INTEGRATED BENEFITS INSTITUTE

SUPPORTING MENTAL HEALTH IN THE WORKFORCE

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EXECUTIVE SUMMARY

Even before the pandemic awareness of mental health challenges in the workforce was rising. Now, due to the effects of social isolation, loneliness, prolonged exposure to stress, fear, and worry, and work and financial instability, all caused by the pandemic, investment in mental health strategies is at an all-time high.

This study provides an update on mental health concerns among employed adults ages 18-64 in the United States. It includes information on the current state of mental health, compared to where we were a year ago, and it offers some new insights on how the continuing burden of COVID-19 and long COVID is associated with anxiety and depression.

Highlights from the report:

- There have been important changes in the rate of anxiety and depression symptoms and work arrangements when comparing 2020 to the study period (July 2021 to August 2022):
    - Symptoms of anxiety or depression have decreased 5%.
    - Individuals taking a mental health prescription medication have increased 2%.
    - 61% are now working in person, 17% working hybrid, and 22% remotely.
- We found that fully remote and hybrid work arrangements within the household were associated with an increased likelihood of anxiety or depression symptoms.
- Respondents who were not currently working had higher rates anxiety or depression symptoms compared to those who were currently working.
- Respondents who reported a recent COVID infection, more severe, or long-COVID were more likely to report symptoms of anxiety or depression.
- Respondents who reported symptoms of anxiety or depression and those with more severe or more recent COVID were more likely to use virtual care options.

When we spoke to employers about their efforts to support mental health in the workforce, we heard that many employers already had existing efforts to support mental health in their workforce, but the pandemic greatly accelerated the progress of these efforts. We also heard that because mental illness is often accompanied by other comorbid conditions such as diabetes and heart disease, providing options that help employees coordinate their care is important. We discussed the importance of helping employees find mental healthcare that is culturally appropriate, that they value, and that they can identify with. We learned that many employers are enhancing peer-support by identifying and training mental health “ambassadors” who can serve as a compassionate, listening ear and help navigate resources and benefits provided by the employer. Finally, we discussed adopting a prevention mindset for mental illness, as we often do for physical illness.

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BACKGROUND

Mental health status contributes substantially to the overall burden of disability, illness, and mortality and has important impacts on individual productivity and economic well-being. Common symptoms of mental illness include having excessive fears or worries, reduced ability to concentrate, persistent feelings of sadness, loss of interest in normal activities, and increased feelings of stress. These problems can impact an individual's daily life, relationships, ability to thrive, and reduce productivity at work.[1]

While the relationship between work environment, work-life balance, and health has been of interest for many years,[2,3] the COVID-19 pandemic brought the relationship between work and mental health into clearer focus. As employees moved to remote work arrangements, mental health symptoms among employed adults began to increase. Concerns about mental health were at an all-time high. However, while chronic stress from the workplace and lack of work-life balance can contribute to behavioral disturbances such as depression, anxiety, and substance use disorders, the workplace can also be a positive source for employees to build community and improve well-being and mental health.[4]

Based on previous IBI research on this topic,[5] some early responses to mental health concerns due to the pandemic include increasing Employee Assistance Programs (EAP) capacity and utilization, increasing education about mental health to decrease stigma, increasing access to mental healthcare through virtual care, hosting expert speakers for trainings/workshops, introducing well-being packages to benefits, increasing Paid Time Off (PTO) and encouraging leave, and educating employees and leaders about their benefits and how to access them.

This report addresses the following research questions:

- What is happening with mental health support in the workplace now?
- How do demographics influence mental health concerns as they relate to employment?
- How do COVID and long-COVID relate to mental health concerns?
- What emerging strategies are employers using to support their staff's mental health?
- How are employers improving access to mental health services, such as virtual care access?

[1] Pollock A, et al. Interventions to support the resilience and mental health of frontline health and social care professionals during and after a disease outbreak, epidemic or pandemic: a mixed methods systematic review. Cochrane Database of Systematic Reviews 2020, Issue 11.

[2] Adams JM. The value of worker well-being. Public Health Reports, 2019;134(6):583-586.

[3] Peters SE, Dennerlein JT, Wagner GR, Sorensen G. Work and worker health in the post-pandemic world: A public health perspective. Lancet Public Health, 2022;7:e188-94.

[4] US Department of Health and Human Services. US Surgeon General's Framework for Mental Health & Well-Being, 2022. Available at: Office of the Surgeon General - Framework for Workplace Mental Health&Well Being (hhs.gov).

[5] IBI. Employee Mental Health, September 2021. Available at: Providing Tools for Healthy Workplaces | Integrated Benefits Institute (ibiweb.org).

METHODOLOGY

Survey Description

In this study, we analyzed data from the Household Pulse Survey (HPS), a data product of the US Census Bureau. The HPS is a 20-minute online survey designed to provide up-to-date data on how the COVID-19 pandemic is affecting people's daily lives. The survey collects information from individuals in all 50 states, plus the District of Columbia and the 15 largest metro areas. It is designed to produce results that are representative of the US. Addresses are sampled and respondents are contacted by email or text and invited to participate.

Beginning in Phase 2 through to the most recently completed Phase 3.5, the survey has been conducted in 2 weeks on, 2 weeks off fashion, with data dissemination occurring after each 2-week collection period has concluded. Our analysis includes weeks 34 to 48. Phase 3.2 includes weeks 34 – 39 and ran from July 21, 2021 to Oct 11, 2021. Phase 3.3 includes weeks 40 to 42, and ran from December 1, 2021 through February 7, 2022. Phase 3.4 includes weeks 43 to 45, and ran from March 2 through May 9, 2022. Phase 3.5 included weeks 46 to 48, and ran from June 1 through August 8, 2022. The questions included in the survey are consistent within each phase but are reviewed and may be modified with each new phase. The average response rate for weeks 34 – 48 included in this analysis is 6.2%. While this is considered a low response rate, the HPS data are statistically adjusted to account for most, if not all, of the bias introduced by the low response rate.

Sample

In our analysis, we included adults, ages 18-64, who responded to the survey between July 2021 and August 2022 and who were employed or on a potentially temporary leave at the time of survey administration. The total sample included 494,138 individuals. Fifty percent are male and 40% female. Thirty-three percent are less than 35 years old, 47% are between the ages of 35 and 54, and 20% are 55 – 64 years old. Eleven percent identified as Black, non-Hispanic, 18% identified as Hispanic, and 6% identified as Asian. Thirty-seven percent have earned a college or graduate degree, and 30% have an annual household income of less than $50,000. Other respondent characteristics are presented in detail in Figures 1 and 2 below. For more information on respondent characteristics, see Table 1 in the Appendix.

Figure 1. Sample Characteristics: Employment Sector

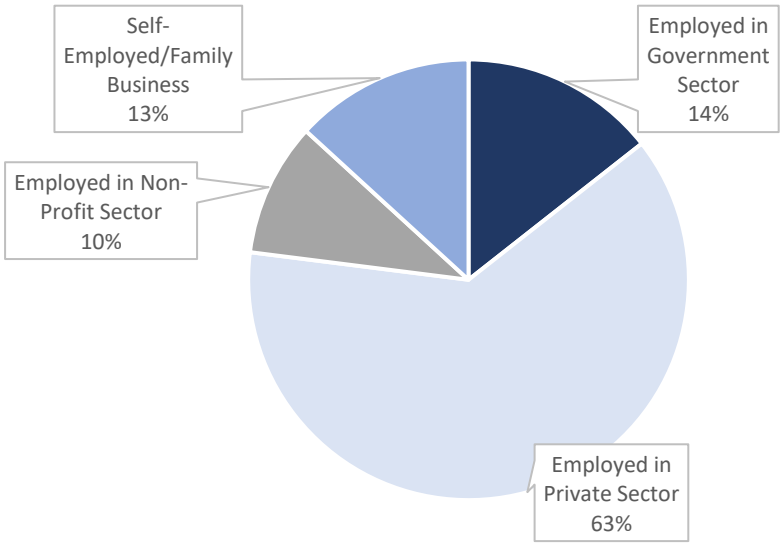
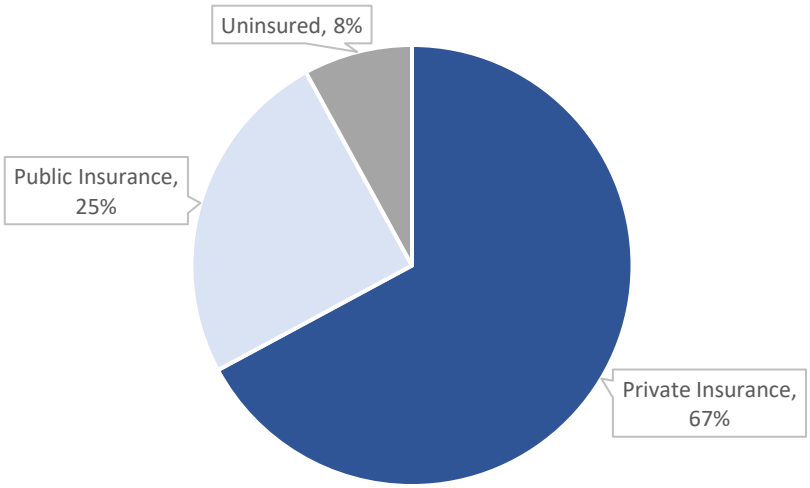


Figure 2. Sample Characteristics: Insurance Type



Measures

This report focuses on mental health symptoms, specifically symptoms of anxiety or depression. To measure these symptoms, respondents were asked 4 questions that assessed if they have been bothered by feeling nervous, anxious, on edge, or unable to stop worrying (symptoms of anxiety) and if they have had little interest/pleasure in doing things or feeling down, depressed, or hopeless (symptoms of depression). Respondents who indicated that they had symptoms of either anxiety or depression more than half the time over the past 2 weeks were coded as having symptoms of anxiety or depression.

When examining reports of symptoms of any illness, rather than occurrence of actual clinical diagnosis, it is important to consider that there are usually many symptoms that may or may not be present for any given condition, that these symptoms can range from mild to severe, and that they can occur over a long period of time or last for only a brief period. Measuring symptoms, rather than presence of an actual clinical diagnosis, will be more sensitive to change and provide information on suffering that may be sub-clinical, but it also makes it more difficult to compare rates across surveys (which may measure a slightly different set of symptoms, of different severity, and over a different period of time).

For example, when the Centers for Disease Control and Prevention (CDC) reports rates of anxiety and depression symptoms from the Household Pulse Survey, which was designed to measure the effects of the COVID-19 pandemic, the rates are similar to those reported in this study (with slight differences due to the fact that this study only considers employed adults 18-64 years old). However, when CDC reports rates of anxiety and depression symptoms from the National Health Interview Survey (NHIS), a long-running public health surveillance tool, the rates are much lower than those reported in the paper. The NHIS is measuring similar symptoms, but that occur more frequently and over a much longer period of time, which focuses attention on more severe forms of anxiety and depression.[6]

Respondents were asked, “Have you or any of the people in your household teleworked or worked from home?” to assess household telework. Finally, to assess current work status, respondents were asked if

[6] FastStats - Mental Health (cdc.gov)

they had worked for either pay or profit in the last 7 days. Those who indicated that they weren't working during the past week because they were: sick or have a disability, caring for someone who's sick, elderly, or a child, concerned about getting or spreading COVID were included in the analysis as their leave was likely temporary.

Analysis

The results presented in this report are based on the multiple logistic regression analytic technique. This technique enables adjustment for characteristics that may obscure the relationship between variables, allowing a more accurate description of the factors associated with anxiety or depression symptoms. All analyses are adjusted for the survey design and results can be generalized to the US population.

RESULTS

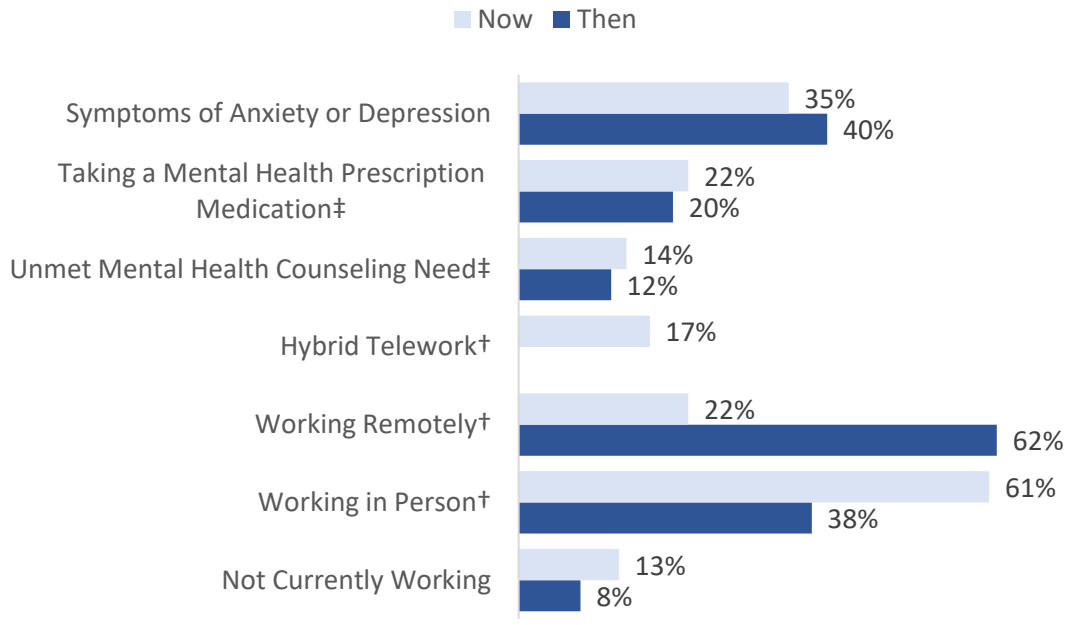
Where We Are Now Versus Where We Were Then

We have seen incredible changes in the world and the way people work since the pandemic began in March 2020. As employers quickly adjusted to enable their employees to work remotely whenever possible, and stay safe from the COVID-19 virus, it became evident that there were substantial negative health consequences of quarantine and stay-at-home orders. Of particular importance, rates of anxiety and depression began to rise precipitously.

Last year, IBI published a report detailing the state of mental health among working adults in the US. To better understand how things have changed since that last report, we have compared some key metrics reported in 2021, with the same metrics reflecting the more updated data.

We found that rates of anxiety or depression symptoms have declined from 40% during the height of the pandemic to 35% during our study period (7/21-8/22). These rates are similar to those reported by the CDC, with slight differences due to the fact that this study considers only employed individuals ages 18-64.[7] However, the rate of individuals taking a mental health prescription medication has increased from 20% to 22% and the unmet need for counseling has also increased from 12% to 14%. While we only have information on "hybrid" working arrangements in the more current data, we found that 61% are now working in person, compared to 38% in the previous report. See Figure 3 below for additional details.

Figure 3. Comparison of Pandemic Period to Current Period: "Now vs. Then"



*Now = July 2021-August 2022 / Then = April 2020-March 2021

[7] Mental Health - Household Pulse Survey - COVID-19 (cdc.gov)

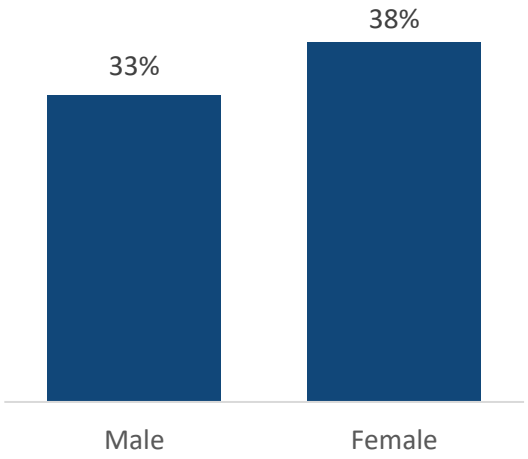
† Now = June 2022-August 2022
‡ Now = July 2021 – May 2022

Diversity, Equity, and Inclusion: Prevalence of Anxiety and Depression Symptoms Differs by Demographic Characteristics

The average rate of anxiety or depression symptoms during the study period (July 2021 – August 2022) was 35%. However, there were important differences by individual characteristics.

Rates of anxiety and depression were higher in women (38%) than men (33%), independent of other demographic characteristics. This aligns with findings from other national surveys.[8] See Figure 4.

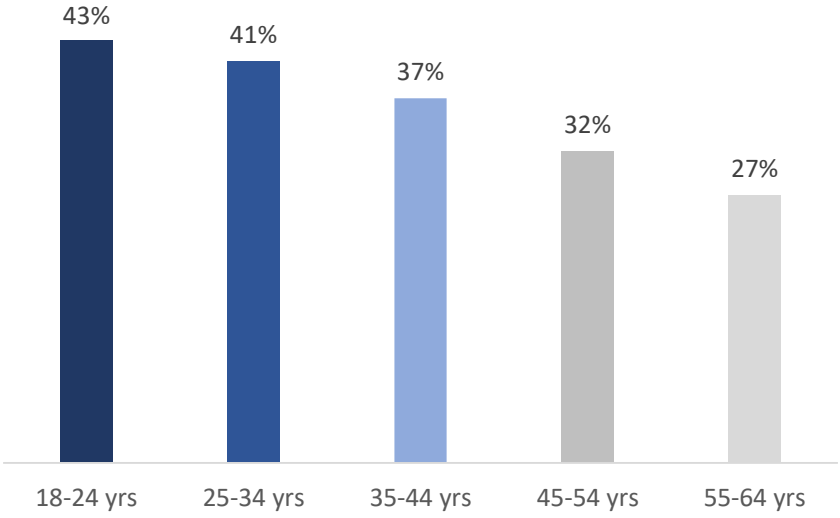
Figure 4. Symptoms of Anxiety or Depression by Gender



Older respondents were less likely to report symptoms of anxiety and depression compared to younger respondents, after accounting for other demographic characteristics (Figure 5). This aligns with findings from other national surveys, including the CDC-sponsored National Health Interview Survey.[9]

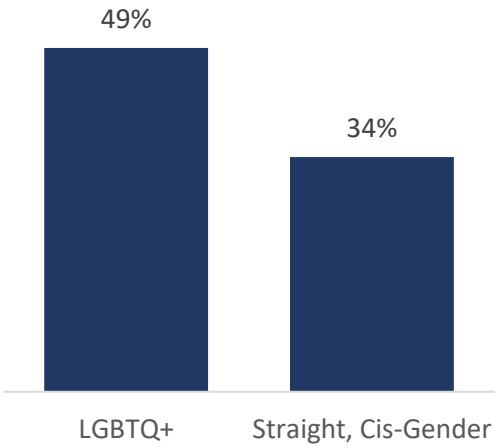
[8] NCHS Data Brief, Number 379, September 2020 (cdc.gov)
[9] NCHS Data Brief, Number 379, September 2020 (cdc.gov)

Figure 5. Anxiety/Depression Symptoms Decrease with Age



Respondents who identified as LGBTQ+ were more likely to report symptoms of anxiety or depression, after adjusting for other demographic characteristics (Figure 6).

Figure 6. LGBTQ+ Respondents Reported Higher Rates of Anxiety/Depression Symptoms

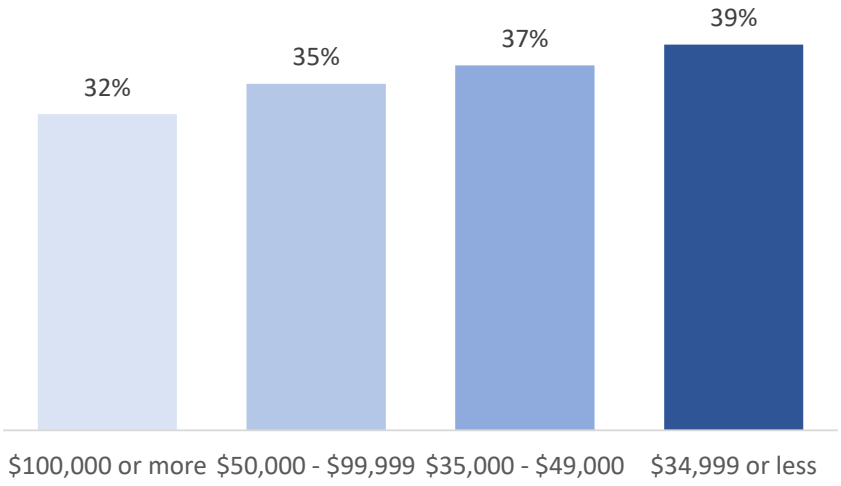


Respondents with lower income and those who had difficulty meeting living expenses had higher rates of depression and anxiety symptoms, after adjusting for other demographic characteristics (Figure 7). This aligns with findings reported elsewhere.[10,11]

[10] Ridley M et al. Poverty, Depression, and Anxiety: Causal Evidence and Mechanisms. Science 370, 6522 (December 2020).

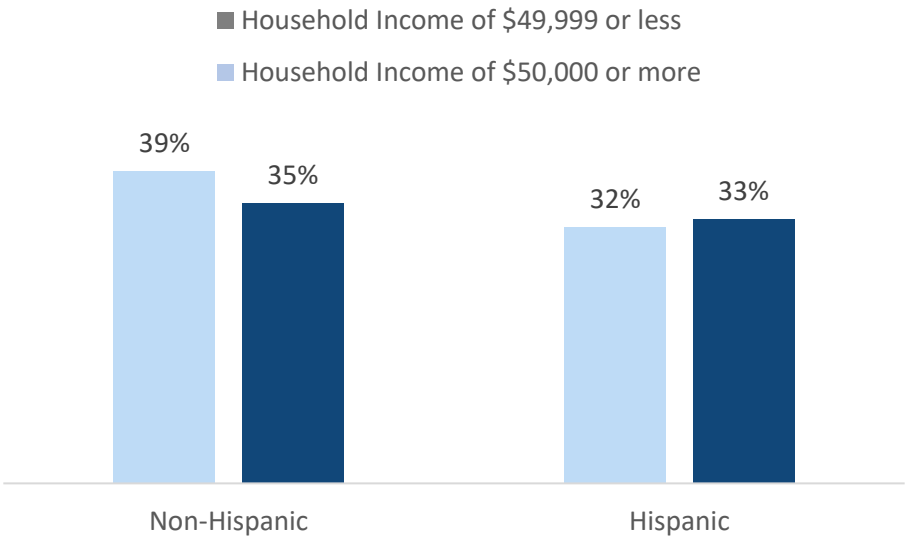
[11] Thompson RM. How do income changes impact on mental health and well-being for working-age adults? A systematic review and meta-analysis. Lancet Public Health, 2022;7:e515-28.

Figure 7. Lower Income Respondents Report more Anxiety/Depression Symptoms



In Figure 8 below, household income is divided into 2 categories – less than $50,000/year and $50,000 or more each year. Among non-Hispanics, those with a lower income have higher rates of anxiety/depression (39% compared to 35%). However, among those identifying as Hispanic, there is a slight increase (1%) among those who earn more compared to those who earn less. All Results are adjusted for: age, gender, race/ethnicity, income, LGBTQ+, difficulty meeting expenses, education, marital status, number of children, and insurance status.

Figure 8. Lower Income is Associated with Higher Rates of Anxiety/Depression Symptoms for All Non-Hispanic Ethnic Groups



For additional information on symptoms of anxiety or depression by respondent characteristics, see Table 2 in the Appendix.

Percentage Reporting Symptoms of Anxiety or Depression by State and Region

When examining rates of anxiety or depression by state, the rate varied from 30% in South Dakota to 41% in West Virginia (Figure 9). Further, the South had the highest (37%) rate of anxiety/depression (Figure 10).

Figure 9. Symptoms of Anxiety or Depression by State

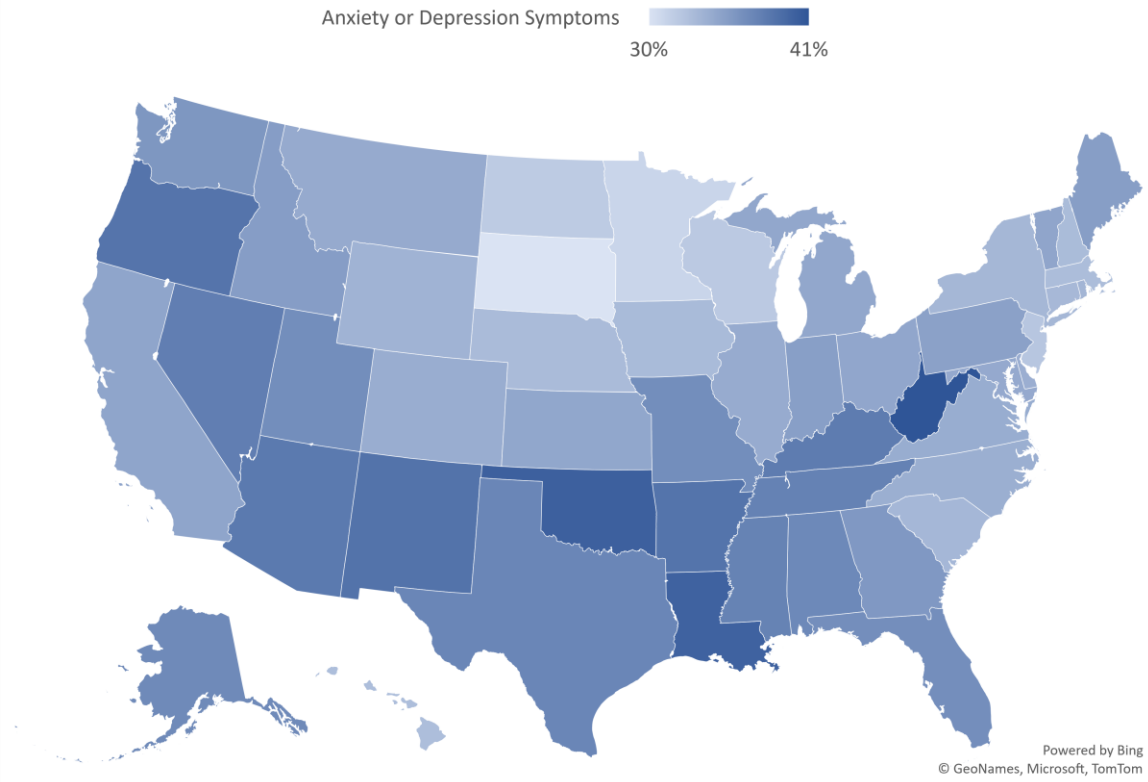


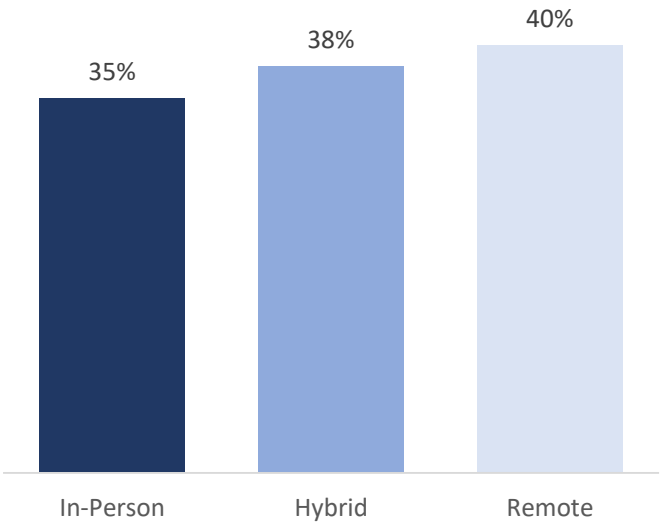
Figure 10. Anxiety/Depression by US Region

US Region	Percentage with Anxiety or Depression Symptoms
Northeast	34%
South	37%
Midwest	34%
West	36%

Prevalence of Anxiety or Depression Symptoms Differ by Work Arrangement

We found that teleworking and hybrid work arrangements within the household were associated with an increased likelihood of anxiety or depression symptoms, after adjusting for demographic confounders (Figure 11). Teleworking was defined as working 5 or more days from home in the past week, and hybrid was defined as working 1 to 4 days from home in the past week. NOTE: This result is based only on data collected recently, between June 2022 and August 2022, as questions about hybrid work arrangements were only available at this time.

Figure 11. Remote and Hybrid Work is Associated with a Higher Prevalence of Anxiety/Depression Symptoms



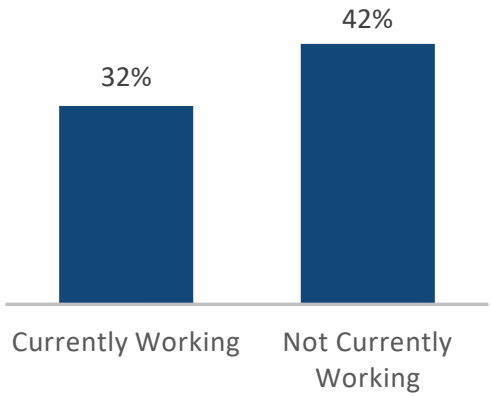
We found that annual household income was an important covariate in the relationship between work arrangement and anxiety/depression symptoms. Previous research on the effect of remote work arrangements and mental health is mixed. While some research results have provided evidence that working remotely is linked to lower stress, negative emotions, depression, strain, and alcohol abuse, others have demonstrated an increase in stress, burnout, and fatigue.[12] Additionally, the rapid acceleration of remote work due to the pandemic has further complicated this relationship. In research published before the COVID-19 pandemic, most found positive effects of remote work, and only about 20% found mixed or no effects. However, in research published during the pandemic, that examined the rapid expansion of remote work in every possible sector, only 23% showed positive effects, while 38% showed mixed results, and another 38% demonstrated negative effects.[13]

[12] Ferrara B et al. Investigating the role of remote working on employees' performance and well-being: An evidence-based systematic review. International Journal of Environmental Research and Public Health, 2022; 19.
[13] Hackney A. Working in the digital economy: A systematic review of the impact of work from home arrangements on personal and organizational performance and productivity. PLOS ONE, October 2022.

Work Status is Associated with Symptoms of Anxiety or Depression

Respondents who reported they were not currently working due to illness or caregiving responsibilities were more likely to report anxiety/depression, after controlling for income and other demographic characteristics (Figure 12).

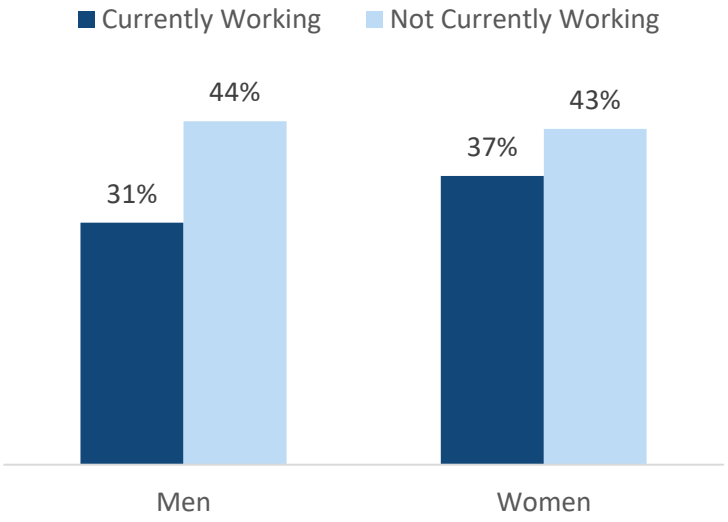
Figure 12. Symptoms of Anxiety/Depression by Work Status



In addition, we found that the effect of this temporary leave tended to change the way other demographic characteristics related to symptoms of anxiety or depression.[14]

It is well-established that women tend to suffer from anxiety and depression more often than men (see Figure 4). However, among those who are currently not working, this difference is reversed, and men have a slighter higher prevalence of anxiety or depression symptoms compared to women (Figure 13).

Figure 13. Symptoms of Anxiety/Depression: Work Status & Gender

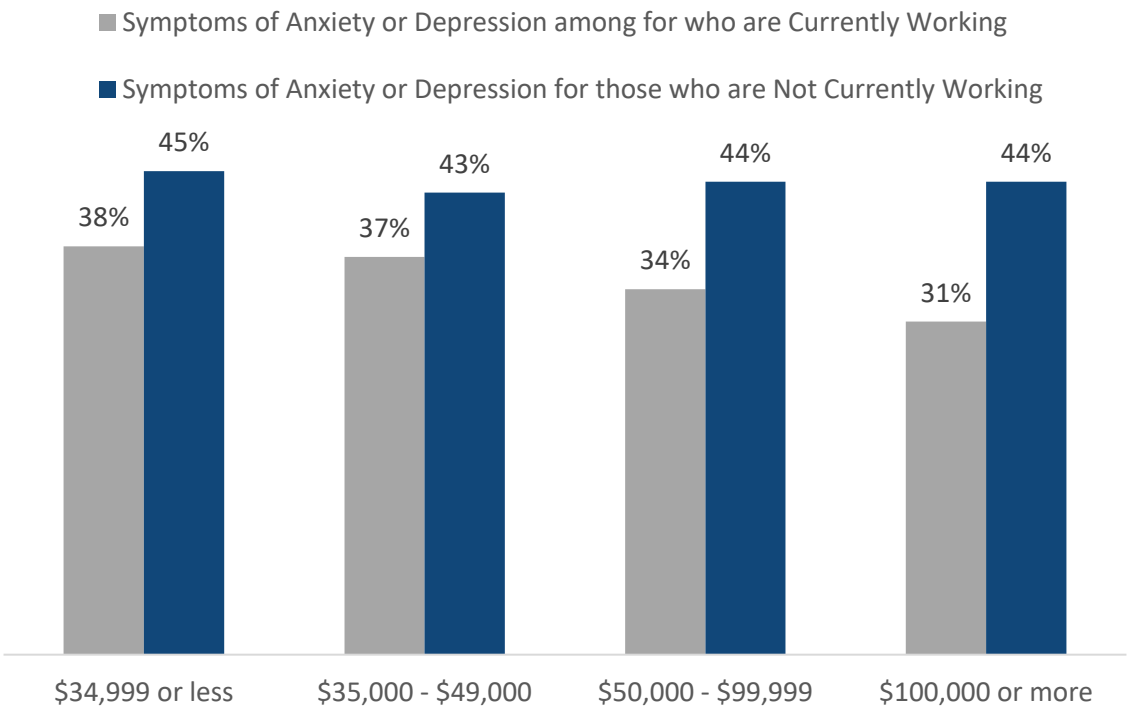


[14] It is worth noting, that because the temporary leave could be due to physical illness, it is possible that the physical illness is causing the symptoms of anxiety or depression. Furthermore, there is evidence that caretaking is associated with higher rates of mental ill-health.

Adjusted for age, gender, education, race/ethnicity, income, ability to meet expenses, marital status, number of children in household, and insurance status.

In addition, based on previous research, we expect that individuals with lower annual household incomes are more likely to suffer poor mental health outcomes. However, among those who are currently not working, the prevalence of anxiety or depression symptoms is uniformly high (ranging from 43% to 45%). Whereas, for those who are currently working, the prevalence is higher among those who have a lower household income (Figure 14).

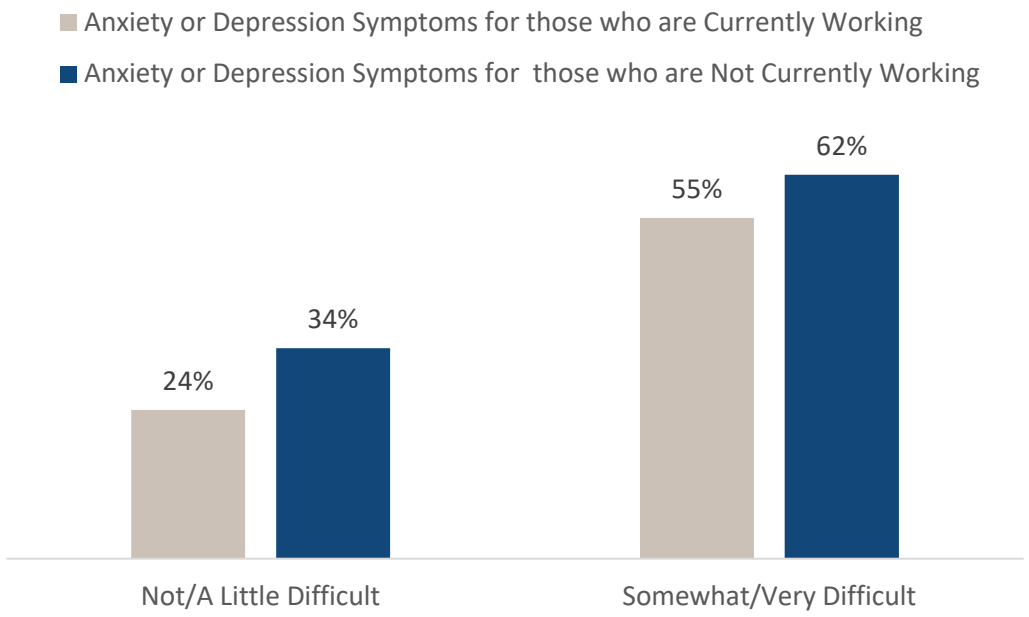
Figure 14. Symptoms of Anxiety/Depression: Work Status & Annual Income



Adjusted for age, gender, education, race/ethnicity, income, ability to meet expenses, marital status, number of children in household, and insurance status.

For those who have difficulty meeting living expenses, rates of anxiety or depression symptoms are much higher for those who are not currently working. However, even for those who are currently working, difficulty meeting expenses are associated with a high likelihood of anxiety or depression (Figure 15).

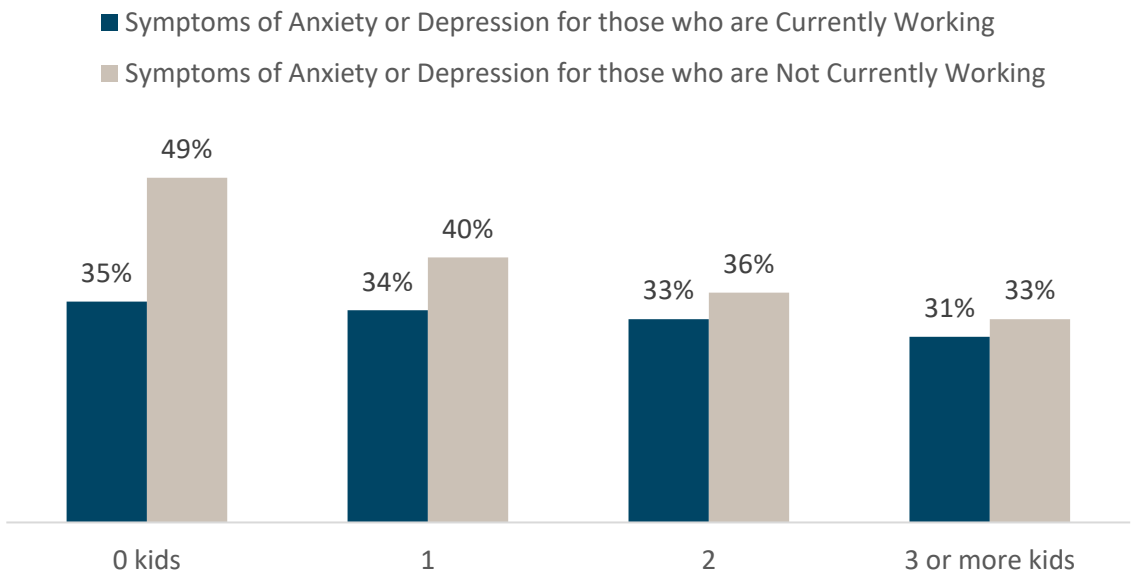
Figure 15. Symptoms of Anxiety/Depression: Work Status & Difficulty Meeting Expenses



Adjusted for age, gender, education, race/ethnicity, income, ability to meet expenses, marital status, number of children in household, and insurance status.

Having children in the household seems to have a beneficial effect on mental health, especially for those who are not currently working (Figure 16).

Figure 16. Symptoms of Anxiety/Depression: Work Status & Number of Kids in Household

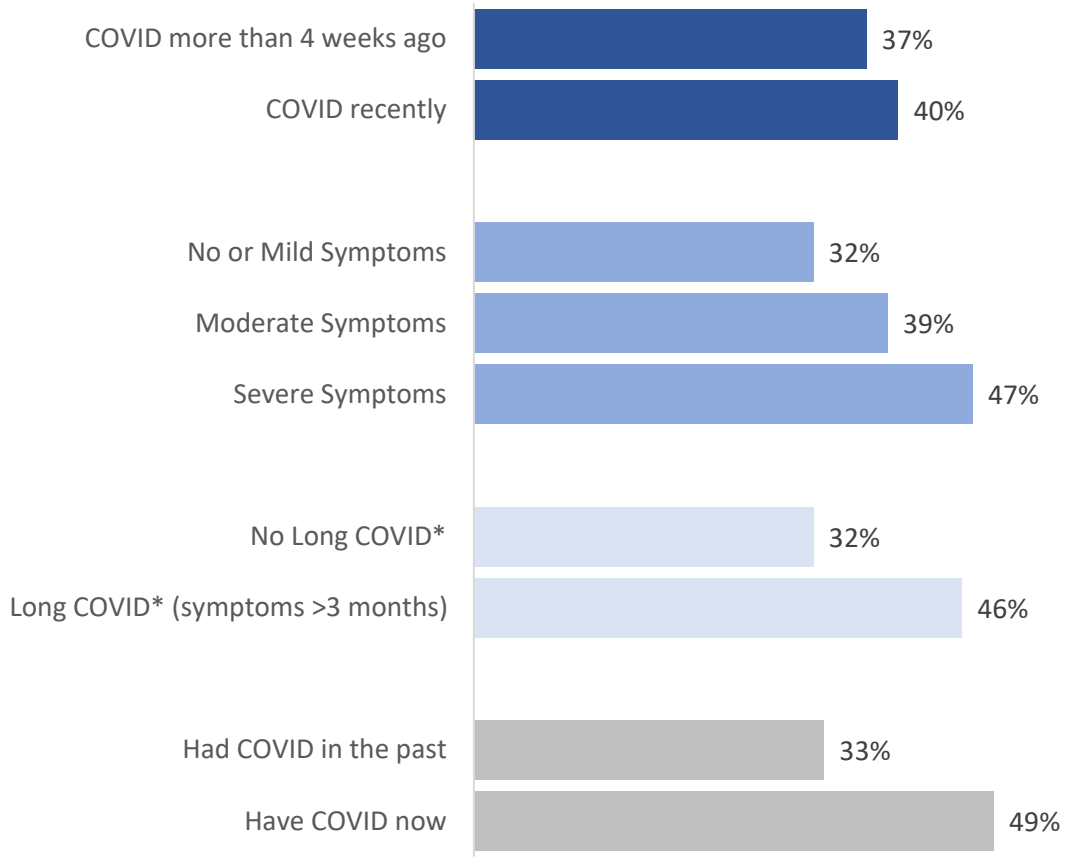


Adjusted for age, gender, education, race/ethnicity, income, ability to meet expenses, marital status, number of children in household, and insurance status.

COVID-19 is Associated with Symptoms of Anxiety or Depression

While anxiety and depression are not symptoms of COVID infection, respondents who reported a recent COVID infection, reported a COVID infection with moderate or severe symptoms, reported that they had Long-COVID, and reported that they had COVID at the time of survey administration were more likely to report symptoms of anxiety or depression (Figure 17).

Figure 17. Respondents who had more Recent, More Severe, or Long-COVID had a Higher Prevalence of Anxiety or Depression Symptoms

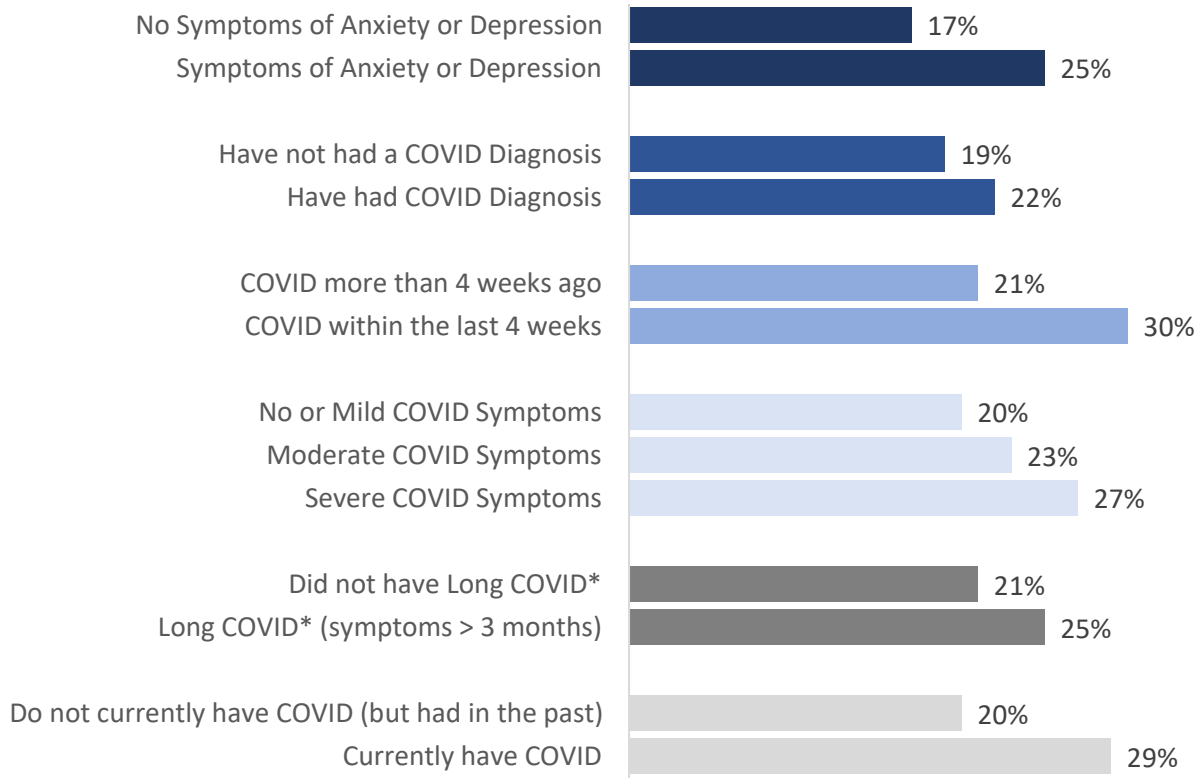


Adjusted for age, gender, education, race/ethnicity, income, ability to meet expenses, marital status, number of children in household, and insurance status.

Virtual Care Update

While the specific use cases where virtual care is especially useful are still yet to be identified, we found that respondents who reported symptoms of anxiety or depression were more likely to have **used virtual care in the last 4 weeks**. We also found that respondents who reported a higher COVID "burden" (more recent illness, more severe symptoms, longer lasting illness, or current illness) were more likely to use virtual care (Figure 18).

Figure 18. Respondents with Anxiety/Depression, with more recent COVID, more severe COVID, and Long COVID were more likely to use Virtual Care in the Last 4 Weeks



*"Virtual Care" includes medical care by either video or phone

Adjusted for age, gender, education, race/ethnicity, income, ability to meet expenses, marital status, number of children in household, and insurance status.

EMPLOYER GUIDANCE

In this study, we found that rates of depression and anxiety symptoms have decreased by 5% since the height of the pandemic among employed adults ages 18-64, and while more people have access to the medication they need, there are many who are still not getting as much evidence-based mental health support like counseling/therapy treatment as they would like. Our study revealed that, within each ethnic group, except for Hispanic, people who earned less were more likely to have symptoms of anxiety or depression. We also found that other demographic groups, such as women, younger adults, and people identifying as LGBTQ+ experience mental health symptoms at increased rates. Finally, our results indicated that while many enjoy the benefits of remote work, it is not necessarily associated with better mental health outcomes.

To put all this information into context, we were able to speak to Human Resource executives at two large national and international companies, ArcBest and Boeing, about workplace mental health support. We wanted to know about how employers had responded to the pandemic and the increased need for mental health support for the workforce. Even more importantly, we asked employers about what they are doing now and where they are looking to focus their attention in the upcoming year. Here's what we found out:

1. The pandemic greatly accelerated existing efforts in mental healthcare

Many employers had already started enhancements to mental healthcare access, and the pandemic helped to amplify this importance. Our contact at Boeing said that the pandemic "took us forward several years", as the importance of mental health care access became clear to everyone. For example, the health care strategy team was hearing reports from employees about difficulty finding available mental health providers. Boeing went to one of their large health insurers and requested additional behavioral health navigation services to help their employees gain access to a therapist. Within 4 months the health insurer had created a program that would locate a provider who was taking new patients and make the first appointment. This program was successful in getting employees the help that they needed. They are now looking to expand this type of behavioral health navigation to all Boeing employees.

Another large employer we spoke to, ArcBest, said that they had already started offering virtual care options to their employees before the pandemic. After the pandemic began, they quickly realized that they needed to increase access to care. One important first step was eliminating copays on virtual primary care and mental health care.

2. Help employees coordinate their mental healthcare with their physical healthcare

People who suffer from mental health conditions often also suffer from other chronic illnesses, such as diabetes and heart disease. However, because neglecting one condition can exacerbate the other, they often benefit from some coordination, as individuals with multiple co-morbid conditions can often have difficulty keeping up with their treatment. To support their employees in managing their health, ArcBest partnered with Included Health after an increase in diabetes management challenges among their employees. They implemented a "Life Skills Coaching" program that helped employees get the support they needed for managing their health. People using this program have demonstrated dramatic

improvements in anxiety and depression symptoms, as well as better condition management for diabetes and cardiac risk.

3. People need mental healthcare that they can identify with

Inclusivity and access to culturally appropriate care is a crucial piece of mental health care access. The Boeing health care strategy team has dug deep to identify the barriers their employees might experience in getting the health care they need. Our contact said "people need to have care that they're comfortable with and feel is valuable to them," and Boeing is acting on this value by expanding their ability to help their employees identify and access therapists that fit their diverse staff. Through examining the data, Boeing has seen that individuals use more services and that there are more people seeking help than in the past – a sure sign that people are finding the help they need.

4. Improve workplace culture and reduce stigma with peer-support networks and education

At Boeing, during the pandemic, they started a program that allowed employees to tell their own stories about mental health struggles, care, and healing. The program was immensely successful, and the employee response to requests for stories was huge. Our contact at Boeing advises, "Don't underestimate the value of an employee telling their story". At Boeing, employees were relieved to have the stigma and silence around mental health issues be lessened because their employer solicited and listened to their stories. The response from people reading the stories was also heartening. Readers were hugely supportive and left encouraging comments about how they related to the story and how these stories help and encourage others with similar struggles.

How do you get the right support out there to the people who need it? One way, suggests our executive contact at ArcBest, is to use data that you have access to and create a network of wellbeing champions, influencers, and early adopters who will help you get to those people.

At Boeing, they continue to chip away at stigma and provide mental health education. They have instituted a new program, "Mental Health Allies" to reduce stigma, improve employees' quality of life, and improve access to resources. These "Allies" are employee volunteers trained by Boeing to be resources for other employees for access to Boeing resources. Boeing is anticipating that this program will improve access and lesson stigma around mental health.

5. Be interested in proactively improving mental health outcomes across employee populations

Our contact at Arc Best asserts that people who think preventive health is important also should "also think *preventive behavioral health* is important". At ArcBest, in their Life Skills Coaching program, the first question of every coaching session is "What are struggling with today?". This focuses the coaching session on the employees' needs in the moment and lets them focus the session to their needs with solutions that work for them. This Life Skills Coaching program targets sub-clinical behavioral health. It is for all of life's challenges, including, but not limited to, relationships, nutritional support, burnout, anxiety, sleep, communication, depression, and grief. Coaches work with individual participants to set goals, create accountability, and establish longitudinal support. However, if the individual needs higher level support, the coach can triage up to higher level care, such as a psychiatrist, therapy, or virtual primary care, and coordinate access.

APPENDIX

Table 1: Sample Characteristics. US Census Household Pulse Survey weeks 34-48 (7/21/21 – 8/8/22). N=494,138

Characteristic	%
Sex	
Male	49.6%
Female	50.4%
Age	
18-24 yrs	8.0%
25-34 yrs	24.6%
35-44 yrs	25.1%
45-54 yrs	22.2%
55-64 yrs	20.2%
Race/Ethnicity	
White, non-Hispanic	61.8%
Black, non-Hispanic	10.7%
Asian, non-Hispanic	6.0%
Other/Multi-race	4.0%
Hispanic	17.5%
Educational Attainment	
High School	31.8%
Some College	21.1%
Associate degree	10.2%
Bachelors' Degree	20.7%
Graduate Degree	16.2%
Annual Household Income	
$34,999 or less	19.8%
$35,000-$49,999	10.2%
$50,000-$99,999	27.2%
$100,000 or more	31.2%
Missing	11.6%
Difficulty with Expenses	
Not/A little Difficult	67.0%
Somewhat/Very Difficult	33.1%
Marital Status	
Now Married	55.3%
Widowed/Divorced/Separated	14.0%
Never Married	30.7%
Number of Kids under 18 in Household	
None	55.8%
1	19.4%
2	15.4%
3 or more	9.4%

Table 2. Percentage Reporting Symptoms of Anxiety or Depression by Characteristic. US Census Household Pulse Survey, Weeks 34 to 48 (7/21/21 – 8/8/22). N=446,934.

Characteristic	% with Symptoms Anx/Dep	Odds Ratio (95% CI)
Race/Ethnicity		
White, non-Hispanic	37.7%	1
Black, non-Hispanic	31.0%	0.74 (0.69 - 0.80)
Asian, non-Hispanic	27.9%	0.63 (0.59 - 0.67)
Other/Multi-race	38.7%	1.10 (1.02 - 1.19)
Hispanic	33.1%	0.90 (0.84 - 0.95)
Annual Household Income		
Less than $50,000	38.2%	1.33 (1.28 - 1.39)
$50,000 or more	34.3%	1
Difficulty with Expenses		
Not/A little Difficult	25.4%	1
Somewhat/Very Difficult	55.9%	4.1 (3.9 - 4.2)
Sex/Gender		
Male	32.6%	1
Female	38.2%	1.3 (1.3 - 1.4)
LGBTQ+		
Straight/Cis-gender	33.6%	1
LGBTQ+	49.0%	2.1 (2.0 - 2.2)
Age		
18-24 yrs	43.1%	1
25-34 yrs	41.0%	0.91 (0.84 - 0.98)
35-44 yrs	37.2%	0.76 (0.70 - 0.83)
45-54 yrs	31.8%	0.57 (0.52 - 0.61)
55-64 yrs	27.3%	0.44 (0.41 - 0.48)
Educational Attainment		
High School	34.5%	1
Some College	37.6%	1.17 (1.12 - 1.23)
Associate's Degree	35.9%	1.08 (1.02 - 1.13)
Bachelors' Degree	35.3%	1.04 (0.99 - 1.09)
Graduate Degree	34.3%	0.99 (0.95 - 1.03)
Marital Status		
Now Married	33.6%	1
Widowed/Divorced/Separated	38.7%	1.30 (1.25 - 1.36)
Never Married	37.2%	1.21 (1.16 - 1.26)
Number of Kids under 18 in Household		
None	36.5%	1
1	35.7%	0.96 (0.92 - 0.99)
2	34.0%	0.88 (0.84 - 0.92)
3 or more	31.6%	0.77 (0.73 - 0.81)
Insurance		
Private Health Insurance	34.6%	1
Public Health Insurance	37.2%	1.14 (1.09 - 1.18)
Uninsured	36.8%	1.12 (1.04 - 1.19)