and use a trauma informed approach to providing care.

You also provided specific examples of how VAC can function as a barrier to you meeting your health and well-being needs. This includes:

Bureaucratic gatekeeping: You reported lengthy wait times for benefits; complex, redundant, and exclusionary eligibility criteria and administrative procedures; and that a lack of integration with other insurers and service providers often resulted in out-of-pocket expenses or unexpected gaps in service-related coverage.

Inadequate information, inconsistent support, and lack of adaptability: You reported being unaware of the VAC benefits available to you; noted limited access to service information; expressed feeling neglected and adrift due to a lack of consistent follow-ups or check-ins; and voiced distrust in VAC's ability or willingness to adapt and provide support for your evolving needs.

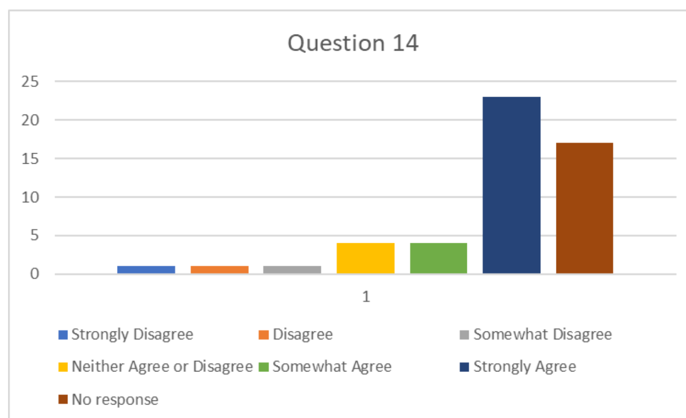
Traumatic administrative processes: You reported cold, impersonal communication with some VAC employees; having to retell often traumatic lived-experiences to achieve eligibility

and receive services; and a sense of feeling unsupported, combined with a lack of military cultural competency and trauma-informed approaches.

Inability to address needs holistically: You reported that VAC does not address your needs in a way that acknowledges the intertwined nature of your physical, mental, emotional, spiritual, social, and cultural health and well-being. You reported that preventative care and/or complementary forms of medicine, such as animal therapy, service pets, or healing retreats, are not consistently eligible for VAC coverage.

Discrimination and inequities: You emphasized inequities in wait times, funding, quality of care, resource availability and support for challenges related to racialized trauma, Indigenous medicine, and reproductive health, etc.

How much do you agree?



SECTION 5 – Health and well-being gaps

In the interviews and focus groups, we asked you - "What are the gaps in Veterans' Health and Well-being services and care?"

Many of you emphasized inequitable access to supports, resources or services that address your unique needs that stem from your varied military service experiences; intersecting characteristics such as sex, gender, race, age, ethnicity, sexual orientation, marital status, etc.; and social roles such as releasing military member, Veteran, spouse, parent, employee, friend, community member, etc.

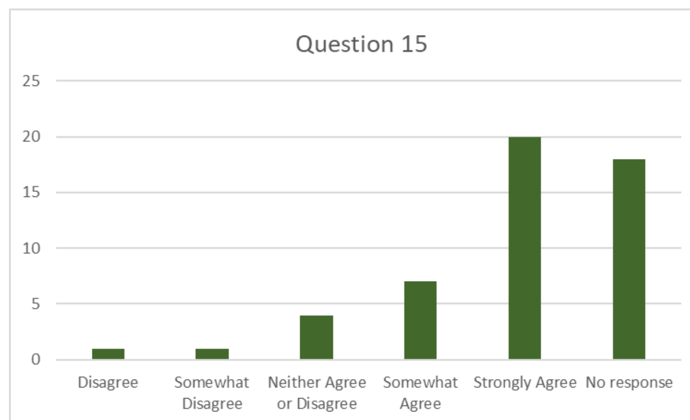
Quote: "If someone wishes to be able to have support with smudging... there is no support available through Veterans Affairs."

Quote: “I feel like I was dropped in the middle of the forest and there was nobody else to help me. There was no military support whatsoever, so I was by myself trying to find solutions for my mental health. I have no primary care provider anymore either. I know the military needs to shut their file, but I wish it would be a follow up.”

Quote: “I have had to go through a lot of therapists that have actually probably caused more trauma than they have helped (...) They are not equipped to deal with women or men with military sexual trauma."

Quote: “It's been identified, for example, that there's racism in the military, and people are saying: "Oh no, there is not, there isn't!" Well, I'm here to tell you I was on the receiving end of it all the time whether it's racism, whether it's systemic barriers, or what not. It was all presented to me numerous times, and of course the higher up and rank I go, the more I would see of it. Now that's affecting me in a huge way, and to find somebody, a therapist for example, which would understand the needs and concerns of a Black Veteran is next to impossible!

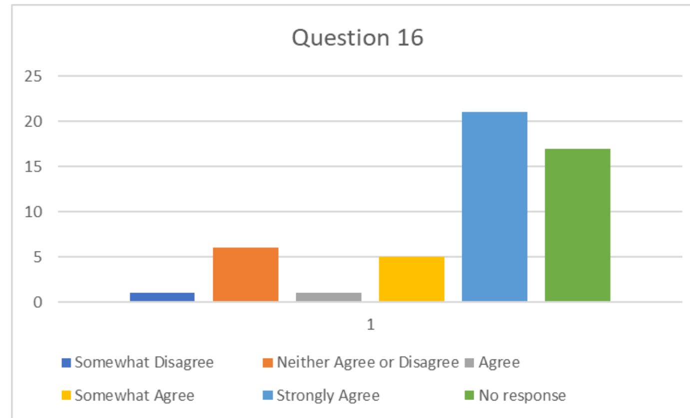
How much do you agree?



Examples of system level gaps **that you shared with us include***:*

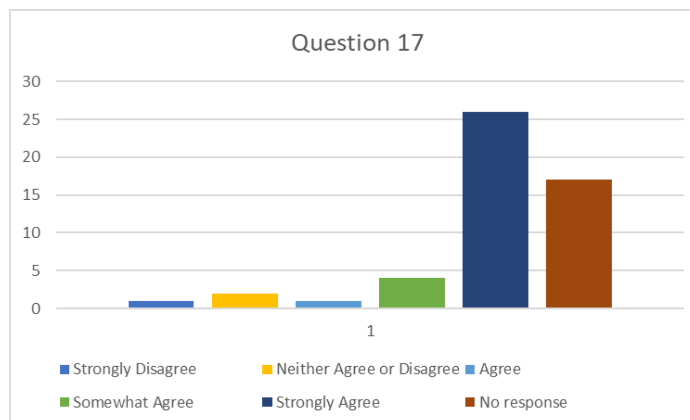
Quote: “There are inequities in providing holistic, culturally sensitive, and adequate resources to equity-deserving groups of Veterans. Healthcare providers may not understand the needs of Veterans, how to provide trauma informed care, and this lack of understanding can cause more harm.”

How much do you agree?



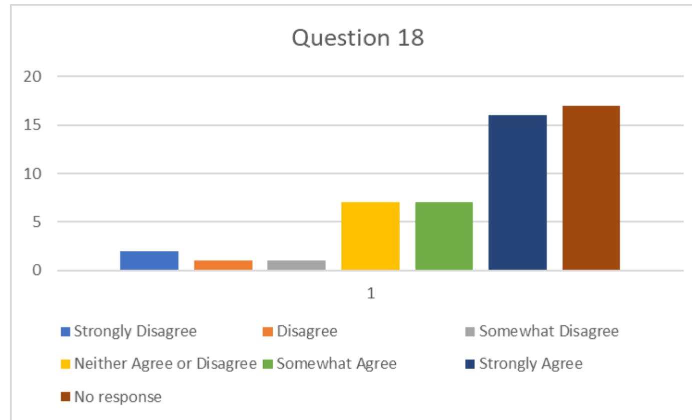
Quote: "Poor coordination among resources can lead to delays, excessive paperwork when applying for services, bureaucratic confusion, feelings of being lost and stressed, re-traumatization, and may lead to reluctance of Veterans to access support."

How much do you agree?



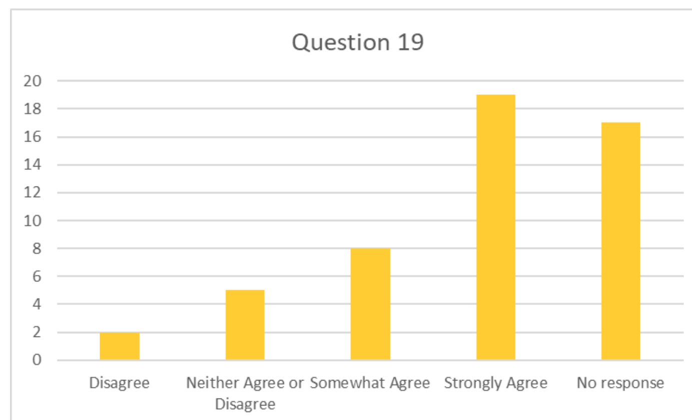
Quote: "Historic and ongoing systemic discrimination in civilian, military and Veteran healthcare systems contributes to an unequal distribution of resources which impacts some Veterans (including Women, 2SLGBTQI+, Indigenous, Black and racialized Veterans) more than others."

How much do you agree?



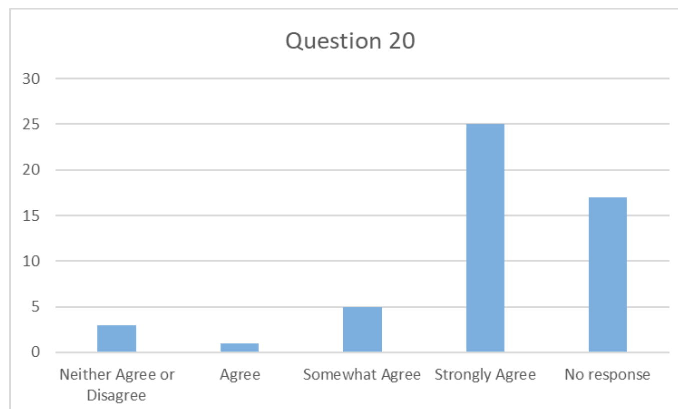
Quote: "Lack of organizational support and resources means many Veterans must rely on third party agencies that do not have evaluation processes in place for Veterans to provide feedback on their experiences. This can put Veterans at risk for potential harm due to lack of oversight and regulation."

How much do you agree?



Quote: "Veteran advocacy groups and grassroots Veteran community support have limited financial and human capacities, which can be easily overwhelmed by an increase in demand from Veterans in need. This demand puts an emotional and financial burden on Veterans who provide this support, whose health and well-being may already be taxed."

How much do you agree?



SECTION 6 – Health and well-being priorities

In the interviews and focus groups, we asked you to identify priorities that you feel would have an impact on Veterans' health and well-being.

Collectively, you identified twenty-three priorities. We recognize that some may be more important to you than others. Please choose your top FIVE.

Reduce reliance on primary care providers for VAC application processes and healthcare access.	16
Streamline VAC bureaucracy	16
Improve access to primary care providers (i.e., physicians, nurse practitioners) and healthcare providers with military cultural competency, and trauma informed approaches to care	15
Increase financial support for Veterans	15
Improve trust and accountability between Veterans and VAC	13
Include Veterans formally in VAC's VAC policy making processes and development	13
Increased awareness, knowledge, and information for Veterans' resources	12
Strengthen coordination among healthcare systems, insurance agencies, VAC, CAF, and DND.	9
Establish skills-based courses on navigating bureaucratic processes	8
Increase support for family, partners, and/or caregivers	8
Acknowledge past and ongoing institutional harms and systemic discrimination from VAC, CAF, and DND.	8
Develop military and Veteran networks and support in rural communities	7
VAC led community building and social engagement initiatives	7

Conduct comparative research on Veterans and Veteran administrations across Five Eyes Countries (UK, USA, NZ, AUS, CAN)	7
Develop a buddy-system to help Veterans navigate their transition experience	6
Provide education and training for organizations and healthcare providers (i.e., military cultural competency, trauma informed and person centric approach)	6
Provincial and federal government departments adopt collaborative, Veteran community-driven and bottom-up policymaking	5
Increase VAC research on health equity, SGBA+ and intersectionality	5
Develop specialized activities, services, and community programs for equity-deserving and hard-to-reach Veterans	4
VAC to adopt a health equity and social justice lens for service delivery, and policy and program development	4
Conduct research on systemic racism, discrimination, sexism, homophobia, etc. within VAC, CAF, and DND	4
VAC increase efforts to evolve Canadians' understanding and recognition of Veteran diversity (i.e., women, 2SLGBTQI+, Indigenous, Black and racialized Veterans)	3
Increase representation of Black Veterans in organizational decision making	2

Thank you for taking the time to provide your feedback and for your overall contribution to this research. It has been a pleasure collaborating with you.