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Review Article

Food Insecurity among United States Military Veterans

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Abstract

This literature review examines why United States military veterans (hereafter, "veterans") are at a higher risk of food insecurity than nonveterans. It provides an overview of the literature regarding the prevalence of food insecurity among veteran subpopulations and how it compares to the general population. Unique risk factors associated with increased probabilities of veterans being food insecure are reported, along with barriers that may inhibit veterans' participation in food assistance programs. Food insecurity risk factor screening in clinical or community settings and recently targeted interventions to support veterans at high risk for experiencing food insecurity are described. Overall, the literature reveals that veterans are at a higher risk of food insecurity than nonveterans due to various risk factors unique to the veteran population. More research is needed to identify significant factors that may be used to target interventions to improve food security among the veteran population.

FOOD INSECURITY AMONG UNITED STATES MILITARY VETERANS

According to the United States Department of Agriculture [1], food security is defined as access by all people at all times to enough food for an active, healthy life; it is one requirement for a healthy, well-nourished population. In contrast, food insecurity is the inability to access sufficient and nutritious food at all times for a healthy lifestyle and is a measure of economic hardship [2]. Those who experience food insecurity, including United States military veterans, suffer from poorer health and health behaviors [3-6].

Food insecurity among the veteran population varies, ranging from 6% to 24%, almost twice that of the general United States population [7]. Some research demonstrates an increasing trend of food insecurity among some veterans [8,9]. Risk factors of food insecurity are complex and associated with various social determinants of health (SDOH), such as socioeconomic status, safe housing, race, education, transportation, and access to health care [4,10]. In addition, experiencing food insecurity has been shown to impact mental and physical health negatively [7,8,11,12].

Veterans who honorably served their country should not be left to live a life with questionable access to nutritious food. The nation's overall health will improve by increasing food security among the veteran population. The results of this review may benefit various stakeholders by increasing awareness about veteran food insecurity rates among the public and healthcare professionals and helping them identify why veterans consume more non-nutritious foods such as added sugars and solid fats than nonveterans. Further, it may promote ideas for improvement efforts within the Veterans Healthcare Administration (VHA) system by pinpointing current challenges associated with screening veterans for food insecurity and providing solutions to resolve the issue.

Definition of Terms

Veteran

It is a term that describes a person who completed active service for any branch of the armed forces, such as the Navy, Air Force, Coast Guard, Marines, Army, or Space Force, and who was discharged or released under conditions other than dishonorable [13].

Nonveteran

"A person who is not a former member of the armed forces; someone who is not a military veteran" (Merriam-Webster, n.d.).

Clinical reminder

It is an embedded tool in the electronic healthcare record that

helps healthcare providers deliver high-quality patient care for preventive health care, manage chronic conditions, and track and improve preventive health care and disease treatment [14].

Cultural competence

It is a term used to identify an awareness of and knowledge about veterans, comfort in collaborating with them, and skills for doing so [15].

Supplemental Nutrition Assistance Program

Provides food benefits to low-income families to supplement their grocery budget [12].

Women, Infants, and Children Program

This program safeguards the health of low-income pregnant and postpartum women, infants, and children younger than five years who are at nutritional risk [1].

Temporary Assistance for Needy Families

This program is federally funded and state-run, otherwise known as welfare [15].

LITERATURE REVIEW

This literature review synthesizes original research and grey literature through government publications. This analysis revealed several main themes from the literature, including the prevalence and risk factors of food insecurity among veterans, barriers to accessing food assistance, the food insecurity clinical screening and interventions process at VHA, and challenges and limitations of the reviewed food insecurity research.

PREVALENCE AND RISK FACTORS OF FOOD INSECURITY

Poverty among veterans has profound implications for food security and health since access to nutritious food for an active, healthy life is critical to maintaining well-being [10]. Rabbitt and Smith [10], state that 1.5 million veterans in the United States live below the federal poverty level (FPL), and an additional 2.4 million live paycheck-to-paycheck (at < 200% of the FPL) [16]. The prevalence of food insecurity/insufficiency among veterans varied widely (5% to 27.6%) across the literature reviewed for this project. The higher rate of 27.6% is about double that of the general population, which is 12.8% as reported by the USDAERS [17]. This broad range of food insecurity prevalence is consistent with the 6% to 24% span reported by Wang et al. [7].

Kamdar et al. [6], used a retrospective, observational design to examine VHA electronic medical records data of 64,789 veterans who screened positive for food insecurity during the fiscal years 2018-2020 and were rescreened within three to five months. Kamdar et al.'s [6], findings indicate that veterans who are male, Hispanic, or Native American, or those with a history of homelessness, psychosis, or substance abuse (illicit drugs) have an increased chance of persistent food insecurity. Notably, enlisted personnel in lower ranks, ethnic minorities, and veterans with poor health reported food insecurity even though they used food assistance programs [13].

Miller et al. [18], used data from the 2005-2013 Current Population Survey Food Security Supplement to identify rates of food insecurity and very low food security in veteran and nonveteran households. Miller et al. [18], found a difference in food insecurity among volunteer versus drafted veterans. Most drafted veterans had trade skills and were employed before enlisting in the military compared to veterans who volunteered to enlist [18]. A higher proportion of volunteers are from impoverished communities and dysfunctional families, and a greater number of them are women [18].

Miller et al.'s [18], results found that 8.4% of veterans ranked their food insecurity as low, and 3.3% ranked it as very low compared to nonveterans, 14.45%, and 5.4 %, respectively. Food insecurity increased in veterans who served from 1975 and onwards, and food insecurity was significantly lower for those who served in the Vietnam War [18]. Veterans' advantages to decrease food insecurity are free health care, educational assistance, specialty home loans, and homeless programs for qualifying veterans [18].

Women veterans are a not highly represented within the veteran food insecurity literature. For example, Brostow et al.'s [3], study of 5,280 male and female respondents consisted of 1254 male veterans and only 47 female veterans. Notably, this survey was the only study of the reviewed literature to report a higher rate of food insecurity among male nonveterans compared to male veterans. Narain, Bean-Mayberry, et al. [8], explicitly studied food insufficiency among women veterans and hypothesized an association between insufficiency and reduced access to care and health outcomes for women veterans. Their study showed a 27.6% prevalence rate of food insufficiency among women veterans. Food insufficiency categorization stemmed from responses of having enough but not always the kinds of food we want (23.6%), sometimes not enough to eat (3.9%), and often not enough (1.2%). Statistically significant increases in probability of delayed or missed medical care, testing positive for anxiety and depression, and fair to poor health ratings were associated with woman veterans experiencing food insufficiency [8].

L'Esperance et al. [13], reported on the 2021 Military Family Support Programming Survey. Results from over 8,600 respondents revealed that one in six (16.6%) military and veteran families experienced food insecurity or hunger, which was an increase compared to the 15% value reported in 2017. Of the 16.6% food insecure veteran and military families, 9.0% were categorized as hungry or very low food security and 7.6% were categorized as food insecure or low food security. Additionally, about 23.3% of enlisted families reported food insecurities compared to around 5% of officer families. The survey also showed that 96% of respondents facing food insecurity used assistance programs such as the Supplemental Nutrition Assistance Program (SNAP) or Women, Infants, and Children

Program (WIC). These programs were described as helpful, but respondents experienced significant issues obtaining assistance.

There is a wide range of risk factors in the literature reported to increase veterans' food insecurity risks. Very few veterans utilize the VHA for their health care services, and those who do are minorities, have lower education attainment, are more apt to be unemployed, have lower income, and are in poor health [7]. Some of the risks for food insecurity are predisposing physical and mental health issues, younger age, African American race, tobacco use, and low socioeconomic status [3,7,12].

Becerra et al. [11], used a secondary analysis of cross-sectional data from the California Health Interview Survey, dates 2009-2011 and 2012. Survey weights were applied to identify univariate means, population estimates, and weighted percentages [11]. The study found that low education and unemployment led to food insecurity and an increased risk of obesity due to poor dietary practices. Low income and low final military pay grade were among the risk factors identified by Widome et al. [9]. They relayed that 25% of male and female veterans experienced food insecurity. In addition to economic factors, these veterans were younger, unmarried, living in households with more children, and were more likely to abuse tobacco and alcohol than nonveterans.

Dong et al. [19], used information obtained from over 30,000 adult veterans and nonveterans using the Healthy Eating Index of the United States Department of Agriculture and the National Cancer Institute. Like Becerra et al. [11], Dong et al. [19], discovered that low income leads to a high intake of added sugar and solid fat foods, leading to health issues. Cypel et al. [2], conducted a critical literature review of 21 studies. They reported that the most dominant factor affecting food insecurity was a veteran's health status, and the most minor factors were social determinants such as homelessness, housing insecurity, and food program participation.

In comparison, Cohen et al. [5], used a retrospective cross-sectional analysis study using VHA administrative data of 3,304,702 veterans, of which 44,298 screened positive for their initial food insecurity assessment. O'Toole et al. [20], used results from initial screenings administered at six Veterans Administration primary care clinics for people experiencing homelessness. Cohen et al. [5], and O'Toole et al. [20], found that previous homelessness or housing instability in the prior year increased the risk for food insecurity. Cohen et al. [5], also found the following factors to affect food insecurity: female gender, under the age of 65 years, unmarried marital status, minority race, and low income. Veterans who used tobacco, sustained military sexual trauma, had predisposing mental health issues, or substance abuse were also at a higher risk for food insecurity than nonveterans [5].

The Veterans Aging Cohort Study by Wang et al. [7], enrolled 6,709 HIV-infected and HIV-uninfected veterans and found that 24% of participants reported being food insecure. Widome et al. [9], randomly sampled Iraq and Afghanistan veterans (800 female and 1200 male) with a 52.3% response rate. The 27% prevalence of food insecurity among the Iraq and Afghanistan veterans was dramatically higher than the United States prevalence of food insecurity of 12.5% in 2012 [9]. Beccera et al. [11], reported that among their 11,011 California veteran participants, 5% lived in poverty with food insecurity, with minimal intake of fruits and vegetables and a high consumption of soda and fast foods. Of the 2,630 veterans screened for food insecurity, 11.5% reported food insecurity and scored higher for depression and suicide ideation [21]. Table 1A of the Appendix lists selected references summarizing food insecurity risk factors among military veterans.

In addition to the clear prevalence and wide range of risk factors, the reviewed literature emphasized the consequences of food insecurity. Veterans and their families who experience food insecurity are more prone to health issues [13]. Food insecurity increases the risk of uncontrolled mental and physical health issues such as hypertension, diabetes mellitus, HIV, obesity, substance abuse, suicide ideation, anxiety, and depression, and an increased probability of delayed or missed health care [7,8,11,12].

BARRIERS TO ACCESSING FOOD ASSISTANCE

While several food insecurity interventions or assistance programs exist, many reviewed sources discussed barriers to veteran participation. Male veterans are less likely to access food banks or use nutrition assistance programs due to the stigma (embarrassment or shame) of using food banks and feeling like they are taking food away from women and children [3,13]. L'Esperance et al. [13], reported that 95% of food-insecure families used federal and community food resources, 34.5% reported support access struggles, and 16.4% reported not utilizing the resources due to stigma. The barriers to accessing food assistance were inconvenient or difficult to access in their geographical area and lacking or having high qualification requirements [13]. Veterans who live in geographically rural areas face additional barriers to accessing food due to transportation, resources, and education [15].

The VHA has recognized food insecurity as a critical concern for the well-being of United States military veterans. The electronic healthcare record food security clinical reminder is a first step toward increasing provider awareness about veteran food insecurity and decreasing the barriers to nutritional foods [4]. Once identified, other clinical staff can address food insecurity by providing the veteran with needed resources to access affordable or free food [4].

VHA CLINICAL REMINDER SCREENING AND INTERVENTIONS

Clinicians need to integrate prevention and mitigation or treatment efforts for food insecurity, depression, and suicide ideations during the veteran's primary care and behavioral health clinic visits. Screening for suicide ideations is imperative since there is an increased risk of suicide when food insecurity

Appendix

Table 1A: Summary of Food Insecurity Risk Factors among United States Veterans

Author (year)	Research design	Population	Key findings
Brostow et al. [3],	Longitudinal study	American adults 50+ who answered the 2013 Health Care and Nutrition Mail Survey; then 12,420 sub-sample was randomly chosen, 65% responded (8,073), those who met its inclusion criteria, a total of 5,280 male and female (only 47 female veterans) respondents (2560 male of which 1254 were veterans)	Among male veterans, 6.4% reported food insecurity, compared to 11.9% of male nonveterans. Younger age, difficulty with daily activities, and depression were significantly associated with increased odds of food insecurity among male veterans aged 50 to 64. Male veterans aged 65 years and older, current smoker, a psychiatric diagnosis, and depression were significantly associated with increased odds of food insecurity. This was the only study reviewed that reported a higher food insecurity among nonveterans.
Cohen et al. [5].	Retrospective cross-sectional study using VHA administrative data	All veterans screened for food insecurity since screening initiation (July 2017–December 2018). For those veterans screened more than once during the study period, restricted analyses to their first food insecurity screen resulted in a final analytic sample of 3,304,702 veterans.	Of 3,304,702 veterans screened for food insecurity, 44,298 were positive on their initial screen (1.3 % of men; 2.0 % of women). Food insecurity was associated with identifying as non-Hispanic Black or Hispanic; <65 y.o., racial/ethnic minority, non-married, low income, previous homelessness or housing instability in the prior year, use tobacco, history of military sexual trauma, depression, post-traumatic stress disorder, and/or substance abuse.
Kamdar et al. [6].	Retrospective, Observational Design to examine data from Veterans Health Administration electronic medical records.	The sample consisted of 64,789 veterans who screened positive for food insecurity in Veterans Health Administration primary care during fiscal years 2018-2020 and were rescreened within 3 to 5 months.	Veterans with increased odds of persistent versus transient food insecurity included men and those from Hispanic or Native American racial and ethnic groups; psychosis, substance abuse disorder (excluding tobacco and alcohol), and homelessness were at increased odds of persistent food insecurity. Married veterans or veterans who had a service-connected disability rating of 70% to 100% had lower odds of persistent versus transient food insecurity.
Kamdar et al. [21].	Adjusted Linear Regression Model	2630 veterans who participated in the National Health and Nutrition Examination Survey 2007–2016.	Of the sample, 11.5% were food insecure. Food insecurity in veterans is associated with increased depression symptoms and suicidal ideation. This association strengthens as food insecurity worsens. Veterans with food insecurity should be screened for depression and suicidal ideation.
L'Esperance et al. [13].	Qualitative and Quantitative Questions	8,638 military veterans	An increase in food insecurity results in poorer health. In 2021, 16.6% of veterans reported food insecurity, while 23.3% of enlisted families reported food insecurity. Veterans who had increased food insecurity were enlisted personnel in lower ranks and ethnic minorities. Of those facing food insecurity, 96% used SNAP or WIC but had significant obstacles to obtaining food assistance. COVID-19 increased food insecurity among veterans.
Miller et al. [18].	Data from the 2005–2013 waves of the Current Population Survey – Food Security Supplement	Veterans of the U.S. Armed Forces and nonveteran households (388, 680)	This research found that nonveteran households (14.4%) were at a higher risk of F.I. than veteran households (8.4%), with older veterans rating at very low risk of food insecurity. The era in which a veteran served influenced the risk of food insecurity (drafted versus volunteer enlistment). Older veterans (drafted era) had lifetime advantages from the G.I. bill and mortgage and healthcare programs. A higher number of veterans who volunteered came from impoverished communities, dysfunctional families, and a greater number of them were women. This study revealed that nonveteran households were at greater risk of food insecurity than veteran households.
Narain, Bean-Mayberry, et al. [8].	Multiple Logistic Regression	818 female veterans	The prevalence of food insufficiency among women veterans was 27.6%. Food insufficiency was associated with 16.4, 15.4, 14.9, and 12.1 percentage point increases in the probability of delayed or missed care, screening positive for anxiety, screening positive for depression, and reporting fair to poor health, respectively. An increased risk of food insecurity was noted in women veterans who were Black, unmarried, or unemployed.
Pooler et al. [12].	Univariant Analysis and 2011-2017 National Health Interview Survey (NHIS) data	5,146 low-income veterans	Of the 5,146 low-income veterans, 22.5% were food insecure. Rates of food insecurity were higher among veterans aged 45-64 (33%) and less than 45 (29.7%) than among veterans aged over 75 (6.4%) and in non-Hispanic Black (31%), Hispanic (25.9%), and non-Hispanic other (30.9%); veterans without a 4-year college degree, unemployed, renters, and SNAP recipients, those who struggle with physical and mental health issues had higher rates of food insecurity. Post-separation programs, civilian support services, and veterans' health providers should be aware of the characteristics that place veterans at the highest risk of food insecurity.
Rabbitt & Smith [10].	Regression Analysis Applied to data from the 2005–2019 Current Population Survey Food Security Supplement (CPS-FSS)	13,852 veterans and 257,217 nonveteran adults between the ages of 18 and 64, living in 134,990 households	After adjusting for observable differences between working-age veterans and nonveterans, the study found veterans are 7.4% more likely to live in a food-insecure household and a 9.2% increase in the likelihood of living in a household with very low food security. 11.1% of working-age veterans lived in food-insecure households, and 5.3% lived in households with very low food security (the food intake of some household members was reduced, and normal eating patterns were disrupted due to limited resources.)

Widome et al. [9].	Cross-Sectional Survey	U.S. military veterans who had served in the wars in Iraq and Afghanistan since October 2001, 800 female and 1200 male veterans who had at least one outpatient healthcare visit in the Minneapolis VA Healthcare System and had a telephone number listed in the record were randomly sampled.	Around 27% of veterans reported past-year food insecurity, with 15% reporting low food security and 12% reporting very low food security. Food-insecure veterans tended to be younger, not married or partnered, living in households with more children, earned lower incomes, had a lower final military pay grade, were more likely to use tobacco, reported more frequent binge drinking, and slept less, compared with those who were food secure. The U.S. prevalence of food insecurity in 2012 was 14.5%, and very low food security at 5.7%.

increases [20,21]. Referrals to food bank resources and including food insecurity in veterans' mental health treatment plans are imperative [20].

The VHA developed a clinical reminder screening tool to help identify veterans at risk for food insecurity [4-6,22]. The reminder was implemented in October 2017 and provides an onscreen alert to screen all noninstitutionalized veterans for food insecurity during the veteran's clinic visit [4-6,22]. A clinical reminder is an embedded tool in the VHA electronic healthcare record that helps healthcare providers deliver high-quality patient care for preventive health care, manage chronic conditions, and track and improve preventive health care and disease treatment [14]. A nurse or social worker completes the food security clinical reminder during the veteran's clinic visit. If the result is positive, social work or nutritional services provide the veteran with food resources and education on accessing food assistance programs [14].

Healthcare teams can connect veterans to needed resources using clinical reminders and create individual and population-level data to inform the VHA and community efforts to address veteran food insecurity [4]. Clinical reminder data are currently used for local quality improvement efforts [4]. They have established the need nationally for formalized partnerships between VHA Social Work Services and Nutrition and Food Services to connect veterans with food and provide them with the best strategies to use available food resources [4].

Post-1975 enlistees (volunteers) should be recipients of targeted outreach programs to improve nutritional outcomes [18]. Addressing food insecurity among the homeless or previous homeless veterans increased awareness of the need to provide a multidisciplinary healthcare approach [20]. Examples of food insecurity programs include the RRV program, Temporary Assistance for Needy Families (TANF) [15], WIC [1], and SNAP [10,11,18]. The RRV pilot program in Indiana and Kentucky set up five rural food pantries for rural, low-income veterans and conducted an initial assessment and a three-month follow-up for food security [15]. The RRV trained the food pantry staff on cultural competence and held monthly outreach events for veterans to obtain food and other services [15]. RRV recruited 234 veterans, of whom 53% completed the follow-up assessment, and found that food security increased, as did enrollment in one or more food assistance programs [15].

RESEARCH CHALLENGES AND LIMITATIONS

Across the sources, several challenges emerged. There is a lack of research on the validity and usability of food insecurity assessment methods in veterans, military service factors, longitudinal effects, and intervention effectiveness lacked sufficient inquiry [2]. Increasing education about food and how to obtain healthier foods does not mean people will change their eating habits because eating habits have much to do with money and food insecurity [23]. In some research, no follow-up was completed after the interventions [6,23]. Wright et al. [15], stated that after the RRV program interventions, no follow-up was completed regarding how many resources or outreach events veterans attended or whether they continued utilizing the rural food pantries.

Concerning the limitations of the presented research, Dong et al.'s [19], review revealed that future research is needed to identify why veterans are more apt to consume foods containing added sugars and solid fats than nonveterans. Future research is needed on the long-term effects of military training in helping veterans and their families adopt healthier lifestyles through health care, food assistance, and nutrition education [19]. The food insecurity data collected is based on self-reported veteran status, so there is room for error, such as underestimating the true prevalence of food insecurity among veterans [5,10]. Wang et al. [7], voiced concern about their study because they used a single item that captured only one aspect of food insecurity, anxiety, and the ability to access food.

Several researchers stated they could not establish a cause-and-effect because food insecurity changes over time [3,4,7,8,10]. Kamdar et al. [21], found that the screening question used by the VHA did not account for the severity of food insecurity, household size, neighborhood, or geographical region that impacts the severity and duration of food insecurity. Future research should include greater gender diversity, such as nonbinary or transgender [6].

O'Toole et al.'s [20], study of 270 veterans with an average age of 53, and most were male (93.1%) was limited to only homeless and formerly homeless veterans who received care at the VHA, so this study could not generalize results to other populations or settings. Pooler et al. [12], reported limitations of their study. First, the National Health Interview Survey (NHIS) excluded actively serving veterans, homeless veterans, or veterans living in nontraditional housing, resulting in lower estimates of food insecurity among the low-income veteran population. Second, SNAP participation might be underreported in the NHIS, resulting in lower estimates than actual participation [12]. According to Wright et al. [15], future research needs to focus on a randomized comparison group to strengthen the evidence of causal improvement.

DISCUSSION

Eliminating food insecurity among the veteran population is highly unlikely. The findings in this literature review revealed interventions to increase food security and predisposing factors that increase food insecurity in veterans who utilize the VHA. Veterans' diets are like those of other Americans, and emphasis must be placed on increasing the intake of nutritious foods, contributing to better health [11]. Education on food assistance programs and completing the food security clinical reminder during veterans' health care visits is just the beginning of decreasing food insecurity. The goal is to recognize and address food insecurity among veterans, as it directly impacts their health and well-being, and to recognize who to refer veterans to at the VHA for further assistance.

Food insecurity among veterans is a new area of research, and continued investigation is needed to identify high-risk veteran populations and predisposing factors. Technological improvement is warranted, such as updating the food security clinical reminder framework or developing new, more effective processes for identifying and addressing food insecurity.

Eliminating the stigma that comes with using SNAP, WIC, or TANF would benefit all veterans, especially male veterans. One way to reduce the stigma is to develop outreach campaigns that engage with veterans, emphasizing the importance of nutrition assistance. Another approach is to provide discussions on support, empathy, and education to ensure veterans understand their eligibility for food assistance programs. Providing understanding, empathy, and support to veterans can create a safe environment where veterans feel comfortable accessing nutrition resources without stigma.

Several predisposing factors increase food insecurity, such as depression, anxiety, post-traumatic stress disorder, bipolar, substance abuse, tobacco abuse, being < 65 years old, low income, housing instability, having no higher education, geographical region, being of a minority group, being female, and being single [3,5-7,9-12,15,20. Based on the findings in the literature review regarding predisposing health factors, it would be interesting to explore how getting those factors under control would affect food insecurity. The money veterans spend on alcohol, illicit drugs, or tobacco products could be used to purchase nutritious foods. Veterans with mental health issues could attend nutritional educational classes at the VHA, and the registered dietician would provide a list of food resources. A whole-health approach is the most thorough way to assess a veteran's needs.

Unfortunately, relatively few veterans use the VHA for their health care, as Rabbitt et al. [10], reported. Veterans who do not utilize the VHA need to be included in the research to understand better if food insecurity is more prevalent in the overall veteran population. It would be interesting to see if assessing veterans who do not access the VHA for their health care would skew the present findings of food insecurity among United States military veterans. One process would be to mail out a food security questionnaire with a self-addressed stamped envelope to all veterans who currently or have served in the United States military. The questionnaire would include the food security clinical reminder questions and if the veteran currently uses the VHA for their health care needs. The questionnaire results would be divided into current users and non-users of the VHA. These results could be used to determine if veteran status does increase the risk of food insecurity among United States military veterans [24].

CONCLUSION

Food insecurity persists among United States military veterans, almost twice that of the general population, and is associated with unhealthy dietary practices, resulting in increased mental and physical health issues. The literature identifies different risk factors contributing to increased food insecurity among veterans and how to address these factors. Utilizing the food security clinical reminder during VA clinic visits is one way to help identify veterans at risk. If the food security clinical reminder is positive for food insecurity, VA staff, such as social workers and nutritional dieticians, connect veterans with food assistance programs, resources, and education.

SDOH also plays a role in food insecurity, especially race, education, socioeconomic status, and geographical area. Veterans who abuse tobacco, alcohol, or drugs, have a history of post-traumatic stress disorder, depression, military sexual trauma, or have a psychiatric diagnosis are at a higher risk of food insecurity. Additional research should be conducted on United States military veterans who do not use the VHA for their health care to determine if the rate of food insecurity is still more prevalent in veterans than in the general population.

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