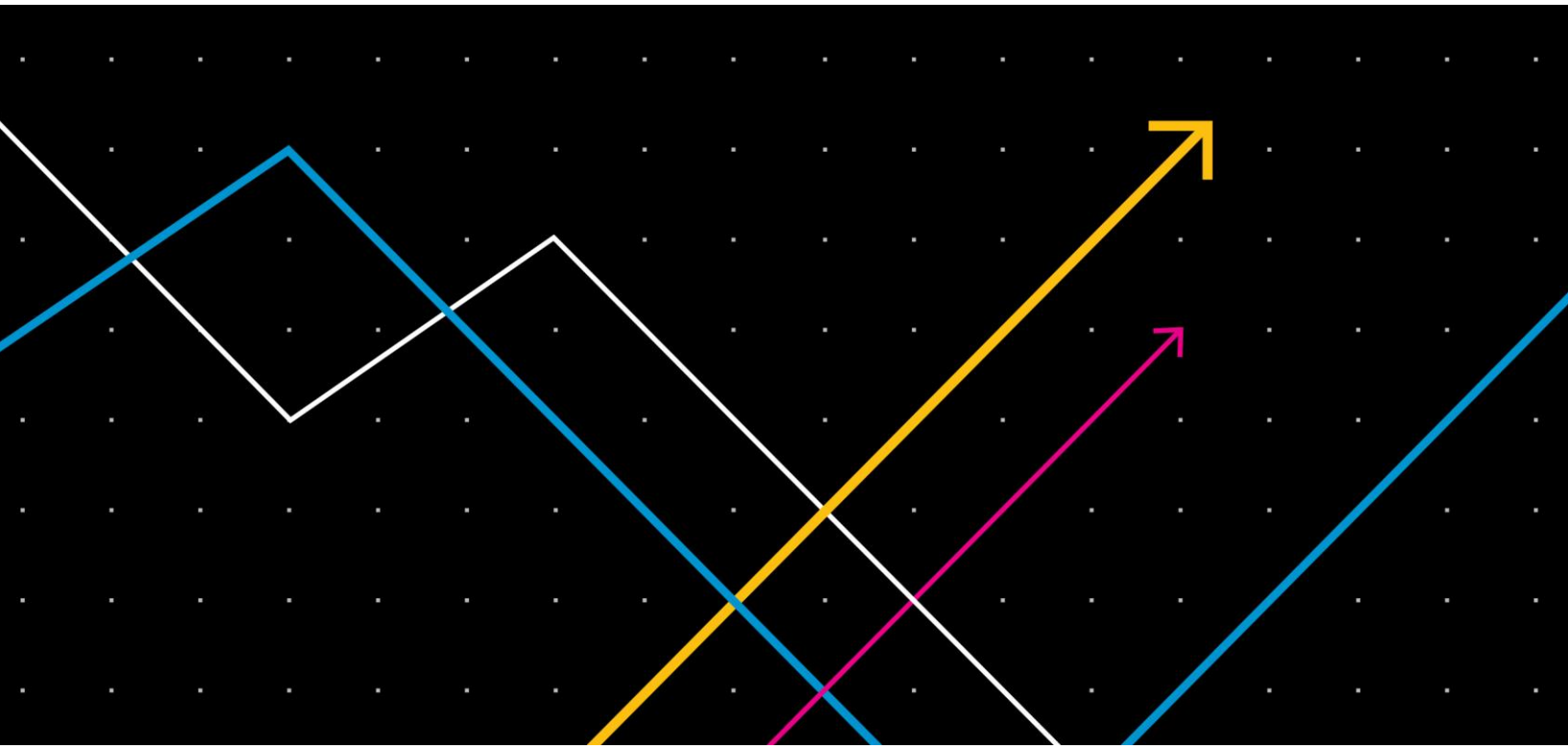

RESEARCH REPORT

Mothers' Mental Health Challenges Predated the COVID-19 Pandemic

Jennifer M. Haley *Stacey McMorrow* *Julia Long*

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Mothers' Mental Health Challenges Predated the COVID-19 Pandemic

The COVID-19 pandemic has been especially challenging for American families with children. The US Surgeon General as well as the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, and the Children's Hospital Association declared a children's mental health crisis in late 2021, citing school closures, social isolation, grief over lost community and family members, and challenges accessing needed care as contributing factors (Office of the US Surgeon General 2021).[1] Parents, and especially mothers, have also borne significant caregiving, health, and health care access burdens that likely contributed to observed increases in mental health challenges since the pandemic began (Patrick et al. 2020; Wade et al. 2021). Importantly, however, women[2] and mothers were already facing significant mental health challenges before the pandemic, and those challenges are likely to persist and evolve as the most acute pandemic stressors subside and new threats to women's health and well-being arise (Goodwin et al. 2020; Stambaugh et al. 2017; Weinberger et al. 2018). Moreover, maternal mental health has important implications for children, and understanding mental health challenges among mothers will be critical to addressing the mental health crisis among children (Biel, Tang, and Zuckerman 2020; Campo, Fontanella, and Bridge 2020).

To better support the mental health and well-being of mothers and children in the aftermath of the pandemic, it is important to understand the patterns that existed before the crisis. In this report, we analyze national patterns of self-reported symptoms of anxiety and depression among custodial mothers of children younger than 18.[3] We use data from the 2019 National Health Interview Survey (NHIS)[4] and self-reported measures based on the Washington Group on Disability Statistics Extended Set on Functioning, which asks about the frequency of feeling worried, nervous, anxious, or depressed and the intensity of those feelings the last time they were experienced.[5] Following guidance from the Washington Group, we use the combined criteria of having such feelings daily at medium or high intensity or weekly at high intensity to identify groups we refer to as having moderate or severe anxiety and moderate or severe depression.[6] We find the following:

- In 2019, 13.5 percent of mothers ages 19 to 64, or about 4.9 million mothers, reported symptoms of moderate or severe anxiety, and 4.8 percent, or about 1.7 million mothers, reported symptoms of moderate or severe depression. About 1.2 million mothers experienced both moderate or severe anxiety and moderate or severe depression.
- Among mothers with moderate or severe anxiety in 2019, about 36 percent had severe anxiety, and among mothers with moderate or severe depression, about 38 percent had severe depression.
- Prevalence of anxiety and depression among mothers varied by age, income, and other demographic and socioeconomic characteristics, with younger mothers having much higher rates of anxiety than older mothers, and mothers with lower incomes having higher rates of both anxiety and depression than mothers with higher incomes.
- Mothers with Medicaid or Children's Health Insurance Program (CHIP) coverage had about twice the rate of moderate or severe anxiety (21.0 percent) compared with mothers with employer coverage (10.5 percent), and the rate of moderate or severe depression among mothers with Medicaid/CHIP was more than three times higher than that for mothers with employer coverage (8.1 versus 2.5 percent).
- Almost two-thirds of mothers with moderate or severe anxiety or depression had not received counseling or therapy from a mental health professional in the past 12 months, and 23.0 percent, or 1.2 million mothers, reported an unmet need for counseling or therapy due to cost in the past 12 months. An estimated 69.6 percent of mothers with Medicaid/CHIP and 61.4 percent of mothers with employer coverage did not receive counseling or therapy from a mental health professional, and about 20 percent of mothers in both groups reported unmet needs for counseling or therapy.

Our findings indicate that many mothers reported symptoms of anxiety and depression even before increases in the stressors facing American families, including the COVID-19 pandemic, the economic downturn, and recent threats to women's reproductive autonomy under the *Dobbs v. Jackson Women's Health Organization* decision that restricted abortion access.[7] They also show that many mothers, including those with insurance coverage, were already reporting unmet needs for mental health services. These findings suggest that addressing mental health challenges among mothers will likely require both maintaining and improving health insurance coverage rates and improving the availability, accessibility, and affordability of mental health services among those with coverage. Mental health coverage could be improved with changes to network adequacy standards, provider payment rates, scope of practice regulations, and covered benefits and cost-sharing policies; enforcement of mental health parity regulations; and increases in the size of the behavioral health workforce. In addition, broader policy interventions including universal early education and care, paid parental leave, pay equity, and flexible workplace policies could help relieve some of the social factors that can contribute

to maternal anxiety and depression. Given the effects of maternal well-being on children in both the short and long terms (Biel, Tang, and Zuckerman 2020; Campo, Fontanella, and Bridge 2020; Kamis 2021; National Scientific Council on the Developing Child and National Forum on Early Childhood Program Evaluation 2009), better supporting the mental health needs of mothers could also help support children as they continue to grapple with the consequences of the pandemic on their mental and physical health.

Background

The effects of the COVID-19 pandemic on daily life have heightened concerns about the mental health of families with children. In 2021, the US Surgeon General issued an advisory on protecting youth mental health, and the American Academy of Pediatrics and others declared a national state of emergency in children's mental health (Office of the US Surgeon General 2021).[8] These statements emphasized the effects of school closures, social isolation, financial distress, and challenges accessing needed medical care on children's mental health and access to mental health care. They also reinforced preexisting challenges such as shortages of mental health providers and inadequate access to evidence-based treatments and interventions for mental health problems.

Though their challenges have not received the same attention from the surgeon general or advocates, parents have also borne significant burdens throughout the pandemic. They have faced navigating child care disruptions and shortages; balancing remote work and schooling arrangements; assessing the risks and benefits of returns to work, school, activities, and interactions with grandparents and other high-risk family members; making health care decisions for themselves and their families; and coping with increased mental health concerns about their children (Patrick et al. 2020; Wade et al. 2021). In mid-2020, more than one-quarter of parents reported their mental health had worsened since the pandemic began (Patrick et al. 2020). Nearly half of parents in an early 2021 American Psychological Association survey reported their stress had increased during the pandemic, and parents were more than twice as likely as other adults to have received mental health treatment or been diagnosed with a mental health disorder during the pandemic.[9]

During this period, mothers, in particular, have shouldered a disproportionate burden of various caregiving responsibilities. In late 2020, 11 percent of mothers reported having quit a job for pandemic-related reasons, with one-half of those related to new caregiving responsibilities. Others had to take time off from work for caregiving and schooling, many without pay. Women were also more likely than men to report additional caregiving responsibilities for a family member, and 54 percent of mothers

reported their mental health was affected by worry or stress related to the pandemic, compared with 35 percent of fathers (Ranji et al. 2021). A study of caregivers in multiple countries found that female caregivers reported greater distress and higher stress impacts related to the pandemic than male caregivers (Wade et al. 2021). For most of the period from early 2020 to late 2022, more than 3 in 10 adults responding to the US Census Bureau's Household Pulse Survey indicated symptoms of anxiety or depression, with higher rates among women than men, particularly for anxiety (Planalp, Hest, and Blewett 2021).[10] Recent data from the 2022 KFF Women's Health Survey found that 50 percent of women ages 18 to 64 reported needing mental health services in the past two years, compared with 35 percent of men (Diep et al. 2022).

Even before the pandemic, many mothers were facing significant mental health challenges (Ertel, Rich-Edwards, and Koenen 2011; Stambaugh et al. 2017), including growing rates of perinatal mood and anxiety disorders (McKee et al. 2020). From 2008 to 2014, mothers were nearly twice as likely as fathers to have any mental illness and they were more than twice as likely to have serious mental illness (Stambaugh et al. 2017). These challenges are thus likely to persist even as the most acute pandemic stressors subside. Moreover, maternal mental health problems could have long-term implications for children, given the impacts of parents' mental health on their children's mental health and well-being (Biel, Tang, and Zuckerman 2020; Campo, Fontanella, and Bridge 2020; Kamis 2021; National Scientific Council on the Developing Child and National Forum on Early Childhood Program Evaluation 2009).

It is also important to understand patterns of mental health challenges for different subgroups. Patterns of mental health problems by race and ethnicity often do not exhibit the extreme disparities that we see in many other health outcomes, which is surprising considering the systematic disadvantages faced by the Black population in particular. This phenomenon is known as the "Black-white mental health paradox" (Erving, Thomas, and Frazier 2019), in which Black people report better mental health than their white counterparts despite higher rates of individual and systemic disadvantages that would often be associated with mental health challenges. That said, addressing the systems and structures that put families at risk are likely to benefit racialized groups with less structural privilege.

In this report, we focus on national patterns of anxiety and depression—the most common mental illnesses reported by US adults—among mothers of dependent children before the pandemic.[11] We examine rates of reported symptoms of moderate or severe anxiety and depression, variation across subgroups of mothers defined by socioeconomic and demographic characteristics and insurance coverage status, and levels of unmet need and receipt of mental health care among those with anxiety or depression. This analysis provides information on the patterns predating the pandemic, which may

offer insights into how mental health service systems could shift to serve those who suffer the most from our inadequate mental health care system and associated policies.

Moreover, just as the pandemic's effects on daily life have been subsiding, new threats to mothers' and women's mental health have emerged. Following the recent Supreme Court decision in *Dobbs v. Jackson Women's Health Organization* restricting reproductive health access, the American Psychiatric Association, the American Psychological Association, and the National Association of Social Workers emphasized the negative consequences of the decision on mental health.[12] In addition, under the omnibus spending package signed into law in December 2022, the continuous coverage requirement of the Families First Coronavirus Response Act will end in April 2023, at which point states will resume redeterminations of Medicaid, placing millions of enrollees at risk of losing coverage (Buettgens and Green 2022).[13] This analysis provides a critical benchmark for evaluating trends in maternal mental health during the public health emergency and beyond.

Data and Methods

We use data from the 2019 NHIS, which is the primary source of information on the nation's health.[14] The survey includes detailed information on demographic and socioeconomic characteristics as well as extensive content on health insurance, health care access and utilization, and health conditions. The NHIS is designed to produce nationally representative estimates of the civilian, noninstitutionalized population and underwent a significant redesign in 2019. To reduce the length of the survey and improve response rates, the recently redesigned NHIS only surveys one adult and one child per household, leading to smaller sample sizes than on past surveys. Though it cut questions in several areas, the redesigned survey also added new content on mental health for both adults and children.

We focus on a sample of custodial mothers ages 19 to 64. Mothers are women identified as the biological parent, adoptive parent, or stepparent of a child younger than 18 residing in their household. Likewise, fathers are male respondents who are identified as the biological, adoptive, or stepparent of a child in the household. Our primary analysis includes a sample of approximately 4,300 mothers, representing approximately 36.7 million mothers across the country when applying NHIS weights.

The 2019 NHIS contains rich content on anxiety and depression. In this analysis, we focus on the survey's indicators of anxiety and depression derived from the Washington Group on Disability Statistics Extended Set on Functioning.[15] The Washington Group was chartered by the United Nations Statistical Commission and the indicators were designed to identify people with functional limitations

at heightened risk of experiencing limited participation in society. The questions have been validated for use in population-based surveys and translated into many languages.

On the 2019 NHIS, the main alternatives to the Washington Group indicators were the Generalized Anxiety Disorder-7 (GAD-7) and the Patient Health Questionnaire-8 (PHQ-8) scales. The GAD-7 and PHQ-8 scales are validated scales focused on identifying symptoms consistent with clinical diagnoses of anxiety and depression (Kroenke, Spitzer, and Williams 2001; Spitzer et al. 2006). Notably, the Washington Group measures do not refer to a specific time frame in the questions, unlike the PHQ-8 and GAD-7 scales, which refer to the last two weeks (Kroenke, Spitzer, and Williams 2001; Spitzer et al. 2006). The National Center for Health Statistics analyzed the relationship between the Washington Group indicators and these scales and found a high level of agreement (above 90 percent) in assigning people to comparable categories of anxiety and depression (Zablotsky et al. 2022).[16] When the two approaches differed, the Washington Group measures were more likely than the GAD-7 scale to identify people as having moderate or severe anxiety and less likely than the PHQ-8 scale to identify people as having moderate or severe depression. We chose the Washington Group measures over the GAD-7 and PHQ-8 scales because the Washington Group indicators are part of the core content on the NHIS and therefore will be asked every year and allow for future analysis of trends.

Our measures of moderate and severe anxiety rely on two questions from the Washington Group. The first asks the frequency of feeling worried, nervous, or anxious and includes responses on a continuum ranging from daily to never. The second asks those who reported ever feeling worried, nervous, or anxious to rank the intensity of those feelings the last time they experienced them, ranging from a little to a lot, or somewhere in between a little and a lot. The questions for depression are similar, first asking the frequency of feeling depressed and then asking the intensity of those feelings the last time they were experienced.[17] Following guidelines established by the Washington Group, we create four categories based on those questions: (1) experienced these feelings a few times a year or never; (2) experienced these feelings daily, weekly, or monthly at low intensity; weekly or monthly at medium intensity; or monthly at high intensity; (3) experienced these feelings daily at medium intensity or weekly at high intensity; and (4) experienced these feelings daily at high intensity.[18] We combine categories 1 and 2 to reflect "no/mild" anxiety or depression, whereas category 3 reflects "moderate" anxiety or depression and category 4 reflects "severe" anxiety or depression. As noted below, we focus primarily on the combined moderate-or-severe category but present some estimates for severe anxiety and depression.

We examine rates of moderate or severe anxiety and depression among mothers overall and by demographic and socioeconomic characteristics including age, race and ethnicity, marital status,

educational attainment, family income relative to poverty, health insurance type at the time of the survey, and rural or urban residence. Family income relative to poverty is calculated by the National Center for Health Statistics using reported or imputed family income from the prior calendar year and the corresponding poverty threshold, accounting for family size and composition. We then classified mothers as having incomes at or below 200 percent of the federal poverty level or above that level. Health insurance is reported at the time of the survey, and we classified mothers into five mutually exclusive categories: employer-sponsored coverage; Medicaid/CHIP; exchange or direct purchase coverage; other coverage, including Medicare, other public coverage, and other private coverage; and uninsured. Urban or rural residence is defined as metropolitan or nonmetropolitan, according to the 2013 National Center for Health Statistics Urban-Rural Classification Scheme for counties.[19] We also examine those rates for mothers who gave birth in the past year.

We present rates separately for anxiety and depression because these conditions have different clinical characteristics and place different burdens on individuals and families (Dozois and Westra 2004). For example, most evidence on the spillover effects of parental mental health on children is focused on depression (Pierce et al. 2020). In addition, although the two disorders regularly occur together, anxiety often precedes the development of depression, which may make it particularly relevant for early detection of mental health issues (Dozois and Westra 2004). We also focus on the combined moderate-or-severe category for both anxiety and depression as that category showed the highest level of agreement across alternative scales (Zablotsky et al. 2022). We present estimates for severe anxiety and depression in Appendix A. Finally, we examine receipt of counseling or therapy and unmet needs for mental health care due to cost overall and by insurance coverage among mothers who reported either moderate or severe anxiety or depression. In this case, we combine the measures of anxiety and depression to provide sufficient sample size for analysis (approximately 600 mothers with moderate or severe anxiety or depression). All estimates use appropriate survey weights and standard errors are adjusted for the complex survey design and multiple imputation of income.

The analysis has several limitations. First, defining our sample based on the constraints of the survey has limitations. We do not capture mothers not living with their children at the time of the survey, pregnant women without other children, and parents who may identify as mothers but who were not identified as female on the survey. Moreover, we may identify some parents who do not identify as mothers in our sample if identification as a female parent is not synonymous with motherhood. Second, some sample sizes are limited. Small sample sizes prevent us from looking at certain groups when examining rates of anxiety and depression across subgroups, including American Indian/Alaska Native mothers and mothers ages 55 to 64. Importantly, we could not examine patterns

of unmet needs and utilization of therapy and counseling services among uninsured mothers with moderate or severe depression or anxiety because of inadequate sample size. In addition, we focused on health insurance coverage at the time of the survey to avoid further sample size constraints required to incorporate coverage gaps in the past year. However, this does not necessarily correspond with the unmet need and service use measures for the prior year. Given patterns of coverage churn in Medicaid (MACPAC 2021a), it is likely that mothers reporting Medicaid coverage at the time of the survey were more likely to have had a gap in coverage during the period for which they were reporting on unmet needs and service use. Despite our best efforts, we do report on some groups with small sample sizes, including mothers with moderate or severe anxiety or depression who had Medicaid/CHIP coverage at the time of the survey (n = 177) and mothers with severe anxiety or depression (n = 216).

Third, our measures of anxiety and depression have limitations. Though the Washington Group measures have been validated for use in adult populations, their performance for specific population subgroups has not been independently assessed. If an assessment of the measure set for different races were available, it might provide insight on whether different interpretations of the questions across races contribute to findings supporting the Black-white mental health paradox (Erving, Thomas, and Frazier 2019). In addition, patterns could differ for respondents who took the survey in a language other than English, and though most NHIS surveys are completed in English, any differences in patterns for those responding in other languages could contribute to patterns by race and ethnicity or other characteristics correlated with non-English responses. That said, given their origins as a means of comparing international disability statistics, the Washington Group questionnaires have been translated into many languages and the translations have undergone cognitive testing (Washington Group on Disability Statistics 2020).

Fourth, these measures of anxiety and depression do not capture other relevant mental health challenges mothers may be facing, such as posttraumatic stress disorder, eating disorders, addiction, substance use, and personality disorders. Further, though we present some measures of mental health care use and reported unmet needs, these measures are limited and it is impossible to know which mothers needed care that they did not receive. In addition, rates of receipt of counseling or therapy from a mental health professional and unmet needs for counseling or therapy do not reflect utilization of or access to treatment received from other providers such as primary care providers, who, research indicates, provide a large share of mental health treatment (Jetty et al. 2021). Among mothers with moderate or severe depression, many were receiving medication for these conditions: 38.8 percent of mothers with moderate or severe anxiety were taking medication for anxiety at the time of survey, and more than 51.9 percent of mothers with moderate or severe depression were taking medication for

depression at the time of survey (data not shown). However, the data do not indicate whether the medication was obtained through a mental health provider, a primary care provider, or some other source. Moreover, some people with anxiety and depression may be receiving sufficient treatment (using medications or other approaches) such that they do not report having symptoms in the Washington Group indicators; to the extent that use of such treatments varies across subgroups, this may affect the levels of reported anxiety and depression we observe in the data.

Fifth, we present only bivariate tabulations in this report and do not attempt to analyze differences when holding other characteristics constant or to assess possible interactions across different characteristics. For instance, the differences by health insurance coverage type we observe may be driven by differences in other characteristics that vary by coverage type such as age, income, or geographic location, which may be contributing to variation in rates. Factors such as low income that determine eligibility for Medicaid may also contribute to higher rates of anxiety and depression. Finally, as with all surveys, all responses are self-reported and may be subject to recall or social desirability biases.

Results

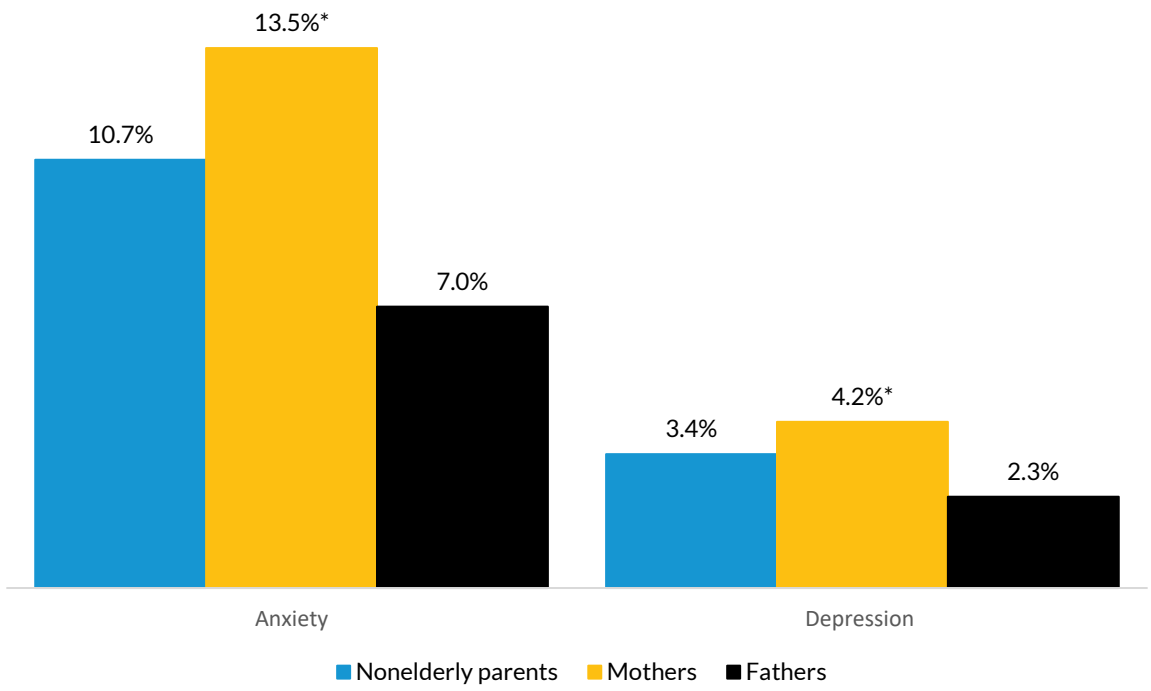
Below we discuss our findings on moderate or severe anxiety and depression among mothers from the 2019 NHIS.

Mothers Were Nearly Twice as Likely as Fathers to Report Symptoms of Moderate or Severe Anxiety or Depression

In 2019, 10.7 percent of nonelderly parents reported symptoms of moderate or severe anxiety and 3.4 percent reported symptoms of moderate or severe depression (figure 1). Rates for mothers were nearly double those for fathers, with an estimated 13.5 percent of mothers having moderate or severe anxiety and 4.2 percent having moderate or severe depression, compared with 7.0 percent and 2.3 percent of fathers.

FIGURE 1

Rates of Reported Symptoms of Anxiety and Depression among Parents Ages 19 to 64, 2019



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Source: Authors' analysis of the 2019 National Health Interview Survey.
Notes: "Anxiety" refers to moderate or severe self-reported anxiety symptoms according to the Washington Group Extended Set Disability Indicators. "Depression" refers to moderate or severe self-reported depression symptoms according to the Washington Group Extended Set Disability Indicators. Parents are biological parents, adoptive parents, or stepparents of a child younger than 18 residing in their household.
* indicates that the difference between mothers' and fathers' anxiety or mothers' and fathers' depression is significant at the $p < 0.05$ level.

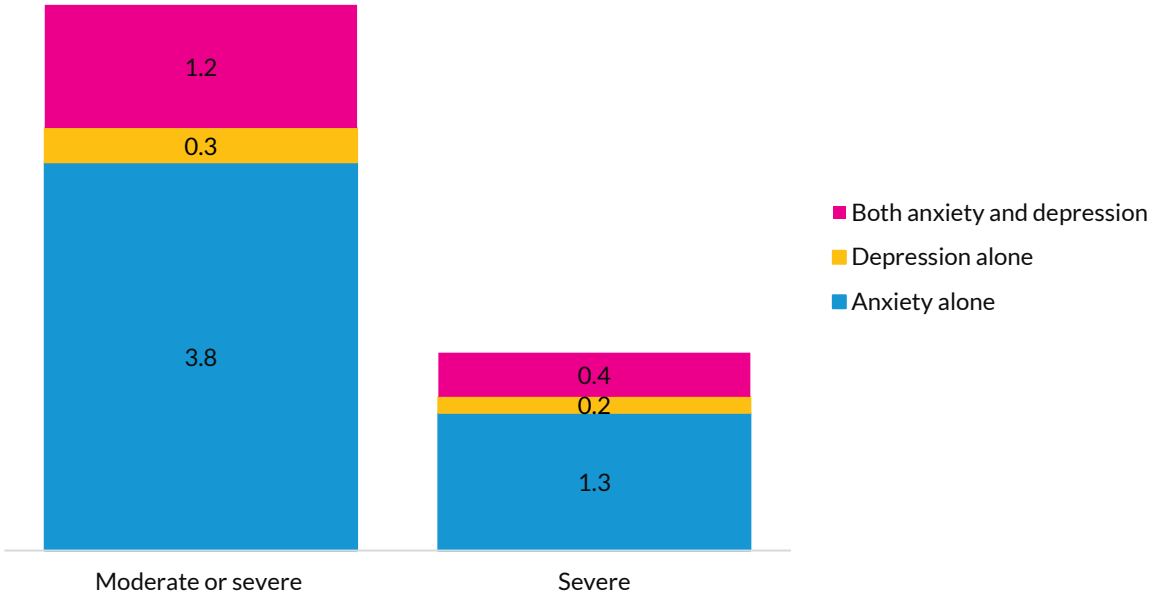
Among Mothers with Moderate or Severe Anxiety, about One-Third Experienced Severe Anxiety, and among Mothers with Moderate or Severe Depression, about One-Half Experienced Severe Depression

In 2019, an estimated 5.3 million mothers had moderate or severe anxiety and/or depression, with 3.8 million reporting symptoms of anxiety alone, 0.3 million reporting symptoms of depression alone, and 1.2 million reporting symptoms of both anxiety and depression (figure 2).

FIGURE 2

Co-occurrence and Severity of Reported Symptoms among Mothers Ages 19 to 64 with Anxiety or Depression, 2019

Millions of mothers



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Source: Authors' analysis of the 2019 National Health Interview Survey.
Notes: "Moderate" and "severe" anxiety and depression refer to self-reported anxiety and depression symptoms according to the Washington Group Extended Set Disability Indicators. Mothers are women reported to be biological parents, adoptive parents, or stepparents of a child younger than 18 residing in their household.

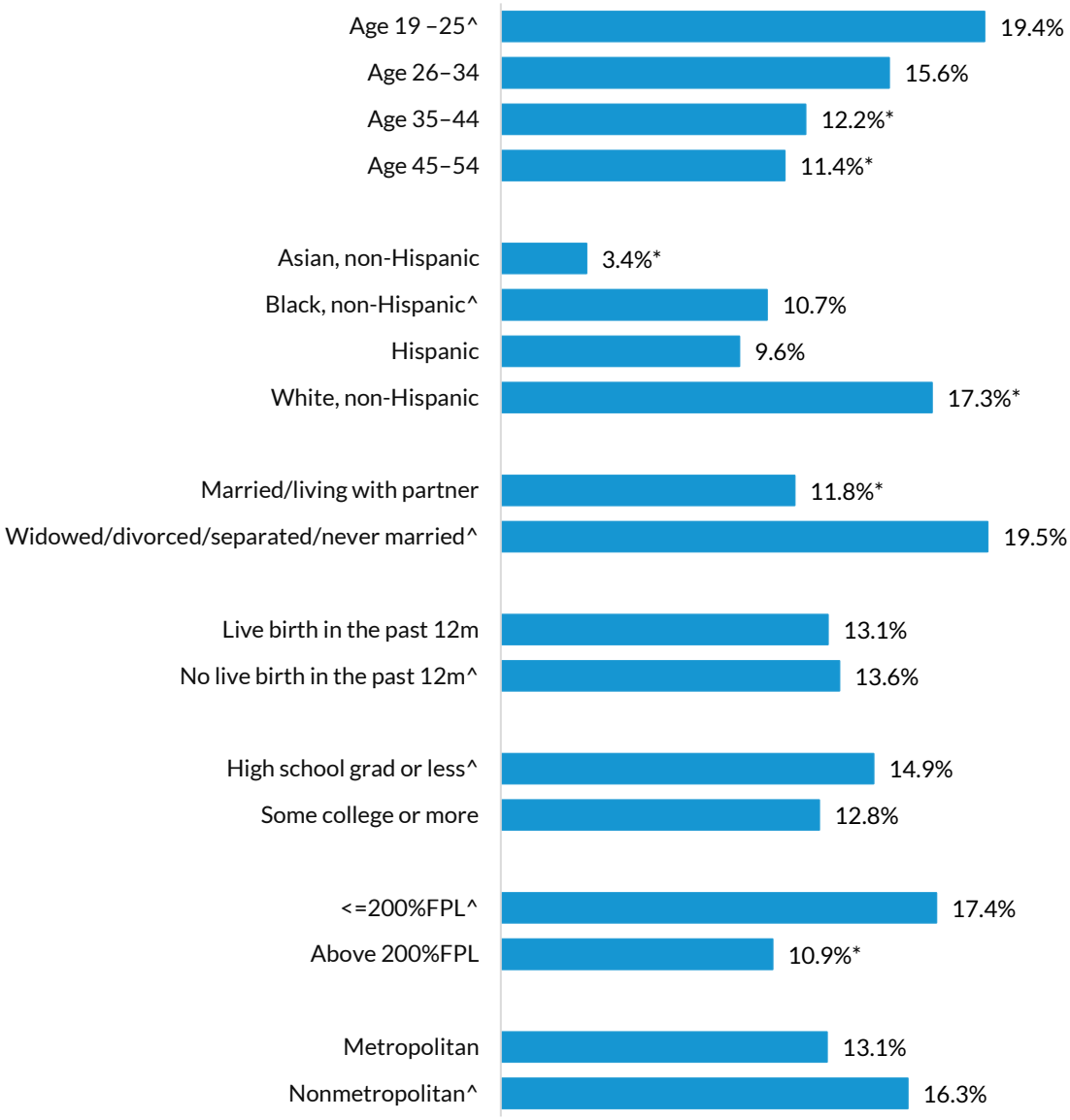
Of the 4.9 million mothers with moderate or severe anxiety, about one-third, or 1.8 million, had severe anxiety. Among the 1.5 million mothers with moderate or severe depression, about 38 percent, or about half a million, had severe depression. In total, an estimated 1.9 million mothers had severe anxiety and/or severe depression. In Appendix A, table A.1 shows the demographic and socioeconomic characteristics of mothers with moderate or severe anxiety or depression and those with severe anxiety or depression.

Patterns of Moderate or Severe Maternal Anxiety and Depression Varied by Age, Income, and Other Demographic and Socioeconomic Characteristics

Rates of reported symptoms of moderate or severe anxiety among mothers varied by age, with 19.4 percent of mothers younger than 26 having moderate or severe anxiety, compared with 12.2 percent of mothers ages 35 to 44 and 11.4 percent of mothers ages 45 to 54 (figure 3). Asian mothers had the lowest rates of anxiety (3.4 percent), Black and Hispanic mothers had similar rates at 10.7 and 9.6 percent, and white mothers had the highest rate (17.3 percent).

FIGURE 3

Rate of Reported Symptoms of Anxiety among Mothers Ages 19 to 64, by Selected Characteristics, 2019



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Source: Authors' analysis of the 2019 National Health Interview Survey.
Notes: m = months. FPL = federal poverty level. Moderate or severe anxiety refers to self-reported anxiety symptoms according to the Washington Group Extended Set Disability Indicators. Mothers are women reported to be biological parents, adoptive parents, or stepparents of a child younger than 18 residing in their household. Estimates are suppressed for mothers ages 55 to 64, non-Hispanic American Indian/Alaska Native mothers, and non-Hispanic mothers of other or multiple races because of insufficient sample sizes.
^ indicates reference group.
* indicates estimate differs significantly from that for the reference group (^) at the $p < 0.05$ level.

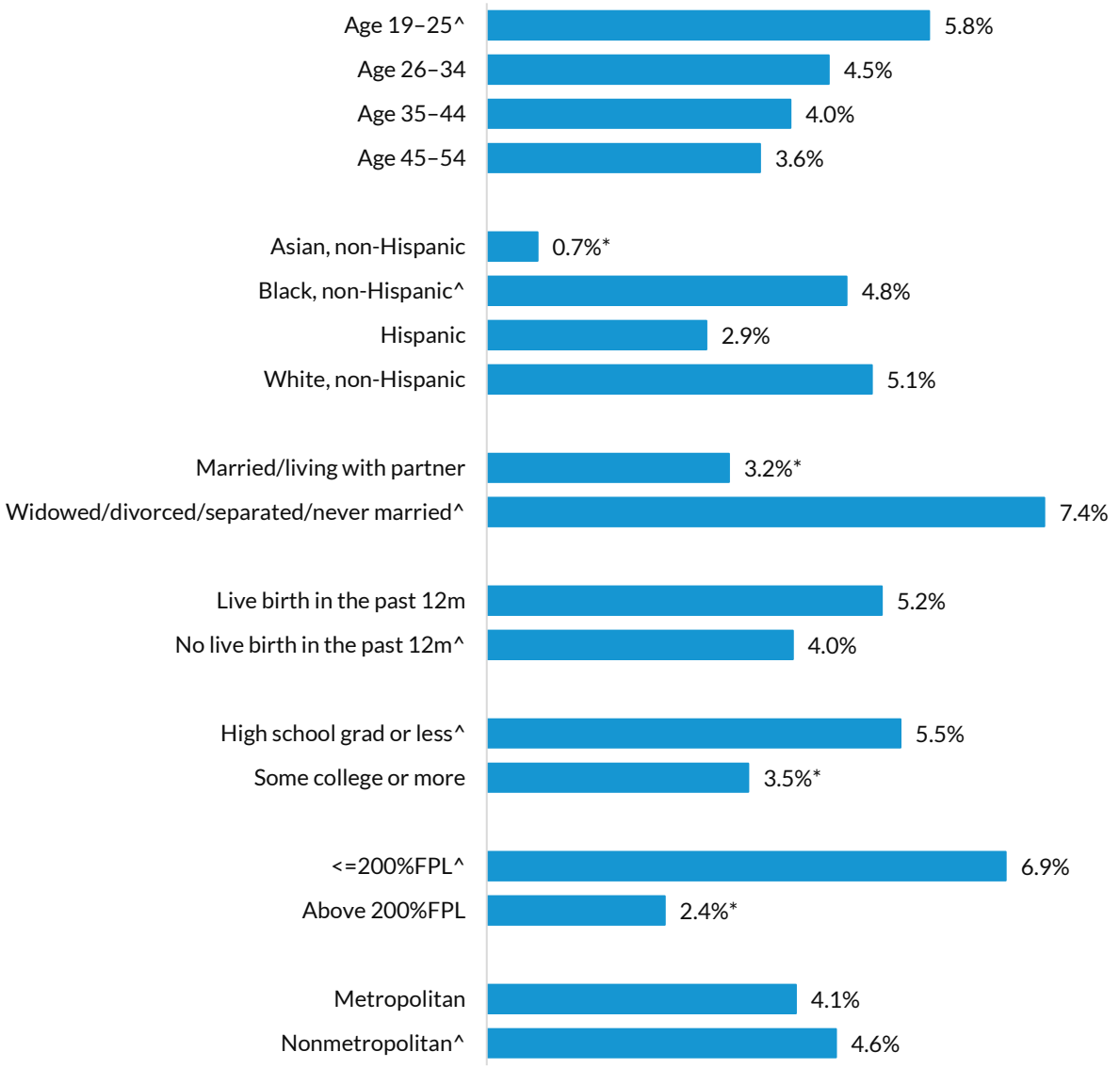
Mothers who were widowed, separated, divorced, or never married were much more likely to have anxiety than those who were married or living with a partner (19.5 versus 11.8 percent). Rates of moderate or severe anxiety for new mothers were similar to those for mothers who did not give birth in the past year.

Anxiety varied widely by family income: about 17.4 percent of mothers with incomes at or below 200 percent of the federal poverty level reported symptoms of moderate or severe anxiety, compared with 10.9 percent of mothers with higher incomes. Rates of anxiety did not differ significantly by educational attainment and rural or urban geography. Patterns of variation by socioeconomic and demographic characteristics for severe anxiety alone (Appendix A, table A.2) were similar to those for moderate or severe anxiety combined (presented in figure 3).

Patterns of variation in moderate or severe depression by marital status and income were similar to those for moderate or severe anxiety (figure 4). For instance, mothers who were widowed, separated, or divorced were more than twice as likely to have moderate or severe depression as those who were married or living with partners (7.4 versus 3.2 percent). Likewise, an estimated 6.9 percent of mothers with family incomes below 200 percent of the federal poverty level had moderate or severe depression, compared with 2.4 percent of those with higher incomes. As with anxiety rates, depression rates did not vary significantly for new mothers versus other mothers or by rural versus urban geography.

FIGURE 4

Rate of Reported Symptoms of Depression among Mothers Ages 19 to 64, by Selected Characteristics, 2019



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Source: Authors' analysis of the 2019 National Health Interview Survey.

Notes: m = month. FPL = federal poverty level. Moderate or severe depression refers to self-reported depression symptoms according to the Washington Group Extended Set Disability Indicators. Mothers are women reported to be biological parents, adoptive parents, or stepparents of a child younger than 18 residing in their household. Estimates are suppressed for mothers ages 55 to 64, non-Hispanic American Indian/Alaska Native mothers, and non-Hispanic mothers of other/multiple races because of insufficient sample sizes.

^ indicates reference group.

* indicates estimate differs significantly from that for the reference group (^) at the $p < 0.05$ level.

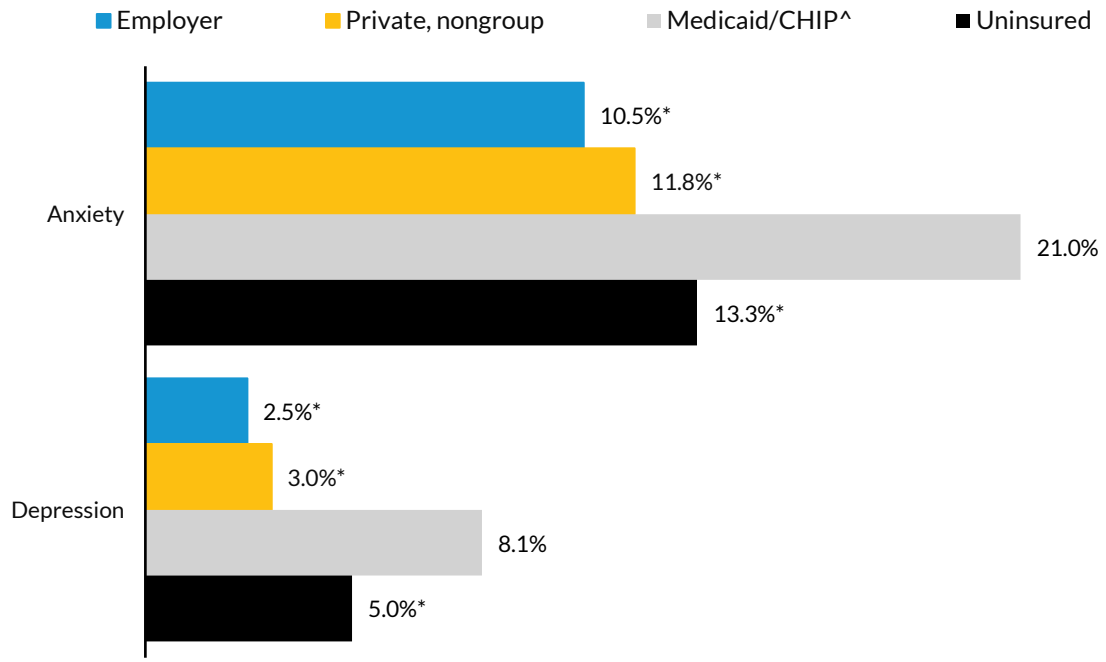
In contrast to anxiety rates, rates of moderate or severe depression were similar across age groups. As with anxiety rates, the rate of moderate or severe depression was lowest among Asian mothers (0.7 percent), and the rate of depression for Hispanic mothers (2.9 percent) was higher than that for Asian mothers and lower than that for white mothers. Unlike with anxiety rates, however, Black and white mothers had similar rates of depression, about 5 percent each. Mothers with a high school degree or less education were also more likely to have moderate or severe depression than their more-educated counterparts. Overall, patterns for severe depression alone were similar, though some differences were not statistically significant (Appendix A, table A.2).

Moderate or Severe Anxiety and Depression Were Much More Common for Mothers with Medicaid/CHIP Coverage Than for Those with Other or No Coverage

Mothers with Medicaid/CHIP were about twice as likely to report symptoms of moderate or severe anxiety (21.0 percent) as mothers with employer and nongroup coverage (10.5 and 11.8 percent), and they were more likely than uninsured mothers (13.3 percent) to have anxiety (figure 5). Mothers with Medicaid/CHIP were also three times as likely as those with employer coverage to experience severe anxiety (Appendix A, table A.2).

FIGURE 5

Reported Rates of Anxiety and Depression Symptoms among Mothers Ages 19 to 64, by Source of Health Insurance Coverage, 2019



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Source: Authors' analysis of the 2019 National Health Interview Survey.
Notes: "Anxiety" refers to moderate or severe self-reported anxiety symptoms according to the Washington Group Extended Set Disability Indicators. "Depression" refers to moderate or severe self-reported depression symptoms according to the Washington Group Extended Set Disability Indicators. "Private, nongroup" refers to exchange coverage and direct purchase private coverage. Mothers are women reported to be biological parents, adoptive parents, or stepparents of a child younger than 18 residing in their household. Estimates for mothers with Medicare and other private or public coverage are suppressed because of sample size constraints.
^ indicates reference group.
* indicates estimate differs significantly from that for the reference group (^) at the $p < 0.05$ level.

Mothers with Medicaid/CHIP coverage also had a higher rate of moderate or severe depression (8.1 percent) than mothers with employer (2.5 percent) or nongroup (3.0 percent) coverage, patterns that were also found for rates of severe depression. Medicaid/CHIP-covered mothers were also more likely than uninsured mothers to have moderate or severe depression (8.1 versus 5.0 percent).

Nearly One-Quarter of Mothers with Moderate or Severe Anxiety or Depression Reported an Unmet Need for Counseling or Therapy Due to Cost in the Past 12 Months, and Two-Thirds Had Not Received Counseling or Therapy from a Mental Health Professional during That Time

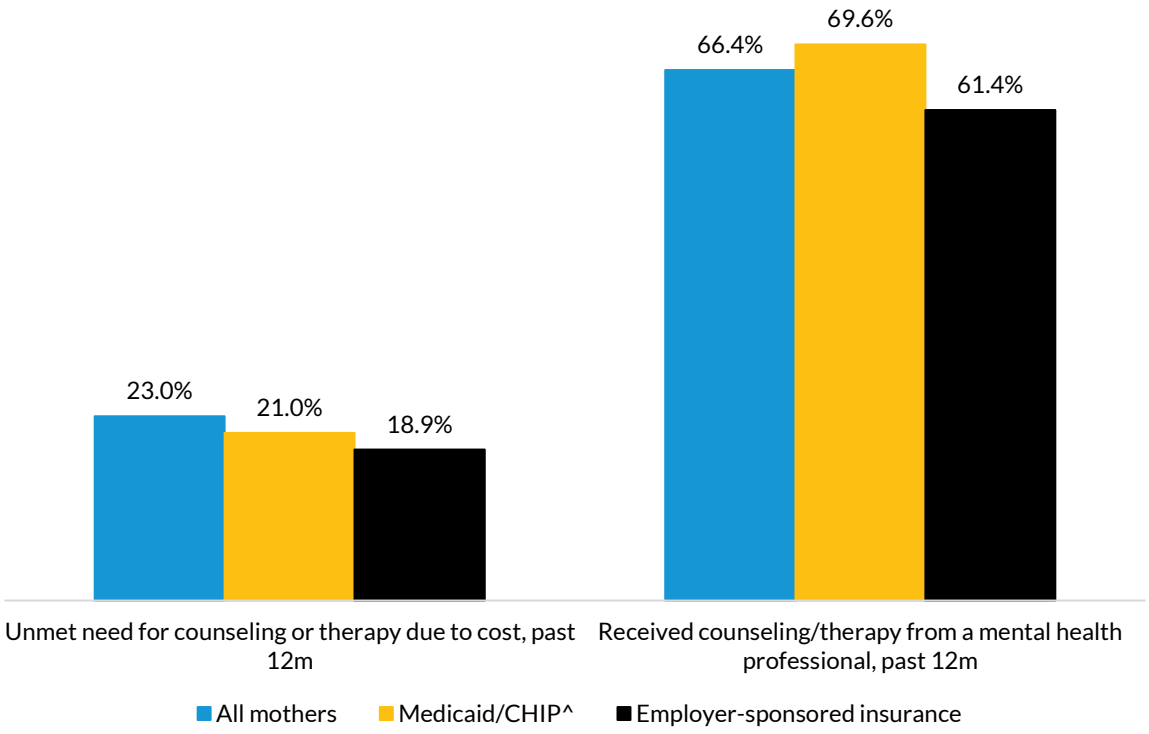
An estimated 23.0 percent of mothers (1.2 million mothers) who reported symptoms of moderate or severe anxiety or depression reported an unmet need for counseling or therapy due to cost in the past 12 months (figure 6). This compares with a rate of 3.7 percent of mothers with neither moderate or severe anxiety nor depression reporting an unmet need (data not shown).

In addition, 66.4 percent of mothers with moderate or severe anxiety or depression reported not receiving counseling or therapy from a mental health professional in the past 12 months, a much higher rate than among those without moderate or severe anxiety or depression (8.7 percent; data not shown). However, some mothers have received other types of health care related to these conditions. For example, we find that 38.8 percent of mothers with moderate or severe anxiety were taking medication for anxiety at the time of the survey, and 51.9 percent with moderate or severe depression were taking medication for depression at the time of the survey (data not shown). We do not know which type of provider prescribed the medication or whether medications were substitutes for or complements to counseling or therapy.

We also found that 69.6 percent of mothers with Medicaid/CHIP and 61.4 percent of mothers with employer coverage had not received counseling or therapy, a difference that was not statistically significant (figure 6). Rates of unmet need were also similar for mothers with Medicaid/CHIP and employer coverage, with about one in five mothers in both groups reporting unmet needs for counseling or therapy due to cost. We could not measure patterns for uninsured mothers with moderate or severe anxiety or depression because of inadequate sample size.

FIGURE 6

Unmet Need for Counseling or Therapy Due to Cost and Receipt of Counseling or Therapy among Mothers Ages 19 to 64 with Anxiety or Depression, by Source of Health Insurance Coverage, 2019



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Source: Authors' analysis of the 2019 National Health Interview Survey.
Notes: m = months. "Anxiety" refers to moderate or severe self-reported anxiety symptoms according to the Washington Group Extended Set Disability Indicators. "Depression" refers to moderate or severe self-reported depression symptoms according to the Washington Group Extended Set Disability Indicators. Mothers are women reported to be biological parents, adoptive parents, or stepparents of a child younger than 18 residing in their household. Estimates for uninsured mothers and those with private nongroup insurance are suppressed because of sample size constraints.
^ indicates reference group. Estimates did not differ significantly from that for the reference group at the $p < 0.05$ level.

Discussion

These findings indicate that millions of mothers were experiencing symptoms of anxiety and depression even before increases in the stressors facing American families, including the COVID-19 pandemic, economic downturn, and recent restrictions on women's reproductive autonomy. In 2019, an estimated 13.5 percent of mothers reported symptoms of moderate or severe anxiety and 4.8 percent reported symptoms of moderate or severe depression. This suggests many mothers were experiencing the

negative effects of such conditions on their quality of life, which, in turn, can have adverse consequences for the long-term well-being of their children (Biel, Tang, and Zuckerman 2020; Brenes 2007; Campo, Fontanella, and Bridge 2020; Kamis 2021; National Scientific Council on the Developing Child and National Forum on Early Childhood Program Evaluation 2009). And, as highlighted in a recent White House issue brief, mental health difficulties extend to society at large and have significant economic impacts (White House 2022).

We found lower rates of both anxiety and depression among Asian and Hispanic mothers relative to white mothers. And although rates of moderate or severe depression were similar for Black and white mothers, we found higher rates of anxiety among white mothers than among Black mothers. These findings are consistent with the so-called Black-white mental health paradox (Erving, Thomas, and Frazier 2019) and may be related to the so-called "healthy immigrant" paradox (Elshahat et al. 2022). However, these findings may also indicate a need for more research on how different groups perceive symptoms related to depression and anxiety and their intensity.

The higher rates of anxiety identified among younger mothers before the pandemic are consistent with prior research on young adults (Goodwin et al. 2020); the higher rates are especially worrisome because children of younger mothers tend to be younger, and, thus, they could be particularly affected by parental mental health issues. Younger mothers also have likely faced greater challenges related to balancing child care and remote schooling with work during the pandemic, putting them under higher stress. For mothers of child-bearing age, concerns about access to reproductive health care have likely intensified in the wake of the *Dobbs* decision. Other patterns related to income, marital status, and education illustrate the interrelated characteristics that may systematically place some women at higher risk of developing or experiencing more intense anxiety and depression. In addition, we found that though considerable attention is being paid to the importance of mental health assistance during pregnancy and postpartum periods (for instance, through the recent introduction of the National Maternal Mental Health Hotline),[20] symptoms of anxiety and depression are just as pronounced for other mothers as for those with infants.

We found that an estimated 13.3 percent of uninsured mothers had moderate or severe anxiety and that 5.0 percent had moderate or severe depression. Though we were unable to separately assess use of counseling or therapy and unmet needs for mental health care among uninsured mothers, other research finds that uninsured people with anxiety or depression are much less likely to receive treatment (Panchal et al. 2022), in line with broader evidence that uninsured people with mental disorders often do not receive care for their conditions (Zur, Musumeci, and Garfield 2017). The stress associated with being uninsured could add to the mental health strain on mothers and could mean

anxiety or depression, as well as other health problems, are underdiagnosed and undertreated (Sullivan, Pearsall, and Bailey 2021). This highlights the importance of safety net providers, such as community health centers, having sufficient resources and capacity to provide needed mental health care to uninsured patients (Taylor 2018).

About 4 in 10 mothers enrolled in Medicaid/CHIP or covered by employer-sponsored coverage who experienced anxiety or depression reported that they received counseling or therapy, and close to 1 in 5 reported unmet needs for counseling or therapy due to cost. Thus, it appears coverage alone is insufficient for ensuring access to needed mental health care. These estimates suggest broad-scale problems with the availability, accessibility, and affordability of mental health services. Therefore, improving access to and use of needed mental health services will likely require implementing a broad array of policy changes that target not only coverage rates but also regulations and other characteristics of the service delivery system (McBain et al. 2021), including the following:

- **Increasing routine screening for mental health problems**. Some mothers may not realize they have mental health conditions and therefore they do not seek care that could benefit them. For example, only about 59 percent of mothers experiencing feelings consistent with moderate or severe anxiety reported that they had ever been diagnosed with anxiety (data not shown). The US Preventive Services Task Force recently recommended routine screening for anxiety for all adults (USPSTF 2022). Offering such screenings in various health care settings, including at well-woman and pediatric visits and as part of contraceptive counseling, could help identify concerns and recommend supports for young mothers who reported higher rates of anxiety symptoms, which would benefit these mothers and their children if they can access treatment. Early detection of anxiety is especially important given evidence that it can often precede the development of depression (Kessler and Wang 2008). But it will also be important that primary care providers use appropriate screening tools sensitive to identifying problems across diverse population subgroups and that they have adequate training and processes to implement screenings and follow up with effective treatment (Mulvaney-Day et al. 2018).
- **Increasing the availability of mental health providers**. Some reported unmet needs for care could owe to a lack of providers—or a lack of providers accepting insurance—in a community because of the nation's mental health provider shortage (Kaiser Family Foundation 2022; MACPAC 2021a; Weiner 2022). Expansion in state scope-of-practice regulations, greater integration of mental health into primary care, incorporation of other community-based providers, and other actions are needed to expand provider availability (Hoge and Paris 2018; MACPAC 2021a; Page et al. 2016).2121 The Senate Finance Committee has proposed

legislation to expand the mental health workforce.[22] It is especially important to address access in rural and other underserved areas where shortages may be even more severe (Weiner 2022), such as through access to telehealth services. Increasing the racial and ethnic diversity of the mental health workforce and ensuring services are culturally and linguistically appropriate are also needed for individuals to have access to providers with whom they are comfortable and who can deliver high-quality care (Antezzo et al. 2021; McGregor et al. 2019).

- **Improving network adequacy standards, increasing provider payment rates, ensuring adequate covered benefits and cost-sharing policies, and enforcing mental health parity regulations**. Though both Medicaid/CHIP and employer plans must cover mental health services, enrollees may have trouble finding providers who accept their insurance and those in employer plans may face high cost sharing or limits on frequency of services (GAO 2022). Federal and state policy changes would be needed to improve affordability and enforce parity and network adequacy requirements between coverage of physical and mental health services (Rapfogel 2022). Ensuring network adequacy will also require addressing so-called "ghost" or "phantom" networks—directories of mental health providers that seem to be in network but are not or do not accept new patients (Busch and Kyanko 2020). Policies being proposed by the Senate Finance Committee would enhance federal requirements for states and Medicaid managed-care organizations to regularly update such directories.[23] In addition, although the Mental Health Parity and Addiction Equity Act regulations require parity between physical and mental health care availability, recent research found that patients' awareness of the regulations was low and that regulators faced challenges enforcing requirements (Volk et al. 2022). In 2021, the Consolidated Appropriations Act (Pub. L. No. 116-260) added new parity protections, and in their 2022 report to Congress, the Departments of Labor, Health and Human Services, and the Treasury highlighted new oversight efforts aimed at enforcing these protections (Department of Labor, Department of Health and Human Services, and Department of the Treasury 2022). And though Medicaid coverage of mental health services is often comprehensive, some states use "carve-outs" that can introduce complexity and coordination issues for enrollees (Guth 2021). In addition, low Medicaid provider payment rates can inhibit providers' participation in networks, suggesting that increases in provider payment rates may be needed to improve Medicaid-covered mothers' access to care (Rapfolgel 2022; Zur, Musimeci, and Garfield 2017).[24]
- **Maintaining and improving access to care within Medicaid.** The higher anxiety and depression rates we observe for mothers enrolled in Medicaid/CHIP and those with lower incomes are consistent with other research on nonelderly adults and highlight the importance of focusing

attention on mental health access in Medicaid (Panchal et al. 2022; Zur, Musumeci, and Garfield 2017). Improving access to needed mental health care services within Medicaid may necessitate taking steps to ensure states cover the full continuum of behavioral health care benefits and strengthen their delivery systems (GAO 2022; Guth 2021; MACPAC 2021b).[25,26] In addition, Medicaid programs could do more to ensure health care patients are being screened and connected to services to help them address financial, housing, nutrition, and other difficulties that may be contributing to their mental health challenges (Billioux et al. 2017; MACPAC 2022; North Carolina Medicaid 2021). Moreover, maintaining access to needed mental health care requires minimizing coverage losses for Medicaid-enrolled mothers who will have to renew their Medicaid coverage for the first time since March 2020 after the Medicaid continuous coverage provision expires in April 2023 (Brooks and Gardner 2022).[27] Expanding the availability of Medicaid by adopting the Affordable Care Act's Medicaid expansion among the 11 remaining nonexpansion states and extending postpartum Medicaid coverage to a full year is also critical to improving the diagnosis and treatment of mothers' mental health challenges (Buettgens and Ramchandani 2022).[28]

This discussion has focused on changes needed in the health care system to better address maternal mental health needs. However, given the evidence that a lack of financial security can contribute directly and indirectly to mental health difficulties (Ryu and Fan 2022), policies such as child care subsidies, paid leave, workplace protections, pay equity, and income supports could relieve some of the underlying causes of maternal anxiety and depression, which may be especially pervasive as concerns about inflation and economic uncertainty persist. Moreover, systemic problems such as discrimination based on sex, sexual orientation and gender identity, disability, race and ethnicity, and other factors must be reduced to relieve some mothers' mental health challenges.

As the pandemic's effects on daily life subside and new threats to mothers' mental health emerge, it will be critical to monitor trends in anxiety and depression, mental health care use, and unmet needs for care. This analysis provides an important benchmark for such monitoring and for analysis of policy interventions aimed at improving mental health outcomes and care access among mothers.

Appendix A. Socioeconomic and Demographic Characteristics of Mothers and Rates of Severe Anxiety and Depression

TABLE A.1

Socioeconomic and Demographic Characteristics of Mothers Ages 19 to 64, by Reported Symptoms of Anxiety and Depression, 2019

	All Mothers			Mothers with Moderate/Severe Anxiety or Depression			Mothers without Moderate/Severe Anxiety or Depression				Mothers with Severe Anxiety or Depression			Mothers without Severe Anxiety or Depression			
	%	SE	*N*	%	SE	*N*	%	SE	*N*		%	SE	*N*	%	SE	*N*	
Age																	
19–25	7.1	0.005	4342	10.0	0.015	632	6.7	0.006	3710	**	11.3	0.026	229	6.9	0.006	4113	*
26–34	30.6	0.008	4342	35.0	0.024	632	29.9	0.009	3710	**	34.2	0.036	229	30.4	0.009	4113	
35–44	39.2	0.009	4342	35.4	0.023	632	39.8	0.010	3710	*	37.6	0.038	229	39.2	0.009	4113	
45–54	20.5	0.007	4342	17.8	0.018	632	20.9	0.008	3710		15.5	0.026	229	20.8	0.008	4113	**
55–64	2.6	0.002	4342	1.8	0.006	632	2.8	0.003	3710		1.4	0.008	229	2.7	0.003	4113	
Race and ethnicity																	
White, non-Hispanic	52.6	0.012	4342	66.2	0.023	632	50.3	0.013	3710	**	71.6	0.036	229	51.6	0.012	4113	**
Black, non-Hispanic	13.8	0.007	4342	11.6	0.015	632	14.2	0.008	3710		10.2	0.023	229	14.0	0.008	4113	
Asian, non-Hispanic	7.5	0.005	4342	2.0	0.006	632	8.4	0.006	3710	**	0.6	0.004	229	7.9	0.005	4113	**
AIAN, non-Hispanic	1.8	0.007	4342	2.0	0.007	632	1.7	0.008	3710		2.1	0.012	229	1.8	0.007	4113	
Other/multiple races, non-Hispanic	1.3	0.002	4342	1.4	0.006	632	1.2	0.002	3710		2.2	0.010	229	1.2	0.002	4113	
Hispanic	23.0	0.011	4342	16.7	0.020	632	24.1	0.012	3710	**	13.3	0.027	229	23.6	0.011	4113	**

	All Mothers			Mothers with Moderate/Severe Anxiety or Depression			Mothers without Moderate/Severe Anxiety or Depression				Mothers with Severe Anxiety or Depression			Mothers without Severe Anxiety or Depression			
	%	SE	N	%	SE	N	%	SE	N		%	SE	N	%	SE	N	
Marital status																	
Married or living with partner	76.5	0.008	4291	65.8	0.022	625	78.4	0.008	3666	**	59.9	0.038	226	77.5	0.008	4065	**
Widowed, divorced, separated, or never married	23.5	0.008	4291	34.2	0.022	625	21.6	0.008	3666	**	40.1	0.038	226	22.5	0.008	4065	**
Educational attainment																	
High school graduate or less	34.4	0.010	4334	38.4	0.024	630	33.7	0.011	3704	*	42.8	0.038	228	33.9	0.010	4106	**
Some college or more	65.6	0.010	4334	61.6	0.024	630	66.3	0.011	3704	*	57.2	0.038	228	66.1	0.010	4106	**
Live birth in the past 12 months																	
Live birth	9.8	0.005	4342	9.7	0.014	632	9.8	0.006	3710		10.2	0.024	229	9.8	0.006	4113	
No live birth	90.2	0.005	4342	90.3	0.014	632	90.2	0.006	3710		89.8	0.024	229	90.2	0.006	4113	
Number of children in the household																	
1	40.4	0.009	4321	42.9	0.023	627	40.0	0.009	3694		41.0	0.040	227	40.4	0.009	4094	
2	35.5	0.008	4321	33.4	0.021	627	35.8	0.009	3694		30.4	0.033	227	35.8	0.008	4094	
3+	24.1	0.008	4321	23.7	0.019	627	24.2	0.009	3694		28.6	0.033	227	23.9	0.008	4094	
Metropolitan status																	
Metropolitan	86.2	0.009	4342	83.3	0.016	632	86.6	0.010	3710	*	84.9	0.026	229	86.2	0.009	4113	
Nonmetropolitan	13.8	0.009	4342	16.7	0.016	632	13.4	0.010	3710	*	15.1	0.026	229	13.8	0.009	4113	
Health insurance coverage																	
ESI	57.9	0.011	4337	44.8	0.023	632	60.1	0.012	3705	**	34.4	0.038	229	59.2	0.011	4108	**
Exchange/direct purchase	6.0	0.005	4337	5.0	0.009	632	6.2	0.005	3705		2.1	0.010	229	6.2	0.005	4108	**
Medicaid/CHIP	18.9	0.009	4337	29.2	0.023	632	17.1	0.009	3705	**	38.0	0.038	229	17.8	0.009	4108	**

	All Mothers			Mothers with Moderate/Severe Anxiety or Depression			Mothers without Moderate/Severe Anxiety or Depression				Mothers with Severe Anxiety or Depression			Mothers without Severe Anxiety or Depression			
	%	SE	N	%	SE	N	%	SE	N		%	SE	N	%	SE	N	
Medicare, other public, other private	2.6	0.003	4337	6.5	0.012	632	1.9	0.003	3705	**	7.8	0.022	229	2.3	0.003	4108	**
Uninsured	14.7	0.008	4337	14.5	0.016	632	14.7	0.009	3705		17.7	0.028	229	14.5	0.008	4108	
Income level																	
≦200% of FPL	40.1	0.011	4342	52.6	0.025	632	38.0	0.012	3710	**	58.8	0.040	229	39.1	0.011	4113	**
Above 200% of FPL	59.9	0.011	4342	47.4	0.025	632	62.0	0.012	3710	**	41.2	0.040	229	60.9	0.011	4113	**

Source: Authors' analysis of the 2019 National Health Interview Survey.

Notes: SE = standard error. N = sample size of mothers. AIAN = American Indian/Alaska Native. ESI = employer-sponsored insurance. CHIP = Children's Health Insurance Program. FPL = federal poverty level. Anxiety and depression are defined by the Washington Group Extended Set Disability Indicators. Mothers are women reported to be biological parents, adoptive parents, or stepparents of a child younger than 18 residing in their household.

*/** indicates estimate is statistically significant from the reference group at the at the $p < 0.10/0.05$ level. For "mothers with moderate/severe anxiety or depression," the reference group is mothers without moderate/severe anxiety or depression. For "mothers with severe anxiety or depression," the reference group is "mothers without severe anxiety or depression."

TABLE A.2

Rates of Severe Anxiety and Severe Depression among Mothers Ages 19 to 64, by Socioeconomic and Demographic Characteristics, 2019

	Severe Anxiety				Severe Depression			
	%	SE	N		%	SE	N	
All mothers	**4.8**	**0.004**	**4342**		**1.6**	**0.002**	**4342**	
Age								
19–25^	7.0	0.018	248		2.5	0.012	248	
26–34	5.5	0.007	1286		1.8	0.004	1286	
35–44	4.7	0.006	1786		1.5	0.004	1786	
45–54	3.4	0.007	896	*	1.4	0.004	896	
Race and ethnicity								
White, non-Hispanic	6.5	0.006	2432	**	2.1	0.003	2432	
Black, non-Hispanic^	3.5	0.009	598		1.4	0.005	598	
Asian, non-Hispanic	0.4	0.003	302	**	0.2	0.002	302	**
Hispanic	2.7	0.006	879		0.7	0.004	879	
Marital status								
Married or living with partner	3.8	0.004	3020	**	1.2	0.002	3020	**
Widowed, divorced, separated, or never married^	8.0	0.010	1271		2.9	0.006	1271	
Educational attainment								
High school graduate or less^	5.7	0.007	1273		2.1	0.005	1273	
Some college or more	4.3	0.004	3061	*	1.4	0.002	3061	
Live birth in the past 12 months								
Live birth^	4.6	0.013	408		2.4	0.010	408	
No live birth	4.8	0.004	3934		1.5	0.002	3934	
Number of children in the household								
1^	4.7	0.006	1729		1.9	0.004	1729	
2	4.1	0.006	1583		1.2	0.003	1583	
3+	6.0	0.009	1009		1.6	0.005	1009	
Metropolitan status								
Metropolitan	4.7	0.004	3696		1.6	0.002	3696	
Nonmetropolitan^	5.4	0.010	646		1.8	0.006	646	
Health insurance coverage								
ESI	3.0	0.004	2625	**	0.8	0.002	2625	**
Exchange/direct purchase	1.6	0.009	244	**	0.6	0.005	244	**
Medicaid/CHIP^	9.0	0.012	793		3.8	0.008	793	
Uninsured	6.1	0.010	563	*	1.9	0.007	563	*
Income level								
≦200% of FPL^	7.0	0.007	1694		2.5	0.004	1694	
Above 200% of FPL	3.3	0.004	2648	**	1.0	0.003	2648	**

Source: Authors' analysis of the 2019 National Health Interview Survey.

Notes: SE = standard error. N = sample size of mothers. ESI = employer-sponsored insurance. CHIP = Children's Health Insurance Program. FPL = federal poverty level. Moderate or severe anxiety or depression is defined by the Washington Group Extended Set Disability Indicators. Mothers are women reported to be biological parents, adoptive parents, or stepparents of a child younger than 18 residing in their household.

^ indicates reference group; */** indicates estimate is statistically significant from the reference group (^) at the at the $p <$ 0.10/0.05 level.

Notes

[1] American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry, and Children's Hospital Association, "Declaration of a National Emergency in Child and Adolescent Mental Health," October 19, 2021, https://www.aap.org/en/advocacy/child-and-adolescent-healthy-mental-development/aap-aacap-cha-declaration-of-a-national-emergency-in-child-and-adolescent-mental-health/.

[2] We strive to use inclusive language to reflect people's diverse identities. We use the terms "women" and "mothers" to align with the information collected in the survey data, but we acknowledge that not all people may identify with the way they are classified in the survey.

[3] Mothers are female respondents identified as the biological parent, adoptive parent, or stepparent of a child younger than 18 residing in their household.

[4] "About the National Health Interview Survey," National Center for Health Statistics, March 3, 2022, https://www.cdc.gov/nchs/nhis/about_nhis.htm.

[5] "WG Extended Set on Functioning (WG-ES)," Washington Group on Disability Statistics, accessed November 10, 2022, https://www.washingtongroup-disability.com/question-sets/wg-extended-set-on-functioning-wg-es/

[6] "WG Extended Set on Functioning (WG-ES) Syntax and Analytic Guidelines," Washington Group on Disability Statistics, accessed November 10, 2022, https://www.washingtongroup-disability.com/analysis/wg-extended-set-on-functioning-wg-es-syntax/.

[7] Dobbs v. Jackson Women's Health Organization, 19-1392, 597 U.S. (2022), https://www.supremecourt.gov/opinions/21pdf/19-1392_6j37.pdf.

[8] American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry, and Children's Hospital Association, "Declaration of a National Emergency in Child and Adolescent Mental Health," October 19, 2021, https://www.aap.org/en/advocacy/child-and-adolescent-healthy-mental-development/aap-aacap-cha-declaration-of-a-national-emergency-in-child-and-adolescent-mental-health/.

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[10] "Anxiety and Depression: Household Pulse Survey," US Census Bureau, updated September 14, 2022, https://www.cdc.gov/nchs/covid19/pulse/mental-health.htm.

[11] "Mental Health by the Numbers," National Alliance on Mental Illness, last updated June 2022, https://www.nami.org/mhstats.

[12] National Association of Social Workers, "Major Mental Health Associations Decry U.S. Supreme Court Decision Overturning Roe v. Wade," (news release), June 24, 2022, https://www.socialworkers.org/News/News-Releases/ID/2504/Major-Mental-Health-Associations-decry-US-Supreme-Court-decision-overturning-Roe-v-Wade.

[13] H.R.2617 - Consolidated Appropriations Act, 2023. https://www.congress.gov/bill/117th-congress/house-bill/2617

[14] "About the National Health Interview Survey," National Center for Health Statistics. https://www.cdc.gov/nchs/nhis/about_nhis.htm.

[15] "WG Extended Set on Functioning (WG-ES)," Washington Group on Disability Statistics, accessed November 10, 2022, https://www.washingtongroup-disability.com/question-sets/wg-extended-set-on-functioning-wg-es/

[16] The Washington Group indicators were also highly correlated with self-reported diagnoses of anxiety and depression. About 58.7 percent of mothers who reported feelings consistent with moderate or severe anxiety

also reported they had at one time been diagnosed with anxiety, and about 83.3 percent of mothers who reported feelings consistent with moderate or severe depression also reported they had at one time been diagnosed with depression.

[17] The wording of the Washington Group questions from the 2019 National Health Interview Survey instrument is as follows:

For anxiety: (1) "How often do you feel worried, nervous, or anxious? Would you say daily, weekly, monthly, a few times a year, or never?" (2) "Thinking about the last time you felt worried, nervous, or anxious, how would you describe the level of these feelings? Would you say a little, a lot, or somewhere in between?"

For depression: (1) "How often do you feel depressed? Would you say daily, weekly, monthly, a few times a year, or never?" (2) "Thinking about the last time you felt depressed, how depressed did you feel? Would you say a little, a lot, or somewhere in between?"

[18] "WG Extended Set on Functioning (WG-ES) Syntax and Analytic Guidelines," Washington Group on Disability Statistics, accessed November 10, 2022, https://www.washingtongroup-disability.com/analysis/wg-extended-set-on-functioning-wg-es-syntax/.

[19] "Urban-Rural Classification Scheme for Counties," Centers for Disease Control and Prevention, National Center for Health Statistics, accessed December 19, 2022, https://www.cdc.gov/nchs/data_access/urban_rural.htm#2013_Urban-Rural_Classification_Scheme_for_Counties.

[20] "National Maternal Mental Health Hotline," Human Resources and Services Administration, last reviewed October 2022, https://mchb.hrsa.gov/national-maternal-mental-health-hotline.

[21] Rachel Nuzum, Reginald Williams III, Nathaniel Counts, Sara Federman, and Celli Horstman, "Expanding Access to Equitable Behavioral Health Services," *To the Point* (blog), Commonwealth Fund, May 12, 2022, https://www.commonwealthfund.org/blog/2022/expanding-access-equitable-behavioral-health-services.

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About the Authors

Jennifer M. Haley is a senior research associate in the Urban Institute's Health Policy Center. Haley's current work includes assessing ways states and communities can improve health equity in response to the COVID-19 pandemic, barriers to enrollment in publicly subsidized health insurance coverage, coverage gaps for postpartum women, and challenges to accessing the safety net for children in immigrant families. She also conducts research on other issues related to Medicaid, the Children's Health Insurance Program, and coverage and care for children and families. Haley holds an MA in sociology from Temple University.

Stacey McMorrow is a principal research associate with extensive experience using quantitative methods to study the factors that affect individual health insurance coverage and access to care as well as the impacts of state and national health reforms on employers and individuals. Her current work uses the Affordable Care Act and past Medicaid expansions to explore the effects of expanding insurance coverage on access to care, service use, and health outcomes for various populations. Through this and other work, McMorrow has developed substantial expertise in analyzing data from several federal surveys, including the National Health Interview Survey and the Medical Expenditure Panel Survey. Other research interests include the role of community health centers and safety net providers under health reform, receipt of preventive and reproductive health services among women, barriers to care for low-income children, and the market-level effects of insurance expansions. McMorrow received her PhD in health economics from the University of Pennsylvania in 2009.

Julia Long is a research analyst in the Urban Institute's Health Policy Center, where her research focus is access to health care for children and families. Long uses quantitative and spatial data analysis to track health reforms and their effects on children's health. Previously, she conducted research at the Cecil G. Sheps Center for Health Services Research on rural health disparities and improving rural access to primary care through graduate medical education development. Long earned a BSPH in health policy and management from the University of North Carolina at Chapel Hill, where she also studied geography and French.

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