



America's Military and Veteran Caregivers

HIDDEN HEROES EMERGING FROM THE SHADOWS

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About This Report

In 2014, RAND published *Hidden Heroes: America's Military Caregivers*, a report commissioned by the Elizabeth Dole Foundation that documented how many American adults were providing care to wounded, ill, and injured service members and veterans; how their experiences compared with those of other caregivers and non-caregivers; the impact that caregiving had on their lives; and the services available to support them. Significant progress has been made in supporting military and veteran caregivers since 2014. There have also been other changes, such as the aging of the veteran population and the coronavirus pandemic, that call for a new examination of this population. In this report, *America's Military and Veteran Caregivers: Hidden Heroes Emerging from the Shadows*, also commissioned by the Elizabeth Dole Foundation, the authors present data from the 2023 RAND Caregiving Survey with new estimates of the number of adults caregiving in the United States today (for which they investigated how those caring for wounded, ill, and injured service members and veterans compare with those caring for civilians and with non-caregivers) and share insights on the potential consequences of caregiving on caregivers' health, their economic security, and their families' well-being. With these groundbreaking data, RAND researchers make recommendations to strengthen national support for these hidden heroes as they continue to emerge from the shadows.

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More than 1,000 caregivers living in the United States today, many of them caring for service members and veterans, took 40 minutes out of their extremely busy schedules to respond to the 2023 RAND Caregiving Survey. To them, we offer profound thanks. We are also grateful to the insights provided by members of the Scientific Advisory Board whose names and affiliations are listed at the end of Chapter 11.

This research benefited from conversations we held with additional subject-matter experts, including Jennifer Olson, Courtney Van Houtven, Anne Tumlinson, and Sheila Bosch. We are also grateful for the input and assistance provided by our RAND colleagues Heather Salazar, Michael Robbins, Bonnie Ghosh-Dastidar, James Marrone, Rosa Maria Torres, Kate Giglio, and Carrie Farmer. The team at NORC was very helpful, especially Stefan Subias and Martha Cowley. Valuable quality assurance reviews were provided by Megan Shepherd-Banigan and Jason Etchegaray, with additional helpful comments provided by Julia Rollison, Daniel Siconolfi, and Laurie Martin. We thank Nora Spiering for meticulous editing. And, finally, we thank Elizabeth Dole for her commitment to improving the lives of military and veteran caregivers and her insistence that this work be informed by research.

Summary

Military and Veteran Caregivers: The Need for a New Examination

Military and veteran caregivers are *hidden heroes*. This term was coined by RAND and the Elizabeth Dole Foundation in 2014, when the organizations partnered to produce *Hidden Heroes: America's Military Caregivers*. That report provided the first national portrait of American people who care, mostly uncompensated, for wounded, ill, and injured service members and veterans. *Hidden Heroes* shed light on a new class of caregivers: spouses, friends, and neighbors caring for service members and veterans with wounds, illnesses, and injuries—including mental health conditions—and how caregiving disproportionately affected them.

Guided in part by the 2014 *Hidden Heroes* report, the Elizabeth Dole Foundation and others created programs and advocated for policies designed to better support military and veteran caregivers. These changes call for a new examination of military and veteran caregivers. This report, *America's Military and Veteran Caregivers: Hidden Heroes Emerging from the Shadows*, presents this new examination of America's hidden heroes.

Key Findings

Military and Veteran Caregivers: Who They Are and What They Do

Approximately 40.5 percent of the U.S. adult population provides some form of caregiving support. The authors found that there are 14.3 million military/veteran caregivers, which is 5.5 percent of the U.S. adult population. There are an additional 91.3 million civilian caregivers (35.0 percent of U.S. adults) caring for wounded, ill, or injured civilian adults. The number of caregivers per state varies but likely exceeds 1 million veteran caregivers in each of Texas, California, and Florida.

These estimates are much higher than those presented in the 2014 report. In part, this is because the 2023 RAND Caregiving Survey asked people about the caregiving tasks they did rather than just whether they saw themselves as caregivers (as in the earlier report).

An additional 3.9 percent of American adults are former military/veteran caregivers, one-third of whom served in this role within the past two years. Almost three-quarters of former military/veteran caregivers are no longer serving as caregivers because the person they were caring for died. On measures of stress, depression, and financial security, former military/veteran caregivers more closely resemble non-caregivers than current military/veteran caregivers.

Differences in military and veteran caregiving experiences are driven by the age of the care recipient. The authors found that the age of the care recipient often influences the conditions and symptoms the care recipient has, their caregiving needs, and the relationship of the caregiver to the care recipient. Because of this, the research team took a closer look at caregivers and their roles in two large groups: those who care for individuals over age 60 and those who care for individuals age 60 and younger. Figure S.1 lists the similarities and differences of both groups.

Caregivers helping with at least one activity of daily living (ADL) spend more time caregiving, on average. Even after accounting for medical diagnoses, caregiver characteristics, and care recipient characteristics, caregivers who assisted with at least one ADL spent more time caregiving than those who provided other types of care. The distribution of time spent caregiving for military/veteran caregivers, by the age of the care recipient for whom they provide care, is provided in Figure S.2.

The Mental and Physical Health of Military and Veteran Caregivers

Military and veteran caregivers to those over 60 tend to have the same health outcomes as non-caregivers. *Health* in this case refers to both mental health outcomes (e.g., depression,

FIGURE S.1

Military and Veteran Caregiving Experiences Differ by the Age of the Care Recipient



Military and Veteran Caregivers: Who They Are and Who They Help



**Care recipients
60 years old and younger**

26 percent of military and veteran caregivers

Nontraditional caregivers: Twenty-seven percent of military/veteran caregivers are neighbors and friends, and 31 percent are relatives, such as siblings, aunts, and uncles.

Care recipients

- 84 percent diagnosed with a chronic condition
- 62 percent diagnosed with a mental health condition or substance use disorder
- 61 percent need help with at least one ADL



**Care recipients
over 60 years old**

74 percent of military and veteran caregivers

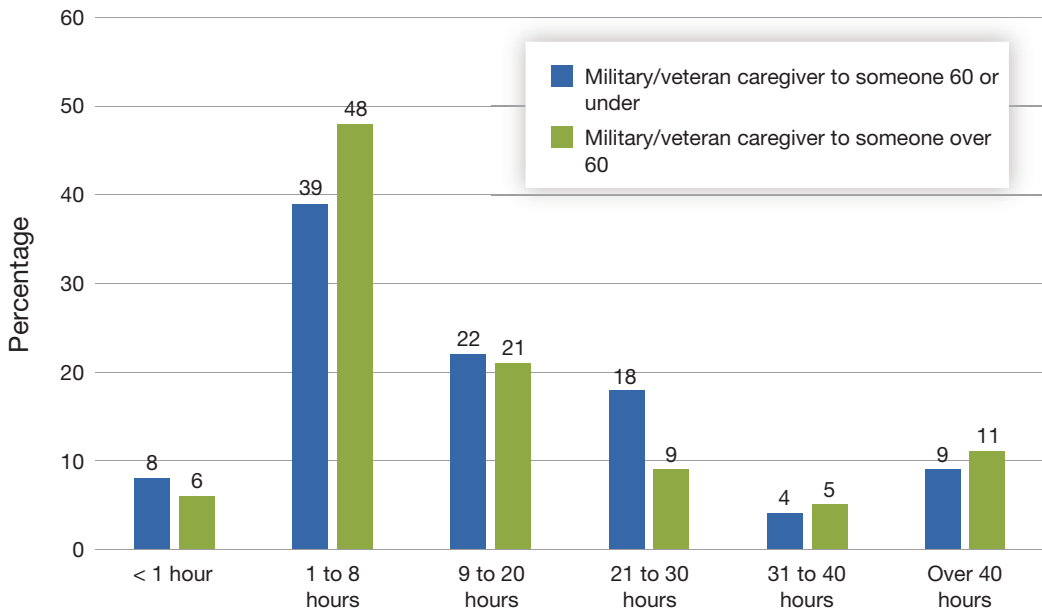
Family: Between 65 percent and 75 percent are children caring for parents or individuals caring for their spouse.

Nontraditional caregivers: Friends and neighbors account for over 20 percent of caregivers for this group.

Care recipients

- Most diagnosed with a chronic condition or hearing or sight impairment
- 40 percent diagnosed with a mental health condition or substance use disorder
- 51 percent need help with at least one ADL

FIGURE S.2

Average Amount of Time Spent Caregiving per Week

stress) and physical health (e.g., overall health, physical functioning). However, 16 percent of military and veteran caregivers to those over 60 needed mental health treatment but did not access it. Cost was the primary barrier in this case.

Military and veteran caregivers to those 60 and under are at higher risk of depression and are less likely to seek care than non-caregivers. The authors found that 43 percent of military and veteran caregivers to those 60 and under met probable criteria for depression; this is almost four times the rate of non-caregivers. About 20 percent of military and veteran caregivers in this group had thoughts in the past year about taking their own lives. This is also four times the rate of non-caregivers. Thirty-six percent felt that they needed mental health care but did not seek it. More than three-quarters of this group reported that they “didn’t have time for treatment,” and 70 percent were concerned about hospitalization or taking medications.

Only around half of military/veteran caregivers to those 60 and under had seen a doctor for any reason in the past year, compared with around three-quarters of non-caregivers.

Nine percent of military/veteran caregivers were “very concerned” or “somewhat concerned” that the person for whom they are caring was at risk of suicide. Compared with military and veteran caregivers *not* concerned about suicide risk, a greater proportion of military/veteran caregivers concerned about suicide risk met criteria for excessive caregiver

burden (65 percent versus 28 percent), probable depression (55 percent versus 19 percent), and hazardous drinking (65 percent versus 24 percent).

Children of military and veteran caregivers are more likely to have problems at school but are also more aware of others' feelings. Thirty-nine percent of children under 18 living in military/veteran caregiving households assume some caregiving responsibilities. The study found that, when compared with children of non-caregivers, military/veteran child caregivers were more likely to miss school because of illness. They also scored higher on emotional symptoms and conduct problems. However, they scored higher on prosocial behaviors as well, such as empathy, based on their parents' reports. Almost a quarter of military/veteran caregivers reported that their caregiving children needed mental health treatment in the past year but did not receive it.

The Costs of Caregiving and Economic Well-Being of Caregivers

Military and veteran caregivers incur an estimated \$8,583 in annual out-of-pocket costs associated with their caregiving responsibilities. There is no evidence of differences in annual costs between military/veteran and civilian caregivers. In addition, military/veteran caregivers forgo an estimated \$4,522 in annual household income, on average. Again, there is no evidence of a difference in forgone income between military/veteran and civilian caregivers.

The estimated economic value generated by military/veteran caregiving activities ranges from \$119 billion to \$485 billion per year. The range is explained by the different activities that caregivers perform, some of which would earn them the state's minimum wage and others of which can be performed only by licensed registered nurses. Table S.1 shows the range of estimated values, which, for this group of caregivers, are largely uncompensated.

Thirty-five percent of military/veteran caregiving households have incomes below 130 percent of the federal poverty level, but some are not using benefits to which they are entitled. Many households in this group are not taking advantage of available benefits, even

TABLE S.1

Estimated Value of Military/Veteran Caregiving Under Various Wage Assumptions

Assumed Caregiver Hourly Wage	Estimated Value of Military/Veteran Caregiving
State minimum wage	\$119 billion
2022 median hourly wage: home health aide	\$162 billion
2022 median hourly wage: nursing assistant	\$201 billion
2022 median hourly wage: registered nurse	\$487 billion

those that are based on assets. Civilian caregivers in households with incomes below 130 percent of the federal poverty level outpace their military/veteran counterparts in the use of the Supplemental Nutrition Assistance Program (SNAP) and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). Among those who are food insecure, only one-quarter to one-third of military/veteran caregivers use SNAP.

Fewer than half of military/veteran caregivers are offered workplace accommodations that could help them more easily perform their caregiving responsibilities. Although not different from non-caregivers, more than half of military/veteran caregivers are unable to telecommute or work from home, about half cannot take paid family leave, and about one-third do not have flexible work hours. Perhaps because of the lack of workplace accommodations, 27 percent of military/veteran caregivers experience workplace disruptions, such as cutting back on their work hours or thinking they are being discriminated against. The study's results suggest that these disruptions are driving income losses associated with caregiving.

Military and Veteran Caregiver Support and Care Networks

Military and veteran caregivers find that support can be hard to come by. The authors found that around half of military/veteran caregivers to those 60 and under had no one else to turn to in their caregiving network. In addition, over half in this group felt that they had no one to call for emotional support. Those caring for someone over 60 fared slightly better; 40 percent of that population felt that they were going it alone.

Between half and two-thirds of military/veteran caregivers use common support programs. Those caring for individuals 60 and under were the greatest users of such programs. Table S.2 compares the use of support programs by military/veteran caregivers of those 60 and under and military/veteran caregivers to those over 60.

TABLE S.2
Past-Year Support Service Utilization by Military and Veteran Caregivers

	Military/Veteran Caregivers to Those 60 and Under	Military/Veteran Caregivers to Those over 60
In-person support groups	30%	10%
Online support groups	15%	8%
Respite	19%	12%
Training	38%	10%
Structured wellness	46%	34%
Case manager	27%	20%
No participation in support services	38%	48%

Military/veteran and civilian caregivers have preferences for types of support programs.

Caregivers to those 60 and under indicated a preference for programs they can do with the person for whom they are caring. Those caring for individuals over 60 wanted programs that help keep the recipient safe and help with filling out forms. All caregivers indicated a preference for programs for reducing stress.

Religion helps ease burdens for some caregivers. Among all caregivers, those for whom religion is an important part of their lives reported less caregiver burden than other caregivers, even after accounting for characteristics of caregiving, characteristics of the care recipient, and characteristics of the caregiver.

Military and Veteran Caregivers' Experiences in Health Care Settings

Many military and veteran caregivers *and* civilian caregivers feel unvalued or hassled by health care providers. The authors found that only approximately one-third of military/veteran *or* civilian caregivers felt that health care providers often sought their input or listened to them about the care recipient. Also, one-third of military/veteran caregivers reported experiencing hassles in health care, such as having to remind staff to do things for the care recipient or experiencing delays in completing paperwork. Among those who experienced hassles, between 25 percent and 30 percent of 18- to 44-year-old caregivers felt that the hassle was due to age discrimination.

There were modest differences in military and veteran caregivers' perceptions of being hassled or undervalued among military/veteran caregivers whose care recipients used U.S. Department of Veterans Affairs (VA) facilities most commonly for their health care and those whose care recipients received care outside of VA. A greater proportion of caregivers who were caring for someone who received most of their care at VA, compared with those who did not receive most of their care at VA, reported staff delays in completing paperwork (22 percent versus 14 percent), feeling excluded from decisions regarding the care recipient's care (20 percent versus 7 percent), and difficulty interacting with the care recipient's physicians (23 percent versus 8 percent). Differences in care recipients who receive care at VA—who tend to be younger, have lower household incomes, are more likely to have mental health and substance use disorders, and have higher disability ratings—may explain some of this variation.

Military and Veteran Caregivers' Families and Locations

The challenges of caregiving can be exaggerated and complicated by distance. While 39 percent of military/veteran caregivers to those 60 and under provide all of their care in person, 28 percent provide *half or more* of their caregiving remotely. In contrast, 70 percent of military/veteran caregivers to those over 60 provide care exclusively in person, and 12 percent provide half or more remotely. A greater proportion of military/veteran caregivers who

provide most care remotely met criteria for excessive burden, high stress, and depression, compared with those who provide most care in person.

Military/veteran caregivers tend to live in areas where most Americans live. This means that over half live in either Southern or Western states and in urban areas. The only notable difference that location had on military/veteran caregivers concerns access to mental health care. Specifically, those in Western states were more likely to access that care but were also more likely to report needing but not accessing that care than caregivers living elsewhere.

Military/veteran caregivers residing in lower-income areas reported *reduced* caregiver burden and depression. It may be that neighbors in lower-income neighborhoods are more likely to offer support or that these communities have concentrations of similar individuals (such as older people who have had to provide care before) who understand caregiver needs. The research on low-income areas and support networks is inconclusive, however, and the authors found no single reason for this finding.

Urban and rural military/veteran caregivers differ most on internet access. Nearly one-quarter of rural military/veteran caregivers did not have reliable broadband internet access at home, compared with 16 percent of urban military/veteran caregivers.

Recommendations

Based on these findings, the authors make nine broad recommendations:

1. **Increase access to mental health and substance use treatment for caregivers and their children.** Up to 42 percent of military/veteran caregivers could have likely benefited from mental health treatment but did not access it. They reported time constraints, concerns about prescription medications or being hospitalized, and cost as barriers to treatment. Novel mental health care delivery models, including telehealth, asynchronous counseling, mobile health applications, task shifting, and Collaborative Care (which integrates evidence-based mental health care into primary care), may help meet the unmet mental health needs of caregivers and their children.
2. **Increase opportunities for caregivers to access available financial support, and offer additional financial compensation to caregivers for the work they perform.** Military/veteran caregivers provide services valued at a minimum of \$119 billion, but they spend approximately \$8,500 in out-of-pocket expenses because of their caregiving, forgo \$4,522 in earnings, and are mostly not accessing benefits that they are likely entitled to receive. Organizations that serve caregivers should inform them about programs that provide financial assistance and help them apply; policymakers should continue to explore tax credit options for caregivers.

3. **Tailor caregiver support programs to reflect caregivers' diverse preferences and needs.** While there has been an expansion of programs to support caregivers, 38 percent to 48 percent of military/veteran caregivers are not using those programs. To increase uptake, organizations that serve this population should consider the following actions:
 - *Change the way they conduct outreach to caregivers.* The approach that RAND researchers used to define caregivers in the 2023 RAND Caregiving Survey identified individuals performing caregiving duties but who do not necessarily identify as caregivers. Programs could take a similar approach to conducting outreach.
 - *Modify the content of some programs.* Military/veteran caregivers are a diverse group with different preferences: Caregivers to those 60 and under want activities to do with the person for whom they are caring, while those caring for veterans over 60 want help keeping the person they are caring for safe at home. Programs should consider the diversity of the population and how needs may differ.
 - *Expand the ways in which programs are delivered.* Many caregivers who wanted but did not receive mental health care suggested that time constraints were a significant barrier. Technology-driven solutions (for example, telehealth and mobile applications) may be attractive to some caregivers who face time pressures. However, more military/veteran caregivers reported participating in in-person groups than in online support groups, suggesting that an exclusive focus on technology may not meet some caregivers' preferences.
 - *Partner with diverse entities and organizations.* Military/veteran caregivers who felt that religion was important to them had lower levels of caregiver burden. Partnerships between caregiver support programs and religious organizations could expand the numbers of those who are served and the ways in which caregivers are supported.
4. **Expand and promote home health care considering how caregivers will be affected.** Caregivers who reported having a medically trained person come to the care recipient's home to help (i.e., caregivers who used home health care) reported lower caregiver burden, and current and proposed policies are aiming to expand such services. However, other research has raised issues (most of which need further study) related to the ways in which home health care could add more burdens to caregivers. Caregivers may need to coordinate and train home health care teams and providers, have increased out-of-pocket costs associated with keeping care recipients at home, and face additional work disruptions negotiating home health care teams. Residential options should continue to be pursued and made accessible, particularly for those care recipients who will be safest in residential placement.

5. **Focus programmatic and social support within the context of local conditions in which military/veteran caregivers live.** Military/veteran caregivers live in less resourced areas compared with non-caregivers; however, there were nuanced findings around associations between neighborhood conditions and military/veteran caregiver outcomes. Policies and interventions aimed at military/veteran caregivers should take local resources, such as housing, food access, and economic conditions, into account. Additional investigation into the mechanisms linking neighborhood conditions to caregiver outcomes is warranted.
6. **Encourage health care systems to better integrate caregivers into health care teams.** Health systems need to be incentivized to better include caregivers into health care teams. To do this, evaluation research should test whether efforts to integrate caregivers into health care environments improve patient outcomes, create cost savings, and increase demand. Additionally, policymakers should create new mechanisms that incentivize health care systems to integrate caregivers into health care teams, expanding on recent efforts that compensate providers for providing training or education to caregivers.
7. **Promote work environments that are supportive of caregivers.** Although employers are increasingly offering temporal and spatial flexibility to workers, among working military and veteran caregivers, only one-half to two-thirds are offered temporal flexibility, and fewer than one-half are offered telework options.
8. **Continue to conduct rigorous evaluations of those initiatives designed to support military and veteran caregivers.** Many caregivers participating in programs exhibit high levels of burden, which may suggest that programs are attracting caregivers in need of support or that these programs are not adequately helping reduce caregiver burden. Evaluation is key to ensuring that programs are achieving their intended outcomes and worth the resources and time that caregivers devote to participating in them.
9. **Continue to conduct research that fully captures the breadth of caregiving and those who serve as caregivers.** Defining caregivers based on descriptions of the caregiving activities they perform, instead of based on their identity as a caregiver, identifies many more individuals who are taking on caregiving roles. However, further describing these caregiving activities, particularly for caregivers to those with mental health conditions, substance use disorders, and neurocognitive conditions (such as traumatic brain injury and dementia), is necessary to fully support caregivers to individuals with these conditions.

The 2023 RAND Caregiving Survey and the 2022 RAND Veterans Survey

The information in this report is derived from two sources. First, RAND researchers administered the 2023 RAND Caregiving Survey, a probabilistic survey of U.S. households that collected detailed information from caregivers and non-caregivers alike. It was designed to establish the number of military and veteran caregivers and to further understand their needs, service utilization, and outcomes. The final analytic sample size was 2,946 respondents, including 513 military and veteran caregivers, and, for comparison, 1,205 civilian caregivers and 1,228 non-caregivers. The 2023 RAND Caregiving Survey was linked to national data characterizing where caregivers live to better understand how rural, regional, and neighborhood characteristics affect caregivers and caregiving.

RAND researchers also administered the 2022 RAND Veterans Survey, a survey of 1,100 veterans residing in the United States. Data from this survey were exclusively used to produce state-level estimates of the numbers of military and veteran caregivers.

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Introduction and Background

In 2014, RAND published *Hidden Heroes: America's Military Caregivers*. Commissioned by the Elizabeth Dole Foundation, *Hidden Heroes* provided the first national portrait of American people who provided care, mostly uncompensated, for wounded, ill, and injured service members and veterans. Using data from the first ever national survey of military and veteran caregivers, RAND researchers estimated the size of the population, described their experiences providing care, and highlighted the ways in which caregivers' health and well-being were compromised relative to other caregivers and non-caregivers. Until then, caregiving had typically been studied in relation to adults caring for their aging parents. *Hidden Heroes* shed light on a new class of caregivers: spouses, friends, and neighbors caring for service members and veterans with wounds, illnesses, and injuries—including mental health conditions—and how caregiving disproportionately affected them.

The results of this research, the advocacy that occurred in conjunction with it, and growing recognition of caregiving in the United States at large led to many changes in programs and policies designed to better support caregivers. As will be described in more detail later in this chapter, the U.S. Department of Veterans Affairs (VA) expanded eligibility to programs for caregivers; health care providers were recently incentivized to work collaboratively with caregivers; and a range of programs, including support groups, trainings, and mental health care, are increasingly available to military and veteran caregivers. Simultaneously, the veteran population is aging, service members and veterans are developing health conditions presumed to be attributed to exposures to environmental toxins encountered during military service, and veterans and caregivers—along with the rest of the country—went through and continue to deal with the acute and prolonged health effects of the coronavirus disease 2019 (COVID-19) pandemic.

These changes call for new examination of military and veteran caregivers. This report, *America's Military and Veteran Caregivers: Hidden Heroes Emerging from the Shadows*, presents a new, contemporary examination of those caring for wounded, ill, and injured service members and veterans. The authors draw on the research RAND conducted in 2014 but expand on it based on research conducted on caregiving and military and veteran caregivers since 2014 and in recognition of the political, programmatic, and social changes that have occurred since then. Specifically, the authors provide contemporary insights into three broad research questions: (1) how many individuals are serving in caregiving roles and how many are providing this care to a service member or veteran; (2) what caregiving duties look like for military/veteran caregivers; and (3) how military/veteran caregivers fare relative to each other and to non-caregivers with respect to their health and well-being, their economic security, and their families' well-being. Answers to these research questions are provided by the 2023 RAND Caregiving Survey, a probabilistic survey of U.S. households that collects detailed information from caregivers and non-caregivers alike. Data from the survey

are complemented by additional data from a nationally representative survey of veterans (the 2022 RAND Veterans Survey).

Background

One of the key sources of data for the findings in the 2014 *Hidden Heroes* report was a national survey of military and veteran caregivers, from which RAND researchers concluded the following:

- There were an estimated 5.5 million military and veteran caregivers in the United States; among these, 1.1 million (19.6 percent) were caring for a person who had served in the military after September 11, 2001 (termed *post-9/11 caregivers*).
- Post-9/11 caregivers differed from pre-9/11 caregivers and civilian caregivers in many ways. Most notably, post-9/11 caregivers were more likely to be younger, caring for a younger individual with a mental health or substance use condition, Hispanic, a veteran themselves, employed, and not connected to a support network.
- Post-9/11 caregivers assisted with fewer basic functional tasks but, because they more often cared for individuals with mental health or substance use conditions, helped more often with such tasks as coping with stressful situations.
- Post-9/11 caregivers used a mix of services and were more likely than other caregivers to use mental health services, helping hand services, structured social support, and structured education on caregiving.
- Caregiving poses a heavy burden: Caregivers report worse health outcomes, more familial strain, and more workplace problems than non-caregivers.
- The cost of lost productivity associated with caregiving was an estimated \$5.9 billion (in 2011 dollars).
- The future for military caregivers, and those they care for, was precarious. As younger caregiving spouses aged, it was not clear whether the strain of caregiving would lead to marital dissolution; as parent caregivers aged, they were faced with the question of who would care for the veteran or service member and who would care for these parent caregivers as they themselves required caregiving support.

The 2014 report also included an environmental scan of services available nationwide to support military and veteran caregivers. RAND researchers identified more than 100 such programs, but most served caregivers incidentally—program services were targeted to the wounded, ill, and injured, and caregivers may have been eligible to participate or otherwise engage in them.

Since the publication of the 2014 report, there has been a burgeoning number of policies, programs, and research to better understand the needs of military and veteran caregivers and how to support them. Below is a brief review of what has occurred since the publication of *Hidden Heroes*.

Notable Advances Since 2014 for Military/Veteran Caregivers

Since 2014, there has been significant progress in (1) nonprofit programs to support military and veteran caregivers; (2) federal policies and programs to support caregivers; and (3) research that has documented the needs of military and veteran caregivers and evaluations of the benefits of programs and initiatives designed to support them. Information about survey respondents' use of supportive programs is in Chapter 4.

Advances in Programs to Support Military/Veteran Caregivers

Since 2014, guided in part by the recommendations of *Hidden Heroes*, the Elizabeth Dole Foundation and other nonprofit organizations have expanded their programs and services for caregivers. Many include military/veteran caregivers among other populations they also serve, such as all caregivers (e.g., AARP or the Rosalynn Carter Institute for Caregivers [RCI]) and military families more broadly (e.g., Blue Star Families), or as an adjunct to their core focus on wounded, ill, or injured veterans (e.g., Wounded Warrior Project and Disabled American Veterans [DAV]). A select list of programs is included at the beginning of this report's appendix; thematically arranged highlights include the following.

Direct Services to Caregivers

Organizations including Easterseals, Wounded Warrior Project, and Access to Respite Care and Help (ARCH) National Respite Network and Resource Center offer respite services to caregivers. Emergency financial assistance is available through the Elizabeth Dole Foundation's Hope Fund for Critical Financial Assistance (Hidden Heroes Organization, undated-b). Caregiver families can apply for financial assistance grants for such issues as medical bills, natural disaster assistance, home repairs or appliances, housing costs, utility assistance, vehicle repairs, and more.

Education and Training

Education and training programs are among the most widely offered resources for caregivers. The Elizabeth Dole Foundation provides education about caregiving (such as free caregiving trainings and other resources) for caregivers and their supporters (e.g., medical providers, etc.) through its online Academy for Inclusive Care (Elizabeth Dole Foundation, undated-a). During the COVID-19 pandemic, the Elizabeth Dole Foundation launched a Health and Wellness Spotlight Series that produced webinars (Hidden Heroes Organization, undated-f) in partnership with VA and Philips to provide information on telehealth, vaccinations, self-care and whole health, sleep solutions, heart health, toxic exposures, and cancer prevention and screening. Through its Campaign for Inclusive Care (Elizabeth Dole Foundation, undated-b), the Elizabeth Dole Foundation is piloting a program in three Veterans Integrated Service Networks aiming to integrate military and veteran caregivers into veterans' VA care teams by building deeper understanding of challenges and opportunities for greater

inclusion; forming a solutions team of clinicians, caregivers, and experts; and establishing a curriculum for Veterans Health Administration (VHA) providers.

Training courses related to caregiving also include the six-week virtual Resilient Family course from Hope for the Warriors, which is designed to develop coping skills and help caregivers effectively manage stress (Hope for the Warriors, 2023). RCI's Operation Family Caregiver (OFC) offers family members virtual support from trained coaches, in English or Spanish, to develop problem-solving skills and strategies to manage challenges more effectively (OFC, undated). It also provides tailored Sesame Street resources to families with young children (Sesame Workshop, undated). The American Red Cross offers online workshops on specific caregiving topics (American Red Cross, undated-a; American Red Cross, undated-b), including some targeted for children and teens. PsychArmor offers free online courses for caregivers on a wide array of topics (PsychArmor, undated-a). The Blue Star Caregivers program offers in-person and online workshops on self-care (Blue Star Families, undated).

Building and Strengthening Community

Organizations also seek to build community among and for military/veteran caregivers. The American Red Cross Military and Veteran Caregiver Network offers a secure, moderated online community where vetted caregivers can connect with peers or participate in support groups in person or online (American Red Cross, undated-b). Caregivers who provide a verification document, such as care recipients' DD Form 214 (Certificate of Release or Discharge from Active Duty), VA rating decision letter, or VA caregiver letter, can access the private Elizabeth Dole Foundation Hidden Heroes Caregiving Community, a Facebook group where caregivers can gain support from other military/veteran caregivers (Hidden Heroes Organization, undated-e).

The Elizabeth Dole Foundation has also formed the Hidden Helpers coalition (Hidden Heroes Organization, undated-a), whose members pledge to support programs and initiatives to support military/veteran caregiver children and youth. Through its Hidden Heroes Cities and Counties Program, the Elizabeth Dole Foundation has garnered pledges from "nearly 200 cities, counties, and states . . . to raise awareness, encourage self-identification, and increase support for the hidden heroes in their communities" (Hidden Heroes Organization, undated-c). The Elizabeth Dole Foundation website provides a toolkit, sample resolution, and menu of ideas for local implementation.

In addition, Dole Caregiver Fellows serve as advocates and representatives on caregiver issues at national, state, and local levels, as well as providing inspiration and support for peers online during two-year terms (Elizabeth Dole Foundation, undated-c). Their stories are archived online to help deepen understanding about caregiving experiences (Hidden Heroes Organization, undated-d).

Advocacy

Nonprofit organizations have advocated for expanded legislation to better support military and veteran caregivers, including the Recognize, Assist, Include, Support, and Engage

(RAISE) Family Caregivers Act (Hidden Heroes Organization, 2018) and the 2018 MISSION Act expanding Program of Comprehensive Assistance for Family Caregivers (PCAFC) eligibility to those who served before 9/11 (DAV, undated-b). In addition, organizations have pressed for improvements in implementation of programs designed to support caregivers, pushing for standardization of the process for evaluating caregiver program eligibility (Hidden Heroes Organization, 2020), expanded eligibility, inclusion of financial planning services, and expansion of veterans' access to home and community-based services (Wounded Warrior Project, 2021).

Advances in Federal Policies to Support Military/Veteran Caregivers

Since 2014, notable policies and programs for military/veteran caregivers have been established, expanded, sunsetted, and proposed.

VA Caregiver Support Program

In May 2010, the Caregivers and Veterans Omnibus Health Services Act of 2010 was signed into law, establishing the Program of General Caregiver Support Services (PGCSS) and PCAFC, both provided through the VA Caregiver Support Program. PGCSS was an existing, though underutilized, VA program offering respite care and other supportive services to all veterans who served in wartime. It now offers peer support mentoring, skills training, coaching, online programs, and referrals to caregivers of eligible veterans enrolled in VA health care; caregivers need not be related to or living with the veteran (VA, undated-c).

PCAFC provides such resources as caregiving training, financial education, a financial stipend, legal support, health insurance, and beneficiary travel benefits to caregivers who are related to or live full time with eligible veterans. The program was originally developed for caregivers of veterans who had incurred or aggravated a serious injury in the line of duty during military service after September 11, 2001. Two large expansions of PCAFC eligibility have taken place since 2014 as a result of the VA MISSION Act of 2018, together granting access to caregivers of veterans of all eras. Phase I expansion, for those who incurred or aggravated a serious injury or illness in the line of duty on or before May 7, 1975 (i.e., the Vietnam War era or earlier), went into effect on October 1, 2020 (VA, 2020c; VA, 2020b). Phase II expansion, expanding PCAFC eligibility to caregivers of veterans or those service members in the process of undergoing a medical discharge who incurred a serious injury between May 7, 1975, and September 11, 2001, went into effect October 1, 2022 (VA, undated-d).

In the July 2020 rule-making for PCAFC regulations, VA added the phrase “need for supervision, protection, or instruction” to broaden eligibility criteria. However, a U.S. Court of Appeals decision in March 2022 set aside VA’s broad definition, causing VA to be more specific in the criteria. Now the regulations state that veterans qualify for PCAFC services if they (1) had a single or combined service-connected disability rating of 70 percent or more and (2) required personal care services for six continuous months based on (a) a need for supervision or protection based on symptoms or residuals of neurological or other impair-

ment or injury or (b) a need for regular or extensive instruction without which the ability of the veteran to function in daily life would be seriously impaired (VA, 2020c).

During expansion of PCAFC, VA began reassessing eligibility for the program among all its legacy participants (those veterans and caregivers who were approved for PCAFC prior to October 1, 2020) to determine whether they met the new eligibility criteria. If the legacy participants met the new criteria resulting in an increased stipend, then the increase would take effect immediately, with retroactive payment to October 1, 2020. If the legacy participants did not meet the new criteria, stipends would have ceased at the beginning of 2023. Caregivers who had been using the program reported concerns about being discharged from the program because they found the monthly stipend and other benefits to be so helpful (Wyse et al., 2020; VA, 2022d).

Facing significant pushback from families and advocates that the new standards were “overly confusing and restricting,” VA acknowledged in March 2022 that approximately 90 percent of legacy participants who had undergone review were scheduled to be discharged from the program, and it temporarily halted dismissals from the program (Shane, 2022a). Shortly thereafter, VA paused reassessments pending development of new eligibility criteria (Shane, 2022b). In February 2023, VA announced that it had extended the transition period and timeline in completing reassessments for legacy participants and applicants until September 30, 2025. During this time, all benefits remain intact without a reduction in stipend or discharge from the program (VA, 2022e; VA, 2023c).

Other VA caregiver support includes the Resources for Enhancing All Caregivers Health (REACH) VA program, which provides caregivers with one-on-one and group coaching, training on the skills needed to care for their veteran, and care planning. This resource is available for caregivers of veterans diagnosed with amyotrophic lateral sclerosis (ALS), dementia, multiple sclerosis, posttraumatic stress disorder (PTSD), or spinal cord injury or disorder (VA, 2023e). Caregivers Finding Important Resources, Support, and Training (Caregivers FIRST) is a four-session VA group training to help those providing care to veterans learn to navigate the VA system of care, connect with one another, and learn new skills to care for themselves and their veteran (VA, 2023h). These and other resources can be accessed by contacting the Caregiver Support Program Team located at each VA Medical Center (VA, 2024). Additionally, VA's Elizabeth Dole Center of Excellence for Veteran and Caregiver Research seeks to expand research on “innovation, training, implementation, evaluation, adoption, and dissemination of best practices” in supporting veteran caregivers (VA, undated-b).

Executive Order on Increasing Access to High-Quality Care and Supporting Caregivers

In April 2023, President Biden issued an executive order to support all caregivers, including military/veteran caregivers. In this order, the President required the Secretary of Health and Human Services to consider a “new health care payment and service delivery model focused on dementia care that would include family caregiver supports such as respite care,” “take steps to ensure that hospitals are actively involving family caregivers in the discharge plan-

ning process,” and “increase beneficiary communications and support family caregivers by increasing promotion of the option for Medicare beneficiaries to choose to give family caregivers access to their Medicare information” (White House, 2023). Two requirements were tasked specifically to the Secretary of VA: “consider issuing a notice of proposed rulemaking by the end of this fiscal year that would make any appropriate modifications to eligibility criteria for the Program of Comprehensive Assistance for Family Caregivers [PCAFC]” and “develop and implement a pilot program to offer psychotherapy via video telehealth to family caregivers within the Program of Comprehensive Assistance for Family Caregivers to improve their access to mental health services” (White House, 2023). More information about caregiver mental health is presented in Chapter 2.

Medicare Reimbursement for Caregiver Training

In November 2023, the Centers for Medicare & Medicaid Services (CMS) finalized its calendar year 2024 Medicare Physician Fee Schedule final rule. The rule included new billing codes that enable CMS to pay health care providers to train caregivers to carry out a treatment plan (CMS, 2023). In publishing its final rule, CMS referenced that this policy aligned with the White House’s April 2023 executive order (White House, 2023). This is a notable advancement in how CMS pays providers, as it is among the first set of billing codes available to allow payment for services delivered to individuals other than the patient and that can be delivered without the patient present. As presented in Chapter 5, 48 percent of military/veteran caregivers reported that the person they are caring for did *not* receive most of their health care at a VA facility; this is consistent with national data suggesting that roughly half of veterans are enrolled in VA and that not all use VA health care in a given year (VA, 2023b). Thus, policy changes affecting Medicare and Medicaid payment services will affect a large number of veterans and their caregivers. More on caregivers’ uptake of caregiver training is provided in Chapter 4, including caregivers’ perspectives on the utility of such training.

Sunsetting of the Assisted Living for Veterans with Traumatic Brain Injury Pilot Program

Under VA’s Assisted Living for Veterans with Traumatic Brain Injury (AL-TBI) Pilot Program, eligible veterans were placed in specialized private sector residential facilities for neurobehavioral rehabilitation. VA launched the program in 2009; it was originally scheduled to end in 2014, but the Veterans Access, Choice, and Accountability Act of 2014 extended it through October 2017 (VA, 2015a). The program has since sunsetted, and advocates have called for it to be reinstated or replaced with a similar program (Wounded Warrior Project, 2020). Although much caregiving is done in people’s homes and, in fact, is performed to keep care recipients *out* of residential facilities, some families may decide that residential placement is the best way to keep individuals safe.

Elizabeth Dole Home- and Community-Based Services for Veterans and Caregivers Act

Although this legislation is not yet a law, on December 5, 2023, the U.S. House of Representatives passed the *Elizabeth Dole Home- and Community-Based Services for Veterans and Caregivers Act* (H.R. 542, 2023). This proposed legislation would expand home and community-based care services to veterans, including raising the cap on how much VA can pay to cover home care costs. It would also provide additional respite services to caregivers of veterans receiving VA home care programs. More details about caregivers to people receiving home health care support is provided in Chapter 5.

Research Advances

Because of how it is catalogued and organized, research on military and veteran caregiving is difficult to synthesize. Some research, such as this report, is specific to military/veteran caregivers and is indexed as such. There is also relevant research on caregivers more broadly that is agnostic to whether the individuals are caring for someone who is currently serving or previously served in the U.S. military. Pockets of research on caregivers of individuals with specific conditions are indexed by the condition instead of the population, such as caregivers to older adults or to people with certain conditions, such as cancer, dementia, or traumatic brain injury (TBI). That research might be also relevant to military and veteran caregivers and might even include military and veteran caregivers in the study samples, but that research is not exclusively focused on this population.

RAND researchers reviewed the scientific literature to summarize advances in knowledge about military and veteran caregivers from studies conducted since 2014.¹ The research can be broadly categorized as evaluation studies, epidemiologic studies, and commentaries and reviews.

Evaluation Studies

Evaluation studies focus on the relationship between caregiver programs and desired outcomes or discuss the implementation of programs. These studies examined such programs as PCAFC (e.g., Bruening et al., 2020; Miller et al., 2019; Miller et al., 2023; Shepherd-Banigan et al., 2018a; Shepherd-Banigan et al., 2018b; Sperber et al., 2020; Van Houtven et al., 2019; Van Houtven et al., 2020; Van Houtven et al., 2022; Wyse et al., 2020), OFC (e.g., Easom et al., 2018; Shepherd-Banigan et al., 2022; Shepherd-Banigan et al., 2020), REACH VA (e.g., Chen et al., 2019; Nichols and Martindale-Adams, 2020; Nichols et al., 2016), and others. Twenty

¹ The keywords used in the search were as follows: [military OR veteran] AND caregiver OR caretaker OR helper OR caregiving. The databases included PubMed and PsychInfo, as well as a search of gray literature. This search resulted in 560 potential sources of literature. After a title, abstract review, and full-text review, 137 articles and reports were deemed relevant. Of these, 17 were commentaries and reviews, 45 were evaluation studies, and 75 were epidemiological studies. Additional citations were provided by the report's quality assurance reviewer, Megan Shepherd-Banigan.

percent of the evaluation studies used a randomized controlled trial design that allows for an experiment in which researchers can compare between groups. However, because of the design of the programs and costs associated with implementing these evaluation studies, this evaluation design is not always possible.

A widely evaluated program was VA's PCAFC, which provides resources and training for military caregivers. One evaluation of PCAFC-enrolled caregivers reported increases in depressive symptoms and perceived financial strain as the duration of caregiving increased, although those receiving higher stipends reported less financial strain (Miller et al., 2019). Another evaluation found that most PCAFC-enrolled caregivers reported increased confidence about caregiving and knowledge about available resources, and participants reported the stipend provided by PCAFC as being the most helpful resource offered (Sperber et al., 2018). In a related study, PCAFC-enrolled caregivers reported declines in financial strain compared with caregivers not approved for participation; additionally, they did not see changes in depressive symptoms, while non-participants saw increases in such symptoms, suggesting that PCAFC might help offset worsening mental health over time (Smith et al., 2019). Caregivers who are also veterans and were enrolled in PCAFC had increased health care diagnoses compared with those who were not enrolled (Miller et al., 2023), which may reflect reduced barriers to accessing health care among veteran PCAFC participants.

Evaluations of PCAFC also considered the impacts on veterans, such as decreased use of long-term care (Shepherd-Banigan et al., 2018b). Three studies demonstrated increased outpatient physical and mental health care use among veterans whose caregivers were enrolled in PCAFC in the short term (Van Houtven et al., 2019), particularly among veterans with PTSD (Shepherd-Banigan et al., 2018a). Notably, veterans whose caregivers were participating in PCAFC were not more likely to receive acute care than the control group, which indicates that increases to costs were likely due to receiving more regular care (Van Houtven et al., 2020). It is unclear whether these differences persist over time (Van Houtven et al., 2020), so more research is needed on the long-term impacts of programs such as PCAFC.

Epidemiologic Research²

Epidemiologic studies address both the health and well-being of the care recipient and caregiver outcomes, the latter of which includes caregiver burden (Bailey and Griffiths, 2018; Brickell et al., 2019; Guevara et al., 2016; Stinson et al., 2014), depression (Bambara et al., 2014; Brier et al., 2018; Moriarty et al., 2018), sleep quality (Bailey and Griffiths, 2018; Kratz et al., 2020), family issues/disruption (Brickell et al. 2018; Carlozzi et al., 2020), and unmet needs of caregivers (Bejjani et al., 2015; Rylee et al., 2019). Although there were numerous outcomes observed in the studies, there were some consistent trends in the characteristics of caregivers who were included in these studies. For example, almost half of the epidemiologic studies focused on caregivers of veterans with TBI (Brickell et al., 2019; Delgado et al., 2018;

² Citations in this section provide illustrative examples and are not exhaustive of what was included in the literature review.

Finn et al., 2022; Winter and Moriarty, 2017). Also, the samples for epidemiologic studies tended to include older participants, who are often recruited from VA (Davis et al., 2019; Fields et al., 2022; Keatley et al., 2019; Phelan et al., 2018) or Walter Reed National Military Medical Center (Brickell et al., 2018) facilities. Most samples are not demographically or geographically representative of veterans in the United States, including those not enrolled in or who do not access care at VA, a gap filled by this study.

Commentaries and Reviews

The commentaries and reviews, which include peer-reviewed literature reviews, government reports, and commentaries in journals, addressed such issues as the mental health impacts of caregiving, best practices for integrating caregivers into medical care teams, strategies for home-based care, and demand for caregiving services (e.g., Dang et al., 2020; Leykum et al., 2022).

Events That May Have Affected Caregivers and the Nature of Caregiving

In addition to advances in programs and policies supporting caregivers, demographic trends in the veteran population and other events may have changed caregivers' experiences. This section describes some of those changes.

Demographic Changes in the Number of Veterans and Their Characteristics

In 2014, there were an estimated 21.6 million veterans living in the United States (Amaral et al., 2018), 1.3 million individuals serving in the active component of the U.S. military, and 832,000 serving in the reserve component (Defense Manpower Data Center, 2024, September 2014 file). In 2022, the number of veterans had decreased by roughly 3 million to 18.6 million (VA, 2020a). From the most recent data available, the number of those in the active component was the same in 2022 as it was in 2014, though there was a reduction in the reserve component (773,000) (Defense Manpower Data Center, 2024, September 2022 file).

As the total number of veterans has decreased, demographic changes in the veteran population may also impact caregiving. As the size of the veteran population decreases, the average age of that population will increase (barring any major policy changes or large-scale conflicts; Eibner et al., 2015). This may increase the number of adults providing care to veterans with conditions associated with aging, including veterans who served after September 11, 2001. In addition, veterans have become more geographically concentrated in the southern and western parts of the United States, a pattern that is expected to continue (VA, 2022a). Finally, the gender mix of veteran population is changing—in 2014, women represented 8 percent of veterans, in 2022 they were estimated to represent 11 percent, and by 2043 they are projected to make up 16 percent of veterans. These demographic shifts may change both *who* is providing caregiving and the types of caregiving they are performing.

Legal Advances for Lesbian, Gay, Bisexual, Transgender, Queer, and Other Veterans and Service Members

The U.S. military's Don't Ask, Don't Tell policy was repealed in September 2011, allowing lesbian, gay, and bisexual adults to serve openly. For transgender service members, the path was more tumultuous: From 2016 to 2019, transgender service members were eligible to serve under certain conditions, they were largely barred from service between 2019 and 2021, and since January 2021 they have been able to serve with little restriction. Since July 2015, same-sex marriages have been legal in all 50 states, making all VA benefits for spouses available to veterans in same-sex marriages. President Barack Obama also directed VA to cease defining a spouse as a member of the opposite sex (VA, 2015b). In addition, in 2021 on the ten-year anniversary of the repeal of Don't Ask Don't Tell, VA issued guidance that "VA adjudicators shall find that all discharged service members whose separation was due to sexual orientation, gender identity or HIV status are considered 'Veterans' who may be eligible for VA benefits" (Williams, 2021). These policy changes affect who is eligible for both health care services and caregiving benefits, although it is unknown whether lesbian, gay, bisexual, transgender, queer, and other (LGBTQ+) caregivers are accessing relevant services and whether such services cater to their unique needs.

Troop Withdrawal from Afghanistan

America's more-than-20-year military campaign in Afghanistan ended in August 2021 as the Taliban took control. In the aftermath of the campaign, many veterans questioned the value of their and their comrades' service—according to one study, 48 percent of veterans felt that the war "was a complete failure," and 70 percent believed that "America did not leave Afghanistan with honor." Many veterans also felt disappointed, angry, betrayed, and even humiliated about the withdrawal of the American military from Afghanistan (Veterans and Citizens Initiative, 2021). The emotional toll of being part of or witnessing the withdrawal may have affected many veterans and their caregivers. Many veterans and veteran-serving organizations, including the Elizabeth Dole Foundation, turned this anger and disappointment into action and concentrated on helping Afghans, particularly those who supported the U.S. military, to leave Afghanistan and resettle in the United States.

Increased Awareness of Service Member Exposure to Environmental Toxins

Concern about service members' exposures to environmental toxins and their cascading health effects has a long history that includes exposure to Agent Orange among those who served in Vietnam. For those who served in Iraq, Afghanistan, and Djibouti after September 11, 2001, respiratory conditions among service members and veterans raised concerns about their exposure to airborne hazards emitted by *burn pits*—open-air environments in which trash was burned. It was only in 2010 that Congress limited the use of burn pits in theater; in 2014, VA created the Airborne Hazards and Open Burn Pit Registry to better understand the effects of exposure to burn pits. In August 2022, the Promise to Address Comprehensive Toxins Act (PACT Act) was signed into law; it extended the period of time in

which veterans can enroll to receive care at VHA, added more than 20 conditions to the list of those presumed to be linked to toxic exposures, and implemented training and screening for toxic exposure within VHA. An increase in health conditions related to these exposures and, in turn, more veterans eligible for care at VA could lead to more caregivers and demand for caregiver support services.

Agent Orange and burn pits are perhaps the most discussed environmental toxins that affect service member and veteran health, but there are also other exposures worth noting, including mustard gas and radiation (VA, 2023d). Such occupational hazards as exposure to asbestos (Lemen and Landrigan, 2021) and jet fuel (Warner, Fuente, and Hickson, 2015) may also be common in certain military occupations and may be linked to adverse health outcomes. There has been concern about toxins that affect not only service members but also their families; these include toxic drinking water on military installations, such as Camp Lejeune (VA, 2023f), and exposure to lead-based paint in some military housing units (Schneyer and Januta, 2018).

COVID-19 and Associated Lockdowns

On February 3, 2020, the United States declared a public health emergency caused by the COVID-19 outbreak, and in March 2020 President Donald Trump declared a national emergency. The first stay-at-home order was issued by California in March 2020, with many states soon following suit (“A Timeline of COVID-19 Developments in 2020,” 2021). There have been notable changes in the world since COVID-19 that are too numerous and too complex to summarize briefly. However, there is evidence that caregivers’ mental health was specifically impacted during the peak of the pandemic (Czeisler et al., 2021). Furthermore, the pandemic witnessed dramatic changes in the economic welfare of American families. Food insecurity peaked, affecting as many as one in five American families (Kim-Mozeleski et al., 2023). Although housing prices had been increasing prior to the pandemic, they have spiked since the pandemic’s outset (Florida, 2022; Mondragon and Wieland, 2022).

The Centers for Disease Control and Prevention (CDC) report that 1.16 million Americans had died from COVID-19 as of November 2023 (CDC, 2023d). According to national data collected in 2022, almost 7 percent of adults have had long COVID, described as having symptoms persisting for three months after having COVID-19, and 3.4 percent currently have long COVID (Adjaye-Gbewonyo et al., 2023). Many of those with severe cases of COVID or long COVID may need caregivers.

Highlights of What *Emerging from the Shadows* Offers

Emerging from the Shadows revisits some of the same questions that RAND researchers answered about military/veteran caregiving in 2014. Specifically, in this report, the authors aim to more accurately (1) quantify the number of military and veteran caregivers and (2) describe who they are, the types of caregiving support they provide, and the impact that caregiving has on their health and well-being.

In recognition of the changes since *Hidden Heroes* was first published, *Emerging from the Shadows* provides a new lens through which to view the questions addressed in *Hidden Heroes* and ask new ones. Some of the most notable changes or additions in this report are detailed in the following sections.

Redefining Caregiving and Caregivers

In 2014, a person qualified as a caregiver if they answered yes to the following question:

Do you provide unpaid care and assistance for, or manage the care of, someone who is at least 18 years old and has an illness, injury or condition for which they require outside support? This may include help with tasks such as personal care, bathing, dressing, feeding, giving medicines or treatments, help with memory tasks for someone with brain injury, help coping with symptoms of Posttraumatic Stress Disorder (PTSD), transportation to doctors' appointments, or arranging for services, etc. You do not need to live with the person. Care and assistance are considered unpaid if you provide them without receiving financial compensation in exchange for doing so.

In reviewing this definition, and in recognition of past research, the authors attempted to improve on the criteria by broadening it and reducing its cognitive burden. Thus, the 2023 RAND Caregiving Survey asks whether the respondent performs any of a series of caregiving tasks (described in more detail in Chapter 1). With this definition, the survey may identify caregivers who may have answered “no” to the question above: for example, a son or daughter who lives apart from their veteran parent but who nonetheless helps coordinate his or her medical care. This new approach and definition reveal more hidden heroes in the American population and offer more refined and detailed descriptions of how much time individuals spend providing caregiving support and the types of caregiving support they provide during this time.

A New Focus on Caregiver Caring for Conditions Attributed to Toxic Exposures

The 2023 RAND Caregiving Survey sheds light on what it means to be a caregiver for a service member or veteran with a condition thought to be caused by exposure to environmental toxins. Military/veteran caregivers are asked the following question:

Do you think any of [name]'s health conditions were a result of exposure to burn pits, Agent Orange, or other toxic substances during [his/her/their] military service?

Answering this question does not require definitive evidence about whether the condition was caused by such exposures. However, by asking it, the authors characterize the types of conditions that *caregivers think* may be related to toxic exposures and the type of caregiving activities that these caregivers are performing. Furthermore, we can examine differences in

the experiences of these caregivers relative to other military/veteran caregivers, which may in part result from the more restrictive VA eligibility requirements that veterans with these conditions had faced prior to passage of the PACT Act.

A New Focus on Caregivers to Those at Risk of Suicide and Caregivers' Own Suicide Risk

More than 40,000 Americans die annually by suicide, including more than 6,000 veterans and more than 300 service members (VA, 2023g). Caregivers and family members are critical to supporting veterans and service members at risk of suicide, but there is little research into these families or how caregivers are managing suicide risk in the person for whom they are caring. Thus, the 2023 RAND Caregiving Survey asks caregivers the following question:

How concerned are you that [the care recipient] may be at risk of suicide?

The COVID-19 pandemic also highlighted the risk of suicide among caregivers. According to one CDC survey, 31 percent of caregivers had considered suicide in the past 30 days, relative to 4 percent of non-caregivers (Czeisler et al., 2021). In 2021, 168 military family members ended their own lives, an estimated rate of 6.5 per 100,000 (Defense Suicide Prevention Office, 2022). To better understand suicide risk among military and veteran caregivers, the 2023 RAND Caregiving Survey asked all respondents about thoughts of suicide, whether respondents had made preparatory suicide plans, and whether respondents had attempted suicide (Chapter 2).

Incorporating the Effects of Place

There has been increased recognition that individual health and well-being is influenced by social and physical surroundings (Berkman, Kawachi, and Glymour, 2014). A wide range of neighborhood characteristics, such as area-level poverty, the food environment, social cohesion, and access to opportunity (including retail, educational, and economic supports), are drivers of an equally broad range of individual outcomes (Diez-Roux, 2007). This has been an important component of social-epidemiological theories of disease distribution, especially theories on the social production of disease, which is the understanding that individuals exist within economic and political contexts, which are fundamental causes of social inequalities in health (Krieger, 2001; Link and Phelan, 1996).

Caregivers and their recipients may be especially dependent on their residential surroundings, in terms of access to opportunity and neighborhood assets that support them. A better understanding of where caregivers live and how their environment affects them is critical to improving the experiences of military and veteran caregivers, their access to place-based opportunities, and the impact on their health and well-being. The 2023 RAND Caregiving Survey not only asked respondents about their environments, but the data were also linked with characteristics of where they live to better understand how their surroundings affect

caregiver health and well-being. The survey enabled analyses that explore, for example, urban and rural differences in caregiver health outcomes, whether living in areas with greater concentrations of veterans impact military and veteran caregivers, and whether neighborhood-based assets and opportunities specifically affect caregiver outcomes (Chapter 7).

Organization of This Report

Chapter 1 presents estimates of how many caregivers and how many military/veteran caregivers exist nationally. It also presents a description of military/veteran caregivers. This includes sociodemographic characteristics of caregivers and the people for whom they provide care, as well as the caregiving activities they perform and the conditions that they are caring for. This chapter also compares these attributes for military/veteran caregivers, civilian caregivers, and non-caregivers.

Chapter 2 describes the mental health and well-being of military and veteran caregivers and their children. It examines, for example, the proportion of caregivers who are likely to meet criteria for depression, the proportion of caregivers who drink alcohol at levels that are potentially hazardous to their health, and the proportion of caregivers who are getting inadequate sleep. It describes the proportion receiving adequate health care, particularly among those caregivers who are likely to benefit from receiving care. It examines the emotional well-being of two unique groups of caregivers: those caring for someone the caregiver perceives to be at risk of suicide and children in military/veteran caregiving households. Finally, it describes the benefits that caregivers perceive in serving as caregivers.

Chapter 3 highlights our estimates of the economics of caregiving. It provides estimates of the value of caregiving, as well as the out-of-pocket costs associated with caregiving. In addition, it provides an estimate of forgone earnings: money that caregivers are forfeiting because they are serving as caregivers. As part of this analysis, it also describes in more detail the employment and job characteristics of military/veteran caregivers. Finally, it includes an examination of financial government support, including participation in such programs as the Supplemental Nutrition Assistance Program (SNAP) and unemployment compensation.

Chapter 4 presents data on the support available to military and veteran caregivers. This includes caregivers' support networks and the social support they receive from their family and friends. It also includes their participation in support programs, such as caregiving training, caregiver support groups, and respite care.

Chapter 5 provides an overview of caregivers' experiences in the health care settings in which the person they are caring for receives care. It describes, in caregivers' perceptions, how well they are integrated into health care teams, whether the physical setting of the health care setting accommodates them adequately, and whether they are hassled by health care staff. Importantly, this chapter also provides information on whether caregivers perceive that they are treated poorly in health care settings because of their caregiver status, their relationship to the care recipient, or a personal attribute, such as their race, ethnicity, sexual orienta-

tion, age, or physical appearance. For military/veteran caregivers, this chapter also estimates how these experiences differ between those caring for someone whose typical health care provider is part of the VA health care system. It also describes caregivers who access home health care for the care recipient and possible benefits of this care.

Chapter 6 provides data on military/veteran caregivers' families and household relationships. The chapter first focuses on children in caregiving households. It examines how engaged children are in school and whether they are taking on caregiving or other household tasks more frequently than children in non-caregiving households. It then examines the degree of household conflict and cohesion in caregiving households, as well as the quality of caregivers' relationships with their significant others (including the care recipient for caregiving spouses or the significant others to caregivers caring for a parent, child, other family member, or friend).

Chapter 7 provides data on where military/veteran caregivers live. It presents estimates of how many veteran caregivers live in each state. It also describes how caregiver experiences and outcomes vary (for example, between rural and urban settings, between regions of the country, and across neighborhoods), as well as how characteristics of communities affect outcomes.

Chapter 8 presents analyses focused on former military and caregivers, including why they are no longer caregiving and how their well-being compares with that of current military and veteran caregivers, as well as with non-caregivers.

Chapter 9 describes remote (or *distance*) caregivers—those who provide care from a distance. It compares these military and veteran caregivers with those who provide most of their care in person.

Chapter 10 concludes this report, with recommendations developed to continue to improve the health and well-being of America's hidden heroes who are, justifiably, finally emerging from the shadows.

In Chapter 11, the 2023 RAND Caregiving Survey is described in further detail, as are the procedures used to validate and analyze the data.

Finally, an appendix is available with (1) a select list of current programs available to support military and veteran caregivers; (2) a comparison of the 2023 RAND Caregiving Survey estimate of caregivers with other, recent national estimates; (3) details on the statistical models used to estimate the costs associated with caregiving and its economic value (the results of which are presented in Chapter 3); (4) details on the validation procedure for confirming PCAFC participation (the results of which are presented in Chapter 4); and (5) details of the statistical models used to provide state-level estimates of caregivers (the results of which are presented in Chapter 7). The appendix also includes details of the constructs used in the 2023 RAND Caregiving Survey.

Because of space constraints, this report primarily presents point estimates. Ninety-five percent confidence intervals for all estimates presented in tables are available in an annex at www.rand.org/t/RRA3212-1.

Caregiving in the United States

Introduction

In this chapter, our approach to defining caregivers in the 2023 RAND Caregiving Survey is described. Then, results are presented for the percentage and number of adults 18 and older who are caring for a wounded, ill, or injured adult; the percentage and number who are caring for someone who is currently serving or had formerly served in the U.S. military (*military and veteran caregivers*); and the percentage and number of those who are caregivers to those who are not currently serving and had not previously served in the U.S. military (*civilian caregivers*). Estimates are also provided for individuals who are not currently serving as caregivers but who had served as caregivers in the past (*former caregivers*).

This chapter then describes caregiving in the United States, distinguishing between those who care for service members and veterans and those who care for civilians. For comparison purposes, data are also provided for non-caregivers, where appropriate. The first section presents the following:

- demographic characteristics of caregivers and non-caregivers
- caregivers' relationship to the person for whom they are caring
- whether caregivers live with the person for whom they are caring or provide care remotely.

The second section describes the people for whom caregivers are caring, referred to as *care recipients*. It describes

- demographic characteristics of care recipients
- characteristics of care recipients' military service (if care recipients are service members or veterans)
- medical conditions care recipients have been diagnosed with
- caregivers' perceptions on whether these conditions can be attributed to military service and/or exposure to environmental toxins.

Finally, the third section describes aspects of caregiving itself, including the following:

- caregiving activities

- length of time serving as a caregiver
- hours spent caregiving.

Key Findings

An estimated 105.6 million adults are caregiving in the United States—40.5 percent of the population. Among these, 14.3 million are military/veteran caregivers. These estimates far exceed past estimates of caregiving, which is likely the result of more specific and precise definitional criteria that may be more likely to include what AARP and the National Alliance for Caregiving (NAC) would categorize as *low-intensity* caregivers. The difference in estimates does not appear to be due to sampling differences or misclassification of non-caregivers as caregivers.

Military/veteran and civilian caregivers to those over 60 are generally comparable with respect to characteristics of caregivers, conditions among care recipients, and caregiving activities. Fifty-seven percent of civilian caregivers and 74 percent of military/veteran caregivers are caring for individuals over 60. They were similar demographically, similar proportions lived with the care recipient, and they performed similar caregiving tasks and for similar numbers of hours per week. They did differ somewhat in that a greater proportion of civilian caregivers were children caring for their parents, whereas military/veteran caregivers had a greater proportion of spouse caregivers. Understandably, more military/veteran caregivers to those over 60 were caring for men. Also, a greater proportion of military/veteran caregivers were caring for individuals who had been diagnosed with a behavioral health condition.

Among those caring for individuals 60 and under, military/veteran caregivers differed significantly from civilian caregivers with respect to their relationship to the care recipient, the care recipients' conditions, and their caregiving activities. Military/veteran caregivers to individuals 60 and under represented more “nontraditional” caregivers than did civilian caregivers to individuals 60 and under: More were friends or relatives, such as siblings or aunts and uncles. Also, more military/veteran caregivers provided half or more of their care remotely. They were more likely to be caring for men, but the conditions they cared for and, correspondingly, the caregiving tasks they performed differed. Among care recipients 60 and under, more military/veteran care recipients than civilian care recipients had been diagnosed with a chronic condition, vision or hearing impairment, or TBI, possibly explaining why more of these caregivers also helped with at least one activity of daily living (ADL).

Caregiving tasks typically asked about in caregiving research may not fully capture the type of help provided to care recipients who have neurologic, mental health, or substance use diagnoses. The 2023 RAND Caregiving Survey asked about providing memory assistance and helping those with behavioral health conditions to avoid triggers, but even after

accounting for these tasks, caregivers for individuals with neurological and mental health conditions still spent more time performing caregiving tasks.

Caregivers helping with at least one ADL spend, on average, more time caregiving. Even after accounting for medical diagnoses, caregiver characteristics, and care recipient characteristics, caregivers who assisted with at least one ADL spent more time caregiving than those who provided other types of care (as measured in the 2023 RAND Caregiving Survey).

Defining Caregiving

A primary objective of this report is to estimate the number of military and veteran caregivers in the United States. This was done by administering a nationally representative, probability-based survey of American households (termed the 2023 RAND Caregiving Survey; see further details in Chapter 11) that screened for caregivers. RAND researchers took a task-oriented approach for defining caregivers. This approach identifies caregivers based on activities they report performing or have performed. Specifically, we asked all respondents the following screening question:

Please indicate if you provided any of the following types of assistance in the past 30 days to someone who has a wound, illness, injury or other condition for which they may need support:

1. *Personal care (for example, bathing, dressing, or feeding)*
2. *Giving medicines or treatments*
3. *Helping someone remember things that, due to a condition like a brain injury or dementia, they may be prone to forget*
4. *Helping someone manage symptoms of psychological disorders (for example, depression, anxiety, or posttraumatic stress disorder)*
5. *Helping arrange for medical or psychological services (for example, finding appropriate providers or making appointments)*
6. *Providing transportation to medical or mental health appointments*
7. *Helping getting in and out of beds and chairs*
8. *Helping with other tasks which people with wounds, illness, or injuries may have difficulty performing themselves*
9. *I do not currently provide any of these types of assistance, but I have in the past*
10. *I have never provided any of these types of assistance to someone else*

Participants who responded “yes” to any of the prompts in 1 to 8 were then asked for how many individuals they provide this assistance and if at least one of the individuals for whom they provide this assistance is 18 years or older. If they provided assistance to at least one individual 18 or older, they were asked whether this person (or, for those providing care to more

than one person, at least one) was a current or former member of the U.S. military, National Guard, or Reserves. Respondents were asked the reason they perform this assistance. They were provided four response options:

- *Providing this assistance is part of my job (for example, you are a home health care aide or other health care worker)*
- *The person I assist is my spouse or partner*
- *The person I assist is a family member or other relative* [or, if caring for more than one individual, at least one person they are caring for is a family member or other relative]
- *The person I assist is a friend or neighbor* [or, if caring for more than one individual, at least one person they are caring for is a friend or neighbor].

Respondents were not included as caregivers if they reported “Providing this assistance is part of my job.” If respondents reported caring for more than one individual 18 or over, the priority was to assign them as a military/veteran caregiver if one of the care recipients had served or currently serves in the U.S. military. If both had served in the U.S. military, they were asked to respond about the person they provided “the most” unpaid care for. Similarly, if they provided care for two or more care recipients, neither who had served in the U.S. military, they were classified as civilian caregivers and asked to respond about the person they provided “the most” unpaid care for.

Quantifying Caregiving

Using the new, task-oriented approach to defining caregiving, the 2023 RAND Caregiving Survey reveals that 40.5 percent of adults 18 and older are caregiving in the United States. The U.S. Census Bureau estimates that in July 2022 there were 260,836,730 adults in the United States. Thus, according to our estimates, an estimated 105.6 million adults are caregiving in the United States (U.S. Census Bureau, 2023c). Among these, 14.3 million (5.5 percent of the U.S. adult population/13.6 percent of caregivers) are estimated to be *military/veteran caregivers*—meaning that they are caring for an adult who is currently serving or had previously served in the U.S. armed forces. Almost 100 million adults (91.3 million), or 35.0 percent of the U.S. adult population, are civilian caregivers, representing the majority (86.4 percent) of caregivers.

The survey further reveals that among U.S. adults, 51.3 percent are non-caregivers. The total of non-caregivers (51.3 percent) and caregivers (40.5 percent) does not equal 100 percent because the remainder (8.3 percent) are paid caregivers or caregivers to someone wounded, ill, or injured under 18. Many of the 51.3 percent of adults not considered current caregivers have had prior experiences caregiving. Twenty-six percent of U.S. adults (representing 66.5 million American adults) are not currently serving as caregivers but did previously (i.e., they responded to the screening question that they “do not currently provide any of these types of assistance, but [they] have in the past”). Almost 4 percent of the U.S. adult popula-

tion (10.2 million adults) are not *currently* military/veteran caregivers but previously cared for an adult who was serving or had formerly served in the U.S. armed forces. Thus, taken together, there are 24.5 million current or former military or veteran caregivers, representing 9 percent of American adults. Former caregivers are included with “non-caregivers” for the remaining analyses in this report, although Chapter 8 provides further description of former caregivers specifically. These data are presented in Table 1.1; definitions and unweighted Ns are presented in Table 1.14 in the supplemental tables at the end of this chapter.

Estimates of caregivers from the 2023 RAND Caregiving Survey greatly exceed those of previous studies. In 2014, the first RAND study of military and veteran caregivers estimated that there were 22.6 million U.S. caregivers (Ramchand et al., 2014). Studies since then have estimated more than 22.6 million, though none are near the 105.6 million indicated in the 2023 RAND Caregiving study.

The appendix provides an overview of other national studies of caregiving. It also explores different reasons why the current estimate may be so different from other recent estimates, with most evidence suggesting that the task-oriented screening approach may be more likely to include what AARP and NAC would categorize as “low-intensity” caregivers.

TABLE 1.1
Adult Caregivers in the U.S. Household Population

	Weighted Percentage of Total U.S. Adult Population (95% confidence interval [CI])	N (based on July 2022 U.S. population estimates)
Total U.S. household population	100	260.8 million
Current caregiver	40.5% (38.7%, 42.3%)	105.6 million
Current military/veteran caregiver	5.5% (4.8%, 6.3%)	14.3 million
Current civilian caregiver	35.0% (33.2%, 36.8%)	91.3 million
Current non-caregiver	51.3% (49.4%, 53.1%)	133.8 million
Former caregiver	25.5% (24.7%, 26.4%)	66.5 million
Former military/veteran caregiver	3.9% (3.5%, 4.3%)	10.2 million
Former civilian caregiver	21.5% (20.7%, 22.4%)	56.1 million

NOTE: Former caregivers are classified as “non-caregivers” for the remaining analyses presented in this report.

Comparisons Between Caregivers

The average age of the veteran population is increasing, suggesting that more military and veteran caregivers may be providing care for older veterans and thus caring for a combination of conditions associated with military service and with aging. The 2023 RAND Caregiving Survey found that three-quarters (74 percent) of military/veteran caregivers are caring for those over age 60, whereas 57 percent of civilian caregivers are caring for those over age 60 (Figure 1.1). Many differences in caregiving experiences are driven by the age of the care recipient, including the conditions and symptoms the care recipient has, their caregiving needs, and the relationship of the caregiver to the care recipient (Ramchand et al., 2014). Any comparison between military and civilian caregivers, and their experiences caregiving, should account for differences in the ages of the individuals for whom they care. Thus, in this chapter, separate estimates are provided for military/veteran caregivers and civilian caregivers to those 60 and under and those over 60.¹ Statistical tests using a weighted Pearson's chi-square were conducted to examine differences between military/veteran and civilian caregivers within both groups (caregivers to those 60 and under and caregivers to those over 60). To avoid the potential of type 2 errors due to multiple comparison testing, tests were not conducted between those caring for individuals 60 and under and those caring for individuals over 60 except when examining attributes specific to military and veteran caregivers (see, for example, Table 1.8).

Characteristics of Caregivers

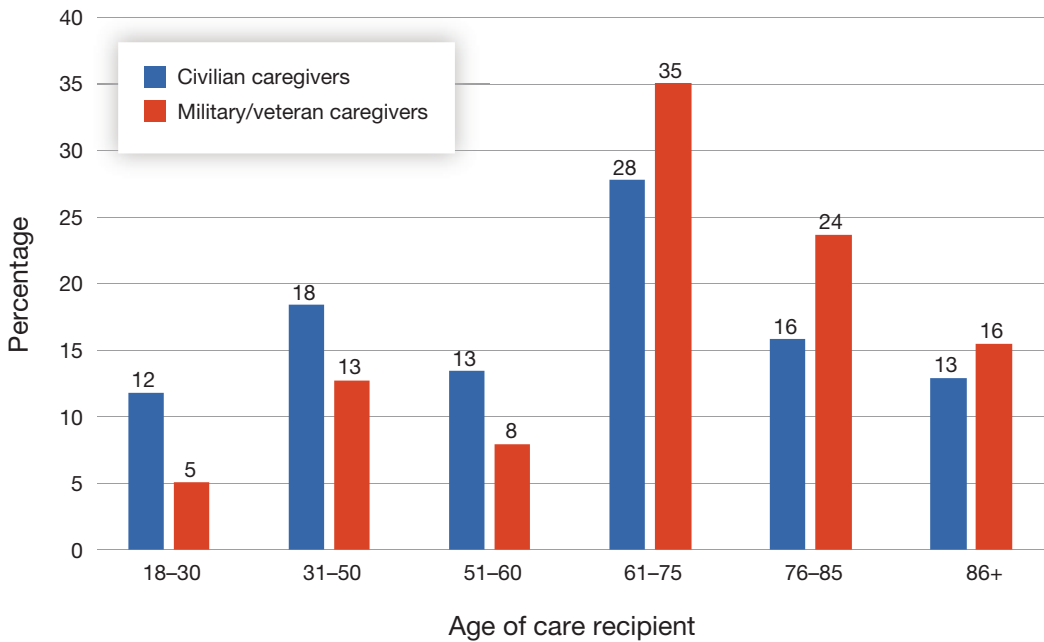
Demographics

Demographic characteristics of caregivers are provided in Table 1.2. Across the demographic characteristics examined (gender, age, race/ethnicity, sexual orientation, education level, and household income), there were no significant differences between military/veteran and civilian caregivers caring for those over 60. Just under half were male, a similar proportion (43–46 percent) were 55 to 75 years old, and almost two-thirds were White. However, military/veteran caregivers to those over 60 were more likely than civilian caregivers to have served in the military (11 percent versus 2 percent).

Military/veteran and civilian caregivers to adults 60 and under also looked similar to each other, except with respect to race/ethnicity. More military/veteran caregivers in this category were non-White than in civilian categories: 34 percent (versus 11 percent) were Black non-Hispanic, and 10 percent (versus 5 percent) were Asian non-Hispanic. On the other

¹ The unweighted sample sizes across groups are as follows: military/veteran caregivers to those 60 and under = 103; civilian caregivers to those 60 and under = 494; military/veteran caregivers to those over 60 = 407; civilian caregivers to those over 60 = 709. Five caregiver survey respondents (three military/veteran caregivers and two civilian caregivers) did not report their care recipients' age and thus were removed from the analyses.

FIGURE 1.1
Care Recipient Age Distribution, Military/Veteran and Civilian Caregivers



hand, there were half as many Hispanic military/veteran caregivers (11 percent) as Hispanic civilian caregivers (22 percent). Like caregivers to those over 60, military/veteran caregivers were more likely than civilian caregivers to have served in the military (30 percent versus 2 percent).

Demographic characteristics of non-caregivers (Table 1.2) largely mirror the demographic characteristics of the U.S. population broadly. Although significance tests were not conducted comparing non-caregivers with caregivers across these characteristics, there are noteworthy differences. First, women represent close to 60 percent of caregivers to those over 60, but they represent only 49 percent of non-caregivers. Second, caregivers to those 60 and under skew younger than non-caregivers. The overrepresentation of younger adults may, in part, explain other differences (for example, educational attainment, household income, and sexual orientation) between non-caregivers and caregivers to those 60 and under. Third, all caregivers are more racially/ethnically diverse than non-caregivers, of whom nearly two-thirds are White, non-Hispanic. Finally, all caregivers appear to be less likely to be employed full-time than non-caregivers.

TABLE 1.2

Demographic Characteristics of Caregivers

		Care Recipient Is 60 or Under		Care Recipient Is over 60	
		Military/Veteran Caregivers	Civilian Caregivers	Military/Veteran Caregivers	Civilian Caregivers
Gender					
Male	51%	47%	53%	42%	45%
Female	49%	53%	47%	58%	55%
Age					
18–24	9%	16%	17%	10%	7%
25–34	15%	33%	25%	18%	13%
35–44	16%	25%	19%	10%	16%
45–54	13%	13%	16%	11%	13%
55–64	20%	10%	14%	21%	24%
65–74	20%	4%	5%	23%	22%
75+	8%	--	3%	7%	5%
Race/ethnicity ^a					
White, non-Hispanic	67%	42%	56%	59%	61%
Black, non-Hispanic	10%	37%	12%	19%	13%
Other, non-Hispanic	1%	2%	3%	1%	1%
Hispanic	15%	10%	23%	17%	18%
Two or more races/ethnicities, non-Hispanic	2%	--	2%	2%	2%
Asian, non-Hispanic	6%	10%	5%	3%	5%
Sexual orientation					
Straight/heterosexual	91%	76%	85%	94%	91%
Gay/lesbian	3%	5%	4%	2%	3%
Bisexual	3%	16%	8%	1%	4%
Other/did not answer	2%	3%	4%	3%	2%
Education level					
Less than high school	9%	15%	16%	4%	7%
High school graduate or equivalent	29%	23%	31%	32%	27%

Table 1.2—Continued

	Non-Caregiver	Care Recipient Is 60 or Under		Care Recipient Is over 60	
		Military/Veteran Caregivers	Civilian Caregivers	Military/Veteran Caregivers	Civilian Caregivers
Vocational/technical school/some college/associate degree	25%	23%	26%	31%	30%
Bachelor's degree	19%	26%	18%	19%	19%
Postgraduate study/professional degree	19%	12%	9%	14%	17%
Military service ^{a,b}					
Current active duty	1%	5%	<1%	--	<1%
Past active duty	1%	18%	1%	7%	1%
Trained for Reserves/National Guard—not activated	<1%	8%	1%	4%	1%
Never served	98%	70%	98%	89%	98%
Employment status					
Working full time (≥35 hours/week)	45%	39%	41%	32%	37%
Working part time (<35 hours/week)	11%	19%	15%	14%	16%
Unemployed and looking for work	4%	12%	8%	4%	4%
Unemployed but not looking for work	<1%	4%	2%	1%	2%
Full-time care of the house and/or children	3%	5%	4%	3%	3%
Full-time caregiver	--	3%	2%	4%	2%
Not working—retired	27%	4%	9%	27%	25%
Not working—disabled	5%	4%	13%	9%	6%
Not working—full-time student	2%	1%	2%	2%	1%
Not working—other	2%	4%	2%	3%	3%
Did not answer	0%	4%	2%	1%	1%

NOTE: Tests for differences between non-caregivers and caregivers were not conducted. "--" indicates that the sample did not have any respondent meeting these criteria.

^a The distribution was significantly different between military and civilian caregivers to adults 60 and under.

^b The distribution was significantly different between military and civilian caregivers to adults over 60.

Relationship to Care Recipient

All military/veteran caregivers differ from civilian caregivers with respect to their relationship to the care recipient. For caregivers to adults 60 and under, the largest group of military/veteran caregivers was “other relative” and included siblings, siblings-in-law, uncles, aunts, and other relatives, comprising 31 percent of military/veteran caregivers but only 18 percent of civilian caregivers. There are also notably more neighbors, friends, and non-relatives among military/veteran caregivers (27 percent) than among civilian caregivers (17 percent). For those caring for adults over 60, the share of adult children who are caregivers for their parents is smaller among military/veteran caregivers (42 percent) than among civilian caregivers (58 percent), while military/veteran caregivers include more spouses (23 percent versus 16 percent) and neighbors, friends, and non-relatives (22 percent versus 15 percent; see Table 1.3).

Living with Care Recipient

As presented in Table 1.4, more caregivers to adults 60 and under (53–60 percent) live with the person they are caring for than caregivers to those adults over 60 (37–38 percent), but there were no differences between military/veteran and civilian caregivers in either group. Among those who live with the person they are caring for, the largest group were spouses, comprising between 42 percent and 57 percent of caregivers who live with the person for whom they are caring. It is notable that adult children caring for their parents over 60 comprise 31 percent of military/veteran caregivers and 49 percent of civilian caregivers who live with the person for whom they are caring. Also, almost a quarter of military/veteran caregivers who are living with and caring for an adult 60 or under are siblings, siblings-in-law, aunts, uncles, or other relatives.

TABLE 1.3
Caregiver Relationship to Care Recipient

	Care Recipient Is 60 or Under		Care Recipient Is over 60	
	Military/Veteran Caregivers	Civilian Caregivers	Military/Veteran Caregivers	Civilian Caregivers
Caregiver is the care recipient's: ^{a,b}				
Child or grandchild	12%	17%	42%	58%
Spouse	24%	36%	23%	16%
Neighbor/friend/ other non-relative	27%	17%	22%	15%
Parent	7%	13%	1%	0%
Other relative	31%	18%	12%	10%

^a The distribution was significantly different between military and civilian caregivers to adults 60 and under.

^b The distribution was significantly different between military and civilian caregivers to adults over 60.

TABLE 1.4

Caregiver Lives with Care Recipient

	Care Recipient Is 60 or Under		Care Recipient Is over 60	
	Military/Veteran Caregivers	Civilian Caregivers	Military/Veteran Caregivers	Civilian Caregivers
Caregiver lives with care recipient	53%	60%	37%	38%
Among those who live with care recipient, caregiver is:				
Child or grandchild	16%	18%	31%	49%
Spouse	42%	54%	57%	42%
Neighbor/friend/other non-relative	15%	3%	6%	5%
Parent	4%	15%	1%	1%
Other relative	23%	11%	6%	4%

NOTE: There was no evidence of significant differences between military and civilian caregivers among those caring for adults 60 and under or over 60. The unweighted sample sizes for those living with the care recipient were as follows: 63 for military/veteran caregivers to those 60 and under, 282 for civilian caregivers to those 60 and under, 170 for military/veteran caregivers to those over 60, and 284 for civilian caregivers to those over 60. Differences in caregivers' relationship to care recipient were not tested among those who live with caregivers.

Remote or Distance Caregiving

Very few caregivers (3 percent or less) provide caregiving support *exclusively* remotely, referred to as *distance caregiving*. However, over a quarter of military/veteran caregivers to adults 60 or under provide *half or more* of their caregiving remotely, while 39 percent do this almost exclusively in person. This is significantly different than the proportion of civilian caregivers who care for adults 60 or under, of whom 70 percent do this exclusively in person, a proportion comparable to the proportion of caregivers to those over 60, of whom 70 to 71 percent provide this care exclusively in person (Table 1.5). More insights about caregivers who provide half or more of their caregiving support remotely are contained in Chapter 9.

Internet Access

The COVID-19 pandemic underscored the importance of internet access as social connection, health care, and other aspects of life were transitioned to virtual platforms. Prior to the pandemic, disparities in reliable broadband access were of concern to the federal government and became a larger priority as the pandemic drove more interactions to the web (Federal Communications Commission, 2023). Data from the 2023 RAND Caregiving Survey indicate that slightly more military/veteran caregivers to those 60 or under do not have internet access (25 percent) relative to non-caregivers and other caregiving groups (range: 9 to 15 percent; see Table 1.6).²

² The percentage of non-caregivers without internet access (12 percent) is slightly lower than the percentage in other research, which indicates that roughly one in five Americans do not have internet access (Internet for All, undated).

TABLE 1.5**In-Person and Remote Caregiving**

	Care Recipient Is 60 or Under		Care Recipient Is over 60	
	Military/Veteran Caregivers	Civilian Caregivers	Military/Veteran Caregivers	Civilian Caregivers
Where caregiving occurs: ^a				
In-person caregiving	39%	70%	70%	71%
Hybrid caregiving: less than half remote	33%	20%	15%	20%
Hybrid caregiving: half or more remote	28%	9%	12%	8%
Remote caregiving	<1%	1%	3%	1%

NOTE: There is no evidence of significant differences between military and civilian caregivers to adults over 60.

^a The distribution was significantly different between military and civilian caregivers to adults 60 or under.

TABLE 1.6**Household Without Internet Access**

	Non-Caregiver	Care Recipient Is 60 or Under		Care Recipient Is over 60	
		Military/Veteran Caregivers	Civilian Caregivers	Military/Veteran Caregivers	Civilian Caregivers
No household internet access	12%	25% ^a	12%	15%	9%

NOTE: There is no evidence of significant differences between military and civilian caregivers to adults over 60.

^a The estimate is significantly different between military and civilian caregivers to adults 60 or under.

Characteristics of Care Recipients

This section of the report describes characteristics of care recipients *as reported by their caregivers*. This is important to note because, as will be shown, in many cases caregivers did not know information about the person they are caring for—in these instances, caregivers who responded to the survey were not required to guess but rather were able to respond “Don’t know.”

Care Recipient Demographics

The aging profile of the veteran population largely explains why most (82 percent) military/veteran caregivers caring for someone over 60 are caring for someone whom caregivers identified as male (Table 1.7). Care recipient gender also is different between military/veteran caregivers caring for an adult 60 or under; however, the gap is much narrower (58 percent of military/veteran caregivers versus 44 percent of civilian caregivers are caring for someone they identify as male), which is most likely attributed to increasing representation of women

TABLE 1.7
Care Recipient Demographic Characteristics

	Care Recipient Is 60 or Under		Care Recipient Is over 60	
	Military/Veteran Caregivers	Civilian Caregivers	Military/Veteran Caregivers	Civilian Caregivers
Gender ^{a,b}				
Male	58%	44%	82%	29%
Female	26%	50%	13%	70%
Other ^c	16%	6%	5%	2%
Age				
18–30	20%	27%	N/A	N/A
31–50	50%	42%	N/A	N/A
51–60	31%	31%	N/A	N/A
61–75	N/A	N/A	47%	49%
76–85	N/A	N/A	34%	31%
86+	N/A	N/A	19%	20%
Race/ethnicity				
White, non-Hispanic	44%	58%	65%	63%
Black, non-Hispanic	19%	9%	18%	12%
Other, non-Hispanic	5%	3%	1%	2%
Hispanic	23%	23%	12%	17%
Two or more races/ ethnicities, non-Hispanic	6%	3%	1%	1%
Asian, non-Hispanic	2%	5%	3%	5%
Education level ^b				
Less than high school	13%	16%	11%	19%
High school graduate or equivalent	29%	36%	31%	39%
Some college, no degree	25%	18%	20%	15%
Associate degree	5%	9%	11%	9%
Bachelor's degree	22%	15%	18%	11%
Postgraduate study/ professional degree	6%	5%	7%	7%

Table 1.7—Continued

	Care Recipient Is 60 or Under		Care Recipient Is over 60	
	Military/Veteran Caregivers	Civilian Caregivers	Military/Veteran Caregivers	Civilian Caregivers
Household income				
Less than \$30,000	43%	44%	42%	48%
\$30,000 to under \$60,000	27%	26%	26%	23%
\$60,000 to under \$100,000	19%	17%	15%	17%
\$100,000 or more	10%	13%	17%	13%

^a The distribution was significantly different between military and civilian caregivers to adults 60 or under.

^b The distribution was significantly different between military and civilian caregivers to adults over 60.

^c “Other” includes caregivers who reported that the care recipient was transgender, genderqueer (neither exclusively male nor female), or none of the response options or who chose not to respond.

in the military over time. Among care recipients over 60, military/veteran care recipients tended to have completed higher levels of education, with 25 percent (versus 18 percent of civilian care recipients) having a college degree or higher.

Table 1.15 in the supplemental tables at the end of this chapter provides a comparison of all military/veteran care recipient characteristics relative to available data on all veterans nationally.

Care Recipient Military Service

Most (98 percent) military/veteran caregivers to those over 60 are caring for someone who served prior to September 11, 2001. Forty-one percent of those caring for an adult 60 or under served in the post-9/11 era (Table 1.8).

Military/veteran care recipients 60 or under had mostly left military service, though 6 percent were in the reserve component (26 percent of caregivers did not know detailed information about how the care recipient left the military or whether their care recipient was still serving). None were currently in the active component. Most (54–56 percent) care recipients served in the Army, though all service branches were represented, including the Coast Guard. Eighteen percent of care recipients 60 or under and one-fifth of care recipients over 60 had served only in the reserve component (this difference was not statistically significant). Finally, approximately 40 percent of care recipients in both groups had deployed to a war zone.

TABLE 1.8
Care Recipient Military Service

	Military/Veteran Care Recipient	
	Care Recipient Is 60 or Under	Care Recipient Is over 60
Era of service ^c		
Pre-9/11	59%	98%
Post-9/11	41%	2%
Military status ^c		
Currently in reserve component	6%	1%
Retired from military	27%	22%
Honorable discharge	27%	44%
General discharge under honorable conditions	7%	5%
Left military—other	1%	3%
Currently in active component	0%	0%
Don't know	26%	24%
Branch of service		
Army	54%	56%
Navy	18%	17%
Air Force	11%	17%
Marine Corps	5%	7%
Space Force	N/A	N/A
Coast Guard	2%	2%
Only served in reserve component	18%	20%
Deployed to a war zone	43%	38%

^c The distribution was significantly different between military care recipients 60 and under and those over 60.

Care Recipient Medical Conditions

Respondents were asked whether the person they were caring for *had been diagnosed* with a series of medical conditions.³ Among care recipients over 60, most (83 to 84 percent) had an underlying chronic condition (e.g., diabetes, cancer, respiratory condition, or cardiovascular disease), with no significant difference between military/veteran and civilian care recipients. Among military/veteran care recipients over 60, the most common conditions after chronic conditions were vision and hearing impairment (68 percent, significantly more than the 54 percent among civilian care recipients over 60), musculoskeletal (43 percent), and substance use disorders or mental health conditions (40 percent, significantly more than the 24 percent among civilian care recipients over 60) and neurological conditions (e.g., dementia, spinal cord injury, stroke—37 percent; see Table 1.9).

Among those 60 and under, chronic conditions were more common among military/veteran care recipients (84 percent) than civilian care recipients (65 percent). Other common conditions are substance use disorders or mental health conditions (62 percent), vision or hearing impairment (49 percent), and musculoskeletal conditions (42 percent). TBI was more common among military/veteran recipients than civilian care recipients 60 or under (21 percent versus 9 percent; see Table 1.9).

TABLE 1.9
Care Recipient Medical Conditions

	Care Recipient Is 60 or Under		Care Recipient Is over 60	
	Military/Veteran Caregivers	Civilian Caregivers	Military/Veteran Caregivers	Civilian Caregivers
Chronic condition ^a	84%	65%	84%	83%
Vision/hearing ^{a,b}	49%	33%	68%	54%
Neurological	20%	14%	37%	38%
TBI ^a	21%	9%	13%	7%
Musculoskeletal	42%	28%	43%	47%
Infection ^b	12%	8%	16%	10%
Substance use disorder or mental health condition ^b	62%	53%	40%	24%
Other ^a	17%	31%	33%	31%
Mean number of conditions ^a (SD)	3.0 (1.9)	2.3 (1.5)	3.2 (1.6)	2.9 (1.4)

NOTE: SD = standard deviation.

^a The distribution was significantly different between military and civilian caregivers to adults 60 and under.

^b The distribution was significantly different between military and civilian caregivers to adults over 60.

³ The list presented in Table 1.9 is a collapsed list of health conditions among care recipients. Prevalence estimates for the more detailed list among military/veteran care recipients are provided in Table 1.10.

Table 1.9 also shows that, of the 17 conditions asked about in the 2023 RAND Caregiving Survey, most care recipients had been diagnosed with between two and three conditions. Qualitatively, means appear to be slightly higher among those care recipients over 60 than those 60 or under; for those 60 or under, the mean number of conditions was higher among military/veteran care recipients than civilian care recipients.

Conditions Perceived to Be Attributed to Military Service

If respondents reported “yes” to a diagnosis, they were asked whether the condition was related to or directly caused by military service. For those 60 or under, the conditions most commonly attributed to military service were PTSD, major depressive disorder (depression, clinical depression), or some other mental health condition (57 of care recipients had a diagnosis; of those, 77 percent attributed the condition to military service); hearing problems (72 percent attributed to military service); and alcohol and substance use disorder (71 percent attributed to military service). For those over 60, PTSD and other mental health conditions were also most commonly attributed to military service (60 percent), but the other most common conditions were TBI (50 percent) and hearing problems (43 percent; Table 1.10). Aside from PTSD and other mental health conditions, the reported prevalence of conditions attributed to military service tended to be lower among care recipients over 60 than their younger counterparts.

Conditions Perceived to Be Caused by Toxic Exposures

Military/veteran caregivers were asked, “Do you think any of [name]’s health conditions were a result of exposure to burn pits, Agent Orange, or other toxic substances during [his/her/their] military service?” Responses to this question are presented in Figure 1.2. There were no significant differences in responses between those caring for service members or veterans 60 and under and those over 60. One-fifth (21 percent) of those caring for someone 60 or under and 13 percent of those caring for someone over 60 felt definite that conditions were caused by exposure to an environmental toxin. In the supplemental tables at the end of this chapter, Table 1.16 presents a list of care recipient health conditions for those who felt definite that the condition was attributed to environmental toxins.

Characteristics of Caregiving

Caregiving Duties

Caregiving duties are frequently defined as activities of daily living (ADLs) and instrumental activities of daily living (IADLs). A list of ADLs and IADLs is provided in Table 1.11. In addition, the 2023 RAND Caregiving Survey asked about additional caregiving duties, also presented in Table 1.11. For these questions, respondents were first asked whether the care recipient needed assistance with the task; if caregivers answered “yes,” they were then asked how often they helped the care recipient with the task (never, sometimes, or often).

TABLE 1.10
Conditions Perceived to Be Attributed to Military Service

	Total Diagnosed %		% Attributed to Military Service	
	Care Recipient 60 or Under	Care Recipient over 60	Care Recipient 60 or Under	Care Recipient over 60
Chronic condition				
Diabetes or another endocrine disorder (thyroid disorder, rheumatic disease such as fibromyalgia or lupus)	43%	33%	25%	20%
A cardiovascular condition such as congestive heart failure, angina or chest pain from heart problem, heart attack, bypass surgery or angioplasty, high blood pressure	27%	50%	55%	23%
A respiratory disorder such as asthma, chronic bronchitis, or emphysema	39%	19%	30%	28%
Cancer during the last 5 years (not including small skin cancers) or other chronic pain	18%	21%	44%	21%
A digestive condition, such as incontinence (due to bladder or bowel problem), irritable bowel, colitis, or an ulcer	25%	24%	47%	23%
Poor blood circulation in the legs	21%	37%	41%	24%
Hearing/vision				
Hearing problems such as tinnitus (ringing in the ears) or hard of hearing	35%	49%	72%	43%
Vision problem or blindness	26%	37%	44%	26%
A neurological condition such as Alzheimer's disease or other dementia, spinal cord injury, or stroke	20%	37%	10%	16%
TBI	21%	13%	43%	50%
A musculoskeletal disorder, such as osteoarthritis or rheumatoid arthritis, osteoporosis (thinning of the bones), chronic back pain or sciatica, or any amputated hands, arms, feet, or legs	42%	43%	41%	27%
An infectious disease such as skin and soft tissue infections, eye or bladder infections, shingles, or West Nile virus	12%	16%	35%	21%
Substance use disorder or mental health condition				
Alcohol or substance use disorder	23%	8%	71%	35%
PTSD, major depressive disorder (depression, clinical depression), or other mental health condition	57%	34%	77%	60%

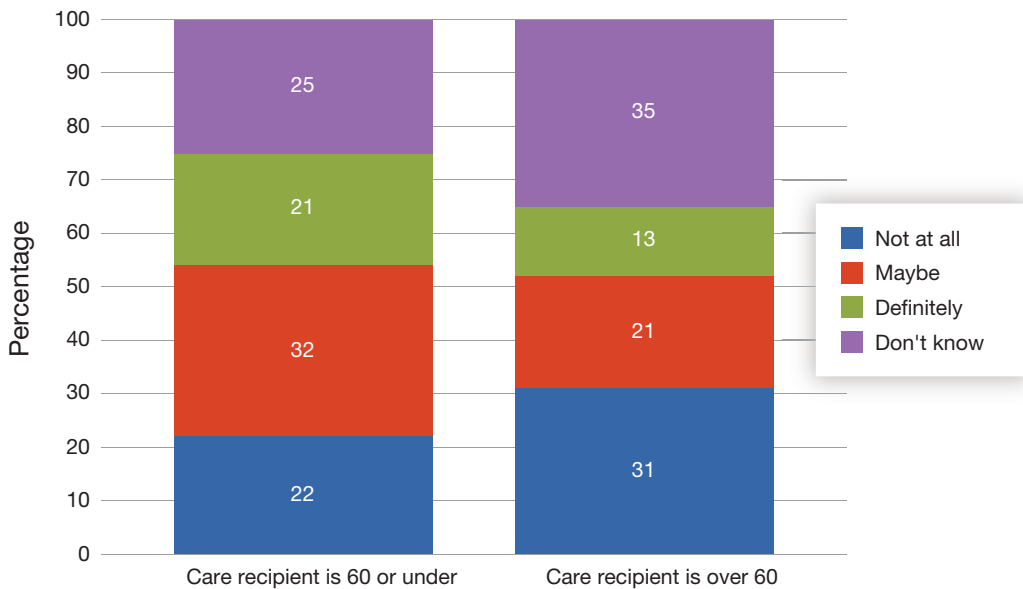
Table 1.10—Continued

	Total Diagnosed %		% Attributed to Military Service	
	Care Recipient 60 or Under	Care Recipient over 60	Care Recipient 60 or Under	Care Recipient over 60
Other				
Genital or reproductive wounds	2%	5%	--	7%
Other medical condition	16%	29%	46%	20%

NOTE: Differences between military/veteran and civilian caregivers for these outcomes were not tested.

FIGURE 1.2

Care Recipients' Perceptions About Whether Any Military/Veteran Care Recipient Health Conditions May Have Been Caused by Exposure to Environmental Toxins



NOTE: Distribution is not significantly different between military care recipients 60 and under and those over 60.

TABLE 1.11**Caregiving Duties Asked of Caregivers in the 2023 RAND Caregiving Survey**

ADLs	IADLs	Additional Caregiving Tasks
<ul style="list-style-type: none"> • Getting in and out of beds and chairs • Getting dressed, bathing or showering • Getting to and from the toilet • Dealing with incontinence or diapers • Eating 	<ul style="list-style-type: none"> • Taking medicines or pills or injections • Managing finances (such as bills or insurance paperwork) • Grocery shopping • Housework (such as dishes, laundry, or straightening up) • Preparing meals • Transportation (driving, helping arrange for transportation, or accompanying on public transit) 	<ul style="list-style-type: none"> • Arranging or supervising paid services (such as nurses, aides, Meals on Wheels, or other services) • Coordinating medical care and rehabilitative services • Gaining access to, or information from, care providers, government agencies, or schools • Remembering what [care recipient] should be doing • Filling out paperwork related to benefits and compensation or legal issues • Coping with stressful situations or avoiding “triggers” of anxiety or antisocial behavior

Full results to these items are provided in Table 1.17 in the supplemental tables at the end of this chapter. However, the categories can be collapsed into three other mutually exclusive categories: assisting with at least one ADL; assisting with emotional or cognitive tasks (i.e., “Remembering what [care recipient] should be doing” or “Coping with stressful situations or avoiding ‘triggers’ of anxiety or antisocial behavior”); and all other tasks, which can be described as “Help administering medications, housework, or administrative support.” Respondents were assigned to these tasks hierarchically (i.e., they were assigned to the first category; if they did not help with at least one ADL, they were assigned to the next category, and so on). As shown in Table 1.12, military/veteran and civilian caregivers caring for someone over 60 are similar with respect to the tasks they perform. Just over half help with at least one ADL, and the remaining half is roughly equally split between those who help with emotional/cognitive tasks and those who help administer medications, help with housework, or provide administrative support. On the other hand, for care recipients 60 and under, military/veteran and civilian caregivers tend to differ from civilian caregivers with respect to the tasks they perform. Notably, more military/veteran caregivers caring for an adult 60 or under (60 percent) help with at least one ADL than civilian caregivers caring for an adult 60 or under (40 percent).

Duration of Caregiving

Across all caregivers, between 57 and 67 percent had been caring for the care recipient for three years or less. In comparison, 7 to 16 percent had been caring for the person for more than ten years. There were no differences between military/veteran and civilian caregivers to those 60 or under or those over 60 (Table 1.13).

TABLE 1.12
Relationship Between Age of Care Recipient and Caregiving Activities

	Care Recipient Is 60 or Under		Care Recipient Is over 60	
	Military/Veteran Caregivers	Civilian Caregivers	Military/Veteran Caregivers	Civilian Caregivers
Caregiving tasks ^a				
Help with at least one ADL	61%	40%	51%	54%
Help with emotional/cognitive tasks	30%	39%	25%	24%
Help administering medications, housework, or administrative support	9%	22%	24%	22%

NOTE: There was no evidence of significant differences between military/veteran and civilian caregivers to adults over 60.

^a The distribution was significantly different between military/veteran and civilian caregivers to adults 60 and under.

TABLE 1.13
Duration of Caregiving

	Care Recipient Is 60 or Under		Care Recipient Is over 60	
	Military/Veteran Caregivers	Civilian Caregivers	Military/Veteran Caregivers	Civilian Caregivers (N = 709)
1 year	27%	34%	30%	23%
2–3 years	40%	24%	34%	34%
4–5 years	15%	12%	21%	19%
5–10 years	10%	14%	9%	16%
>10 years	8%	16%	7%	9%

NOTE: There were no significant differences between military and civilian caregivers among those caring for adults 60 and under or over 60.

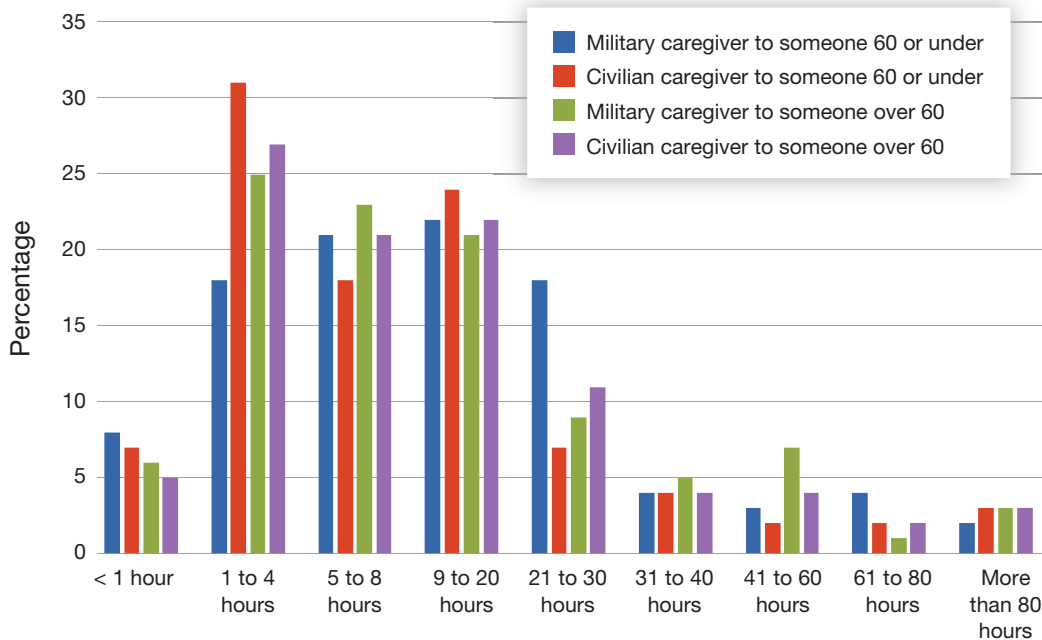
Weekly Hours of Caregiving

All caregivers were asked: “In a typical week, about how many hours, in total, do you spend helping [NAME] in all of the ways you just indicated?” Responses are displayed in Figure 1.3. Across all caregivers, the majority reported spending between one and 30 hours per week. Very few (<10 percent) reported spending less than one hour. Between 11 and 16 percent spent 31 hours or more per week caregiving.

Correlates of Time Spent Caregiving

To identify characteristics of caregivers who spent more time per week providing care, we estimated linear weighted regression models. Potential predictors included characteristics of

FIGURE 1.3
Average Time Spent Caregiving per Week



NOTE: There were no significant differences between military and civilian caregivers among those caring for adults 60 or under or over 60.

caregivers, care recipients, and caregiving activities (full results are presented in Table 1.18 in the supplemental tables at the end of this chapter). When examined independently, performing at least one ADL is associated with more time spent caregiving. Being a spouse caregiver and living with the person for whom the caregiver is caring also is associated with more hours per week spent caregiving. However, when included in the model simultaneously, not all of the patterns remain significant. After controlling for other factors, helping with at least one ADL is associated with more time spent caregiving relative to helping with emotional/cognitive tasks or helping administer medications. Helping with neurological conditions or with substance use disorders/mental health conditions remains associated with more time spent caregiving. This suggests that caring for neurological conditions (including Parkinson's and Alzheimer's disease) and mental health and substance use disorders may entail tasks unaccounted for in the caregiving tasks asked about in the 2023 RAND Caregiving Survey. Finally, there is no longer evidence that being a spouse is associated with more time spent caregiving, but living with the care recipient is. It may be that given the strong correlation between being a spouse and living with a care recipient, the effect of cohabitation explains why, when cohabitation is not part of the model, spouses tend to spend more time caregiving.

Chapter 1 Supplemental Tables

TABLE 1.14
Caregiving Definitions from the 2023 RAND Caregiving Survey

	Weighted Percentage	Unweighted N	Definition (See table note for prompts)
Total U.S. household population	100	N/A	
Current caregiver	40.5%	1,718	Responded “yes” to at least one of the 8 prompts from 1–8 and was providing care to at least one person who was age 18 or older
Current military/veteran caregiver	5.5%	513	Met criteria for current caregiver and at least one of the individuals the person was caring for is a current or former member of the U.S. military, whether in active or reserve component
Current civilian caregiver	35.0%	1,205	Met criteria for current caregiver and none of the individuals the person is caring for is a current or former member of the U.S. military, whether in active or reserve component
Current non-caregiver	51.3%	1,228	Responded “yes” to prompt 10
Former caregiver	25.5%	651	Responded “yes” to prompt 9 and provided care to at least one person who was age 18 or older
Former military/veteran caregiver	3.9%	98	Met criteria for former caregiver and at least one of the individuals the person cared for was a current or former member of the U.S. military, National Guard, or Reserves
Former civilian caregiver	21.5%	550	Met criteria for former caregiver and none of the individuals the person cared for was a current or former member of the U.S. military, National Guard, or Reserves

NOTE: The weighted percentages reflect the entire screened population. The unweighted Ns reflect only those eligible to participate in the survey, excluding paid caregivers, caregivers to children, and those who did not consent to the survey but still completed the screening questions.

The prompts are (1) Personal care (for example, bathing, dressing, or feeding); (2) Giving medicines or treatments; (3) Helping someone remember things that, due to a condition like a brain injury or dementia, they may be prone to forget; (4) Helping someone manage symptoms of psychological disorders (for example, depression, anxiety, or posttraumatic stress disorder); (5) Helping arrange for medical or psychological services (for example, finding appropriate providers or making appointments); (6) Providing transportation to medical or mental health appointments; (7) Helping getting in and out of beds and chairs; (8) Helping with other tasks which people with wounds, illness, or injuries may have difficulty performing themselves; (9) I do not currently provide any of these types of assistance, but I have in the past; (10) I have never provided any of these types of assistance to someone else.

TABLE 1.15**Demographic Characteristics of Military/Veteran Care Recipients Compared with National Data on Veterans**

	Military/Veteran Care Recipients from 2023 RAND Caregiving Survey	Veteran Population (2022)
Age		
18–30 (<20–29)	5%	5%
31–55 (30–54)	17%	30%
56–65 (55–64)	13%	19%
66–80 (65–79)	40%	32%
81+ (80+)	24%	14%
Undisclosed	1%	N/A
Education level		
Less than high school	12%	4%
High school graduate or equivalent	31%	37%
Vocational/technical school/some college/ associate degree	31%	28%
Bachelor's degree	19%	18%
Postgraduate study/professional degree	7%	13%
Don't know	1%	N/A
Era of service		
Pre-9/11	88%	72%
Post-9/11	12%	28%
Branch of service (not mutually exclusive)		
Army	56%	44%
Navy	17%	21%
Air Force	15%	17%
Space Force	--	--
Marine Corps	7%	11%
Coast Guard	2%	N/A

Table 1.15—Continued

	Military/Veteran Care Recipients from 2023 RAND Caregiving Survey	Veteran Population (2022)
VA disability rating		
No rating	61%	71%
Don't know	5%	N/A
0%	0%	<1%
10 or 20%	5%	7%
30 or 40%	13%	4%
50 or 60%	5%	4%
70%	3%	3%
80%	1%	3%
90%	<1%	3%
100%	7%	6%
Over 70% but don't know how much	1%	N/A

SOURCES: Information about veteran population: age, era of service, and branch of service: VA, 2022c; education: Ruggles et al., 2024; VA disability rating: Veterans Benefits Administration, 2022.

TABLE 1.16
Conditions Among Those Who Perceive at Least One of Care Recipient's Medical Conditions Is "Definitely" Attributed to Toxic Exposures

	Not at All Toxic Exposure	Definitely Toxic Exposure
Diabetes or another endocrine disorder (thyroid disorder, rheumatic disease such as fibromyalgia or lupus)	23%	17%
Hearing problems such as tinnitus (ringing in the ears) or hard of hearing	22%	19%
Vision problem or blindness	23%	12%
A neurological condition such as Alzheimer's disease or other dementia, spinal cord injury, or stroke	22%	17%
TBI	9%	28%
A cardiovascular condition such as congestive heart failure, angina or chest pain from heart problem, heart attack, bypass surgery or angioplasty, high blood pressure	28%	14%
A respiratory disorder such as asthma, chronic bronchitis, or emphysema	23%	22%
Cancer during the last 5 years (not including small skin cancers) or other chronic pain	23%	19%
A digestive condition, such as incontinence (due to bladder or bowel problem), irritable bowel, colitis, or an ulcer	24%	28%
A musculoskeletal disorder, such as osteoarthritis or rheumatoid arthritis, osteoporosis (thinning of the bones), chronic back pain or sciatica, or any amputated hands, arms, feet, or legs	26%	14%
An infectious disease such as skin and soft tissue infections, eye or bladder infections, shingles, or West Nile virus	16%	27%
Poor blood circulation in the legs	25%	16%
Alcohol or substance use disorder	14%	25%
PTSD, major depressive disorder (depression, clinical depression), or other mental health condition	16%	24%
Genital or reproductive wounds	7%	31%
Other medical condition	31%	13%

TABLE 1.17
Detailed Prevalence of Caregiving Tasks

	Care Recipient Is 60 or Under		Care Recipient Is over 60	
	Military/Veteran Caregivers	Civilian Caregivers	Military/Veteran Caregivers	Civilian Caregivers
ADLs				
Getting in and out of beds and chairs	27%	25%	31%	38%
Getting dressed, bathing or showering	19%	25%	29%	33%
Getting to and from the toilet	19%	14%	20%	21%
Dealing with incontinence or diapers	16%	10%	20%	24%
Eating	22%	12%	20%	17%
Emotional/cognitive tasks				
Remembering what [care recipient] should be doing	52%	35%	50%	50%
Coping with stressful situations or avoiding “triggers” of anxiety or antisocial behavior	61%	57%	41%	38%
Administering medications, housework, or administrative support				
Taking medicines or pills or injections	41%	44%	45%	50%
Managing finances (such as bills or insurance paperwork)	51%	44%	54%	57%
Grocery shopping	50%	55%	65%	72%
Housework (such as dishes, laundry, or straightening up)	58%	60%	64%	69%
Preparing meals	29%	45%	55%	57%
Transportation (driving, helping arrange for transportation, or accompanying on public transit)	55%	52%	65%	72%
Arranging or supervising paid services (such as nurses, aides, Meals on Wheels, or other services)	37%	15%	35%	36%
Coordinating medical care and rehabilitative services	47%	39%	53%	57%

Table 1.17—Continued

	Care Recipient Is 60 or Under		Care Recipient Is over 60	
	Military/Veteran Caregivers	Civilian Caregivers	Military/Veteran Caregivers	Civilian Caregivers
Gaining access to, or information from, care providers, government agencies, or schools	47%	32%	49%	54%
Filling out paperwork related to benefits and compensation or legal issues	55%	43%	56%	60%

TABLE 1.18
Regression Estimates of Time Spent Caregiving Among Military and Civilian Caregivers

	Univariate Estimate		Multivariate Estimate	
	Estimate	p	Estimate	p
Military/veteran caregiver (ref)				
Civilian caregiver	-0.17	0.18	-0.08	0.56
Care recipient is 60 or under (ref)				
Care recipient 60+	0.11	0.35	0.14	0.30
Caregiving activities				
Help with at least one ADL (ref)				
Help with emotional/cognitive tasks	-0.82	<0.001	-0.74	<0.001
Help administering medications, housework, or administrative support	-1.30	<0.001	-0.95	<0.001
Care recipient conditions				
Chronic condition	0.62	<0.001	0.15	0.20
Vision/hearing	0.44	<0.001	0.11	0.30
Neurological	0.59	<0.001	0.36	0.01
TBI	0.49	0.04	0.26	0.25
Musculoskeletal	0.46	<0.001	0.11	0.30
Infection	0.32	0.10	0.13	0.51
Substance use disorder or mental health condition	0.39	0.001	0.28	0.02
Other	0.41	0.001	0.20	0.08
Caregiver is the care recipient's:				
Child or grandchild (ref)				
Spouse	0.34	0.01	0.01	0.96
Neighbor/friend/other non-relative	-0.43	0.005	-0.06	0.70
Parent	-0.11	0.62	0.07	0.76
Other relative	0.08	0.68	0.17	0.37
Caregiver lives with care recipient	0.85	<0.001	0.87	<0.001

NOTE: Bolded estimates indicate $p < 0.05$. All variables listed were included in the multivariate model. Ref = reference.

The Mental Health and Well-Being of Caregivers and Their Children

Introduction

Caregiving often places significant strain on caregivers and increases their risk for developing physical and mental health conditions (Buyck et al., 2013; Ji et al., 2012; Shaffer et al., 2017). Despite these increased health risks, caregivers often place their health needs behind those they are caring for (Applebaum et al., 2014; Shaw et al., 2013). Caregivers neglecting their own health can lead to burnout, stress, decreased effectiveness in their caregiving, and decline in overall health. In order to provide the best possible care for those they are caring for, caregivers must care for their own health and well-being.

This chapter provides an overview of the health and well-being of caregivers. It presents data from the 2023 RAND Caregiving Survey on mental health outcomes and caregivers' own thoughts of suicide, as well as information about the proportion of caregivers receiving mental health treatment. For those not receiving mental health treatment but who could benefit from it, this chapter identifies the reasons caregivers report for not receiving care.

Next, the chapter presents data on caregiver substance use, including hazardous alcohol use. It also provides data on the mental health of those military and veteran caregivers who are concerned that the person they are caring for is at risk of suicide. That is followed with data on caregiver loneliness—the U.S. Surgeon General has deemed loneliness an American epidemic (U.S. Department of Health and Human Services, 2023b), and caregivers may be disproportionately affected.

In Chapter 6, the report further describes children of military and veteran caregivers; however, this chapter provides data on these children's mental and emotional well-being.

This chapter then turns to other measures of health, including information on sleep quantity and quality. Data are also presented on how caregivers view their overall health and any functional limitations they have that are due to physical illness.

The last part of the chapter focuses on positive aspects of caregiving and identifies how caregivers grow or learn from their experiences caregiving, as well as the characteristics of caregivers and of caregiving most likely to contribute to this growth.

In general, weighted regression models are used in this chapter to test differences in outcomes between caregiver groups and *non-caregivers*, though not *between* caregiver groups.¹

Key Findings

Caregivers to those 60 and under are not faring well on many areas of health and well-being domains. Compared with non-caregivers, a greater proportion of caregivers to those 60 and under have probable depression and high rates of perceived stress, and 20 percent of military/veteran caregivers in this group have thought about taking their own lives. Though there is not strong evidence of differences in substance use, approximately one-quarter of caregivers meet criteria for comorbid depression and hazardous drinking. These caregivers are also more likely than non-caregivers to report a role limitation that is due to a physical health condition. And while a greater proportion of caregivers to those 60 and under sought a mental health care provider in the past year, a greater proportion also felt that they needed mental health care but did not seek it.

Though cost is a barrier to mental health care for caregivers, time constraints and perceptions of mental health care treatments also hinder caregivers from receiving this care. More than three-quarters of caregivers to those 60 and under who wanted mental health treatment but did not access it reported that they “didn’t have time for treatment,” and 70 percent were concerned about hospitalization or taking medications. In comparison, cost was only a concern for half of caregivers to those 60 and under but was a top concern among non-caregivers and military/veteran caregivers to those over 60.

Older caregivers appear to be buffered from negative caregiving outcomes. When examining correlates of depression, even after accounting for caregiving and other factors, caregivers who were 55 and older were less likely to meet criteria for depression, and, among caregivers, age was inversely associated with feelings of loneliness.

Caregivers who are concerned about suicide risk in the person they are caring for experience disproportionate stress. Nine percent of military/veteran caregivers are “very concerned” or “somewhat concerned” that the person they are caring for is at risk of suicide. Compared with military/veteran caregivers *not* concerned about suicide risk, a greater proportion of military/veteran caregivers who are concerned about suicide risk meet criteria for excessive caregiver burden (65 percent versus 28 percent), probable depression (55 percent versus 19 percent), and hazardous drinking (65 percent versus 24 percent).

¹ In some instances, measures are not available for non-caregivers (e.g., caregiver burden was not measured among non-caregivers). In these instances, a caregiver reference group is selected, and the other groups are compared to it.

Children of military/veteran caregivers experience greater emotional and behavioral problems but are also more prosocial. Compared with children of non-caregivers, children of military/veteran caregivers were more likely to miss school due to illness and scored higher on emotional symptoms and conduct problems, but they also scored higher on prosocial behaviors.

Children of military/veteran caregivers have unmet needs for mental health care and mentorship. Children of all caregivers were more likely to have seen a mental health care provider in the past year, but almost a quarter of military/veteran child caregivers needed mental health treatment in the past year but did not receive it. When caregivers were asked to indicate which services their child needs but is not currently receiving, the most frequently selected service for military/veteran child caregivers was mentorship.

The Mental Health of Caregivers

Poor mental health among caregivers can significantly impact their well-being. Mental health symptoms can be debilitating in and of themselves but also affect caregivers' physical health (Roshanaei-Moghaddam, Katon, and Russo, 2009), familial relationships (Brickell et al., 2022), work performance (Lerner and Henke, 2008), social functioning (Kupferberg, Bicks, and Hasler, 2016), and spiritual well-being (Braam and Koenig, 2019). Either directly or due to the effects of mental health on these other aspects of well-being, mental health conditions can affect both the amount and quality of caregiving support that caregivers provide. This can, in turn, affect the lives of care recipients. Intervening early to prevent mental health conditions, and offering support when needed, can yield benefits that support not only caregivers but also those they are caring for.

Mental health has been one of the most widely studied outcome among caregivers. As of 2003, the pooled effect across more than 80 studies found elevated rates of depression among caregivers compared with non-caregivers (Pinquart and Sörensen, 2003). In a survey conducted in the American population in March 2020, two-thirds (66 percent) of unpaid caregivers reported one or more adverse mental or behavioral health symptoms, double the proportion of non-caregivers (32 percent; Czeisler et al., 2020).

The 2023 RAND Caregiving Survey examined four domains of mental health: caregiver burden, perceived stress, depression, and suicidality. This is an expansive list that is not restricted to mental health diagnoses but includes one diagnostic category (depression) and three that reflect mental health domains mostly likely to be elevated among caregivers. Table 2.1 presents the proportion of non-caregivers and caregivers meeting criteria for *excessive* caregiver burden, *high levels* of perceived stress, and *probable* depression, using established criteria.²

² Means for these scales are presented in Table 2.16 in the supplemental tables at the end of this chapter.

TABLE 2.1

Mental Health Conditions, Non-Caregivers and Caregivers

	Non-Caregivers	Caregivers to Those 60 and Under		Caregivers to Those over 60	
		Military/Veteran Caregivers	Civilian Caregivers	Military/Veteran Caregivers	Civilian Caregivers
Caregiver burden	N/A	52%	31% ^{a,c}	24% ^{a,c}	29% ^{a,c}
Perceived stress	43%	75% ^{b,c}	64% ^{b,c}	44%	52% ^{b,c}
Depression	13%	43% ^{b,c}	25% ^{b,c}	15%	18% ^{b,c}

NOTE: For caregiver burden, the reference group was military/veteran caregivers to those 60 and under. For that outcome, ^a signifies significantly different from the reference group in unadjusted models, and ^c signifies significantly different from the reference group in weighted logistic regression models with covariates. For perceived stress and depression, the reference group was non-caregivers, and ^b signifies significantly different from non-caregivers in unadjusted models, and ^c denotes a statistically significant difference from the referent group in weighted logistic regression models with covariates. Regression models with covariates controlled for gender, age, marital status, household size, income, and residence in a metropolitan area.

Caregiver Burden

Caregiver burden can be defined as “the level of multifaceted strain perceived by the caregiver from caring for a family member and/or loved one over time” (Liu, Heffernan, and Tan, 2020). *Multifaceted strain* refers to strain due to neglect of one’s own health, emotional and psychological distress, disruption in family function, constrained social activities, and economic consequences. This and other sections of the report describe specifically how caregivers fare across many of these domains, but caregiver burden provides a useful, encompassing measure.

Caregivers were asked about caregiver burden with the six-item Zarit Burden Interview. These six questions ask how often caregivers feel a certain way when caring for a care recipient, from never (0) to nearly always (4). When combined, scale values range from 0 to 24; a threshold of 9 or greater was used to indicate excessive caregiver burden (Higginson et al., 2010; Yu, Yap, and Liew, 2019). Over half of military/veteran caregivers to those 60 and under report excessive caregiving burden, a proportion that is significantly greater than that of civilian caregivers to those 60 and under and both military/veteran and civilian caregivers to those over 60. These differences remained even after adjusting for differences in caregiver gender, age, marital status, household size, and living in a metropolitan area.

Perceived Stress

Very broadly, individuals experience stress when the demands placed on them exceed personal resources to meet these demands. Without additional resources, caregiving demands are likely to exceed many individuals’ personal resources. While stress is common and normal, higher levels of stress are associated with many adverse outcomes, including cardiovascular disease (Rosengren et al., 2004) and early mortality (Arnold et al., 2012). Perceived stress was measured in the 2023 RAND Caregiving Survey with the four-item Per-

ceived Stress Scale (PSS-4), which asks how often in the past month respondents felt different symptoms of stress (e.g., “you were unable to control the important things in your life”) with response options of never (0) to very often (4); two questions are reverse coded. Scale values range from 0 to 16; a threshold of 6 or greater was used to indicate high levels of perceived stress (Malik et al., 2020).

Forty-three percent of American non-caregivers perceive their stress levels as being at a level that could be considered as high. For caregivers to those 60 or under, 74 percent of military/veteran caregivers and 64 percent of civilian caregivers reported high levels of perceived stress, significantly more than among non-caregivers. The difference in perceived stress among civilian caregivers to those over 60 (52 percent) is elevated relative to non-caregivers, though not nearly as elevated as among caregivers to those 60 and under. Differences between these three caregiving groups and non-caregivers persisted after adjustment (see the note at the end of Table 2.1 for a list of covariates). There is no evidence of a significant difference in perceived stress between non-caregivers and military/veteran caregivers to those 60 or over.

Depression

Caregiver burden and perceived stress are correlated with, and in many instances causally related to, depression. In fact, data from the 2023 RAND Caregiving Survey describe high correlation between these constructs.³ As defined by the National Institute of Mental Health, *depression* is a mood disorder that “causes severe symptoms that affect how a person feels, thinks, and handles daily activities, such as sleeping, eating, or working” (National Institute of Mental Health, 2023b).

In 2014, RAND researchers found that 38 percent of post-9/11 military/veteran caregivers and 19 percent of pre-9/11 caregivers met probable criteria for depression, relative to 20 percent of civilian caregivers and 10 percent of non-caregivers (Ramchand et al., 2014). However, since 2014, rates of depression among adults in the United States have increased (Goodwin et al., 2022). Furthermore, mental health conditions were exacerbated during the COVID-19 pandemic and associated lockdowns (Ettman et al., 2020). The 2023 RAND Caregiving Survey assessed probable depression with the eight-item Patient Health Questionnaire (PHQ-8). Questions refer to the frequency of depression symptoms in the past two weeks, with response options ranging from not at all (0) to nearly every day (3). Scale values range from 0 to 24; a threshold of 10 or greater was used to indicate probable depression (Kroenke et al., 2009).

Thirteen percent of *non-caregivers* met probable criteria for depression.⁴ Depression is significantly higher among most caregiver groups relative to non-caregivers. Prevalence

³ In unweighted analysis, the correlation between total symptom scores of caregiver burden and depression is $\rho = 0.52$ and between perceived stress and depression is $\rho = 0.58$.

⁴ This is comparable to national estimates of depression from the 2021 National Survey on Drug Use and Health, which estimates that 8.3 percent of adults had a past-year major depressive disorder (Substance

estimates are highest among military/veteran caregivers caring for someone 60 or under (43 percent) and second-highest among civilian caregivers caring for someone 60 or under (25 percent). These differences remained after adjustment for demographic covariates of the caregiver (see the note at the end of Table 2.1 for a list of covariates). Estimates are comparable between military/veteran and civilian caregivers to those over 60 (15 percent and 18 percent, respectively, though the difference between military/veteran caregivers to those over 60 and non-caregivers is not statistically significant).

Logistic regression models were estimated to identify caregivers more or less likely to meet probable criteria for depression. Across studies, caregiver burden is consistently associated with depression (del-Pino-Casado et al., 2019). For this reason, caregiver burden was included in the regression model and is hypothesized to be related with depression. Any covariate significantly associated with depression controlling for caregiver burden would indicate characteristics of caregivers with higher rates of depression not explained by higher levels of caregiver burden. The range of factors included in the model is presented in Table 2.17 in the supplemental tables at the end of this chapter and includes both demographic and caregiving characteristics. As anticipated, caregivers who report higher levels of caregiver burden are more likely to meet criteria for depression independently (odds ratio = 1.16, $p < 0.001$) and after adjustment (odds ratio = 1.18, $p < 0.001$). After adjusting for caregiver burden, the following items were associated with elevated odds of depression:

- individuals caring for individuals with chronic conditions
- caregivers who were neighbors or friends of the care recipient
- caregivers who were never married.

Also, certain characteristics were associated with *reduced* odds of depression:

- caregivers over age 55
- caregivers with household incomes between \$30,000 and \$60,000 (relative to those with incomes less than \$30,000).

Suicidality

Each year, approximately 45,000 Americans die by suicide (CDC, 2023b). In 2021, this reflected at least a 4 percent increase from the prior year (Curtin, Garnett, and Ahmad, 2022). Recent research during the COVID-19 pandemic and associated lockdowns suggests that caregivers had elevated rates of thoughts of suicide (i.e., suicidal ideation) relative to non-caregivers (Czeisler et al., 2021). This finding added to an emerging literature examining suicidality among caregivers, including among military/veteran caregivers (e.g., Delgado et al.,

Abuse and Mental Health Services Administration [SAMHSA], 2023a). The slightly elevated rate may be due to screening in the 2023 RAND Caregiving Survey with the PHQ-8, which might yield a slight overestimate (Thombs et al., 2018).

2021). In addition to suicidal ideation, the 2023 RAND Caregiving Survey also asked respondents whether they had made a plan to end their lives and had attempted to end their lives. All questions were taken from the National Survey on Drug Use and Health.

Five percent of non-caregivers reported having thoughts of suicide in the past year, 1 percent reported having made a plan to end their lives, and 1 percent reported attempting to end their lives (Table 2.2). These estimates are comparable to national estimates from 2022 (SAMHSA, 2023b). Sadly, suicidal thoughts were elevated among all caregiver groups relative to non-caregivers, but especially among military/veteran caregivers to adults 60 and under, 22 percent of whom reported having thought about ending their lives in the past year. Prevalence estimates of past-year suicide plans and attempts were slightly elevated among some caregiving groups, though small cell sizes prohibited testing for statistical differences for these outcomes.⁵

Mental Health Care Utilization and Unmet Needs

There are many effective treatments for people with mental health conditions. There are evidence-based pharmacotherapies and psychotherapies that can help individuals with depression lower and manage their symptoms (Stecher, Cloonan, and Domino, 2023). New treatments are also emerging and amassing evidence, including such treatments as ketamine/esketamine (Boudieu et al., 2023) and transcranial magnetic brain stimulation (Hsu et al., 2024).

However, such treatments will only benefit individuals who access mental health care. Unfortunately, a confluence of factors—including a mental health care workforce shortage and stigmatizing attitudes toward mental health treatment—impede many of those who could benefit from mental health treatment from accessing this type of care (Olfson, 2016; Corrigan, Druss, and Perlick, 2014).

TABLE 2.2
Past-Year Suicidality, Non-Caregivers and Caregivers

	Non-Caregivers	Caregivers to Those 60 and Under		Caregivers to Those over 60	
		Military/Veteran Caregivers	Civilian Caregivers	Military/Veteran Caregivers	Civilian Caregivers
Suicidal ideation	5%	22% ^a	11% ^a	7%	6%
Suicide plan	1%	4%	3%	3%	1%
Suicide attempt	1%	1%	2%	4%	1%

NOTE: Adjusted models and statistical tests for differences in suicide plans and attempts were not conducted due to small sample sizes.

^a Indicates significantly different from non-caregivers.

⁵ In the total sample, 50 survey respondents reported having made a suicide plan in the past year, and 27 survey respondents reported having attempted suicide in the past year.

Among non-caregivers, 14 percent spoke with or saw a mental health care professional in the past 12 months.⁶ More caregivers to those 60 and under, both military and civilian, accessed mental health care in the past year relative to non-caregivers (34 percent and 22 percent, respectively). There was no evidence that mental health care use was higher among caregivers to those over 60 than among non-caregivers (Table 2.3).

Differences in accessing mental health care in the past year may be attributed to differences in need; as presented earlier in Table 2.1, depression is higher among some caregiving groups than among non-caregivers. Thus, Table 2.3 also presents estimates of past-year mental health care use among respondents who met probable criteria for depression. As expected, a greater proportion of those meeting probable criteria for depression accessed mental health care in the past year, including almost 50 percent of military/veteran caregivers to those 60 and under. On the other hand, only between 18 and 30 percent of the other caregiver groups meeting probable criteria for depression saw or spoke with a mental health care provider in the past year, indicating substantial unmet need among caregivers. There was no evidence of differences between caregivers and non-caregivers meeting criteria for depression who saw a mental health care provider in the past year.

To better understand *why* individuals may not be accessing mental health care, the 2023 RAND Caregiving Survey asked two additional questions to all respondents. First, all respondents were asked, “[D]uring the past 12 months, was there any time when you needed mental health treatment or counseling for yourself but didn’t get it?” Those who responded “yes” were asked the reasons why they did not get the mental health treatment or counseling they needed and presented with the options listed in Table 2.4. Over one-third of military/veteran

TABLE 2.3
Mental Health Care Utilization, Non-Caregivers and Caregivers

	Non-Caregivers	Caregivers to Those 60 and Under		Caregivers to Those over 60	
		Military/Veteran Caregivers	Civilian Caregivers	Military/Veteran Caregivers	Civilian Caregivers
Talked to or saw a mental health care professional in the past 12 months	14%	34% ^a	22% ^a	15%	15%
Met criteria for depression but did not talk to or see a mental health care professional in the past 12 months	32%	44%	29%	17%	30%
Needed mental health care in the past 12 months but did not receive it.	16%	36% ^a	22% ^a	16%	16%

^a Signifies unadjusted significant difference from non-caregivers.

⁶ This estimate is slightly lower than the 22 percent of the U.S. adult population that in 2022 reported past-year receipt of mental health treatment (SAMHSA, 2023c).

TABLE 2.4**Reasons for Not Accessing Mental Health Care Among Those with a Perceived Need, Non-Caregivers and Caregivers**

	Non-Caregivers	Caregivers to Those 60 and Under		Caregivers to Those over 60	
		Military/Veteran Caregivers	Civilian Caregivers	Military/Veteran Caregivers	Civilian Caregivers
Concerned about cost	61%	42%	51%	70%	59%
Concerned about privacy	18%	36%	25%	29%	30%
Didn't have time for treatment	40%	78%	45%	43%	47%
Didn't know where to get services	48%	64%	32%	36%	48%
Couldn't get an appointment	28%	43%	37%	13%	25%
Concerned about hospitalization or taking medications	16%	70%	25%	38%	34%
Other reasons	36%	27%	30%	22%	31%

NOTE: Differences between groups were not tested.

caregivers to those 60 and under reported needing, but not receiving, mental health care in the past year; among non-caregivers and other caregiver groups, the proportion ranged from 16 to 22 percent.

Reasons why those needing mental health care did not receive it are presented in Table 2.4. The most frequently reported reasons for not accessing mental health care among military/veteran caregivers to individuals 60 and under were lack of time (78 percent), concern about hospitalization or taking medication (70 percent) and lack of knowledge as to where to get services (64 percent). Lack of time was also among the top three reasons reported by other caregiving groups, but cost was the primary barrier for non-caregivers, civilian caregivers to those 60 and under, and both military/veteran and civilian caregivers to those over 60. These reasons align with national data indicating that cost is the top reason for not accessing needed mental health care (Conroy, Lin, and Ghaness, 2020).

Substance Use

Substance use among caregivers has not received much research attention, though during the COVID-19 pandemic and associated lockdowns a national study estimated that nearly six times as many caregivers (35 percent) as non-caregivers (6 percent) “started or increased

substance use, (e.g., alcohol, drugs) to cope with stress or emotions related to COVID-19” (Czeisler et al., 2021).

Among non-caregivers, past-year estimates of hazardous alcohol use (43 percent when restricted to those who drank alcohol in the past year), marijuana use (16 percent), and non-prescribed opiate use (3.5 percent) are comparable to existing national estimates (Table 2.5; SAMHSA, 2023c; Delaney et al., 2014). Caregivers have comparable rates to non-caregivers with two exceptions: First, fewer military/veteran caregivers caring for someone over 60 and civilian caregivers to those 60 and under reported hazardous alcohol use in the past year, compared with non-caregivers; second, more civilian caregivers caring for someone 60 or under reported using marijuana in the past year (22 percent versus 16 percent among non-caregivers). However, these differences were attenuated in models that accounted for differences between the groups with respect to gender, age, household size, household income, and residence in a metropolitan area. There is some indication that use of non-prescribed opiates, non-prescribed sleep or anxiety medications, or other illegal or non-prescribed drugs may be elevated among military/veteran caregivers to those 60 and under, but the estimates were too small for these substances to conduct statistical tests.

Just short of one-quarter to almost 40 percent of all caregivers met criteria for hazardous alcohol use in the past year. One reason caregivers may use alcohol is to cope with depression

TABLE 2.5
Substance Use, Non-Caregivers and Caregivers

	Non-Caregivers	Caregivers to Those 60 and Under		Caregivers to Those over 60	
		Military/Veteran Caregivers	Civilian Caregivers	Military/Veteran Caregivers	Civilian Caregivers
Hazardous alcohol use	30%	39%	24% ^a	23% ^a	27%
Hazardous alcohol use among past year drinkers	44%	61%	38%	40%	44%
Marijuana use	16%	20%	22%	16%	19%
Non-prescribed opiates	2%	7%	3%	2%	2%
Non-prescribed sleep or anxiety medications	3%	2%	9%	3%	3%
Non-prescribed ADHD medications	1%	6%	1%	1%	0%
Other illegal or non-prescribed drugs	3%	9%	3%	1%	2%

NOTE: There was no evidence of significant differences from non-caregivers in weighted logistic regression models after controlling for gender, age, marital status, household size, income, and residence in a metropolitan area. Statistical tests were not conducted for non-prescribed opiates, non-prescribed sleep or ADHD medications, or other illegal or non-prescribed drugs. ADHD = attention deficit/hyperactivity disorder.

^a Indicates significantly different from non-caregivers.

symptoms (Magee and Connell, 2021). The co-occurrence of hazardous drinking and depression increases the severity of impairment (Brière et al., 2014), increases suicide risk (Berglund and Ojehagen, 1998), and presents treatment challenges (Baker et al., 2012). Relative to non-caregivers, more caregivers to those 60 and under met criteria for both hazardous alcohol use and depression (24 percent among military/veteran caregivers and 10 percent among civilian caregivers, compared with 6 percent among non-caregivers). Among caregivers to those 60 and under, over half of those who are hazardous drinkers also met criteria for depression, and half of those who met criteria for depression were hazardous drinkers (Table 2.6).

Loneliness

In 2023, the U.S. Surgeon General highlighted America’s epidemic of loneliness (U.S. Department of Health and Human Services, 2023b). Caregiving can be isolating, and caregivers’ feelings of loneliness have been a concern among researchers and service providers in recent years. Feelings of loneliness are associated with the quality, rather than the quantity, of social relationships, and people can feel alone even when they are surrounded by others with whom they interact often (Cacioppo and Cacioppo, 2014). Military caregivers, even though they are in frequent contact with their care recipient, often report feeling lonely (Brickell et al., 2020; NAC, 2010; Trail et al., 2020). Feelings of loneliness are also consistently associated with increased depressive symptoms, independent of social ties (e.g., Cacioppo and Cacioppo, 2014; Cacioppo, Hawkley, and Thisted, 2010).

TABLE 2.6
Depression and Hazardous Drinking Comorbidity, Caregivers and Non-Caregivers

	Non-Caregivers	Caregivers to Those 60 and Under		Caregivers to Those over 60	
		Military/Veteran Caregivers	Civilian Caregivers	Military/Veteran Caregivers	Civilian Caregivers
Co-occurring hazardous alcohol use and depression	6%	24% ^{a,b}	10% ^a	4%	7%
Depression among hazardous alcohol drinkers	17%	55%	37%	14%	24%
Hazardous alcohol use among those with depression	42%	50%	36%	22%	36%

NOTE: Tests for differences between groups with respect to depression among hazardous drinkers and hazardous alcohol use among those with depression were not conducted.

^a Signifies significantly different from non-caregivers.

^b Signifies a significant difference in weighted logistic regression models after controlling for gender, age, marital status, household size, income, and residence in a metropolitan area.

The 2023 RAND Caregiving Survey asked about loneliness using three items from the short University of California, Los Angeles (UCLA) Loneliness Scale (Hughes et al., 2004). Respondents were asked how often they lacked friendship/companionship, felt left out, and felt isolated from others and responded on a four-point scale from “hardly ever” to “always.” When responses are averaged, the scale ranges from 1 to 4. As shown in Table 2.7, military/veteran and civilian caregivers to those 60 and under reported higher levels of loneliness compared with non-caregivers. However, when regression models accounted for differences in respondents’ gender, age, marital status, household size, presence of children, household income, and residence in a metro area, there was no evidence of a difference between caregivers to those 60 and under and non-caregivers. This suggests that demographic differences between these groups account for differences in reported feelings of loneliness.

Because the experience of loneliness is an important factor in a caregiver’s quality of life, regression models were used to identify characteristics of caregivers at risk of feeling lonely as well as those factors that may protect against feeling lonely. These results are presented in Table 2.18 in the supplemental tables at the end of this chapter. Only two factors emerged as increasing risk for loneliness among caregivers: Caregivers experiencing higher levels of *caregiver burden* also report experiencing greater feelings of loneliness, and those participating in online caregiver support groups report experiencing greater feelings of loneliness (which may explain why they are participating in support groups and should not be used to evaluate the quality of these groups). Unlike previous research with military/veteran caregivers, caring for someone with a mental health condition was not associated with increased feelings of loneliness (NAC, 2010).

On the other hand, a range of factors were related to *improved* loneliness. These include the following:

- **Caregiver age:** Older caregivers reported lesser feelings of loneliness.
- **Household size:** Caregivers in larger households reported lesser feelings of loneliness.
- **Residence in a metropolitan area:** Caregivers living in a metropolitan area experienced lesser feelings of loneliness compared with those not in metropolitan areas.

TABLE 2.7
Loneliness, Non-Caregivers and Caregivers

	Non-Caregivers Mean (SE)	Caregivers to Those 60 and Under		Caregivers to Those over 60	
		Military/Veteran Caregivers Mean (SE)	Civilian Caregivers Mean (SE)	Military/Veteran Caregivers Mean (SE)	Civilian Caregivers Mean (SE)
Loneliness (continuous scale)	1.64 (0.03)	2.07 (0.11) ^a	1.89 (0.05) ^a	1.68 (0.08)	1.69 (0.03)

NOTE: There was no evidence of differences in weighted logistic regression models after controlling for gender, age, marital status, household size, income, and residence in a metropolitan area. SE = standard error.

^a Indicates significantly different from non-caregivers without adjustment.

- **Relationship to care recipient:** Caregivers who are married to their care recipient reported lesser feelings of loneliness compared with those caring for family members or friends.
- **Caregiving network:** Caregivers with more people helping with caregiving tasks reported lesser feelings of loneliness.
- **Social cohesion:** Caregivers living in communities with higher levels of social cohesion reported lesser feelings of loneliness.

Caregivers Who Are Concerned About Suicide Risk

In 2021, 6,392 veterans died by suicide.⁷ This equates to a rate that, even after accounting for differences in the age and sex distribution between populations, is nearly 72 percent higher for veterans than non-veterans (VA, 2023g). The veteran suicide rate has been higher than that of non-veterans for the past 20 years, with the gap only growing larger. There are many initiatives in place by VA, the Department of Defense (Defense Suicide Prevention Office, 2022; VA, 2023g), and the nonprofit and private sectors (Face the Fight Organization, undated) to prevent veteran suicide. Family members generally and caregivers specifically have been the focus of some of these initiatives. For example, in 2022, VA produced a VA Suicide Prevention Toolkit for Caregivers (VA, 2022a), and the National Alliance on Mental Illness offers Family-to-Family, which is an evidence-based educational program for family members, significant others, and friends of people with mental health conditions, a known risk factor for suicide (National Alliance on Mental Illness, undated; Mercado et al., 2016; Moitra et al., 2021).

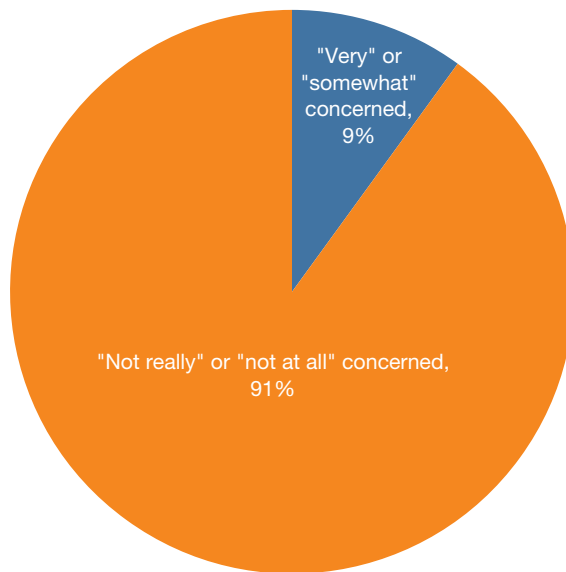
The 2023 RAND Caregiving Survey provides data to help combat these troubling rates of suicide. The data can help identify the types of caregivers who could benefit from targeted information to help them provide adequate, suicide-specific care while also attending to the challenges that providing care to individuals at risk of suicide might entail. Specifically, the survey provides information on the proportion of caregivers who are worried about suicide risk among those they are caring for, characteristics of those thought to be at risk, and how caring for individuals thought to be at risk of suicide affects caregivers' own mental health.

Concern About Suicide Risk

Nine percent of military/veteran caregivers are “very concerned” or “somewhat concerned” that the person they are caring for is at risk of suicide. The remaining 91 percent reported that they were “not really” or “not at all” concerned about suicide risk (Figure 2.1).

⁷ 2021 is the most recent year for which data on veteran suicide deaths are available.

FIGURE 2.1
Military/Veteran Caregivers' Concern About
Suicide Risk in the Person They Are Caring For
(N = 507)



Characteristics of Care Recipients Whose Caregivers Are Concerned About Suicide

Table 2.8 presents data on characteristics of military/veteran care recipients whose caregivers were concerned about suicide risk compared with caregivers who were not concerned. As suggested by the table, the groups differed by characteristics that are relevant to suicide risk:

- **Care recipient conditions:** Behavioral health conditions (which include both mental health conditions and substance use disorders [Moitra et al., 2021; Wilcox, Conner, and Caine, 2004] and TBI [Brenner et al., 2023]) are risk factors for suicide death. These conditions are more common among care recipients whose caregivers are concerned about suicide risk (behavioral health: 75 percent versus 40 percent; TBI: 40 percent versus 13 percent).
- **Age:** Among veterans, suicide rates are highest among younger veterans (18- to 34-year-olds: 49.6 per 100,000 in 2021). However, over half (59 percent; N = 3,753) of veteran suicide deaths in 2021 occurred among veterans 55 or older (VA, 2023g). Fifty-five percent of care recipients whose caregivers were concerned about suicide were 60 or under, a much greater proportion than among care recipients for whom suicide was not a concern (22 percent).

TABLE 2.8

Comparison of Military/Veteran Care Recipients Whose Caregivers Are Concerned About Suicide Risk (Versus Caregivers Who Are Not Concerned)

	Concerned About Suicide Risk (N = 36)	Not Concerned About Suicide Risk (N = 471)
Care recipient conditions		
Mental health or substance use disorder ^a	75%	40%
TBI ^a	40%	13%
Care recipient age ^a		
60 or under	55%	22%
Over 60	45%	78%
Service era		
Pre-9/11	85%	88%
Post-9/11	15%	12%
Care recipient gender ^a		
Male	54%	79%
Female	22%	16%
Other	24%	6%
Care recipient firearm availability	48%	28%
Care recipient VA user	46%	35%

NOTE: The unweighted sample sizes are as follows: military/veteran caregivers concerned about suicide risk = 36; military/veteran caregivers not concerned about suicide risk = 471.

^a Indicates distribution significantly different between caregivers who are concerned about suicide risk from those who are not.

- **Service era:** There were no significant differences between care recipients for whom suicide was a concern and those for whom it was not with respect to service era: in both groups, roughly 85 percent served exclusively in the pre-9/11 era and 15 percent served in the post-9/11 era.⁸
- **Gender:** A striking finding from the 2023 RAND Caregiving Survey is that while people who identify as neither male nor female represent only 6 percent of those for whom suicide was not a concern, people who identify as neither male nor female represent 24 percent of those for whom suicide is a concern. This includes care recipients who are transgender, and past research has found that veterans who are transgender have increased risk of suicide (Blosnich et al., 2013).

⁸ Recent VA suicide data do not present rates separately by era of service.

- **Firearm availability:** Nearly three-quarters of veteran suicides involve a firearm (VA, 2023g). Because access to a firearm may increase suicide risk (RAND Corporation, 2018), many efforts are underway to limit access to firearms by encouraging veterans to lock their firearms securely or, during periods of risk, to store them temporarily in a place more difficult to access. Among those whose caregivers are concerned about suicide risk, 48 percent of military/veteran care recipients have access to a firearm relative to 28 percent among those care recipients for whom caregivers are not concerned about suicide risk, though this difference is not statistically significant. It is possible that care recipient access to a firearm is what causes caregivers to be concerned about suicide risk.
- **Receiving care at VA:** Finally, just over one-third (38 percent) of veterans who died by suicide in 2021 had had a care encounter with VHA in 2020 or 2021 (VA, 2023g). Among those concerned about suicide risk for the person for whom they were caring, 46 percent reported that the care recipient received most of their care at a VA facility, relative to 35 percent of those for whom suicide was not a concern (the difference was not statistically significant).

Military/Veteran Caregiver Mental Health

Caregivers concerned about suicide in the person they are caring for may feel additional burden and stress caring for those who they worry might harm themselves. Relative to those without such concerns, more caregivers concerned about suicide risk met criteria for excessive caregiver burden (65 percent versus 28 percent), excessive stress (78 percent versus 51 percent), probable depression (55 percent versus 19 percent), and hazardous drinking (65 percent versus 24 percent), all differences that are statistically significant (Table 2.9).

TABLE 2.9

Mental Health Conditions Among Caregivers (by Concern About Care Recipient Suicide Risk)

	Concerned About Suicide Risk	Not Concerned About Suicide Risk
Caregiver burden ^a	65%	28%
Caregiver perceived stress ^a	78%	51%
Caregiver depression ^a	55%	19%
Caregiver hazardous drinking ^a	65%	24%

^a Indicates distribution significantly different between caregivers who are concerned about suicide risk from those who are not.

Mental Health of Child Caregivers

Chapter 6 provides detailed information about children in caregiving households, including those who perform caregiving duties. In that chapter, we provide data that among children under 18 in caregiving households, 40 percent in military/veteran caregiving households and 27 percent in civilian caregiving households take on caregiving duties. These children who provide care may be at increased risk for poor child behavioral outcomes, and past research has shown that children who help care for a wounded, ill, or injured family member exhibit more behavioral problems than similar non-caregiving children (Naiditch, Levine, and Hunt, 2005) and that child caregivers of veterans with TBI experience poor behavioral and physical health outcomes (Brickell et al., 2018). Recent research shows that injuries experienced during deployments are associated with higher levels of child emotional and conduct problems among service members' children (Briggs et al., 2020). Similarly, increased service member PTSD symptoms are associated with greater reports of child behavioral problems (DeVoe et al., 2018), and children of veterans are more likely to exhibit externalizing behaviors compared with children of civilians (Bommersbach, Rosenheck, and Rhee, 2022).

Child well-being was assessed in the 2023 RAND Caregiving Survey using two measures: frequency that the child missed school due to illness (five-point scale from “Never” to “Very often”) (Bauman et al., 2006) and parent-rated scores on the following three subscales of the child Strengths and Difficulties Questionnaire (Goodman, 1997):

- **The Emotional Symptoms** subscale asks questions about depressed mood and worry/anxiousness.
- **The Conduct Problems** subscale asks questions about losing one's temper and fighting with other children.
- **The Prosocial Behaviors** subscale asks questions about getting along with other children and being considerate with their feelings.

Each subscale consisted of five items with three response options (“not true,” “somewhat true,” and “definitely true”), which, when combined, produce an average value between 1 and 3, with higher scores indicating more emotional symptoms, conduct problems, or prosocial behaviors. Military/veteran child caregivers were significantly more likely to have missed school because of illness compared with civilian child caregivers and children of non-caregivers, who did not differ from one another (Table 2.10). Examining the percentage of respondents reporting that their child missed school *sometimes*, *often*, or *very often*, 39 percent of military/veteran caregivers reported that the focal child caregiver missed school due to illness compared with 23 percent of civilian child caregivers and 18 percent of non-caregiver children.

Examining the Strengths and Difficulties Questionnaire scales, compared with children of non-caregivers, military/veteran child caregivers scored higher on emotional symptoms and conduct problems. After controlling for the child's age, the ages of children in the household, household income, and whether the caregiving parent lives with the care recipi-

TABLE 2.10**Well-Being of Child Caregivers and Non-Caregivers**

	Non-Caregiver Children	Military/Veteran Child Caregivers	Civilian Child Caregivers
Missed school due to illness	1.8	2.8 ^{a,b}	1.9
Emotional Symptoms subscale	1.4	1.8 ^{a,b}	1.5
Conduct Problems subscale	1.3	1.8 ^{a,b}	1.4 ^{a,b}
Prosocial Behaviors subscale	2.1	2.2 ^b	2.1

NOTE: The unweighted N are military/veteran caregivers = 25, civilian caregivers = 99, and non-caregivers = 296. For missed school due to illness, response, options were 1 = Never, 2 = Rarely, 3 = Sometimes, 4 = Often, and 5 = Very often. Scale items for emotional symptoms, conduct problems, and prosocial behaviors were rated 1 = Not true, 2 = Somewhat true, and 3 = Definitely true.

^a Denotes a statistically significant difference from children of non-caregivers.

^b Denotes a statistically significant difference from children of non-caregivers in weighted linear regression models after controlling for the child's age, the ages of children in the household, household income, and whether the caregiving parent lives with the care recipient.

ent, military/veteran child caregivers also scored significantly higher on prosocial behaviors and civilian child caregivers scored higher on conduct problems compared with children of non-caregivers.

Child Caregiver Access to Mental Health Care

Early intervention to treat mental health issues can prevent them from developing into more serious mental health disorders (McGorry and Mei, 2018). Nationally, almost 30 percent of adolescents (age 12–17) received mental health treatment or counseling in 2022 (SAMHSA, 2022), and almost half of adolescents who had a major depressive episode did not receive mental health treatment or counseling (SAMHSA, 2022). Researchers have suggested that difficulty accessing mental health care is an issue among children of military caregivers (Malick et al., 2021).

The 2023 RAND Caregiving Survey asked individuals with children under 18 in the household whether their child had needed mental health treatment or counseling in the past 12 months but did not get it and whether their child had seen or talked with a mental health care professional in the past 12 months (SAMHSA, 2020). Results are presented in Table 2.11. After controlling for the caregiver parent's insurance coverage, the child's age, the ages of children in the household, household income, and whether the caregiving parent lives with the care recipient, child caregivers were more likely to have seen a mental health care provider in the past year. Insurance coverage was also a significant predictor, with children whose parents have insurance coverage more likely to have seen a mental health care professional in the past year compared with children whose parents do not have insurance coverage. In addition, controlling for these variables, military/veteran child caregivers were more likely to have needed mental health treatment in the past year but not received it. Compared with 8 percent

TABLE 2.11**Child Access to Mental Health Care**

	Non-Caregiver Children	Military/Veteran Child Caregivers	Civilian Child Caregivers
Saw a mental health care provider in the past year	13%	27% ^b	22% ^b
Needed mental health treatment or counseling in the past 12 months but did not get it	8%	24% ^{a,b}	13%

NOTE: The unweighted N are military/veteran caregivers = 25, civilian caregivers = 99, and non-caregivers = 309.

^a Denotes a statistically significant difference from children of non-caregivers.

^b Denotes a statistically significant difference from children of non-caregivers in weighted linear regression models after controlling for the caregiver parent's insurance coverage, the child's age, the ages of children in the household, household income, and whether the caregiving parent lives with the care recipient.

of children in non-caregiving households, almost a quarter of military/veteran child caregivers needed mental health treatment in the past year but did not receive it (Table 2.11). This suggests that military/veteran child caregivers may have unmet needs for mental health care.

Caregiver Physical Health

Health is a fundamental aspect of human well-being. A healthy body enables individuals to lead fulfilling lives, pursue their goals, and contribute to society. Physical health provides the foundation for vitality, energy, and resilience, enabling individuals to actively participate in their daily activities and maintain an overall sense of well-being. This is especially important for caregivers because their well-being directly impacts those they care for. The 2023 RAND Caregiving Survey assessed two domains of physical health: self-related health and physical role limitations.

Self-Related Health and Role Limitations Due to Physical Health

Respondents responded to a single question: "In general, would you say that your health is excellent, very good, good, fair, or poor?" Among non-caregivers, 18 percent reported poor or fair health, a common way to operationalize responses to this question (Manor, Matthews, and Power, 2000). More civilian caregivers to those 60 and under reported poor or fair health (26 percent), though this difference was attenuated after accounting for differences in gender, age, marital status, household size, income, and residence in a metropolitan area (Table 2.12).

Role limitations due to physical health were assessed with a subscale from the RAND 36-Item Short Form Survey (SF-36; RAND Corporation, undated). Specifically, respondents were asked four questions (with yes/no response options) about whether in the past four weeks they had reduced the time devoted to work, caregiving duties, or other regular daily activities; achieved less than desired; experienced limitations in work, caregiving, or other daily activities; and encountered difficulties in performing work-related tasks or other activi-

TABLE 2.12**Caregivers with Role Limitations Due to Physical Health**

	Non-Caregivers	Caregivers to Those 60 and Under		Caregivers to Those over 60	
		Military/Veteran Caregivers	Civilian Caregivers	Military/Veteran Caregivers	Civilian Caregivers
Fair/poor self-reported health	18%	21%	26% ^a	22%	24%
Physical limitations	47%	60% ^{a,b}	53% ^{a,b}	55% ^a	54% ^a

^a Signifies an unadjusted significant difference from non-caregivers.

^b Denotes a statistically significant difference from non-caregivers in weighted logistic regression models after controlling for gender, age, marital status, household size, income, and residence in a metropolitan area.

ties as a result of their physical health. More caregivers across all groups reported at least one physical limitation relative to non-caregivers (47 percent), but, even after adjustment, rates remained elevated for military/veteran (60 percent) and civilian (53 percent) caregivers to those 60 and under.

Sleep

For caregivers, the impact of poor sleep quantity and quality can be particularly detrimental, potentially leading to burnout and decreased ability to provide effective care. Research on sleep among adults shows that insufficient sleep can hinder productivity, concentration, health, and overall quality of life (Medic, Wille, and Hemels, 2017; Grandner, 2019; Abbott and Videnovic, 2016; Liew and Aung, 2021). The 2023 RAND Caregiving Survey asked about the average number of hours that respondents slept per night (in the past seven nights) and the quality of their sleep, from very poor (1) to very good (5).

On average, around half of all non-caregivers and caregivers reported insufficient sleep—less than an average of seven hours per night (Table 2.13).⁹ More civilian caregivers to those 60 and under tended to report lower-quality sleep than non-caregivers (70 percent versus 58 percent), but this difference was attenuated after adjusting for differences between the groups.

Health Care Utilization and Unmet Needs

Individuals' use of health care is influenced by multiple factors, encompassing an individual's health care requirements, their recognition of these needs, their inclination to pursue treatment, their access to care, and their financial capability to cover the expenses, whether through insurance or personal funds (National Academies of Sciences, Engineering, and Medicine, 2018). Like the question on mental health care utilization described above, respondents to the 2023 RAND Caregiving Survey were asked, "About how long has it been since

⁹ National estimates report that slightly fewer adults (34 percent) have inadequate sleep (CDC, 2022b).

TABLE 2.13**Past Seven Days' Sleep, Non-Caregivers and Caregivers**

	Non-Caregivers	Caregivers to Those 60 and Under		Caregivers to Those over 60	
		Military/Veteran Caregivers	Civilian Caregivers	Military/Veteran Caregivers	Civilian Caregivers
Short sleep (less than 7 hours)	43%	49%	50%	52%	48%
Fair, poor, or very poor sleep quality	58%	53%	70% ^a	54% ^{a,b}	62%

^a Signifies an unadjusted significant difference from non-caregivers.

^b Denotes a statistically significant difference from non-caregivers in weighted logistic regression models after controlling for gender, age, marital status, household size, income, and residence in a metropolitan area.

you last visited a doctor for a routine checkup?” and could respond “within the past year,” “past two years,” “past five years,” or “five years ago or more.”

Caregivers to those 60 and under were less likely to have received health care in the past year (52 percent of military/veteran caregivers, 63 percent of civilian caregivers) than non-caregivers (71 percent). When restricted to respondents who reported that their health was “fair” or “poor” and could arguably benefit from seeing a health care provider, more military/veteran caregivers to those 60 and under were still less likely to have had seen a health care provider in the past year (57 percent) than non-caregivers, civilian caregivers, or military/veteran caregivers to those over 60 (range: 25 to 34 percent; Table 2.14). Similar patterns were observed when restricted to individuals who reported at least one role limitation due to physical health. More information about health insurance coverage, which may contribute to patterns of health care utilization (or lack thereof), is presented in Chapter 3.

Personal Gain from Caregiving

This chapter has provided an overview of many of the negative experiences associated with caregiving, from mental health symptoms to forgone medical care to loneliness. And though caregiving may present difficulties, it may not be a uniformly negative experience. In many cases, caregivers report that there are positive aspects of caregiving, and many benefit from their experiences. However, there are mixed previous findings about caregivers more or less likely to benefit from the experience. Research using the National Long-Term Care Survey (a longitudinal study of Medicare beneficiaries) suggests that wife caregivers were the least likely to report positive experiences of caregiving (Lin, Fee, and Wu, 2012), but a systematic review on the caregiving burden of the spouses and partners to military personnel suggests that there may also be positive benefits to caring for one’s partner, as it can strengthen intimate relationships (Thandi et al., 2018). The type of caregiving, hours per week of caregiving, and caregiver networks may also impact how caregivers view caregiving (Koerner et al., 2009).

TABLE 2.14**Past-Year Health Utilization, Non-Caregivers and Caregivers**

	Non-Caregivers	Caregivers to Those 60 and Under		Caregivers to Those over 60	
		Military/Veteran Caregivers	Civilian Caregivers	Military/Veteran Caregivers	Civilian Caregivers
Saw a doctor for a routine checkup in the past 12 months	71%	52% ^a	63% ^a	71%	73%
Had poor/fair health and did not see a doctor in the past 12 months	21%	57% ^{a,b}	33% ^a	25%	34% ^a
Those with role limitations due to physical health and did not see a doctor in the past 12 months	25%	45% ^a	38% ^a	29%	27%

^a Indicates a significant difference from non-caregivers.

^b Denotes a statistically significant difference from non-caregivers in weighted logistic regression models after controlling for gender, age, marital status, household size, income, and residence in a metropolitan area.

The 2023 RAND Caregiving Survey asked caregivers the four-item Personal Gain Scale (Skaff and Pearlin, 1992; Pearlin et al., 1990): “[T]hinking about your time caring for [care recipient], how much have you . . .

- become more aware of your inner strengths
- become more self-confident
- grown as a person
- learned to do things you didn’t do before.”

Responses ranged from “not at all” (1) to “very much” (4) ($\alpha = 0.855$). Across all caregiver groups, responses to these questions averaged around 2.5—midway between the least affirming response (“not at all”) and the most affirming response (“very much”; Table 2.15). There were no significant differences in how different types of caregivers rated their personal gains from caregiving.

Regression models were estimated to identify what characteristics were associated with personal gain from caregiving. Caregiver characteristics, including measures for caregiving intensity and demographics, as well as care recipient needs and medical conditions, were considered. The univariate estimates examine how each caregiver characteristic is related to personal gain from caregiving, and the multivariate estimate takes all characteristics (covariates) into account. The full model results are presented in Table 2.19 in the supplemental tables at the end of this chapter.

TABLE 2.15

Means and Standard Errors of Personal Gain from Caregiving

	Caregivers to Those 60 and Under		Caregivers to Those over 60	
	Military/Veteran Caregivers Mean (SE)	Civilian Caregivers Mean (SE)	Military/Veteran Caregivers Mean (SE)	Civilian Caregivers Mean (SE)
Personal gain from caregiving (continuous scale)	2.6 (0.1)	2.6 (0)	2.7 (0)	2.6 (0)

NOTE: There was no evidence of significant differences between caregiving groups.

Measures for caregiver intensity are associated with higher levels of personal gain from caregiving. These include the following:

- **Increased hours caregiving per week:** Compared with those who provided less than eight hours of a care a week, caregivers providing more time were more likely to report higher levels of personal gain from caregiving.
- **Longer time having provided care:** Compared with those who have provided care for less than a year, caregivers who had cared for more than five years were more likely to report greater personal gain from caregiving.
- **Helping with ADLs:** When compared with those providing help with emotional and cognitive tasks, caregivers helping with ADLs were more likely to report higher levels of personal gain from caregiving.
- **Spouses and partners** were more likely than siblings and non-relatives to report greater personal gain from caregiving.

Chapter 2 Supplemental Tables

TABLE 2.16

Mental Health Conditions, Non-Caregivers and Caregivers, Means

	Non-Caregivers	Caregivers to Those 60 and Under		Caregivers to Those over 60	
	Mean (95% CI)	Military/Veteran Caregivers Mean (95% CI)	Civilian Caregivers Mean (95% CI)	Military/Veteran Caregivers Mean (95% CI)	Civilian Caregivers Mean (95% CI)
Caregiver burden Range: 0–24	N/A	8.6 (7.0, 10.0)	6.0 (5.4, 6.5)	5.0 (4.3, 5.7)	6.0 (5.5, 6.5)
Depression Range: 0–24	4.6 (4.2, 4.9)	9.6 (7.8, 11.3)	6.6 (6.0, 7.2)	4.7 (3.8, 5.4)	5.2 (4.7, 5.6)
Perceived stress Range: 0–16	6.8 (6.6, 7.0)	8.4 (7.6, 9.3)	7.8 (7.4, 8.1)	7.0 (6.6, 7.4)	7.3 (7.1, 7.6)

TABLE 2.17

Correlates of Depression Among Military and Civilian Caregivers, With and Without Adjustment

	Univariate Estimate		Multivariate Estimate	
	Estimate	p	Estimate	p
Military/veteran caregiver (ref)				
Civilian caregiver	0.80	0.16	0.86	0.47
Care recipient 60 or under (ref)				
Care recipient 60+	0.50	<0.001	0.63	0.06
Time spent caregiving	1.05	0.16	0.95	0.40
Caregiver burden	1.16	<0.001	1.18	<0.001
Caregiving activities				
Help with at least one ADL (ref)				
Help with emotional/cognitive tasks	0.93	0.65	1.13	0.57
Help administering medications, housework, or administrative support	0.96	0.82	0.89	0.68
Care recipient conditions				
Chronic condition	1.18	0.28	1.88	0.02
Vision/hearing	1.00	0.99	0.97	0.88
Neurological	0.86	0.33	0.76	0.20

Table 2.17—Continued

	Univariate Estimate		Multivariate Estimate	
	Estimate	p	Estimate	p
TBI	1.31	0.25	1.19	0.58
Musculoskeletal/reproductive wounds	1.31	0.58	1.01	0.98
Infection	0.70	0.001	1.33	0.37
Substance use disorder or mental health condition	1.33	0.04	0.72	0.17
Other	0.96	0.78	1.23	0.28
Caregiver is the care recipient's:				
Child or grandchild (ref)				
Spouse	0.80	0.19	0.76	0.39
Neighbor/friend/other non-relative	1.08	0.69	1.77	0.03
Parent	0.65	0.19	0.99	0.99
Other relative	0.86	0.49	0.83	0.54
Caregiver lives with care recipient	1.29	0.06	1.47	0.10
Caregiver is female (reference: male)	1.13	0.23	0.74	0.08
Caregiver age				
18–24				
25–34	0.80	0.31	1.00	0.99
35–44	0.54	0.006	0.67	0.30
45–54	0.52	0.004	0.82	0.61
55–64	0.36	<0.001	0.42	0.03
65–74	0.28	<0.001	0.43	0.07
75+	0.24	<0.001	0.28	0.04
Caregiver race/ethnicity				
White, non-Hispanic				
Black, non-Hispanic	1.19	0.34	0.72	0.26
Other, non-Hispanic	0.58	0.26	0.40	0.15
Hispanic	1.42	0.01	0.94	0.78

Table 2.17—Continued

	Univariate Estimate		Multivariate Estimate	
	Estimate	p	Estimate	p
Two or more races/ethnicities, non-Hispanic	3.46	<0.001	1.93	0.16
Asian, non-Hispanic	1.23	0.46	1.13	0.76
Caregiver sexual identity				
Gay/lesbian or gay				
Straight—that is, not gay	0.66	0.19	0.76	0.45
Bisexual	1.83	0.11	1.72	0.26
Something else	1.46	0.43	2.76	0.12
I don't know the answer	2.73	0.10	3.13	0.19
Caregiver educational attainment				
Less than high school				
High school graduate or equivalent	0.68	0.09	0.91	0.82
Some college/associate degree	0.59	0.01	0.98	0.95
Bachelor's degree	0.40	<0.001	0.65	0.29
Postgraduate study/professional degree	0.31	<0.001	0.76	0.52
Caregiver household income				
Less than \$30,000				
\$30,000 to under \$60,000	0.62	0.002	0.55	0.009
\$60,000 to under \$100,000	0.58	0.001	0.78	0.35
\$100,000 or more	0.40	<0.001	0.74	0.33
Caregiver lives in metropolitan area	0.75	0.04	0.74	0.22
Caregiver marital status				
Married				
Widowed	0.98	0.94	1.11	0.80
Divorced	1.21	0.27	1.36	0.28
Separated	1.48	0.13	0.96	0.93
Never married	2.23	<0.001	1.69	0.03

Table 2.17—Continued

	Univariate Estimate		Multivariate Estimate	
	Estimate	p	Estimate	p
Current or past military service	2.81	0.001	1.57	0.41
Primary caregiver	0.98	0.86	0.96	0.86
Kids under 18 in household	1.52	<0.001	1.22	0.35

NOTE: Bolded estimates indicate those that are statistically significant ($p < 0.05$). All variables listed were included in the multivariate model.

TABLE 2.18

Correlates of Loneliness Among Military and Civilian Caregivers, With and Without Adjustment

	Univariate Estimate		Multivariate Estimate	
	Estimate	p	Estimate	p
Male caregiver (versus female)	−0.02	0.61	0.00	0.91
Caregiver age	−0.01	<0.001	−0.01	<0.001
Household size	0.03	0.02	−0.06	<0.001
Household income	−0.05	<0.001	−0.01	0.20
Residence in a metropolitan area	−0.10	0.06	−0.15	0.01
Care recipient age group (over 60 versus 60 and under)	−0.01	0.75	−0.09	0.07
Care recipient veteran status (veteran versus civilian)	0.09	0.20	−0.09	0.41
Care recipient age group by veteran status	−0.39	0.006	0.17	0.18
Care recipient is the spouse or partner	−0.07	0.18	−0.13	0.01
Number of people in their caregiving network	−0.04	0.07	−0.05	0.006
Community social cohesion	−0.07	<0.001	−0.04	<0.001
Caregiver burden	0.08	<0.001	0.07	<0.001
Care recipient has a mental health condition (e.g., PTSD, depression)	0.20	<0.001	−0.06	0.25
Participation in online caregiver support groups	0.46	0.002	0.30	0.02
Participation in in-person caregiver support groups	0.06	0.55	−0.15	0.08

NOTE: Bolded estimates indicate those that are statistically significant ($p < 0.05$). All variables listed were included in the multivariate model.

TABLE 2.19
Correlates of Personal Gain from Caregiving, With and Without Adjustment

	Univariate Estimate		Multivariate Estimate	
	Estimate	p	Estimate	p
Military/veteran caregiver (ref)				
Civilian caregiver	0.13	0.46	0.21	0.35
Care recipient 60 or under (ref)				
Care recipient 60+	-0.19	0.29	0.25	0.36
Time spent caregiving				
<8 hours (ref)				
9–20 hours	0.80	<0.001	0.48	0.054
21–40 hours	1.42	<0.001	0.97	0.001
41+	2.17	<0.001	1.45	<0.001
Skipped	1.00	0.46	0.24	0.87
Duration of caregiving				
<1 year (ref)				
1–2 years	0.47	0.07	0.12	0.67
2–5 years	0.19	0.39	0.10	0.69
5–10 years	0.93	<0.001	0.77	0.02
10+ years	1.14	<0.001	0.68	0.049
Not the primary caregiver	-0.72	<0.001	-0.01	0.97
Caregiving activities				
Help with at least one ADL (ref)				
Help with emotional/cognitive tasks	-0.74	<0.001	-0.82	0.003
Help administering medications, housework, or administrative support	-1.12	<0.001	-0.40	0.09
Care recipient conditions				
Chronic condition	0.28	0.17	-0.16	0.51
Vision/hearing	-0.05	0.77	-0.17	0.41
Neurological	0.10	0.59	-0.10	0.64
TBI	0.30	0.33	-0.11	0.75
Musculoskeletal	0.10	0.57	-0.20	0.31

Table 2.19—Continued

	Univariate Estimate		Multivariate Estimate	
	Estimate	p	Estimate	p
Infectious disease	−0.05	0.86	−0.34	0.27
Substance use disorder or mental health condition	0.57	0.001	0.40	0.07
Other	0.18	0.30	−0.14	0.51
Caregiver is the care recipient's:				
Child or child-in-law	−0.20	0.63	−0.34	0.49
Friend, neighbor, or non-relative	−0.70	0.007	−0.79	0.02
Parent, grandparent, or parent-in-law	−0.71	0.001	−0.55	0.08
Sibling, in-law, or other relative	−0.63	0.02	−0.79	0.02
Spouse, partner, or former spouse/partner (ref)				
Caregiver is female (ref: male)	0.42	0.01	0.10	0.63
Caregiver age				
18–30	0.66	0.02	0.37	0.33
31–55	0.61	0.01	0.43	0.11
56–65 (ref)				
66–80	0.62	0.02	0.73	0.02
81+	1.40	0.03	1.30	0.10
Caregiver race/ethnicity				
White, non-Hispanic (ref)				
Black, non-Hispanic	1.70	<0.001	1.31	0.048
Other, non-Hispanic	1.27	0.049	0.03	0.97
Hispanic	0.94	<0.001	0.34	0.59
Two or more races/ethnicities, non-Hispanic	0.47	0.38	0.75	0.38
Asian, non-Hispanic	0.18	0.68	0.42	0.49
Caregiver educational attainment				
Less than high school	0.58	0.13	0.38	0.40
High school graduate or equivalent	0.14	0.55	0.02	0.95

Table 2.19—Continued

	Univariate Estimate		Multivariate Estimate	
	Estimate	p	Estimate	p
Some college/associate degree (ref)				
Bachelor's degree	−0.04	0.88	0.05	0.86
Postgraduate study/ professional degree	−0.16	0.51	−0.20	0.50
Caregiver household income				
Less than \$30,000 (ref)				
\$30,000 to under \$60,000	−0.38	0.10	−0.09	0.75
\$60,000 to under \$100,000	−0.48	0.045	−0.18	0.54
\$100,000 or more	−0.98	<0.001	−0.36	0.27
Caregiver lives in metropolitan area	0.31	0.20	0.35	0.16
Caregiver marital status				
Married (ref)				
Widowed	−0.03	0.95	−0.22	0.63
Divorced	−0.31	0.25	−0.22	0.48
Separated	−0.22	0.61	−0.18	0.71
Never married	0.11	0.59	−0.16	0.56

NOTE: Bolded estimates indicate those that are statistically significant ($p < 0.05$).

The Economic and Financial Toll of Caregiving

Introduction

Caregiving can influence a household's financial situation by incurring several economic costs. Most directly, caregivers may incur monetary costs related to the care recipient's needs, such as out-of-pocket medical costs or the installation and maintenance of accommodations within the home (e.g., motorized stair climbers, accessible bathroom appliances). On top of these monetary costs, caregivers may experience a range of *opportunity costs*. Caregivers may reallocate time away from paid labor activities to unpaid caregiving activities, thereby foregoing possible earnings. They may also, either by choice or as a result of labor market discrimination, forgo promotions or higher-paying job opportunities they otherwise would have received. Finally, the stresses of caregiving may impose physical or emotional costs on the caregiver, which may in turn cause financial costs associated with poor health.

Caregiving also generates economic value. The activities involved in caregiving, such as helping a person move around, bathe, or take medications, command a wage when performed in an employment setting. However, when caregiving is performed in the home by a loved one or friend, it is usually not compensated monetarily. As a result, estimating the economic value of caregiving is not as straightforward as estimating the value of traditionally compensated labor market activities. The approach employed in this section is to assign a proxy wage from a related occupation, such as home health aide, nursing assistant, or registered nurse, which involves similar tasks. In essence, this estimates what the caregiver would have been paid if their caregiving activities had been performed in the labor market.

This chapter presents estimates of the value and costs of military/veteran caregiving using data from the 2023 RAND Survey on Caregiving. Estimates of value and costs are based on military/veteran caregivers' self-reported hours spent on caregiving activities. Descriptive information is also presented on the economic or financial well-being of military and veteran caregivers, including their self-reported work disruptions, financial capability and security, and such workplace amenities as flexible work hours. Data are also presented on their uptake of health insurance and safety net programs to which they may be entitled, such as SNAP.

Key Findings

Military/veteran caregivers incur an estimated \$8,583 in annual out-of-pocket costs associated with their caregiving responsibilities. This estimate is of a comparable magnitude to past estimates; there is no evidence of differences in annual costs between military/veteran and civilian caregivers.

Military/veteran caregivers forgo an estimated \$4,522 in annual household income, on average. There is no evidence of a difference in forgone income between military/veteran and civilian caregivers. Income losses are greater among the 27 percent of military/veteran caregivers with self-reported work disruptions, such as cutting back hours or switching jobs to facilitate their caregiving responsibilities.

The estimated aggregate economic value generated by military/veteran caregiving activities, which are largely uncompensated, ranges from \$119 billion to \$485 billion per year. A wide range, the estimate varies depending on the occupation selected to represent caregiving activities as a proxy wage.

Military/veteran caregivers to those 60 and under experience greater financial insecurity. Seventy percent of military/veteran caregivers to those 60 and under reported difficulty in paying their bills, nearly double the proportion of non-caregivers.

There is low uptake of available benefits, including those for which eligibility is asset-based among caregiving households with likely need. There is a sizable proportion of military/veteran caregivers with incomes below 130 percent of the federal poverty level. In the receipt of benefits including SNAP and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), only 4 to 8 percent of military/veteran caregivers use the benefit. On the other hand, over a quarter of military/veteran caregivers to those 60 and under receive disability income.

Cost of Caregiving

Direct Monetary Costs

The 2023 RAND Caregiving Survey asked about two key categories of direct monetary costs associated with caregiving: housing expenses and out-of-pocket medical expenses. AARP's 2021 Caregiving Out-of-Pocket Costs Study found that these two categories were the largest among out-of-pocket caregiving costs, comprising 52 percent and 17 percent of total costs, respectively (Skufca and Rainville, 2021). To obtain an estimate of total direct monetary costs, RAND researchers employed a modeling approach that assumes that these percentages also hold for the 2023 RAND Caregiving Survey sample; estimates of housing and medical

expenses were scaled up to account for the remaining 31 percent of costs unobserved in the 2023 RAND Caregiving Survey data. In the AARP study, these costs include the caregiver's personal expenses; personal care expenses for the care recipient; and recreation, education, legal, and other expenses. Technical information on the methods used to estimate direct monetary costs is provided in the appendix.

As shown in Table 3.1, for military/veteran caregivers, each additional hour of caregiving is associated with about \$5.53 in additional monthly housing expenses and \$1.42 in additional monthly out-of-pocket medical expenses. Neither of these estimates is statistically different from comparable estimates for civilian caregivers in our survey sample (\$6.02 and \$0.93, respectively). These estimates imply total annual caregiving-associated expenses of \$4,713 for housing and \$1,210 for out-of-pocket medical costs. Finally, scaling up for the assumed 31 percent of costs in other categories that we did not observe, we estimate average total annual out-of-pocket caregiving expenses of \$8,583 per year. This is generally similar to AARP's 2021 estimate of \$7,242 per year. Our higher estimate for annual caregiving-associated housing costs (\$4,713 in our sample versus \$3,766 per year in the AARP study) may be partly explained by significant increases in residential property values, rents, and mortgage interest rates from early 2021, when the AARP study was conducted, to early 2023, when the 2023 RAND Caregiving Survey was conducted.

TABLE 3.1

Out-of-Pocket Caregiving Costs, Military/Veteran and Civilian Caregivers

	Military/Veteran Caregivers, 2023 RAND Caregiving Survey	Civilian Caregivers, 2023 RAND Caregiving Survey	Caregivers, AARP 2021 Study
Housing costs			
Monthly (per additional hour of caregiving)	\$5.53	\$6.02	N/A
Annually (based on average hours of caregiving)	\$4,713	\$4,655	\$3,766
Out-of-pocket medical expenses			
Monthly (per additional hour of caregiving)	\$1.42	\$0.93	N/A
Annually (based on average hours of caregiving)	\$1,210	\$719	\$1,225
31-percent scale-up for unobserved costs			
Monthly (per additional hour of caregiving)	\$3.12	\$3.12	N/A
Annually (based on average hours of caregiving)	\$2,661	\$2,414	\$2,226
Annual total costs	\$8,583	\$7,788	\$7,242

Forgone Income

Data from the 2023 RAND Caregiving Survey reveal an inverse relationship between weekly caregiving hours and household income. This suggests that military/veteran caregivers forgo about \$4,522 per year from an estimated baseline average of \$71,143 (see the appendix for technical details on the modeling approach). In relative terms, this means that military/veteran caregivers' household incomes are about 6 percent lower on average than the model estimates they would be in the absence of caregiving responsibilities, which is approximately similar to prior estimates (Maestas, Messel, and Truskinovsky, 2023).

In addition, the 2023 RAND Caregiving survey asks all caregivers: "As a result of caregiving for [care recipient], did you ever:

- Cut back on hours or temporarily quit work and/or school?
- Move to a job that pays less or provides fewer benefits, but that fits better with your caregiving schedule or responsibilities?
- Quit working/going to school earlier than you would have?
- Experience unequal treatment by your employer (for example, not receiving a promotion you were up for, not receiving a job assignment you wanted)?"

Results to this question are provided in Table 3.2. Descriptively, military/veteran caregivers report slightly elevated work disruptions relative to civilian caregivers. About 27 percent of military/veteran caregivers report at least one disruption compared with 24 percent of civilian caregivers.

Regression models were estimated to discern the extent to which caregiver income losses differ significantly between military/veteran caregivers with self-reported disruptions and those without. The model suggests that caregivers with at least one self-reported work disruption forgo about \$11,168 in annual household income, while those without self-reported disruptions forgo about \$2,016. The estimated association between caregiving hours and household income is statistically significant for those with disruptions, while it is not statistically significant (albeit still negative) for those without. This suggests intuitively that the income

TABLE 3.2
Work Disruptions, Military/Veteran and Civilian Caregivers

	Military/Veteran Caregivers	Civilian Caregivers
At least one work disruption	27%	24%
Cutting back hours	16%	16%
Switching jobs	11%	8%
Quitting work or school early	14%	10%
Experiencing perceived workplace discrimination	12%	6%

NOTE: Differences between groups were not tested.

losses associated with caregiving are primarily driven by the four self-reported disruptions to caregivers' work lives elicited on the survey. At the population level, these estimates suggest total income losses among an estimated 14.3 million veteran/civilian caregivers (see Chapter 1) of about \$65 billion per year.

Workplace Amenities

Such job features as flexible work hours, remote work capabilities, and the ability to take leave as needed may help caregivers maintain employment while also fulfilling their caregiving responsibilities. To ascertain how common these features are for employed caregivers, respondents were asked whether their employer offers seven types of amenities. Table 3.3 summarizes their responses. Overall, the workplace amenities offered by employers of caregivers do not appear to systematically differ from those offered by employers of non-caregivers except for employee assistance programs (EAPs), which are less frequently offered to caregivers. More than half of caregivers are unable to telecommute or work from home, about half of caregivers cannot take paid family leave, and about a third of caregivers do not have flexible work hours. While it is not possible with these data to estimate the effect of these amenities on caregiver employee retention, the lack of these amenities for many employed caregivers may partially explain the self-reported work disruptions that caregivers reported in Table 3.2.

TABLE 3.3
Workplace Amenities for Employed Caregivers and Non-Caregivers

	Non-Caregivers	Caregivers to Those 60 and Under		Caregivers to Those over 60	
		Military/Veteran Caregivers	Civilian Caregivers	Military/Veteran Caregivers	Civilian Caregivers
Flexible work hours	56%	50%	59%	64%	64%
Telecommuting or working from home	42%	48%	34%	40%	39%
Programs that provide information, referrals, counseling, or an EAP	52%	44%	48%	39%	36%
Paid family leave	54%	46%	52%	50%	44%
Paid sick days	69%	69%	69%	60%	58%
Unpaid family leave	67%	58%	62%	64%	54%
Compressed work week that allows you to work a traditional 35–40 hour workweek in less than five workdays	27%	46%	30%	33%	26%

NOTE: Differences between groups were not tested.

Value of Caregiving

Three inputs were used to estimate the annual economic value of military/veteran caregiving in the United States:

- the estimated number of military/veteran caregivers (about 14.3 million; see Chapter 1)
- the average number of hours spent caregiving by military/veteran caregivers (about 16 hours per week; see Chapter 1)
- a range of state-level proxy wages, including minimum wage and the hourly median wages for home health aides, nursing assistants, and registered nurses, respectively.

Estimates of the annual value of military/veteran caregiving range from \$119 billion to \$487 billion per year (see Table 3.4). The range reflects the effects of choosing different proxy wages. At the lower bound, we used the state minimum wage applied to caregivers within each state, which ranged from \$7.25 (the federal minimum) to \$16.10 (the District of Columbia) in 2022. This is a conservative estimate because it is the lowest possible wage the caregiver's activities would have commanded on the labor market. At the upper bound, we used the 2022 median hourly wage of a registered nurse in the respondent's state from the Bureau of Labor Statistics Occupational Employment and Wage Statistics survey, which ranged from \$30.33 (Alabama) to \$63.78 (California). We obtained intermediate estimates of \$162 billion using the wages of home health aides and \$201 billion using the wages of nursing assistants. More details on proxy wages by state and the self-reported hours spent caregiving on which these estimates are based are available in the appendix.

Our estimates of the value of military/veteran caregiving span a large range because the responsibilities of caregivers also vary substantially in the types of skills required. Caregiver duties range from activities that home health care attendants/certified nursing assistants are legally able to perform, such as assisting with mobility and bathing, to those that only registered nurses are able to perform, such as administering medications or giving injections; inserting, irrigating, or replacing catheters; administering gastronomy or nasogastric (nasal) tube feedings; and administering oxygen (CNAClasses, undated). Because we do not have detailed time use information indicating how much time each caregiver spent on each

TABLE 3.4
Estimated Value of Military/Veteran Caregiving Under Various Wage Assumptions

Assumed Caregiver Hourly Wage	Estimated Value of Military/Veteran Caregiving
State minimum wage	\$119 billion
2022 median hourly wage: home health aide	\$162 billion
2022 median hourly wage: nursing assistant	\$201 billion
2022 median hourly wage: registered nurse	\$487 billion

type of activity, we cannot differentiate between these types of activities when estimating the economic value of their caregiving time. Instead, we present a range that captures the full breadth of feasible values for all possible caregiving activities.

Economic Well-Being

Financial Capability and Security

Approximately one-quarter of caregivers have experienced work disruptions, which may cause economic strain for these caregivers as they forgo employment opportunities. In order to best serve these caregivers, it is important to examine how financially capable and secure they feel, as well as whether there are differences between different kinds of caregiver groups. To examine perceived economic strain, the 2023 RAND Caregiving Survey asked two questions.

First, respondents were asked, “During the past 6 months, how much difficulty did your household have paying bills?” Response options include “no difficulty at all,” “a little difficulty,” “some difficulty,” and “a great deal of difficulty.”¹ Results suggest that caregivers may have trouble paying their bills. Thirty-nine percent of non-caregivers reported difficulty paying their bills.² Caregivers, across all groups, reported more difficulty paying their bills: About half of those caring for individuals over 60 had difficulty paying their bills, and almost two-thirds of caregivers to those 60 and under had difficulty paying their bills (Table 3.5).

Respondents were also asked whether or not they have set aside “emergency or rainy day funds that would cover your expenses for 3 months, in case of sickness, job loss, economic downturn, or other emergencies.” Thirty-eight percent of non-caregivers do not have emergency funds set aside, less than the proportion of civilian caregivers (among civilian caregivers to those 60 and under, 59 percent do not have emergency funds; among civilian caregivers to those over 60, 47 percent do not have emergency funds).³ After accounting for demographic differences with non-caregivers, there is no evidence that military/veteran caregivers are more or less likely to have emergency funds set aside than non-caregivers (Table 3.5).

Health Insurance Coverage

Chapter 2 presented data showing that, relative to non-caregivers, caregivers to those 60 and under were less likely to have seen a medical care provider for a routine checkup in the past year, even among those who likely needed to see one. Individuals lacking insurance cover-

¹ This question comes from the Economic Strain Scale (Pearlin et al., 1981) and was also asked in the 2014 RAND Caregiving Survey.

² This estimate is comparable to a recent national estimate finding that 46 percent of Americans had difficulty paying their bills (Lin et al., 2022).

³ This estimate for non-caregivers is relatively similar to the recent national estimate of 53 percent of Americans with a rainy day fund (Lin et al., 2022).

TABLE 3.5**Financial Security and Capability, Caregivers and Non-Caregivers**

	Non-Caregivers	Caregivers to Those 60 and Under		Caregivers to Those over 60	
		Military/Veteran Caregivers	Civilian Caregivers	Military/Veteran Caregivers	Civilian Caregivers
Any difficulty paying bills	39%	66% ^{a,b}	65% ^{a,b}	46%	50% ^{a,b}
No rainy day fund set aside	38%	46% ^a	59% ^{a,b}	43%	47% ^{a,b}

^a Denotes a statistically significant difference from non-caregivers.

^b Denotes a statistically significant difference from non-caregivers in weighted logistic regression models after controlling for caregiver gender, age, marital status, presence of a child under age 18 in the household, household size, income, and residence in a metropolitan area.

age experience more-limited health care access compared with those with insurance. There is widespread evidence that people without insurance are at a lower probability of receiving preventive health care and essential services for significant medical issues and chronic ailments (Liang, Beydoun, and Eid, 2019; O'Lawrence, 2019; Rahman et al., 2019). When asked in the 2023 RAND Caregiving Survey whether they had any kind of health care coverage, between 13 percent and 16 percent of non-caregivers and caregivers to those over 60 reported having no coverage. Many more caregivers to those 60 and under reported having no health care coverage (39 percent of military/veteran caregivers and 24 percent of civilian caregivers; see Table 3.6), and these differences persisted after adjusting for demographic differences between the groups.⁴ Table 3.11 in the supplemental tables at the end of this chapter describes characteristics of military and civilian caregivers without health insurance; of note, most (63 percent) military/veteran caregivers without health insurance live in Southern states, 59 percent are non-White, 45 percent have never been married, and 47 percent have incomes below 100 percent of the federal poverty level.

Use of Safety Net and Government Programs

There are numerous federal safety net programs intended to provide support to people during times of economic hardship (Office of the Assistant Secretary for Planning and Evaluation, undated). These programs were enacted by federal law but differ in eligibility requirements and in whether they are state- or federally administered. Generally, having an income below 130 percent of the federal poverty level qualifies a household for these programs (U.S. Department of Agriculture [USDA], Food and Nutrition Service, 2023).⁵ There were no significant differences in the distribution of household incomes between military/veteran and civilian

⁴ This estimate is slightly higher compared with national estimates suggesting that 11.6 percent of people did not have health insurance (Keisler-Starkey and Bunch, 2022).

⁵ In fiscal year 2022, a family of three with a household income below 130 percent of the federal poverty level would have a gross income less than \$2,379 per month or \$28,548 per year.

TABLE 3.6

Past-Year Health Care Insurance Coverage, Non-Caregivers and Caregivers

	Non-Caregivers	Caregivers to Those 60 and Under		Caregivers to Those over 60	
		Military/Veteran Caregivers	Civilian Caregivers	Military/Veteran Caregivers	Civilian Caregivers
No health care coverage	13%	39% ^{a,b}	24% ^a	14%	16% ^{a,b}

^a Signifies an unadjusted significant difference from non-caregivers.

^b Denotes a statistically significant difference from non-caregivers in weighted logistic regression models after controlling for gender, age, marital status, household size, income, and residence in a metropolitan area.

caregivers (either among those caring for someone 60 or under or those caring for someone over 60; Table 3.7). However, according to data from the 2023 RAND Caregiving Survey, approximately 35 percent of military/veteran caregivers had incomes below 130 percent of the federal poverty level, compared with 41 percent of civilian caregivers and 31 percent of the non-caregivers (Figure 3.1).⁶

The 2023 RAND Caregiving Survey asked respondents, “[I]n the past year, has your household received payments from the following sources . . .” and then provided a list of programs. These programs, and brief descriptions about them, are provided in Table 3.12 in the supplemental tables at the end of this chapter. Eligibility for these programs varies with need, age, disability status, work status, and presence of children; some are intended to reach the most vulnerable, and some are not.

Table 3.8 shows those respondents who reported receiving income from survivor benefits, disability, or stimulus payments—programs that are not necessarily restricted to households with incomes below 130 percent of the federal poverty level. For non-caregivers, the most widely used benefit was the stimulus payment offered as part of the 2020 Coronavirus Aid, Relief, and Economic Security Act (CARES Act). For most caregiver groups, a comparable proportion reported receiving stimulus payments⁷ and disability income: For example, among military/veteran caregivers to those over 60, 12 percent reported receiving stimulus payments, and 12 percent reported disability income. This pattern, however, is different for military/veteran caregivers to those 60 and under. Among this group, 27 percent reported receiving disability income, but only 7 percent received stimulus payments. Military/veteran caregivers with care recipients over 60 had the highest percentage (6 percent) of those who

⁶ Our estimate of 31 percent of non-caregivers having household incomes below 130 percent of the federal poverty level is substantially higher than similar estimates from other sources. In the 2020 U.S. census, about 15 percent of individuals had household incomes below 125 percent of the federal poverty level (Shrider et al., 2021). This may be because the AmeriSpeak panel oversamples lower-income individuals (NORC at the University of Chicago, 2019).

⁷ The 2023 RAND Caregiving Survey was administered between January and March 2023, and stimulus payment questions referred to the prior 12 months, likely the reason why the sample reported relatively low rates of stimulus payments relative to publicly available data on the proportion of eligible households that received the payment in 2020 (Becker-Medina et al., 2023).

TABLE 3.7

Household Income of Non-Caregivers and Caregivers

		Caregivers to Those 60 and Under		Caregivers to Those over 60	
		Military/Veteran Caregivers	Civilian Caregivers	Military/Veteran Caregivers	Civilian Caregivers
Non-Caregivers					
Household income					
Less than \$30,000	18%	31%	32%	28%	24%
\$30,000 to under \$60,000	24%	26%	30%	27%	27%
\$60,000 to under \$100,000	26%	27%	21%	24%	23%
\$100,000 or more	31%	16%	17%	21%	27%

FIGURE 3.1

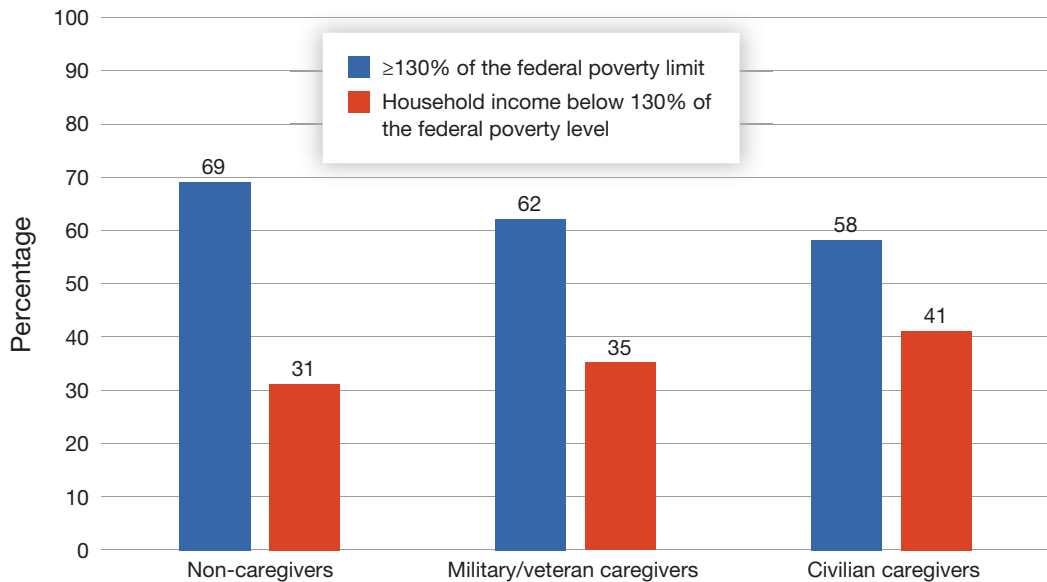
Household Income Level of Caregivers Compared with the Federal Poverty Level

TABLE 3.8

Past-Year Receipt of Survivor Benefits, Disability, and Stimulus Payment, Caregivers and Non-Caregivers

	Non-Caregiver	Caregiver with a Care Recipient 60 or Under		Caregiver with a Care Recipient over 60	
		Military/Veteran Caregiver	Civilian Caregiver	Military/Veteran Caregiver	Civilian Caregiver
Survivor benefits	2%	3%	3%	6%	3%
Disability income	7%	27%	15%	12%	11%
Stimulus payment	20%	7%	15%	12%	13%

NOTE: Differences between caregiver groups were not tested due to small cell sizes. See Table 3.12 in the supplemental tables at the end of this chapter for definitions of programs.

reported receiving survivor benefits compared with the other groups, in which receipt was between 2 and 3 percent.

Table 3.9 presents receipt of payments from SNAP, WIC, Supplemental Security Income (SSI) or Public Assistance, and pandemic-related Electronic Benefits Transfer (EBT) among those respondents with household incomes below 130 percent of the federal poverty level. These data reveal discrepancies in receiving SNAP or WIC. Just 4 percent of military/veteran caregivers with a care recipient 60 or under received SNAP or WIC, while 10 percent of similar civilian caregivers participated in these programs. For those caregivers with a care recipient over 60, 8 percent of military/veteran caregivers reported receiving SNAP or WIC relative to 5 percent of civilian caregivers and 4 percent of non-caregivers.

Among those with household incomes of under 130 percent of the federal poverty level, more caregivers with a care recipient 60 or under reported receiving pandemic-related EBT (military/veteran caregivers: 12 percent; civilian caregivers: 8 percent) than non-caregivers (2 percent) or caregivers to those over 60 (military/veteran caregivers: 4 percent; civilian caregivers: 2 percent). SSI payments were also higher among military/veteran caregivers to those 60 or under (12 percent) relative to other caregiving groups (6–7 percent), as well as non-caregivers (3 percent).

Food-Insecure Caregivers and Use of SNAP

In part due to the COVID-19 pandemic, food insecurity and uptake of SNAP has increasingly become a concern. *Food insecurity* refers to having limited or uncertain access to adequate food. In 2022, 13 percent of American households were food insecure, an increase from 2021 estimates (Rabbitt et al., 2023). Data from USDA suggest that food insecurity is comparable between working-age veterans and non-veterans (Rabbitt and Smith, 2021). However, disability status (and thus increasing the need for a caregiver) is associated with food insecurity among both veterans and non-veterans. Specifically, approximately one-third of working age

TABLE 3.9

Past-Year Receipt of SNAP or WIC, Pandemic-Related EBT, and SSI Payments Among Households with Incomes Below 130 Percent of the Federal Poverty Level

	Non-Caregiver	Caregiver with a Care Recipient 60 or Under		Caregiver with a Care Recipient over 60	
		Military/Veteran Caregiver	Civilian Caregiver	Military/Veteran Caregiver	Civilian Caregiver
SNAP or WIC	4%	4%	10%	8%	5%
Pandemic-related EBT	2%	12%	8%	4%	2%
SSI payments	3%	14%	7%	6%	6%

NOTE: Differences between caregiver groups were not tested due to small cell sizes. The unweighted N for each group was non-caregivers = 373, military/veteran caregivers to those 60 and under = 49, civilian caregivers to those 60 and under = 265, military/veteran caregivers to those over 60 = 129, and civilian caregivers to those over 60 = 266. See Table 3.12 in the supplemental tables at the end of this chapter for definitions of programs.

veterans *with a disability* are food insecure compared with 11 percent of *all* working age veterans (Rabbitt and Smith, 2021).⁸

With respect to caregivers, recent analyses of data from four Southern states using the 2015 Behavioral Risk Factor Surveillance System (BRFSS) suggest that food insecurity is more prevalent among caregivers than non-caregivers (Goswami et al., 2022). Specifically, 36 percent of caregivers and 26 percent of non-caregivers met criteria for being food insecure.

Table 3.10 displays the prevalence of food insecurity among non-caregivers and caregivers in the 2023 RAND Caregiving Survey. Notably, most caregivers are more likely to be food insecure than non-caregivers; among caregivers to those 60 and under, 38 to 40 percent are food insecure, a proportion much higher than among caregivers to those over 60 (22 to 26 percent are food insecure) and non-caregivers (17 percent).⁹

Although there is no evidence of differences in food insecurity between veteran and non-veteran households, their uptake of SNAP does differ, with veterans being significantly less likely to participate in the program (Dubowitz et al., 2023). Table 3.10 presents data on the proportions of caregivers and non-caregivers meeting criteria for food insecurity that had used SNAP in the past year. Across groups, approximately one-quarter to one-third of those who were food insecure had used SNAP in the past year, estimates in line with past research on SNAP uptake of food-insecure veterans (Dubowitz et al., 2023). There were no statistically significant differences in SNAP uptake between different groups of caregivers and non-caregivers.

⁸ While there is some heterogeneity among veterans at risk for food insecurity, in general, rates are consistent across veteran subgroups, including by era of service (e.g., food insecurity affects 10.7 percent of post-9/11 veterans, 9.5 percent of pre-9/11 Gulf War veterans, 12.6 percent of veterans who served between May 1975 and July 1990, and 12.5 percent of Vietnam-era veterans; Rabbitt and Smith, 2021).

⁹ The food insecurity estimates for all groups are higher than the more recent national average of 12.8 percent reported in 2022 (USDA, Economic Research Service, 2023), particularly among the caregiver groups. However, the estimates are more in line with the estimates of low food security among working-age disabled veterans (33.6 percent).

TABLE 3.10

Food Insecurity, Caregivers and Non-Caregivers

	Non-Caregiver	Caregiver with a Care Recipient 60 or Under		Caregiver with a Care Recipient over 60	
		Military/Veteran Caregiver	Civilian Caregiver	Military/Veteran Caregiver	Civilian Caregiver
Food insecure	17%	40% ^a	38% ^a	22% ^a	26%
SNAP use	24%	25%	36%	35%	30%

NOTE: There is no evidence of statistically significant differences in SNAP uptake between different groups of caregivers and non-caregivers. Unweighted sample sizes for estimates of SNAP use are as follows: non-caregivers = 182, military/veteran caregivers to someone 60 or under = 35, civilian caregivers to someone 60 or under = 180, military/veteran caregivers to someone over 60 = 67, and civilian caregivers to someone over 60 = 172. See Table 3.12 in the supplemental tables at the end of this chapter for the definition of SNAP.

^a Indicates statistically significant different from non-caregivers.

Chapter 3 Supplemental Tables

TABLE 3.11
Characteristics of Those Without Health Insurance, Military/Veteran and Civilian Caregivers

	Military/Veteran Caregivers	Civilian Caregivers
Total without health insurance	20.5%	19.2%
Gender		
Male	56.9%	51.9%
Female	38.9%	43.5%
Other	0.4%	0.3%
Race and ethnicity		
White, non-Hispanic	37.9%	43.9%
Black, non-Hispanic	27.5%	18.6%
Hispanic	18.4%	29.6%
Asian, non-Hispanic	13.2%	6.6%
Other, non-Hispanic	2.6%	1.3%
2 or more races, non-Hispanic	0.38%	3.3%
Marital status		
Married	40.0%	32.3%
Widowed	1.3%	1.1%
Divorced	9.7%	10.7%
Separated	3.6%	4.6%
Never married	45.3%	51.2%
Region of the country		
Northeast	8.4%	12.8%
Midwest	12.1%	16.7%
South	62.9%	47.5%
West	16.6%	22.8%

Table 3.11—Continued

	Military/Veteran Caregivers	Civilian Caregivers
Federal poverty level		
<100% poor	47.4%	58.7%
100–199% low income	29.6%	19.3%
200–399% middle income	11.1%	13.9%
400+% high income	12.0%	8.2%
Work status		
Working full time (typically 35 or more hours per week in one or more jobs; including self-employment)	34.6%	41.3%
Working part time (typically less than 35 hours per week)	17.7%	18.6%
Unemployed and looking for work	13.3%	10.6%
Unemployed but not looking for work	2.4%	2.1%
Full-time care of the house and/or children	7.5%	4.9%
Full-time caregiver	3.1%	2.7%
Not working—retired	1.9%	3.3%
Not working—disabled	3.6%	2.1%
Not working—full-time student	2.5%	3.5%
Not working—other	10.1%	6.3%

TABLE 3.12

Safety Net and Government Programs

Program Name	Description
Supplemental Nutrition Assistance Program (SNAP)	SNAP plays a critical role in alleviating poverty and food insecurity (Tiehen, Jolliffe, and Gundersen, 2012; Gundersen and Ziliak, 2015). Typically, households are eligible for SNAP if their gross income is below 130% of the federal poverty level and if they meet broader eligibility requirements (e.g., asset limits); a household of four, for example, can receive up to \$973 per month to offset expenses (USDA, Food and Nutrition Service, 2023).
Pandemic-related Electronic Benefits Transfer (EBT)	In March 2020, temporary SNAP emergency allotments were enacted as part of the Families First Coronavirus Response Act to “address temporary food needs” during the pandemic. The law gave USDA the authority to approve states’ requests for emergency allotments for as long as the federal government’s public health emergency was in effect and the state had issued an emergency or disaster declaration (Rosenbaum, Bergh, and Hall, 2023).
Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	WIC is a federal nutrition program targeted toward pregnant women, new mothers, and young children who have incomes near the federal poverty level and who are at nutritional risk. The program provides federal grants to states for supplemental foods, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and non-breastfeeding postpartum women and to infants and children up to age 5.
Supplemental Security Income (SSI)	SSI provides monthly payments to people with disabilities and older adults who have limited income or resources. Monthly payment depends primarily on income, living situation, and assets.
Survivor benefits	Social Security Survivors Benefits are paid to widows, widowers, and dependents of eligible workers. Family members may receive survivors benefits if they are dependent on someone who is working and paying into Social Security. In addition, a VA Survivors Pension offers monthly payments to qualified surviving spouses and unmarried dependent children of wartime veterans who meet certain income and net worth limits set by Congress (VA, 2023i). The survey asked about “survivor benefits,” and so this could have been interpreted as any of these programs.
Disability income	Social Security pays disability benefits through two programs: the Social Security Disability Insurance program and the SSI program. Disability benefits are paid when someone cannot work because they have a medical condition that is expected to last at least one year or result in death.
Stimulus payments	In March 2020, the CARES Act provided Economic Impact Payments of up to \$1,200 per adult for eligible individuals and \$500 per qualifying child under age 17. For a family of four, these Economic Impact Payments provided up to \$3,400 of direct financial relief. In 2021, the American Rescue Plan provided economic impact payments of up to \$1,400 for eligible individuals or \$2,800 for married couples filing jointly, plus \$1,400 for each qualifying dependent.
Unemployment benefits ^a	Unemployment insurance programs provide benefits to eligible workers who become unemployed through no fault of their own and who meet certain requirements. The program is administered by individual states.
Temporary Assistance for Needy Families (TANF) ^b	TANF provides grant funds to states and territories to give families financial assistance and related support services. Applicants must be a resident of the state in which they apply and a U.S. citizen, legal immigrant, or qualified immigrant. Applicants must be unemployed or underemployed and have low or very low income. Applicants also must have a child 18 years of age or younger, be pregnant, or be 18 years of age or younger and the head of the household.

Table 3.12—Continued

Program Name	Description
Department of Human Services General Assistance ^c	The General Assistance program provides a monthly cash assistance allowance to low-income people who do not meet the requirements for the TANF program yet are still eligible as individuals or couples with no dependent children and have temporary or permanent disabilities that prevent their employment.
Federal/military child care programs ^d	Military child care program types include child development centers, family child care providers, school-age care programs, and 24/7 centers. Military families who would like to enroll their child in a military-run child care program must submit a child care request through MilitaryChildCare.

^a Although asked about unemployment benefits, the proportion looking for work and reporting receipt of this benefit was too small to present for analyses.

^b Although asked about receipt of TANF, the proportion reporting receipt of the benefit was too small to present for analyses.

^c Although asked about receipt of Department of Human Services General Assistance, the proportion reporting receipt of the benefit was too small to present for analyses.

^d Although asked about support from federal and military child programs, when examined among respondents with at least one child in the household, the proportion reporting receipt of the benefit was too small to present for analyses.

Caregiver Networks and Support

Introduction

This chapter provides information on various sources of support available to caregivers, including support provided by family and friends, support that may come from religion, and support with respect to programs available to caregivers. This includes support groups, respite care, caregiver training, structured wellness programs, and case management. It also provides information on how use of some of these supports, such as religion and programs for caregivers, relates to caregiver burden. Differences are tested between caregivers to those 60 and under and other caregiving groups, generally using weighted regression models.

Key Findings

Military/veteran caregivers to those 60 and under lack both social support and caregiving support but are more likely to access services. Caregivers to those 60 and under tend to have fewer people in their support networks, and military/veteran caregivers to those 60 and under have fewer people they can call on for emotional support. Perhaps because of the lack of this support, but also because there has been an influx of programs (as described in the “Introduction and Background” chapter), more military/veteran caregivers of those to individuals 60 and under are accessing caregiver support programs, such as support groups and trainings.

Though caregivers are generally satisfied with caregiver support services, there is room for improving these programs. On average, very few caregivers who used programs in the past year were unsatisfied with them. On the other hand, there is broad room for improvement. Only around two-thirds of those who accessed respite were “very satisfied” with the services they received, 60 percent who accessed training were “very satisfied,” and half or fewer of those who accessed structured wellness or case management were “very satisfied.”

Caregivers have specific preferences for the services they want to support them. Caregivers to those 60 and under indicate a preference for programs they can do with the person they are caring for; those caring for individuals over 60 want programs that help keep the recipi-

ent safe and also want help with filling out forms. All caregivers indicated a preference for programs for reducing stress.

Caregivers for whom religion is an important part of their lives report less caregiver burden. This association persists even after accounting for characteristics of caregiving, characteristics of the care recipient, and characteristics of the caregiver.

Social Support

Caregivers' social experiences providing care run the gamut: They can be surrounded by relatives and friends who assist with caregiving tasks, potentially providing a source of respite care when they want to take a break, or they can perform their caregiving duties alone, relying only on paid health care resources for help. Outside of caregiving duties, they can have others to rely on for social and emotional support, or they can have no one they can count on. Even when they are surrounded by others who help them care for the care recipient, they can still feel isolated and alone. Social isolation can be manifested as a deficit in the characteristics or structure of one's social network of connections, or it can be a perceived deficit in social connections, which is manifested in feelings of loneliness, described further in Chapter 2 (Cacioppo and Cacioppo, 2014).

A lack of social support and connections is detrimental to caregivers' well-being. Female spouses of veterans with TBI and/or PTSD expressed feelings of isolation from their military and civilian communities, which amplified the stressors of their daily lives (Voris and Steinkopf, 2019). Caregivers of cancer patients who experienced higher levels of social support and social connection reported lower levels of caregiver burden (Yuen et al., 2023).

The 2023 RAND Caregiving Survey asked about social support, with questions about emotional and task-related support provided by others (AARP and NAC, 2020; Ramchand et al., 2014). When asked, "If you needed someone to listen to your problems if you were feeling low, are there enough people you can count on, not enough people, or is there no one you can count on?" over half (56 percent) of military/veteran caregivers to those 60 and under reported "not enough people" or "no one," more than non-caregivers (19 percent), and a difference that persisted even after adjusting for differences between the groups with respect to gender, age, marital status, household size, income, and residence in a metropolitan area (Table 4.1).

Examining task-related social support, the survey asked caregivers (1) how difficult it would be for them to get help providing care to their care recipient and (2) how difficult it would be for them to get someone else to take on their caregiving responsibilities, if needed. Between one-third and half of all caregivers reported that it would be very or somewhat difficult to receive support to provide care, and for most caregiver groups a comparable proportion reported that it would be very or somewhat difficult to get someone to take on their caregiving tasks. However, for military/veteran caregivers to those 60 and under, many fewer (41 percent) reported that it would be difficult to find someone to take on caregiving responsibilities than reported that it would be difficult to find help to provide care (55 per-

TABLE 4.1**Social Support, Caregivers and Non-Caregivers**

	Non-Caregivers	Caregivers to Those 60 and Under		Caregivers to Those over 60	
		Military/Veteran Caregivers	Civilian Caregivers	Military/Veteran Caregivers	Civilian Caregivers
Emotional social support					
Not enough people/ No one you can count on	19%	56% ^a	37%	28%	26%
Task-related social support					
Very difficult/ Somewhat difficult obtaining task support to provide care	N/A	55%	44%	39%	44%
Very difficult/ Somewhat difficult obtaining task support to take a break	N/A	41%	48%	38%	49%

^a Denotes a statistically significant difference from non-caregivers in weighted linear regression models after controlling for gender, age, marital status, household size, income, and residence in a metropolitan area.

cent). However, the proportion of caregivers reporting difficulty on both sets of task-related support did not differ across caregiving groups, including after accounting for differences between groups with respect to gender, age, marital status, household size, income, and residence in a metropolitan area. In summary, military/veteran caregivers to those 60 and under reported having less social support compared with non-caregivers, but task-related support did not differ between caregiving groups.

Caregiving Network

Between a third and half of caregivers are sole caregivers, meaning that they reported no other additional caregivers in their support network. The same proportion of civilian (41 percent combined) and military/veteran caregivers (39 percent combined) were sole caregivers (data not shown). However, military/veteran and civilian caregivers to those 60 and under were significantly more likely to be sole caregivers (49 percent combined) compared with caregivers to those over 60 (34 percent of military/veteran and civilian caregivers combined). This difference persisted even after adjusting for differences between the groups with respect to gender, age, marital status, household size, income, and residence in a metropolitan area, with civilian caregivers to those 60 and under even more likely to be sole caregivers compared with all other groups (Table 4.2).

TABLE 4.2**Number of Additional Caregivers in Caregiving Network**

	Caregivers to Those 60 and Under		Caregivers to Those over 60	
	Military/Veteran Caregivers	Civilian Caregivers	Military/Veteran Caregivers	Civilian Caregivers
Number of additional caregivers in support network				
None	45%	50% ^{a,b}	36% ^b	34% ^{a,b}
1	27%	26%	29%	31%
2	16%	14%	19%	20%
3–5	12%	10%	16%	15%

^a Denotes a statistically significant difference from military/veteran caregivers to those age 60 and under.

^b Denotes a statistically significant difference from military/veteran caregivers to those age 60 and under in weighted linear regression models after controlling for caregiver gender, age, marital status, presence of a child under age 18 in the household, household size, income, and residence in a metropolitan area.

As shown in Table 4.3, characteristics of sole caregivers and caregivers who are part of a caregiving network were similar between military and civilian caregivers. One exception is that almost three-quarters of sole military/veteran caregivers are female, compared with around half of civilian sole caregivers and caregivers who are part of a caregiving network. Across military and civilian caregivers, about 40 percent of sole caregivers were married to their care recipient, compared with around 10 percent of caregivers who are part of a caregiving network. Around two-thirds of sole caregivers live with their care recipient, compared with around one-third of caregivers who are part of a caregiving network. Around 40 percent of sole caregivers provided help to someone who had needs with ADLs, compared with 50 to 60 percent of caregivers who are part of a caregiving network.

Religious Support

Caregiving often requires great sacrifice. A person's willingness to make those sacrifices (and their acceptance of making those sacrifices) could be driven by their religious identity. A very religious person may view caregiving as a moral imperative and/or may derive more personal benefit from being a caregiver (Kleinman, 2012).¹ Caregivers may also rely on religious institutions for support. Religious communities may provide support groups and respite care for

¹ It is worth noting that much of the literature on this topic is not recent, and religiosity has decreased in the United States over time. Comparing Pew Research Center data between 2007 and 2014 suggests that fewer people are saying that religion is "very important" in their lives and more people are saying that religion is "not at all important" in their lives (Pew Research Center, 2015). Older adults tend to feel that religion is very important in their lives, and younger adults are more likely to report that religion is less important in their lives (Pew Research Center, 2015).

TABLE 4.3

Characteristics of Sole Military and Civilian Caregivers

Caregiver Characteristic	Sole Caregivers		Caregivers Who Are Part of a Network	
	Military/Veteran Caregivers	Civilian Caregivers	Military/Veteran Caregivers	Civilian Caregivers
Average age	52	47 ^a	44 ^a	46 ^a
Percentage female caregivers	72%	50% ^a	49% ^a	52%
Are the spouse or partner of care recipient	43%	44%	8%	10%
Are the child of the care recipient	14%	24%	33%	37%
Live with the care recipient	61%	65%	30%	35%
Help someone with ADL needs	40%	41%	62%	53%
Help someone with a cognitive impairment	64%	64%	68%	63%

NOTE: The unweighted sample size in each group was as follows: sole military/veteran caregivers = 212, sole civilian caregivers = 480, networked military/veteran caregivers = 292, and networked civilian caregivers = 715.

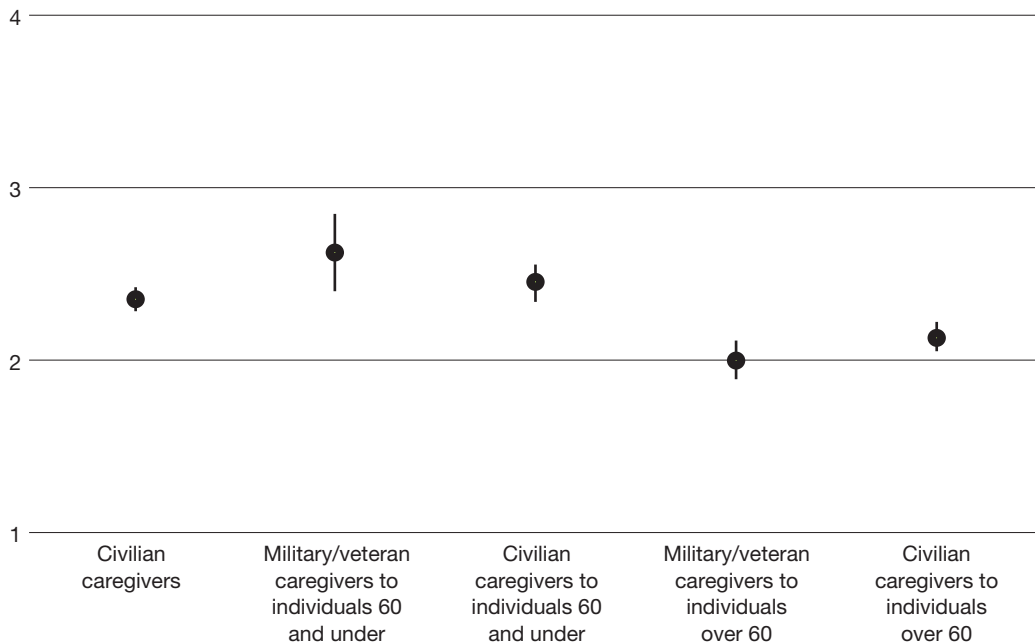
^a Denotes a statistically significant difference from military/veteran sole caregivers.

caregivers. These resources are likely made available to members of those communities, leaving less-religious and religiously unaffiliated caregivers potentially without access to those resources. In other words, the emotional and spiritual needs of caregivers may be supported by their faith, but it is also possible that caregivers benefit from their religious ties in other aspects of their lives.

The 2023 RAND Caregiving Survey asked caregivers how important religion was in their lives, with response options of “very important” (1) to “not at all important” (4). On average, religion is between “somewhat important” and “not too important” across all caregiver groups, as well as among non-caregivers, with no evidence of differences between the groups (Figure 4.1).

A caregiver’s religion may affect their well-being, but research evidence is mixed, possibly attributable to the different ways well-being outcomes and religion/spirituality are measured across research studies (Hebert et al., 2006). However, in some cases, religiosity and the religious behavior of a person were associated with better self-rated physical and mental health outcomes (Burgener, 1999; Moen, Robison, and McClain, 1995; Rammohan, Rao, and Subbakrishna, 2002; Sherif et al., 2001) and less caregiving burden (Folkman et al., 1994; Roff et al., 2004). The relationship between caregiver outcomes and religiosity could depend on

FIGURE 4.1
Mean Religiosity Scores



NOTE: Response options are “very important” (1), “somewhat important” (2), “not too important” (3), and “not at all important” (4).

the care recipient’s needs; caregivers to those who require more care may rely more on religion and spirituality to maintain their quality of life (Hanks et al., 2020).

To examine these types of relationships, regression modeling was used to examine how religiosity is related to caregiver burden (described in more detail in Chapter 2). *Religiosity* was defined as reporting that religion is “very important” or “somewhat important” to the caregiver, relative to those who report that religion is “a little important” or “not at all important” to them. Full model results are presented in Table 4.10 in the supplemental tables at the end of this chapter. The results indicate that caregivers who consider religion to be important in their lives also report less caregiver-related burden, even after accounting for characteristics of caregiving (e.g., time spent caregiving), characteristics of the care recipient (e.g., care recipients’ condition), and characteristics of the caregiver (e.g., demographic characteristics). That said, the hours per week spent caregiving, the duration of caregiving, and whether the caregiver provided assistance with ADLs were all also positively associated with caregiving burden. This suggests that religiosity cannot fully alleviate caregiving burdens.

Support Services

The 2023 RAND Caregiving Survey asked all military and civilian caregivers if, in the past year, they had used any of six support services: in-person support groups, online support groups, respite programs, caregiving training programs to help care for the care recipient, structured wellness programs (e.g., exercise classes or group activities for yoga/meditation, healthy eating), and an advocate or case manager (i.e., someone to try to get help or coordinate help for the care recipient). Responses are provided in Table 4.4. The survey also asked military/veteran caregivers about use of PCAFC, but responses to those questions are presented separately later in this chapter.

There are two general findings from these results. First, structured wellness programs are the most widely utilized resource, with between 27 and 46 percent of caregivers accessing these programs. In comparison, online support groups were least commonly used, with only 3 to 15 percent of caregivers using these groups. The second finding is that military/veteran caregivers to those 60 and under access support programs two to four times more commonly than any other caregiver group, differences that are significant for in-person and online support groups and caregiver training. On average, military/veteran caregivers to those 60 or under have availed themselves of two programs in the past year, compared with other caregiver groups who, on average, availed themselves of one or none.

For each type of support services, caregivers who used those services provided further information, including who provided the service, who paid for the service, and how satisfied caregivers were with the service. Results from these items are presented in the sections that follow.

TABLE 4.4
Past-Year Support Service Utilization Among Caregivers

	Caregivers to Those 60 and Under		Caregivers to Those over 60	
	Military/Veteran Caregivers	Civilian Caregivers	Military/Veteran Caregivers	Civilian Caregivers
In-person support groups	30%	8% ^a	10% ^a	6% ^a
Online support groups	15%	5% ^a	8% ^a	3% ^a
Respite	19%	8%	12%	15%
Training	38%	9% ^a	10% ^a	9% ^a
Structured wellness	46%	28%	34%	27%
Case manager	27%	12% ^a	20%	16%
Total number of support services (mean)	1.8	0.7	1.0	0.7
No participation in support services	38%	55%	48%	52%

^a Denotes a significant difference from military/veteran caregivers to individuals 60 and under.

Support Groups

Some studies have found that support groups can be beneficial for caregivers who may otherwise be socially isolated. Some participants in one study of VA's PGCSS reported that caregiver support groups provided important psychological support, valuable connections to others who have similar experiences (Bruening et al., 2020), and information about other available resources, though those with unique needs reported less satisfaction. Other studies have found that those with higher participation in online groups perceived less social isolation over time (Trail et al., 2020) and that caregivers providing more care used more online support systems (Friedman et al., 2018).

Several national organizations offer online and/or in-person support groups for military/veteran caregivers, such as the Elizabeth Dole Foundation's Hidden Heroes Caregiving Community on Facebook and the Military and Veteran Caregiver Network from the American Red Cross, which offers vetted caregivers access to peer-facilitated support groups in person or online, a secure and moderated online community, and mentors (American Red Cross, undated-b). The Defense Health Agency's Warrior Care Recovery Coordination Program offers the Military Caregiver Personalized Experiences, Engagement and Resources (PEER) Forum initiative to encourage caregivers to provide peer support and share resources virtually and in person (Defense Health Agency, undated-b). Some organizations offer virtual support forums to all caregivers, including military/veteran caregivers, such as AARP (AARP, undated-a).

As described in Table 4.5, more caregivers access in-person groups than those offered online. Among those who attend in-person groups, almost half attend these at local hospitals (including at VA for military/veteran caregivers) and/or local community centers and organizations. Over three-quarters of caregivers who attend support groups attend them either daily, weekly, or multiple times per month.

Evidence presented in Chapter 2 indicates that caregivers who participate in support groups are more lonely than those who do not. This may be because caregivers who feel more lonely are also more likely to choose to participate in support groups. Similar findings were observed for emotional social support: In regression models, participating in online support groups is significantly related to *lower* perceptions of emotional support. Like loneliness, this may be because those who do not experience emotional support among their in-person social network are more likely to seek out emotional support online. There was no evidence that participating in online support groups is related to receiving task-related social support. Participating in in-person support groups was not significantly related to emotional support, but those who participated in in-person support groups reported significantly less difficulty getting help providing care and less difficulty finding someone else to take on their caregiving responsibilities (e.g., provide respite care). Full regression results are in Tables 4.11 through 4.13 in the supplemental tables at the end of this chapter.

TABLE 4.5
Characteristics of Caregiver Support Group Participation

	Military/Veteran Caregivers	Civilian Caregivers
In-person support groups		
Location of support groups		
Local hospital or health care organization	25%	44%
Local VA	35%	N/A
Local community center or organization	45%	41%
Church, synagogue, mosque, or other religious organization	14%	32%
Other	3%	8%
Frequency of attendance		
Daily	16%	7%
Weekly	21%	32%
A few times per month	38%	31%
Once a month or less	23%	23%
Online support groups		
Organizer/facilitator of online support group		
Online support group run by a veteran or caregiving organization	54%	N/A
Online caregiver support group run by AARP	6%	25%
Online support group run by VA	43%	N/A
A Facebook group or other social media caregivers support group	27%	39%
Online caregiver support group run by a disease or condition specific organization	3%	32%
Other	5%	24%
Frequency of attendance		
Daily	9%	19%
Weekly	16%	28%
A few times per month	59%	42%
Once a month or less	16%	11%

NOTE: The unweighted N for in-person support groups was as follows: military/veteran caregivers = 43 and civilian caregivers = 80; for online support groups, the unweighted N was military/veteran caregivers = 28 and civilian caregivers = 47. Differences between military/veteran and civilian caregivers were not tested.

Respite

Respite care, in which caregivers receive a temporary break from their caregiving responsibilities either in the home or outside the home, is widely seen as an important component of reducing caregiver burden and potentially therefore enabling caregivers to continue in their caregiving role for a longer period. However, rigorous empirical research into the effectiveness of respite care remains somewhat limited, and findings are mixed. Positive effects, particularly of day services, can include decreases in caregiver burden and stress-related factors among those caring for individuals with dementia but also accelerated nursing home admissions (Vandepitte et al., 2016). Additionally, research on respite care among those with mental health conditions is particularly lacking (Jeon, Brodaty, and Chesterson, 2005).

Several nonprofit organizations offer some form of respite care. Some, such as Easterseals, may offer center-based or in-home services directly or in partnership with other organizations, with variability by location (Easterseals, undated). Wounded Warrior Project may offer respite care as part of individualized support plans developed for catastrophically wounded veterans (Wounded Warrior Project, undated-b). Among caregivers who reported accessing respite care in the 2023 RAND Caregiving Survey, there was no dominant form of respite provider, with a roughly equal proportion (26 to 35 percent) of military/veteran caregivers selecting each of the four sources, including “professional adult daycare staff, health care aide or health care provider” (Table 4.6).

The most common place where respite was provided was in a private residence. However, it is also noteworthy that 16 percent of military/veteran caregivers reported receiving respite “at an adult daycare center at a church, synagogue, mosque, or other religious organization,” especially in comparison with the proportion that reported receiving respite at a “community adult daycare center” (3 percent) or “at an adult daycare center at the Department of Veterans Affairs” (8 percent).

In terms of payment, approximately one-quarter of military/veteran caregivers did not have their respite paid for. Otherwise, among military/veteran caregivers, respite was paid for by VA (20 percent), Medicare (19 percent), or their own out-of-pocket resources (15 percent). Eleven percent of military/veteran caregivers reported that their respite care was paid for by the Elizabeth Dole Foundation. This program provided respite support during the pandemic; VA is currently piloting expanded respite offerings.

Training

Clinical skills training for caregivers can reduce care recipient hospital stays and delay their nursing home placement, as well as decrease caregiver burden and depression (Bruening et al., 2020; Easom et al., 2018). More general training on problem-solving skills has also been associated with reduced depression and burden, as well as increased life satisfaction, among military caregivers (Easom et al., 2018).

Around 10 percent of military/veteran and civilian caregivers to those over 60 and a similar proportion of civilian caregivers to those 60 and under had taken a training to help with

TABLE 4.6

Caregiver Respite Participation

	Military/Veteran Caregivers	Civilian Caregivers
Respite care provider		
Another family member or other person in the household	28%	35%
Another family member outside the household	35%	29%
A friend or neighbor	26%	15%
Professional adult daycare staff, health care aide or health care provider	26%	36%
Where respite occurs		
Private residence	56%	78%
At an adult daycare center at a church, synagogue, mosque, or other religious organization	16%	5%
At a community adult daycare center	3%	5%
At an adult daycare center at VA	8%	N/A
Other	3%	12%
Respite payor		
Care recipient private health insurance	11%	16%
Medicaid	6%	16%
Medicare	19%	20%
VA	20%	N/A
Elizabeth Dole Foundation	11%	N/A
Care recipient: Out-of-pocket	10%	20%
Caregiver: Out-of-pocket	15%	14%
Someone else: Out-of-pocket	0%	5%
Not paid for	26%	39%

NOTE: The unweighted N was military/veteran caregivers = 57 and civilian caregivers = 148. Differences between military/veteran and civilian caregivers were not tested.

caregiving in the past year; in comparison, almost 40 percent of military/veteran caregivers to those 60 and under had taken a caregiving training course (see Table 4.4). Among military/veteran caregivers, the most commonly accessed trainings were those offered by VA (see Table 4.7). VA offers caregivers enrolled in both PCAFC and PGCSS access to the online Building Better Caregivers six-week self-paced online workshop, which also offers peer support both during and after the program (VA, undated-a). In addition, VA offers caregiver self-care and resilience in-person and virtual courses, coaching, and mentoring (VA, undated-c). Trainings from local governments, religious organizations, military/veteran caregiver support groups, and other national organizations were taken by around 15 to 20 percent of military/veteran caregivers. Among civilian caregivers, most (38 percent) selected an “other” category, and around one-third reporting training from local state governments.

Structured Wellness and Case Management

Structured wellness programs were the most commonly endorsed of all support programs. This may be due to the broad way in which the question was worded: “In the past year, have you used structured wellness activities for yourself? For example, exercise classes or group activities for yoga/meditation, healthy eating, etc.” This can include classes and activities offered to all individuals in a community but may also include programs specifically for military and veteran caregivers. For example, Blue Star Families offers online and virtual cohorts in its Caregivers Empowering Caregivers program, which offers workshops (training) that focus on self-care (wellness) in a social setting to encourage resource-sharing and peer support (support groups) (Blue Star Families, undated).

Case management refers to services provided to help caregivers navigate care for the care recipient. Programs that provide case management, such as Wounded Warrior Project, may

TABLE 4.7

Source of Caregiving Training Among Caregivers Who Received Training

	Military/Veteran Caregivers	Civilian Caregivers
VA	37%	N/A
Military/veteran caregiver support group	14%	N/A
Local state government	21%	32%
Religious organization	15%	13%
National organization	16%	21%
Other	14%	38%

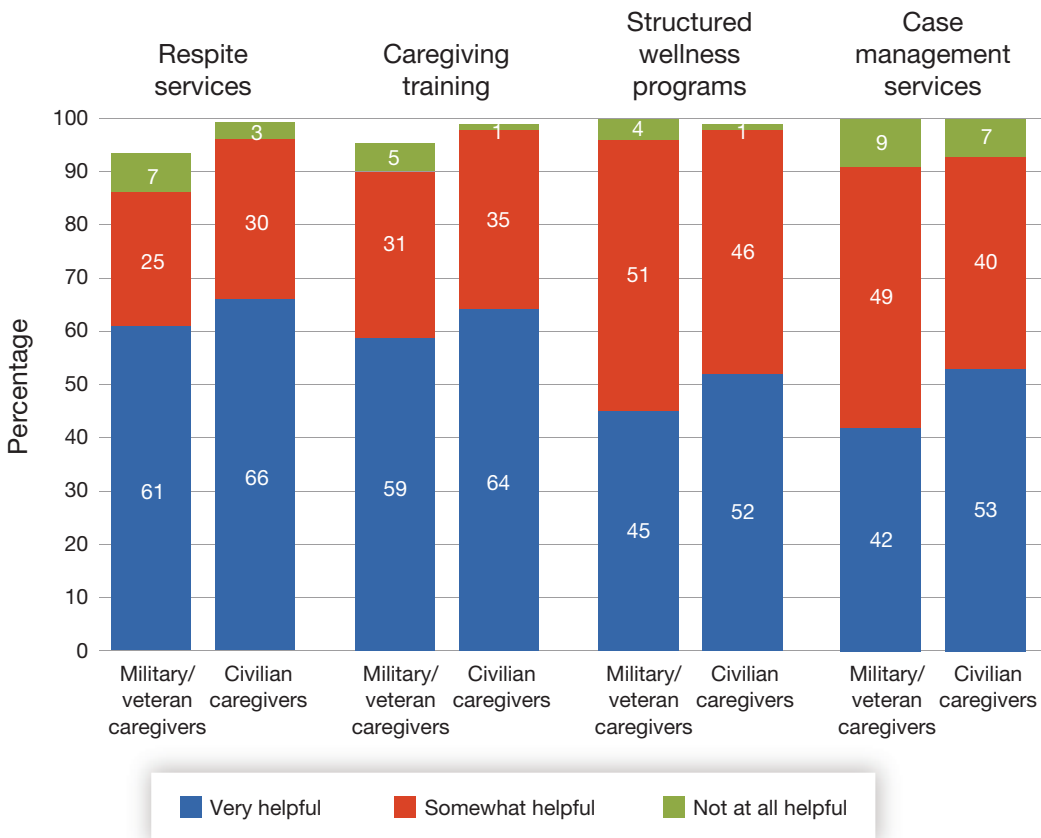
NOTE: The unweighted N was as follows: military/veteran caregivers = 60 and civilian caregivers = 440. Differences between military/veteran and civilian caregivers was not tested. Other training includes those who responded “Other.” National organization refers to organizations such as the Elizabeth Dole Foundation, AARP, and Family Caregiver Alliance.

also provide personal wellness care, retreats, respite, mental health care, and more (Wounded Warrior Project, undated-b). Case management was used by 12 to 28 percent of caregivers.

Satisfaction with Services

For those who endorsed using respite, training, structured wellness, or case management, the 2023 RAND Caregiving Survey asked for each, “How helpful was this resource?” Responses are presented in Figure 4.2. Approximately two-thirds of caregivers who used respite services found them “very helpful,” but 7 percent of military/veteran caregivers found them “not at all helpful.” A similar proportion (59 percent) of military/veteran caregivers found trainings “very helpful,” and one-third found trainings “somewhat helpful.” Around half of caregivers

FIGURE 4.2
Caregiver Satisfaction with Support Services, Among Users



NOTE: Totals do not add to 100 percent because of respondents who skipped this question on the survey. The unweighted N for the groups is as follows: respite services: military/veteran caregivers = 57 and civilian caregivers = 148; caregiving training: military/veteran caregivers = 60 and civilian caregivers = 115; structured wellness programs: military/veteran caregivers = 179 and civilian caregivers = 359; and case management services: military/veteran caregivers = 90 and civilian caregivers = 169. Differences between military/veteran and civilian caregivers were not tested.

found wellness programs to be “very helpful,” with not much difference between military/veteran and civilian caregivers. Finally, fewer than half of military/veteran caregivers (versus 53 percent of civilian caregivers) found their case management services “very helpful.” What is most striking is that almost 10 percent of military/veteran and civilian caregivers reported that the case management services they had received in the past year were “not at all helpful.”

Program Participation and Caregiver Burden

Participation in support groups and structured wellness activities, receiving respite support, undergoing caregiving training, and having case management are intended to simplify life for caregivers. Chapter 2 describes the proportion of caregivers who met criteria for excessive caregiver burden. Table 4.8 describes the proportion of those caregivers participating in programs who met criteria for excessive burden. For most program types, approximately half of caregivers using the resource met these criteria, suggesting that these programs are serving those caregivers in need (the exception is structured wellness, of whom only approximately one-third of those participating met criteria for excessive burden). On the other hand, Table 4.8 also provides data on the proportion of those meeting criteria for excessive burden who have participated in these programs. Most used is structured wellness, which was used by approximately one-third of those caregivers who met criteria for excessive burden. However, it is notable that support groups and caregiver training were used by less than 15 percent of caregivers who met criteria for excessive burden.

TABLE 4.8
Past-Year Support Service Utilization Among Caregivers Meeting Criteria for Excessive Caregiver Burden

	Among Those Who Participate in the Program, Percentage Meeting Criteria for Excessive Caregiver Burden	Among Those Meeting Criteria for Excessive Caregiver Burden, Percentage Who Participate in the Program
In-person support groups	42%	11%
Online support groups	51%	8%
Respite	44%	18%
Training	41%	14%
Structured wellness	32%	31%
Case manager	41%	21%

NOTE: The unweighted N for the groups is as follows: in-person support groups = 122, online support groups = 75, respite = 205, training = 175, structured wellness = 543, and case manager = 261. The unweighted N for caregiver burden is N = 525.

Caregivers' Reported Needs for Support

The 2023 RAND Caregiving Survey also asked caregivers, “Which of the following topics do you feel you need more help or information related to caregiving of [care recipient]?” with the list of topics provided in Table 4.9. Few caregivers selected any options, with the highest endorsement among caregivers to those 60 and under for “activities you could do with care recipient” (18–25 percent) and “managing your emotional and physical health” (15–21 percent). Caregivers to those over 60 also wanted help managing stress (17–19 percent), but almost a quarter (22–24 percent) also wanted help or information about keeping the care recipient safe at home.

TABLE 4.9

Caregivers' Self-Reported Need for Information or Assistance

Topics	Caregivers to Those 60 and Under		Caregivers to Those over 60	
	Military/Veteran Caregivers	Civilian Caregivers	Military/Veteran Caregivers	Civilian Caregivers
Keeping care recipient safe at home	12%	13%	22%	24%
Managing care recipient's challenging behaviors	10%	14%	17%	14%
Activities you could do with care recipient	25%	18%	19%	17%
Choosing a home care agency	7%	3%	8%	9%
Managing your emotional and physical stress	15%	21%	17%	19%
Making end-of-life decisions	10%	2%	9%	11%
Finding educational materials	5%	6%	7%	7%
Figuring out forms	10%	11%	13%	16%
Managing or handling your own personal finances	7%	10%	6%	10%
Using technology to care for care recipient	11%	5%	7%	10%
Finding child care	3%	2%	3%	1%
Other	1%	3%	3%	2%

Participation in the Program of Comprehensive Assistance for Family Caregivers

As discussed in the “Introduction and Background” chapter of this report, PCAFC provides resources for caregivers of eligible veterans. The program provides a range of resources, including a monthly stipend, respite care, health insurance, beneficiary travel benefits, and other support. Initially, the program was intended for caregivers of post-9/11 veterans, but it has expanded over time. Since October 1, 2022, PCAFC has been available for caregivers of veterans from all eras.

The 2023 RAND Caregiving Survey asked caregivers about their participation in the program. However, when conducting validation checks, it became apparent that some respondents who reported being enrolled in PCAFC were unlikely to be actually enrolled, perhaps confusing it with something else. Thus, the 2023 RAND Caregiving Survey lacked the statistical power to examine participation in this program. This validation assessment is presented in the appendix.

Chapter 4 Supplemental Tables

TABLE 4.10

Correlates of Caregiver Burden by Religiosity Among Caregivers, With and Without Adjustment

	Univariate Estimate		Multivariate Estimate	
	Estimate	p	Estimate	p
Religiosity				
Very/somewhat important (ref)	-0.82	0.002	-1.05	<0.001
Military/veteran caregiver (ref)				
Civilian caregiver	0.28	0.33	1.02	0.002
Care recipient 60 or under (ref)				
Care recipient 60+	-0.53	0.05	-0.75	0.05
Time spent caregiving				
<8 hours (ref)				
9–20 hours	2.34	<0.001	1.09	0.002
21–40 hours	3.51	<0.001	1.86	<0.001
41+	3.28	<0.001	1.40	0.01
Skipped	-1.43	0.46	-2.15	0.31
Duration of caregiving				
<1 year (ref)				
1–2 years	1.50	<0.001	0.70	0.10
2–5 years	2.23	<0.001	1.03	0.006
5–10 years	2.61	<0.001	1.03	0.03
10+ years	3.02	<0.001	1.65	0.001
Not the primary caregiver	-1.38	<0.001	-0.54	0.09
Caregiving activities				
Help with at least one ADL (ref)				
Help with emotional/cognitive tasks	-0.92	0.001	-0.78	0.02
Help administering medications, housework, or administrative support	-3.42	<0.001	-1.89	<0.001

Table 4.10—Continued

	Univariate Estimate		Multivariate Estimate	
	Estimate	p	Estimate	p
Care recipient conditions				
Chronic condition	1.99	<0.001	1.17	<0.001
Vision/hearing	1.32	<0.001	0.55	0.05
Neurological	1.91	<0.001	1.46	<0.001
TBI	1.66	<0.001	0.69	0.16
Musculoskeletal	0.89	<0.001	0.11	0.71
Infectious disease	1.93	<0.001	1.60	<0.001
Substance use disorder or mental health condition	1.83	<0.001	0.95	0.003
Other	0.78	0.006	0.39	0.18
Caregiver is the care recipient's:				
Child or child-in-law	-1.10	0.09	-0.90	0.21
Friend, neighbor, or non-relative	-2.72	<0.001	-1.47	0.003
Parent, grandparent, or parent-in-law	-0.30	0.36	-0.24	0.59
Sibling, in-law, or other relative	-1.22	0.004	-0.68	0.16
Spouse, partner, or former spouse/partner (ref)				
Caregiver is female (ref: male)	0.91	<0.001	1.01	<0.001
Caregiver age				
18–30	0.42	0.33	0.36	0.50
31–55	0.52	0.14	0.14	0.71
56–65 (ref)				
66–80	-0.62	0.12	-0.24	0.59
81+	-1.59	0.12	-1.53	0.17
Caregiver race/ethnicity				
White, non-Hispanic (ref)				
Black, non-Hispanic	-0.66	0.12	-0.86	0.06
Other, non-Hispanic	0.59	0.56	-0.10	0.92
Hispanic	0.54	0.14	0.15	0.72

Table 4.10—Continued

	Univariate Estimate		Multivariate Estimate	
	Estimate	p	Estimate	p
Two or more races/ethnicities, non-Hispanic	2.15	0.01	2.46	0.007
Asian, non-Hispanic	1.41	0.05	1.09	0.21
Caregiver educational attainment				
Less than high school	−0.06	0.92	−0.59	0.36
High school graduate or equivalent	−0.25	0.50	0.09	0.82
Some college/associate degree (ref)				
Bachelor's degree	0.35	0.33	0.54	0.16
Postgraduate study/professional degree	0.37	0.33	0.90	0.04
Caregiver household income				
Less than \$30,000 (ref)				
\$30,000 to under \$60,000	0.22	0.54	0.79	0.04
\$60,000 to under \$100,000	0.76	0.045	1.15	0.007
\$100,000 or more	0.09	0.81	0.59	0.21
Caregiver lives in metropolitan area	−0.07	0.86	0.11	0.76
Caregiver marital status				
Married (ref)				
Widowed	0.09	0.88	1.42	0.03
Divorced	−0.57	0.18	0.12	0.79
Separated	0.57	0.39	0.91	0.19
Never married	−0.15	0.63	0.17	0.66

NOTE: Bolded estimates indicate those that are statistically significant ($p < 0.05$).

TABLE 4.11**Regression Models Predicting Emotional Social Support from Participation in Online and In-Person Support Groups**

	Univariate Estimate		Multivariate Estimate	
	Estimate	p	Estimate	p
Male caregiver (versus female)	-0.24	<0.001	-0.21	0.003
Caregiver age	0.03	<0.001	0.03	<0.001
Marital status	0.23	<0.001	0.07	0.39
Household size	-0.05	0.22	0.06	0.25
Household income	0.07	0.02	0.03	0.28
Residence in a metropolitan area	0.08	0.39	0.05	0.62
Care recipient age group (over 60 versus 60 and under)	0.28	<0.001	0.26	0.009
Care recipient veteran status (veteran versus civilian)	-0.10	0.20	-0.18	0.06
Care recipient age group by veteran status	0.17	0.07	0.17	0.08
Participation in online caregiver support groups	-0.67	<0.001	-0.55	<0.001
Participation in in-person caregiver support groups	-0.71	0.004	-0.16	0.58

NOTE: Bolded estimates indicate those that are statistically significant ($p < 0.05$).

TABLE 4.12

Regression Models Predicting Task Social Support to Provide Care from Participation in Online and In-Person Support Groups

	Univariate Estimate		Multivariate Estimate	
	Estimate	p	Estimate	p
Male caregiver (versus female)	0.12	0.07	0.14	0.04
Caregiver age	0.01	0.10	0.01	0.047
Marital status	−0.03	0.68	−0.05	0.48
Household size	−0.02	0.59	0.02	0.72
Household income	−0.01	0.72	−0.01	0.71
Residence in a metropolitan area	0.03	0.72	0.02	0.81
Care recipient age group (over 60 versus 60 and under)	0.04	0.59	0.15	0.12
Care recipient veteran status (veteran versus civilian)	0.01	0.91	−0.08	0.42
Care recipient age group by veteran status	0.15	0.10	0.18	0.07
Participation in online caregiver support groups	−0.1	0.51	−0.26	0.12
Participation in in-person caregiver support groups	0.4	0.12	0.64	0.02

NOTE: Bolded estimates indicate those that are statistically significant ($p < 0.05$).

TABLE 4.13

Regression Models Predicting Task Social Support to Provide Respite Care from Participation in Online and In-Person Support Groups

	Univariate Estimate		Multivariate Estimate	
	Estimate	p	Estimate	p
Male caregiver (versus female)	0.04	0.55	0.04	0.51
Caregiver age	−0.01	0.23	0.00	0.44
Marital status	−0.04	0.51	−0.01	0.89
Household size	0.03	0.50	0.01	0.78
Household income	−0.03	0.27	−0.02	0.51
Residence in a metropolitan area	−0.11	0.21	−0.11	0.23
Care recipient age group (over 60 versus 60 and under)	0.002	0.97	0.11	0.24
Care recipient veteran status (veteran versus civilian)	0.20	0.01	0.12	0.17
Care recipient age group by veteran status	0.05	0.60	0.10	0.28
Participation in online caregiver support groups	0.12	0.40	−0.09	0.56
Participation in in-person caregiver support groups	0.79	0.002	0.79	0.004

NOTE: Bolded estimates indicate those that are statistically significant ($p < 0.05$).

Caregivers' Experiences in Health Care Settings

Introduction

The contributions of family members and other caregivers to achieving positive patient outcomes have been recognized by health practitioners for years. However, caregivers have nonetheless been excluded from important clinical and administrative decisions and care management discussions that could be beneficial to the care of the care recipient. This is reflected in how caregivers felt treated by the providers and health systems in which the care recipient is receiving care.

This chapter provides a comprehensive exploration of various facets that influence caregiving experiences in health care settings. Specifically, it addresses how caregivers feel about how their care recipients' providers integrate them into care decisions and care planning for the care recipient (i.e., caregiver integration into the health care team) and whether they report experiencing administrative or other hassles accessing or receiving care for the care recipient that may contribute to caregiver burden.

There is also evidence that such burdens may not be experienced uniformly. Approximately one in five adults report feeling discriminated against in health care, with 17 percent of those reporting discrimination based on race or ethnicity, the most commonly reported type of discrimination (Nong et al., 2020). Such perceptions of discrimination in health care may extend to caregivers as well. Discrimination is a psychosocial stressor that when experienced—or perceived as such—leads to a cascade of stress-related emotional, physiologic, and behavioral changes (Davis, 2020; Lewis, Cogburn, and Williams, 2015; Miller et al., 2021; Slopen, Lewis, and Williams, 2016; Williams et al., 2019). Feeling discriminated against can create stress, anxiety, and a sense of distrust, impacting the caregiver's mental health and diminishing their capacity to offer optimal care (Pascoe and Richman, 2009; Schmitt et al., 2014). Thus, this chapter also presents data on whether caregivers who report experiencing hassles perceive that such treatment is due to personal attributes, such as their race, ethnicity, age, gender, sexual orientation, body size, or even their relationship to the caregiver.

In addition, the physical environment of health care settings may affect caregivers. Caregivers who spend significant amounts of time in health care settings may feel more or less integrated if there are features of the setting that accommodate their needs, such as the food

that is available, comfortable seating options, cleanliness, and privacy. Caregivers in the 2023 RAND Caregiving Survey rated their satisfaction with these and other features, and those results are presented in this chapter as well.

Finally, health care settings are shifting back to the home as more older Americans and those with chronic conditions prefer to receive care in their homes. More and more home health care services are becoming available, but who uses these services and how they benefit caregivers is less well understood. This chapter provides information on characteristics of the caregivers and care recipients who use home health care, how often they use it, and how it benefits the caregiver.

In other report chapters, caregivers are stratified by military or civilian caregivers *and* those who provide care to people 60 and under or those who are over 60. This chapter distinguishes only between military/veteran and civilian caregivers because there was no a priori hypothesis on why the age distinction was relevant for these outcomes. However, this chapter does provide information on how the aforementioned experiences in health care differ between military/veteran caregivers providing care for a veteran who primarily uses a VA facility for their health care needs and those who do not.

Key Findings

Few caregivers feel integrated into health care teams. When asked about five aspects of integration, only approximately one-third of military/veteran or civilian caregivers felt that they were listened to or that health care providers sought their input about the care recipient.

One-third of caregivers reported experiencing hassles in health care. Most commonly, caregivers had to remind staff to do things for the care recipient or experienced delays in health care staff completing paperwork. Caregivers who experienced more hassles also reported experiencing higher levels of stress. Between a quarter to 30 percent of 18- to 44-year-old caregivers who reported experiencing hassles felt that it was because of their age, more than any other age group. Feeling discriminated against because of age was the most commonly endorsed type of discrimination among caregivers.

Caregivers tend to be satisfied with the physical characteristics of health care environments, except for available food options. Two-thirds to three-quarters of caregivers were satisfied with the comforts provided to them and their families at health care settings, but fewer than half were satisfied with the food options available.

There were slight differences in caregiver integration, experiencing hassles, and perceptions of the physical health care environment between military/veteran caregivers whose care recipients used VA facilities most commonly for their health care. There was some

evidence that a greater proportion of caregivers who were caring for someone who received most of their care at VA, compared with those who did not receive most of their care at VA, reported staff delays in completing paperwork, feeling excluded from decision regarding the care recipient's care, and difficulty interacting with care recipient's physicians. Differences in care recipients who receive care at VA—who tend to be younger, have lower household incomes, are more likely to have mental health and substance use disorders, and have higher disability ratings—may explain some of this variation.

One-third of caregivers have used home health care and appear to have benefited from it, but use of these services appears to be concentrated among certain caregivers and care recipients. Those who had accessed home health care in the past two years to help care for the care recipient reported less caregiver burden, a relationship maintained even after adjusting for characteristics of caregivers, the care recipient, and caregiving activities. However, home health care was used more by those caring for individuals needing assistance with ADLs, and spouse caregivers did not report using home health care as much as other caregivers.

Caregiver Integration into the Health Care Team

Caregivers' experiences in health care facilities impact patient outcomes, the quality of care provided, and caregivers' well-being. Caregivers offer useful insights into patients' day-to-day experiences, preferences, and needs, providing a unique perspective that complements the clinical expertise of health care providers (Davies et al., 2011; Schulz and Eden, 2016; Warner et al., 2021). This collaborative approach can lead to more-informed treatment decisions, personalized care plans, and improved adherence to medical recommendations for care recipients (Davies et al., 2011; Griffin et al., 2022; Warner et al., 2021).

Effective integration of caregivers into health care teams also facilitates better coordination of care, preventing gaps in services and ensuring that care aligns with the specific needs of care recipients. This empowerment through knowledge and skills boosts caregivers' confidence, enabling them to navigate complex medical tasks and address emotional needs with greater proficiency (Duncan et al., 2023). In essence, caregiver integration into the health system serves as a cornerstone for fostering more positive, sustainable, and fulfilling caregiving experiences.

Despite the benefits of integrating caregivers into health care teams, relationships between caregivers and health care workers can be strained and antagonistic (Levine and Zuckerman, 1999; Swan, 2012). Initiatives aimed at involving caregivers in health discussions frequently face barriers due to complex and inconsistent policies and procedures surrounding caregiver inclusion (Raj and Singer, 2021; Schulz and Eden, 2016; Griffin et al., 2022). For instance, *patients* may be given instructions for care, but those instructions may be rarely communicated to *caregivers* responsible for administering the care. This lack of communication with caregivers or the exclusion of caregivers from health care teams may lead to negative patient

outcomes, as well as poor well-being and increased burden for caregivers (Adelman et al., 2014).

Caregivers' experiences in health care settings were assessed in the 2023 RAND Caregiving Survey with a series of five questions derived from past research about caregivers' experiences communicating and interacting with health care providers (listed in Table 5.1; Stephens, Ogrocki, and Kinney, 1991). The 2023 RAND Caregiving Survey reveals significant deficits in caregivers' integration into health care teams. As presented in Table 5.1, most commonly reported were feeling listened to and being asked whether they understood the care recipient's treatment, though these were reported by only 34 to 42 percent of caregivers. Fewer caregivers spoke often to providers about care (14–20 percent) or were asked by providers if they needed assistance in managing care (22–25 percent). However, somewhat surprising was that only 25 to 34 percent of caregivers reported that communicating with providers helped with caregiving "a lot." Military/veteran and civilian caregivers reported similar levels of experiences, though civilian caregivers reported more communication with medical providers than military/veteran caregivers (20 percent versus 14 percent).

Caregiver integration into the health system not only can improve the health outcomes of patients but can also positively impact caregiver well-being. When caregivers are actively included in the health care team, they gain access to valuable information, training, and assistance, reducing feelings of isolation and uncertainty (Nickell et al., 2020). This involvement also leads to a more balanced distribution of care responsibilities, with past research indicating that such integration reduces caregiver burden and the risk of burnout (Demirbağ et al., 2018). Data from the 2023 RAND Caregiving Survey indicated no evidence of a rela-

TABLE 5.1
Past-Year Caregiver Integration into the Health Care Team

	Military/Veteran Caregivers	Civilian Caregivers
Talked often to care recipients' providers about care	14%	20% ^a
Communicating with providers helped with caregiving	25%	34%
Providers always listened to caregiver	34%	42%
Providers always sought caregiver's understanding on care recipient's health treatment	35%	40%
Providers always inquired if caregiver required assistance in managing the care recipient's health treatment	22%	25%

NOTE: For the first item, percentages indicate respondents who reported "often" to a question with response options that included "often," "sometimes," "rarely," and "never." The second through fifth items were only asked among those reported "often," "sometimes," or "rarely" to the first question. For the second item, percentages indicate respondents who reported "a lot" to a question with response options that included "a lot," "sometimes," "rarely," and "never." For the last three items, percentages indicate respondents who reported "always" to a question with response options that included "always," "usually," "sometimes," and "never." These thresholds are based on existing research using these same items (Friedman and Tong, 2020). Those who answered "never" to the first question were assigned "never" to the second through fifth items.

^a Indicates a significant difference between military and civilian caregivers.

tionship between integration with the health care team and self-reported caregiver burden (caregiver burden is described in more detail in Chapter 2).¹

Caregiving Hassles and Discrimination

At the opposite end of the spectrum from caregiver integration are caregiver hassles. These are negative experiences that caregivers may experience, ranging from communication barriers with health care professionals to systemic issues, such as delays in paperwork and feeling excluded from decisionmaking processes (Travis et al., 2007). Caregivers in the 2023 RAND Caregiving Survey were asked about seven caregiving hassles they may have experienced in the past year, presented in Table 5.2 (Stephens, Ogrocki, and Kinney, 1991).

Table 5.2 presents the proportion of military/veteran and civilian caregivers who reported a series of hassles with health care staff. Thirty-nine percent of military/veteran caregivers and 34 percent of civilian caregivers reported any of the hassles. The most common hassles caregivers experienced were reminding health care staff to do things for the care recipient and staff delays in completing paperwork, both of which were experienced by less than 20 percent

TABLE 5.2
Caregiver-Reported Hassles with Health Care Staff

	Military/Veteran Caregivers	Civilian Caregivers
Report <i>any</i> hassle	39%	34%
Staff members being rude to caregiver	14%	11%
Caregiver needing to tell the staff how to care for care recipient	13%	16%
Caregiver reminding staff to do things for care recipient	18%	16%
Staff delays in completing paperwork	17%	17%
Caregiver feeling left out of decisions made about care recipient	12%	9%
Staff complaining to caregiver about care recipient	9%	5% ^a
Staff making caregiver feel unwelcomed	11%	7% ^a
Difficulty interacting with care recipient physician	13%	9%

^a Indicates a significant difference between military and civilian caregivers (Stephens, Ogrocki, and Kinney, 1991).

¹ A scale of integration with the health care team was created by averaging values from the five items presented in Table 5.1 (possible range from 1 [high integration] to 5 [low integration]). The weighted mean across all caregivers was 2.2 (range from 1 to 4.4, SE = 0.03, alpha = 0.76). In weighted bivariate linear regression models with integration predicting caregiver burden, the coefficient estimate was 0.3 (p = 0.20). In weighted bivariate logistic regression models with integration predicting high caregiver burden (see Chapter 2), the odds ratio was 1.1 (p = 0.43).

of all caregivers (see Table 5.2). Fewer than 10 percent reported that health care staff complained to the caregiver about the care recipient. A similar proportion of military and civilian caregivers reported experiencing these hassles, except that more military/veteran caregivers reported that staff complained to caregivers about the care recipient (9 versus 5 percent) and made the caregiver feel unwelcome (11 percent versus 7 percent).

Such hassles may contribute to caregiver stress. Data from the 2023 RAND Caregiving Survey reveal a positive association between the number of hassles caregivers report experiencing and their perceived stress.²

Discrimination

Some of the hassles caregivers experience may be due to personal attributes, including caregivers' race and ethnicity, gender, or age. In some instances, caregivers who are not spouses, parents, or children may also be treated differently. Such treatment may be due to personally held beliefs among health care providers (Hall et al., 2015), systemic issues that create inequities in financing for the care available to racial/ethnic minority patients and their caregivers (Yearby, Clark, and Figueroa, 2022), or even policies that constrain the sharing of health information to non-family members or designated personnel (Schulz and Eden, 2016, Appendix H).

Caregivers who reported "yes" to any of the hassles described in Table 5.2 were asked "[D]o you think that any of the hassles you experienced were due to . . ." and provided with 13 potential factors ranging from gender and age to education level and their role as a caregiver (see Table 5.3). The most frequently endorsed reason was age: Among those reporting hassles, 20 percent of military/veteran caregivers and 16 percent of civilian caregivers reported that it was due to their age. Fifteen and 16 percent of those experiencing hassles reported that it was simply because they were a caregiver, 12 and 11 percent reported that it was due to their relationship with the care recipient, and 11 and 14 percent reported that it was due to physical attributes (e.g., height or weight).

Table 5.3 also presents the proportion of caregivers in certain groups who reported hassles due to certain types of discrimination. This helps identify who the discrimination is targeting. For example, among 18- to 44-year-old caregivers, 29 percent of military/veteran caregivers and 24 percent of civilian caregivers perceived experiencing hassles due to age discrimination, compared with 10 percent or fewer in all other age categories. This suggests that perceived age discrimination is felt most prominently among *younger* caregivers. Sixteen percent of non-family members reporting hassles said that it was due to their relationship with the care recipient. There are two noteworthy differences between military/veteran and civilian caregivers: Among those caregivers who did not identify as heterosexual, 20 percent of military/veteran caregivers (versus 5 percent of civilian caregivers) experiencing hassles

² The caregiver hassles listed in Table 5.2 were summed to create a total number of hassles that could range from 0 to 8. The weighted mean across all caregivers was 0.9 (SE = 0.05). In weighted bivariate linear regression models with total number of hassles predicting perceived stress, the coefficient estimate was 0.4 ($p = 0.05$). In weighted bivariate logistic regression models with total hassles predicting high perceived stress (see Chapter 2), the odds ratio was 1.2 ($p < 0.001$).

TABLE 5.3

Caregiver Perceptions of Discrimination by Health Care Providers

	Among Caregivers Who Reported Experiencing Any Hassles	
	Military/Veteran Caregivers	Civilian Caregivers
My age	20%	16%
Among 18- to 44-year-olds	29%	24%
Among 45- to 59-year-olds	7%	5%
Among 60+-year-olds	10%	8%
My role as a caregiver	15%	16%
My gender	9%	8%
Among women	6%	11%
Among men	11%	6%
My relationship to the care recipient	12%	11%
Among siblings and extended family	11%	15%
Among non-family	16%	17%
Physical attributes	11%	14%
My education or income level	6%	7%
Among those with less than a college degree	9%	9%
My religion	6%	2%
My sexual orientation	3%	3%
Among non-heterosexual respondents	20%	5%
My ancestry or national origin	5%	3%
My racial/ethnic background	3%	10%
Among non-White respondents	6%	19%
Something else about me	4%	6%
Other	49%	56%

NOTE: Differences between military and civilian caregivers were not tested. The unweighted sample sizes for the columns are military/veteran caregivers = 187 and civilian caregivers = 417.

attributed it to their sexual orientation. Among those who identified as non-White, 6 percent of military/veteran caregivers (versus 19 percent of civilian caregivers) who experienced hassles attributed it to their race/ethnicity.

Caregiver-Friendly Health Care Facility Physical Environment

Caregiver satisfaction with the health care facility's physical environment can help ensure the well-being of both caregivers and care recipients (Kaelin and Okland, 2018). The layout and features of an environment affect the support and opportunities it offers to individuals (Bosch and Lorusso, 2019). This, in turn, affects individuals' level of engagement in care and experience of care, ultimately leading to positive or negative health care experiences and health outcomes (Bosch and Lorusso, 2019).³ Thus, a conducive and comfortable physical environment can significantly enhance the caregiving experience (Bosch and Lorusso, 2019; Frampton, 2012; Frampton et al., 2017). It provides a supportive backdrop for caregiving activities, reducing stress and fatigue for caregivers (Bosch and Lorusso, 2019; Ulrich, 1991). A well-designed and accessible facility can facilitate ease of movement and ADLs for care recipients, promoting their comfort and overall sense of well-being (Frampton, 2012; Frampton et al., 2017; Ulrich, 1991). Additionally, a satisfactory physical environment can contribute to a positive perception of the quality of care provided, instilling confidence and trust in the health care system (Frampton et al., 2017; Kaelin and Okland, 2018).

Data from the 2023 RAND Caregiving Survey reveal that two-thirds to three-quarters of all caregivers were satisfied with comfortable seating options, cleanliness of health care facilities, and cell phone service and internet access (Table 5.4). Fewer, though still more than half, were satisfied with spaces to have private conversations with health care teams. Fewer than half (41–45 percent) were satisfied with the food options available. Among those with a child under 10, 77 to 78 percent were satisfied with the availability of child-friendly spaces, a proportion that was even higher (73 to 93 percent) among those with children between ages 10 and 18.⁴

Military and civilian caregivers were similarly satisfied across most dimensions, with the exception of child-friendly spaces: More civilian caregivers reported satisfaction with child-friendly spaces compared with military/veteran caregivers (72 versus 67 percent).

³ This is based on a theoretical model of health care design developed by R. S. Ulrich (1991).

⁴ Having a child was defined as answering “yes” to the question “How many children under the age of 18, including step-children and/or foster children, do you have who live with you at least half of the time?” More information on children in caregiving households is presented in Chapter 6.

TABLE 5.4

Caregiver Satisfaction with Physical Aspects of Health Care Facility

	Military/Veteran Caregivers	Civilian Caregivers
Comfortable seating options	67%	75%
Cleanliness of the facility	73%	78%
Cell phone service and internet access/Wi-Fi availability	64%	67%
Available food options	45%	41%
Spaces for private conversation with health care team	62%	64%
Child-friendly spaces (of those who reported children under 18 years old in the home)	67%	72% ^a
Those with children 10 years and under	77%	78%
Those with children over 10 years	93%	73%

NOTE: Participants were asked to rank their satisfaction on a four-point Likert-scale of “very satisfied” to “very dissatisfied.” The results presented show aggregate results for those who selected “satisfied” and “very satisfied” with their health care facility physical environment.

^a Indicates a significant difference between military and civilian caregivers.

Caregivers' Experiences Within VA

The data from the 2023 RAND Caregiving Survey reveal that 35 percent of military/veteran caregivers are caring for someone who receives most of their care from VA.⁵ Table 5.5 describes characteristics of these veteran care recipients relative to those care recipients receiving most of their care outside of VA. There are differences between the groups worth noting, many of which align with VA eligibility requirements.

- **Care recipient age:** A greater proportion of those veterans receiving care outside of VA are older (e.g., 49 percent are over age 75 versus 25 percent of those receiving care at VA).
- **Care recipient household income:** A greater proportion of veterans receiving care outside of VA have household incomes of \$100,000 or more (21 percent versus 8 percent).
- **Era of service:** A greater proportion of veterans receiving care within VA served after September 11, 2001 (21 versus 7 percent).
- **Care recipient conditions:** Certain conditions are more prevalent among veterans receiving care within VA, particularly mental health or substance use disorders (57 versus 32 percent).

⁵ The question specifically asked, “Is the facility where [care recipient] gets most of [his/her/their] health care part of the U.S. Department of Veterans Affairs health system?”

TABLE 5.5**Demographics of Military/Veteran Care Recipient by VA/Non-VA Facility**

	Military/Veteran Care Recipients Who Get Most Care at VA	Military/Veteran Care Recipients Who Get Most Care Outside of VA
Gender		
Male	81%	75%
Female	12%	15%
Other	7%	10%
Age ^a		
18–30	5%	5%
31–50	21%	7%
51–60	11%	6%
61–75	38%	32%
76–85	18%	30%
86+	7%	19%
Household income ^a		
Less than \$30,000	53%	33%
\$30,000 to under \$60,000	26%	29%
\$60,000 to under \$100,000	14%	18%
\$100,000 or more	8%	21%
Era of service ^a		
Pre-9/11	79%	93%
Post-9/11	21%	7%
Caregiving assistance needed		
At least one ADL	59%	52%
Cognitive/emotional	25%	27%
Administering medications, administrative support, and/or housework	16%	22%
VA disability rating ^a		
10 or 20%	11%	19%
30 or 40%	33%	29%

Table 5.5—Continued

	Military/Veteran Care Recipients Who Get Most Care at VA	Military/Veteran Care Recipients Who Get Most Care Outside of VA
50 or 60%	7%	19%
70% or greater	40%	18%
Unknown	9%	15%
Deployed to a war zone ^a	63%	25%
Care recipient conditions		
Chronic condition	83%	82%
Vision/hearing problems	61%	62%
Neurological	28%	34%
TBI	21%	10%
Musculoskeletal	49%	46%
Infection	11%	21%
Substance use disorder or mental health condition ^a	57%	32%
Other ^a	21%	36%
Any condition attributed to military service ^a	76%	41%
Any condition attributed to toxic exposure ("definitely" versus all other response options) ^a	24%	6%

NOTE: In the 2023 RAND Caregiving Survey, caregivers were asked: "Is the facility where [care recipient] gets most of [his/her/their] health care part of the U.S. Department of Veterans Affairs health system?" The unweighted sample sizes for the groups are military/veteran care recipients who get most care at VA = 165 and military/veteran care recipients who get most care outside of VA = 348.

^a Denotes a statistically significant difference between groups.

- **Military service and toxic exposures:** 76 percent of caregivers to veterans receiving care within VA attributed at least one care recipient condition to military service, and 24 percent attributed a condition to toxic exposures. In comparison, of those receiving most care outside of VA, 41 percent attributed at least one condition to military service and 6 percent to toxic exposure.
- **Service-connected disability rating:** As expected, more care recipients without disability ratings were receiving most of their care outside VA, whereas more care recipients with disability ratings of 70 percent or higher were receiving most of their care at VA.

These differences between the types of patients receiving care at VA and outside of VA are important to keep in mind when comparing how caregivers report their integration with the caregiving team, aspects of the physical environment, and caregiver hassles and perceptions

of discrimination. Another important limitation is that the survey question used to identify VA care recipients from non-VA care recipients and the questions about integration, physical aspects, and caregiver hassles lack precision. It is impossible to specify whether responses to these latter questions reflect *only* VA or *only* non-VA facilities.

Caregiver Integration in the Health Care Team

More caregivers whose care recipient received most of their care outside of VA than those who received most of their care inside of VA reported that providers always listened to caregivers (34 versus 18 percent; $p < 0.05$). None of the other five measures of caregiving integration were different between the groups (see Table 5.6).

Caregiver Hassles and Discrimination

For most of the types of hassles assessed in the 2023 RAND Caregiving Survey, a similar proportion of military/veteran caregivers caring for someone who received most care in VA and those caring for someone receiving most care outside of VA reported hassles. In three instances, more caregivers caring for someone in VA reported hassles: with respect to staff delays in completing paperwork (22 versus 14 percent), feeling excluded from decisions regarding the care recipient's care (20 versus 7 percent), and difficulty interacting with the care recipient's physicians (23 versus 8 percent; see Table 5.7).

TABLE 5.6

Past-Year Caregiver Integration into the Health Care Team, by VA and Non-VA Facilities

	Military/Veteran Caregivers Who Are Caring for Someone Who Gets Most Care at VA	Military/Veteran Caregivers Who Are Caring for Someone Who Gets Most Care Outside of VA
Talked often to care recipients' providers about care	15%	17%
Communicating with providers always helped with caregiving	22%	21%
Providers always listened to caregiver	18%	34% ^a
Providers always sought caregiver's understanding on care recipient's health treatment	25%	29%
Providers always inquired if caregiver required assistance in managing the care recipient's health treatment	19%	15%

NOTE: See Table 5.1 for thresholds applied to each item.

^a Denotes a statistically significant difference between groups.

TABLE 5.7

Caregiver-Reported Hassles with Health Care Staff, by VA and Non-VA Facilities

	Military/Veteran Caregivers Who Are Caring for Someone Who Gets Most Care at VA	Military/Veteran Caregivers Who Are Caring for Someone Who Gets Most Care Outside of VA
Staff members being rude to caregiver	15%	16%
Caregiver needing to tell the staff how to care for care recipient	17%	12%
Caregiver reminding staff to do things for care recipient	20%	18%
Staff delays in completing paperwork	22%	14%
Caregiver feeling left out of decisions made about care recipient	20%	7% ^a
Staff complaining to caregiver about care recipient	13%	8%
Staff making caregiver feel unwelcomed	10%	12%
Difficulty interacting with care recipient physician	23%	8% ^a

^a Denotes a statistically significant difference between groups.

Caregiver-Friendly Health Care Physical Environments

There was no statistically significant difference in the reported satisfaction with the health care facility between military/veteran caregivers providing care to an individual who received most care within the VA system and those who were caring for someone who received most care outside of VA.

Use of Home Health Care Services

The nation is experiencing a dramatic shift in demographics, with people older than 65 about to outnumber those younger than 18 for the first time in U.S. history (U.S. Census Bureau, 2022a). In addition, as adults age, they want to stay in place and receive care at home rather than institutional settings (Davis, 2022; Landers et al., 2016). Home health care attempts to fill this growing need and may play a role in the overall well-being and quality of life of individuals who require medical assistance or assistance with daily activities in their own homes. Home health care is usually less expensive, more convenient, and just as effective as care provided in health care facilities (Fikar and Hirsch, 2017). And while home health care may ease some caregiving burdens, it may be accompanied by additional burdens for caregivers associated with coordinating home health care aides, overseeing the quality of care that they provide, and navigating financing options for that care (Tumlinson, 2022).

Home health care is generally financed through Medicaid or state- or locally run programs, or families pay for it out of pocket (Harrison, 2023). VA provides a range of home

health care options, depending on veterans' needs and eligibility (Harrison, 2023); recently introduced legislation, including the Elizabeth Dole Home Care Act, would expand these services.

The 2023 RAND Caregiving Survey asked caregivers, "[I]n the last two years, did any medically-trained person come to your/[the care recipient]'s home to help [the care recipient]?" Fifty-three percent of military/veteran caregivers have used home health care assistance in the past two years, relative to 39 percent of civilian caregivers ($p < 0.006$). Among those who had used home health care, between 40 and 50 percent had the home health care aide visit the care recipient weekly or a few times a month; only 11 to 15 percent had the home health care aide come daily. Characteristics of military/veteran caregivers who used home health care (versus those who did not in the past two years) are presented in Table 5.8; characteristics of their care recipients are presented in Table 5.9.

In general, caregivers who used and did not use home health care looked similar, with two exceptions. First, men and women were equally represented among caregivers who used home health care, though women were overrepresented among caregivers who did not use home health care. Second, spouse caregivers were underrepresented among those who used home health care relative to those who did not; on the other hand, non-relatives and other relatives were overrepresented among caregivers who used home health care (Table 5.8). There were few differences in care recipient characteristics, except that 67 percent of care recipients accessing home health care needed assistance with at least one ADL, relative to 38 percent of those not using home health care (Table 5.9).

Though care recipients may prefer to receive care from home, there may be unintended consequences that place additional burdens on caregivers. Regression modeling was used to estimate the extent to which receiving home health care may be related to caregiver burden. Full results are presented in Table 5.10 at the end of this chapter. Caregivers whose care recipient used home health care have *reduced* odds of excessive caregiver burden. This relationship remained significant even after controlling for characteristics associated with caregivers, the care recipient, and caregiving activities.

TABLE 5.8

Caregiver Characteristics of Those Using Home Health Care, Military/Veteran Caregivers

	Military/Veteran Caregivers Who Used Home Health Care	Military/Veteran Care Recipients Who Did Not Use Home Health Care
Gender ^a		
Male	52%	33%
Female	48%	67%
Age		
18–29	21%	14%
30–44	34%	24%
45–59	20%	25%
60+	25%	37%
Household income		
Less than \$30,000	29%	28%
\$30,000 to under \$60,000	26%	28%
\$60,000 to under \$100,000	24%	27%
\$100,000 or more	22%	18%
Caregiver is care recipient's ^a		
Child	34%	33%
Spouse	13%	35%
Non-relative	28%	19%
Parent	1%	3%
Other relative	23%	10%
Caregiver lives with care recipient	38%	46%
Metro	85%	84%

NOTE: The unweighted sample sizes for the groups were military/veteran caregivers who used home health care = 241 and military/veteran caregivers who did not use home health care = 271.

^a Denotes a statistically significant difference between groups.

TABLE 5.9**Care Recipient Characteristics of Those Using Home Health Care, Military/Veteran Care Recipients**

	Military/Veteran Care Recipients Who Used Home Health Care	Military/Veteran Care Recipients Who Did Not Use Home Health Care
Age		
60 or under	25%	26%
Over 60	75%	74%
VA disability rating		
No rating	59%	57%
10 or 20%	7%	2%
30 or 40%	14%	12%
50 or 60%	6%	4%
70% or higher	10%	14%
Don't know	5%	12%
Receives most care at VA	36%	34%
Caregiving assistance needed ^a		
Help with at least one ADL	67%	38%
Help with emotional/cognitive tasks	17%	36%
Help administering medications, housework, or administrative support	15%	26%
Care recipient conditions		
Chronic condition	89%	68%
Vision/hearing problems	62%	57%
Neurological	43%	21%
TBI	18%	12%
Musculoskeletal	44%	41%
Infection	21%	7%
Substance use disorder or mental health condition	47%	38%
Other	30%	24%

^a Denotes a statistically significant difference between groups.

Chapter 5 Supplemental Table

TABLE 5.10
Correlates of Caregiver Burden by Home Health Care Utilization Among Caregivers, With and Without Adjustment

	Univariate		Multivariate	
	Odds Ratio	p-value	Odds Ratio	p-value
Home health care	0.72	0.002	0.77	0.04
Female	1.10	0.40	1.03	0.83
Civilian caregiver (ref)			Ref	Ref
Military/veteran caregiver	1.00	0.99	0.67	0.008
Care recipient 60 or under (ref)			Ref	Ref
Care recipient 60+	1.30	0.02	1.29	0.08
Time spent caregiving	1.01	0.10	0.99	0.42
Caregiving activities				
Help with at least one ADL (ref)			Ref	Ref
Help with emotional/cognitive tasks	0.84	0.13	1.02	0.88
Help administering medications, housework, or administrative support	0.23	<0.001	0.48	<0.001
Care recipient conditions				
Chronic condition	1.91	<0.001	1.71	<0.001
Vision/hearing	1.44	<0.001	1.32	0.02
Neurological	1.83	<0.001	1.32	0.02
TBI	2.14	<0.001	1.68	<0.001
Musculoskeletal	1.27	0.03	0.95	0.79
Infection	1.48	0.02	0.98	0.90
Substance use disorder or mental health condition	2.13	<0.001	2.08	<0.001
Other	1.33	<0.001	1.78	<0.001
Caregiver is the care recipient's:				
Parent (ref)			Ref	Ref
Child or grandchild	0.71	0.22	0.67	0.18
Spouse	1.15	0.36	1.21	0.32
Neighbor/friend/other non-relative	0.45	<0.001	0.46	<0.001

Table 5.10—Continued

	Univariate		Multivariate	
	Odds Ratio	p-value	Odds Ratio	p-value
Other relative	0.88	0.45	0.56	0.001
Caregiver lives with care recipient	0.59	<0.001	0.76	0.06

NOTE: Bolded estimates indicate those that are statistically significant ($p < 0.05$).

Military/Veteran Caregivers' Families

Being a caregiver affects not only the person performing caring duties but also their family—and family members will often assist with caregiving directly by assuming some caregiving duties or indirectly by assuming additional household duties in support of the caregiver. This chapter provides an overview of how caregivers' family life may be affected by caregiving, as well as how family members, particularly children in caregiving households, are faring.

First, the chapter examines *sandwich caregivers*: caregivers who are caring for someone 18 or over but also have a child under 18 in the household. Estimates are provided for both military/veteran and civilian caregivers.

The chapter then turns to focusing on children in caregiving households. The chapter examines three aspects related to this group: participation in household and caregiving tasks, participation in school and social activities, and unmet child needs for services. Details on the well-being and mental health care utilization of children who assume caregiving duties (i.e., "child caregivers") are presented in Chapter 2.

Lastly, the chapter compares military and civilian caregiving households, relative to non-caregiving households, on two metrics of well-being: household conflict and household cohesion. Similar comparisons are then conducted examining caregivers' relationship quality with their spouse/romantic partner as well as the quality of their relationship with the care recipient.

Key Findings

Around 40 percent of military/veteran caregivers are also caring for a child under age 18 (sandwich caregivers), and civilian caregivers were equally likely to be sandwich caregivers.

About 40 percent of children in military/veteran caregiver households helped with one or more caregiving tasks, compared with about a quarter of children in civilian caregiver households. The most common caregiving tasks, reported by around a fifth of children in military/veteran caregiving households, were assisting with the administration of medicine, pills, or shots; helping the care recipient to talk with doctors or nurses; and providing transportation for the care recipient.

Caregiving children might take on more adult or parental roles in the household. In age- and demographic-adjusted models, children of military/veteran caregivers were more likely to engage in such household tasks as doing the household grocery shopping and cooking meals for the household than children of non-caregivers. Child caregivers were equally likely to engage in leisure activities, such as organized afterschool activities and playing or hanging out with friends. However, military/veteran and civilian child caregivers were also more likely to take care of their brothers and sisters than non-caregiver children.

Compared with non-caregivers, military/veteran caregivers to those 60 and under experience lower intimate partner relationship quality, higher family conflict, and lower family cohesion. Compared with non-caregivers, military and civilian caregivers had lower levels of intimate partner relationship quality when their care recipient was also their spouse or partner, but military/veteran caregivers to those under age 60 also experienced lower relationship quality with their non-care-recipient spouse or partner. Relative to non-caregivers, caregivers experienced higher family conflict, with military/veteran caregivers to those over 60 having higher levels of family conflict than other groups; military/veteran caregivers to those 60 and under have lower family cohesion than all other groups.

Sandwich Caregivers

Sandwich caregivers in previous studies are individuals providing care to an aging parent while also raising a child. These caregivers often face demands to balance their time between working, raising a family, and caregiving, and they experience high levels of financial and emotional strain (NAC, 2019).

Sandwich caregivers are defined in the 2023 RAND Caregiving Survey as anyone who qualifies as a caregiver for the study (defined in Chapter 1) who also has a child under 18 in their household. In other words, they were not required to be caring for a parent. Similar proportions of military/veteran caregivers (27 percent) and civilian caregivers (32 percent) are sandwich caregivers, and these proportions do not significantly differ between military/veteran or civilian caregivers of those 60 and under or over 60.

Though the strains that accompany being a sandwich caregiver may be significant, the survey results revealed no evidence that the proportion meeting criteria for probable depression was different between military/veteran caregivers who were sandwich caregivers and those who were not, nor was there evidence of a difference between civilian sandwich caregivers and those who were not. There was also no evidence of a difference between military/veteran sandwich caregivers and civilian sandwich caregivers. Similar patterns (i.e., no evidence of differences) were also found for perceived stress and loneliness (these outcomes are discussed in more detail in Chapter 2).

Children in Caregiving Households

The well-being of child caregivers has been a growing concern among advocacy groups and policymakers. A landmark study by Mathematica and the Elizabeth Dole Foundation estimated that there were about 2.3 million children living in households with a veteran who has a disability (Malick et al., 2021). The study included interviews with children providing care to wounded, ill, or injured service members and veterans. They found that children in caregiving households experience social isolation and need additional support to cope with the demands of caregiving (Malick et al., 2021). Other research suggests that children in caregiving households experience greater risk for negative mental health outcomes (Briggs et al., 2020) and behavioral problems (Glenn et al., 2002), especially among young children (DeVoe et al., 2018).

Identifying and Assessing Child Caregiver Households

The 2023 RAND Caregiving Survey explored two aspects of caregiver households with children. First, it asked caregivers about the characteristics of children in their households who perform caregiving tasks and the health and well-being of these child caregivers. The survey asks similar questions to caregivers about children living in the caregiver's household but not performing caregiving tasks. To assess the impact of caregiving on children, this section compares these groups with children in non-caregiver households.

In the survey, respondents reported how many children under the age of 18 lived with them at least half of the time. If any children lived with the respondent, the survey asked respondents to indicate whether any of their children performed a series of household tasks (e.g., doing laundry for the household; see Table 6.1) and caregiving tasks (e.g., helping the care recipient take medicine, pills, or shots, which was asked only among caregivers with children; see Table 6.2). If caregivers reported that any child performed one or more caregiving tasks, that child was counted as a child caregiver.¹ Note that, because the study did not specifically sample caregiving households with children, the results are not meant to be representative of all child caregivers in the United States. Instead, the results are suggestive of the issues facing children in military/veteran and civilian caregiver households.

Household Tasks

There has been growing concern among developmental psychologists and child advocates about the role of children conducting household tasks or providing care that is more appropriate for adults (East, 2010; Aldridge, 2008). Research on this “adultification” or “parentifica-

¹ If respondents had more than one child, follow-up questions identified which child spent the most time performing caregiving tasks and identified that child as the child caregiver. For non-caregiver and caregiver households where respondents indicated that their children did not perform caregiving tasks, respondents were randomly asked to select their oldest or youngest child to be the subject of additional questions.

tion” of child caregivers has yielded mixed results, with some research finding that children gain a sense of competency, empathy, and self-worth from performing more adult household tasks or providing care, and other studies finding that increased amounts of time performing adult tasks is associated with poor outcomes, such as academic difficulties and behavioral problems (East, 2010; D’Amen, Socci, and Santini, 2021).

The 2023 RAND Caregiving Survey asked respondents with children about three common household tasks (Bauman et al., 2006; Naiditch, Levine, and Hunt, 2005). As shown in Table 6.1, the most common task is doing laundry, performed by 34 to 40 percent of children in caregiving households, followed by cooking meals (20–32 percent) and grocery shopping (11–24 percent). Because performing household tasks is related to child age, with older children more likely to perform such household tasks as laundry, cooking, and grocery shopping, regression models were estimated to determine whether these differences were maintained when accounting for differences in the ages of children in the household, household income, and whether the caregiving parent lives with the care recipient.² Compared with children of non-caregivers, children of military/veteran caregivers were more likely to do the grocery shopping and cook meals for the household. Children of military and civilian caregivers did not significantly differ on these tasks.

Caregiving Tasks

As with adult caregivers, child caregivers were identified as children of caregivers who perform specific caregiving tasks for the care recipient. Caregiving tasks included on the survey were adapted from earlier research (Bauman et al., 2006; Naiditch, Levine, and Hunt, 2005). As shown in Table 6.2, approximately one-fifth of children in military/veteran caregiving households help administer medications, talk to the care recipients’ doctors and nurses, and provide transportation for the care recipient. Although these percentages are notably lower

TABLE 6.1
Household Tasks by Any Child in the Household

	Non-Caregiver Household	Military/Veteran Caregiver Household	Civilian Caregiver Household
Doing laundry for the household	36%	40% ^b	34%
Doing the grocery shopping for the household	8%	24% ^{a,b}	11%
Cooking meals for the household	19%	32% ^{a,b}	20%

NOTE: There was no evidence of differences between children of military/veteran and civilian caregivers. The unweighted N for the groups are non-caregivers = 299, military/veteran caregivers = 102, and civilian caregivers = 363.

^a Denotes a statistically significant difference from children of non-caregivers.

^b Denotes a statistically significant difference from children of non-caregivers in weighted linear regression models after controlling for ages of children in the household, household income, and whether the caregiving parent lives with the care recipient.

² These comparisons were conducted using weighted logistic regression models.

TABLE 6.2

Child Caregiving Tasks (Percentage Among Caregiver Households with Children)

	Military/Veteran Caregiver Household	Civilian Caregiver Household
Helping the care recipient take medicine, pills, or shots	21%	11%
Helping the care recipient to talk with doctors or nurses	21%	8%
Calling or arranging for someone else to come in and help the care recipient	14%	8%
Providing transportation for the care recipient	21%	7%
Helping with other care tasks for the care recipient	27%	22%
Help with at least one caregiving task above	39%	27%

NOTE: There was no evidence that differences between military/veteran and civilian caregivers were statistically significant in unadjusted or adjusted models (see footnote 36 for a list of covariates in the adjusted model). The unweighted N for the groups are military/veteran caregivers = 102 and civilian caregivers = 363.

in civilian caregiving households, there was no evidence that these differences were statistically significant.³

Among military/veteran caregivers with children, almost 40 percent indicated that at least one of their children helped with one or more caregiving tasks (unweighted $n = 26$) compared with 27 percent of civilian caregivers with children (unweighted $n = 101$). Most caregivers with caregiving children reported that one child helped with caregiving tasks (83 percent of military/veteran caregivers and 57 percent of civilian caregivers), and 25 percent reported that two children helped with caregiving tasks.

Child Participation in School and Social Activities

Providing care can take time and attention away from other childhood activities, such as participating in leisure activities and engaging with friends, which are important factors in building child caregiver social adjustment and resilience (Gilligan, 2000; Gough and Gulliford, 2020; Thomas et al., 2003). In addition, prior studies found that child caregivers often have child care responsibilities for siblings (Naiditch, Levine, and Hunt, 2005), which is one aspect of the parentification of child caregivers (Bauman et al., 2006). The 2023 RAND Caregiving Survey asked parents about the activities their child caregiver participated in, using items

³ Weighted logistic regressions comparing likelihood of task performance between military and civilian child caregivers controlling for the child's age, number of children in different age groups in the household, household income, and whether the child lives with the care recipient also found no evidence of statistically significant differences between military/veteran and civilian caregiving households.

from a previous survey of child caregivers (Naiditch, Levine, and Hunt, 2005). The questions assessed how often the child performed each activity “in a normal week” using the following response options: “Never,” “Rarely,” “Sometimes,” “Often,” or “Very often” (Table 6.3).

Across outcomes, military/veteran child caregivers on average *sometimes* participate in organized afterschool or weekend activities, *often* play or hang out with friends, *sometimes* engage in hobbies or interests alone, and *rarely* take care of brothers or sisters (Table 6.3). Controlling for the child’s age, ages of other children in the household, household income, and whether the caregiving parent lives with the care recipient, military/veteran and civilian child caregivers take care of their brothers and sisters more often than non-caregiver children, whereas other activities were comparable between caregiving children and children in non-caregiving households.

Unmet Need for Child Services Among Child Caregivers

Survey respondents were provided with a list of services and asked to indicate which services their caregiver child needed but was not currently receiving. These questions were *only* asked for children who reported conducting caregiving tasks. As shown in Table 6.4, just *over* half of civilian caregivers and about a third of military/veteran caregivers indicated that their caregiving child did not need any services they were not already receiving, and just *under* half of civilian caregivers and almost three-quarters of military/veteran caregivers indicated that their child needed services they were not receiving. The services most frequently cited as an unmet need for military/veteran child caregivers were mentorship (28 percent), summer activities (21 percent), and assistance paying for meals during school (11 percent). The services most frequently cited as an unmet need for civilian child caregivers were counseling or mental health care (14 percent) and help with academics (10 percent).

TABLE 6.3
Child Time Spent on Other Activities (on Five-Point Scale)

	Non-Caregiver Children	Military/Veteran Child Caregivers	Civilian Child Caregivers
Participate in organized afterschool or weekend activities, such as sports teams, clubs, scouts, or lessons for things like music, art, or dance	2.6	2.7	2.9
Play or hang out with friends	3.1	3.8 ^a	3.2
Engage in hobbies or interests by him/herself	3.3	3.0	3.5
Take care of brothers or sisters	1.8	2.9 ^{a,b}	2.4 ^{a,b}

NOTE: Response options are 1 = Never, 2 = Rarely, 3 = Sometimes, 4 = Often, 5 = Very often. The unweighted N for the groups are non-caregivers = 299, military/veteran caregivers = 25, and civilian caregivers = 100.

^a Denotes a statistically significant difference from children of non-caregivers.

^b Denotes a statistically significant difference from children of non-caregivers in weighted linear regression models after controlling for the child’s age, ages of children in the household, household income, and whether the caregiving parent lives with the care recipient.

TABLE 6.4
Percentage of Child Caregivers with Unmet Needs by Service Needed

Service Needed	Military/Veteran Child Caregivers	Civilian Child Caregivers
Physical health care	4%	5%
Counseling or mental health care to help with managing behaviors or mental health	9%	14%
Summer activities, such as camps	21%	7%
Mentorship, such as guidance from an adult relative or family friend	28%	5%
Help with academics, such as tutoring	4%	10%
Peer support from other kids who are caregivers, such as an online network of child caregivers	5%	4%
Access to afterschool or child care activities	9%	1%
Assistance with paying for meals during school	11%	2%
Assistance with meals on the weekends	0%	2%
Other	0%	0%
No services needed	30%	57%

NOTE: The unweighted N are military/veteran caregivers = 25 and civilian caregivers = 100. Respondents could check all that apply, so percentages do not add to 100.

Household Relationships

Household Conflict and Cohesion

Caregiving can add stress to households, creating conflicts within them and altering existing relationships. Many of those providing care to a family member with a TBI experience high and prolonged levels of stress that can negatively impact family relationship functioning (Hanks, Rapport, and Vangel, 2007; Malec et al., 2017). Caregiver family functioning has been found to partially account for the negative impact of caregiving burden on caregiver distress, with better-functioning families more able to endure caregiving burden (Mitrani et al., 2006).⁴

Household conflict. All respondents of the RAND 2023 survey were provided with three items potentially describing their family and then selected between three options: “describes

⁴ Chapter 2 discusses in more detail the relationship between caregiver burden and distress.

my family well,” “describes my family somewhat,” and “does not describe my family at all.”⁵ When combined, the scale ranges from 3 (low conflict) to 9 (high conflict). These statements were as follows:

- Family members often put each other down.
- We fight a lot in our family.
- Family members sometimes get so angry they throw things.

Data from the 2023 RAND Caregiving Survey reveal that most American households have low levels of conflict, with mean values between 3 and 5. However, caregiver households experienced higher levels of conflict compared with non-caregiver households (means: military/veteran caregivers = 4.2, civilian caregivers = 4.1, non-caregivers = 3.7). Furthermore, military/veteran caregivers to those 60 and under have statistically significantly greater levels of household conflict than all other groups (mean = 4.9; see Table 6.5). After accounting for household differences with respect to caregiver gender, age, marital status, presence of a child under age 18 in the household, household size, income, and residence in a metropolitan area, caregivers to service members/veterans 60 and under still experienced significantly higher levels of conflict than all other groups.

Household cohesion. Household cohesion was measured similarly to household conflict, in which respondents selected from the same three response options for three additional items. Again, the scale ranges from 3 (low cohesion) to 9 (high cohesion). The items were as follows:

- There is a feeling of togetherness in our family.
- Family members really help and support one another.
- We really get along well with each other.⁶

TABLE 6.5
Household Conflict and Cohesion

	Non-Caregivers	Caregivers to Those 60 and Under		Caregivers to Those over 60	
		Military/Veteran Caregivers	Civilian Caregivers	Military/Veteran Caregivers	Civilian Caregivers
Household conflict	3.7	4.9 ^{a,b}	4.3 ^{a,b}	4.0	3.9 ^{a,b}
Household cohesion	7.7	6.3 ^{a,b}	7.3	7.4	7.3 ^{a,b}

NOTE: The scale ranges from 3 (low conflict/low cohesion) to 9 (high conflict/high cohesion).

^a Denotes a statistically significant difference from non-caregivers.

^b Denotes a statistically significant difference from non-caregivers in weighted linear regression models after controlling for caregiver gender, age, marital status, presence of a child under age 18 in the household, household size, income, and residence in a metropolitan area.

⁵ These items were adapted from the Family Environment Scale (Moos, 1994).

⁶ These items were adapted from the Family Environment Scale (Moos, 1994).

Results indicate that household cohesion is high among most American households (means = 6.3 to 7.7). However, there is again evidence that cohesion is lower in households with military/veteran caregivers (mean = 7.2) and civilian caregivers (mean = 7.3) compared with non-caregiver households (mean = 7.7). In addition, military/veteran caregivers caring for someone 60 or under and civilian caregivers to those over 60 had statistically significantly lower levels of household cohesion compared with non-caregivers (see Table 6.5). Regression results accounting for household differences with respect to caregiver gender, age, marital status, presence of a child under age 18 in the household, household size, income, and residence in a metropolitan area yielded the same results and indicated that military/veteran caregiving households providing care to someone 60 and under experienced significantly lower levels of household cohesiveness compared with all other groups.

Relationship Quality

Providing care can also negatively impact relationship quality: between the caregiver and care recipient and, if the care recipient is not a spouse or significant other, between a caregiver and their spouse or significant other. For example, military couples in which the service member experiences more symptoms of combat-related PTSD reported lower relationship quality (Karney and Trail, 2017). Research has also identified positive aspects of caring for a wounded, ill, or injured veteran for intimate relationships (Thandi et al., 2018), and perceiving the benefits of the relationship with one's care recipient is associated with greater relationship quality (Winter and Moriarty, 2017).⁷ A few studies have found that 30 to 50 percent of those caring for partners who have a TBI dissolve the relationship within eight to ten years of the injury (Verhaeghe, Defloor, and Grypdonck, 2005). The RAND 2014 study of military and veteran caregivers study found that, compared with pre-9/11 and civilian caregivers, post-9/11 caregivers caring for a spouse or partner experienced lower relationship quality (Ramchand et al., 2014).

The 2023 RAND Caregiving Survey asked about the quality of *two* of caregivers' relationships: with their spouse or significant other and with the care recipient. Those with a spouse or significant other, regardless of whether they were the care recipient, were asked: "Taking things altogether, how satisfied are you with your relationship with your spouse or partner right now?" Responses ranged from "very satisfied" (1) to "very dissatisfied" (5). Those not caring for a spouse or significant other were asked a separate question: "Taking everything into consideration, how close do you feel in the relationship between you and [the care recipient]?" Response options ranged from "not at all close" (1) to "extremely close" (5).

Relationship quality with intimate partners was significantly lower among most military/veteran and civilian caregivers caring for a spouse compared with non-caregivers (means of 4.1, 3.9, and 4.3, respectively). This difference held in regression analyses controlling for care-

⁷ More about the benefits of caregiving is provided in Chapter 2.

giver gender, age, marital status, presence of a child under age 18 in the household, household size, income, and residence in a metropolitan area.

Providing care to a friend or relative can potentially impact caregivers' relationships with their spouse or partner as well. For example, providing care to an aging parent can take time and attention away from one's spouse or partner, which may negatively impact the quality of that relationship. Caregivers caring for someone 60 or under who was not a spouse reported lower relationship quality with their intimate partners than non-caregivers (means of 4.0 and 4.3, respectively), a difference that persisted for military/veteran caregivers (mean of 3.2) even after controlling for differences between groups.

Finally, among caregivers not caring for a spouse or intimate partner, there were no significant differences in non-intimate partner relationship quality with the care recipient.

Where Military/Veteran Caregivers Live and How Where They Live Affects Them

Introduction

The fields of both public health and medicine (including health care) have increasingly recognized the factors apart from medical care that strongly influence health, or *social determinants*. This includes *place*, which is the geographic areas and conditions within which individuals live, work, learn, pray, and play. This chapter focuses on aspects of place, showcasing how caregivers' experiences vary across aspects of place, as well as how place-based factors influence caregivers' experiences.

This chapter also provides state-level estimates of the number of veterans receiving caregiving support, the number of veterans needing but not receiving caregiving support, and the number of veteran caregivers. Because the state-level estimates use a different method for enumerating caregivers, these results are also contextualized and compared with estimates from the 2023 RAND Caregiving Survey.

The chapter describes the methods used to examine features of place. Next, it describes where caregivers live in the United States by describing the proportion that live in rural regions, those living across four census regions, and finally characteristics of the neighborhoods in which they live. The chapter delves more deeply into these three areas, describing rural/urban differences in the experiences of military/veteran caregivers, regional differences, and, finally, how neighborhood factors may shape where caregivers live.

Key Findings

The number of caregivers per state varies but, with some assumptions, likely exceeds 1 million veteran caregivers in each of Texas, California, and Florida. State-level estimates also suggest that veterans face significant caregiving needs in seven states: West Virginia, Arkansas, Mississippi, Oklahoma, Kentucky, Alabama, and Louisiana. In these states, between 12 and 15 percent of veterans are receiving caregiving support, and comparable proportions need but are not receiving caregiving support.

Military/veteran caregivers tend to live in areas where most Americans live. With a few exceptions, similar proportions of military/veteran caregivers live where non-caregivers live. The majority live in urban areas, and over half live in either Southern or Western states. There is some suggestive evidence that military/veteran caregivers may live in neighborhoods with more households with incomes below the federal poverty level, higher levels of unemployment, and less opportunity.

There are not striking differences in urban and rural military/veteran caregivers or those that they are caring for. Although some evidence suggests that caregivers in rural areas may have worse outcomes and less access to resources (NAC and AARP, 2020b), there is no strong evidence of this in the 2023 RAND Caregiving Survey. There are some exceptions—most notably, 24 percent of rural military/veteran caregivers do not have reliable broadband internet access at home (compared with 16 percent of urban military/veteran caregivers).

There are not striking differences between caregiver outcomes across regions of the United States. One exception is mental health care access and need: More military/veteran caregivers in the West reported accessing mental health care in the past 12 months, and more military/veteran caregivers in the West reported needing but not accessing mental health care in the past 12 months, than military/veteran caregivers in the South, where estimates were no different from the East and Midwest regions.

Military/veteran caregivers residing in neighborhoods with a higher proportion of households below the poverty line have *reduced* caregiver burden and depression. These findings are not necessarily contradictory and may relate to social capital built around communities where needs may be elevated, a topic explored in more detail in Chapter 10, Recommendation 5.

State-Level Estimates of Caregiving

The 2023 RAND Caregiving Survey includes survey respondents from across the United States. However, the sample is designed to produce estimates that are representative of the country, not each individual state. For example, the number of military/veteran caregivers in the survey who live in Texas cannot be used to determine how many military/veteran caregivers are in Texas, nor the characteristics of Texas caregivers. Because many policies and programs related to military/veteran caregiving are implemented regionally or at the state level, it would be useful to be able to describe caregiving and unmet need for caregiving at the state level. RAND researchers implemented an alternative approach to estimate the number of veterans with one or more unpaid caregivers and the number with unmet need for such care, and from these estimated the number of veteran caregivers per state. Because these estimates reflect possible differences across states in veterans' demographic, economic, health,

and disability characteristics, they may provide more useful information than national estimates for guiding many types of policies and programs.

Estimation Procedure

We estimated the state prevalence of veterans with a caregiver in three steps. First, RAND researchers conducted a survey of veterans (2022 RAND Veterans Survey; $N = 1,100$) asking about care they had received in the past 30 days and care that they may have needed, sampled from NORC's AmeriSpeak Panel (see Chapter 11). This sample of veterans is too small on its own to support state-specific estimates of veterans' needs, so instead statistical models were used that combine information from the 2022 RAND Veterans Survey with existing, detailed information about the demographics, health status, and health conditions of veterans in all states. Specifically, we used the 2022 RAND Veterans Survey to create a statistical model of the relationship between veterans who reported that they had caregivers and a wide range of veteran characteristics, including demographics, economic status, health status, health conditions, and other characteristics asked about in the survey. In the final step, this model was used to predict veterans' need for and receipt of caregiving in the much larger and state-representative BRFSS survey data for 2019–2021, thereby producing state-representative estimates of the number of veterans in need of caregiving, the number receiving unpaid care, and the number with unmet needs. BRFSS is a large-sample, state-representative telephone survey sponsored by the CDC that collects data from U.S. residents regarding their health-related risk behaviors, chronic health conditions, and preventive service use (CDC, 2022a).

Veterans in the 2022 RAND Veterans Survey were counted as having a caregiver if they reported receiving help with same eight tasks used to screen for caregivers in the 2023 RAND Caregiving Survey: bathing, dressing, feeding, getting in and out of chairs or bed, administering medications, remembering things due to a brain injury or dementia, making medical appointments, and getting transportation to medical appointments. To be counted as having an unpaid caregiver, the veteran needed to have received such help in the last 30 days, must have had need for the help “due to a wound, illness, injury, or other condition,” and must have received help from one or more unpaid caregivers. The question specifically asked, “Please select any of the following types of support someone has provided you due to a wound, illness, injury, or other condition, in the past 30 days.” Veterans receiving such care were also asked how many different people had provided it to them over the past 30 days. In a separate question, veterans were also asked, “Please select any tasks from the list below where in the past 30 days you wanted help but did not get it.” Those who reported not getting all the help that they wanted were counted as having unmet need for care.

In addition to the questions on caregiving that matched the 2023 RAND Caregiving Survey, the 2022 RAND Veterans Survey also collected some information that matched data collected on the BRFSS survey. Specifically, it collected demographic information (age, gender, race, education level, marital status, number of children, employment status, household income, state of residence, and whether respondents lived in a metro area), as well as

self-reports of disabilities related to hearing impairments; vision impairments; concentration or memory problems related to physical, mental, or emotional conditions; mobility impairments; and problems with ADLs (see the appendix for survey questions). Additional information collected on all RAND and BRFSS respondents included characteristics of the states in which they lived: population density, the percentage of the state population over age 65, and the percentage of the state population that is obese (see the appendix).

To generalize the findings from the 2022 RAND Veterans Survey to the much larger sample of veterans in the BRFSS sample, we estimated machine learning models to predict each of the three caregiver outcomes (receipt of caregiving, number of caregivers, and unmet need for care) in the 2022 RAND Veterans Survey, using all the survey items and state characteristics available in both surveys. These models then predicted caregiver needs, receipt of care, and number of caregivers among the veteran subsample of the larger and state-representative BRFSS sample. This produced estimates of the proportion of veterans in each state with each of the outcomes of interest. Finally, estimates of the total number of veterans who have a caregiver or who have unmet need were derived by applying the estimated proportions in the population to the veteran population sizes of each state, as estimated by VA for 2021. The credible intervals—a measure of the uncertainty of our estimates—around these state-level estimates of caregiving combine the uncertainty in our model-based predictions with the uncertainty in the population estimates based on the 2019–2021 BRFSS data, meaning that they should faithfully describe uncertainties produced in each step of our modeling (see the appendix for additional modeling details).

Veterans with One or More Unpaid Caregivers

Approximately one in ten veterans in the United States had one or more unpaid caregivers. Given the size of the veteran population in 2021, that corresponds to roughly 1,930,000 of 18,795,000 veterans (80-percent credible interval: 1,573,000–2,288,000).

Figure 7.1 displays the proportion of veterans in each state with one or more unpaid caregivers. These estimates range from 8 percent of veterans in New Hampshire, Hawaii, and Connecticut to 13 percent in Kentucky, West Virginia, and Mississippi. Nevertheless, the 80-percent credible intervals are wide, meaning that the proportion of veterans in each state with an unpaid caregiver could be several percentage points higher or lower. Table 7.1 contains the estimated numbers of veterans with such a caregiver by state.

Veterans with Unmet Need for Caregiving Support

Approximately 1,861,000 veterans in 2021 wanted more help than they received (80-percent credible interval: 1,808,000–1,914,000).

Figure 7.2 displays the proportion of veterans in each state with unmet need for assistance. These range from 7 percent of veterans in Connecticut to 14 percent in West Virginia. Although there is again considerable uncertainty for each of these estimates, it is notable that the seven states with the highest proportion of *unmet* caregiver needs are also the seven with

FIGURE 7.1
Veterans with One or More Unpaid Caregivers, by State

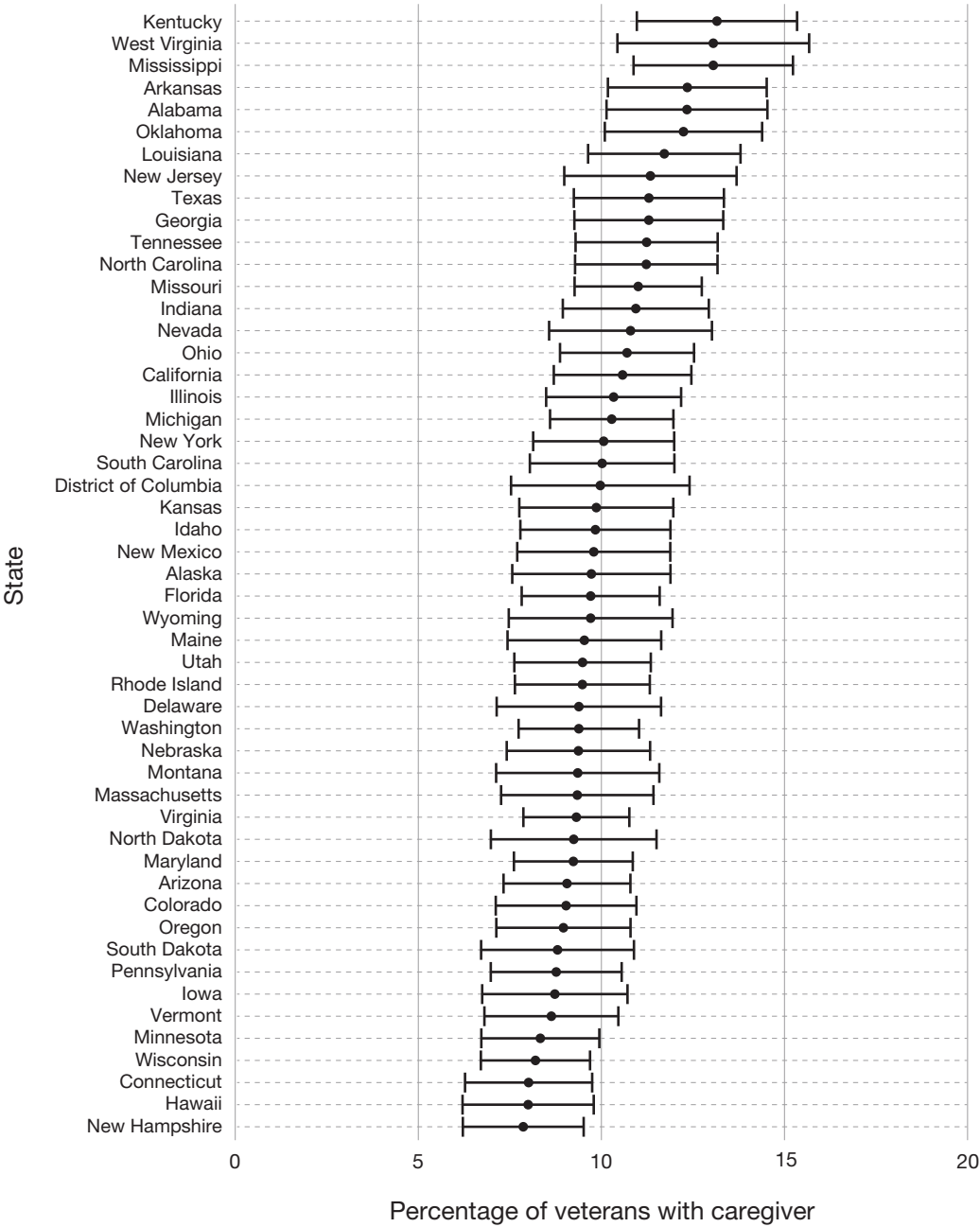


TABLE 7.1

State-Level Estimates of the Number of Veterans with Caregivers and the Number of Veterans with Unmet Need for Caregiving Support

State	Veterans	Number of Veterans with Caregivers		Number of Veterans with Unmet Need for Care	
		Estimate	80% Credible Interval	Estimate	80% Credible Interval
AK	70,645	6,867	(5,344–8,390)	6,742	(5,245–8,239)
AL	354,835	43,733	(35,954–51,512)	44,059	(36,609–51,509)
AR	207,257	25,564	(21,079–30,048)	27,994	(23,329–32,659)
AZ	502,404	45,493	(36,808–54,178)	46,686	(38,164–55,208)
CA	1,585,037	167,545	(137,836–197,255)	145,377	(115,678–175,076)
CO	379,436	34,268	(26,995–41,540)	31,907	(24,664–39,150)
CT	164,789	13,199	(10,344–16,054)	12,067	(9,394–14,740)
DC	28,822	2,872	(2,171–3,573)	2,523	(1,863–3,182)
DE	69,679	6,535	(4,975–8,096)	6,982	(5,328–8,637)
FL	1,469,840	142,592	(114,957–170,226)	133,011	(105,948–160,075)
GA	683,485	77,132	(63,269–90,996)	70,671	(56,908–84,435)
HI	109,775	8,779	(6,817–10,741)	8,276	(6,437–10,114)
IA	187,730	16,379	(12,662–20,096)	19,219	(14,969–23,470)
ID	126,868	12,471	(9,877–15,065)	12,087	(9,618–14,557)
IL	587,233	60,642	(49,844–71,440)	56,309	(46,195–66,422)
IN	396,542	43,347	(35,458–51,235)	42,796	(34,812–50,781)
KS	190,343	18,757	(14,763–22,751)	20,438	(16,237–24,640)
KY	276,882	36,388	(30,344–42,433)	36,678	(30,744–42,611)
LA	272,805	31,939	(26,273–37,605)	32,974	(26,840–39,108)
MA	296,700	27,700	(21,541–33,860)	22,932	(17,937–27,928)
MD	363,531	33,550	(27,664–39,436)	29,195	(23,407–34,984)
ME	109,960	10,478	(8,176–12,781)	11,584	(9,254–13,914)
MI	545,194	56,017	(46,855–65,179)	57,249	(46,304–68,193)
MN	303,272	25,260	(20,384–30,136)	24,337	(19,636–29,039)
MO	406,753	44,725	(37,676–51,775)	44,303	(36,265–52,341)
MS	184,220	24,026	(20,024–28,027)	24,031	(19,462–28,599)
MT	87,653	8,194	(6,245–10,142)	8,515	(6,594–10,435)

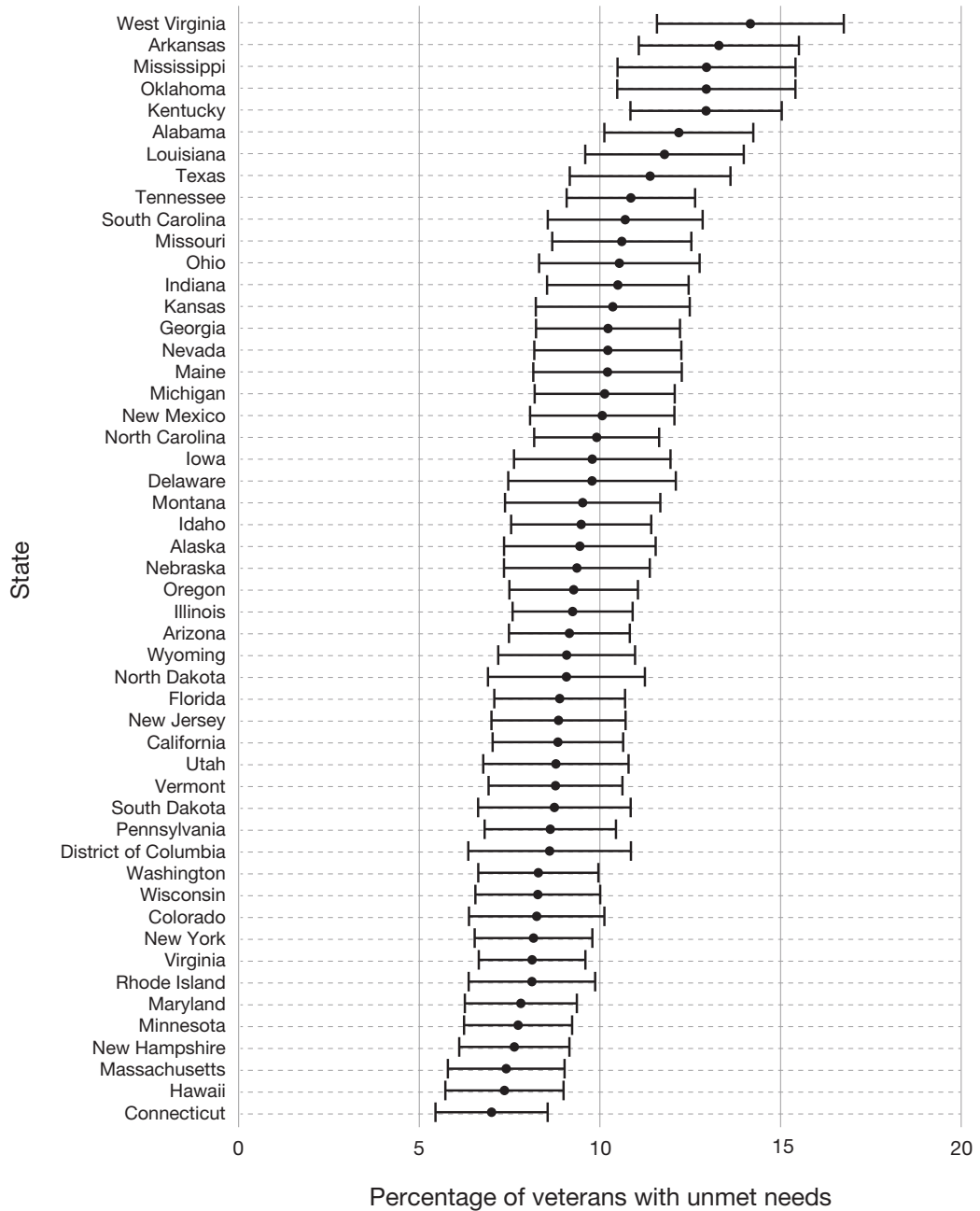
Table 7.1—Continued

State	Veterans	Number of Veterans with Caregivers		Number of Veterans with Unmet Need for Care	
		Estimate	80% Credible Interval	Estimate	80% Credible Interval
NC	694,280	77,875	(64,398–91,351)	69,894	(57,706–82,082)
ND	51,943	4,799	(3,626–5,971)	4,841	(3,683–5,998)
NE	122,493	11,474	(9,081–13,867)	11,749	(9,218–14,279)
NH	98,588	7,753	(6,130–9,376)	7,665	(6,135–9,196)
NJ	323,281	36,625	(29,035–44,215)	29,895	(23,634–36,157)
NM	146,673	14,352	(11,294–17,410)	15,149	(12,144–18,155)
NV	217,768	23,491	(18,660–28,322)	22,419	(17,957–26,880)
NY	715,611	71,957	(58,208–85,707)	61,089	(48,907–73,271)
OH	710,856	76,000	(63,020–88,980)	77,168	(60,912–93,425)
OK	286,002	34,977	(28,848–41,107)	37,863	(30,653–45,073)
OR	277,412	24,851	(19,778–29,924)	26,292	(21,252–31,332)
PA	742,287	65,041	(51,804–78,279)	66,550	(52,538–80,562)
RI	59,964	5,681	(4,579–6,783)	5,063	(3,972–6,154)
SC	390,596	39,110	(31,419–46,801)	42,126	(33,693–50,559)
SD	64,266	5,654	(4,316–6,992)	5,626	(4,268–6,984)
TN	448,372	50,332	(41,650–59,015)	49,186	(41,138–57,233)
TX	1,552,958	175,285	(143,528–207,042)	178,788	(143,891–213,685)
UT	130,668	12,388	(9,958–14,818)	11,636	(8,973–14,298)
VA	698,776	65,062	(54,973–75,151)	57,541	(47,099–67,983)
VT	40,800	3,521	(2,776–4,266)	3,713	(2,929–4,496)
WA	541,669	50,798	(41,908–59,688)	45,795	(36,625–54,965)
WI	340,057	27,872	(22,814–32,929)	28,955	(22,919–34,991)
WV	131,496	17,150	(13,715–20,585)	19,188	(15,687–22,690)
WY	46,106	4,472	(3,444–5,501)	4,298	(3,402–5,194)

NOTE: Veteran population estimates are from the VA VetPop model estimates for 2021 (VA, 2023b).

FIGURE 7.2

Proportion of Veterans with Unmet Need for Care, by State



the highest proportion of veterans *receiving caregiving support* (these seven states are West Virginia, Arkansas, Mississippi, Oklahoma, Kentucky, Alabama, and Louisiana). This suggests that the veteran populations in these states include a relatively high proportion of veterans requiring care. Table 7.1 contains the estimated numbers of veterans with an unmet need for assistance by state, computed by multiplying these rates and credible intervals by the size of the veteran population in each state in 2021 from VA.

Numbers of Unpaid Veteran Caregivers

The 2022 RAND Veterans Survey asked veterans who had a caregiver the number of individuals who had provided unpaid care to them in the prior 30 days; on average, they reported 1.4 caregivers. Because of the relatively small number of veterans in the 2022 RAND Veterans Survey who were asked this question—only 10 percent of the sample reported having a caregiver—it is difficult to estimate the precise number of individuals who are serving as unpaid caregivers in the population. One can, however, produce a rough estimate of the total number of unpaid caregivers by multiplying estimates of the number of veterans with one or more caregivers by 1.4, the average number of unpaid caregivers per veteran with one or more caregiver. This method yields an estimated 2,700,000 unpaid caregivers annually aiding veterans nationally, given the size of the veteran population in 2021 (VA, 2023b). Similarly crude estimates can be produced for each state by multiplying the estimated number of veterans with caregivers by 1.4 (see Table 7.2). The uncertainty in these estimates is not easily characterized and could be substantial—for example, the true value could plausibly be 30 percent more than or 30 percent less than the estimate. Nonetheless, the number of caregivers to veterans is particularly high in Texas, California, and Florida.

Reconciling with the 2023 RAND Caregiving Survey

The total national estimate of veteran caregivers produced using the estimation methods results in an estimate that is one-sixth of the estimate produced by the 2023 RAND Caregiving Survey. This is likely the result of the exclusion of certain veterans more likely to require caregiver support in the 2022 RAND Veterans Survey and misclassification in veterans' reports of receiving caregiving support. It may also be due to overestimates of those reporting providing caregiving support in the 2023 RAND Caregiving Survey.

AmeriSpeak employs a sampling procedure intended to generalize to the U.S. household population. This excludes adults living in institutional settings (including nursing homes and assisted living facilities) yet who are still receiving caregiving support. In the 2023 RAND Caregiving Survey, 14 percent of military/veteran caregivers were caregivers to someone “currently staying in a medical center, nursing home, or some other care facility.” There are also challenges to recruiting and ensuring participation in survey research of certain groups needing caregiving support, particularly those with cognitive impairments, such as dementia (Lepore et al., 2017); as described in Table 1.12, as many as 30 percent of caregivers are providing care to someone requiring help with emotional or cognitive tasks. Other veterans too ill to participate in surveys may be similarly excluded.

TABLE 7.2**State-Level Estimates of Veteran Caregivers**

State	Number of Veteran Caregivers	80% Credible Interval
AK	9,614	(7,481, 11,745)
AL	61,226	(50,335, 72,117)
AR	35,790	(29,510, 42,068)
AZ	63,690	(51,531, 75,849)
CA	234,563	(192,970, 276,156)
CO	47,975	(37,794, 58,157)
CT	18,479	(14,482, 22,475)
DC	4,021	(3,039, 5,002)
DE	9,149	(6,964, 11,335)
FL	199,629	(160,940, 238,316)
GA	107,985	(88,577, 127,394)
HI	12,291	(9,543, 15,037)
IA	22,931	(17,726, 28,134)
ID	17,459	(13,827, 21,091)
IL	84,899	(69,782, 100,016)
IN	60,686	(49,641, 71,730)
KS	26,260	(20,669, 31,852)
KY	50,943	(42,481, 59,406)
LA	44,715	(36,782, 52,646)
MA	38,780	(30,157, 47,403)
MD	46,970	(38,729, 55,211)
ME	14,669	(11,446, 17,893)
MI	78,424	(65,597, 91,251)
MN	35,364	(28,537, 42,190)
MO	62,615	(52,746, 72,485)
MS	33,636	(28,034, 39,238)
MT	11,472	(8,743, 14,199)
NC	109,025	(90,158, 127,892)

Table 7.2—Continued

State	Number of Veteran Caregivers	80% Credible Interval
ND	6,719	(5,077, 8,360)
NE	16,064	(12,713, 19,413)
NH	10,854	(8,582, 13,126)
NJ	51,275	(40,649, 61,901)
NM	20,093	(15,811, 24,374)
NV	32,887	(26,124, 39,651)
NY	100,740	(81,491, 119,989)
OH	106,400	(88,228, 124,572)
OK	48,968	(40,387, 57,549)
OR	34,791	(27,689, 41,893)
PA	91,057	(72,525, 109,591)
RI	7,953	(6,411, 9,497)
SC	54,754	(43,986, 65,522)
SD	7,916	(6,042, 9,789)
TN	70,465	(58,311, 82,620)
TX	245,399	(200,940, 289,859)
UT	17,343	(13,941, 20,745)
VA	91,087	(76,963, 105,211)
VT	4,929	(3,887, 5,972)
WA	71,117	(58,672, 83,563)
WI	39,021	(31,940, 46,101)
WV	24,010	(19,200, 28,819)
WY	6,261	(4,821, 7,701)

NOTE: The number of caregivers is a rough extrapolation from the number of veterans who have one or more caregivers multiplied by the average number of caregivers reported by veterans with one or more caregivers in the 2022 RAND Veterans Survey. The credible interval for this estimate does not reflect uncertainty in the number of caregivers per veteran (for veterans who have one or more caregivers) and thus underestimates the uncertainty in these estimates.

The 2022 RAND Veterans Survey also relied on veterans reporting that they received caregiver support. Surveys that rely on care recipients to report on receiving caregiver support consistently produce lower estimates of caregivers than surveys that rely on caregivers who serve in this role (Giovannetti and Wolff, 2010). This may be because veterans, like other people, overestimate their independence and abilities and underestimate their need for and receipt of assistance (Kruger and Savitsky, 2006), and caregivers may similarly overestimate the degree to which their care is required. Specifically, in a meta-analysis examining results from ten surveys used to enumerate caregivers to older adults in the United States, there was a fivefold difference in reports generated from care recipients (mean across surveys: 4.8 million) than those from caregivers (mean across surveys: 24.4 million; Giovannetti and Wolff, 2010). Although that meta-analysis focused on a different population (disabled older adults), included surveys with a range of different definitions of caregiving, and had other material differences from our veteran and caregiver surveys, it is possible that the roughly sixfold difference in caregiver estimates when based on a survey of veterans than when based on a survey of caregivers to veterans with the general public is comparable to the fivefold difference reported by Giovannetti and Wolff (2010).

Table 7.2 presents state-level estimates of the number of caregivers for veterans with corresponding 80-percent credible intervals. If we used the Giovannetti and Wolff (2010) estimates to project how many caregivers would be identified in a national survey of adults based on the number of caregivers reported by veterans in the 2022 RAND Veterans Survey (by multiplying the estimate from the Veterans Survey by a factor of 5), this calculation would yield a total estimate of 13.5 million veteran caregivers, close to the 14 million estimated with the 2023 RAND Caregiving Survey.

This calculation is designed only to illustrate that the large difference in estimated caregivers when based on a survey of veterans compared with when based on a survey of the public asking about their care for veterans is nevertheless still within a range of values that might be expected from surveys of care recipients compared with those of the general public asking about their care for that group of recipients. In particular, we do not suggest that veterans “underestimate” the care they receive by a factor of five, nor that caregivers overestimate the number veterans they provide essential care for by a similar amount. It seems likely that both underestimation and overestimation play some role in the gap between estimates from the two populations, but at present we cannot say which estimate is more biased.

Limitations

In addition to the exclusion of institutionalized care recipients and potential underreporting of receiving caregiver support, the state estimates provided in this chapter may be biased by other sources of error. First, both the 2022 RAND Veterans Survey and the BRFSS survey exclude some veterans who may be unwilling to participate in surveys for other reasons. If these inaccessible veterans have different patterns of need or receipt of caregiving than those surveyed, the estimates may not accurately describe caregiving for the entire population of

veterans in each state. Similarly, although the RAND survey was drawn from an existing panel that strives to be representative of the population both through its sampling procedures and its survey weights, nonparticipation in the AmeriSpeak Panel and in the 2022 RAND Veterans Survey might lead to non-representativeness in the sample available for our analyses, which might in turn bias our estimates. In addition, both sets of estimates have considerable uncertainty, and the point estimates provided should be interpreted with reference to intervals that define the plausible range of population values.

Defining *Place*

Each survey respondent was matched with a Federal Information Processing System code at the census tract level, which allowed us to characterize the places where respondents live. Census tracts are relatively permanent subdivisions of a county with an average of between 1,200 and 8,000 inhabitants. The areas are designed to be relatively permanent over time, and data at the tract level are publicly available from the U.S. Census Bureau, VA, and the Health Resources & Services Administration (HRSA). Thus, data are available for each respondent on characteristics of the communities in which they live, such as the proportion of households with incomes that are below the federal poverty level, the proportion of veterans who live in the census tract, median household income, Health Professional Shortage Areas (HPSAs), and VA facilities (at the county level).

Respondents came from 2,536 different census tracts across the United States. Table 7.3 provides information about neighborhood, or census tract, characteristics that were merged with the 2023 RAND Caregiving Survey data available for each respondent.

Where Caregivers Live

Table 7.4 illustrates regional and selected geographic characteristics among non-caregivers, civilian caregivers, and military/veteran caregivers. Caregivers (civilian and military/veteran) were stratified by care recipients who are 60 or under and care recipients who are over 60 years.

Compared with all other groups, military/veteran caregivers with a care recipient who is 60 or under live in more-rural areas. Twenty-four percent of military/veteran caregivers with a care recipient who is 60 or under live in rural areas. In contrast, between 13 and 16 percent of each of the other groups (non-caregivers, civilian caregivers with a care recipient who is 60 or under, and military/veteran caregivers and civilian caregivers with a care recipient who is over 60) live in rural areas.

There are no statistically significant differences between military/veteran caregivers and non-caregivers with respect to characteristics of the neighborhoods in which they live. However, some of the lack of evidence may be attributed to the lack of statistical power to discern these differences. For example, non-caregivers live in neighborhoods where, on average,

TABLE 7.3

Neighborhood Characteristics Merged with the 2023 RAND Caregiving Survey Data

Neighborhood Characteristic	Description	Source, Year
Rural (versus urban)	Households not living in a Metropolitan Statistical Area, as defined by the U.S. Office of Management and Budget. Based on 2010 census.	U.S. Census Bureau, 2022b
Proportion of households with incomes below the federal poverty level	Households in poverty are defined by comparing pretax income to a poverty threshold that is adjusted by family composition. In 2021, a family of four would be under the poverty line if they earned \$27,479/year or less.	American Community Survey (ACS) 5-year estimates, 2021 (U.S. Census Bureau, 2022c)
Percentage of veterans living in the neighborhood	The census collects information on whether there are veterans in the household. Specifically, veterans are defined as those who have served, but are not currently serving, on active duty in the U.S. Army, Navy, Air Force, Marine Corps, or the Coast Guard, or who served in the U.S. Merchant Marine during World War II.	ACS 5-year estimates, 2021 (U.S. Census Bureau, 2022c)
Median household income	The census asks about pretax income for the household, or all the people who occupy a housing unit.	ACS 5-year estimates, 2021 (U.S. Census Bureau, 2022c)
Opportunity index	The Opportunity Index is based on the diversitydatakids.org Child Opportunity Index, which is a composite index measured at the census tract level. The index is based on 29 indicators spanning three domains: education, health and environment, and social and economic. It captures neighborhood resources and conditions that matter for children's healthy development in a single metric.	2015 census tract Child Opportunity Index data from diversitydatakids.org, undated
County has a VA facility	Included sites labeled as any of the following: VA Medical Center, Primary Care Community-Based Outpatient Clinic, or Health Care Center. Because of very small numbers of respondents living in census tracts with a VA facility, coordinates were then rolled up to the county level.	Geodatabase of VA facilities, last updated 3/31/2021 (VA, 2021); VA, 2022c
HPSA	HRSA compiles HPSAs, which are geographic areas with a shortage of primary, dental, or mental health care providers.	Area Health Resource Files 2021 county-level data from data.HRSA.gov (undated)

TABLE 7.4
Characteristics of Where Caregivers Reside

		Care Recipient Is 60 or Under		Care Recipient Is over 60	
		Military/Veteran Caregivers	Civilian Caregivers	Military/Veteran Caregivers	Civilian Caregivers
Place of residence ^c					
Urban %	87%	76% ^a	84%	87%	85%
Rural %	13%	24% ^a	16%	13%	15%
Region ^c					
Northeast %	17%	15%	16%	14%	18%
Midwest %	20%	17%	24%	17%	21%
South %	38%	41%	39%	48%	37%
West %	25%	27%	22%	21%	24%
Neighborhood characteristics ^d					
Percentage of households with income below federal poverty level	9%	10%	10% ^a	11%	10% ^a
Percentage of non-White population	29%	33%	31% ^a	31%	32% ^a
Percentage of veteran population ≥65 years old	49%	50%	49%	51%	49%
Percentage of neighborhood veteran population	7%	8%	6%	7%	6%
Median income	\$77,550	\$64,592	\$68,139	\$71,029	\$70,959
Percentage unemployed within neighborhood	3%	4%	4% ^a	4%	3%
Child Opportunity Index (0–100)	54	39	45 ^a	44	47 ^{a,b}

^a Denotes a statistically significant difference from non-caregivers without adjustment.

^b Denotes a statistically significant difference from non-caregivers in adjusted models including caregiver gender, age, marital status, household size, and income.

^c Place of residence and region show the proportion of caregivers who live in those types of neighborhoods/regions.

^d Neighborhood characteristics reflect composition of the neighborhoods where non-caregivers and caregivers (military/veteran and civilian) live.

9 percent of the households have incomes below the federal poverty level. Civilian caregivers live in neighborhoods where, on average, 10 percent of households have incomes below the federal poverty level—differences that are significant. Military/veteran caregivers live in neighborhoods where, on average, 11 percent of households have incomes below the federal poverty level—but the difference from non-caregivers is not significant. A similar pattern is observed with the percentage of those unemployed in the neighborhood and with the Child Opportunity Index. The Child Opportunity Index, which is a composite measure of neighborhood quality and resources, was notably higher in non-caregiver neighborhoods compared with civilian caregivers. On a scale that ranges from 0 to 100, with higher scores indicating more opportunity, non-caregivers, on average, lived in neighborhoods with an opportunity index of 54. This contrasted to the opportunity index of 45 and 47 for civilian caregivers, differences that were statistically significant. The opportunity index was even lower for military/veteran caregivers with a care recipients over 60 (opportunity index of 44) and aged 60 or under (opportunity index of 39), but there was no evidence that these were statistically different from non-caregivers.

Table 7.5 similarly shows that the availability of health care resources is, on average, comparable in neighborhoods of non-caregivers compared with neighborhoods of caregivers. Between 55 and 64 percent of non-caregivers and caregivers live in a county with a VA facility. Five to 7 percent live in a health care provider shortage area, approximately 10 percent live in a mental health care provider shortage area, and between 40 and 50 percent live in a primary care provider shortage area.

TABLE 7.5
Availability of Health Care Resources

	Non-Caregivers	Care Recipient Is 60 or Under		Care Recipient Is over 60	
		Military/ Veteran Caregivers	Civilian Caregivers	Military/Veteran Caregivers	Civilian Caregivers
Living in a county with a VA facility	63%	55%	56%	56%	60%
Health care provider shortage area	5%	6%	7%	7%	6%
Mental health care provider shortage area	10%	9%	10%	10%	9%
Primary care provider shortage area	40%	48%	47%	45%	46%

NOTE: There is no evidence of statistically significant differences between groups.

Rural and Urban Caregiving Differences

Rural caregivers may have difficulty accessing support services, and there are known challenges of caregiving in rural settings, including having lower education and lower incomes and finding affordable health care services for the care recipient within their community (AARP and NAC, 2020). That said, few studies compare experiences of caregivers across the rural-urban continuum to understand how rural caregivers differ from urban caregivers. A notable exception found that rural caregivers were more likely than their urban counterparts to provide more than 20 hours a week of caregiving (Cohen et al., 2022). Another study found that rural caregivers experienced more financial difficulties than urban caregivers (Bouldin et al., 2018). Together, these findings suggest that caregivers in rural areas may provide more care and may face more financial hardships than those in urban settings. For military/veteran caregivers in particular, reduced ability to access supports related to more-complicated care recipient conditions, greater distances to reach opportunities (retail, economic, social, etc.), and even differences in Wi-Fi/broadband access may create unique needs.

This section focuses exclusively on military and veteran caregivers and compares those who live in rural communities with those who live in urban areas.

Differences Between Urban and Rural Military/Veteran Caregivers' Sociodemographic Characteristics

Table 7.6 shows the comparisons between the sociodemographic characteristics of military/veteran caregivers living in urban and rural areas.¹ Overall, urban and rural caregivers are very similar demographically, though rural caregivers are less likely to identify as Black or Hispanic after controlling for caregiver gender, age, marital status, household size, and income. In addition, 24 percent of rural military caregivers report not having reliable internet access at home, significantly more than urban caregivers.

Table 7.7 presents the relationships between caregiver and care recipient among urban and rural military/veteran caregivers. While the proportions reported are very different (e.g., 37 percent of urban caregivers are caring for a parent versus 17 percent of rural caregivers), there is no evidence of a statistical difference between urban and rural military/veteran caregivers with respect to their relationship to the care recipient or co-residence.

Contrary to other studies (Cohen et al., 2022), there is no evidence that rural military/veteran caregivers spend more hours per week caregiving (see Table 7.8). However, 46 percent of rural military/veteran caregivers provide help with cognitive or emotional tasks (with no ADL support), greater than the 22 percent of urban military/veteran caregivers who do so.

RAND researchers also examined the financial security and reserves among military/veteran caregivers in rural and urban settings, finding no evidence of differences in whether

¹ We operationalize rural by using “non-metro” Metropolitan Statistical Area designation, as defined by the U.S. Office of Management and Budget, based on 2010 census data (U.S. Census Bureau, 2022b).

TABLE 7.6**Demographic Characteristics of Military/Veteran Caregivers, by Rural/Urban Residence**

	Urban	Rural
Mean age	48.6	44.0
18–30	20%	30%
31–55	39%	37%
56–65	19%	18%
66–80	20%	15%
81+	2%	0%
Female	56%	63%
Race/ethnicity		
White, non-Hispanic	51%	74%
Black, non-Hispanic	25%	15% ^b
Asian, non-Hispanic	5%	–
Other, non-Hispanic	1%	1%
Two or more races/ ethnicities, non-Hispanic	2%	1%
Hispanic	17%	8% ^b
Education		
Less than high school	6%	17%
High school or equivalent	29%	34%
Some college/associate degree	30%	24%
Bachelor's degree	22%	15%
Postgraduate	13%	10%
Marital status		
Married	48%	47%
Widowed	3%	5%
Divorced	12%	11%
Separated	3%	7%
Never married	33%	29%

Table 7.6—Continued

	Urban	Rural
Household income		
Less than \$30,000	26%	43%
\$30,000 to under \$60,000	27%	26%
\$60,000 to under \$100,000	26%	21%
\$100,00 or more	22%	11%
No home internet access	16%	24% ^{a,b}

NOTE: The unweighted N for each group is urban = 429 and rural = 84.

^a Indicates a statistically significant difference between urban and rural military/veteran caregivers in unadjusted models.

^b Indicates a statistically significant difference between urban and rural military/veteran caregivers in adjusted models including caregiver gender, age, marital status, household size, and income.

TABLE 7.7

Military/Veteran Caregivers' Relationship to Care Recipients and Co-Residence, by Rural/Urban Residence

	Urban	Rural
Relationship to care recipient		
Child or grandchild	37%	17%
Spouse/partner or former spouse/ partner	22%	28%
Neighbor/friend/other non-relative	24%	25%
Parent	2%	4%
Other relative	15%	27%
Lives with caregiver	41%	45%

NOTE: There is no evidence of statistically significant differences between groups in models adjusted for caregiver gender, age, marital status, household size, and income.

TABLE 7.8**Caregiving Intensity and Activities of Military Caregivers, by Rural/Urban Residence**

	Urban	Rural
Hours per week caregiving		
≤8 hours	55%	33%
9–20 hours	20%	27%
21–40 hours	15%	25%
41+ hours	10%	15%
Caregiving activities		
Requires help with at least one ADL	55%	46%
Requires help with at least one cognitive or emotional task	22%	46% ^{a,b}
Requires help with medications, housework, and administrative support	23%	7%

^a Indicates a statistically significant difference between urban and rural military/veteran caregivers in unadjusted models.

^b Indicates a statistically significant difference between urban and rural military/veteran caregivers in adjusted models including caregiver gender, age, marital status, household size, and income.

they experienced difficulties in paying bills over the past six months, nor whether they had “rainy day funds” for an emergency (discussed in further detail in Chapter 3).

Rural Military/Veteran Care Recipient Characteristics

Understanding the differences of care recipients in rural versus urban areas can provide guidance about where particular types of care and support services could be offered. Table 7.9 presents information about the characteristics of rural and urban veteran care recipients. Similar to caregivers, only 5 percent of rural military/veteran care recipients are identified as Black relative to 21 percent of urban military/veteran care recipients. In addition, rural care recipients are more likely to care for those with vision and hearing diagnoses (79 percent) than are urban care recipients (56 percent).

Rural Caregiver Health, Well-Being, and Program Utilization

Estimates of caregiver burden, perceived stress, depression, hazardous drinking, self-rated health, and personal gain from caregiving among military/veteran caregivers are presented in Chapter 2. There was no evidence in differences in these outcomes among military/veteran caregivers in urban versus rural areas. Similarly, there were no significant differences between urban and rural military/veteran caregivers with respect to mental health service utilization (estimates are also presented in Chapter 2).

TABLE 7.9**Military/Veteran Care Recipient Characteristics**

	Urban	Rural
Mean age	62	69
18–30	3%	15%
31–55	17%	18%
56–65	14%	7%
66–80	39%	46%
81+	26%	15%
Race/ethnicity		
White, non-Hispanic	55%	78%
Black, non-Hispanic	21%	5% ^{a,b}
Other, non-Hispanic	2%	3%
Hispanic	15%	13%
Two or more races/ethnicities, non-Hispanic	3%	1%
Asian, non-Hispanic	3%	-
Care recipient conditions		
Chronic condition	76%	92%
Vision/hearing	56%	79% ^{a,b}
Neurological	33%	29%
TBI	14%	18%
Musculoskeletal	43%	41%
Infectious disease	14%	17%
Mental health or substance use	41%	52%
Other	28%	22%

^a Indicates a statistically significant difference between urban and rural military/veteran caregivers in unadjusted models.

^b Indicates a statistically significant difference between urban and rural military/veteran caregivers in adjusted models including caregiver gender, age, marital status, household size, and income.

Chapter 4 describes the use of support services, including support groups, respite care, structured wellness, and case management. Regression models were estimated to identify whether use of these services differed between rural and urban military/veteran caregivers. Living in a rural area was not associated with uptake of caregiver support programs.

Regional Differences

The U.S. Census Bureau groups the 50 states and the District of Columbia, for statistical purposes, into four geographic regions—the Northeast, Midwest, South, and West (CDC, 2023c). Boundaries between these regions are historical in nature, and these regional geographic areas are large and heterogeneous. However, broad relationships across regions can permit more extensive place-based efforts across groups of states. Health outcomes, including mortality rates, vary across regions, with notable attention paid to socioeconomic and health disparities generally more pronounced across the South and Midwest compared with the Northeast and West (Murray et al., 2006). Similarly, differences in health care spending, utilization, and social services exist across regions of the United States, yet there is limited work specific to the implications for caregivers and caregiving.

The analyses below compare military/veteran caregivers in the South (unweighted N = 183), where most military/veteran caregivers live, with those living in the other regions.

Military Caregiver Sociodemographic Characteristics by Region

Table 7.10 shows sociodemographic comparisons between military/veteran caregivers living in the Northeast, Midwest, South, and West of the United States. The mean age of caregivers was similar (between 47 and 50 years) across all regions, and while there appear to be differences in the demographic composition of caregivers in different regions, there were no statistically significant differences with respect to race, education, marital status, income, or internet access.

In Table 7.11, military/veteran caregivers' relationship to care recipients and co-residence is reported, by region. There were not differences in types of caregiver–care recipient relationships or with co-residence. However, in the Northeast, the greatest share of military/veteran caregivers were children or grandchildren of the care recipient (38 percent); in the Midwest, South, and West, children caring for their parents represent a similar proportion of military/veteran caregivers.

There are not statistically significant differences in financial security and capability of military caregivers across regions.

Table 7.12 illustrates caregiving intensity and activities of military caregivers, by region. There are no significant differences in caregiving intensity or activities across the four regions.

TABLE 7.10
Demographic Characteristics of Military/Veteran Caregivers, by Region

	Northeast	Midwest	South	West
Mean age	50	49	47	47
Female	52%	71%	57%	50%
Race/ethnicity				
White, non-Hispanic	75%	69%	42%	56%
Black, non-Hispanic	12%	27%	30%	13%
Asian, non-Hispanic	4%	0%	5%	6%
Other, non-Hispanic	-	-	2%	1%
Two or more races/ethnicities, non-Hispanic	1%	1%	2%	1%
Hispanic	7%	3%	20%	23%
Education				
Less than high school	5%	8%	9%	5%
High school or equivalent	33%	35%	29%	26%
Some college/associate degree	20%	30%	32%	28%
Bachelor's degree	25%	17%	19%	25%
Postgraduate	17%	10%	11%	15%
Marital status				
Married	52%	44%	44%	56%
Widowed	2%	4%	4%	3%
Divorced	11%	9%	13%	14%
Separated	2%	4%	6%	2%
Never married	34%	40%	33%	25%
Mean income (in dollars)	\$92,047	\$64,574	\$73,164	\$95,212
No home internet access	16%	11%	21%	14%

NOTE: The unweighted N for each region are Northeast = 70, Midwest = 139, South = 183, and West = 121. There is no evidence of statistically significant differences between military/veteran caregivers in the South and those living in other regions.

TABLE 7.11**Military/Veteran Caregivers' Relationship to Care Recipients and Co-Residence, by Region**

	Northeast	Midwest	South	West
Caregiver is the care recipient's				
Child or grandchild	38%	34%	34%	31%
Spouse/partner or former spouse/partner	14%	30%	22%	27%
Neighbor/friend/other non-relative	31%	18%	27%	18%
Parent	3%	–	3%	2%
Other relative	14%	18%	15%	22%
Lives with caregiver	27%	43%	47%	39%

NOTE: There is no evidence of statistically significant differences between military/veteran caregivers in the South and those living in other regions.

TABLE 7.12**Caregiving Intensity and Activities of Military Caregivers, by Region**

	Northeast	Midwest	South	West
Hours per week caregiving				
<8 hours	51%	51%	51%	54%
9–20 hours	32%	16%	20%	23%
21–40 hours	14%	20%	16%	15%
41+ hours	3%	13%	14%	7%
Caregiving activities				
Requires help with at least one ADL	40%	47%	57%	61%
Requires help with at least one cognitive or emotional task	36%	30%	22%	26%
Requires help with medications, housework, and administrative support	24%	24%	22%	13%

NOTE: There is no evidence of statistically significant differences between groups.

Table 7.13 shows care recipient characteristics across United States regions. Care recipients' differences in characteristics follow many of the differences observed among military/veteran caregivers. For example, there is a majority of White care recipients of military/veteran caregivers everywhere except for the South, where White, non-Hispanic care recipients composed 49 percent of the population, 26 percent of recipients identify as Black, non-Hispanic, and 20 percent of care recipients identify as Hispanic.

Regarding their conditions, care recipients in the West were more likely than those in the South to need care with musculoskeletal issues (58 percent versus 40 percent), but there were no other significant differences.

Table 7.14 shows military/veteran caregiver health and well-being outcomes. These outcomes are discussed in greater detail in Chapter 2. There are no differences across regions

TABLE 7.13
Care Recipient Characteristics

	Northeast	Midwest	South	West
Mean age	71	67	67	67
Race				
White, non-Hispanic	77%	73%	49%	58%
Black, non-Hispanic	6%	20%	26%	9%
Other, non-Hispanic	5%	-	0%	4%
Hispanic	9%	3%	20%	17%
Two or more races/ ethnicities, non-Hispanic	-	4%	0%	7%
Asian, non-Hispanic	3%	-	3%	3%
Care recipient conditions				
Chronic condition	91%	82%	75%	76%
Vision/hearing	70%	54%	59%	58%
Neurological	25%	30%	32%	41%
TBI	5%	7%	20%	16%
Musculoskeletal	35%	36%	40%	58% ^{a,b}
Infectious disease	17%	10%	16%	14%
Mental health or substance use	40%	37%	46%	42%
Other	41%	31%	22%	26%

^a Indicates a statistically significant difference from military/veteran caregivers in the South in unadjusted models.

^b Indicates a statistically significant difference from military/veteran caregivers in the South in adjusted models including caregiver gender, age, marital status, household size, and income.

TABLE 7.14
Military Caregiver Health and Well-Being

	Northeast	Midwest	South	West
Caregiver burden	34%	28%	26%	44%
Perceived stress	50%	47%	58%	47%
Depression	19%	19%	22%	26%
Loneliness	15%	15%	13%	5%
Potentially hazardous drinking (%)	29%	35%	24%	28%
Self-rated health				
Excellent	11%	7%	7%	5%
Very good	23%	33%	29%	33%
Good	43%	37%	43%	39%
Fair	12%	22%	18%	19%
Poor	11% ^{a,b}	2%	3%	3%

^a Indicates a statistically significant difference from military/veteran caregivers in the South.

^b Indicates a statistically significant difference from military/veteran caregivers in the South in adjusted models including caregiver gender, age, marital status, household size, and income.

for caregiver burden, perceived stress, depression, loneliness, and alcohol use. However, military/veteran caregivers in the Northeast are more likely to report having poor health than those in the South (11 percent versus 3 percent).

Finally, Table 7.15 shows service utilization among military caregivers by region. Insurance coverage of military/veteran caregivers is lowest in the South (72 percent) and highest in the Midwest and West (85 percent). Differences in mental health utilization were also observed, with 15 percent of military/veteran caregivers having reported talking with a mental health care professional in the past year in the Midwest and South, compared with 20 percent in the Northeast and 33 percent in the West. At the same time, 33 percent of military/veteran caregivers in the West reported an unmet need for mental health care in the past year, significantly more than those in other regions, even after accounting for caregiver characteristics.

The Neighborhood Environment and Military/Veteran Caregiver Health and Well-Being

One's immediate social and built environment, or neighborhood surroundings, are critical to health and present the opportunity to understand how conditions—such as safety and crime, air quality, food options, and safe places to play and exercise—might ultimately impact resident health and well-being. We sought to understand to what extent neighborhood con-

TABLE 7.15
Military Caregiver Service Utilization by Region

	Northeast	Midwest	South	West
Insurance coverage	82%	85%	72%	85%
Had a routine checkup in past year	73%	76%	64%	58%
Talked to a mental health professional in past year	20%	15%	15%	33% ^a
Unmet need for mental health care in past year	19%	14%	17%	33% ^{a,b}

^a Indicates a statistically significant difference from military/veteran caregivers in the South.

^b Indicates a statistically significant difference from military/veteran caregivers in the South in adjusted models including caregiver gender, age, marital status, household size, and income.

text may impact military/veteran caregiver mental health, program utilization, and caregiver health care.

Although limited work has focused specifically on neighborhood factors and their influence on caregiving, several studies have looked at neighborhood social cohesion, or places where residents perceive their neighbors to be helpful and trustworthy, and its impact on caregivers' well-being. One study found that Mexican-American caregivers who reported high levels of neighborhood cohesion reported fewer depressive symptoms than those who provided care to older adults in less cohesive neighborhoods (Rote et al., 2018). Another study found the same among spousal caregivers (Choi and Ailshire, 2024). Studies have also shown that communities with high levels of crime and lack of community resources (e.g., community centers, libraries) can contribute to poor health and poor mental health for caregivers (Brummett et al., 2005). Yet there are still mixed results. Another study of caregivers found unexpected patterns, with caregivers who resided in medically underserved areas and areas with increased poverty and air pollution less likely to be depressed and reporting more positive aspects of caregiving after adjusting for known individual-level risk factors (Beach, Kinnee, and Schulz, 2019).

The Effects of Neighborhood Poverty on Caregiver Stress and Depression

To understand whether there were neighborhood-level characteristics associated with perceived stress and depression among military/veteran caregivers, analyses were conducted to examine how the proportion of households with incomes below the federal poverty level in the neighborhood affected military/veteran caregivers' depression or stress. Looking only at military/veteran caregivers, models suggest that both depression and perceived stress are inversely associated with the proportion of households in caregivers' neighborhoods with incomes below the federal poverty level. It should also be noted that included in the model

was whether caregivers had a care recipient 60 or under or a care recipient over 60 years. The model shows that for caregivers with a care recipient 60 or under, the strong positive association and effect size with perceived stress and depression counterbalances the association between the proportion of households with incomes below the federal poverty level and the outcomes of perceived stress and depression (Table 7.16). Thus, adjusting for caregiving burden, household income, caregiver age, and caregiver race/ethnicity, on a neighborhood level, the relationship remained: As the proportion of households with incomes below the federal poverty level *increased*, levels of perceived stress *decreased*. The same association was found for depression: As the proportion of households with incomes below the federal poverty level increased, caregivers reported fewer depression symptoms. However, if caregivers had a care recipient 60 or under, the effect of households with incomes below the federal poverty level was counterbalanced for both the association with perceived stress and for depression. There were positive statistically significant associations between caregivers with a care recipient 60 or under for both perceived stress and depression.

The Effects of Neighborhood Poverty and Proximity to a VA Facility on Utilization of Support Programs

Military caregiver neighborhood resources and characteristics were examined for potential associations with caregiver engagement with support groups, respite care, structured wellness, and use of case management (Coburn et al., 2016; Rahman et al., 2020). Few neighborhood characteristics stood out among military caregivers in particular. Specifically, analyses did not find large or significant associations between neighborhood characteristics and utilization of support programs. Data are summarized in Table 7.17.

TABLE 7.16
Adjusted Correlates of the Proportion of Households with Incomes Below the Federal Poverty Level and Perceived Stress Among Military Caregivers

	Perceived Stress		Depression	
	Estimate	p	Estimate	p
Proportion of households with incomes below the federal poverty level	−0.03	0.03	−0.09	<0.001
Care recipient 60 or under	0.74	0.02	1.98	<0.001

NOTE: Weighted linear regression models also adjusted for caregiving burden, household income, caregiver age, caregiver race/ethnicity, and regional random effects.

TABLE 7.17

Support Program Participation and Neighborhood Characteristics

	Support Group (Odds Ratio)	Respite Care (Odds Ratio)	Structured Wellness (Odds Ratio)	Case Management (Odds Ratio)
Percentage of households with incomes below the federal poverty level	1.02	1.0	0.99 ^a	0.99
Median household income/\$1,000	0.99 ^a	1.0	1.0	1.0
Percentage living in a county with VA facility	1.19	0.83	0.89	0.98

^a Denotes $p < 0.05$ in models adjusted for caregiver income, age, race/ethnicity, care recipient age, and military/veteran or civilian caregiver status.

The Effects of Health Care Provider Availability on Caregiver Health Care Utilization

HPSA designations are areas within the United States that are experiencing a shortage of health professionals (HRSA, 2023). The designation is made based on the number of health professionals relative to the population. For primary medical care, the population to provider ratio must be at least 3,500 to 1.

Table 7.18 shows regression models examining caregivers living in HPSAs and health care utilization by caregivers, adjusting for caregiver age, race/ethnicity, and income. The first row looks at all caregivers, and the second row looks just at military/veteran caregivers. Notably, for military/veteran caregivers, there was evidence of a counterintuitive relationship for those caregivers who lived in an HPSA: Military/veteran caregivers who lived in shortage areas were more likely to have seen a doctor in the past year. While this result is somewhat unexpected, other studies have found similar results: Residents of areas in which primary care physicians were more readily available did not have better cardiovascular risk factor awareness or control (Allen et al., 2011). There is also evidence that caregivers living in medically underserved areas were less likely to be depressed and reported more positive aspects of caregiving (Beach, Kinnee, and Schulz, 2019).

However, caregivers living in HPSAs had significantly lower odds of seeing a mental health care provider and for needing mental health care and not getting it. This was the case for the regression model that looked at military/veteran and civilian caregivers combined (row 1 of Table 7.18), as well as for the regression model that looked at just military/veteran caregivers (row 2). Military/veteran caregivers who lived in an HPSA had 89 percent lower odds of seeing a mental health care provider compared with those who lived in areas that were not shortage areas.

TABLE 7.18**Health Professional Shortage Areas and Caregiver Health Care**

	Insured (Odds Ratios)	Saw Doctor Within the Past Year (Odds Ratios)	Talked to/Saw a Mental Health Care Provider in the Past 12 Months (Odds Ratios)	Needed Mental Health Care in the Past 12 Months but Did Not Get It (Odds Ratios)
HPSA (for military/ veteran caregivers and civilian caregivers)	1.03	1.73 ^a	0.59 ^a	0.49 ^a
HPSA (analyses restricted to military/veteran caregivers)	0.25	2.28	0.11 ^a	0.26 ^a

^a Denotes statistically significant odds ratios in regression models that adjust for income, age, and race/ethnicity.

Former Military and Veteran Caregivers

In 2023, the Elizabeth Dole Foundation, in collaboration with the Tragedy Assistance Program for Survivors (TAPS) and the Red Cross Military and Veteran Caregiver Network, released *The Journey of Loving, Caring, Losing, Grieving, and Living On: The Experiences and Challenges of America's Military and Veteran Caregiver Survivors—Caregiver to Survivor (C2S) Partnership Report 2023* (TAPS, Red Cross Military and Veteran Caregiver Network, and the Elizabeth Dole Foundation, 2023). This report shed light on the experiences of caregivers who had lost the person they were caring for and described how the loss affected them. This period, referred to in the academic literature as *postcaregiving*, can include a mix of emotions, from feelings of “relief, a burden removed” to “depression and hopelessness due to their already depleted emotional state” (Orzeck, 2016). The loss of caregiving responsibilities also can impact many caregivers’ sense of identity, because, for many, being a caregiver assumes prominence over other roles and responsibilities (Orzeck, 2016).

Throughout this report, former caregivers are included in the “non-caregiver” group for comparison purposes. However, this section isolates former military/veteran caregivers, describes them, and identifies how they are faring—particularly in the postcaregiving period.

Key Findings

Most former military/veteran caregivers lost the person they were caring for, but in many ways they look more similar to non-caregivers than current military/veteran caregivers. Just over 4 percent of American adults are former military/veteran caregivers. Almost three-quarters are no longer serving as caregivers because the person they were caring for died. On measures of stress, depression, and financial security, former military/veteran caregivers more closely resemble non-caregivers than current military/veteran caregivers.

Former Military and Veteran Caregivers

As described in Chapter 1, 4.3 percent of American adults identify as former caregivers. As shown in Table 8.1, around two-thirds (62 percent) of former military or veteran caregivers served in this role more than two years ago (which is outside the traditionally defined postcaregiving period; Orzeck, 2016), and 38 percent had been caregivers within the past two

TABLE 8.1**Caregiving Characteristics of Former Military/Veteran Caregivers**

	Percentage of Former Military/Veteran Caregivers
When last served as caregiver	
Less than one year ago	17%
Within past two years	21%
More than two years ago	62%
Reason no longer serving as caregiver	
Care recipient died	72%
Care recipient improved	16%
Another person is now providing care	12%

NOTE: The unweighted N of this group is 98.

years. Unfortunately, 72 percent no longer identified as caregivers because the person they were caring for passed away; the remainder were split between those whose care recipient improved and no longer needed support (16 percent) and those who reported that someone else now provides caregiving support (12 percent).

Table 8.2 provides further insight into the caregiving experiences of former caregivers. Those whose caregiving experiences ended because the care recipient had died had the oldest care recipients (average age = 77) relative to those whose care recipient's condition improved (average age = 67 years) or care was taken over by another person (average age = 75 years). The average duration of care provided across groups was between two and four years.

Health and Well-Being of Former Military/Veteran Caregivers

Chapter 2 provides a thorough review of the health and well-being of military/veteran caregivers, including their mental health. There was no evidence that former military/veteran caregivers, whether they ended caregiving within the past two years or longer, had different prevalence of high stress or depression relative to non-caregivers, as shown in Table 8.3.

Financial Insecurity and Employment Status of Former Caregivers

Chapter 3 provides a thorough review of financial security of military/veteran caregivers. There is no evidence of differences in financial security between former caregivers, regardless of how recently they filled that role, and non-caregivers.

TABLE 8.2**Caregiving Experiences of Former Military/Veteran Caregivers (N = 98)**

	Care Recipient Died	Care Recipient Improved	Another Person Is Now Providing Care
Mean age of care recipient when last provided care	77 years	67 years	75 years
% 60 or under	18%	25%	21%
% over 60	82%	75%	79%
Average duration of care	41 months (3.4 years)	43 months (3.6 years)	31 months (2.6 years)

NOTE: The unweighted N for the groups is care recipient died = 67, care recipient improved = 18, and another person is now providing care = 13.

TABLE 8.3**Stress and Depression Among Current, Former, and Non-Caregivers**

	Non-Caregivers (see note)	Former Military/ Veteran Caregivers (<2 years)	Former Military/ Veteran Caregivers (2+ years)	Current Military/ Veteran Caregivers
Perceived stress	41%	43%	32%	53% ^a
Depression	11%	13%	12%	22% ^a

NOTE: Thresholds for perceived stress and depression are provided in Chapter 2. Non-caregivers also exclude those who are former caregivers to civilians. The unweighted N of each group is non-caregivers = 577, former military veteran caregivers (<2 years) = 38, former military/veteran caregivers (2+ years) = 60, and current military/veteran caregivers = 513.

^a Indicates statistically significantly different from non-caregivers.

Support for Former Caregivers

Emotional social support among current caregivers is discussed more fully in Chapter 4. Table 8.4 shows that while there is no difference in the level of emotional social support (defined by answering “enough people you can count on” versus either “not enough people” or “no one you can count on” to the question “If you needed someone to listen to your problems if you were feeling low, are there enough people you can count on, not enough people, or is there no one you can count on?”) reported by non-caregivers (80 percent) and those who were military/veteran caregivers within the last two years (79 percent). However, current caregivers reported lower levels of support (63 percent), and those who were military/veteran caregivers more than two years ago reported higher levels of support (92 percent).

TABLE 8.4**Emotional Social Support Among Current, Former, and Non-Caregivers**

	Non-Caregivers (see note)	Former Military/ Veteran Caregivers (<2 years)	Former Military/ Veteran Caregivers (2+ years)	Current Military/ Veteran Caregivers
Emotional social support	80%	79%	92% ^a	63% ^a

NOTE: Non-caregivers also exclude those who are former caregivers to civilians.

^a Indicates statistically significantly different from non-caregivers.

Remote, or *Distance*, Caregivers

Millions of Americans provide regular care for a loved one from a distance (AARP and NAC, 2020; MetLife Mature Market Institute, 2004). Remote caregivers (sometimes called *distance caregivers*) are a significant but understudied subset of caregivers (Cagle and Munn, 2012). Few studies consider the unique experiences of these individuals, and fewer still consider military and veteran caregivers who support a loved one remotely. There is no standard definition of a remote caregiver (Bledsoe, Moore, and Collins, 2010), though many, including the National Institute on Aging and AARP, consider a caregiver to be remote if they live an hour or more away from the individual for whom they care (AARP and NAC, 2020; Koerin and Harrigan, 2003; MetLife Mature Market Institute, 2004; National Institutes of Health, undated). One in five Americans live over an hour's drive from their nearest extended family member (Hurst, 2022). In their 2020 report on caregiving in the United States, AARP and NAC estimated that distance caregivers account for 11 percent of all caregivers, or more than 5 million individuals (AARP and NAC, 2020) in the United States.

Remote caregivers participate in a wide variety of common caregiving tasks (MetLife Mature Market Institute, 2004) but experience unique challenges, such as difficulty judging the health status of their care recipient (Koerin and Harrigan, 2003), issues communicating with health care providers (Mazanec et al., 2011; Starr et al., 2023), and financial strain from traveling to visit their care recipient (Douglas et al., 2016; MetLife Mature Market Institute, 2004). In 2004, *Miles Away: MetLife Study of Long-Distance Caregiving* surveyed more than 1,000 remote caregivers and found, despite an average distance of 450 miles and 7.23 hours of travel time one way, that the majority of remote caregivers visited their care recipient more than once per month (MetLife Mature Market Institute, 2004). Given this, it is unsurprising that very few caregivers who participated in the 2023 RAND Caregiving Survey (less than 2 percent) characterize the support they provide as exclusively remote.

In Chapter 1, we presented data on the percentage of caregivers who provide their care exclusively in person, exclusively remotely, and those who provide hybrid caregiving (i.e., mostly remotely, mostly in person). In this chapter, we compare *mostly remote military/veteran caregivers*, defined as those who provide care from a distance over half the time, with *mostly in-person military/veteran caregivers*, who provide care in person over half the time.

Key Findings

The challenges of caregiving can be exaggerated and complicated by distance. Approximately 70 percent of most military/veteran caregiver groups provide care exclusively in person; however, 28 percent of military/veteran caregivers to adults 60 or under are caregiving half of the time or more away from the care recipient. A greater proportion of military/veteran caregivers who provide most care remotely, compared to those who provide most care in person, met criteria for excessive burden, high stress, and depression.

Characteristics of Remote Caregivers

Most studies of distance caregiving found that remote caregivers tend to be younger, more highly educated, more likely to be employed, and more affluent than in-person caregivers (Douglas et al., 2016; Joseph and Hallman, 1998; MetLife Mature Market Institute, 2004). Commonly, remote caregivers are adults who have moved away from home, often away from older family members, to pursue education or employment opportunities.

There are few nationally representative samples of remote caregivers. One such study from 1997 found that women made up the slight majority (57 percent) of distance caregivers (Koerin and Harrigan, 2003), while the 2004 MetLife survey (Koerin and Harrigan, 2003) found that men were the slight majority (58 percent). In the 2023 RAND Caregiving Survey, 61 percent of *mostly remote* military/veteran caregivers were male, while 61 percent of *mostly in-person* military/veteran caregivers were female (Figure 9.1).

FIGURE 9.1
Gender of Mostly Remote and Mostly In-Person Military/Veteran Caregivers

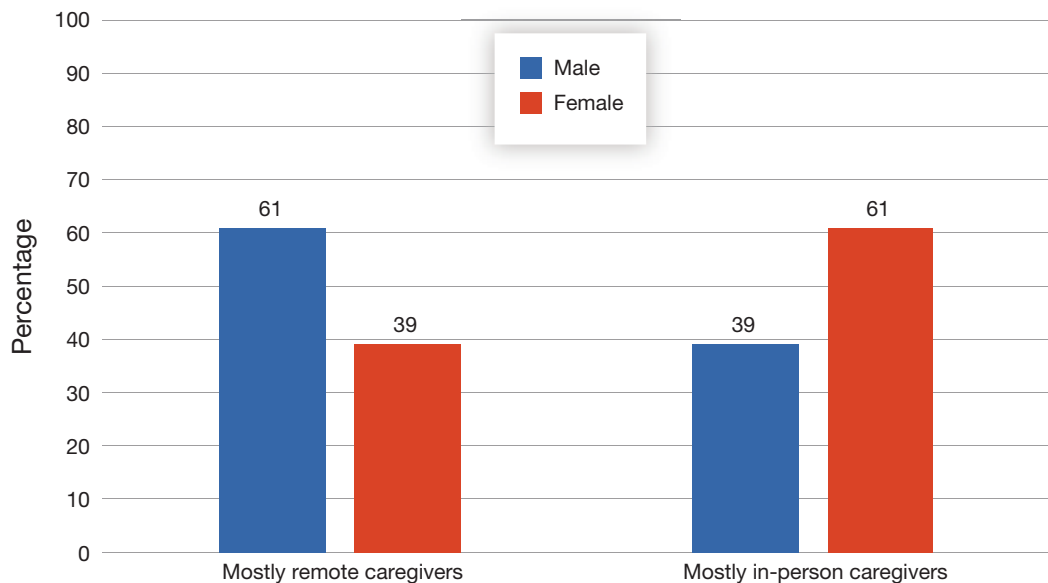


Figure 9.2 shows that approximately one-third (35 percent) of military/veteran caregivers who primarily provide support remotely are over the age of 45, while the majority (57 percent) of mostly in-person military/veteran caregivers are 45 or older. Primarily remote military/veteran caregivers are fairly evenly distributed across the younger age ranges: 20 to 25 percent are between 18 and 44 years old.

Relative to mostly in-person military/veteran caregivers, those who primarily provide support from a distance report higher annual income. Over half (55 percent) of mostly remote military/veteran caregivers earn \$60,000 or more per year, compared with 43 percent of mostly in-person military/veteran caregivers (Figure 9.3).

A complete summary of the demographic characteristics of military/veteran caregivers by whether they provide mostly remote or mostly in-person care is displayed in Table 9.1.

FIGURE 9.2

Age of Mostly Remote and Mostly In-Person Military/Veteran Caregivers

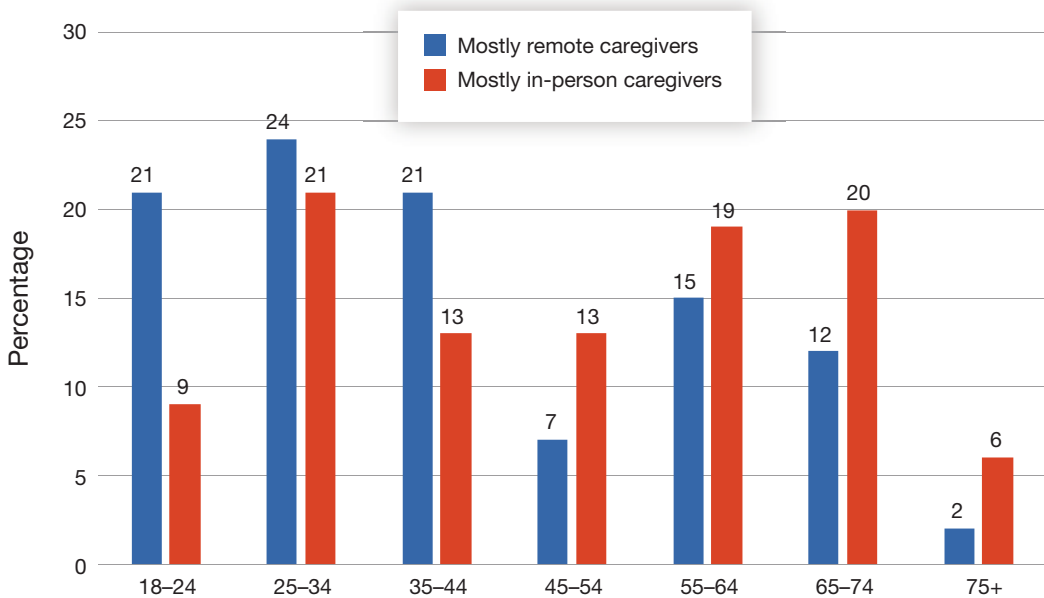
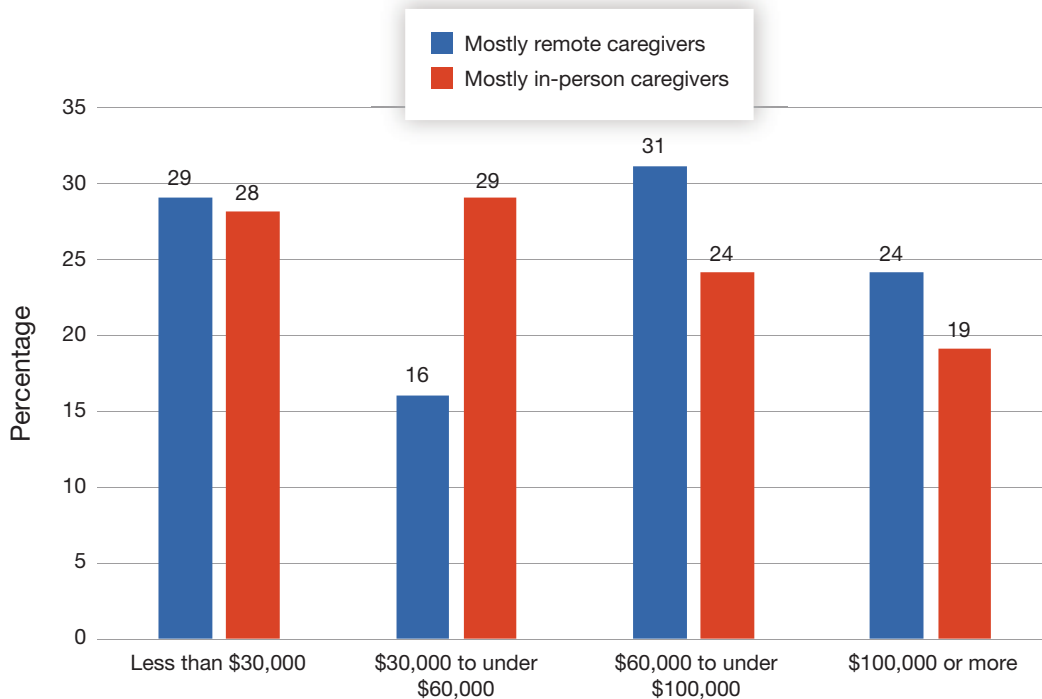


FIGURE 9.3**Income of Mostly Remote and Mostly In-Person Caregivers**

Characteristics of Remote Caregiving

Relationship to Care Recipient and Support from Other Caregivers

As shown in Figure 9.4, the largest portion (38 percent) of mostly remote military/veteran caregivers provide support for an “other relative” (i.e., a sibling, cousin, aunt, or uncle). Only 12 percent of mostly in-person caregivers support an “other relative.” Approximately one-third of mostly remote military/veteran caregivers are a child or grandchild caring for a parent or grandparent, a proportion comparable to the proportion of mostly in-person caregivers (i.e., 32 percent of mostly remote caregivers and 34 percent of mostly in-person caregivers). Nineteen percent of mostly remote military/veteran caregivers care for a neighbor, friend, or non-relative compared with a quarter (25 percent) of mostly in-person caregivers. Few (7 percent) military/veteran caregivers who primarily provide support from a distance are the spouse of their care recipient; in comparison, 27 percent of mostly in-person caregivers are spouses.

Almost a quarter of mostly remote military/veteran caregivers reported that they are the sole caregiver for their care recipient—not a secondary helper, as one might expect in situations when there is distance between a caregiver and care recipient. Forty-four percent of mostly remote caregivers share caregiving responsibilities with just one other individual (see Figure 9.5).

TABLE 9.1

Demographic Characteristics of Mostly Remote and Mostly In-Person Caregivers

	Mostly Remote Caregivers	Mostly In-Person Caregivers
Gender		
Male	61%	39%
Female	39%	61%
Age		
18–24	21%	9% ^{a,b}
25–34	24%	21%
35–44	21%	13% ^{a,b}
45–54	7%	13%
55–64	15%	19%
65–74	12%	20%
75+	2%	6%
Urbanicity		
Urban	79%	85%
Rural/highly rural	21%	15%
Race/ethnicity		
White, non-Hispanic	50%	55%
Black, non-Hispanic	27%	22%
Other, non-Hispanic	<1%	1%
Hispanic	14%	16%
Two or more races/ethnicities, non-Hispanic	<1%	2%
Asian, non-Hispanic	8%	3% ^{a,b}
Income		
Less than \$30,000	29%	28%
\$30,000 to under \$60,000	16%	29%
\$60,000 to under \$100,000	31%	24%
\$100,000 or more	24%	19%
Education		
Less than high school	19%	5%
High school graduate or equivalent	21%	32%
Some college/associate degree	28%	30%
Bachelor's degree	17%	22%

Table 9.1—Continued

	Mostly Remote Caregivers	Mostly In-Person Caregivers
Postgraduate study/professional degree	15%	12%
Employment status		
Working full time (≥ 35 hours/week)	39%	33%
Working part time (< 35 hours/week)	18%	15%
Unemployed and looking for work	9%	5%
Unemployed but not looking for work	0%	3%
Full-time care of the house and/or children	8%	3%
Full-time caregiver	2%	4%
Not working (retired, disabled, student, other)	18%	37%
Did not answer	6%	1%

^a Denotes statistically significant differences between remote and in-person caregivers in unadjusted regression models.

^b Denotes statistically significant differences between remote and in-person caregivers in regression models that adjust for income, age, and race/ethnicity.

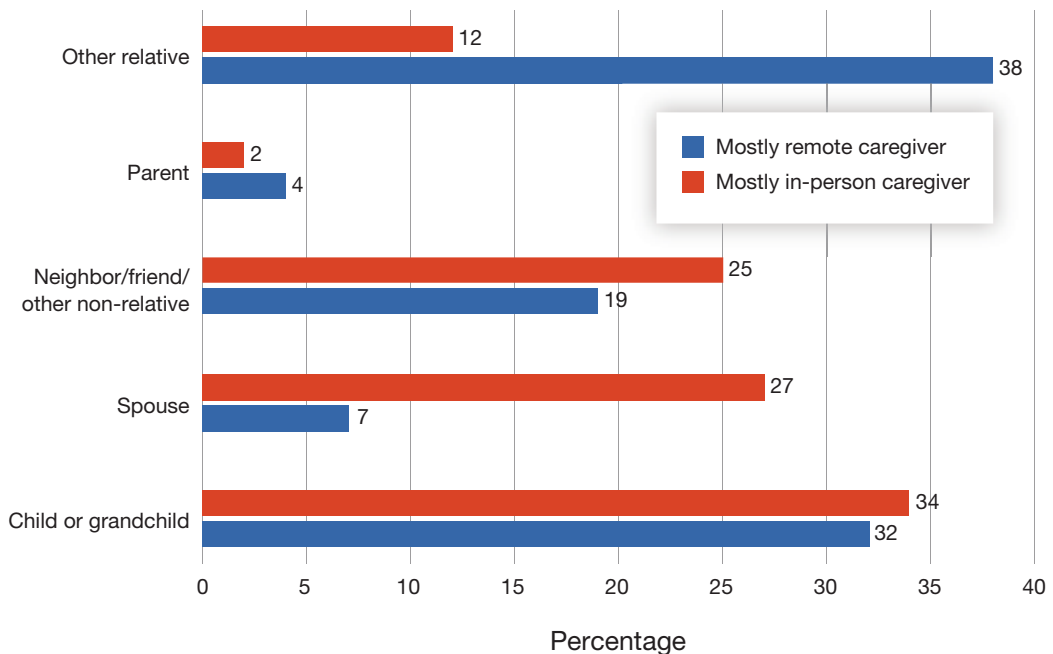
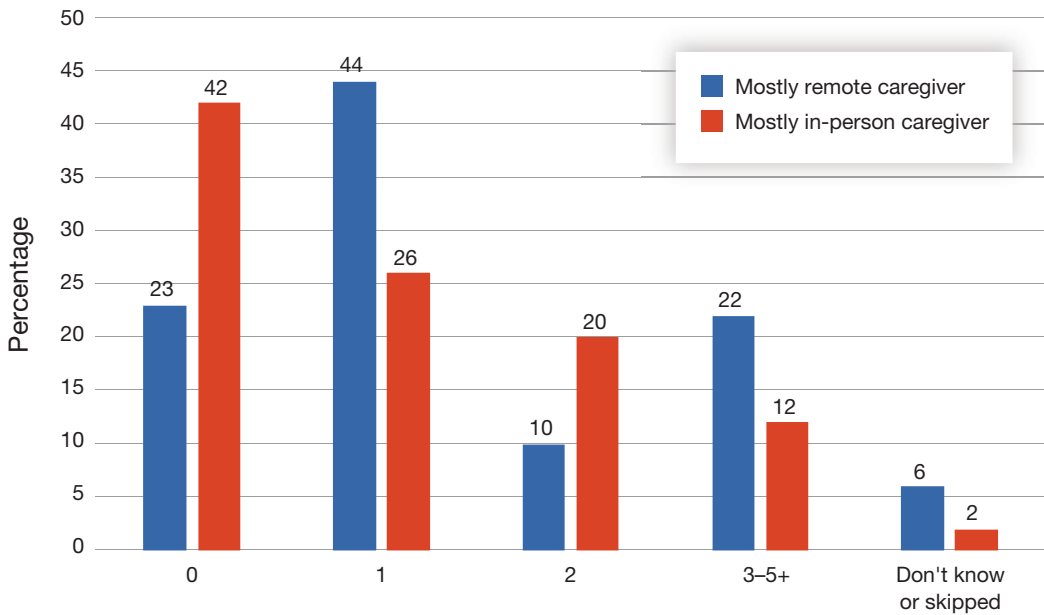
FIGURE 9.4
Caregiver Relationship to Care Recipient


FIGURE 9.5
Number of Additional Caregivers

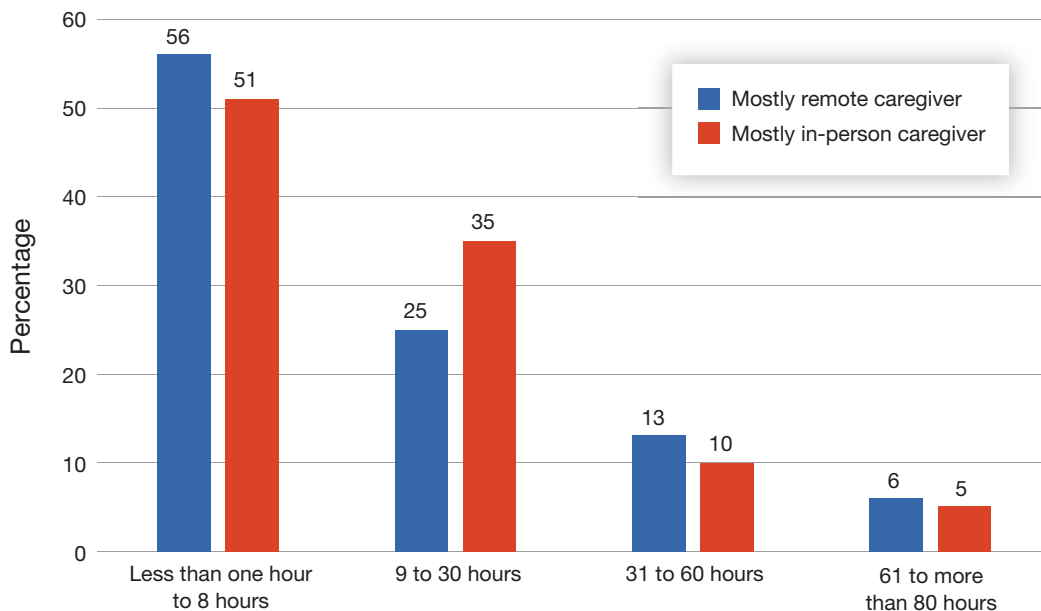


Hours Spent Caregiving

Figure 9.6 shows the number of hours military/veteran caregivers spend helping their care recipient in a typical week, and both caregivers who are mostly remote and those who are mostly in person spend similar and substantial periods of time helping their care recipients. Across both groups, nearly half of the caregivers spend between one and eight hours per week caregiving (49 percent of mostly remote caregivers and 45 percent of mostly in-person caregivers). A quarter of mostly remote caregivers and 35 percent of mostly in-person caregivers spend between nine and 30 hours helping their care recipient in a given week. Thirteen percent of mostly remote and 10 percent of mostly in-person military/veteran caregivers spend between 31 and 60 hours a week providing care. Only 6 percent of mostly remote and 5 percent of mostly in-person military/veteran caregivers spend over 61 hours per week helping their care recipient. This contradicts a misconception that remote caregivers do not spend much time caregiving. Though the survey did not ask specific details, such caregiving may be provided in discreet chunks of time (i.e., over a weekend or week), and/or the caregiver could be more regularly and frequently managing or coordinating care from a distance.

Caregiving Tasks

As described in Chapter 1, the 2023 RAND Caregiving Survey asked about caregiving tasks, including ADLs, IADLs, and emotional and cognitive tasks. For these questions, respondents were first asked whether the care recipient needed assistance with the task. If “yes,” they were then asked how often they assist their care recipient with the task (“never,” “sometimes,” or “often”).

FIGURE 9.6**Average Time Spent Caregiving per Week (remote versus in-person caregivers)****Activities of Daily Living**

Some forms of assistance are simply not feasible from a distance; however, most military/veteran caregivers who provide care remotely don't do so exclusively. So, it is unsurprising that mostly remote caregivers do assist with ADLs. Figure 9.7 shows the percentage of military/veteran caregivers who *ever* provide support across five ADLs, separately for mostly remote and mostly in-person caregivers.

Emotional and Cognitive Tasks

Caregivers also provide support with emotional and cognitive tasks. The 2023 RAND Caregiving Survey asked about assistance “remembering what [care recipient] should be doing” and “coping with stressful situations or avoiding ‘triggers’ of anxiety or anti-social behavior.” Mostly remote and mostly in-person caregivers report assisting with these tasks at similar rates (Figure 9.8).

Administering Medications, Doing Housework, and Providing Other Administrative Support

Table 9.2 shows the percentage of mostly remote and mostly in-person military and veteran caregivers who assist with a variety of administrative tasks included in the 2023 RAND Caregiving Survey. Mostly in-person caregivers more commonly report that they provide help with most of these tasks, with the exception of coordinating medical care and rehabilitative services. In particular, higher percentages of in-person caregivers report helping with duties that tend to require frequent in-person assistance, such as grocery shopping, preparing meals, housework (e.g., dishes, laundry, straightening up), and transportation.

FIGURE 9.7

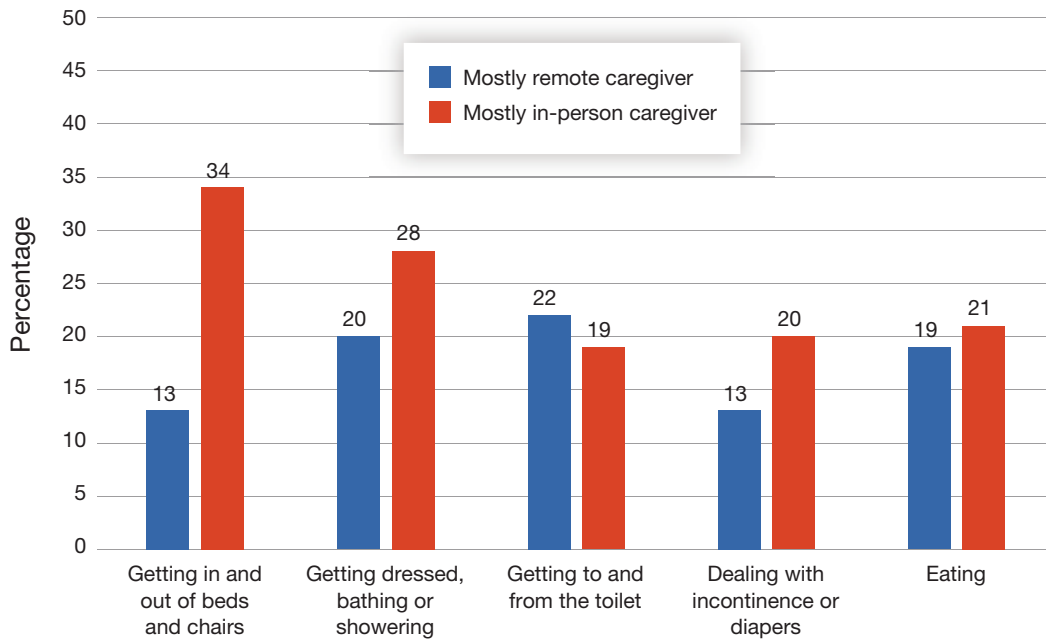
Assistance with ADLs

FIGURE 9.8

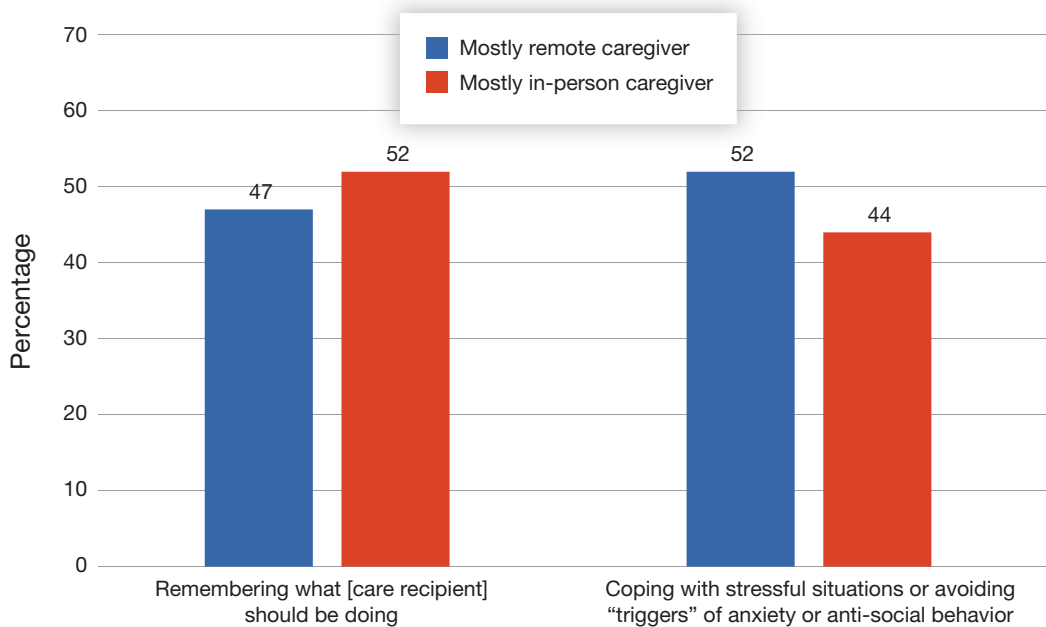
Assistance with Emotional and Cognitive Tasks

TABLE 9.2**Assistance Administering Medications, Housework, and Other Administrative Support**

	Mostly Remote Caregiver	Mostly In-Person Caregiver
Taking medicines or pills or injections	40%	45%
Managing finances (such as bills or insurance paperwork)	46%	55%
Grocery shopping	33%	67%
Preparing meals	19%	55%
Housework (such as dishes, laundry, or straightening up)	37%	68%
Transportation (driving, helping arrange for transportation, or accompanying on public transit)	35%	69%
Arranging or supervising paid services (such as nurses, aides, Meals on Wheels, or other services)	25%	37%
Coordinating medical care and rehabilitative services	57%	50%
Gaining access to, or information from, care providers, government agencies, or schools	44%	50%
Filling out paperwork related to benefits and compensation or legal issues	53%	56%

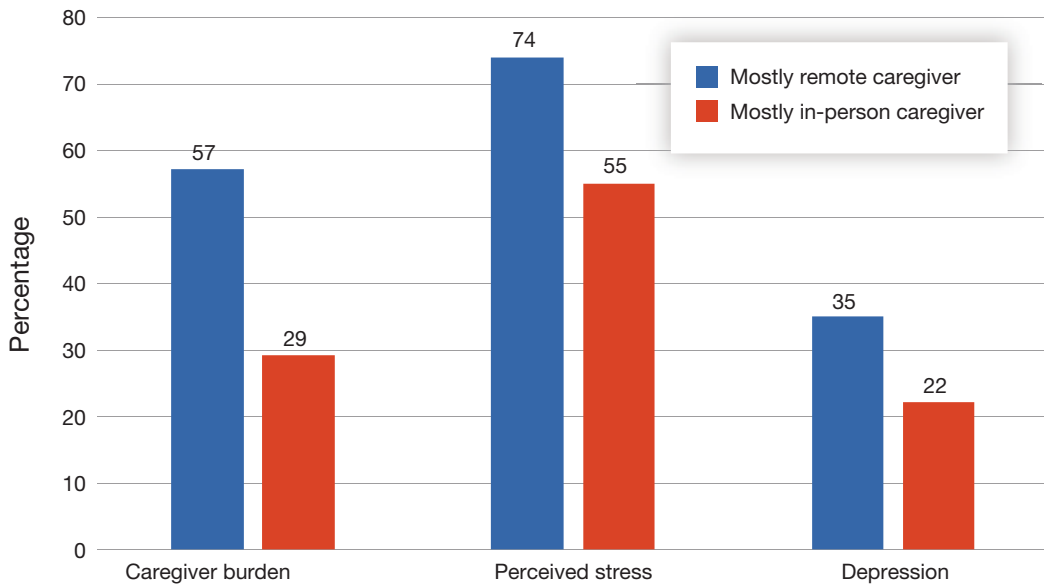
Mental Health of Remote Military and Veteran Caregivers

Mental Health Conditions

Figure 9.9 compares mostly remote and mostly in-person military/veteran caregivers across three mental health conditions: caregiver burden, perceived stress, and depression. For more information on these measures, see Chapter 2.

Across all three domains, higher percentages of mostly remote caregivers than mostly in-person caregivers report experiencing these conditions, differences that were statistically significant. Over half (57 percent) of the mostly remote military/veteran caregivers report experiencing excessive caregiver burden, compared with 29 percent of caregivers who provide help mostly in person. Nearly three-quarters (74 percent) of mostly remote caregivers and over half (55 percent) of mostly in-person caregivers perceive their level of stress to be high. Over a third (35 percent) of mostly remote military/veteran caregivers met probable criteria for depression, relative to 22 percent of mostly in-person caregivers.

FIGURE 9.9

Mental Health Conditions

NOTE: All differences are significant at $p < 0.05$.

Personal Gain from Remote Caregiving

Though there can be negative experiences associated with caregiving, there are many positive and rewarding experiences as well. The 2023 RAND Caregiving Survey asked caregivers the four-item Personal Gain Scale (see Chapter 2 for more information), which includes questions about becoming more aware of inner strengths, becoming more self-confident, growing as a person, and learning to do new things. Both mostly remote and mostly in-person caregivers had an average personal gain from caregiving score of 2.6, which is just over midway between the least affirming and most affirming.

Conclusions and Recommendations

Across the previous chapters, *Emerging from the Shadows* has provided insights into military and veteran caregivers. In addition to enumerating the size of the population, it has described them, those for whom they are caring, and the caregiving activities they perform; the support programs that caregivers access; and the positive and negative consequences of caregiving. It has shown how military and veteran caregivers differ from civilian caregivers, how those caring for individuals 60 and under differ from those who care for individuals over 60, and how caregivers differ from each other based on where they live. It has also described how caregivers' families and children are faring and how institutions, such as health care facilities and workplaces, are and are not accommodating caregivers. Finally, it has provided estimates of the costs of caregiving, including out-of-pocket expenditures and forgone earnings, as well as estimates of the value that caregiving provides to society.

Summary of Key Findings

This research initiative set out to address the following broad questions.

1. How many individuals are serving in caregiving roles, and how many are providing this care to a service member or veteran?

There are 14.3 million military/veteran caregivers, which is 5.5 percent of the U.S. adult population. There are an additional 91.3 million civilian caregivers (35.0 percent of U.S. adults) caring for wounded, ill, or injured civilian adults. The number of caregivers per state varies but likely exceeds 1 million veteran caregivers in each of Texas, California, and Florida. These estimates are substantially larger than past estimates, which is likely due to implementing a new approach for identifying caregivers that asked respondents whether they conducted specific caregiving activities instead of whether they identified as a caregiver.

2. What do military/veteran caregiving duties look like?

Military/veteran caregivers are a heterogeneous group; in this report, those providing care to service members and veterans 60 and under were often examined independently from those

caring for veterans over 60. Three-quarters of military/veteran caregivers are providing care to those over 60. Most of this group of caregivers were children caring for aging fathers or spouses caring for a husband (most veteran care recipients over 60 are men). Many of these veteran care recipients have chronic conditions (such as diabetes or cardiovascular conditions) and/or hearing or vision impairments. Half of their caregivers help with at least one ADL, and an additional 25 percent help provide cognitive support (e.g., memory) or emotional support.

The remaining one-quarter of military/veteran caregivers to individuals 60 and under look very different from those providing care to veterans over 60, and they are also different from their peers caring for civilians 60 and under. These military/veteran caregivers include more friends, siblings, and aunts and uncles. They were also providing care to individuals with chronic conditions and vision or hearing impairments, but two-thirds were caring for someone with a diagnosed mental health and/or substance use disorder, and one-fifth were caring for someone with a TBI diagnosis. However, the research revealed that existing scales and measures used to describe caregiving tasks (such as providing assistance with ADLs and IADLs) do not adequately capture the duties and activities associated with caring for individuals with mental health or cognitive conditions, such as dementia.

3. How are military/veteran caregivers faring relative to each other and to non-caregivers with respect to their health and well-being, their economic security, and their families' well-being?

Caregivers to wounded, ill, or injured service members or veterans 60 and under are faring particularly poorly. Forty-three percent met criteria for probable depression, and approximately one-third thought that they needed mental health care but did not access it, largely due to time constraints. Seventy percent reported some difficulty paying bills, and 40 percent met criteria for being food insecure. These proportions generally surpass the percentage meeting these criteria among non-caregivers.

Caregivers to wounded, ill, or injured service members or veterans over 60 generally fare comparably to non-caregivers, but this does not suggest that they do not also have unmet needs. For example, 15 percent met criteria for probable depression, and 16 percent wanted, but did not access, mental health care—largely due to concerns about the cost of this care. Around half reported some difficulty paying their bills.

Military and veteran caregivers provide tremendous value to society, estimated anywhere between \$119 billion and \$487 billion per year. However, caregiving comes with financial costs: on average, \$8,583 in out-of-pocket costs per year and over \$4,000 in forgone earnings. These costs may be one contributing factor to the proportion of military/veteran caregivers (35 percent) with incomes below 130 percent of the federal poverty level.

Caregiving also affects families. Caregivers caring for a wounded, ill, or injured service member or veteran 60 or under reported lower levels of relationship quality and family cohesion, and higher levels of conflict, relative to non-caregivers. Around 40 percent of military/

veteran caregivers are also caring for a child. Many of these children help with caregiving tasks and also take on more household chores than children in non-caregiving households. Children of military/veteran caregivers also experience greater emotional and behavioral problems than non-caregivers.

However, there are positive findings in this research as well. Many caregivers reported personal gains due to caregiving, particularly spouses, those who assist with ADLs, and those who have provided caregiving support for longer periods of time. Those who said that religion was very important to them reported less caregiver burden. Children of military/veteran caregivers exhibited more prosocial behaviors than their peers. And, finally, caregivers who use support programs are often satisfied with the support they receive.

Limitations

Before describing the recommendations stemming from this research, it is important to note its limitations. Most of these limitations are common in survey research. We specifically note the following.

- **Nonresponse bias:** There are two-sources of nonresponse bias. First is *sample nonresponse*, in which those who respond to the invitation to participate in the survey differ from those who do not. The nonresponse weights described in Chapter 11 attempt to address this under the assumption that by adjusting on *observable* characteristics (e.g., gender, age, etc.), differences in unobserved characteristics is also minimized. However, this assumption is difficult to test, and it is not clear how it may bias results. Perhaps caregivers who devote tremendous amounts of time to caregiving or are balancing too many responsibilities are systematically excluded simply because they do not elect to take time to participate in survey research. The sample for the 2023 RAND Caregiving Survey was representative of the U.S. population as a whole, in which all members of the U.S. population had an equal chance to participate in the survey. To guard against systematic nonresponse among caregivers, one would need to design a nationally representative sample of caregivers, in which all caregivers had an equal chance to participate.

The second form of nonresponse bias is *item nonresponse*, in which those who skip or do not answer specific questions differ from those who do. To honor survey respondents, none were forced to answer a question, but if they opted not to answer they were given a second chance to respond before moving to the next question.

- **Self-report bias:** By its nature, survey data are self-reported, which creates biases. There are many forms of self-report bias that could impact the study results. *Social desirability bias* occurs when respondents report answers to questions that conform to what they believe is acceptable or appropriate. For example, Chapter 2 presents information on such constructs as depressive symptoms, suicidal ideation, and alcohol and drug use. Respondents may report not engaging in certain behaviors or minimize the frequency

in which they engage in certain behaviors (or have certain thoughts). Thus, the results presented in this report may be *underestimates* due to social desirability.

Another form of self-report bias is *recall bias*, in which survey respondents misrecall events that occurred in the past. For example, Chapter 4 presents information on caregivers' participation in programs that offer support. When taking the 2023 RAND Caregiving Survey, some respondents may forget having taken a training or attending a support group. They may also not know a program by its formal name or by the way it was asked about in the 2023 RAND Caregiving Survey. A specific type of recall bias is *telescoping bias*, in which respondents recall something from the past but remember it occurring further or more recently in the past than it actually occurred. Many of the questions in the 2023 RAND Caregiving Survey ask about "the past two weeks," "the past month," or "the past year." Survey respondents may recall things that occurred more than a year ago as happening in the past year. This is mentioned in Chapter 3 as a potential reason why survey respondents reported higher rates of receiving stimulus payments than would be expected given the timing of the survey.

- **Proxy respondent bias:** Chapter 1 presents information about care recipients, and Chapter 6 presents information about respondents' children, but both types of information come from the respondents. It may be that respondents do not know the information or do not know the correct information. For example, some civilian caregivers may not know that the person they are caring for served in the military, particularly if they served for a short period of time many years ago. Military/veteran caregivers may not have correctly responded about the service branch in which the care recipient served, era of service, characterization of discharge, or VA disability rating.
- **Cross-sectional analyses:** The survey is cross-sectional, and, for the most part, data are provided descriptively. However, in certain instances, regression models are estimated to discern relationships between constructs. In estimating these models, a relationship is assumed: For example, in Chapter 2, hours per week spent caregiving is examined (along with many other covariates) in relation to depressive symptoms. Although interpretation of the model may imply that more hours spent caregiving *lead to* depressive symptoms, it is also possible that caregivers with elevated depressive symptoms systematically overreport how many hours they spend caregiving, generating the same pattern of results.
- **Misspecification:** Some questions lack precision that would be important to truly evaluate a program or experience. For example, in Chapter 4, caregivers were asked whether they had participated in a series of programs, and those who reported participating were asked how satisfied they were with the programs. For those who have participated in multiple support groups, trainings, respite programs, or other programs, satisfaction ratings reflect general perceptions and should not be used to evaluate specific programs. The same is true for information presented in Chapter 5: Although information is presented for those whose care recipients receive *most* care at VA, the responses to these items may not pertain specifically to experiences at VA facilities.

- **Subpopulation analyses:** Finally, estimates are presented for subpopulations of military/veteran caregivers, including caregivers concerned about suicide risk (Chapter 2), caregivers with children who perform caregiving tasks (Chapter 6), and rural caregivers (Chapter 7). In these instances, results are meant to be *suggestive* of the experiences of these subpopulations. However, because the sampling procedure was not specifically conducted to sample caregivers in these subpopulations, the estimates are not necessarily *representative* of the entire subpopulation.
- There are additional limitations, which are specific to modeling approaches associated with estimating the value and costs of caregiving (Chapter 3) and used to estimate caregivers by state (Chapter 7). Those limitations are discussed in more detail in those sections.

Recommendations

In review of the results, we make nine recommendations for better supporting military and veteran caregivers specifically, but these recommendations will likely also benefit all caregivers. These recommendations are primarily intended for policymakers and organizations working to support military and veteran caregivers and those for whom they are caring. However, the recommendations will likely also be of relevance to other audiences, including employers, those who run health care systems (including insurers), researchers, and—most importantly—caregivers themselves.

Beyond these specific recommendations, it is worth noting that military/veteran caregivers are affected by challenges that beset other members of their communities as well. Issues such as shortages of child care, high housing costs, insufficient numbers of mental health care providers, and inflation burden many Americans. Policies and programs designed to alleviate these and other widespread problems will also benefit caregivers. Accordingly, those wishing to improve outcomes for caregivers should consider supporting initiatives designed for broader communities that would *also* benefit our nation's hidden heroes as they emerge from the shadows.

Recommendation 1. Increase access to mental health and substance use treatment for caregivers and their children.

Access to high-quality mental health care for those who need it is a perennial problem for the entire American population, including military and veteran caregivers and their families. Access challenges have only increased since the COVID-19 pandemic and associated lockdowns, which, as described in Chapter 2, increased demand for mental health care. There are known shortages of mental health care providers (Counts, 2023); unequal distribution of providers across the United States (Counts, 2023); cost barriers exacerbated by an increasing number of out-of-network providers who only take private payment (Carlo et al., 2023); and known gaps in the quality of care offered, particularly culturally competent care for service

members, veterans, and their families (Tanielian et al., 2014). Inaccurate information about mental health care also remains prevalent, as evidenced in part by data provided in Chapter 2: Many of those wanting but not accessing mental health care are concerned about hospitalization or taking medications.

However, need for mental health care among caregivers is high. A quarter to nearly half of military and veteran caregivers met criteria for probable depression, of whom only 20 to 50 percent were accessing mental health care. Among military and veteran caregivers to those 60 or under, 20 percent have had recent thoughts about ending their own lives. Care for substance use is also necessary: A quarter to 40 percent of military and veteran caregivers drink amounts of alcohol that are considered unhealthy. The need is also great for children in caregiving households: Nearly a quarter of military and veteran caregivers with a child under 18 reported that the child needed mental health care but did not receive it. In fact, the shortage of child mental health care providers is even more pronounced than the shortage of providers who serve adults (American Academy of Child & Adolescent Psychiatry, 2023).

There are efforts to increase mental health care access to military and veteran caregivers. As of May 2023, there was a pilot program offering mental health care to caregivers enrolled in VA's PCAFC. Networks of providers, including Cohen Veterans Network and the Headstrong Project, offer mental health care to service members, veterans, and their families. Continued partnerships between those organizations serving military and veteran caregivers and these resources are critical.

There are additional opportunities to expand access to mental health care as well. As described in Recommendation 3, new modes of delivery—including tele-mental health and asynchronous counseling—may be effective ways to reach caregivers. However, there are some barriers here as well. For example, state licensure requirements often restrict where mental health care providers can practice, which can stand in the way of a provider in New Jersey caring, via telehealth, for a patient in Arkansas. The Interstate License Compact attempts to address this by granting interstate licensure, but at the time this report was written (spring 2024), only 37 states were members, and some states with high numbers of military and veteran caregivers were not yet members, such as Florida (where legislation was recently introduced), California, Arkansas, Virginia, and South Carolina (Interstate Medical Licensure Compact, undated).

For low-acuity mental health needs, mobile health applications may hold promise, as described in Recommendation 3. The use of paraprofessionals may be another way to address low-acuity mental health needs of caregivers. Termed *task-shifting* or *task-sharing*, this process equips individuals, particularly those already serving in roles that involve regularly interacting with people with mental health needs, with skills and tools to address low-acuity mental health symptoms in the people they encounter, as well as referral strategies for those with more serious needs. A recent RAND evaluation of New York City's task-shifting program, called Connection to Care, yielded positive results (Ayer and Schultz, 2020).

Between 50 and 75 percent of military and veteran caregivers have seen a doctor for a routine checkup in the past year. Better integrating mental health care into primary care

may also help address caregivers' mental health needs. This may be particularly important for military and veteran caregivers in rural communities who, as described in Chapter 7, were more likely to have had a checkup in the past year but less likely to have seen a mental health care professional, even when there was a need. Collaborative Care is a specific model of integrating mental health care into primary care that "focuses on defined patient populations tracked in a registry, measurement-based practice, and treatment to target. Trained primary care providers and embedded behavioral health professionals provide evidence-based medication or psychosocial treatments, supported by regular psychiatric case consultation and treatment adjustment for patients who are not improving as expected" (University of Washington, Medicine, Department of Psychiatry and Behavioral Sciences, undated). Collaborative Care has been tested and shown to improve mental health symptoms, and the Path Forward advocates for increased implementation of the model across the United States. Organizations interested in improving mental health care for caregivers should consider promoting Collaborative Care in primary care settings that serve these caregivers.

Recommendation 2. Increase opportunities for caregivers to access available financial support, and offer additional financial compensation to caregivers for the work they perform.

Caregivers provide enormous value to society. According to estimates provided in Chapter 3, military and veteran caregivers provide a value to society that ranges from \$119 billion to \$485 billion annually. Yet, aside from those who are enrolled in VA's PCAFC, few are compensated in any way for this care. In fact, caregivers are monetarily penalized: Over a quarter of military and veteran caregivers reported that, because of caregiving, they had cut back the hours they work, switched jobs, quit working or left school early, or felt that they were discriminated against at work. These disruptions translate to lost income: According to the survey estimates, military and veteran caregivers who cut back on their work or schooling because of caregiving lose approximately \$10,000 in household income in a given year. And caregivers are struggling: Between 50 and 70 percent of military and veteran caregivers have difficulty paying bills, and 22 to 40 percent are food insecure.

To begin, organizations that serve caregivers should inform them of programs that may be able to provide additional financial assistance and help them apply for this assistance. For example, only a quarter to a third of military and veteran caregivers who are food insecure and could possibly benefit from SNAP are enrolled in the program. For military and veteran caregivers with incomes below 130 percent of the federal poverty level, fewer than 15 percent receive SSI. More caregivers are eligible for these financial benefits than are accessing them, and programs should promote uptake in a humanizing and non-stigmatizing way. This may include knowing what programs caregivers may be eligible for, providing resources on these programs, and even helping caregivers apply for them. Organizations serving military and veteran caregivers should also complement VA's own outreach and application assistance for those eligible for PCAFC, which includes a monthly stipend as one of the program benefits.

In January 2024, a bipartisan group of senators reintroduced the Credit for Caring Act, which would provide up to a \$5,000 federal tax credit for eligible caregivers. This aligns with the 2021 expansion of the Child Tax Credit during COVID-19 under the American Rescue Plan Act that was estimated to have raised 4.3 million people out of poverty (Center on Budget and Policy Priorities, 2022b) and the Earned Income Tax Credit available to low- and middle-income working people that is estimated to have lifted 5.6 million people above the federal poverty level (Center on Budget and Policy Priorities, 2022a). A caregiving tax credit may provide similar benefits for caregivers, particularly the 35 percent of military caregivers who have incomes below 130 percent of the federal poverty level.

The Elizabeth Dole Foundation offers emergency financial assistance through the Hope Fund, and emergency funds are available for eligible veterans from other organizations as well. Only around half of all military and veteran caregivers have rainy day funds set aside, and caregivers may be more likely to experience economic shocks due to increased out-of-pocket expenses associated with caregiving and/or reductions in income due to work disruptions caused by caregiving. Ensuring that military and veteran caregivers are aware of available resources and encouraging those in need to avail themselves of them—again, in a humanizing and non-stigmatizing way—are important for organizations that support these caregivers. However, it is also important to encourage caregivers to think about and plan for the future to ensure that they have resources to accommodate future caregiving and personal needs.

Recommendation 3. Tailor caregiver support programs to reflect caregivers' diverse preferences and needs.

Many caregivers who are struggling are not accessing programs and care: Fewer than half of military and veteran caregivers who were excessively burdened used a support service, and between 16 and 36 percent of those who think they need mental health services have not accessed such care. As described in the Introduction and Background chapter, there has been an influx of programs to support caregivers, and the results suggest that these programs are warranted.

The 2023 RAND Caregiving Survey did not ask about specific barriers to program participation but did ask about barriers to care among those who wanted but did not access mental health services. Drawing on this evidence, as well as insights provided from other areas of the 2023 RAND Caregiving Survey and other research, programs may need to tailor programs to better align with caregivers' preferences and needs to increase uptake of these support services. This can be accomplished with the way programs conduct outreach, the content of the programs they deliver, how they deliver these programs, and the partnerships they form to maximize their impact.

Recommendations for Tailoring Program Content

Caregivers are anything but a homogeneous group: For example, this report has showcased how military and veteran caregivers differ from each other, but also how those caring for ser-

vice members and veterans over 60 differ from those caring for service members and veterans 60 and under. Programs are needed for both groups: Caregivers to those over 60 account for three-quarters of all military and veteran caregivers. However, military and veteran caregivers to those 60 and under are, by many metrics, struggling the most; for example, they have higher rates of mental health conditions and substance use and are less likely to have another caregiver in their caregiving network.

The programs afforded to both groups, however, should reflect their preferences, which are listed in Table 4.9. The most commonly sought-after programming by military and veteran caregivers to those 60 and under were activities they could do with the person they were caring for. On the other hand, for those caring for individuals over 60, the most sought-after programs were those focused on keeping the care recipient safe at home. Not all programs need tailoring, however; around one in five caregivers across all groups sought programs on managing physical and emotional stress.

In addition to these recommendations, rates of potentially hazardous drinking were elevated among caregivers to those 60 and under. Those offering recreational programs for this group of caregivers should consider whether to serve alcohol at these events or whether there are non-alcoholic options to offer or promote.

Recommendations for Tailoring Program Delivery

Caregivers may not be accessing programs because they are not being offered in formats that align with caregivers' needs and preferences. Although the 2023 RAND Caregiving Survey did not ask about all caregivers' preferences or barriers to care, three-quarters of military and veteran caregivers to those 60 and under who thought they needed mental health treatment but did not receive it reported that time constraints affected their ability to access care. This finding suggests that those offering programs need to demonstrate the value that their programs provide to caregivers and ensure that caregivers are aware of these benefits (which relates to Recommendation 8 described below). But it also suggests that programs may need to adapt to meet the time pressures and schedules of caregivers. This adaptation may include more online options (for example, increased telehealth options for accessing mental health care, which are expanding; Cantor et al., 2024) and/or more programs offered on different days of the week and at different times of day (including on weekends and evenings). It may also require considering new modes of program delivery. For example, asynchronous telepsychiatry occurs when patients provide information to clinicians at their preferred time, and clinicians review this information and make clinical decisions at a later time. Such programs have improved non-urgent mental health concerns (Yellowlees et al., 2021) and may provide an attractive model for delivering mental health care or other programs to caregivers with demanding schedules. There is also evidence that psychoeducation provided via mobile health apps can reduce stress and may also be an option for offering support to caregivers on their schedules and addressing their desire to help with stress reduction (Egger et al., 2023). Finally, VA is piloting a Technology Enabled Homecare Respite Model that may make respite care more accessible to caregivers.

The benefits afforded by technology (i.e., tele-mental health, asynchronous programs, mobile health apps) should be considered alongside caregivers' preferences. The 2023 RAND Caregiving Survey did not ask respondents their preferences for online versus in-person support, though, as described in Chapter 4, at least as many—and potentially more—caregivers accessed in-person support groups as they did online support groups. This may indicate a preference for in-person connections with other caregivers. As described in Chapter 4, caregivers who participate in in-person support groups have less difficulty getting help providing care and less difficulty finding someone else to take on their caregiver responsibilities while they are away from home. Just as online programs may better meet some aspects of caregivers' needs, these results suggest that in-person support also provides unique benefits. Thus, organizations wanting to support caregivers should explore the benefits that technology may offer, not necessarily to replace the in-person services they are already offering but as a means to expand them. In fact, expanding both in-person and online programming may be the best approach for better serving all caregivers.

Recommendations for Tailoring Outreach

The number of people who identified as performing caregiving duties in the 2023 RAND Caregiving Survey, relative to those who identified as caregivers in past studies, suggests a significant population of caregivers who do not identify as such. Efforts may be needed to educate caregivers to identify as such and thus recognize and avail themselves of services and benefits available to them. At the same time, programs offering support should consider alternative messaging strategies to reach those in need. For example, rather than advertising a support group to “caregivers to persons with dementia,” a program may advertise a support group for individuals “who help loved ones remember things due to dementia.”

In addition to how programs conduct outreach, the results presented in Chapter 7 suggest that outreach, and programs, should be concentrated where military and veteran caregivers live. Although where military and veteran caregivers live generally align with where Americans live, with many in California, New York, and Ohio, it is notable that almost half of military and veteran caregivers live in the South. According to estimates provided in Chapter 7, within the South, there are large numbers of caregivers in Texas, Florida, Georgia, and North Carolina. Targeted outreach in these states is warranted. It is also noteworthy that nearly a third of military and veteran caregivers to those 60 and under live in rural communities; programs tailored to military and veteran caregivers living in rural communities, within these states specifically but also across all states, are needed.

Recommendations for Tailoring Program Partnerships

There is evidence of strong collaborations across organizations seeking to support military and veteran caregivers, including the Elizabeth Dole Foundation, American Red Cross, Wounded Warrior Project, AARP, Blue Star Families, TAPS, and many others (see the appendix). Strengthening partnerships with religious institutions may help bolster supports to mil-

itary and veteran caregivers. In Chapter 4, evidence is provided that caregivers who deem religion as “very important” or “somewhat important” in their lives report less caregiver-related burden. Although this report does not delve into the mechanisms underlying this relationship, religion can provide both spiritual support and instrumental support from a community with shared religious beliefs. Partnering with religious institutions could both expand the network of those committed to caring for military and veteran caregivers and potentially improve the quality of support caregivers may receive.

There are various models for partnering with religious institutions to expand support services. For example, a RAND study evaluated a partnership between the National Alliance on Mental Illness and the Diocese of San Bernardino to examine a parish-based approach for reducing stigma, improving mental health literacy, and increasing access to mental health care among Latino parishioners (Wong et al., 2023). In addition, the National Action Alliance for Suicide Prevention has produced a guide for faith leaders to help prevent youth suicide (U.S. Department of Health and Human Services, 2023a). Bilateral conversations between religious organizations, many of which have long histories of both formal and informal support for caregivers, and organizations that work to support military and veteran caregivers will likely produce shared learnings that could expand reach, services, and the support provided to caregivers. VA’s Center for Faith-Based and Neighborhood Partnerships could play a role in facilitating these discussions (VA, 2022b).

Recommendation 4. Expand and promote home health care considering how caregivers will be affected.

In recognition of most older Americans’ desire to age at home, there has been a recent expansion of home and community-based health care options, including home health care aides, adult day programs, and assisted living options. VA offers a suite of these options to eligible veterans, including home-based primary care, respite care, and hospice care (Harrison, 2023). Approximately half of military and veteran caregivers reported using home health care in the past two years.

Home health care affords benefits to care recipients and caregivers. It often accommodates care recipients’ preferences, it may be less expensive than institutional care, and it may be as effective (Fikar and Hirsch, 2017). It may also reduce infections, such as methicillin-resistant *Staphylococcus aureus* (MRSA), that are transmitted by workers in health care settings and nursing homes (Roghamann et al., 2016). For caregivers, it may alleviate transportation requirements to and from medical appointments for the care recipient. According to analyses presented in Chapter 5, caregivers who used home health care report less caregiver burden, even after accounting for many caregiving activities, time spent caregiving, and the care recipients’ health conditions.

While there are benefits, less is known about the impact on caregivers. We do not currently know, and our study did not assess, whether expansion of home health care will create new burdens or duties that have not yet been considered. For example, although home health

care may alleviate some caregiving duties, it may also create new ones, such as coordinating and training home health care teams and providers. It may also increase out-of-pocket costs associated with purchasing furniture or other equipment to keep care recipients safe at home. If home health care aides are unavailable, it may cause more work disruptions for the caregiver and result in additional forgone earnings. Caregivers may also need to create protocols to monitor the quality of care being provided to the care recipient because home health care aides do not have supervisors on site with them. And, finally, caregivers will have to identify how to pay for home and community-based services. As previously mentioned, VA provides some of these services for those eligible for them, but additional services are rarely paid for by private insurance. Rather, they are financed via state and local programs, via Medicaid, and out of pocket; caregivers will need support to identify the appropriate services for them and how they will pay for these services.

Helping caregivers navigate home health care will require a multi-pronged approach. Most immediately, caregivers may benefit from guidance about what to look for in a home health aide, how to ensure that the care is high quality, and how to pay for this care. Organizations such as AARP already provide some of this information. But policy changes and structural changes to better deliver this care are also needed and can help ease caregivers' burden managing this care. For some patients, one researcher advocates that primary care groups operating under value-based payment in Medicare Advantage may be well poised to organize, deliver, and ultimately be accountable for the care delivered in homes (Tumlinson, 2022). More-specific recommendations are beyond the scope of this report, but it is important that those who support caregivers pay attention to the expansion of home and community-based services, how such expansions affect and will affect caregivers, and potential solutions—including policy solutions—that can help caregivers and care recipients truly benefit from care provided in the home.

In addition, home and community-based care may not be appropriate for everyone. VA's AL-TBI pilot program provided residential care to veterans with TBI but has since sunsetted. Though the pilot program was supposed to be evaluated, we were unable to find the evaluation to determine the pilot program's impact on care recipients or their caregivers. In addition, the optimal suite of home and community-based services for care recipients with conditions such as dementia, depression, and PTSD is still unclear (Harrison, 2023). Thus, though home and community-based services hold promise, they will not entirely eliminate the need for long-term residential care facilities. Policymakers need to plan carefully to ensure the appropriate mix of services to better care for current wounded, ill, and injured veterans, as well as the projected needs as the veteran population ages.

Recommendation 5. Focus programmatic and social support within the context of local conditions in which military/veteran caregivers live.

Military/veteran caregivers live in neighborhoods that have few resources. This is especially the case for military/veteran caregivers with care recipients who are 60 and under. Though there was not necessarily statistical evidence of differences with non-caregivers, this was likely attributed to a lack of statistical power, because the median neighborhood income of military/veteran caregivers with care recipients 60 and under was \$64,592; an average of 11 percent of households where these caregivers live have incomes below the federal poverty level; and the average Child Opportunity Index, which reflects a range of neighborhood resources and quality, is 39—lower than among all other groups. These differences speak to structural and systematic differences in where military/veteran caregivers live in the United States, and how resourced their neighborhoods are.

Yet, analyses specific to military and veteran caregivers found that lower socioeconomic conditions were associated with fewer reported depression symptoms. There were similar unexpected results with use of support programs. Such findings suggest that a more nuanced approach to understanding the mechanism of such associations is necessary. It may be that for individuals in need of support, such as caregivers, those in lower socioeconomic neighborhoods may receive more support from their neighbors. There is compelling research that concentrations of similar individuals within a community can provide support: For example, older widows living in communities with higher concentrations of other older widows had lower risk of mortality than those in communities without such concentrations (Population Reference Bureau, undated). However, this research is not conclusive—neighborhood ethnic enclaves may promote health and well-being in some ways (Kovalchik et al., 2015) but are also indicative of racially segregated communities that can be deleterious to one's health (Freedman, Grafova, and Rogowski, 2011).

A National Academies of Sciences, Engineering, and Medicine report on family caregiving (Schulz and Eden, 2016) called for a transformation in the policies and practices affecting the role of families in the support and care of older adults. From a health-equity perspective, military/veteran caregiver well-being depends in part on the well-being of where they live. Unequal allocations of resources in neighborhoods manifest into unequal social, economic, and environmental drivers of residents' well-being.

In this light, policies and interventions that target local resources, such as housing, food access, or economic conditions, for low-resourced communities generally hold promise to ultimately impact military/veteran caregivers' health and well-being. These policies and programs are often local in nature and thus require national organizations advocating for military and veteran caregivers to ensure a focus on state- and community-level policies. For example, access to SNAP benefits to support those who are food insecure varies by state, and food-insecure veterans in states with broad-based categorical eligibility, combined applications with SSI, and call centers are more likely to enroll in SNAP than those living in states without these options (Dubowitz et al., 2023). Thus, employing these practices in states that

do not currently use them, while not uniquely focused on military/veteran caregivers, may nonetheless benefit caregivers that are food insecure.

There are initiatives to build more-networked and more-supportive communities. One effort is Weave: The Social Fabric Project, by the Aspen Institute. Weave seeks to “move from a culture of isolation and individualism to one of relationalism” and does so by connecting trusted social leaders across communities; supporting them with funding, speaking opportunities, and storytelling; and inspiring more people to “live a weaving way of life that values relationships as highly as their own achievements” (Aspen Institute, undated). Efforts such as these that seek to build communities locally and strengthen informal sources of support may also yield benefits to caregivers.

Recommendation 6. Encourage health care systems to better integrate caregivers into health care teams.

In *Hidden Heroes*, RAND researchers recommended that “[H]ealth care environments catering to military and veteran care recipients should make efforts to acknowledge caregivers as part of the health care team” (Ramchand et al., 2014, p. xxii). Following this recommendation, the Elizabeth Dole Foundation created the Campaign for Inclusive Care, offering a training academy to “shift culture of care at VA hospitals to include caregivers on their wounded warriors’ medical team, reduce the challenges of being a caregiver, and ultimately improve health outcomes for both our Veterans and caregivers” (Elizabeth Dole Foundation, undated-b; Sperber et al., 2023). Results from this study suggest that such efforts are still needed. Only 25 percent of military/veteran caregivers feel that they are listened to by the patient’s provider, and only 25 percent reported that the provider sought the caregiver’s insights into the care recipient’s health. There were few differences between caregivers who were caring for veterans who accessed most care in VA and those who accessed care outside of VA.

This study focused on caregivers and their experiences being integrated in health care teams; it did not focus on providers and barriers they reported related to working collaboratively with caregivers. But there are multiple efforts to educate providers on how to better integrate caregivers into health care teams, and there is still work to do. In addition to evaluating existing efforts (per Recommendation 8), it may be that providers need to be *incentivized* to work collaboratively with caregivers. There are at least two incentive mechanisms. First, health care systems need to understand the *value* of integrating caregivers into health care teams. In this context, value can be measured by improvements in care recipients’ health: shorter hospital stays, fewer medical needs, and improved survival and quality of life. Value may also be demonstrated through increased demand, particularly in areas where families have choices about where to receive health care. Research should focus on documenting positive health outcomes, cost savings, and profits associated with better integrating caregivers into health care teams.

Second, there could be more opportunities to monetarily incentivize providers to integrate caregivers into health care teams. As discussed in the Introduction and Background chapter, as of January 1, 2024, health care providers can bill Medicare for providing education to caregivers using one of three newly introduced Current Procedural Terminology codes. These are the first codes in the Medicare Physician Fee Schedule that allow billing for care provided to someone other than the patient. Monitoring how these codes are used, and the benefits observed, will be critical for determining whether these three codes could be expanded to include additional reimbursement options for supporting caregivers.

These recommendations align with other work by RAND researchers that provides a framework to help health care systems integrate caregivers into health care teams (Friedman and Tong, 2020). That framework includes six components: (1) identify and record information on caregivers; (2) incentivize providers to engage with family caregivers; (3) invest in programs that provide supportive services for family caregivers; (4) expand access to and funding for care coordinators to support caregivers and connect them to clinical information; (5) implement training programs for providers and caregivers to facilitate effective communication; and (6) develop, test, and improve caregiver access to technologies that foster caregiver-provider care integration and information-sharing. Other frameworks and suggestions have been offered to provide additional examples of what health systems should do to better integrate caregivers into health care teams (Dang et al., 2020; Leykum et al., 2022).

Recommendation 7. Promote work environments that are supportive of caregivers.

This recommendation is identical to a recommendation that RAND researchers made in *Hidden Heroes* in 2014. However, since 2014, how Americans work has changed dramatically, and work styles exemplifying new ways of working, in which employers offer temporal flexibility (the number of hours worked and when those hours are worked) and spatial flexibility (where work is performed; Kotera and Vione, 2020) have become more prominent. During lockdowns associated with responses to the COVID-19 pandemic, most Americans who were able to work from home did so almost exclusively (Parker, Horowitz, and Minkin, 2020). The new way of working can be beneficial to caregivers. However, many caregivers are not afforded these options: As described in Chapter 3, among working military and veteran caregivers, only half to two-thirds are offered temporal flexibility, and fewer than half are offered telework options. Many factors may explain this, though, nationally, workers with higher levels of educational attainment and higher incomes are more likely to be in jobs that can be done from home (Parker, Horowitz, and Minkin, 2020). A recent report highlights the increased stratification of salaried versus wage employees, with the latter group having less access to more-flexible work accommodations (Lerner and Palm, 2024).

In addition to accommodating caregivers, workplaces can provide resources or help caregivers identify resources that could support them. However, fewer than half of working military and veteran caregivers indicate that their workplace offers programs that provide

information, referrals, counseling, or an EAP. This is consistent with research indicating that about half of workers have access to an EAP (Attridge, 2023). EAPs are more common among large employers than smaller employers, but the U.S. Chamber of Commerce provides a list of EAP options that may better suit small businesses (Heaslip, 2023).

RCI runs a program called Working While Caring to help working caregivers balance their work and caregiving responsibilities. In a recent report, they suggested strategies for employers interested in supporting caregivers (Lerner and Palm, 2024). These are presented in Table 10.1.

Recommendation 8. Continue to conduct rigorous evaluations of those initiatives designed to support military and veteran caregivers.

One notable finding from Chapter 4 is that between one-third and half of all military and veteran caregivers who had accessed caregiver support services in the past year met criteria for excessive caregiver burden. There are two interpretations of this finding: that programs

TABLE 10.1

Recommendations for Employers to Create More Caregiver-Friendly Work Environments and Communities

Recommendations for Employers

- Establish an employee caregiving interest group or cross-business stakeholder group, representing a diverse range of caregivers and other stakeholders, to serve as a resource to management and other employees.
- Know your data. On employee surveys, gather information about caregiver status.
- Conduct an audit of existing policies and services that affect caregivers, vetting alignment with known caregiver issues, potential biases, and barriers to their effectiveness and use. Pay close attention to leave policies and procedures that may include unnecessary barriers.
- Normalize caregiving. Engage leadership in showing support for caregivers and reducing stigma, and ensure that employees and managers know about the benefits and services they now have and how to use them.
- Prepare current caregivers and all employees with information about Medicare and Medicaid coverage for home care, long-term care, and other community-based services, including identifying gaps in coverage and options for addressing those gaps (recognizing that there are not solutions to all circumstances).
- Train managers on policies and procedures relevant to caregivers and provide them with the resources and support they need to support caregivers.
- Work with existing health care insurers and third-party claims processing companies to evaluate the accuracy of claims and billing and reduce errors that are financially and emotionally costly to caregivers and their families.
- When preparing requests for proposals and contracts for service suppliers including health care insurers and providers, concierge caregiver firms, and EAPs, require inclusion of caregiving-friendly workplace services and evidence-based practices (e.g., cognitive behavioral therapy for caregiver strain) and mandate reporting on key performance and outcome metrics (e.g., utilization of paid leave, decreasing work hours, presenteeism, and absenteeism).
- Collaborate with your local and regional business groups' efforts to identify gaps in caregiver benefits and services, create guidelines for a minimum benefits package, standardize vendor/supplier metrics and benchmarking reports, and influence policymaking.

SOURCE: Adapted from Lerner and Palm, 2024, p. 18.

are attracting caregivers in need of support or that these programs are not adequately helping reduce caregiver burden. Participating in these programs takes resources and time, and caregivers should be assured that the benefits outweigh these investments. Evaluation is key to ensuring that programs are achieving their intended outcomes and worth the resources and time that caregivers devote to participating in them.

Since 2014, there has been an expansion in the number of evaluation studies of programs aimed at military and veteran caregivers, most of which showed beneficial results. VA's PCAFC program, for example, showed that, relative to non-enrollees, enrolled caregivers experienced increased confidence (Sperber et al., 2018), less financial strain, and fewer depressive symptoms (Smith et al., 2019) and that these benefits extended to veterans, who were also accessing more health care (Shepherd-Banigan et al., 2018a; Van Houtven et al., 2019). Similarly, programs to support caregivers, including OFC, REACH VA, and Veterans In-Home Program are well received and may be associated with decreases in caregiver depression and burden (Easom et al., 2018; Moriarty et al., 2016; Stevens et al., 2015). Caregiver training and manuals have been shown to be associated with better self-esteem (Stevens et al., 2015) and increased knowledge (Thomas, 2017). Furthermore, these benefits have been shown to be present in the short term; even one month of involvement may yield benefits (Garand, 2021).

On the other hand, one significant gap in the literature is whether short-term caregiver benefits are sustained over time. For example, one study found that support groups may be helpful for reducing social isolation after three months, but the effects did not persist after six months (Trail et al., 2020). PCAFC participation was not able to detect cost-effectiveness after six years; the authors posit that this may be due to changes in sample composition that rendered them unable to make statistical determinations about impact (Van Houtven et al., 2020). Thus, evaluations should be designed to examine both short- and long-term outcomes, with attention paid to program attrition.

The COVID-19 pandemic necessitated almost complete virtual programming, but VA and other organizations serving veterans and caregivers had been providing online/virtual programming prior to the pandemic (Friedman et al., 2018; Trail et al., 2020). Though limited, evaluations of these initiatives have also yielded promising results. Online support groups may help offset social isolation for short interventions (Trail et al., 2020) and may be particularly helpful for caregivers with heavy caregiver demands (Friedman et al., 2018). Therefore, online options may be useful for caregivers who are unable to participate in in-person programming (Haselden et al., 2020). More research is needed to determine whether there are differences in outcomes among those who receive in-person versus virtual programming (e.g., Haselden et al., 2019) and in what contexts caregivers might benefit from virtual programming (e.g., among rural caregivers, those with high levels of caregiver burden).

Recommendation 9. Continue to conduct research that fully captures the breadth of caregiving and those who serve as caregivers.

The method used in this study to identify caregivers in the United States yielded an estimate that far surpassed past estimates of caregiving. The approach relied less on people identifying as a caregiver and more on them reporting about caregiving duties they perform. Though it is large, the number the method produced demonstrates the sheer number of people who are assisting their loved ones with symptoms associated with wounds, injuries, and illnesses. It is consistent with former First Lady Rosalynn Carter's quote: "There are only four kinds of people in the world—those that have been caregivers, those that are caregivers, those who will be caregivers, and those who will need caregivers" (RCI, undated). Future research endeavors on caregiving should consider how caregiving (or caregivers) are defined and consider alternative ways to measure caregiving; this study provides one option.

Responses to the survey also reveal its limitations and areas critical for future research. Perhaps the most significant is whether and how the experiences of caregivers to those in need of emotional and cognitive support are fully recognized. This includes, but is not necessarily limited to, caregivers assisting individuals with mental health conditions, substance use disorders, and such neurological conditions as TBI and dementia. The 2023 RAND Caregiving Survey asked about only two specific caregiving tasks associated with caring for these conditions (memory assistance and avoiding triggers), but the results from Chapter 1 suggest that these two questions are insufficient. Understanding the scope of these tasks is important because it will help researchers, program developers, and policymakers understand the range of support activities these caregivers provide and whether programs are targeting the activities for which caregivers need additional support. It may also reveal that even more of our neighbors are serving in caregiver roles.

A Note on RAND's Complementary Research

As a complement to the research presented in this report, additional research is being released from three additional sources. First, we administered the 2023 RAND Caregiving Survey to two groups of caregivers specifically caring for veterans and service members who served after September 11, 2001. We will blend that data with the AmeriSpeak sample to produce estimates of caregiving exclusively among these post-9/11 caregivers. Second, we conducted follow-up, qualitative interviews with select military and veteran caregivers identified in the survey that met certain criteria of interest. Third, we visited a number of health centers across the United States to learn of existing and promising practices employed by health systems to better accommodate, support, and integrate caregivers into their care delivery. Details of those methods are presented separately in those publications.

Conclusion

In the United States today, 14.3 million adults, representing 5.5 percent of the adult population, are caring for wounded, ill, or injured service members or veterans. These caregivers are helping service members and veterans eat and walk; helping manage mental health symptoms and memory deficits; and helping administer medications, prepare meals, and provide transportation to medical appointments, pharmacies, and grocery stores. Many are family members doing this out of love and obligation, but they are also friends and neighbors who are taking on these duties out of caring and kindness. Care recipients benefit from the work these caregivers do, and caregivers benefit as well. But caregiving is not without its costs, both financial and emotional. *Emerging from the Shadows* provides insights that document the diversity of caregivers, their contributions to society, and the challenges many still face. Though the results can inform many calls to action, the nine recommendations included in this chapter are those that we have identified as priorities and, if pursued, hold promise for supporting America's hidden heroes.

Methods

Introduction

Emerging from the Shadows relies primarily on data from two surveys: the 2023 RAND Caregiving Survey and the 2022 RAND Veterans Survey. All research activities have been guided by a Scientific Advisory Board jointly convened by RAND and the Elizabeth Dole Foundation. All components of research were approved by RAND's Human Subjects Research Protection Committee, which is RAND's Institutional Review Board.

About the 2023 RAND Caregiving Survey

The 2023 RAND Caregiving Survey was the primary data source for this project. It was designed with two main objectives: to enumerate the number of military and veteran caregivers and to further understand their needs, service utilization, and outcomes. Following the precedent set forth by the 2014 RAND Caregiving Survey (Ramchand et al., 2014), the 2023 survey included nationally representative samples of military/veteran caregivers, civilian caregivers, and non-caregivers, for comparison purposes. An overview of the survey methodology is provided below. Additional details on recruitment, sampling and response, weights, variables, and all analyses are available on request.

Recruitment to AmeriSpeak

Respondents to the 2023 RAND Caregiving Survey were recruited through AmeriSpeak, a probability-based panel of U.S. adults designed to be representative of U.S. households. As described in AmeriSpeak technical documentation:

Funded and operated by NORC at the University of Chicago, AmeriSpeak is a probability-based panel designed to be representative of the US household population. Randomly selected US households are sampled using area probability and address-based sampling, with a known, non-zero probability of selection from the NORC National Sample Frame. These sampled households are then contacted by US mail, telephone, and field interviewers (face to face). The panel provides sample coverage of approximately 97% of the U.S. household population. Those excluded from the sample include people with P.O. Box only

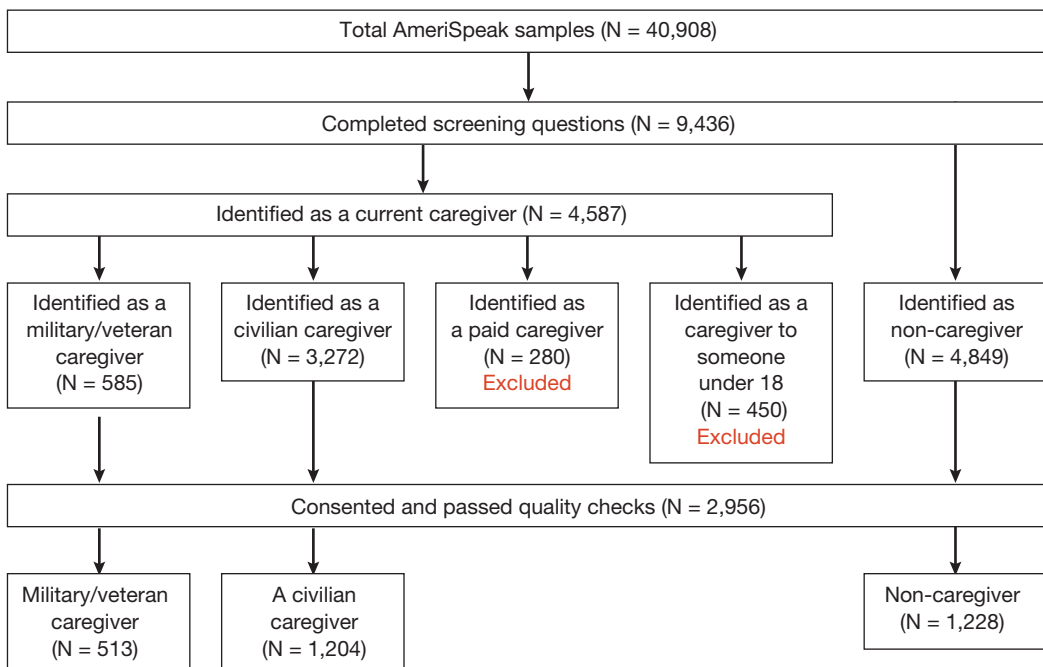
addresses, some addresses not listed in the USPS [U.S. Postal Service] Delivery Sequence File, and some newly constructed dwellings. While most AmeriSpeak households participate in surveys by web, non-internet households can participate in AmeriSpeak surveys by telephone. Households without conventional internet access but having web access via smartphones are allowed to participate in AmeriSpeak surveys by web. AmeriSpeak panelists participate in NORC studies or studies conducted by NORC on behalf of governmental agencies, academic researchers, and media and commercial organizations. (NORC at the University of Chicago, undated)

Sampling and Response to the 2023 RAND Caregiving Survey

The 2023 RAND Caregiving Survey was fielded in February and March 2023, was offered in English and Spanish, and was available in two modes: web or phone. Recruitment to the survey is presented in Figure 11.1. At the time of the survey, there were 40,908 eligible participants in the AmeriSpeak panel invited to complete a survey screening question to see whether they qualified for the survey. Of those, 9,436 completed the screening questions, and 9,156 were determined eligible. A total of 3,858 AmeriSpeak panel members completed the survey; however, 128 respondents were removed for data quality concerns (e.g., those who “sped through” the survey, those who skipped or refused more than 60 percent of eligible questions, those who “straight-lined” grid-item questions, and those who changed responses).

FIGURE 11.1

Recruitment to the 2023 RAND Caregiving Survey Sample



730 respondents did not qualify based on criteria applied by RAND and NORC: They were caregivers to wounded, ill, or injured children under 18 or caregiving was part of their job. Additionally, 54 caregivers did not consent to the survey. Thus, the final analytic sample size was 2,946. Among these, 513 were military/veteran caregivers, 1,205 were civilian caregivers, and 1,228 were non-caregivers (specific definitions are provided in Chapter 1).

Among the survey respondents, 2,836 completed the survey via web mode, and 110 completed the survey over the phone. Seventy respondents completed the survey in Spanish. The median time to complete the survey via the web and phone was 22 and 37 minutes, respectively, though it was almost double the time for caregivers than non-caregivers. Panelists were offered incentives for taking the survey proportional to the time it took to complete the survey, the equivalent of \$10 for caregivers and the equivalent of \$2 for non-caregivers.

Weights

Weights were applied to analyses to account for the probability of selection into the study and to adjust responses so that they reflect the U.S. household population. The Current Population Survey (CPS) was used to construct population benchmarks. NORC created all weights.

First, *panel weights* were constructed to account for selection into the AmeriSpeak panel. Household-level nonresponse weights were constructed as the inverse of the probability of selection from the NORC National Frame. These were then adjusted using weighting classes defined by some household characteristics. Household nonresponse weights were post-stratified to match the number of households per census division obtained from the most recent CPS. Person-level weights were then adjusted to compensate for nonresponding adults within a recruited household. The nonresponse-adjusted person-level weights were then “raked” to population totals associated with age, gender, census division, race/ethnicity, education, housing tenure, household phone status, the interaction of age and gender, and the interaction of age and race/ethnicity.

A second set of *study-specific base weights* account for selection from the AmeriSpeak panel to the 2023 RAND Caregiving Survey. These weights adjust for unequal selection probabilities from the AmeriSpeak panel and differential nonresponse across subpopulations based on past survey completion rates with the AmeriSpeak panel and frame coverage limitations.

A third set of *study-specific final weights* was constructed to ensure that the final analytic sample of caregivers and non-caregivers was representative of the U.S. household population. Person-level nonresponse adjusted weights were raked to align eligible survey completions with target population benchmarks associated with the interactions of age and caregiver status, race/ethnicity and caregiver status, gender and caregiver status, region and caregiver status, education and caregiver status, age and gender, age and race/ethnicity, and race/ethnicity and gender.

Extreme weights were trimmed and re-calibrated to produce final study weights. Weights were applied in all analyses unless otherwise noted, with different weights used when (a) examining the entire study population (i.e., enumerating the number of caregivers); (b) describing

the entire screened population; or (c) describing characteristics specifically among military/veteran caregivers, civilian caregivers, or non-caregivers.

Measures

The 2023 RAND Caregiving Survey took almost 40 minutes for caregivers to complete. This is because the survey queried about a range of factors related to caregiving. It included information on caregivers themselves, those to whom they were providing care, caregivers' families and friends, the communities in which caregivers live, and the systems (e.g., health care system or support services) with whom caregivers regularly interact. When possible, these constructs were assessed using validated scales or items used in past research on caregiving. A list of the constructs across these domains is presented in the appendix.

Analyses

All analyses were conducted using weighted analyses in Stata MP/16.1 or SAS 9.4. Comparisons between populations were conducted using either a weighted Pearson's chi-square test or weighted logistic regression (for dichotomous outcomes) or weighted linear regression (for continuous outcomes). Missing data were not imputed, and listwise deletion was used in inferential analyses. Chapter 3 presents details on analyses used to estimate the economic value, out-of-pocket costs, and forgone earnings of caregivers; Chapter 7 presents further details on the analyses used to create state-specific estimates of caregivers and details on analyses used to estimate the effects of community-level factors on caregiver outcomes. Further details on all analyses are provided throughout the report for specific analyses, and 95 percent CIs for all estimates presented in tables are available in an annex at www.rand.org/t/RRA3212-1.

2022 RAND Veterans Survey

In addition to the 2023 RAND Caregiving Survey, we also fielded the 2022 RAND Veterans Survey, a survey of veterans to produce state-level estimates of military/veteran caregivers, described in Chapter 7. The 2022 RAND Veterans Survey was also recruited from AmeriSpeak. 3,213 panelists deemed likely to be eligible based on past surveys in which respondents reported prior military service were invited to take the survey in November 2022. 1,153 completed the screening question and were deemed eligible; 1,100 completed the survey (1,039 by web and 61 by phone). Interviews were complete by mid-December 2022, and participants were provided the equivalent of \$3 for their participation. More details of the 2022 RAND Veterans Survey are provided in the appendix.

Scientific Advisory Board

The entire research enterprise was guided by a group of experts who agreed to participate without compensation on a study-specific Scientific Advisory Board. Guidance from the board occurred during quarterly meetings when RAND researchers provided progress updates; dates and focal topics of these meetings are included in Table 11.1. Additional email correspondence and meetings with individual board members also guided the work. Members of the Scientific Advisory Board for this project who agreed to have their names listed are provided in Table 11.2.

TABLE 11.1
Scientific Advisory Board Meeting Dates and Focal Areas of Discussion

Date	Discussion Focal Areas
February 2022	Overview of the proposed research study
June 2022	Proposed survey content
September 2022	Subpopulations to consider for qualitative interviews
January 2023	Literature review and overview of state-level estimation procedure
April 2023	Qualitative interview subpopulations review and overview of place-based analyses
August 2023	Overview of economic analyses and discussion about caregivers to people with mental/cognitive challenges

TABLE 11.2
Scientific Advisory Board Members

- Scott Blackburn, Senior Partner, McKinsey
- Lynda C. Davis, Senior Strategic Advisor/C2S Project Lead, Tragedy Assistance Program for Survivors (TAPS)
- Roxana Delgado, Professor/Military Health Scholar, UT Health San Antonio
- Pete Jeffries, National Director of Strategic Campaigns & Integrated Field Management, AARP
- Cleo Jacobs Johnson, Senior Researcher and Director of DEI Implementation and Engagement, Mathematica
- Meg Kabat, Principal Senior Advisor, U.S. Department of Veterans Affairs
- Ken Kizer, Chief Healthcare Transformation Officer and Senior Executive Vice President, Atlas Research
- Luci K. Leykum, Center Lead, VA Elizabeth Dole Center of Excellence for Veteran and Caregiver Research, Affiliate Professor, Dell Medical School, the University of Texas at Austin
- Michael Linnington, CEO, Wounded Warrior Project
- Rajiv Mehta, CEO, Atlas of Care
- Kimberly Mingo, VP Government Sales and Business Strategy, Philips
- Steve Schwab, CEO, Elizabeth Dole Foundation
- Kevin Vigilante, EVP and Chief Medical Officer, Booz Allen Hamilton
- Shelley MacDermid Wadsworth, Director Emerita of the Center for Families and Director of the Military Family Research Institute, Purdue University

Support Program Information and Survey Details

Table A.1 presents details on selected military/veteran caregiver support programs.

TABLE A.1
Select Military/Veteran Caregiver Support Programs

Organization	Programs/Services	Website
AARP	AARP collaborated with the Elizabeth Dole Foundation to create a Military Caregiving Guide with recommended resources, a needs assessment, and checklists to maximize organization and planning. It also provides online resources for all veterans, including a fraud center to combat scams targeting the military community and relevant news updates, as well as extensive online resources, such as information, toolkits, and peer support for all caregivers.	https://www.aarp.org/content/dam/aarp/caregiving/pdf/family-caregiving-guide/military-veterans.pdf (AARP, 2021) https://www.aarp.org/caregiving/ (AARP, undated-b) https://www.aarp.org/home-family/voices/veterans/ (AARP, undated-c)
American Red Cross	The Military and Veteran Caregiver Network offers ways for vetted caregivers to connect with peers in a secure, moderated online community; engage in peer-mentor relationships; join confidential, peer-facilitated support groups in person or online; and access online courses, well-being practices, and more. There is also a searchable Hero Care Resource Directory to find local or national support across multiple categories.	https://www.redcross.org/get-help/military-families/services-for-veterans/military-veteran-caregiver-network.html (American Red Cross, undated-b)
Blue Star Families	The Blue Star Caregivers Program offers the Caregivers Empowering Caregivers program, which provides workshops that focus on self-care in a social setting to encourage resource-sharing and peer support. Workshops are available virtually and in person at some chapter locations. Links to curated resources from other organizations are also provided.	https://bluestarfam.org/caregivers/ (Blue Star Families, undated)

Table A.1—Continued

Organization	Programs/Services	Website
Disabled American Veterans (DAV)	DAV's Caregivers Support provides online resources, risk screenings, digital tools, and personalized care plans and support from trained specialists at no cost.	https://www.dav.org/get-help-now/dav-caregivers-support/ (DAV, undated-a)
Easterseals	Local Easterseals sites may offer respite care, transportation, center-based adult day services or in-home services, and more for military caregivers and their families. There are also free online military caregiving webinars and a military caregiver tobacco cessation tool kit.	https://www.easterseals.com/support-and-education/for-caregivers/military-veteran-caregivers.html (Easterseals, undated)
Hope for the Warriors	Hope for the Warriors offers a free online six-week virtual Resilient Family course to develop coping skills and effectively manage stress as well as scholarships for military spouses and caregivers.	https://www.hopeforthewarriors.org/resilient/ (Hope for the Warriors, undated-b) https://www.hopeforthewarriors.org/transition/military-spouse-scholarships/ (Hope for the Warriors, undated-a)
Independence Fund	Independence Fund offers small group retreats with peer-to-peer support and respite for military caregivers of all eras, emergency financial support, and caseworkers to help navigate other resources.	https://independencefund.org (Independence Fund, undated)
Military OneSource	Military OneSource consultants can help eligible beneficiaries navigate resources; it also provides free financial counseling, health and wellness coaches, non-medical counseling, and peer support. Military OneSource has a downloadable "Keeping It All Together" notebook to organize treatment and recovery plans, as well as toolkits to track progress and medical information.	https://www.militaryonesource.mil/benefits/caregiver-support-services/ (Military OneSource, undated)
PsychArmor	PsychArmor includes free online training courses for caregivers on topics that include respite, understanding VA, connecting with the veteran, self-care, legal issues and documents, intimate partner violence, and caregiving in a rural setting. Those who complete four designated courses and register with the Elizabeth Dole Foundation receive a Military Caregiver Recognition Award and Badge.	https://psycharmor.org/ (PsychArmor, 2024) https://learn.psycharmor.org/courses/military-caregiver-award (PsychArmor, undated-b)

Table A.1—Continued

Organization	Programs/Services	Website
Rosalynn Carter Institute for Caregivers (RCI)	RCI's Operation Family Caregiver (OFC) provides free and confidential support from trained coaches to help the families of returning service members and veterans develop problem-solving skills to manage challenges. Support is available virtually anywhere in the United States or in person in 12 cities. RCI also provides targeted Sesame Street resources to families with young children. Some resources, such as the Unwinding with Sharecare mental well-being app and the caregiver crisis text line, are available to all caregivers. RCI also supports research and offers resources for employers.	http://www.operationfamilycaregiver.org/ (OFC, 2024) https://rosalynncarter.org/ (RCI, undated) https://sesameworkshop.org/topics/caregiving/ (Sesame Workshop, undated)
Veterans Families United	Veterans Families United provides a list of other resources for caregivers.	https://veteransfamiliesunited.org/caregiver-resources/ (Veterans Families United, undated)
Warrior Care Recovery Coordination Program, Defense Health Agency	The Warrior Care Recovery Coordination Program at the Defense Health Agency provides links to service-specific resources for wounded warriors; an Electronic Caregiver Resource Directory listing hundreds of local and national resources across an array of topics; a Military Caregiver Personalized Experiences, Engagement and Resources (PEER) Forum initiative to encourage caregivers to provide peer support and share resources; and PEER Support Coordinators in ten geographical regions to provide direct support, convene PEER Forums, conduct outreach, and identify and report on gaps in available support.	https://warriorcare.dodlive.mil/Caregiver-Resources/ (Defense Health Agency, undated-a) https://warriorcare.dodlive.mil/Caregiver-Resources/Military-Caregiver-Support/ (Defense Health Agency, undated-b)
Wounded Warrior Project	Wounded Warrior Project offers an array of programs and supports for families and caregivers of wounded, ill, and injured post-9/11 veterans, including advocacy and assistance navigating other resources; the Project Odyssey mental health program for veterans, couples, or families; intensive outpatient programs at academic medical centers, including family programming; and long-term support for catastrophically wounded veterans and their caregivers, including therapy, respite and personal wellness care, estate and financial planning, and more.	https://www.woundedwarriorproject.org/ (Wounded Warrior Project, undated-a)

Comparing Estimates of Caregiving from the 2023 RAND Caregiving Survey with Other National Estimates of Caregiving

Estimates of caregivers from the 2023 RAND Caregiving Survey greatly exceed those of previous studies. In 2014, the first RAND study of military and veteran caregivers estimated that there were 22.6 million caregivers (Ramchand et al., 2014). Studies since then have estimated more than 22.6 million, though still none are near the 105.6 million indicated in the 2023 RAND Caregiving Study. Table A.2 provides an overview of national studies of caregiving.

There are three possible explanations for why the prevalence estimates from the 2023 RAND Caregiving Survey exceed those of past estimates: (1) differences in how caregiving is measured, (2) differences in survey samples; and (3) misclassification of caregivers. The sections below describe each and provide evidence for why they may or may not account for the estimate produced in the current study.

Differences in How Caregiving Is Measured

Prior to the 2023 RAND Caregiving Survey, all studies measured caregiving with a single screening question that asked respondents whether they provided unpaid care or assistance to an adult with an illness or injury. Further details were usually provided as part of the question; these details would include examples of what constitutes care and assistance and provide clarity that, for example, the respondent need not live with the person they are caring for (see Table A.2). In contrast, the 2023 RAND Caregiving Survey asked about a series of eight tasks, then excluded those who reported that these tasks were done as part of one's job or to someone under the age of 18.

The single-item screener used in past studies required caregivers to interpret for themselves what “care” and/or “assistance” entails, though the clarifying statements and examples tried to ensure broad coverage of caregivers. In survey research, providing specific questions often yields more precise estimates than questions that respondents may interpret differently. This was made clear in RAND research that queried service members about specific types of sexual assaults and, for male service members, resulted in estimates double than when a more general question was used, which the authors attribute to male service members interpreting certain behaviors as “hazing” and not “assault” (Morrall, Gore, and Schell, 2016).

In addition, some of the screening questions from other surveys are restricted to a subgroup of caregivers. For example, the American Time Use Survey (ATUS) and Long-Term Care Poll, which are inputs for the method AARP uses to estimate caregiving, asks about caregivers to older adults. The ATUS asks: “The next set of questions are about times you may have recently spent assisting or caring for an adult who needed help because of a condition related to aging.” The Long-Term Care Poll asks: “Some people need ongoing living assistance as they get older. . . . Are you currently providing ongoing living assistance on a regular basis to a family member or close friend or not?”

TABLE A.2
Recent Estimates of Caregiving in the United States

Survey	Estimated Number of Caregivers	Referent Time Period	Survey Method	Definition
2023 RAND Caregiving Survey (Current)	<ul style="list-style-type: none"> 105.6 million caregivers who are providing care to an adult 14.3 million military/veteran caregivers 	Past 30 days	Nationally representative (web + phone) survey of the U.S. population conducted in 2023 (using the AmeriSpeak panel)	<p>Two Questions: 1. Please indicate if you provided any of the following types of assistance in the past 30 days to someone who has a wound, illness, injury or other condition for which they may need support:</p> <ul style="list-style-type: none"> Personal care (for example, bathing, dressing, or feeding) Giving medicines or treatments Helping someone remember things that, due to a condition like a brain injury or dementia, they may be prone to forget Helping someone manage symptoms of psychological disorders (for example, depression, anxiety, or posttraumatic stress disorder) Helping arrange for medical or psychological services (for example, finding appropriate providers or making appointments) Providing transportation to medical or mental health appointments Helping getting in and out of beds and chairs Helping with other tasks which people with wounds, illness, or injuries may have difficulty performing themselves I do not currently provide any of these types of assistance, but I have in the past I have never provided any of these types of assistance to someone else <p>2. What are the main reasons you provide this assistance?</p> <ul style="list-style-type: none"> Providing this assistance is part of my job (for example, you are a home health care aide or other health care worker) The person I assist is my spouse or partner The person I assist is a family member or other relative (or, if caring for more than one individual, at least one person they are caring for is a family member or other relative) The person I assist is a friend or neighbor (or, if caring for more than one individual, at least one person they are caring for is a friend or neighbor).

Table A.2—Continued

Survey	Estimated Number of Caregivers	Referent Time Period	Survey Method	Definition
Hidden Heroes (RAND; Ramchand et al., 2014)	<ul style="list-style-type: none"> • 22.6 million caregivers who are providing care to an adult • 5.5 million military/veteran caregivers 	Current (further detail not specified)	Nationally representative (web) survey of the U.S. population (using KnowledgePanel)	Single question: Do you provide unpaid care and assistance for, or manage the care of, someone who is at least 18 years old and has an illness, injury, or condition for which they require outside support? <i>This may include help with tasks such as personal care, bathing, dressing, feeding, giving medicines or treatments, help with memory tasks for someone with brain injury, help coping with symptoms of Posttraumatic Stress Disorder (PTSD), transportation to doctors' appointments, or arranging for services, etc.</i> You do not need to live with the person. Care and assistance are considered unpaid if you provide them without receiving financial compensation in exchange for doing so.

Table A.2—Continued

Survey	Estimated Number of Caregivers	Referent Time Period	Survey Method	Definition
Valuing the Invaluable (AARP; Reinhard et al., 2023)	<ul style="list-style-type: none"> 38.0 million caregivers 	<ul style="list-style-type: none"> ATUS: ~Past 3 months BRFSS: Past 30 days <i>Caregiving in the U.S. 2020</i> (NAC and AARP, 2020a): Past 12 months Long-Term Care Poll: Current 	<p>A weighted average from four sources:</p> <ul style="list-style-type: none"> ATUS BRFSS <i>Caregiving in the U.S. 2020</i> (NAC and AARP, 2020a) Long-Term Care Poll <p>Each data source was weighted differently when aggregated to create a total estimate.</p>	<p>ATUS: The next set of questions are about times you may have recently spent assisting or caring for an adult who needed help because of a condition related to aging. For example, as people grow older, it sometimes becomes difficult for them to perform various activities without help—such as grooming, driving, managing the household, taking medication, or other common activities. Care may be provided in your home, their home, or at a care facility. Not including financial assistance or help you provided as part of your paid job, since the 1st of [reference month three months prior to interview date], have you provided any care or assistance for an adult who needed help because of a condition related to aging?</p> <p>BRFSS: People may provide regular care or assistance to a friend or family member who has a health problem, long-term illness, or disability. During the past 30 days, did you provide regular care or assistance to a friend or family member who has a health problem or disability?</p> <p><i>Caregiving in the U.S. 2020</i> (NAC and AARP, 2020a): At any time in the last 12 months, has anyone in your household provided unpaid care to a relative or friend 18 years or older to help them take care of themselves? This may include helping with personal needs or household chores. It might be managing a person's finances, arranging for outside services, or visiting regularly to see how they are doing. This adult does not need to live with you.</p> <p>Long-Term Care Poll: Some people need ongoing living assistance as they get older. This assistance can be help with things like keeping house, cooking, bathing, getting dressed, getting around, paying bills, remembering to take medicine, or just having someone check in to see that everything is okay. This help can happen at your own home, in a family member's home, in a nursing home, or in a senior community. And, it can be provided by a family member, a friend, a volunteer, or a health care professional. Are you currently providing ongoing living assistance on a regular basis to a family member or close friend or not?</p>

Table A.2—Continued

Survey	Estimated Number of Caregivers	Referent Time Period	Survey Method	Definition
Caregiving in the United States. 2020 (AARP and NAC, 2020)	<ul style="list-style-type: none"> 47.9 million caregivers who are providing care to an adult 	Past 12 months	Nationally representative (web) survey of the U.S. population (using KnowledgePanel) conducted in 2019	Single question: At any time in the last 12 months, has anyone in your household provided unpaid care to a relative or friend 18 years or older to help them take care of themselves? This may include helping with personal needs or household chores. It might be managing a person's finances, arranging for outside services, or visiting regularly to see how they are doing. This adult need not live with you. Further validation required caregivers to report providing help with at least one ADL, IADL, or medical/nursing task.
Caregiving in the U.S. 2015 (AARP Public Policy Institute and NAC, 2015)	<ul style="list-style-type: none"> 39.8 million caregivers who are providing care to an adult 	Past 12 months	Nationally representative (web) survey of the U.S. population (using KnowledgePanel) conducted in 2014	Single question: At any time in the last 12 months, has anyone in your household provided unpaid care to a relative or friend 18 years or older to help them take care of themselves? This may include helping with personal needs or household chores. It might be managing a person's finances, arranging for outside services, or visiting regularly to see how they are doing. This adult need not live with you.

Specificity in defining caregiving may be especially poignant in survey research. Caregivers, particularly those caring for a family member, may only identify as caregivers when they interact with others (for example, health care providers); otherwise, they may see what they do as fulfilling a family member role (O'Connor, 2007). In the Blue Star Families 2020 Military Family Lifestyle Survey, 26 percent of individuals in military families who indicated that they were “exceedingly burdened” by caregiving tasks did not identify as a caregiver (Strong et al., 2021). Thus, there are reasons why a single-item screener may miss a significant portion of caregivers in the United States.

Differences in the Survey Samples

Estimates from three studies (Ramchand et al., 2014; AARP Public Policy Institute and NAC, 2015; AARP and NAC, 2020) use the same, nationally representative panel: KnowledgePanel. In comparison, the 2023 RAND Caregiving Survey uses a different nationally representative panel: AmeriSpeak. Both KnowledgePanel and AmeriSpeak recruit their samples using address-based sampling, with additional recruitment for AmeriSpeak provided from the NORC National Frame. Both panels recruit panelists by mail and telephone, but AmeriSpeak also recruits using field interviewers to knock on doors and recruit participants. All KnowledgePanel surveys are conducted online, and panelists without internet access are provided, at no cost, a laptop and an internet service provider connection. Panelists recruited for AmeriSpeak choose whether they prefer to take surveys by web or phone, with the intent to ensure that the sample includes individuals without internet access, those whose only internet access is via a smartphone, and those unwilling to provide an email address. KnowledgePanel and AmeriSpeak surveys are conducted in English and Spanish. Both survey vendors (Ipsos, which runs KnowledgePanel, and NORC, which runs AmeriSpeak) provide survey weights to ensure that the sample results are generalizable to the U.S. household population.

Estimates from AARP’s *Valuing the Invaluable* are based on aggregating data from four sources (Reinhard et al., 2023). These are Caregiving in the U.S. (which relies on KnowledgePanel), the Long-Term Care Poll (which relies on AmeriSpeak), ATUS (a national telephone survey of how Americans 15 and older spend their time that uses the CPS as its sampling frame), and BRFSS, a state-based telephone survey on Americans’ health behaviors.

Although there are differences between the samples used by KnowledgePanel, AmeriSpeak, ATUS, and BRFSS, there is little evidence to suggest that sampling procedures may explain any discrepancy in estimates.

Misclassification of Caregivers

Some respondents included as caregivers in the 2023 RAND Caregiving Survey may have been misclassified, meaning that they may not necessarily perform tasks that constitute a traditional notion of caregiving. For example, these misclassified respondents might include “good neighbors” who occasionally make meals for an aging neighbor or parents helping their 18- to 25-year-old manage minor mental health challenges. To discern potential mis-

classification, data were analyzed in three ways: caregiving activity typologies, caregiving activities for parent caregivers to 18- to 25-year-olds, and caregiving intensity.

Caregiving Activities

For those who were identified as caregivers by answering “yes” to one of the initial eight tasks, the 2023 RAND Caregiving Survey asked more-detailed questions about 17 different caregiving activities. These were combined into three tiered, mutually exclusive categories, meaning that if respondents qualify for the first category (helping with at least one ADL), they would not be counted in the second category (helping with at least one emotional or cognitive task). If the new estimate had been overwhelmed by “good neighbors,” one would expect an overrepresentation of caregivers not helping with any ADLs or with any emotional or cognitive tasks. Table A.3 presents these categories, the tasks that defined them, and the weighted percentage of caregivers in each.

Almost half of all caregivers in the 2023 RAND Caregiving Survey were assisting with at least one ADL; 30 percent were assisting with at least one emotional/cognitive task; and

TABLE A.3
Caregiver Groupings by Caregiving Activities

Caregiving Category	Caregiving Tasks	Weighted Percentage of Caregivers
Caregivers who help with at least one ADL	<ul style="list-style-type: none"> • Getting in and out of beds and chairs • Getting dressed, bathing or showering • Getting to and from the toilet • Dealing with incontinence or diapers • Eating 	49%
Caregivers who help with at least one emotional or cognitive task (These caregivers do not help with one or more ADLs.)	<ul style="list-style-type: none"> • Remembering what [care recipient] should be doing • Coping with stressful situations or avoiding “triggers” of anxiety or anti-social behavior 	30%
Caregivers who administer medications, perform housework, or provide administrative support (These caregivers do not help with one or more ADLs or with emotional or cognitive tasks.)	<ul style="list-style-type: none"> • Taking medicines or pills or injections • Managing finances (such as bills or insurance paperwork) • Grocery shopping • Housework (such as dishes, laundry, or straightening up) • Preparing meals • Transportation (driving, helping arrange for transportation, or accompanying on public transit) • Arranging or supervising paid services (such as nurses, aides, Meals on Wheels, or other services) • Coordinating medical care and rehabilitative services • Gaining access to, or information from, care providers, government agencies, or schools • Filling out paperwork related to benefits and compensation or legal issues 	21%

21 percent were included in the last category (administering medications, performing housework, or providing administrative support). However, the majority were providing significant assistance with these tasks; only 1.5 percent of caregivers reported helping only with “grocery shopping,” “housework,” or “preparing meals” (i.e., potential “good neighbors”). Thus, “good neighbors” do not appear to be driving the estimate and are retained in the final sample to ensure the broadest coverage of caregiving and caregivers. It is unlikely that the 2023 RAND Caregiving Survey estimate is inflated due to overrepresentation of these caregivers.

Caregivers to Young Adult Children

In the United States, nearly 60 percent of 18- to 24-year-old men and 55 percent of 18- to 24-year-old women live in their parents’ home (U.S. Census Bureau, 2023b). In 2021, approximately one-third of 18- to 24-year-olds had a mental illness in the past year (National Institute of Mental Health, 2023a). Using data from the 2023 RAND Caregiving Survey, parents were identified who were caring for their 18- to 24-year-old children only by helping them manage symptoms of psychological disorders or helping arrange for medical or psychological services, caregiving tasks that some might argue are extensions of parenting.¹ Just under 2 percent (1.7 percent) of those identified as caregivers in the survey met these criteria. They were included as caregivers for the remainder of the study because caring for adults with mental health conditions can take a toll on caregivers, including parents: In *Hidden Heroes*, caregivers whose tasks included “helping care recipients cope with behavioral problems” had elevated risk of meeting criteria for probable depression themselves, even after adjustment for demographic characteristics and other caregiving tasks (Ramchand et al., 2014).

Caregiving Intensity

AARP and NAC have created a Level of Care Index (AARP and NAC, 2020) that assigns points to caregivers based on the hours they spend caregiving and the number of ADLs and IADLs they perform. This approach was replicated using the 2023 RAND Caregiving Survey.

First, caregivers were assigned points based on hours per week spent providing care:²

- 0 to 8 hours: 1 point
- 9 to 20 hours: 2 points
- 21 to 40 hours: 3 points
- 41 or more hours: 4 points.

¹ These caregivers reported “no” to the following six caregiving tasks: personal care; giving medicines or treatment; helping someone remember things that, due to a condition like a brain injury or dementia, they may be prone to forget; providing transportation to medical or mental health appointments; help getting in and out of beds and chairs; and helping with other tasks which people with wounds, illnesses, or injuries may have difficulty performing themselves.

² Figure 1.3 presents the number of hours per week caregivers spend on caregiving activities.

Next, caregivers were assigned points based on the number of ADLs and IADLs they perform (Table A.4).

The 2023 RAND Caregiving Survey asked about four additional caregiving tasks not included in the AARP and NAC report. These were treated the same as the other IADLs. These four tasks are as follows:

- Gaining access to, or information from, care providers, government agencies, or schools
- Remembering what [care recipient] should be doing
- Filling out paperwork related to benefits and compensation or legal issues
- Coping with stressful situations or avoiding “triggers” of anxiety or anti-social behavior.

Points were then summed, and caregivers were assigned a category:

- Low intensity: 4 or fewer points
- Medium intensity: 5 points
- High intensity: 6–8 points.

Using these categories, the distribution of caregivers from the 2023 RAND Caregiving Survey and the 2020 Caregiving in the United States study (AARP and NAC, 2020) suggests that the 2023 RAND Caregiving Survey overrepresents low-intensity caregivers and underrepresents high-intensity caregivers, as shown in Table A.5.

When the AARP and NAC Level of Care Index categories were cross-tabulated with the caregiving task categories presented in Table A.3, the distribution across those caregivers who help with at least one ADL skews to higher-intensity caregiving: 80 percent of caregivers who help with at least one ADL were categorized as medium- or high-intensity caregivers. On the other hand, the distribution is opposite for those who help with at least one cognitive or emotional task: 86 percent of these caregivers were represented in the low-intensity group (Table A.6).

TABLE A.4
Designation of Points to Caregiving Activities to Create the AARP and NAC Level of Care Index of Types of Care Provided

Number of ADLs and IADLs Performed	Points Assigned
0 ADL, 1 IADL	1 point
0 ADL, 2+ IADL	2 points
1 ADL, any number of IADLs	3 points
2+ ADLs, any number of IADLs	4 points

TABLE A.5**Caregiver Categories: AARP and NAC Level of Care Index**

	2023 RAND Caregiving Survey Weighted Percentage	AARP and NAC Weighted Percentage
Low intensity	52%	43%
Medium intensity	22%	16%
High intensity	26%	40%

TABLE A.6**Cross-Tabulation of Caregiver Task Categories by AARP and NAC Level of Care Index Categories**

	Low Intensity Row Weighted Percentage	Medium Intensity Row Weighted Percentage	High Intensity Row Weighted Percentage
Help with at least one ADL	20%	33%	47%
Help with at least one cognitive or emotional task (no ADL)	86%	10%	5%
Help administering medications (no ADL, no cognitive or emotional tasks)	90%	8%	1%

These results may suggest a potential bias in how the Level of Care Index is constructed because it more easily assigns a high-intensity threshold to caregivers assisting with ADLs versus those providing cognitive or emotional support. For those caregivers not assisting with ADLs, those assisting with one IADL, including providing cognitive or emotional support, would need to provide weekly care for 41 hours or more to be categorized as medium-intensity caregivers (versus those assisting with one ADL, which would only require nine hours of weekly care). Those assisting with two IADLS would need to provide care for 21 hours or more to be categorized as medium-intensity caregivers. Thus, while the 2023 RAND Caregiving Survey may yield results that skew toward lower-intensity caregivers, there may also be limitations in how low-, medium-, and high-intensity caregiving are currently defined.

Detailed Methods for Producing State-Level Estimates of Veterans with Caregiving Needs and the Caregivers Assisting Them

Definition of Outcomes

The number of veterans with one or more unpaid caregivers, the number with unmet need for such care, and the number of veteran caregivers per state were coded by combining information from multiple questions on the 2022 RAND Veterans Survey. Below we provide the text of the survey question and the rule for determining each outcome.

Does the Veteran Have an Unpaid Caregiver?

Survey Question

S4: Please select any of the following types of support someone has provided you due to a wound, illness, injury, or other condition, in the past 30 days.

- S4_1: Personal care, bathing, dressing, or feeding
- S4_2: Administering medicines or treatments
- S4_3: Helping remember things that, due to a condition like a brain injury or dementia, I may be prone to forget
- S4_4: Help with managing symptoms of psychological disorders (for example, depression, anxiety, or posttraumatic stress disorder)
- S4_5: Helping arrange for medical or psychological services (for example, finding appropriate providers or making appointments)
- S4_6: Providing transportation to medical or mental health appointment
- S4_7: Helping with getting in and out of beds and chairs
- S4_8: Helping with other tasks with wounds, illness, or injury that I may have difficulty performing myself
- S4_9: I do not currently receive any of these types of assistance, but I have in the past
- S4_10: I have never needed any of these types of assistance from someone else
- S4_DK: [respondent indicates they don't know]
- S4_SKP: [respondent provides no response to this question]
- S4_REF: [respondent refuses to answer this question]

Rule for establishing if veteran has a caregiver (note that requiring S7 to be one or greater makes this item identify receipt of *unpaid* care):

IF S4_1==1 OR S4_1==1 OR S4_2==1 OR S4_3==1 OR S4_4==1 OR S4_5==1 OR S4_6==1 OR S4_7==1 OR S4_8==1 & S7>=1, **THEN** “veteran has caregiver”,
ELSE IF S4_DK==1 OR S4_SKP==1 OR S4_REF==1 OR is.na(S7) **THEN** missing,
ELSE “veteran does not have a caregiver”

Does the Veteran Have Unmet Need for Care?

Survey Question

S5: Please select any tasks from the list below where in the past 30 days you wanted help but did not get it.

- S5_1: Personal care, bathing, dressing, or feeding
- S5_2: Administering medicines or treatments
- S5_3: Helping remember things that, due to a condition like a brain injury or dementia, I may be prone to forget
- S5_4: Help with managing symptoms of psychological disorders (for example, depression, anxiety, or posttraumatic stress disorder)
- S5_5: Helping arrange for medical or psychological services (for example, finding appropriate providers or making appointments)
- S5_6: Providing transportation to medical or mental health appointments
- S5_7: Helping with getting in and out of beds and chairs
- S5_8: Helping with other tasks with wounds, illness, or injury that I may have difficulty performing myself
- S5_9: I did not want help

Rule for establishing unmet need for a caregiver:

IF S5_1==1 OR S5_1==1 OR S5_2==1 OR S5_3==1 OR S5_4==1 OR S5_5==1 OR S5_6==1 OR S5_7==1 OR S5_8==1 **THEN** “unmet need”,
ELSE IF S5_DK==1 OR S5_SKP == 1 OR S5_REF == 1 **THEN** missing,
ELSE “no unmet need”

Number of Unpaid Caregivers

Survey question asked of those who responded “yes” to one or more of questions S4_1 through S4_8:

S7: How many people provide unpaid care for you?

Survey Questions in Both the 2022 RAND Veterans Survey and the 2018–2020 BRFSS Surveys Used to Predict Caregiving Outcomes

The 2022 RAND Veterans Survey included many questions that were identical to those found in BRFSS surveys between 2018 and 2020. Table A.7 lists these questions concerning disability and caregiver needs available to model caregiving outcomes. In addition to these items, NORC survey panel demographic data were used to construct variables that aligned with BRFSS items. These included questions about gender (SEX), race (RACE), marital status (married versus not married; MARITAL), age (17–44, 45–64, and 65+; AGE), children under the age of 18 in the household (CHILDREN), employment status (EMPLOY1), income level (INCOME3), and whether the respondent lives in a rural or urban area (URBSTAT). All questions were all asked in ways that mapped directly to analogous questions in the BRFSS.

TABLE A.7**Items on the 2022 RAND Veterans Survey That Match BRFSS Items Concerning Disability and Caregiver Needs**

Variable Name	Survey Question
BLIND	Are you blind or do you have serious difficulty seeing, even when wearing glasses?
DIFFALON	Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?
DECIDE	Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?
DIFFWALK	Do you have serious difficulty walking or climbing stairs?
DIFFDRES	Do you have difficulty dressing or bathing?
GENHLTH	Would you say that in general your health is . . . Excellent, Very good, Fair, Poor
POORHLTH	During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?
HHADULT	Some people who are deaf or have serious difficulty hearing use assistive devices to communicate by phone. Are you deaf or do you have serious difficulty hearing?

Finally, three state characteristics associated with need for or receipt of care were included in these models. These were state population density in 2020 (POP.DENSE; U.S. Department of Commerce and U.S. Census Bureau, 2020), proportion of state residents over the age of 65 (OVER.65, Flood et al., 2023), and the proportion of residents who were obese in 2020 (OBESE.2020; CDC, 2023a).

The BRFSS survey data were combined over three years (2019–2021) and subset to veterans in the 50 U.S. states and Washington, D.C. (N = 151,934). The RAND survey data had minimal missingness. Nine respondents were excluded from at least one model because of missing the outcome variable; one was dropped for missing more than four of the survey prediction items. Other minor missingness was automatically handled by the machine learning algorithm. The BRFSS data had more significant missingness that needed to be addressed prior to its use. Specifically, respondents with five or more missing values on predictors listed above were removed from the analysis (N = 3,621), resulting in a final sample of 148,313 veterans. Respondents missing one to four variables (N = 27,918) were kept in the analysis; their continuous responses were mean imputed, and their categorical variables were mode imputed.

Predicting Caregiving Outcomes in the RAND Data

Probit Bayesian Additive Regression Trees (BART; Chipman, George, and McCulloch, 2010) were used to predict the probability that an individual had a caregiver and the probability that they had unmet need for care in the 2022 RAND Veterans Survey data. These are flex-

ible machine-learning models that produce a posterior distribution of expected probabilities of each outcome for each individual conditioned on the predictors. Model-tuning parameters for BART were selected to minimize fivefold cross-validated error. CHILDREN and employment status contributed little explanatory power to the models and were excluded in the final model. The final models of the probability that an individual had a caregiver and the probability that they had unmet need for care included the following variables: BLIND, DIFFALON, DECIDE, DIFFWALK, DIFFDRES, GENHLTH, POORHLTH, HHADULT, CHILDREN, MARITAL, AGE, SEX, INCOME3, URBSTAT, POP.DENSE, OVER.65, and OBESITY.2020.

Final BART models predicted these two outcomes reasonably well. The average model-predicted probability of having a caregiver among RAND respondents who did have a caregiver was 0.31, whereas the average model-predicted probability of having a caregiver among respondents with no caregiver was 0.09, for a Tjur's D of 0.22. The average model-predicted probability of having an unmet need for assistance with caregiving tasks among RAND respondents with unmet need was 0.27, whereas the model-predicted probability of unmet need among RAND respondents with no unmet need was 0.09, for a Tjur's D of 0.18.

Generating Population Estimates from BRFSS Data

The two models fit to the 2022 RAND Veterans Survey data were used to generate predicted probabilities of those two outcomes in the large, nationally representative BRFSS data. For each individual veteran respondent in the BRFSS data, the model was used to generate a posterior distribution of the probability that they had a caregiver and the probability that they had an unmet need for such care, based on their health status, sociodemographic characteristics, and state characteristics. Specifically, the posterior distributions from the BART model were thinned to 100 samples, such that each BRFSS respondent had 100 estimates of the probability of each caregiving outcome, which represent the range of possible outcome probabilities consistent with their individual characteristics.

For each of these samples from the posterior, we generated a survey-weighted average of the proportion in the population with that outcome. Those estimates were then averaged across samples to get a final estimate, and the uncertainty across results from the individual samples was included in the standard errors using Rubin's rule (Rubin, 1987). This procedure ensures that the credible intervals for these estimated proportions fully account for three types of uncertainty: (1) uncertainty in the predicted probabilities of these outcomes generated by the model estimated on the 2022 RAND Veterans Survey sample, (2) uncertainty in estimating population characteristics based on the BRFSS survey sample, and (3) uncertainty in estimating population characteristics due to variance from the survey weights applied to the BRFSS sample.

Because our analyses combined data across multiple years of BRFSS data and analyzed only the veteran subsample from the larger BRFSS data, the standard survey weights provided with BRFSS data were slightly modified. Specifically, as is commonly done when combining BRFSS data across years, the weights provided for each year's data were rescaled so

that respondents had the same average weight across years within each state (CDC, 2022a). Secondly, the BRFSS weights were originally designed to be representative of the entire population of each state across a wide range of dimensions. However, they do not specifically ensure that the veteran subsample from the survey is representative of the veteran population of each state. To better ensure representativeness of the veteran subsample, we added a post-stratification step to the BRFSS weights so that they matched the population distribution of veterans published by VA (e.g., Valliant, Dever, and Kreuter, 2013). Specifically, the proportion of the sample in each age group within each state and gender group was weighted to be directly proportional to the corresponding population sizes taken from VA. Similarly, when producing estimates of the number of veterans who have a caregiver or with an unmet need for care, these numbers are based on VA's published numbers of veterans in each state.

RAND's Validation of Responses to PCAFC Participation

The 2023 RAND Caregiving Survey was not designed to be exactly aligned with VA's eligibility requirements, but many of the items in the survey can serve as a validity check for whether those reporting participation in PCAFC would be eligible. Eligibility criteria, as outlined by VA, that the 2023 RAND Caregiving Survey can assess include the following:

- Veteran status and era of service (though veterans of all ages can participate, PCAFC was initially developed for post-9/11 veterans, so it is likely that fewer pre-9/11 veterans participate)
- The veteran must have a service-connected disability rating of 70 percent or more (the 2023 RAND Caregiving Survey directly asks this)
- The veteran is unable to perform an ADL or has a need for supervision based on symptoms of neurological or other impairment or injury or has the need for regular to extensive supervision (this can be examined through ADL status, medical conditions, and caregiving intensity)
- The caregiver is the veteran's family member or lives with the veteran full time (the 2023 RAND Caregiving Survey asks these questions separately that can be analyzed in tandem).

Validation proceeded in four stages. In stage one, participation in PCAFC and age were examined by military/veteran caregivers to those 60 and under and those over 60. As shown in Table A.8, 28 percent of military/veteran caregivers who care for someone 60 or under participate in PCAFC, more than those caring for a veteran over 60 (8 percent). Given the rollout of the program to serve caregivers to post-9/11 veterans first, this is understandable.

PCAFC requires veteran care recipients to have a disability rating of 70 percent or higher. In stage two of validation, veterans' service-connected disability rating (as reported by caregivers) was examined among those caregivers reporting participation in PCAFC (Table A.9). The large proportion (41 percent) with a rating below 70 percent raises significant concern.

TABLE A.8
PCAFC Application

	Military/Veteran Caregivers to Those 60 and Under Weighted Percentage	Military/Veteran Caregivers to Those over 60 Weighted Percentage
Used program in the past year	28%	8%
Did not use program in the past year		
Used in the past but no longer enrolled	6%	<1%
Applied but not accepted	5%	2%
Plan to apply for the program	4%	5%
Do not plan to apply for or participate	9%	20%
Not aware of the program	44%	62%

NOTE: Column percentages do not add to 100 percent because some respondents (<2 percent) skipped or refused to answer the question. The unweighted sample size for each group is military/veteran caregivers to those 60 and under: N = 84, military/veteran caregivers to those over 60: N = 375.

TABLE A.9
Disability Rating Among Care Recipients Enrolled in PCAFC, as Indicated by Their Caregivers

	Frequency	Unweighted Percentage
10–20%	3	8%
30–40%	8	22%
50–60%	4	11%
70–90%	3	8%
100%	5	14%
Don't know	1	3%
Missing	12	33%

There are various eligibility requirements that relate to care recipients' need for assistance to participate in PCAFC; stage three of the validation examined these. These are that the care recipient be consistently unable to perform at least one ADL (bathing or showering, getting in and out of bed or a chair, dressing, walking, using the toilet, and eating) or need supervision due to a neurological condition or need extensive supervision. Eighty-nine percent of those using PCAFC reported that the caregiver needs assistance with at least one ADL. While that result is higher than the percentage of non-PCAFC participants, it should have been closer to 100 percent (Table A.10).

TABLE A.10**Care Recipient Requires Assistance with ADLs, by Self-Reported PCAFC Status**

	Military/Veteran Caregivers Who Participate in PCAFC Weighted Percentage	Military/Veteran Caregivers Who Do Not Participate in PCAFC Weighted Percentage
Any ADL	89%	48%
Getting in and out of beds and chairs	51%	30%
Getting dressed, bathing, or showering	52%	29%
Getting to and from the toilet	57%	17%
Dealing with incontinence or diapers	39%	23%
Eating	57%	17%

NOTE: The unweighted sample size for each group is military/veteran caregivers who report participating in PCAFC: N = 36, and military/veteran caregivers who do not participate in PCAFC: N = 466.

However, it is possible for a veteran to qualify for PCAFC if they deal with serious impairment due to neurological conditions. Table A.11 displays the percentages of veterans experiencing different medical conditions by PCAFC status. Forty-one percent and 33 percent of those participating in PCAFC were experiencing neurological conditions or TBI.

Caregivers may also qualify based on veterans' needs for extensive care. Table A.12 displays the number of hours per week that caregivers provide care. Again, while this is not perfectly aligned with PCAFC eligibility criteria, these results may help indicate whether caregivers appear to meet the criteria laid out by VA. Notably, over half of reported participants in PCAFC provide eight hours of care or less per week. It would be expected that they would provide more care.

Fourth, PCAFC requires that the care recipient be a family member or a person who lives with the veteran care recipient. Table A.13 displays, of those reporting to participate in PCAFC, the relationship the caregiver has to the care recipient, as well whether they live with the care recipient. While it is possible that the family caregiver does not live with the care recipient, the eligibility requirements state that the caregiver needs to be either a family member or someone who lives with the care recipient full time. So, non-relatives who do not live with the care recipient are almost certainly not eligible.

The high proportion of responses that do not align with PCAFC eligibility criteria prohibited us from interpreting responses to the question about PCAFC participation as indicating true participation in PCAFC.

TABLE A.11**Medical Conditions of Care Recipient by PCAFC Participation**

	Military/Veteran Caregivers Who Participate in PCAFC Weighted Percentage	Military/Veteran Caregivers Who Do Not Participate in PCAFC Weighted Percentage
Chronic condition	91%	77%
Vision/hearing	65%	59%
Neurological	41%	31%
TBI	33%	12%
Musculoskeletal	51%	42%
Infection	23%	13%
Substance use disorder or mental health condition	57%	40%
Other	19%	27%

NOTE: The unweighted sample size for each group is military/veteran caregivers who report participating in PCAFC: N = 36, and military/veteran caregivers who do not participate in PCAFC: N = 466.

TABLE A.12**Hours per Week Caregivers Provide Care by PCAFC Participation**

	Military/Veteran Caregivers Who Participate in PCAFC Weighted Percentage	Military/Veteran Caregivers Who Do Not Participate in PCAFC Weighted Percentage
≤8 hours per week	57%	51%
9–20 hours per week	10%	23%
21–40 hours per week	20%	16%
41+ hours per week	13%	10%

TABLE A.13**Caregiver Relationship with Care Recipient by Co-Residence Among Military/Veteran Caregivers Reporting Participating in PCAFC**

	Lives with Care Recipient		Does Not Live with Care Recipient		Skipped Question About Co-Residence	
	N	Unweighted Row %	N	Unweighted Row %	N	Unweighted Row %
Spouse/partner	5	83%	1	17%	0	0%
Parent/grandparent/parent-in-law	3	30%	7	70%	0	0%
Child or child-in-law	0	0%	1	100%	0	0%
Sibling, in-law, or other relative	2	18%	9	82%	0	0%
Former spouse/partner	0	0%	1	100%	0	0%
Friend/neighbor/non-relative	3	43%	3	43%	1	14%

Estimating the Cost of Caregiving

Costs of caregiving were estimated using a regression-based approach on the subset of self-identified caregivers (both veteran and civilian) in the 2023 RAND Caregiving Survey data. The approach estimates the marginal change in each type of cost (housing expenses, out-of-pocket medical expenses, and forgone income) associated with an additional hour of self-reported caregiving activities per week. Civilian caregivers were included in the regression sample, and an interaction term was used to estimate the difference in this marginal change between veteran and civilian caregivers, respectively. The following subsections explain the approach for each type of cost in more detail. Following these subsections, Table A.15 presents regression coefficients from which the cost estimates derive.

Estimating Direct Monetary Costs

Direct monetary costs derive from an estimation strategy that associates caregivers' self-reported weekly hours on caregiving activities with out-of-pocket housing and medical expenses, respectively. The model regresses out-of-pocket housing and medical expenses respectively on self-reported caregiving hours, obtaining an estimate of the additional expenses associated with one additional hour of caregiving. This estimate of costs per hour is multiplied by each caregiver's self-reported hours to obtain an estimate of their total out-of-pocket expenditures, which are then summed to produce a total estimate.

This approach is more robust than a direct comparison of caregivers with non-caregivers because it is restricted to the subsample of caregivers, thereby eliminating potential confounding systematic differences in demographic, geographic, or other characteristics between caregivers and non-caregivers. To further reduce potential sources of confound-

ing, controls for the gender, age, age squared, race/ethnicity, educational attainment, and marital status of the caregiver were included to absorb systematic differences in hours spent caregiving across demographic groups. A necessary assumption for this estimate to be valid is that out-of-pocket expenses increase linearly with hours spent caregiving. If the true relationship between out-of-pocket expenses and caregiving is not linear (e.g., there are certain fixed expenses associated with caregiving that do not depend on hours spent caregiving, or expenses increase exponentially with hours spent caregiving, etc.), this approach may under- or overestimate out-of-pocket expenses associated with caregiving.

Estimating Forgone Income

The estimate of forgone income uses a similar regression-based approach relating veteran caregivers' hours spent caregiving to their annual household income. Similar to housing and medical expenses, caregivers self-reported their annual household income by selecting one of 18 bins ranging from "Less than \$5,000" to "More than \$200,000." We assigned an income of \$2,500 to the lowest bin, \$200,000 to the highest bin, and the midpoint of each intermediate bin to obtain an approximate numerical value.³ The specific income value assigned to each bin is presented in Table A.14:

For the model estimating household income, an indicator variable is included that equals one if the caregiver self-reports any work-related disruptions (cutting back hours, switching jobs, quitting work or school early, or experiencing perceived workplace discrimination). In addition to this indicator variable, the model includes hours spent caregiving and controls for gender, age, age squared, race/ethnicity, educational attainment, and marital status. An interaction term between hours spent caregiving and work disruptions is included to examine differential impacts of caregiving on income associated with self-reported disruptions.

To estimate forgone income, the regression model predicts what each caregiver's income would have been in a counterfactual scenario where their hours spent caregiving and self-reported work disruptions equaled zero and all other characteristics remained the same. We compared this counterfactual prediction to the fitted value for their income in the regression model (i.e., the prediction for their actual value of caregiving hours and work disruptions along with their characteristics), with the difference representing their lost income.

Regression Estimates

Table A.15 presents the estimated coefficients from each regression.

The estimate of \$5.69 in additional housing expenses per hour of weekly caregiving activities is the sum of the coefficient for weekly caregiving hours (\$6.02) and the coefficient for the interaction term between weekly caregiving hours and veteran caregiver (−\$0.49). These coefficients suggest that there is a highly statistically significant, positive association between

³ For the bin "\$2,500 to \$9,999" the assigned value was \$7,500 to create more evenly spaced values.

TABLE A.14**Annual Income Assigned to Survey Response Options**

Survey Response Options	Assigned Value
Less than \$2,500	\$2,500
\$2,500 to \$9,999	\$7,500
\$10,000 to \$14,999	\$12,500
\$15,000 to \$19,999	\$17,500
\$20,000 to \$24,999	\$22,500
\$25,000 to \$29,999	\$27,500
\$30,000 to \$34,999	\$32,500
\$35,000 to \$39,999	\$37,500
\$40,000 to \$49,999	\$45,000
\$50,000 to \$59,999	\$55,000
\$60,000 to \$74,999	\$67,500
\$75,000 to \$84,999	\$80,000
\$85,000 to \$99,999	\$92,500
\$100,000 to \$124,999	\$112,500
\$125,000 to \$149,999	\$137,500
\$150,000 to \$174,999	\$162,500
\$175,000 to \$199,999	\$187,500
\$200,000 or more	\$200,000

weekly caregiving hours and housing expenses, and the magnitude of this association is slightly (but not statistically significantly) smaller for military/veteran caregivers than for civilian caregivers.

The estimate of \$1.42 in additional out-of-pocket medical expenses is the sum of the coefficient on weekly caregiving hours (\$0.93) and the coefficient on the interaction term (\$0.49) for this outcome. It is important to note that neither estimate is statistically significant. In an alternative model that restricts the sample to only military/veteran caregivers and eliminates the interaction term, the model provides a similar point estimate of \$1.33 on weekly caregiving hours and a marginally nonsignificant p-value of 0.16. Because the estimated association between caregiving hours and out-of-pocket medical expenses is substantially smaller than the estimate for housing expenses, it is likely that the model is underpowered to detect this smaller association. The lack of significance may also be attributable to the coarseness of our measure of weekly caregiving hours; while the true distribution of weekly caregiving hours is likely continuous, we measured it discretely in bins and topcoded responses at 80 for any

TABLE A.15
Costs of Caregiving Regression Estimates

	Housing Expenses	Out-of-Pocket Medical Expenses	Household Income
	Estimate (SE)	Estimate (SE)	Estimate (SE)
Weekly caregiving hours	6.02*** (2.04)	0.93 (0.64)	−190.04** (87.01)
Weekly caregiving hours × veteran caregiver	−0.49 (3.64)	0.49 (1.14)	46.11 (158.72)
Weekly caregiving hours × self-reported work disruption × veteran caregiver			−393.80 (278.82)
Veteran caregiver	129.54 (89.40)	5.20 (28.08)	3,637.71 (3,538.93)
Self-reported work disruption			980.63 (4,204.91)
Weekly caregiving hours × self-reported work disruption			86.52 (155.14)
Self-reported work disruption × veteran caregiver			−2,129.17 (7,713.41)
Female	−45.65 (63.52)	−66.39*** (19.95)	−9,934.57*** (2,245.60)
Transgender	−1,126.98** (554.88)	−9.50 (174.30)	−29,019.09 (19,550.71)
Other gender identity	−209.13 (375.56)	−28.53 (117.97)	1,664.30 (13,205.53)
Age	12.53 (12.22)	0.84 (3.84)	605.76 (429.56)
Age squared	−0.17 (0.12)	−0.02 (0.04)	−5.60 (4.27)
Black non-Hispanic	118.05 (94.61)	69.87** (29.72)	−19,659.94*** (3,367.79)

Table A.15—Continued

	Housing Expenses	Out-of-Pocket Medical Expenses	Household Income
	Estimate (SE)	Estimate (SE)	Estimate (SE)
Other non-Hispanic	344.71 (251.23)	100.96 (78.92)	-174.30 (8,897.04)
Hispanic	453.56*** (83.76)	88.88*** (26.31)	-6,461.93** (2,956.21)
Multiracial non-Hispanic	-1.32 (222.51)	98.57 (69.89)	-1,925.18 (7,828.53)
Asian non-Hispanic	413.16*** (148.40)	84.48* (46.62)	18,484.35*** (5,249.19)
High school graduate or equivalent	460.97*** (121.75)	-22.71 (38.24)	-1,415.69 (4,301.38)
Some college or associate degree	600.60*** (122.75)	-45.44 (38.56)	9,861.71** (4,322.55)
Bachelor's degree	822.50*** (131.91)	10.35 (41.44)	32,466.11*** (4,650.58)
Postgraduate study or professional degree	1,037.34*** (142.42)	67.87 (44.74)	42,053.94*** (5,021.17)
Widowed	-38.55 (169.13)	-21.26 (53.13)	-11,504.54* (5,962.09)
Divorced	-298.73*** (104.07)	-80.50** (32.69)	-28,604.17*** (3,659.88)
Separated	-418.96*** (160.79)	-145.09*** (50.51)	-24,445.39*** (5,658.03)
Never married	-301.61*** (85.32)	-90.39*** (26.80)	-15,746.89*** (3,011.36)
Observations	1,635	1,635	1,635
R ²	0.089	0.042	0.267

NOTE: * p < 0.1, ** p < 0.05, *** p < 0.01.

individual who spends more than 80 hours caregiving. This reduces variation and therefore reduces statistical power.

Finally, for forgone income, two models are estimated. The first estimates annual household income using the observed values of caregiving hours and self-reported work disruptions. The second is estimated on a counterfactual dataset which assumes caregiving hours and self-reported work disruptions are both zero, and then uses the regression model to predict these values. Forgone income is the difference in these estimates.

The regression estimates suggest a statistically significant, negative association between weekly caregiving hours and household income for the full sample, with each additional hour of caregiving associated with a decrease of about \$190 in household income. However, the estimated coefficient on the triple-interaction term that isolates the association between weekly caregiving hours and household income for military/veteran caregivers with at least one self-reported work disruption is negative and large in magnitude, albeit not statistically significant at conventional levels (p -value of approximately 0.16). This results in an estimated income loss of about \$9,163 in annual household income for the average military/veteran caregiver with at least one work disruption compared with an estimate of about \$1,984 for military/veteran caregivers without work disruptions. The difference in magnitude between these estimates is a function of both this triple-interaction term coefficient and the fact that military/veteran caregivers with self-reported work disruptions spend more time on caregiving activities (about 22 hours per week on average) than military/veteran caregivers without work disruptions (about 14 hours per week on average). In essence, military/veteran caregivers with self-reported work disruptions lose more income both because they spend more time on caregiving *and* because each hour of caregiving they spend comes with a larger penalty than for their counterparts without work disruptions. The statistical insignificance of the triple-interaction term likely reflects that the model is underpowered to detect triple differences; 108 military/veteran caregivers in our survey sample had self-reported work disruptions, resulting in a relatively small cell size to estimate this triple interaction, especially with a coarsely binned measure of household income.

Estimating the Value of Caregiving

Three inputs were used to estimate the annual economic value of veteran caregiving in the United States using three components:

- the estimated number of military/veteran caregivers (about 14.3 million; see Chapter 1)
- the average number of hours spent caregiving by military/veteran caregivers (about 16 hours per week; see Chapter 1)
- a range of state-level proxy wages, including minimum wage and the hourly median wage for home health aides, nursing assistants, and registered nurses, respectively.

Each military/veteran caregiver in the 2023 RAND Caregiving Survey is assigned one of four representative wages from their state of residence: the minimum hourly wage, the median hourly wage for home health aides, the median hourly wage for nursing assistants, and the median hourly wage for registered nurses, respectively. These wages were obtained from 2022 Bureau of Labor Statistics data on median wages by occupation and state. In all 50 states, these wages compare as follows: registered nurses >> nursing assistants >= home health aides > minimum hourly wage. These occupational wages represent a range of possible amounts a caregiver would be paid if they performed their caregiving activities in a paid labor setting. Caregiving activities vary in skills required, and, therefore, the most applicable proxy wage varies by activity. Because the survey does not measure hours spent caregiving broken down by activity, the approach provides a range of possible value estimates that encompasses the range of analogous labor market activities associated with each activity the caregiver may perform. Table A.16 shows the range of proxy wages by state.

Each proxy state wage was then multiplied by caregivers' self-reported number of hours spent caregiving per week. Survey participants were asked to self-report their hours spent caregiving per week by choosing one of nine bins. To be able to multiply by a wage and calculate an average, a representative value is assigned to each bin. These bins and their assigned representative values are presented in Table A.17.

Finally, a weighted average value of weekly caregiving among veteran caregivers was calculated and multiplied by the estimated total number of caregivers to arrive at a topline estimate.

TABLE A.16

Proxy Wages by State

State	2022 Minimum Hourly Wage	2022 Home Health Aide Median Wage	2022 Nursing Assistant Median Wage	2022 Registered Nurse Median Wage
Alabama	\$7.25	\$10.83	\$13.50	\$30.33
Alaska	\$10.34	\$17.24	\$20.34	\$49.16
Arizona	\$12.80	\$14.46	\$17.90	\$39.58
Arkansas	\$11.00	\$12.56	\$14.03	\$30.83
California	\$14.00	\$14.95	\$19.25	\$63.78
Colorado	\$12.56	\$15.99	\$18.01	\$39.63
Connecticut	\$14.00	\$16.19	\$17.63	\$45.77
Delaware	\$10.50	\$13.55	\$17.85	\$39.54
District of Columbia	\$16.10	\$16.39	N/A	N/A
Florida	\$11.00	\$13.33	\$15.51	\$37.36
Georgia	\$7.25	\$12.18	\$14.35	\$38.19
Hawaii	\$10.10	\$15.42	\$17.91	\$57.74
Idaho	\$7.25	\$13.24	\$17.07	\$37.47
Illinois	\$12.00	\$15.26	\$17.61	\$37.97
Indiana	\$7.25	\$13.56	\$16.44	\$35.24
Iowa	\$7.25	\$14.92	\$16.68	\$31.25
Kansas	\$7.25	\$12.02	\$15.33	\$31.95
Kentucky	\$7.25	\$13.54	\$15.52	\$36.44
Louisiana	\$7.25	\$9.46	\$13.39	\$35.18
Maine	\$12.75	\$15.91	\$17.63	\$37.18
Maryland	\$12.20	\$15.26	\$17.45	\$40.31
Massachusetts	\$14.25	\$16.40	\$18.83	\$47.37
Michigan	\$9.87	\$13.73	\$17.37	\$38.07
Minnesota	\$8.42	\$15.19	\$18.60	\$40.41
Mississippi	\$7.25	\$10.52	\$13.19	\$30.45
Missouri	\$11.15	\$12.65	\$15.13	\$34.35
Montana	\$9.20	\$14.01	\$17.09	\$36.80

Table A.16—Continued

State	2022 Minimum Hourly Wage	2022 Home Health Aide Median Wage	2022 Nursing Assistant Median Wage	2022 Registered Nurse Median Wage
Nebraska	\$9.00	\$14.04	\$17.06	\$36.05
Nevada	\$9.50	\$12.51	\$18.53	\$45.64
New Hampshire	\$7.25	\$15.16	\$18.64	\$38.73
New Jersey	\$11.90	\$15.42	\$18.26	\$47.16
New Mexico	\$11.50	\$11.62	\$15.15	\$39.42
New York	\$13.20	\$16.19	\$21.19	\$48.26
North Carolina	\$7.25	\$12.06	\$15.31	\$36.75
North Dakota	\$7.25	\$17.07	\$18.02	\$33.48
Ohio	\$9.30	\$13.19	\$16.82	\$36.93
Oklahoma	\$7.25	\$11.19	\$14.34	\$35.83
Oregon	\$12.50	\$16.86	\$19.88	\$51.29
Pennsylvania	\$7.25	\$13.35	\$17.47	\$37.86
Rhode Island	\$12.25	\$16.27	\$17.71	\$41.33
South Carolina	\$7.25	\$12.04	\$14.92	\$36.35
South Dakota	\$9.95	\$14.78	\$14.85	\$30.25
Tennessee	\$7.25	\$12.73	\$14.68	\$31.63
Texas	\$7.25	\$10.52	\$14.84	\$38.38
Utah	\$7.25	\$14.98	\$15.96	\$37.14
Vermont	\$12.55	\$14.23	\$17.84	\$37.13
Virginia	\$11.00	\$12.02	\$15.69	\$38.32
Washington	\$14.49	\$18.25	\$19.60	\$48.67
West Virginia	\$8.75	\$11.35	\$15.06	\$35.65
Wisconsin	\$7.25	\$14.03	\$17.68	\$38.34
Wyoming	\$7.25	\$14.51	\$16.65	\$37.37
National	\$9.94	\$13.48	\$16.62	\$40.70

SOURCE: Bureau of Labor Statistics data on 2022 occupational wages by state accessed through BLS Data Finder (U.S. Bureau of Labor Statistics, 2018).

TABLE A.17
Caregiving Hours Assigned to Survey Response Options

Survey Response Option	Assigned Value
Less than one hour	1
1 to 4 hours	2.5
5 to 8 hours	6.5
9 to 20 hours	14.5
21 to 30 hours	25.5
31 to 40 hours	35.5
41 to 60 hours	50.5
61 to 80 hours	70.5
More than 80 hours	80

2023 RAND Caregiving Survey Constructs

Table A.18 describes the constructs included in the 2023 RAND Caregiving Survey. This information should be helpful for those interested in learning more about how measures such as caregiver burden or depression were assessed, whether those questions derived from existing scales or were created by RAND researchers specifically for this survey, and which caregivers were asked specific questions. The table presents the following information for each construct:

- **Socio-ecological level:** The level of the socio-ecological framework to which the question relates. There are five levels: care recipients, caregivers, family and friends, community, and system.
- **Constructs:** What is being measured
- **Respondents:** Describes who was asked the question:
 - All = All survey respondents
 - ACG = All caregivers
 - MCG = Only military/veteran caregivers
 - ChAll = All respondents with at least one child under 18 who lives with them
 - ChCG = Caregivers with at least one child under 18 who lives with them
 - NCG = Non-caregivers
- **Variable names:** Variable name(s) included in this construct
- **Notes on operationalization:** Survey response options and details on how groups of items were combined if part of a scale
- **References:** Source of measure or other relevant information.

TABLE A.18

Construct Table for the 2023 RAND Caregiving Survey

Socio-Ecological Level	Constructs	Respondents	Variable Names	Notes on Operationalization	References
Care recipients	Relationship of care recipient to caregiver	ACG	VDEM3	14-option categorical variable	AARP and NAC, 2020; U.S. Census Bureau, 2023a
	Care recipient demographic information	ACG	VDEM4; VDEM7; VGENDER1; VDEM2; VDEM8; VDEM9; VDEM10; VDEM11	8 questions; age, education, gender, preferred pronouns, ethnicity, race, employment status, and marital status	Ramchand et al., 2014
	Care recipient household income in past year	ACG	VDEM13	Write-in	Ramchand et al., 2014
	Care recipient in nursing home or other facility	ACG	VDEM5_2	Yes/no	AARP and NAC, 2020
	Era of service	MCG	VM1	11 options	U.S. Census Bureau, 2023a
	War zone deployment	MCG	VM2; VM2_1	Yes/no Write-in	Ramchand et al., 2014; U.S. Census Bureau, 2023a
	Years of military service	MCG	VM3	Numeric	Ramchand et al., 2014; U.S. Census Bureau, 2023a
	Current military status	MCG	VM4	6 options (<i>currently in National Guard or Reserve, retired, honorable discharge, general discharge, other category, currently active</i>)	Ramchand et al., 2014; U.S. Census Bureau, 2023a
	Disability status	MCG	VM4_1	<i>Permanent disability, temporary disability, or neither</i>	Ramchand et al., 2014; U.S. Census Bureau, 2023a

Table A.18—Continued

Socio-Ecological Level	Constructs	Respondents	Variable Names	Notes on Operationalization	References
	Branch of service	MCG	VM5	13 options	Ramchand et al., 2014; U.S. Census Bureau, 2023a
	Years since most recent military separation	MCG	VM42	Write-in	Ramchand et al., 2014; U.S. Census Bureau, 2023a
	Hospital for regular care	MCG	HOSP1; HOSP2; HOSP3	Type of facility in which care recipient receives most of care; Whether it is part of the VA system; Name/location of the facility	Not applicable
	Medical conditions	ACG	WELL2A	Based on categories from HERO CARE Survey; 16 options different conditions; respondents answered yes or no to each	Ramchand et al., 2014; Dang et al., 2023; VA, 2023a
	Medical conditions caused by military service	MCG	WELL2B	Using categories marked yes from WELL2A, respondents provide yes or no answers to whether the conditions were related to military service	Ramchand et al., 2014; VA, 2023a
	Toxic exposure	MCG	TOXIC1	Whether the caregiver thinks the care recipient's medical conditions are related to toxic exposures during military service	Not applicable
	Service-connected disability rating	MCG	WELL3; WELL3_1; S12a	Disability categories mirroring ACS; Additional questions to capture higher levels of disability	U.S. Census Bureau, 2023a

Table A.18—Continued

Socio-Ecological Level	Constructs	Respondents	Variable Names	Notes on Operationalization	References
	ADLs, IADLs, and other tasks for which caregiving assistance is needed	ACG	WELL4_1;	17 options for whether or not the care recipient needs assistance with tasks;	Ramchand et al., 2014
			WELL4_2	How frequently the caregiver helps with these tasks	
	Potential suicidality	ACG	VETSUI	<i>Very concerned, somewhat concerned, not really concerned, not at all concerned</i>	Miller et al., 2015
	Firearm availability and storage	ACG	FIRE1;	Yes/no question about whether there are firearms in the care recipient's house;	Ramchand et al., 2014
			FIRE2;	If yes, whether they are loaded;	
			FIRE3	If yes, whether they are unlocked	
	Caregivers				
Caregiver screener	All	S2_1;	List of 8 possible ways the caregiver could help the care recipient, if they had provided care in the past but not currently, and if they had never provided assistance;	Not applicable	
		S2_2;	Write-in for how many people they provide assistance to;		
		S2_3;	Whether or not any of them are over 18;		
		S2_4;	Whether their care recipient served in the military;		
		S2_4a-b	If so, how many served in the military		

Table A.18—Continued

Socio-Ecological Level	Constructs	Respondents	Variable Names	Notes on Operationalization	References
	Past caregiving experience	NCG	S2_1_8a;	If respondents said they did not currently provide assistance but had in the past to S2_1, they were asked if they provided this care less than a year ago, 1–2 years ago, or more than 2 years ago;	Not applicable
			S2_1_8b;	Years and months for how long they provided that assistance;	
			S2_1_8c;	How old the care recipient was;	
			S2_1_8d;	Whether the care recipient had ever been a member of the military;	
			S2_1_8e;	Why they are no longer providing assistance;	
			S2_5	Why they provide assistance	
	Military service	All	S1;	Categorical variable capturing whether the caregiver is currently or has ever been on active duty, if they trained for the Reserves or National Guard but were never activated, or had never served in the military	Ramchand, 2014; U.S. Census Bureau, 2023a
			MIL5	13 options for branches, similar to VM5	
	Co-residence of care recipient and caregiver	ACG	VDEM5; VDEM5_1	Yes/no; Distance in miles caregiver and care recipient live from each other	Ramchand, 2014; U.S. Census Bureau, 2023a
	Primary caregiver status	ACG	VDEM6	<i>Me, someone else, me and someone else about equally, me and at least two others</i>	Ramchand, 2014; U.S. Census Bureau, 2023a

Table A.18—Continued

Socio-Ecological Level	Constructs	Respondents	Variable Names	Notes on Operationalization	References
	Time spent caregiving	ACG	CARE1	9 categories for hours spent caregiving	AARP and NAC, 2020; Ramchand, 2014; U.S. Census Bureau, 2023a
	Remote caregiver	ACG	CARE1a	<i>Always in person; Mostly in person, sometimes remotely; Evenly split between in-person and remotely; Mostly remotely, sometimes in person; Always remotely</i>	Not applicable
	Length of time as a caregiver	ACG	CARE4	Write-in (years)	Ramchand et al., 2014
	Employment status	All	W1; PART1	10 options for current employment status; 11 options for part time work	NORC at the University of Chicago, 2024
	Impact of caregiving or other activities on work	All	FS3a-d	Yes/no	Ramchand, 2014; U.S. Census Bureau, 2023a
	Caregiver burden	ACG	ZBI1a-f	Six-item Zarit Burden Interview. Scale values range from 0 to 24; a threshold of 9 or greater is used to indicate excessive caregiver burden	Morycz, 1985; Yu, Yap, and Liew, 2019*
	Use of in-home health care	ACG	HOME_C1; HOME_C2	Yes/no; <i>How often (daily, weekly, a few times a month, once a month or less, or not applicable)</i>	Juster and Suzman, 1995
	Loneliness	All	LONELY1a-c	Three-item UCLA Loneliness Scale	Hughes et al., 2004*
	Suicidality	All	SUI01; SUI02; SUI03	In past 12 months, suicide ideation (yes/no); In past 12 months, suicide plans (yes/no); In past 12 months, suicide attempts (yes/no)	Miller et al., 2015

Table A.18—Continued

Socio-Ecological Level	Constructs	Respondents	Variable Names	Notes on Operationalization	References
	Depression	All	CDEPa-h	Eight-item Patient Health Questionnaire (PHQ-8). Scale values range from 0 to 24; a threshold of 10 or greater is used to indicate probable depression in past 2 weeks	Kroenke et al., 2009*
	Perceived stress	All	PSSa-d	Four-item Perceived Stress Scale (PSS-4). Scale values range from 0 to 16; a threshold of 6 or greater is used to indicate high levels of perceived stress	Cohen and Williamson, 1988*
	Role limitations due to physical health	All	C_PH3a-d	Role limitations from SF-36; Recoded Yes=0; No=100; four items averaged	Hays, Sherbourne, and Mazel, 1993*
	Health insurance	All	C_UTIL1	Yes/no	CDC, 2024; U.S. Census Bureau, 2023a
	Health care utilization	All	C_UTIL4	4 options for length of time since last routine checkup	CDC, 2024; U.S. Census Bureau, 2023a
	Mental health care utilization and unmet needs	All	C_UTIL5;	Yes/no for whether caregiver has seen a mental health care professional in last 12 months;	SAMHSA, 2016; U.S. Census Bureau, 2023a
			COUNS1;	Yes/no for whether caregiver has unmet need for mental health care in last 12 months;	
			COUNS1_a-g	7 yes/no options for reasons of unmet need	
	Sleep	All	SLEEP1;	Write-in for average hours of sleep in past week;	Perez et al., 2020;
			SLEEP2	<i>Very poor, poor, fair, good, very good sleep quality</i>	Kotronoulas, Wengström, and Kearney, 2013

Table A.18—Continued

Socio-Ecological Level	Constructs	Respondents	Variable Names	Notes on Operationalization	References
	Food insecurity	All	HH3; HH4; AD1; AD1a; AD2; AD3	<i>Often and sometimes</i> =1; <i>Often and sometimes</i> =1; Yes=1; <i>Almost every month and some months but not every month</i> =1; Yes=1; Yes=1; Items are summed; a score of 0–1 refers to high or marginal food security; a score of 2–4 refers to low food security; a score of 5–6 refers to very low food security; low and very low can be combined	Rabbitt and Smith, 2021
	Financial capability	All	FCAP; FS2	Yes/no; 8 options	Lusardi, Schneider, and Tufano, 2011
	Financial insecurity	All	FS1	No difficulty at all (yes=1)	Lusardi, Schneider, and Tufano, 2011; Carman and Nataraj, 2020

Table A.18—Continued

Socio-Ecological Level	Constructs	Respondents	Variable Names	Notes on Operationalization	References
	Drug use	All	SUB1;	In past 12 months, frequency of drug use;	French et al., 2001
			SUB2;	In past 12 months, frequency of illegal prescription drug use;	
			SUB3;	In past 12 months, yes/no to marijuana use;	
			SUB4;	^^ cocaine or methamphetamine;	
			SUB5;	^^ heroin;	
			SUB6;	^^ illegal opiate pain relievers;	
			SUB7;	^^ illegal anxiety or sleep prescriptions;	
			SUB8;	^^ illegal ADHD prescriptions;	
			SUB9	^^ other drugs;	
	Alcohol use	All	ALC1;	<i>Never=0, Monthly or less=1, Two to four times a month=2, Two to three times a week=3, Four or more times a week=4;</i> <i>1 or 2=0, 3 or 4=1, 5 or 6=2, 7 to 9=3, 10 or more=4;</i>	Bradley et al., 2007*
			ALC2;	<i>Never=0, Less than monthly=1, Monthly=2, Weekly=3, Daily or almost daily=4;</i>	
			ALC3	Alcohol Use Disorders Information Test (AUDIT-C); sum three scores; can be dichotomized where ≥ 4 for men and ≥ 3 for women indicates alcohol misuse	

Table A.18—Continued

Socio-Ecological Level	Constructs	Respondents	Variable Names	Notes on Operationalization	References
	Religiosity	All	RELIG1	4 options; can be dichotomized by <i>very/somewhat</i> versus <i>not too/not at all</i>	Pew Research Center, 2014
	Personal gain from caregiving	ACG	CRG1a-d	Four-item Personal Gain from Caregiving scale; items are summed and averaged	Pearlin et al., 1990
	Topics where caregiver needs more help or information	ACG	CHELP2	13 options including write-in for other and none of the above	Not applicable
	Demographics	All	GENDER_CURRENT; LGBT; AGE; INCOME; MARITAL	Gender; Lesbian, gay, bisexual, or transgender identification; Respondent age; Household income; Marital status	NORC at the University of Chicago, 2024
Family and friends					
	Roster and basic info on all caregivers	ACG	CARE5; CARE5_1A_N1 through C5_1a_6e	Number of other caregivers; Name or initials for caregiver, age of caregiver, whether they live with the care recipient, relationship to the care recipient	U.S. Census Bureau, 2023a
	Support from other caregivers (to take a break)	ACG	CARE2;	Level of difficulty to get help providing care;	U.S. Census Bureau, 2023a
			CARE3;	Level of difficulty to find someone to help you take a break;	
			CARE7	Whether care recipient has <i>too few, right number</i> , or <i>too many</i> caregivers	

Table A.18—Continued

Socio-Ecological Level	Constructs	Respondents	Variable Names	Notes on Operationalization	References
	Number of care recipient's household residents	All	VDEM12	Write-in	
	Social support	All	C_ESUP	Enough people you can count on, not enough people, or no one you can count on	AARP and NAC, 2020
	Relationship quality	All	RQ; CRRQ	Level of satisfaction with relationship; Closeness felt; Relationship Assessment Scale	Skaff and Pearlin, 1992
	Live alone	All	LIVE_ALONE; HH01-HH18OV	Yes/no; Ages of household members	NORC at the University of Chicago, 2024
	Household conflict and cohesion	All	FES1_1-6	Adapted from the Family Environment Scale: six items with options <i>describes my family well, describes my family somewhat, and does not describe my family at all</i>	Moos, 1994; Hendrick, 1988
	Identifying child caregiver and demographic information	ChAll	CHILD1	How many children live with the caregiver	AARP and NAC, 2020
	Household and caregiving tasks	ChAll	CHILD_TASKS1a-h; CHILD_C2	Yes/no to 8 items; How many children assist with that task	Bauman et al., 2006
	Inventory and child caregiver demographics	ChAll	CHDEM; CHDEM2; CHDEM1; CHDEM5; CHDEM6	Name or initials, rank in age; Preferred pronouns; Age; Ethnicity; Race	
	Time spent on other activities (e.g., school, hobbies, socializing)	ChAll	MISSED1a-e	Frequency that children engage in 5 different activities during a normal week (<i>never, rarely, sometimes, often, and very often</i>)	NAC, 2005

Table A.18—Continued

Socio-Ecological Level	Constructs	Respondents	Variable Names	Notes on Operationalization	References
	Child well-being	ChAll	SDQa-o	Last 6 months, whether statements are <i>not true, somewhat true, or definitely true</i> ; Strengths and Difficulties Questionnaire	Goodman, 1997
	Child unmet needs for mental health care	ChAll	CHCOUNS1	Last 12 months, yes/no	
	Child mental health care use	ChAll	CHUTIL3	Last 12 months, yes/no	SAMHSA, 2016
	Child program resource use and unmet needs	ChAll	CHACT1; CHACT4	6 yes/no options for activities; 10 options for potential services	Not applicable
Community					
	Community characteristics	All	TRACT_FIPS; METRO; REGION4	Enables merging of secondary/contextual datasets; Yes/no for whether respondent lives in a metro area; Whether respondent lives in Northeast, Midwest, South, or West	NORC (provided directly to the authors)
	Support groups	ACG	Groups1; Groups1a; Groups1b; Groups2; Groups2a; Groups2b	Yes/no for involvement in support groups; 6 yes/no options for types of groups; Frequency of participation (<i>daily, weekly, a few times a month, once a month or less</i>); Yes/no for participating in online support groups; 10 options for types of online support groups; Frequency of participation (<i>daily, weekly, a few times a month, once a month or less</i>)	Trail et al., 2020

Table A.18—Continued

Socio-Ecological Level	Constructs	Respondents	Variable Names	Notes on Operationalization	References
	Community cohesion	All	COHES1a-e	Level of agreement (<i>strongly agree, agree, neither agree nor disagree, disagree, or strongly disagree</i>) with 5 statements about one's community; items d and e are reverse coded for agreement	Li et al., 2005; Earls et al., 1999
System					
	PCAFC	MCG	C_RES10;	Yes/no for whether they participated in PCAFC in the past year;	Not applicable
			PCAFC_Q1;	5 options for degree of participation;	
			PCAFC_Q2;	6 options for resources used;	
			C_RES10_A	Degree of helpfulness (<i>Very helpful, somewhat helpful, not at all helpful</i>)	
	Caregiver-friendly health care facility physical environment	ACG	PHYS2a-f	Level of satisfaction with 6 aspects of the health care facility	Not applicable

Table A.18—Continued

Socio-Ecological Level	Constructs	Respondents	Variable Names	Notes on Operationalization	References
	Integration into health care team	ACG	HOSP4;	In last year, how often there was communication with medical providers (<i>often, sometimes, rarely, never</i>);	Stephens, Ogrocki, and Kinney, 1991
			HOSP5;	Helpfulness of communication (<i>a lot, somewhat, a little, not at all</i>);	
			HOSP6;	Whether most frequent communication was with the usual provider or someone else;	
			HOSP7a-c;	Frequency of integration with team (<i>always, usually, sometimes, never, not applicable</i>);	
			DISC1a-h	In the past 12 months, whether 8 hassles had occurred (yes/no); Caregiver Hassles Scale	
	Caregiving discrimination	ACG	DISC2	14 options for why discrimination might occur	Not applicable
	Use of respite care	ACG	C_RES1;	Yes/no for using respite care in past year;	Not applicable
			C_RES1a;	Select all that apply for who provided respite care;	
			C_RES1b;	Select all that apply for where the care was provided;	
			C_RES1c;	Select all that apply for who paid for the care;	
			C_RES1d	Degree of helpfulness (<i>very helpful, somewhat helpful, not at all helpful</i>)	

Table A.18—Continued

Socio-Ecological Level	Constructs	Respondents	Variable Names	Notes on Operationalization	References
245	Receipt of caregiver training	ACG	C_RES3; C_RES3_A; C_RES3_B	Yes/no for training in past year; Select all that apply for who provided the training; Degree of helpfulness (<i>very helpful, somewhat helpful, not at all helpful</i>)	Not applicable
	Use of structured wellness activities	ACG	C_RES6; C_RES6A	Yes/no for structured wellness activities in past year; Degree of helpfulness (<i>very helpful, somewhat helpful, not at all helpful</i>)	Not applicable
	Use of advocate or case manager	ACG	C_RES8; C_RES8_A	Yes/no for using an advocate or case manager in past year; Degree of helpfulness (<i>very helpful, somewhat helpful, not at all helpful</i>)	Not applicable
	Receipt of government benefits/payments	All	C_RES14	Check all that apply for use of government benefits in past year (SNAP, etc.)	Not applicable
	Caregiver-friendly employment	All	N16_1a-g	Yes/no	Not applicable
	Monthly spending on health care	All	EXP2	6 categories	Not applicable
	Monthly spending on housing	All	EXP1	7 categories	Not applicable

NOTE: Validated outcomes are denoted with an asterisk in the References column.

Abbreviations

ACS	American Community Survey
ADHD	attention deficit/hyperactivity disorder
ADL	activity of daily living
AL-TBI	Assisted Living for Veterans with Traumatic Brain Injury
ATUS	American Time Use Survey
BART	Bayesian Additive Regression Trees
BRFSS	Behavioral Risk Factor Surveillance System
CARES Act	Coronavirus Aid, Relief, and Economic Security Act
CDC	Centers for Disease Control and Prevention
CI	confidence interval
CMS	Centers for Medicare & Medicaid Services
COVID-19	coronavirus disease 2019
CPS	Current Population Survey
DAV	Disabled American Veterans
EAP	employee assistance program
EBT	Electronic Benefits Transfer
HPSA	Health Professional Shortage Area
HRSA	Health Resources & Services Administration
IADL	instrumental activity of daily living
LGBTQ+	lesbian, gay, bisexual, transgender, queer, and other
MRSA	methicillin-resistant <i>Staphylococcus aureus</i>
NAC	National Alliance for Caregiving
OFC	Operation Family Caregiver
PACT Act	Promise to Address Comprehensive Toxins Act
PCAFC	Program of Comprehensive Assistance for Family Caregivers
PEER	Personalized Experiences, Engagement and Resources
PHQ-8	eight-item Patient Health Questionnaire
PGCSS	Program of General Caregiver Support Services
PSS-4	four-item Perceived Stress Scale
PTSD	posttraumatic stress disorder
RAISE	Recognize, Assist, Include, Support, and Engage
RCI	Rosalynn Carter Institute for Caregivers
REACH	Resources for Enhancing All Caregivers Health
SAMHSA	Substance Abuse and Mental Health Services Administration

SD	standard deviation
SE	standard error
SF-36	36-Item Short Form Survey
SNAP	Supplemental Nutrition Assistance Program
SSI	Supplemental Security Income
TANF	Temporary Assistance for Needy Families
TAPS	Tragedy Assistance Program for Survivors
TBI	traumatic brain injury
UCLA	University of California, Los Angeles
VA	U.S. Department of Veterans Affairs
VHA	Veterans Health Administration
WIC	Special Supplemental Nutrition Program for Women, Infants, and Children

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The authors produced new estimates of the number of adults caregiving in the United States today; investigated how those caring for wounded, ill, and injured service members and veterans compare with those caring for civilians and with non-caregivers; and share insights on the potential consequences of caregiving on caregivers' health, their economic security, and their families' well-being. They also propose recommendations to strengthen caregiver support.

There are 14.3 million military and veteran caregivers, representing 5.5 percent of the U.S. adult population. There are an additional 91.3 million civilian caregivers (35.0 percent of U.S. adults) caring for wounded, ill, or injured civilian adults.

Across all caregivers, most (78 to 81 percent) spend between one and 30 hours per week providing care. Under 10 percent spend less than one hour per week, and 11 to 16 percent spend 31 hours or more per week caregiving.

The estimated aggregate economic value generated by military/veteran caregiving activities, which are largely uncompensated, ranges from \$119 billion to \$485 billion per year. Military/veteran caregivers incur an estimated \$8,583 in annual out-of-pocket costs associated with their caregiving responsibilities. Military/veteran caregivers forgo an estimated \$4,522 in annual household income.

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