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MEASURING OUR COMMUNITIES:

The State of Military and Veteran Families in the United States

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Marine Corps Cpl. Makayla Longbrake presents arms during an activation ceremony at Marine Corps Base Hawaii, June 24, 2022. Photo by Marine Corps Cpl. Patrick King

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INTRODUCTION

Welcome to the Military Family Research Institute's third report on the state of military and veteran families in the United States. Since the last report, the nation has experienced significant events: a new White House administration, a once-in-a-lifetime global pandemic, and withdrawal of military troops from Afghanistan after more than two decades. Military and veteran families have experienced these events along with the rest of the nation but with different perspectives owing to their military service. For instance, many service members and veterans who deployed to Afghanistan have connections to the Afghan nationals and have worked closely with them over two decades.

The nation's response to COVID-19 has included military deployments of both active duty and reserve forces. The active component has seen deployments of U.S. Navy hospital ships and other active military personnel supporting civilian hospitals and vaccination sites. The National Guard has deployed for natural disaster response efforts, civil unrest and COVID-19 relief on a scale that has not been seen since WWII, according to a statement from the director of public affairs for the Air National Guard. A press release from the National Guard Bureau[1] on June 8, 2020, reported on that particular day, more than 119,000 National Guard service members were deployed inside and outside the United States. In January 2022, there were still more than 13,700 National Guard members deployed assisting in COVID-19 operations nationwide.[2] These deployments bring additional stressors to military families during unprecedented stressful times at home. The Department of Defense deployed active duty, reserve, and National Guard service members to installations across the country in fall 2021 in support of immigrant visa applications for Afghans who had been evacuated from their home country; those deployments were in addition to ones necessitated by the ever-changing needs of U.S. communities throughout the course of the pandemic.

With these changes, it is even important to understand the current state of military and veteran families across the country. As communities large and small look to address the needs of their citizens, the needs of minority communities such as military and veteran families could be overlooked as the competition for finite time and resources might make their needs less visible.

In each section of the report, we share the current status of American military and veteran families using the most recent data available. Unique to this report is data on the status of military and veteran families both before and during the pandemic in cases where such data is available.

Most of the current pandemic information comes from organizations that have surveyed this population, notably, Blue Star Families, the Military Family Advisory Network and the Wounded Warrior Project; we thank them for their partnership.

MEASURING COMMUNITIES is an online data resource designed to strengthen community efforts to support military and veteran families. Data from more than 30 government and nonprofit sources provide military-specific information about communities across the U.S. Interactive maps as well as charts and tables display national and regional military- and veteran-specific information according to 10 domains.

Since 2016, individual users from across the nation and more than 160 organizations have used Measuring Communities to find gaps in local services, benchmark their communities against others, and strengthen their engagement with the military and veteran community. Measuring Communities helps organizations to "move the needle" for military and veteran families.

The Measuring Communities initiative brings together expertise from two organizations at Purdue University: The Military Family Research Institute, with expertise about military and veteran families; and the Purdue Center for Regional Development, with expertise in data visualization and mapping. Subject matter experts and users have been involved at every step, helping to inform selection of domains, relevant indicators and design of user experiences. Many site components are a direct result of feedback and advice from these subject matter experts and users. We are very grateful for their guidance, but we want readers to know that we, not our expert colleagues, are responsible for any errors or inaccuracies.

CHANGES TO THE ONLINE PORTAL Since the last report, new indicators have been added, such as racial diversity of veterans by state, and participation by veteran families in the Supplemental Nutrition Assistance Program (SNAP). Congressional districts have been added as a new resource for geographic assessments. Two new user tools have been added as a result of collaboration with Purdue University's Department of Public Health: a state-level Hospital Compare report comparing six different measures of quality for VA and non-VA hospitals, and Congressional Snapshots, focusing on health and well-being of veterans, both of which are available for download.

IN THIS REPORT This year's report contains dedicated sections for each of nine domains: demographics, community, employment, education (K-12 and post secondary), housing, behavioral health, medical and financial. The report also includes a special COVID-19 section using data that national organizations have gathered. Within each domain, the **What we Know** section directs readers' attention to key points. The body of each section provides more detailed information. The **Call to Action** makes specific suggestions about ways to address challenges related to each domain.

AREAS WHERE HAVE COMMUNITIES MADE PROGRESS
The number of homeless veterans appears to continue trending downward; in fact, there has been more than a 42% decrease in the number of homeless veterans since 2011. The 2021 Point in Time count numbers are advisory, since many Continuum of Care (CoCs) were not able to accurately count veterans due to COVID-19 restrictions on social distancing. Federal COVID-19 relief funds have supported efforts to reach this vulnerable population. The employment picture for veterans continues to improve in most areas of the country despite the COVID-19 pandemic, although the outlook for military spouse employment is less positive.

The pandemic has ushered in an explosion of telemedicine use for both medical and behavioral health care. The VA has been a telehealth leader providing telehealth services to veterans for almost two decades. With pandemic-related restrictions of in-person medical and behavioral health visits, the VA was able to ramp up its telehealth services in order to continue serving their population, with a resulting increase of more than 1,800% from January 2020 to January 2021.[3]

AREAS WHERE COMMUNITIES CONTINUE TO STRUGGLE
The veteran population continues to shrink in many communities. Where there are fewer veterans, there are generally fewer services. Suicide rates among both veterans and service members continue to be of concern. Challenges with medical and mental health shortage areas still exist. Reduced access to medical and mental health care for veterans and family members due to a focus on pandemic-related conditions may have negative outcomes for this population that are as yet unknown.

USING THE DATA Measuring Communities uses data compiled from a variety of credible sources. Variations in the methods used to gather data should be taken into account by decision makers so that information is used appropriately. Measuring Communities incorporates a confidence index to help users quickly know what to be aware of when using information. The index is scored on a scale from 1 to 5.

Characteristics that affect the level of confidence readers can have in data include those described below.

RANDOM OR PROBABILITY SAMPLES When participants are selected for surveys or research using random or probability methods, it increases the chance that the results do a good job of representing the larger population. Probability methods reduce bias that can occur when some individuals never learn about a survey and thus don't participate, or when some individuals choose to participate because they have particularly strong feelings about the topic. On the other hand, when surveys are conducted within the membership of a particular organization or broad groups with unknown composition, it can also be hard to know how much the resulting data can be generalized to all the organizations members or the population in general.

SIZE AND DIVERSITY OF SAMPLES AND RESPONSE RATES When the number of people who respond to a survey is small, unusual responses can skew the overall results. With small studies, it is also harder to fully and accurately represent all of the diversity present in the population.

VALIDITY AND RELIABILITY Just because researchers ask a question about a particular topic does not mean that the information they obtain is of high quality. It is important to be sure that the questions will produce data that are valid – that is, they measure what they are intended to measure. Usually, this means using instruments that have been verified using specific scientific procedures.

DATA WEIGHTING When data are gathered from random samples, participants are selected from a list. If characteristics of the individuals on the list are known, it is possible to use well-established procedures to give some responses more or less weight in the final analyses so that the overall results will be representative of the entire population. Common examples would be results that are weighted to match the population of members of the civilian labor force or the military population. When samples are not selected from a list, it is very difficult to ensure that they accurately represent the population.

CONFIDENCE INDEX SCORING Each data source within Measuring Communities has been assigned a score of 1 to 5, with 5 being the highest level of confidence. For each of the characteristics listed above, a score is assigned for that characteristic, and the points are totaled, resulting in the overall score. For example, a survey with well-validated measures and administered to thousands of participants selected using probability methods would receive a higher confidence score (5) than a survey administered to a small convenience sample using newly developed questions which would have a lower confidence score (1).

Higher scores on the confidence index mean that decisions can be based more heavily on that information. When confidence scores are low, the information may need to be verified in the local area or with more people before basing decisions on the data.

This report uses data from many government, scientific and non-profit sources including those mentioned earlier. All these data sources have limitations. Surveys and reports from non-profit organizations may have lower confidence index scores because of non-probability sampling, but often may be one of the only sources of specific COVID-19 related data collected directly from military members, veterans and their families.

Using the principles of the confidence index, readers should use these findings in an advisory capacity and search out additional local or regional sources to confirm or help frame possible actions.

DECENNIAL CENSUS Every decade, the U.S. Census Bureau counts the number of living people in the United States. This count is known as the census, and is required by the U.S. Constitution Article I, Section 2. The 2020 Census is the 24th time that the population has been counted. The 2020 Census is also the first time in the nation's history that people were able to complete the census questionnaire using four methods — in person, mail, phone or online.

In between each decennial census, the U.S. Census Bureau estimates the population based on the previous census count. For example, after the 2010 Census, each year from 2011 to 2019, Census Bureau staff calculated the size of the population. In 2020, the Bureau once again systematically counted the United States population again.

MEASURING COMMUNITIES WEBSITE If you would like to do a deeper dive into the data for your community, visit the Measuring Communities website at **www.measuringcommunities.org**. Please see the instructions at the end of this report for accessing local data.

Important Definitions

Military-connected: Military-connected individual is an inclusive term for veterans, service members and family members.

Non-veterans: All civilians 18 years old and older who are not classified as veterans

Rural: for the purposes of this report, "rural" uses the 2013 Rural-Urban Continuum Codes[4] that distinguish metropolitan counties by the population size of their metro area, and nonmetropolitan counties by degree of urbanization and adjacency to a metro area. The official Office of Management and Budget (OMB) metro and non-metro categories have been subdivided into three metro and six non-metro categories. Each county in the U.S. is assigned one of the nine codes. Counties considered "very rural" have a score of 7, 8 or 9.

Service member: Service member is an inclusive term to include currently-serving active duty, reserve and National Guard members in all branches of the Armed Forces.

Veteran: Unless otherwise noted, the term veteran reflects the American Community Survey(ACS) definition of veteran, which is a person 18 years old or over who has served (even for a short time), but is not now serving on active duty in the U.S. Army, Navy, Air Force, Marine Corps or the Coast Guard, or who served in the Merchant Marine during World War II. People who served in the National Guard or Reserves are classified as veterans only if they were ever called or ordered to active duty, not counting the four to six months for initial training or yearly summer camps.

DEMOGRAPHICS

What we know

- **The demographics of active duty and selected reserve members are changing.**
- **The number of military family members is decreasing.**
- **Women veterans are more racially diverse than their male veteran counterparts.**
- **The veteran population is decreasing overall, but increasing in some areas of the country.**

DEMOGRAPHIC SHIFTS Over the last decade, the demographics of those currently serving have shifted. The active force is getting smaller. A review of the Department of Defense (DoD) Demographics reports from 2010 to 2020 shows that the number of active duty and selected reserve members decreased by approximately 6%, or more than 138,000 members. Although the total military force continues to be predominately male, the percentage of service members who are women has increased significantly over the past ten years. The representation of women in the active component increased from 14.4% to 17.2%, while women serving in the selected reserves increased from 17.9% to 21.1% during the same time frame.

The racial makeup of the force also continues to change. Typically the makeup of the U.S. military mirrors that of the civilian population, but according to the 2010[1] and 2020[2] Department of Defense Demographics reports, the racial diversity of the military is increasing. While the active component is more diverse than the selected reserves, the 10-year trend shows the selected reserves also becoming more diverse. In the selected reserves, for example, the percentage of African American service members increased a full percentage point to 15.9% of the force, as compared to representation in the U.S. population of 13.4%. The percentage of Asian service members increased from 2.8% to 4.5%, and the percentage of multi-racial service members increased from .7% to 1.8%.

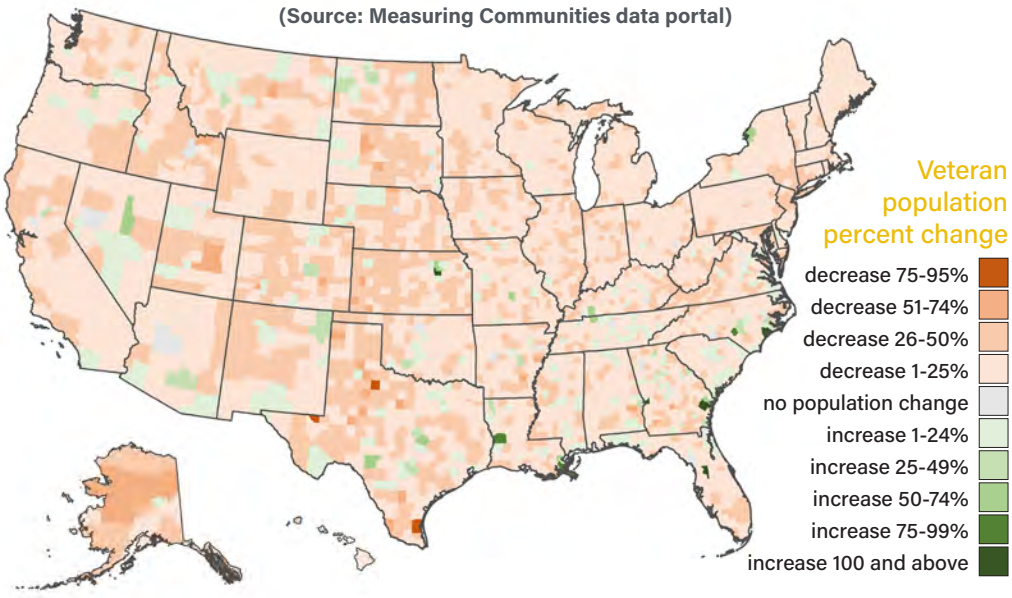
CHANGING FAMILIES Historically, military members are generally young, more likely to be married than not, and if parents, to have young children. During the past 10 years, military families have been changing along with military members. The 2020 DoD Demographics Report[3] indicates that for the first time in more than 15 years, more active duty service members are unmarried than married, and only 44% selected reserve members are married. Additionally, there has been a decline in service members who have children. In the 2010 report, there were just under 2 million children of U. S. military and just over 1.6 million reported in the 2020 edition. This represents a decline of more than 22% for children of active duty members and an almost 11% decline in children of selected reserves. The U.S. population saw a decrease of only 1.4% in the number of children under 18 during this same period.[4]

There may be questions about why this decline is occurring given military benefits which may incentivize marriage and families. The U.S. military could reflect the societal changes of marrying later, deciding to never marry, or having fewer children. Another possibility is that current DoD counting may not truly reflect the current family diversity of U.S. service members. The 2019 National Academies of Sciences report[5] on the current support systems for military families concluded that current DoD data structures might not be capturing the true makeup of military families. For example, the DoD Demographics Report makes no distinction between unmarried personnel who do or do not have partners.

WOMEN VETERANS AND RACIAL DIVERSITY According to the U.S Department of Labor[6], in all age groups and racial

Veteran Population Change 2010-2019

(Source: Measuring Communities data portal)



categories except one, women veterans include higher percentages of minorities than their male counterparts. The median age of a woman veteran is 51, compared to 65 for their male counterparts, which may partially explain the greater racial diversity among women veterans, as younger U.S. demographic groups generally are more racially diverse. Among women veterans aged 18-34, African Americans represent 22.4% of the population, as compared to 12.4% for men. Asian women of the same age make up 3.7% of women veterans as compared to 2.9% for males.

VETERAN POPULATION INCREASES IN SELECT AREAS Previous Measuring Our Communities reports indicated that the total number of veterans is decreasing. In the last 10 years, the veteran population has declined almost 20%. On average, veterans account for 8.9% of the total population. The 2019 Veteran Population[7] trends indicate that every U.S. county still has residents who are veterans, but only 9.3%, or 295 counties, have populations that remained the same or increased during this time.

Notably during the last decade, six U.S. counties experienced veteran population increases of at least 100%. Long, Liberty and Chattahoochee counties in Georgia; Onslow County in North Carolina; Geary County in Kansas; and Sumter County in Florida all experienced increases between 101% to 156% in veteran populations.

All of these counties except one, Sumter County, Florida, are located close to military installations. The support services available at installations, such as medical treatment facilities and commissaries, may be important reasons why veterans choose to live in these areas. Population estimates from the VA show veteran numbers declining to about 13.6 million by 2048[8]. As the number of veterans in individual communities shrinks, their needs for support and services are at greater risk of being overlooked.

Call to action

- **Use 2020 Census Bureau data as soon as they are available to get an accurate count of veterans in your community. Identify the shifting composition of the veteran population in order to offer the correct mix of services.**
- **Use Measuring Communities data to identify the number of military family members in your community, making sure they get comparable attention.**
- **As women veteran numbers increase, study the availability and types of community resources to support them.**

COMMUNITY

What we know

- **Veterans' sense of service benefits the communities in which they live.**
- **Veterans living in rural communities face limited medical and behavioral health care access relative to their non-rural veteran counterparts.**
- **Feelings of community support are vital to the well-being of veteran and military families.**

VETERANS STILL SERVE While their population may be shrinking, veterans' roles in their communities are not. According to the 2021 Veterans Civic Health Index (CHI) report[1], veterans continue to be more engaged than their non-veteran counterparts in all aspects of civic involvement. The report indicates that veterans are more likely to vote than their non-veteran counterparts and voted in higher numbers in the 2020 presidential election (74.7% versus 66.9%) They are also more likely to contribute to charity (60% versus 52%), and they volunteer about 30% more hours to community organizations than their non-veteran neighbors. Since the first CHI report in 2013 until 2019, volunteering among veterans rose from 26% to 30%, while voter participation increased from 71% to 74.7%.

Overall, the proportion of state and federal legislators who have served in the military continues to decline. In our last report[2], 20% (117) governors or members of the 114th Congress had served, but currently only 18% or 98 of congressional leaders and governors have had military service[3]. There are 12 states without any current service members or veterans in their congressional delegation. A bright spot is that among younger members of Congress (45 years or younger), 27% have served in the military. Of the 91 congressional members with military service, 55% have served since 2000.

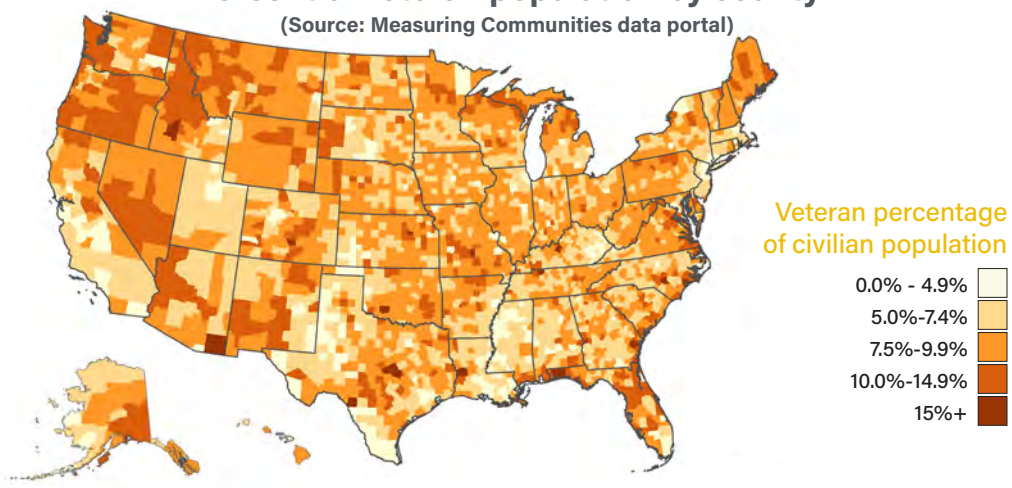
The National Conference of State Legislatures (NCSL)[4] identified 911 military veterans in the 50 state and five U.S. territorial legislatures, or 12.4% of state legislators nationwide for the 2020 election cycle. Idaho has the highest percentage of military veterans and New Hampshire has the largest number, at 72 veteran legislators. These high percentages of veterans serving in elected positions suggest that military service is a positive attribute for those aspiring to political office.

RURAL CHALLENGES According to the National Center for Veterans Analysis and Statistics and the Office of Rural Health[5] in the U.S. Department of Veterans Affairs, approximately 4.7 million veterans live in rural communities. Of these veterans, 58% are enrolled in VA health services as compared to 37% for urban veterans. The other 42% must rely on community health services. Federally Qualified Health centers (FQHC) are the safety net for these rural communities, and serve one in five rural residents. Rural health services are facing their own challenges, however. Thomas Klobuchar, executive director of the VA Office of Rural Health[6], has noted that 80% of rural communities are medically underserved, and 93% of rural counties have no licensed psychologists, making mental health care access extremely limited.

Additionally, rural hospitals in communities across the country continue to close, further limiting medical care access for both veterans and non-veterans. According to the Cecil G. Shelps Center for Health Services Research, in the last decade, 136 rural hospitals have closed; in 2020 alone, a record number of 20 hospitals shuttered. Texas and Tennessee led the country in closures, with 21 and 16 hospitals respectively.[7] According to Census Bureau data, there are approximately 300,000 and 172,000 rural veterans in Texas and Tennessee[8].

Percent of veteran population by county

(Source: Measuring Communities data portal)



COMMUNITY CONNECTIONS Previous Measuring Our Communities reports have addressed challenges military and veteran families face regarding connection and belonging in their their civilian communities, and their specific feelings that their sacrifices are often not appreciated and understood. Connections provide an important safety net for military families, most of whom live in civilian communities rather than on installations. In the 2019 DoD Survey of Active Duty Spouses[9], only half (52%) reported that if there were an emergency, there would be people in the community to assist, even if they did not know them. Stress on military spouses and families is a concern. On the 2019 DoD Survey of Active Duty Spouses[10] and Survey of Reserve Component Spouses,[11] 54% of active duty spouses and 37% of selected reserve spouses reported their current personal level of stress as "more than usual." Lack of community connections might be a contributing factor to these stress levels.

However, in the 2020 Blue Star Military Lifestyle Survey[12] fielded during the pandemic, sense of community understanding and support had improved from previous surveys. In 2019[13], only 37% of active duty respondents indicated that their local communities appreciated military family sacrifices, and only 17% indicated an understanding ofthe sacrifices. By the 2020 survey, 50% of active duty respondents reported sacrifices being appreciated and 33% sacrifices being understood. Similar increases were seen with National Guard family respondents. In 2019, 41% reported feeling appreciated and 20% 20% reported being understood, but by 2020, these proportions rose to 58% and 46% respectively.

While the MFLS survey has fewer survey respondents than the DoD spouse survey and may not be representative of all military families, we can see a similar pattern of reserve component families reporting a higher level of appreciation and understanding than their active duty counterparts. This is a notable increase for such a short time. While it is difficult to pinpoint any specific reason or reasons, some data[14] suggests that service members' work in distributing food, providing vaccine support, and supporting health care systems during the pandemic increased public awareness and appreciation of their service.

Community connections are especially important for wounded service members and veterans. In the past two years, pandemic-related social distancing and lockdowns have separated many individuals from their normal support systems and resources, increasing their risk of social isolation that in turn can contribute to worsening medical and mental health conditions. A 2020 Wounded Warrior report on COVID-19[15] examined the effects of social isolation on combat veterans who had incurred a physical or emotional wound; 60% of the respondents indicated that they had been experiencing moderate to severe depression, while 66% reported loneliness. These statistics highlight the need for wounded warriors to stay connected to their support networks during highly stressful times and for communities to ensure that these local support systems and networks exist.

Call to action

- **Educate community members about the challenges and opportunities of military service, engaging military members and their families in these efforts.**
- **Grow community connections with military families through employment and education networks.**
- **Identify military or veteran support groups in local areas, support their outreach efforts and assist in documenting impact.**
- **For organizations that encounter new families within communities, consider asking families — both civilian and military — about feelings of connectedness with their new community. Identify gaps in their perceptions, and direct efforts based on the results.**

EMPLOYMENT

What we know

- **COVID-19 has had a significant transitory impact on veteran employment, which has since shown improvement.**
- **Military spouse employment has been significantly impacted by the pandemic and is a challenge requiring continued focus and action.**
- **Increases in remote and telework opportunities are changing the employment landscape. This newfound flexibility may increase opportunities for military spouse employment.**

SPIKES IN VETERAN UNEMPLOYMENT The 2019 employment situation for veterans was one of the strongest in recent times. The U.S. Bureau of Labor Statistics (BLS) 2019 Employment Situation of Veterans Summary[1] reported that 3.5%, or approximately 284,000 veterans, were unemployed. Unfortunately, that number grew to 581,000 (6.5%) in 2020[2], a 104% increase, mainly due to the COVID-19 pandemic. Veteran unemployment numbers have continued to improve since this time with the 2021 report[3] showing a 4.4% unemployment rate.

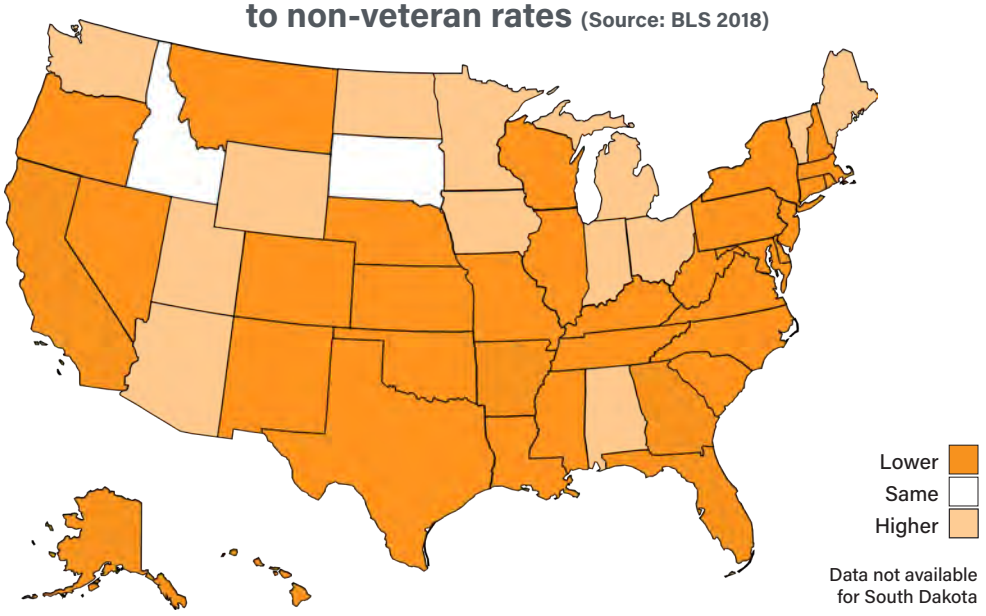
In 2021, veterans ages 25 to 54 were more likely to be unemployed than any other age group (56%) with the youngest veterans, ages 18 to 24, least likely to be out of work (5%). Female veterans, at 4.2% unemployment, fared slightly better than their male counterparts, at 4.4%. Increases in unemployment during the pandemic were smaller for veterans with service-connected disabilities, from 4.8% to 6.2%, compared to 3.7% to 7.2% among veterans without disabilities. Some of this difference might be attributed to the high percentage of veterans employed by the federal government, the largest employer of veterans, or to federal preferential hiring practices for veterans with service-connected disabilities. In the federal workforce, 32% have had prior service.

VETERANS DOING BETTER THAN NON-VETERANS Historically, veterans have had lower unemployment rates than their non-veteran counterparts. In the past ten years of the Current Population Survey[4], veterans had lower unemployment rates than non-veterans in all but five months. At the height of pandemic, for the month of April 2020, unemployment rates for veterans were 11.9%, relative to 14.8% for non-veterans. Despite the spike in April 2020, the annual unemployment rate in 2020 for veterans and non-veterans was 6.5% and 8.0% respectively.

State unemployment data mirrors the national data. In only 13 states are veteran unemployment rates above those of non-veterans, with the largest differences in North Dakota, Minnesota and Iowa. Conversely, Hawaii, Alaska, Colorado and Nevada have the largest differences favoring veterans.

MILITARY SPOUSE UNEMPLOYMENT Military spouse employment continues to be concerning for both military families and the Department of Defense, and COVID-19 intensified this challenge. Historically, military spouses are less likely to participate in the workforce, and more likely to be unemployed than their civilian counterparts. Every two years the DoD conducts large surveys of military spouses[5], and the 2019 survey reported that 22% of active duty and 7% of selected reserve spouses were unemployed. This was marginally better than in 2017[6] [7], when unemployment rates were 24% and 8% respectively. Among employed military spouses, only 56% reported that they were employed in a field related to their education or training, which was unchanged since the 2015 report. Data are not yet available for the 2021 survey, which was fielded in August 2021.

Unemployment rates: Veteran rates compared to non-veteran rates (Source: BLS 2018)



The annual Military Family Lifestyle Survey (MFLS) conducted by Blue Star Families has continually listed military spouse employment as one of the top issues for active duty *spouses,* but the 2020 MFLS[8], which included data about COVID-19, was the first time in the history of the survey that spousal employment made the top five list for active duty service *members*. This most recent survey also noted that unemployment is more challenging for respondents of color and for spouses who have recently relocated.

The MFLS results indicated that COVID-19 had substantial effects on military spouses in the workforce[9]. More than four in ten (42%) active duty spouses who were employed pre-pandemic stopped working at some point, mainly due to layoffs and furloughs. Nationwide, families had to decide how to best balance work-family obligations due to school and day care closures, and military families faced these same challenges. The Blue Star Family Pain Points Poll Deep Dive[10], which examined major points of stress for families during each of the study weeks in 2020, reported that 13% of respondents took leave from employment to address childcare or educational needs. Spouses 30-39 years of age were more likely than other age groups to be working reduced hours due to lack of childcare or educational resources, and spouses aged 18-29 were more likely to report challenges entering the workforce.

COVID-19 brought about significant, and in some cases, permanent, changes in how America works. The U.S. Bureau of Labor Statistics[11] reports that for those occupations suited for telework, more than 57% workers worked remotely during May-June 2020. This trend may not have held for military spouses, however. The BSF Pain Points Poll showed that only 32% of active duty spouses reported being able to continue working in a remote or telework arrangement. Military spouses, especially those of junior enlisted service members, are more likely to work in civilian jobs not suitable for telework such as hospitality and service sectors.

10 States with highest vet unemployment rates

(Source: Measuring Communities data portal)

1. Puerto Rico
2. Virginia
3. Alaska
4. Alabama
5. Mississippi
6. New Mexico
7. South Carolina
8. Georgia
9. Arizona
10. Texas

Call to action

- **Investigate local and micro-targeted approaches to focus on reducing veteran unemployment in the small yet dispersed labor markets where the employment outlook for veterans is not as favorable as it is for non-veterans.**
- **Capitalize on the experiences of pandemic telework arrangements. Raise visibility and encourage programmatic private and public sector initiatives to target military spouses for remote work opportunities.**
- **Encourage employers and their sourcing partners to add military spouses to their talent pipelines for telework opportunities.**

K-12 EDUCATION

What we know

- **Children's education is a priority for military families and often involves making sacrifices.**
- **Military children's education, especially children with special needs, has been severely affected by COVID-19.**

MILITARY CHILDREN'S EDUCATION In 2020, more than 914,000 school-aged children had a military parent[1]. Military children face educational and social challenges due to frequent moves. The Department of Defense estimates that military-connected children will attend six to nine different schools during their first twelve years of schooling. The 2020 Blue Star Families Military Family Lifestyle Survey (MFLS)[2] indicated that children's education is one of the top five concerns for active duty parents.

It is important to help military parents be effective advocates for their children. The Interstate Compact for the Education of Military Children[3] provides resources for both schools and families through the compact commission, the state commissions and the military's school liaison officers. Additionally, the Military Child Education Coalition (MCEC) recently created a Purple Star School Designation initiative with the purpose of easing the transition to a new school.[4] While national education legislation might impact all military-connected children, the most impactful decisions are made at the local school district and state levels.

Moving to a new community, especially one where education discussions have become polarized, can add to parents' anxiety for their children. Many military families make sacrifices to ensure their children have the best education possible. The 2020 MFLS[5] reported that 85% of active duty families who live off-installation have housing costs that exceed their housing stipend, and 41% of these families report that access to a desirable school district is one of the reasons. A large majority of these families (76%) pay more than $200 per month in out-of-pocket expenses to live in these areas.

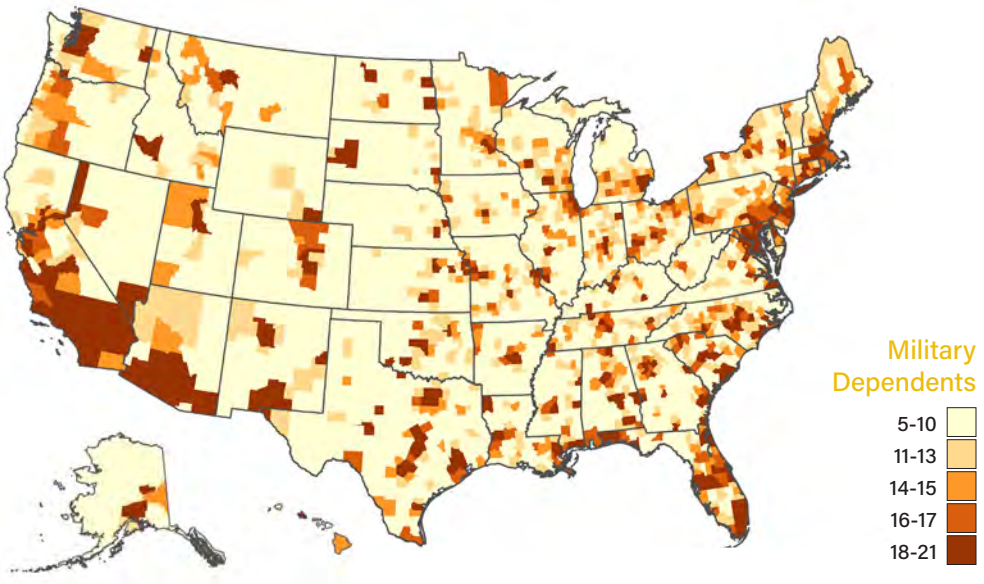
Many families endure voluntary separations to ensure children's academic progress, especially those who have children with special needs. The term "geo-baching" refers to circumstances in which a military family voluntarily lives apart from their service member. The MFLS[6] reported that 23% of survey respondents had geo-baching arrangements during the previous five years. Of these respondents, about 49% reported that children's education was one of the reasons for voluntary separation. However, if families had a child with identified special needs, that percentage rose to 65%.

Some families have chosen homeschooling as a solution. Homeschooling saw a tremendous increase with the onset of the pandemic and virtual learning. In 2019, only 8% of active duty families responding to the MFLS[7] reported using homeschooling options for their children. In 2020, that number rose to 13%, higher than the civilian population. For many families, homeschooling offsets military family lifestyle challenges like frequent relocations and education gaps[8].

Another possible solution is education savings accounts. A bill reintroduced in Congress, the Education Savings Account for Military Families Act of 2021, would direct the Secretary of Education to create an education savings account for military families to use for educational expenses for their child, including private

Map of Military Dependents by County

(Source: Measuring Communities data portal)



school tuition, online learning programs or other expenses. Similar to a college savings fund, the ESA would allow military families to have more control over their child's educational options.

COVID-19 AND CHILDREN While much of the nation "sheltered in place" in the early months of the pandemic, military families were still moving, requiring military children to change school districts. Starting a new school creates difficulties on its own, but remote learning and the inability to connect with classmates due to quarantine and other restrictions created additional challenges. Due to the mobility of military children, school districts working to help students who have fallen behind becasue of remote learning may or may not have robust services in place to assist transitioning military children whose learning and socialization skills were affected by the isolation of the pandemic.

Educational challenges are magnified for families who have children with special needs. The 2020 MFLS[9] reported that only 22% of active duty family respondents who have children with special needs were able to retain all of their child's special needs supports during the COVID-19 pandemic, and 39% reported they were not able to retain any supports. Initiatives such as the Military Child Education Coalition's Purple Star School[10] program is one way parents can identify schools and school districts that have put initiatives in place to support military-connected children.

Call to action

- Encourage local and state education leaders to expand outreach to military parents as partners in quality children's education.
- Identify best practices that support military families with special needs children and work to implement them within local school districts.

POST-SECONDARY EDUCATION

What we know

- **Veterans encounter challenges translating military training to the civilian workforce.**
- **Veterans with Post- 9/11 GI Bill benefits have been negatively affected by COVID-19 campus closures.**

VETERANS AND NON-DEGREE CREDENTIALS The Post-9/11 (or "Forever") GI Bill provides financial support for veterans and service members pursuing education. The Veterans Benefits Administration has reported[1] that a majority of veterans using this benefit (61%) were obtaining undergraduate or graduate degrees, and 38.2% were enrolled in two-year degree programs or vocational/technical education.

Service members engage in continuous training throughout their military service, but a disconnect persists between this education and how it translates to the civilian workforce. Certificate programs can help close some of the gap and seem appealing to veterans. Recent data[2] shows that veterans hold non-degree certificates at a much higher rate than their non-veteran counterparts – 57% for veterans compared to 35% for non-veterans. The data also indicated that, on average, individuals with occupational non-degree credentials earn $10,000 more than those without these specific credentials.

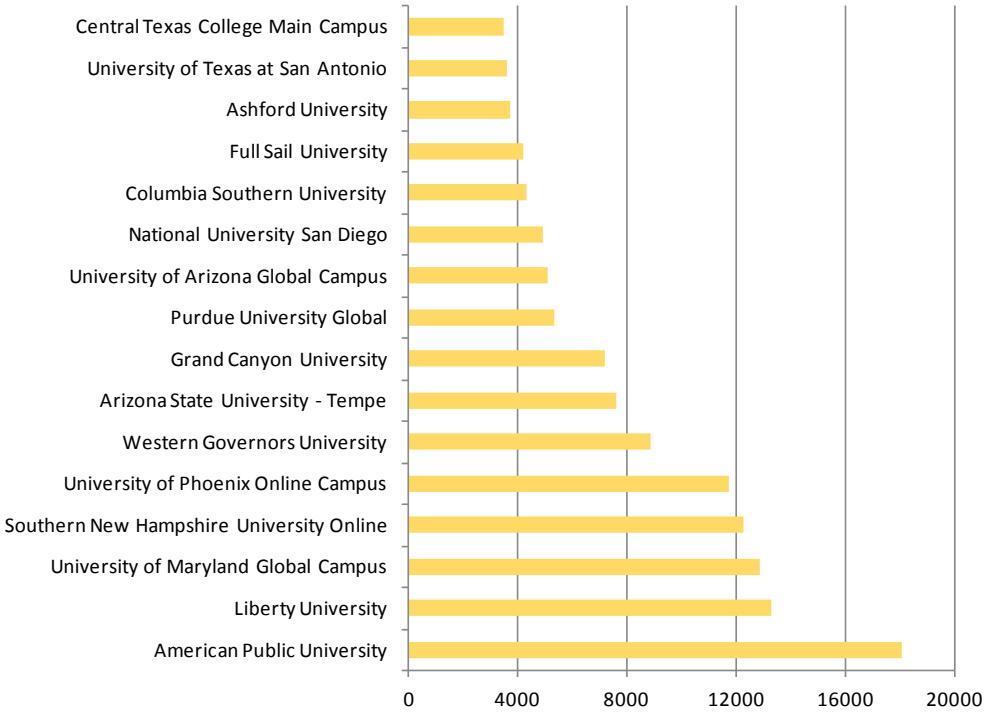
With a changing economy and workforce, individuals with credentials are better prepared for the demand for new skills and thus are more employable than those without. As service members transition to the civilian labor market, finding employment is a top concern. Service members with these certificates or credentials may be able to transition to gainful civilian employment faster than those without them.[3]

EFFECTS OF COVID-19 Service members join the military for a variety of reasons, including the availability of education benefits. The Post-9/11 GI Bill[4] provides funds for tuition, fees and monthly housing allowances (MHA) based on the campus location where veterans physically attend most of their classes. If a student engages in distance learning, then their MHA is based on 50% of the national average.

When the pandemic shifted learning from in-person to online, veterans were in danger of receiving reduced MHA to match the distance learning rate. For some veterans, the Post-9/11 GI Bill was their only means of support, and a reduction in the MHA would have meant significant financial stress. A series of special COVID-19 rules allowed the VA to continue providing the resident rate of MHA through December 21, 2021.[5] An additional extension was granted until June 1, 2022.

This resident rate protection is for only those veterans who registered for in-person classes before their higher education institution moved the class to remote or virtual learning. As the pandemic continues to bring changes to all levels of education, GI Bill recipients must pay close attention to any changes in benefits to potentially avoid financial hardship. Additionally, lessons learned from the pandemic for the VA and others should be incorporated into future practices in order to improve the support provided to student veterans.

G.I. Bill Campuses Enrollment



Not all veterans and service members using GI bill benefits had to switch to remote learning, as many were already taking advantage of increased availability of online degrees. Of the top 10 campus systems enrolling individuals using GI Bill benefits, six are strictly online institutions serving almost 56,000 students[6].

Call to action

- Promote educational certificate and credential programs to service members and recent veterans as one option for transitioning to civilian employment.
- Encourage post-9/11 GI Bill recipients to closely follow changes in benefit limitations as post-secondary institutions continue to make changes to in-person learning in response to the pandemic. Encourage the VA to adopt policies that will minimize disruptions in support of veteran education.

HOUSING

What we know

- **Prior to the pandemic, the number of homeless veterans increased only slightly from 2019 to 2020.**
- **The percentage of homeless veterans and non-veterans who are sheltered continues to decline.**
- **The 2021 national Point-in-Time counts are likely less accurate than those in previous years due to complications of COVID-19.**

PRE-PANDEMIC NUMBERS The 2020 Point-in-Time Count (PIT)[1], conducted in January, showed a slight increase of 167 homeless veterans over the prior year, or a 0.5% increase in homelessness among veterans, compared to a 2.2% overall increase in homelessness in the U.S. Twenty-one states and territories experienced increases, with California, Nevada, Texas and Pennsylvania each gaining more than 100 homeless veterans in 2020. Five states – Montana, Arkansas, West Virginia, South Dakota and Utah – experienced a decrease of 20% or more in the number of homeless veterans. The number of homeless women veterans decreased by 5%, while the homeless male veteran population increased 1%.

SHELTERING VETERANS In the last five years, the percentage of sheltered homeless veterans has continued to decrease. In the 2020 Annual Homeless Assessment Report (AHAR) to Congress, the U.S. Department of Housing and Urban Development (HUD) reported that 59% of all homeless veterans were sheltered, meaning they had been placed in some type of temporary or permanent housing.[2] This was a decrease from 2018 when 62% of veterans were sheltered.

Where homeless veterans are located makes a difference in their ability to obtain supportive housing. While a majority of homeless veterans are located within the 48 major Continuum of Care (CoCs) cities, only 54.8% of those veterans are sheltered. Veterans located in in rural CoCs are sheltered at rates of 57.7%, while rates among those in other largely urban CoCs are sheltered exceed 70%.[3]

Fourteen states and territories report percentages of sheltered veterans below the national average, which is unchanged from our last report. Four states (Georgia, Oregon, New Mexico and California) and the four territories (Puerto Rico, Guam, Northern Mariana Islands and Virgin Islands) report rates of sheltered veterans below the 50% mark. Fourteen states report sheltering 90% or more of their homeless veterans, which is down from our 2018 report when 17 states reported sheltering 90% or more of their homeless veterans.

COVID-19 IMPACT The 2020 Point-in-Time Count (PIT) was conducted in January 2020, prior to the start of the pandemic in the United States. This count can provide a benchmark to help measure the impact of this event on the homeless. COVID-19 has imposed many challenges on the organizations that serve people who are homeless. Many factors beyond the obvious health risks – such as availability of support services, increased unemployment rates and evictions – will have an impact on the number of people who are homeless in the future. In addition, reports of shelters closing or limiting occupancy also impact the percentage of homeless individuals and veterans counted as sheltered. In a recent analysis, economist Brendon O'Flaherty at Columbia University estimated that homeless numbers in the general population could increase by up to 40%, based on unemployment statistics.[4]

Total homeless veterans by year

(Source: AHAR 2013-2018)

Year	Total	Male	Female	Other
2013	57,849	53,393	4,456	Not reported
2014	49,933	44,940*	4,993*	Not reported
2015	47,725	43,295	4,338	92
2016	39,471	35,955	3,328	188
2017	40,056	36,302	3,571	183
2018	37,878	34,412	3,219	247
2019	37,085	33,492	3,292	301
2020	37,252	33,862	3,126	264

*Estimated

While the numbers for the 2021 PIT are not yet published, it is anticipated that actual counts of homeless individuals will be less accurate than in the past. In response to the pandemic, the U.S. Department of Housing and Urban Development allowed "cancellations or modifications of unsheltered counts."[5] The National Alliance to End Homelessness reports in their recent survey that almost a third of the CoCs have cancelled their counts or modified their data collection such as head count only. As such, they indicate that the 2021 count may be missing important data.

FEDERAL SUPPORT The VA has a robust portfolio of programs and services for homeless veterans, as well as with interagency collaborations. However, VA funding limits the types of services it provides to homeless veterans. The Homeless Veterans Coronavirus Response Act of 2020 expanded the VA's authority to provide items like food, phones, clothing and other supplies to homeless veterans.

During the pandemic, numerous economic relief funds have been authorized to address COVID-related challenges. While some homeless shelters have shuttered, the VA has received significant funding to bolster their response and support for homeless veterans. In an effort to streamline funding to VA-supported grant and per diem shelters, Congress passed the Grant Regulation Adjustment during the Coronavirus Emergency (GRACE) for Homeless Veterans Act of 2020.[6] The intent of the GRACE act is to remove "bureaucratic red tape on VA grants for organizations assisting homeless veterans during the pandemic."

Change in the number of homeless veterans from 2019-2020

(Source: Measuring Communities data portal)

Top 10 increase

1. Northern Mariana Islands
2. Nevada
3. Delaware
4. Oklahoma
5. Pennsylvania
6. Alabama
7. Ohio, New Jersey, Texas
8. Illinois, Michigan, Kansas
9. Minnesota
10. Louisiana

Top 10 decrease

1. Utah
2. South Dakota
3. West Virginia
4. Arkansas
5. Montana
6. Vermont
7. Tennessee
8. Alaska
9. Nebraska
10. North Carolina, Virginia

Call to action

- Develop strategies and action plans to address the anticipated increase in homeless veterans due to COVID-19.
- Identify strategies that can increase the percentage of homeless veterans with shelter in rural and major city CoCs.
- Investigate opportunities and/or systems to collect data year-round to ensure more accurate counts of individuals who are homeless.

BEHAVIORAL HEALTH

What we know

- **Veteran suicide rates decreased from 2017 to 2019.**
- **Post-9/11 service member and veteran deaths by suicide outnumber the number of combat deaths.**
- **Suicide rates among members of military families have remained consistent since documentation started in 2017.**
- **COVID-19 has affected the mental health of service members, veterans and their families.**
- **Access to behavioral health care during COVID-19 was better for veterans with VA eligibility than other populations.**

SUICIDE RATES AMONG VETERANS Suicide remains a concern in communities across the country. The latest data provides some positive news, with 399 fewer suicides among veterans in 2019 — a 7.2% decrease. Among veterans from 2017 to 2019, the age-adjusted rate declined slightly from 36.5 to 35.3. In the general population, the age-adjusted suicide rate among non-veterans remained the same at 16.9 per 100,000 between 2017 and 2019, according to the 2020 VA National Suicide Data Report[1]. Veterans' suicide rates remain the highest among young males (aged 18-34), at 50.6 per 100,000. This rate is 93% higher than their non-veteran counterparts. Older veterans (those 75 years and older) are the only age group with a suicide rate lower than their non-veteran counterparts. The suicide rate among women veterans dropped significantly from its historic high in 2017 of 19.9 per 100,000 to 15.4 in 2019. However, the suicide rate among women veterans is more than double that of women non-veterans. In 2019, suicide rates among women veterans were highest among those aged 18-34, at 17.8 per 100,000.

VETERANS WITH COVID-19 Covid-19 has brought about social isolation, economic challenges and other stressors. Questions about how these unique stressors might impact the behavioral health of veterans are important to ask. Has COVID-19 increased behavioral health issues and suicide rates? A recent study examining the mental health of veterans infected with COVID-19 indicates that veterans who survived COVID-19 have greater prevalence of psychiatric conditions including suicidal ideation as compared to veterans who did not have COVID-19. Also, pre-pandemic behavioral health conditions were strong predictors of post-pandemic psychiatric disorders. Strong community engagement and integration, along with higher household income, were protective factors.

SUICIDE RATES AMONG SERVICE MEMBERS The Department of Defense's (DoD) Suicide Event Report for Calendar Year 2020[2], the most recent official report available, details a 16% increase in the total number of service members deaths by suicide, with 580 deaths as compared to 498 in 2019. While this is not a statistically significant increase, DoD does report a statistically significant increase over a five-year period (2015 to 2020).

Rates in the Reserves and National Guard were unchanged from 2015 to 2020 and are not tied to duty status. DoD suicide data for 2021[3] is available only through September 30. Approximately 383 service members died by suicide in the first nine months of the year. Rates among active duty (28.7 per 100,000), reserve (21.7 per 100,000) and National Guard (27 per 100,000) members were consistent with those for the U.S. population overall after adjusting for age and sex.

With the onset of the COVID-19 pandemic, both DoD and VA began monitoring[4 5] trends in mental health and suicide. Challenges with social isolation, financial

Suicide numbers by branch

(Source: Armed Forces Medical Examiner System)

Military Service	CY2018		CY2019		CY2020	
	Count	Rate	Count	Rate	Count	Rate
Active Component	326	24.9	349	26.3	384	28.7
Reserve Component	81	22.9	65	18.2	77	21.7
National Guard	136	30.8	90	20.5	119	27.0

stressors, health concerns and deployments for those currently serving raised concerns that the pandemic would result in an increased suicide rate among veterans and service members. So far, DoD data have not shown an increased suicide rate due to the pandemic.

MILITARY FAMILY SUICIDE 2017 was the first year DoD began gathering data on suicides among military family members.[6] In the three years these data have been collected, suicide rates among spouses and dependents have remained fairly consistent. The overall rate for spouses in 2017 was 11.5 per 100,000, and in 2019 it was 12.6 per 100,000[7]. However, the rate among male spouses was several times higher, at 51.7, than the rate among female spouses at 6.8. The rate among female spouses is comparable to their civilian counterparts, but the rate among male spouses is statistically higher. With only three years of data, it is difficult to reliably assess trends, but the consistency in rates over these first three years provides a good baseline for determining the effectiveness of DoD suicide prevention efforts going forward.

Typically, military families weather challenges related to their service members' military experiences with few lasting effects on family functioning. A 2016 RAND longitudinal study of military families[8] found that most families are resilient in the face of deployments, with most returning to an almost pre-deployment baseline functioning within months of the service member's return.

COVID-19 has imposed challenges on families across the country. A national survey of U.S. households indicated that 26.9% of parents reported worsening behavioral health conditions for themselves, and 16.7% reported this for their children.[9] Military families report similar challenges with more than half of the veteran and military family respondents to the Blue Star Families weekly Pain Points Poll[10] reporting elevated levels of stress.

ACCESS TO CARE COVID-19 restrictions and lockdowns caused a significant decrease in the utilization of behavioral health services. A report from the Centers for Medicare & Medicaid Services (CMA)[11] reported a decline of 12 million behavioral health care visits from March through October 2020 (22%) as compared to the same time in 2019. Veterans, who relied on the VA for behavioral health care, fared better than their non-veteran counterparts. A recent report[12] indicated a decrease in behavioral health care visits in the first weeks of the pandemic but within several months, the number of visits reached pre-pandemic levels.

Veterans and non-veterans suicide rates by age & gender

(Source: VA National Suicide Data Report 2005-2016)

Male veterans

Age	2017	2019
18-34	50.8	50.6
35-54	36.4	35.8
55-74	30.2	30.2
75+	33.6	30.5

Male non-veterans

Age	2017	2019
18-34	26.1	26.2
35-54	28.1	27.6
55-74	27.9	28.5
75+	45.9	48.1

Female veterans

	2017	2019
18-34	23.5	17.8
35-54	17.9	16.9
55-74	18.9	11.7

Female non-veterans

Age	2017	2019
18-34	6.9	6.3
35-54	9.3	9.1
55-74	6.7	6.7

Call to action

- Continue work to increase internet access for rural veterans to access telehealth.
- Examine the OHR Rural Promising Practices for ways to improve health access for rural veterans.
- Pay attention to military and veteran subpopulations, such as women and National Guard, when exploring suicide prevention strategies. Use information about their protective factors when engaging these individuals.

MEDICAL

What we know

- **Access to and satisfaction with medical care remains a primary concern for many military-connected demographic groups.**
- **Veterans may be at higher risk for post-COVID conditions than their civilian counterparts, due to their service-connected health challenges.**
- **COVID-19 disruptionsto routine health screenings may have long term impacts for conditions that benefit from early detection.**
- **Increased VA telehealth capacity still faces challenges in meeting the needs of rural veterans due to the digital divide.**

ACCESS TO HEALTH CARE Access to and satisfaction with health care services continues to be a main concern for most segments of the military population: veteran, veteran spouse, military retirees and those currently serving. The 2019 Survey of Active Duty Spouses (2019 ADSS)[1] reported that 90% of active duty spouses say that access to quality health care is an important benefit. The 2019 Survey of Reserve Component Spouses (2019 RCSS)[2] indicated that 78% of spouses with deployed service members have used military medical coverage (TRICARE).

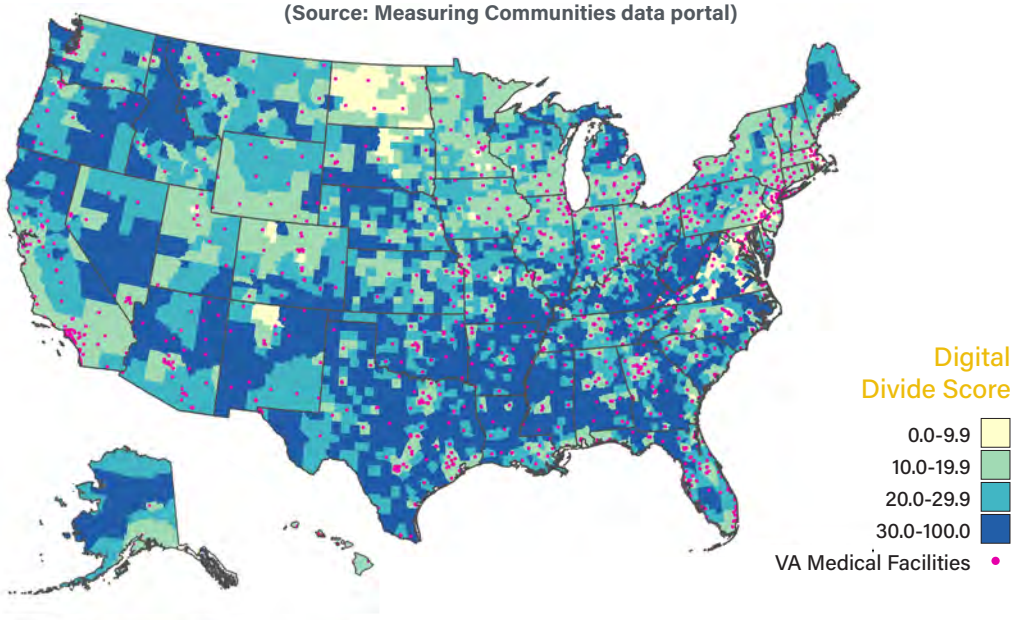
Access to and satisfaction with care received are two very different issues. Military Family Advisory Network and the Wounded Warrior Project (WWP) surveyed military retirees and post-9/11 veterans. For this survey, post-9/11 veterans were defined as those who left service before they were eligible for retirement benefits. In comparison to military retirees, post-9/11 veterans reported higher dissatisfaction rates with the overall health care they receive, their ability to access care and the quality of the providers themselves[3]. In addition, almost 30% of the post-9/11 veterans and their spouses had to travel more than 20 miles to receive care. Telehealth services have increased dramatically in the last year, which has increased access to care. However, both veteran groups in this survey had a high preference for in-person care, with 70.3% of military retirees and 59.7% of post-9/11 veterans preferring face-to-face medicine over telemedicine. Spouses of these two groups were more willing to engage in telehealth or a combination of the two.

COVID-19 IMPLICATIONS Approximately 10% of all COVID-19 patients have become long haulers[4], presenting symptoms for over six weeks even though they have since tested negative for the disease. These long-term effects do not seem to discriminate based on severity of the COVID infection.

As of January 2022, more than 417,000 veterans had contracted COVID-19 as reported by the VA health care system, with an unknown number of veterans being served in community health settings. Many new veterans may not be enrolled in VA care and opt to use TRICARE or health care benefits from their civilian employer. If we use the 10% estimate of individuals in the general population who become COVID long-haulers, then we would anticipate more than 41,000 veterans being at risk for long-term health impacts. However, veterans may be at greater risk for these long-term health impacts than their non-veteran counterparts. Research shows that veterans of both[5] [6] sexes report poorer health in multiple categories, including those the Mayo Clinic considers risk factors for COVID infections such as being overweight or obese, having lung or heart disease and being older.

Veteran medical facilities and the digital divide

(Source: Measuring Communities data portal)



Veterans may also be at risk for complications due to the pandemic. As early as March 2020, most health care systems, including the VA, placed significant limitations and restrictions on elective medical care, screenings and procedures in order to address possible surges of COVID-19 patients. A recent study of the VA health care system[7] looked at effects of the delay in cancer diagnoses and screenings. Using a baseline for four main cancers from two prior years, the study showed a 10 to 27% decline of new cancer cases, with screening procedures decreasing from 54 to 80% during the same time period. The study indicated it is too early to determine the long-term impact of these delays but suggested that some cancers when now diagnosed may require more complex treatment than if the cancer had been caught and treated earlier.

COVID-19 Active duty and Selected Reserve members also are affected by COVID-19 despite being typically young and healthy. As of January 2022, the Department of Defense had reported 273,724 cases and 86 deaths.[8] However, service branches may not be tracking the number exhibiting long-term symptoms. The Veterans Health Care and Benefits Improvement Act of 2020[9] granted VA benefit eligibility to service members who contracted COVID-19 while on federal active duty. With this provision, if service members have to exit military service due to COVID-19 long-haul symptoms, they are able to apply for VA disability benefits.

TELEHEALTH SURGE MISSING RURAL VETERANS The VA has invested billions of dollars in telehealth since the launch of VA Video Connect in 2017. In fiscal year (FY) 2019, the VA conducted more than 2.6 million telehealth visits. Since the beginning of the pandemic, the VA has seen a dramatic 1,831% increase in the number of telehealth visits, which rose from 41,000 visits per month in January 2020 to 965,000 per month in March 2021.

One goal of telehealth is to reach rural veterans. In FY2019, 45% of veteran telehealth appointments were made by rural veterans, but dropped to only 32% in the following year. While the VA continues to address the connectivity of veterans through access to reliable broadband or technology such as iPads for access, connecting with rural veterans remains a challenge. Other factors including socioeconomic and education need to be considered. A recent study in the Journal of Medical Internet Research found that rural veterans who are older and have less formal education are not as able or willing to engage in telehealth as other veterans.

Call to action

- Community and VA health systems can closely coordinate to address veterans' increased health needs due to COVID-19.
- Redouble efforts to encourage the resumption of preventive health screenings for veterans who might be at risk for certain conditions.
- Engage community health providers to increase access to medical care for those veterans who might need care closer to home to include post-9/11 veterans.
- Community and educational supports may be needed to bolster rural veterans' access to VA telehealth services.

$ FINANCIAL

What we know

- **Overall, veterans continue to do better financially than their non-veteran counterparts, but the gap is narrowing.**
- **Young service members and veterans are at greater risk for negative financial outcomes.**
- **Food insecurity among military and veteran families is a growing concern for military and government leaders.**
- **COVID-19 caused socioeconomic challenges for veterans.**

A NARROWING INCOME GAP As shared in previous editions of this report, veterans are typically better off than their non-veteran counterparts in many domains. Nationally, the median income for veterans 18 to 64 is higher than for non-veterans. The gap is narrowing, however, dropping from 1.45 in 2010 to 1.39 in 2019.

Puerto Rico (44%) and Virginia (38%) have the greatest income gaps between veterans and non-veterans. Massachusetts has the smallest gap, with only a 14% difference. The District of Columbia and Maryland have the highest veteran median income, while Puerto Rico and Arkansas have the lowest.

Even with this narrowing gap, veterans of all education levels and most ethnic minority groups have higher median incomes as compared to their non-veteran counterparts. A December 2019 Pew Research report indicated[1] that for Black and Hispanic veteran households, the median household income for those aged 25 to 54 was approximately $27,000 and $30,000 higher respectively than non-veterans of the same age.

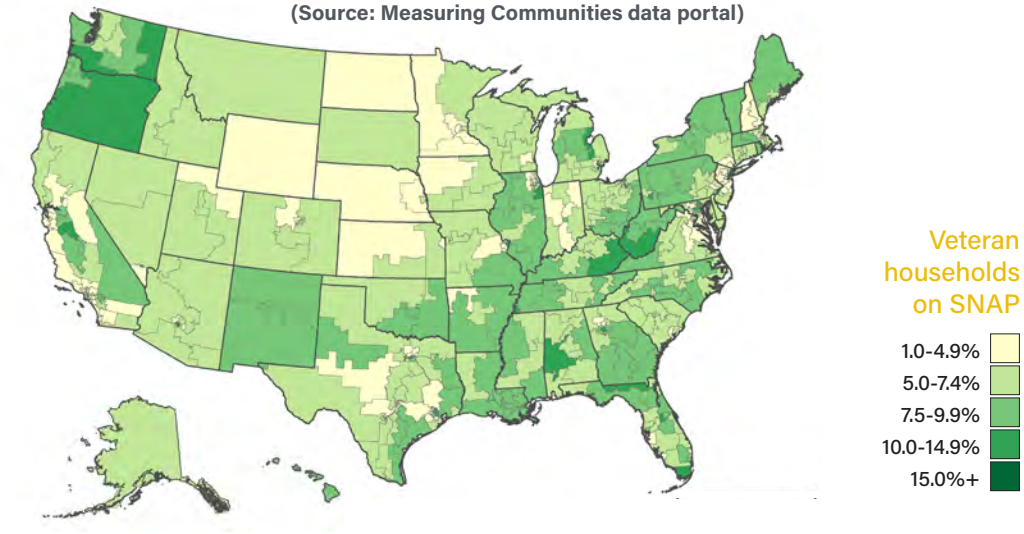
YOUNG SERVICE MEMBERS AND VETERANS AT RISK An April 2019 report by the Consumer Financial Protection Bureau (CFPB)[2] showed that overall, veterans were reporting higher levels of financial well-being than their non-veteran counterparts. However, young veterans aged 18-35 reported the lowest financial well-being scores among all veteran age groups.

A July 2020 CFPB report[3] indicated that service members who join before age 21 are more likely to have problems with debt than those who joined after. These young service members rely on different credit accounts than others, with higher rates of auto loans (73% vs 39%) and credit card debt (80% vs 69%) as compared to service members who joined after age 24. A November 2020[4] report indicated that junior enlisted members who served between seven and 35 months are at greater risk than those who completed their first term of service of receiving derogatory marks and delinquencies on credit reports. However, service members who stay in the service for at least five years are reported to have healthier credit scores than their non-veteran counterparts.[5]

FOOD INSECURITY Since 2012, the organization MAZON: A Jewish Response to Hunger has prioritized military and veteran families experiencing food insecurity. Its April 2021 report, "Hungry in the Military: Food Insecurity Among Military Families in the U.S."[6], recommended that housing allowances no longer be considered income and that the Military Family Basic Needs Allowance be included in the National Defense Authorization Act. The report included 2018-2019 data the Department of Defense stating that one-third of children attending DoD-supported schools were eligible to receive free or reduced price meals.

Congressional districts and percent of veteran families on SNAP

(Source: Measuring Communities data portal)



A 2020 Blue Star Families survey revealed that 14% of junior enlisted and 12% of veteran respondents reported low or very low food security.

Veterans also encounter food insecurity. A United States Department of Agriculture (USDA) analysis of data from 2015-2019 suggested that 11.1% of veterans were in households experiencing food insecurity. The report identifies the risk factors for this population of veterans as similar to non-veterans, with one exception:

> "Minority veterans are less likely to live in food-insecure households than minority nonveterans. This may indicate that military service provides veterans from disadvantaged backgrounds with increased social networks and occupational skills."

Using data from the American Community Survey (ACS 2018 and 2019), the USDA has published on veterans receiving Supplemental Nutrition Assistance Program (SNAP) benefits by state[7]. Overall, 6.6% of veterans are receiving these benefits, with states varying from a low of 2.3% of veterans in Wyoming to a high of 11% in Oregon.

A Military Family Advisory Network survey (7,785 respondents) and subsequent report (1,363 respondents) highlighted a possible increase in food insecurity during the pandemic. The report[8] compared survey results fall 2019 to winter 2021 using the USDA six-item food security scale. Food insecurity rose from one in eight respondents in 2019 to one in five in 2021. Additionally, an increase in those experiencing hunger rose from 7.7% to 10.5%, with the percentage of respondents experiencing low food security nearly doubled from 5% to 9.1%. While respondents might not be the same individuals in both reports, the trend in food insecurity warrants closer inspection.

COVID-19 Pandemic-related financial stressors may be amplified for some populations of veterans, such as those facing behavioral health challenges or homelessness. A recent study[9] examined socioeconomic challenges among three groups of veterans: those with behavioral health conditions, homeless veterans recently housed through supportive housing and a control group. Each group experienced financial hardships, but the patterns of challenges were different. Not surprisingly, homeless veterans who were recently housed reported lower levels of financial well-being and experienced more material hardships and food insecurity as compared to the other two groups. Unexpectedly, the control group appeared to be most vulnerable to financial shocks such as expensive repairs or lost wages. Veterans with behavioral health challenges, while experiencing financial stressors, appeared to fare better than expected. The authors surmise that because these veterans were already engaged in VA services, they could access additional support services earlier.

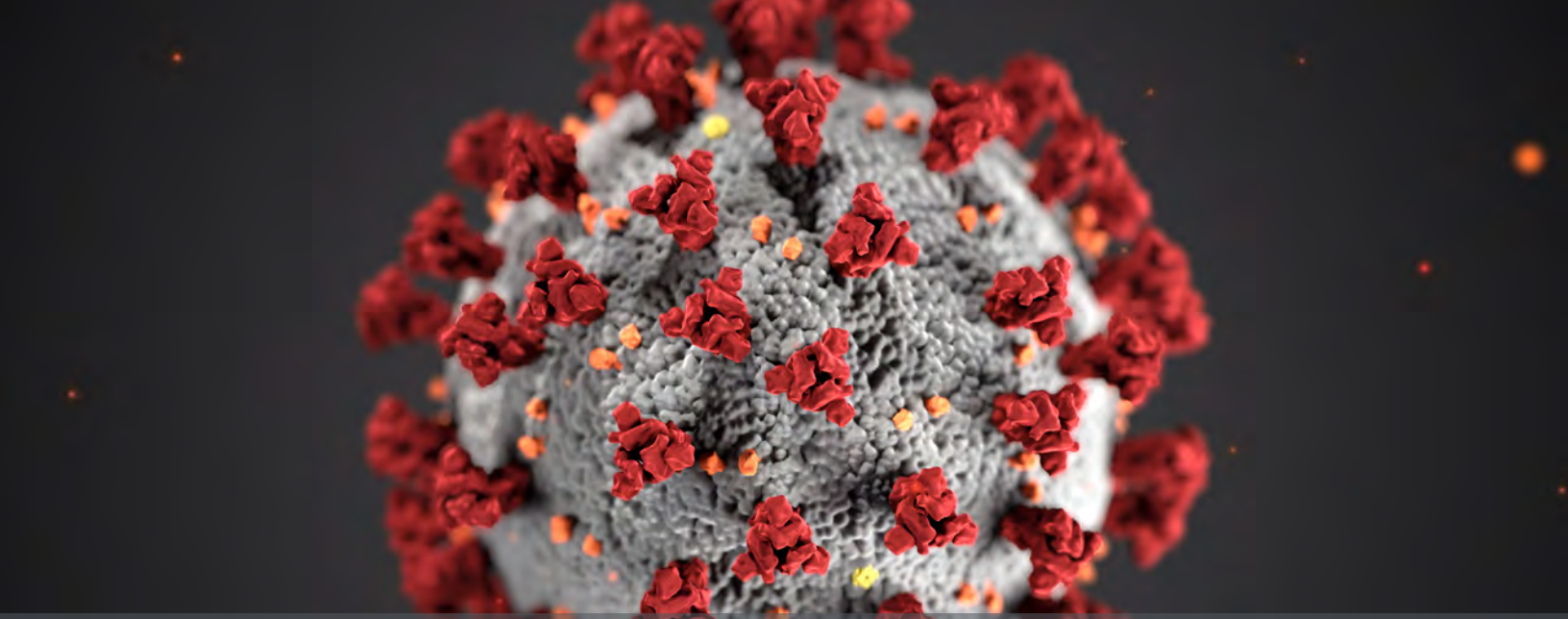
States with largest margins of income differences between veterans and non-veterans

(Source: Measuring Communities data portal)

1	Puerto Rico
2	Virginia
3	Alaska
4	Alabama
5	Mississippi
6	New Mexico
7	South Carolina
8	Georgia
9	Arizona
10	Texas

Call to action

- Identify possible financial risks when working with young veterans leaving the service and focus on financial skill-building to improve their outcomes.
- Educate community organizations about food insecurity and military members. Coordinate outreach efforts to reach these families.
- Follow legislation on military allowances and SNAP eligibility requirements. Advocate for change in these rules.



COVID-19

The COVID-19 pandemic has touched every corner of the globe. At home, active duty and reserve component service members have been deployed to support everything from food distribution to vaccination clinics. The VA has energized its workforce to support vulnerable veterans. However, questions regarding how COVID-19 is affecting the military-connected population specifically have yet to be answered in full.

Many federal data sources that will shed light on the effect of COVID-19 experience a 12- to 18-month lag time from data collection to publication. We thus rely on data gathered from military-serving organizations that have surveyed this population and gathered data on their well-being. Data from surveys conducted by Blue Star Families, the Military Family Advisory Network, the Wounded Warrior Project and others have provided much of the information shared in this section of the report. While these surveys and reports have some methodological limitations such as nonprobability samples, they provide timely insight into issues facing many military and veteran families.

FINANCIAL STRESSORS There is an expectation that COVID-19 will affect the financial situation of many veterans and service members. Certain sectors of the economy are at greater risk for business closures due to community health mandates. A March 2020 report by the Bob Woodruff Foundation[1] identified five industries most likely to have job layoffs; chief among them is the travel and hospitality industry, which employs more than 1.2 million veterans.

Military families may be especially affected by COVID-19 financial challenges. In the Blue Star Families Pain Points Poll[2] conducted in the early days of the pandemic, military spouse employment was a significant concern. In the Deep Dive report on spousal employment, of those responding to the survey who were employed prior to the pandemic, 17% reported losing their job, 20% reported losing income and 13% reported having to take time off (paid or unpaid) to care for children. Younger spouses reported more difficulties getting or starting employment, while older spouses reported more difficulties with childcare. The Blue Star Family Resilience Under Stress Study (RUSS)[3] also conducted in 2020 indicated only 15% of military family respondents felt the pandemic was a threat to their financial situation, as compared to 34% of the non-veteran population. These statistics, while not representative of the whole military population, can be used in an advisory capacity and indicate a need for further study to determine the financial implications of the pandemic on military families. Moving forward, it will be important to watch this population to see how they fare post-pandemic.

FOOD INSECURITY The COVID-19 pandemic has brought significant attention to food insecurity in communities. A recent report[6] noted that food pantries in 2020 were serving 55% more clients than before the pandemic, and four in 10 clients were using this service for the first time. A national survey about the impact of COVID-19[7] on families showed that parents reported more food insecurity (32.6% vs 36%) in June 2020 than before the pandemic.

LOCATION MATTERS In most aspects of life, where one lives has a tremendous influence on one's quality of life. Throughout the pandemic, news reports highlighted COVID hot spots and reported surging cases in various states, only to have new hot spots emerge weeks later. What characteristics of these places make those who live there more vulnerable to the virus?

Surgo Ventures developed a COVID-19 Community Vulnerability Index[4] using a variety of indicators to identify communities that may be more vulnerable to the impact of the virus. These data can help direct efforts and resources to the most at-risk. Focused on seven themes (socioeconomic status, race and ethnicity, household and transportation, epidemiological factors, health care systems, high-risk environments and population density), an aggregate score identifies at-risk communities.

Using county level data, we used this information to determine which states had the highest percentage of their veteran population in at-risk areas. Three states – Alabama, Florida and Arizona – had more than 90% of their veteran population living in the highest vulnerability areas, with 93.7%, 93.3% and 93.1% respectively. Twelve states had no veterans living in these high vulnerability areas. In contrast, one state, Utah, had 100% of their veteran population living in very low vulnerability areas. Two other states, Missouri and North Carolina, also had very high percentages of veterans in low vulnerability areas – 92.7 and 86.3 respectively.

COVID-19 DEPLOYMENTS Since the beginning of the pandemic, military members in both active duty and reserve components have been deployed to assist at the state and federal level. For example, the U.S. Northern Command[5] has worked closely with the Federal Emergency Management Agency (FEMA), providing more than 5,100 personnel to 48 vaccination sites, administering almost 5 million vaccines. During the last two years, every state has deployed their National Guard forces to support state COVID relief efforts[6] including distribution of medical equipment, support for nursing homes, food distribution and state emergency operations. According to the National Guard, more than 14,000 Guard troops have been deployed to more than 800 vaccination sites and have assisted in delivering more than 10 million vaccines.[7]

Deployment stressors are not new for active duty and selected reserve members. The Department of Defense has combat operational stress control initiatives and doctrine to assist service members in managing the stressful effects of combat deployments. However, domestic deployments supporting COVID-19 bring different challenges and stressors to military members. A recent article from an Army National Guard Behavioral Health Officer[8] identified non-combat stressors he observed. While financial stressors were present for many selected reserve members who were without civilian employment, unique stressors regarding personal risk of infection, fear of spreading COVID-19 to vulnerable family members and providing support in places where social distancing was not possible are not stressors normally found in combat situations.

MILITARY FAMILY WELL-BEING The uncertainty of the pandemic and deployment has created additional concerns and stressors for families. The same 2020 BFS survey[9] indicated that more than 50% of active duty respondents reported that their overall happiness, personal mental health, children's education and children's mental health were worse or much worse than before the pandemic. One of the major concerns was the effect on children's education; 52% of those active duty respondents reported children attending virtual school, creating downstream challenges on employment opportunities and childcare. Almost 60% of those responding had children under 18 years of age at home and reported having to make alternate work arrangements due to lack of childcare and/or school.

Organizations that support veterans worry about the effects of the pandemic on our most vulnerable veterans. Many in the behavioral health community worry about the impact of social isolation on veterans and more specifically on those with mental health issues. The Wounded Warrior Project conducts an annual survey in order to better understand and respond to the needs of this population of wounded veterans. The 2020 survey[10] results showed that one of the most common pandemic-related challenges was accessing physical and mental health care with many appointments postponed or cancelled. This lack of care places additional burdens on a population already facing many challenges. The data from the survey showed that the lack of social connection along with their mental health conditions has compounded their situation.

One recent study[11] looked at the effects of the pandemic on veterans with a history of depression and substance use, specifically alcohol. The study showed that overall, veterans showed a decrease in alcohol use; however, those with depression prior to the pandemic had higher levels of substance use during the pandemic. Loneliness magnified the effects on depression and alcohol use.

It is difficult to determine the full effects of the pandemic on veteran and military families after almost two full years of public health emergency orders, deployments, social distancing and other restrictions. Organizations such as Blue Star Families and the Wounded Warrior Project have historical data from surveys conducted prior to the pandemic. Using this data to see the long-term changes in this population will help other organizations plan their efforts to help mitigate these challenges.

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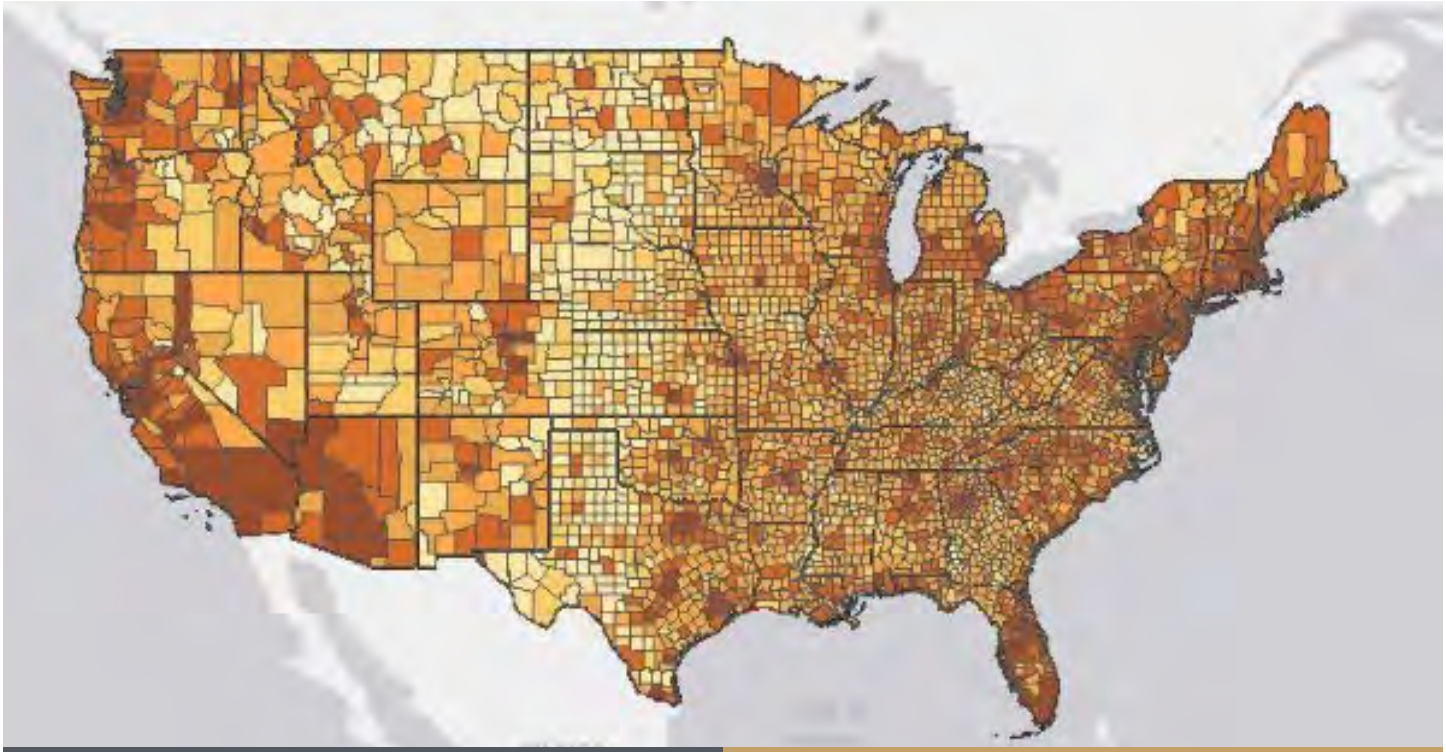

HOW TO ACCESS LOCAL DATA

IN MEASURING COMMUNITIES

Access to the Measuring Communities site is free. To sign up, contact Katie Walter, MFRI community outreach specialist, at schmit59@purdue.edu. You will be provided with a member ID.

One you're logged in with your member ID, you may explore data at the state, congressional district and county level. Use the data for:

- propelling community action
- tracking local progress
- sustaining attention to issues
- advocating for policies and programs

- Navigate to www.measuringcommunities.org
- Click Explore Web Based Data
- Enter your name, email and member ID*
- On the landing page, click the Topics tab
- Choose one of 10 topics
- Click View Data
- Select an indicator
- Refine your results by state, county and year
- Choose up to five data fields
- Click Submit
- View data in table, graph or map form
- Download or print data for future use

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ABOUT THE PURDUE CENTER FOR REGIONAL DEVELOPMENT

The Purdue Center for Regional Development (PCRD) seeks to pioneer new ideas and strategies that contribute to regional collaboration, innovation and prosperity. Founded in 2005, the Center partners with public, private, nonprofit and philanthropic organizations to pursue applied research and engagement activities. Its key goals include:

(1) developing and strengthening access to high quality data and visualization tools to guide the development of local and regional plans;
(2) advancing the capacity of regions to pursue programs and projects that embrace the principles of collaboration, broad-based engagement and sound planning;
(3) developing and promoting the of programs and projects that build on the existing economic assets and emerging business development opportunities of regions; and
(4) exploring the mix of factors shaping the overall well-being of people and the local/regional places in which they live.

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ABOUT THE MILITARY FAMILY RESEARCH INSTITUTE

The Military Family Research Institute (MFRI) at Purdue University conducts research on issues that affect military and veteran families and works to shape policies, programs and practices that improve their well-being. Founded in 2000, MFRI envisions a diverse support community that understands the most pressing needs of military and veteran families. To achieve this, MFRI collaborates to create meaningful solutions for them. This internationally-recognized organization is located at Purdue University's College of Health and Human Sciences, in the Department of: Human Development and Family Studies.

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Mapping Progress for Military & Veteran Families

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