



America's Forgotten Orphans

An Urgent Call for the White House and Congress to
Address Childhood Bereavement



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Contributors

Evermore is a national nonpartisan nonprofit organization dedicated to advancing bereavement care for all bereaved children and families. We believe in a healthy and prosperous future for everyone in America. If you are interested in advancing bereavement science, advocating for meaningful policy change, and seeding bereavement innovation in local communities, join us at www.live-evermore.org.

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Letter from Evermore Leadership

Dear legislators and policy makers,

More than 2.2 million children under the age of eighteen in the United States have experienced the death of a co-resident parent. As a result of their loss, many of these children face significant physical, social, and economic hardships. **Yet upwards of 95 percent of these parentally bereaved children are at risk of being left behind by federal lawmakers, philanthropists, and other public figures who seek to prioritize support for children who have lost a parent to COVID-19. We emphatically disagree with this targeted approach, which focuses on a single cause of death.**

Rather, we believe that all parentally bereaved children, regardless of what caused their parents' death, deserve the chance to pursue a healthy and prosperous future. We believe America should support the children who have been bereaved by overdose, suicide, homicide, traffic fatalities, maternal mortality, and all other causes of death, including heart attacks and strokes, in addition to those orphaned by COVID-19.

When compared to nonbereaved children, parentally bereaved children are at heightened risk of academic failure, mental illness, substance abuse, violent crime, self-harm, suicide attempts, suicide, and premature death from all causes. The death of a parent becomes an initiating event, leaving children vulnerable to these and many other risks that can alter the trajectory of their lives. An orphaned child's potential for lifelong success, well-being, and prosperity depends on the support he or she receives soon after bereavement. This is a crisis hiding in plain sight.

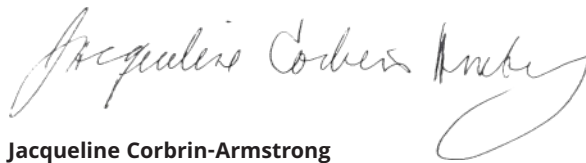
We believe it's time for change, not just in America but also across the globe. Unfortunately, bereavement remains absent from the United Nations Sustainable Development Goals, a significant driver of the world's philanthropy. To our knowledge, there is no individual, charitable organization, or foundation seeking to codify bereavement policy, systems, and science and thereby achieve large-scale transformational social change.

In the following pages, we offer not only some of the statistics of parentally bereaved children in America but also a policy road map. (Notably, we examine only *parentally* bereaved children in this report, not situations in which children experience the deaths of siblings, extended family, or close friends, even though each of these losses carries its own unique grief patterns and potential for poor life outcomes. There is so much to be done.) **It is our promise to you—and the children of this nation—that we will continue to fight until that policy road map becomes reality. We hope you will join us.**



Joyal Mulheron

Founder & Executive Director, Evermore



Jacqueline Corbrin-Armstrong

Chair, Board of Directors



Letter from Our Founding Contributor



Since 2015, Veros Technologies has been a proud partner of Evermore in advancing bereavement care for all bereaved children and families. As a values-first company focused on serving others, we aim to support organizations that advance the health and well-being of marginalized populations. Evermore has been one of our first—and most steadfast—partners. We are honored to support its mission.

Evermore works with urgency to address the ripple effects that bereavement has on individuals, families, and communities following a loss. Often, these people and groups are not adequately supported or equipped to cope with the practical complexities of grief.

We are proud to stand with Evermore as it shines a light on the needs of our grieving families and friends. Only when our nation is better educated about the deep impact of grief will our communities and employers be equipped to drive meaningful change for those who mourn.

A handwritten signature in black ink, appearing to read "BDenny".

Brian Denny
CEO, Veros Technologies





Part I

**Bereavement Is a Social, Economic, and Health Crisis:
The Fierce Urgency of Now**

Executive Summary

At the time of this writing, many politicians and other stakeholders are making the case that federal support should be provided only to children who have lost a parent or caregiver to COVID-19.¹ Their efforts have been so successful that the Biden administration has codified its support for a COVID-only strategy in the National COVID-19 Preparedness Plan.²

If the United States advances a national policy agenda that exclusively supports children who are parentally bereaved as a result of COVID-19, such as the plan being circulated in current policy proposals, more than 95 percent of America’s parentally bereaved children will be left behind. This amounts to more than two million children—see page 36.

Evermore calls on Congress and the Biden administration to create a coordinated, evidence-based, substantive approach to addressing the growing childhood bereavement crisis in the United States, regardless of the parents’ or caregivers’ cause of death.

Bereavement Is a Gateway to Other Public Emergencies

As of 2022, there are 2.2 million parentally bereaved children* in the United States (see tables 1 and 4), accounting for 3 percent of the nation’s 73 million children.† Extensive evidence indicates that bereavement serves as a significant risk factor for a wide variety of serious conditions. Bereaved children face an array of hardships that pervade every aspect of their lives, creating formidable, and in some cases insurmountable, obstacles to their long-term health, economic security, and social stability. Compared to nonbereaved children, bereaved children are at higher risk of academic failure,³ depression,⁴ alcohol and substance misuse,⁵ violent crime,⁶ suicide attempts,⁷ suicide,⁸ and premature death from any cause.⁹ In addition, there is preliminary evidence that a significant proportion of incarcerated youth experienced the death of a loved one prior to incarceration.^{10,11} Each of these is a public health emergency in its own right. Exposure to death may pave the way or even accelerate children toward situations that threaten their health, and in some cases even their lives.

* Parentally bereaved children are defined as children and adolescents under the age of eighteen who have experienced the death of a co-resident parent—that is, a parent who lives in the same home with the children. These may be biological children, stepchildren, or adopted children (see page 52). Note that we do not differentiate between children who have lost one versus both parents. Also note that for a child under the age of eighteen to experience the death of both parents is rare, in terms of both of deaths specific to COVID-19 and all-cause deaths.

† Evermore calculation using IPUMS USA data; see https://usa.ipums.org/usa-action/variables/NCHILD#description_section. Evermore includes each of the fifty states and Washington, DC, in this estimate.



Bereavement Is an Urgent Health Concern for Children of All Races and Ethnicities

In 2021, childhood bereavement reached a twenty-year high because of America's concurrency of mortality epidemics, rising in nearly every state in the nation and across every racial and ethnic group (see figure 1).



Indigenous Children Are in Crisis

Given the disproportionate variations in bereavement rates among racial and ethnic populations, state rankings are affected by the racial and ethnic composition of their child populations (see figure 2). This is particularly true for Indigenous children. For example, Alaska and New Mexico are two of the five states with the largest number of parentally bereaved children. This is because they both have a concentration of Indigenous children, who have a disproportionately high exposure to parental death. In Alaska, Indigenous children make up only 19 percent of the child population, but these children account for 44 percent of the bereaved child population. Similarly, in New Mexico, Indigenous children comprise 10 percent of the child population but 19 percent of the bereaved child population.

Indigenous Children

- Since 2000, Indigenous children have been parentally bereaved at a higher rate* than every other racial or ethnic group, **reaching an all-time high of 2.2 times the national rate in 2021.**

Black Children

- Black children have experienced a nearly 20 percent increase in annual rates of childhood bereavement since 2000 and an increase of 51 percent since 2013. **Their 2021 rate—579 newly bereaved children per 100,000—is second only to that of Indigenous children.**

Asian Children

- From 2000 to 2021, the annual rate of **childhood bereavement among Asian children increased by more than 22 percent.**

Hispanic Children

- From 2019 to 2020, **Hispanic children experienced a 40 percent increase in the annual rate of childhood bereavement**, the greatest single-year percentage increase in the past twenty years.

White Children

- From 2000 to 2021, the annual rate of parentally bereaved White children increased by 65 percent. As a result, as of 2020, **more than 1.3 million White children experienced bereavement during their lifetimes.**

* According to the National Cancer Institute, a rate is "the number of new cases . . . occurring in a specified population per year, usually expressed as the number of cases per 100,000."

In Bereavement, Timing Is Everything



Bereavement is neither a lifestyle choice nor a chronic disease whose origins are difficult to discern. When a child is bereaved, there is an exact inflection point at which their short- and long-term physiological, psychological, and sociological fitness are placed at risk. Immediately after a parent dies, the people who support individuals, families, and communities have a distinct and rare opportunity to intervene, thus altering the trajectory of a child's life toward stability—before his or her mental, social, and economic well-being becomes fragile and destabilized. As such, the federal

government must act right away to support the growing number of bereaved and orphaned children in America.

National Policy Agenda for All Bereaved and Orphaned Children: The Basics

Evermore's policy recommendations fall into four broad categories—those that provide economic security, those that provide access to health care, those that enable the development of community-based support programs, and those that advance investment.

Provide Economic Security for Families

1. The Social Security Administration should ensure that all bereaved children receive the Social Security benefits to which they are entitled yet which they often do not access.
2. Congress should reinstate and expand the Social Security student benefit program to provide postsecondary education benefits for all bereaved and orphaned children.
3. The Federal Trade Commission should regulate pricing practices among funeral providers and pass protections that require price transparency for consumers.
4. Congress should amend the Family and Medical Leave Act to include bereavement as an eligible event for job protection and study the feasibility of offering financial incentives to employers that provide five days of paid bereavement leave to their employees.
5. Congress should give states an incentive to ease enrollment in and increase service coordination among existing federal economic, social, and health programs that buffer vulnerable children from the shock of bereavement.

Provide Access to Health Care

1. As it does for children in the foster care system, the Centers for Medicare and Medicaid Services should extend automatic Medicaid eligibility to all bereaved and orphaned children below the age of eighteen and offer means testing and other eligibility pathways to individuals up to the age of twenty-six.
2. The Center for Medicare and Medicaid Innovation should develop reimbursement payment structures that support and promote qualified bereavement care and bereavement care systems outside the medical-industrial complex.
3. Congress should adopt the Senate appropriations language for fiscal year 2023, encouraging the Agency for Healthcare Research and Quality to develop evidence-based credentialing standards for therapeutic providers who serve as frontline bereavement responders.
4. The Health Resources and Services Administration and the Community Oriented Policing Services should institute training and support programs to prevent burnout among healthcare workers, first responders, law enforcement personnel, and others who are routinely exposed to intense death events and grief in their occupations.
5. The Health Resources and Services Administration should expand the Title V Maternal and Child Health Block Grant program to include bereavement services for families in addition to child death reviews.

Develop Supportive Community-Based Programs

1. The Agency for Healthcare Research and Quality should partner with the Department of Education to optimize telehealth availability for grieving children within school settings, which are increasingly important centers of health care for school-aged children.
2. The Department of Education should work with states and school districts to develop bereavement policies that support students who are grieving and mourning their losses.
3. The Department of Health and Human Services and the Department of Justice should commit resources to highly affected jurisdictions, ensuring that bereavement care for at-risk youth is a tenet of community-based programs aimed at reducing gang affiliation, criminal activities, and imprisonment.
4. The Department of Health and the Department of Justice should pilot new and evidence-based programs that nurture bereaved children and families.

Invest in Data Collection and Research

1. The Centers for Disease Control and Prevention and the Social Security Administration should partner with state associations to collect bereavement data on children and families.
2. Congress should direct the National Institutes of Health to establish a National Center of Excellence in Bereavement Care.
3. The Centers for Disease Control and Prevention should expand the definitions of adverse childhood experiences (ACEs) and social determinants of health (SDOH) to include bereavement.
4. Congress should adopt the Senate appropriations language for fiscal year 2023, encouraging the Office of the Assistant Secretary for Planning and Evaluation, in collaboration with key divisions of the Department of Health and Human Services, to study the scope of need and best practices for high-quality evidence-based bereavement and grief services for youths and adults.

A Policy Framework for the White House and Congress

Given the escalating levels of childhood bereavement in the United States, in every racial and ethnic population, now is the moment for lawmakers to intervene and alter the course of children's lives for the better. There is a powerful correlation between bereavement and many other national public health, social, and economic emergencies—including COVID-19, overdose, homicide, suicide, maternal mortality, traffic fatalities, and disasters resulting from climate change. As such, bereavement plays a key role in bringing together a diverse array of seemingly disconnected crises because it precedes so many of them. Legislation proposed in the wake of the COVID-19 pandemic offers a rare opportunity to effect long-needed and long-awaited systemic changes by compassionately lightening the burden of bereavement, which encumbers and shortens so many lives, especially in disadvantaged populations.

The Imperative of National Leadership

Between 2019 and 2021, our national life expectancy—an index of overall population health—dropped by more than three years for males and two years for females. Because of this, people throughout America are experiencing high levels of bereavement and its potential for pernicious consequences.¹² The dramatic 6.6-year drop in life expectancy among Indigenous populations, coupled with the findings of this report—that childhood bereavement among Indigenous children reached an all-time high of 2.2 times the national rate in 2021 (see figure 1)—demonstrate the urgent need for our nation's leadership to ensure parity of prosperity. As a nation, we have not experienced such a precipitous drop in life expectancy in all racial and ethnic groups since 1943, during World War II.¹³

The implications of these statistics are sobering. They indicate not only that many middle-aged people of child-bearing and child-rearing years are dying but also that many children and adolescents are losing their parents, grandparents, aunts, uncles, and mentors. Because of the scale of loss, bereavement under tragic and often traumatic circumstances has now become a commonplace fact of life for many US residents. Further, COVID-19 and our nation's other concurrent mortality epidemics have set back progress in closing the racial gap in quality of health by years and, in some cases, by decades.^{14,15}

The White House and members of Congress, regardless of political affiliation, should act immediately and in the best interest of all the nation's bereaved and orphaned children. The unexpected death of a loved one poses a dual threat to our national well-being: it is both one of the most common major life stressors and the single worst lifetime experience, as reported by Americans in national surveys.¹⁶ Losing a loved one not only is a personal tragedy but also casts a long shadow that can extend for decades, placing surviving parents, children, siblings, and spouses at significant risk for impaired health, premature death, and underachievement.

Bereavement Policy As a National Priority

Bereavement’s long-standing absence from public policy debates and national health priorities, along with its newfound urgency, requires an exploratory approach to policy making. Evermore’s agenda identifies and addresses gaps in current federal programs, examines former programs that resulted in improved outcomes for bereaved children and families, and expands or emulates other model social programs. Our approach to policy is that it serves as the scaffolding for individual and family well-being, stability, and prosperity. Our agenda is not monolithic in its attempt to “solve” bereavement: rather, it is continual and will evolve over time, but undoubtedly we must get started.



Policy is complicated in its conception, and its challenges multiply with execution and implementation, particularly when new factors, actors, and nuances emerge. As bereavement is gradually integrated into national priorities and agendas, new best practices will emerge as we evolve toward a holistic and systematic approach to serving children and families in the aftermath of death.

Based on the 2022 estimates of childhood bereavement data from this report, with every day the nation waits, another 850 children experience the death of a parent (see appendix 4, table 4B), thus challenging their ability to attain health and prosperity. Failure to take immediate action would be unconscionable and irresponsible.

National Policy Agenda for All Bereaved and Orphaned Children: The Details

While there are many elements to creating a comprehensive and holistic strategy for bereaved children and families. Evermore’s policy agenda provides the foundation that local programs, policies, and support agencies can build on, as well as suggestions for creating future evidence-based policies and programs.

As such, our agenda includes four imperatives that collectively provide the scaffolding for a broad policy agenda:

- (1) provide economic security for families,
- (2) provide access to health care,
- (3) develop supportive community-based programs, and
- (4) invest in data collection and research.



1. PROVIDE ECONOMIC SECURITY FOR FAMILIES



The Social Security Administration should ensure that all bereaved children receive the Social Security benefits to which they are entitled yet which they often do not access.

Of the nation's two million children who have a deceased biological mother or father, only an estimated 45 percent receive Social Security benefits. The number of fully orphaned children receiving the benefit is similarly low—49 percent.¹⁷

But when Social Security and other government programs are accessed, evidence suggests that child well-being is stabilized,

thus plausibly facilitating better educational, health, and economic outcomes—a benefit not only to individuals but also to the nation in terms of elevated human capital, productivity, and innovation.¹⁸ Conversely, as a result of not receiving Social Security benefits, bereaved children are more likely to fail academically, grow up in poverty, and suffer from low lifetime earnings.¹⁹ To reduce lifelong poverty and inequity, the Social Security Administration should ensure that 100 percent of eligible bereaved children are enrolled in the Social Security benefit program.

Congress should reinstate and expand the Social Security student benefit program to provide postsecondary education benefits for all bereaved and orphaned children.

For nearly a century, Congress recognized the unique needs of children, particularly those who experienced the death of a parent. In 1935, as an amendment to the Social Security Act, Congress expanded the law to include family benefits, including those for bereaved and orphaned children under the age of sixteen (or under age eighteen, if the child was enrolled in school full-time). In 1972, the House Committee on Ways and Means concluded that “a child who cannot look to a father for support . . . is at a disadvantage in completing his education,” whether in college or vocational school.²⁰ In response, the committee provided postsecondary benefits to children up to age twenty-two to facilitate the completion of a four-year college degree.²¹ Since the elimination of this benefit, in 1982, researchers have found that college enrollment dropped by an estimated 18 percent among bereaved and orphaned children.²² Congress should reinstate the Social Security student benefit program for all bereaved and orphaned children.

The Federal Trade Commission should regulate pricing practices among funeral providers and pass protections that require price transparency for consumers.

In 1982, the Federal Trade Commission (FTC) released its Funeral Rule after discovering widespread deceptive practices in the funeral industry that limited consumers' ability to make informed decisions.²³ The Funeral Rule was aimed at prohibiting these practices; however, it has not successfully done so. In 1996, the Funeral Rule Offenders Program (FROP) was launched to address these persistent violations. But FROP is operated by the National Funeral Directors Association, an industry lobbying group, which means that offending funeral homes pay only 0.8 percent of their average gross income in penalties and remain anonymous to the general public, thus depriving consumers of important information that could protect them from predatory pricing practices.²⁴ Recent FTC undercover investigations²⁵ have found that funeral homes continue to offend yet are protected by FROP from the court of public opinion and the public's elected representatives. In October of 2022, the FTC provided advance notice of proposed changes to the Funeral Rule.²⁶ The notice outlines the intent to address funeral homes' failure to furnish accurate price information,²⁷ their requirement that consumers purchase services in bulk,²⁸ and their imposition of a fee for embalment without consumer authorization where embalming is not required by law.²⁹ The timing of the proposed changes is unclear, and they may be challenged in court.



Congress should amend the Family and Medical Leave Act to include bereavement as an eligible event for job protection and study the feasibility of offering financial incentives to employers that provide five days of paid bereavement leave to their employees.

Bereavement is currently not acceptable grounds for taking unpaid leave under the Family and Medical Leave Act, despite recent efforts to add it. According to the Bureau of Labor Statistics, as of March 2020, only 58 percent of American workers have access to paid funeral leave. While 83 percent of the top 10 percent of wage earners have access to this benefit, the figure drops to 14 percent and 25 percent for the lowest 10 percent and 25 percent of wage earners respectively.³⁰ Congress should pass a law requiring that employers grant five days of bereavement leave to each employee, thus ensuring job protection following a death event. Further, Congress should consider offering incentives to employers that continue to pay wages during bereavement leave, thus ensuring benefit parity between low-paid and high-paid workers.

Congress should give states an incentive to ease enrollment in and increase service coordination among existing federal economic, social, and health programs that buffer vulnerable children from the shock of bereavement.

By some estimates, there are more than eighty means-tested federal support programs.^{31,32} These programs largely provide two forms of assistance: healthcare security and income security, both pillars of Evermore's policy agenda. There is some evidence that when bereaved children access federal programs, they are generally not as likely to experience greater poverty or hardship than their nonbereaved peers.³³ Yet those same bereaved children are more likely to be expelled from school, be excluded from classes for gifted children, and have a disability.³⁴ Of note, researchers have found that the younger a child is when a parental death occurs, the more likely that death is to cause cumulative hardship that follows a child for life.³⁵ These hardships exacerbate racial and socioeconomic inequities, making upward mobility a substantial challenge for bereaved children and families. Congress should give states an incentive to enhance service coordination among existing federal programs, thus buffering vulnerable children from the shock of the death of a parent or guardian and thereby supporting children and families in crisis.



2. PROVIDE ACCESS TO HEALTH CARE



As it does for children in the foster care system, the Centers for Medicare and Medicaid Services should extend automatic Medicaid eligibility to all bereaved and orphaned children below the age of eighteen and offer means testing and other eligibility pathways to individuals up to the age of twenty-six.

Childhood bereavement is a social and health risk that can render a child uninsured or underinsured. It also places children at risk of poor health outcomes. It remains unknown just how many of the nation's 2.2 million bereaved and orphaned children are currently enrolled in Medicaid and the Children's Health Insurance Program, which provide health insurance coverage to nearly thirty-nine million children, including many children of diverse racial and ethnic backgrounds. However, racial and ethnic bias in the quality of pediatric care delivery is well documented.³⁶ These biases place additional hardships on grieving families by compounding negative social determinants. The Centers for Medicare and Medicaid Services (CMS) should extend automatic Medicaid eligibility to all bereaved and orphaned children up to the age of twenty-six, consistent with the Affordable Care Act. In addition, as it does for children in the foster care system, CMS should extend automatic Medicaid eligibility to all bereaved and orphaned children below the age of eighteen, with continued coverage up to the age of twenty-six for individuals with significant health and health-related needs.

The Center for Medicare and Medicaid Innovation should develop reimbursement payment structures that support and promote qualified bereavement care and bereavement care systems outside the medical-industrial complex.

Reimbursable bereavement care is an important strategy for shifting the focus of the nation's healthcare payment and delivery systems toward the prevention of disease and poor outcomes. Bereavement providers may exist within healthcare systems, but more often they exist within communities (such as Rotary clubs and food pantries) and understand the multidimensional challenges families face. The Centers for Medicare and Medicaid Services should consider reimbursing these providers if they meet eligibility and certification standards. Reimbursing providers outside medical settings may also help prevent the overmedicalization of bereavement and overpathologizing of grief. Indeed, the great majority of bereaved individuals grieve within the normative-adaptive range, which does not require specialized therapeutic intervention.^{37,38} Rather, normative grief reactions may instead benefit from community-based support measures that promote adaptive coping and adjustment instead of, or in addition to, clinical diagnosis and therapeutic intervention, which requires specialized training and can be very costly. The Centers for Medicare and Medicaid Innovation should pilot new payment and delivery systems among qualified bereavement providers.

Congress should adopt the Senate appropriations language for fiscal year 2023, encouraging the Agency for Healthcare Research and Quality to develop evidence-based credentialing standards for therapeutic providers who serve as frontline bereavement responders.

Today, therapists and social workers can self-identify as having the skills and training needed to serve bereaved families simply by checking a box stating that they will accept patients experiencing grief. Notably, grief can result from many conditions, including job loss, divorce, relationship breakups, and limb amputation. Bereavement, by contrast, is the loss of a loved one through death, and given the vast variation in causes of death, therapeutic professionals should retain demonstrated competencies in subspecialties. For example, a bereaved child who loses a parent to cancer may receive hospice support but experience severe financial hardship in the aftermath. Or a bereaved child who loses a parent to homicide may experience prolonged judicial proceedings in which the value of a parent's life is continually compared to the value of an incarcerated individual's life, a situation that may be sensationalized by the media without family consent. Current standards are thus too lax, allowing unqualified professionals to clinically practice mental-health bereavement care without proper training. This type of cavalier practice endangers well-being, risks lives—in the case of suicidal individuals—and can add to the profound pain bereaved children and families face. It also runs contrary to basic tenets of responsible professional care that are hallmarks of evidence-based medicine and evidence-based mental-health practice.



Quality providers are a necessary component of any comprehensive public health strategy. In this sense, bereavement care merits national attention and a resource investment of the kind that trauma-informed care has enjoyed for the past twenty years. As proposed in the Senate Labor, Health and Human Services, Education, and Related Agencies appropriations bill for fiscal year 2023,³⁹ the Agency for Healthcare Research and Quality (AHRQ) should develop evidence-based consensus standards for therapeutic responders by convening panels of experts in bereavement and bereavement care (including those well versed in the longitudinal effects of bereavement, assessment and diagnosis, specialized clinical care, general support, and peer support) as well as experts in public health, healthcare payment structures and financing, clinical practice, and quality measures. Drawing defined scope-of-practices standards will help develop a trained professional workforce that can attend to the diagnosis, treatment (where applicable), stabilization, functional coping, and adaptive processing of bereaved individuals. Congress should adopt the Senate appropriations language for fiscal year 2023 when the bill goes to conference, thereby encouraging AHRQ to develop evidence-based credentialing standards for therapeutic providers who serve as frontline bereavement responders.



The Health Resources and Services Administration and the Community Oriented Policing Services should institute training and support programs to prevent burnout among healthcare workers, first responders, law enforcement personnel, and others who are routinely exposed to intense death events and grief in their occupations.

Prolonged exposure to death poses a real risk of secondary traumatic stress and burnout, both of which diminish a professional's ability to respond in a compassionate manner. Equally sobering, these prolonged exposures also place providers themselves at risk—not only of poor physical and mental health⁴⁰ but also of suicide, particularly among women.⁴¹ Although

clinicians, emergency services personnel, and law enforcement officials receive training that enables them to perform the technical aspects of their jobs, when it comes to their most sensitive and difficult duties—such as next-of-kin notification—limited evidence indicates that many of these dedicated professionals have received little or no training or guidance in how to communicate news of a death compassionately and respectfully.^{42,43} As a result, death notification and bereavement care are often performed in a suboptimal manner, which can further victimize and potentially traumatize individuals and families. Since interactions with healthcare workers and death-scene investigators can either positively or negatively influence a family's experience and long-term ability to cope, the White House should direct the Department of Health and Human Services' Health Resources and Services Administration and the Department of Justice's Community Oriented Policing Services to develop professional bereavement-care resources and tools to support frontline responders throughout the United States.

The Health Resources and Services Administration should expand the Title V Maternal and Child Health Block Grant program to include bereavement services for families in addition to child death reviews.

Today, 98 percent of all infants and 60 percent of all children, including those with special needs, have access to health care and public health services as part of the Title V Maternal and Child Health Block Grant program (MCH).⁴⁴ The degree of overlap between current MCH beneficiaries and children who are parentally bereaved or orphaned remains unknown; however, in many states, MCH funds are used to conduct child death reviews. Yet little or no attention is directed toward bereavement care or programming. The White House should work with the Health Resources and Services Administration to expand the definition of "preventive and primary care services" under MCH, thus enabling states to attend to the health needs of bereaved and orphaned children.



3. DEVELOP SUPPORTIVE COMMUNITY-BASED PROGRAMS

The Agency for Healthcare Research and Quality should partner with the Department of Education to optimize telehealth availability for grieving children within school settings, which are increasingly important centers of health care for school-age children.

On any given school day, nearly fifty million children attend public school in the United States, and close to five million children attend private school.⁴⁵ As such, schools are a logical touch point for the delivery of health and social services, particularly for children who face substantial hardship and adversity and lack frequent or consistent care from the conventional healthcare sector. Investments in telehealth technology, which can expand services and provide subspecialty care within school settings, can help remove barriers to needed care. Telehealth services can also reduce marginalization and maladaptive coping for even the most hard-to-reach children. In addition, as the United States moves toward achieving clinical and cost parity between in-person care and telehealth, ensuring that bereavement and associated support services are readily accessible and timely enables teachers to focus on pedagogy, optimizes taxpayer investments, and allows children and families to access care within their communities. For these reasons, the Agency for Healthcare Research and Quality should develop school-based telehealth resources to attend to the physical and behavioral needs of grieving students.



The Department of Education should work with states and school districts to develop bereavement policies that support students who are grieving and mourning their losses.

According to the Department of Education, more than seventy-three million students attended schools in 2020. This figure includes students at every level, from those in kindergarten to those in postsecondary institutions (e.g., colleges and universities).^{46,47} As concurrent mortality epidemics sweep the nation, students are not immune from the toll that death has taken on families. By some estimates, 40 percent of university students have experienced the death of a loved one in the previous two years;⁴⁸ however, while the number of bereavement-leave policies aimed at supporting students in school settings has increased in the last few years, they are the exception, not the rule.⁴⁹ By Evermore's estimates, approximately four of five parentally bereaved children are of primary and secondary school age.

One notable difference between primary and secondary institutions and colleges and universities is the way they identify the children who are at risk. In primary and secondary settings, schools could offer parents and guardians the ability to report a child's bereavement status during the annual student registration process, much as they can report health concerns (e.g., allergies), guardians' occupational status (e.g., parents who are in the military), and academic challenges (e.g., dyslexia). Where reporting of bereavement status is available, additional support and accommodations may be offered. Research indicates that school-age bereaved children, including those who have lost a maternal grandmother, are at higher risk of academic failure than their nonbereaved counterparts.^{50,51} Depending on who has died in the household, other insecurities may ensue, resulting in food, housing, and/or healthcare insecurity. These insecurities, along with the demands of academic rigor and competition, can accumulate and impair a student's ability to succeed. Currently, there is no mechanism through which schools can identify grieving children and refer them to school- or community-based resources.

Beyond the ability to identify and report bereavement status, creating a policy that honors a student’s grieving and mourning may include several elements, such as

- specifying the number of days a student will be excused from class;
- determining whether the absences may be taken consecutively or otherwise;
- determining whether additional excused absences are required for out-of-state travel;
- outlining the requirements for a death certificate, obituary, or other proof of bereavement;
- offering access to grief support during the school day; and
- offering training opportunities to faculty and staff so they can better understand and support grieving students (e.g., suggesting the revision or replacement of assignments that require family trees).



The opportunity to participate in school or community-based programs should complement any existing student bereavement-leave policy, particularly for students who may not have access to these services otherwise. Preliminary evidence demonstrates that both grief and trauma interventions delivered in school settings have had some success.

Because schools increasingly serve as primary points of care for children, the Department of Education should work with states and school districts to develop bereavement policies that allow students to grieve and mourn their losses.

The Department of Health and Human Services and the Department of Justice should commit resources to highly affected jurisdictions, ensuring that bereavement care for at-risk youth is a tenet of community-based programs aimed at reducing gang affiliation, criminal activities, and imprisonment.

A study of incarcerated teens between the ages of sixteen and eighteen in California found that 77 percent of the teenagers reported experiencing a meaningful or important death prior to incarceration and that 68.8 percent had experienced at least two such deaths.⁵² Of these teenagers, more than half had lost a parent or other primary caregiver. Several reported a number of serious consequences as a result of the death, including worsening school or work performance (49.4 percent), joining or becoming more involved with a gang (33.8 percent), and undergoing a change in caregivers (13 percent). A longitudinal study in Illinois found that 88.3 percent of detained adolescents had experienced the death of at least one person close to them, with 21.3 percent experiencing the death of a caregiver, 13.9 percent experiencing the death of a sibling, and 67.6 percent experiencing the death of a close friend.⁵³ Two-thirds of the teenagers had experienced a loss resulting from violence, and two-thirds had experienced more than one loss. The subjects reported numerous adverse consequences following these deaths, including moving to a different home, separation from siblings, joining a gang, and declining grades. Detained teenagers who had experienced a loss were at least three times as likely to have a mood disorder (e.g., a major depressive episode, dysthymia, a manic episode, and a hypomanic episode) compared to those who had not experienced a loss.

Bereavement may be an overlooked and underaddressed correlate of incarceration among historically marginalized children and adolescents. Incarceration, in turn, is associated with poor physical, social, and economic health throughout the life span. Preliminary research has found that adolescent bereavement is a precipitating risk factor for juvenile delinquency and subsequent adjudication and incarceration.⁵⁴ Current practices in the juvenile incarceration system do not facilitate the detection and care of bereavement. Thus grieving youths remain at risk of incarceration, threatening their physical and mental health as well as their adaptive developmental progression and their ability to live successful and productive lives. Congress should commit specific resources to providing grieving adolescents with a pathway to opportunity, health, and long-term stability.



The Department of Health and the Department of Justice should pilot new and evidence-based programs that nurture bereaved children and families.

Evidence indicates that non-White people experience more losses earlier in life than White people do. Poverty and crime disproportionately affect historically marginalized populations, yet federal and philanthropic investments have yet to include bereavement programs and services in efforts to reduce inequities in income and health care. Communities experience these persistent hardships, many of which are social or public health crises, with little support and with outdated approaches to care.

Because large-scale investments in grief and bereavement programming have languished for decades—or, arguably, have been absent—community leaders have been filling the gap. Thousands of local bereavement micro-organizations provide a frontline response to grieving children and families. This homegrown, organic, yet fractured infrastructure of community providers has never received the federal investment that would allow it to create a coordinated, well-developed network of support for families dealing with the aftermath of a death.

Investments that retain and build local centers allow communities to adhere to their cultural norms and attitudes while remaining agile during man-made or natural crises. In addition, local providers offer “upstream” healthcare delivery, thereby helping prevent the multitude of poor health and behavioral outcomes associated with bereavement.

To spark innovation and strengthen existing evidence-based programming for grieving children and adolescents, the Department of Health and the Department of Justice should pilot new services, tools, and supports tailored to specific groups and their needs. Projects should explore the unique geographical, spiritual, and cultural factors affecting the bereavement experience and the economic stressors endured by families and communities.



4. INVEST IN DATA COLLECTION AND RESEARCH



The Centers for Disease Control and Prevention and the Social Security Administration should partner with state associations to collect bereavement data on children and families.

To date, there is no national system that collects annualized data for the many dimensions of bereavement, such as demographics (e.g., trends by race and geography), cause of death, and family kinship. As a result, bereavement as a public health and social concern remains invisible, although it is ubiquitous and carries the potential for significant medical, behavioral, and economic hardship. Using annualized data, experts can extrapolate bereavement risk factors and identify trends,

hot spots, persistent vulnerabilities, and susceptible populations as well as examine the interrelationships between death and its associated outcomes among survivors. Without epidemiological data, the nation misses an opportunity to surveil, monitor, and learn from our national epidemics and mount an effective response. To facilitate and inform future policy making and national investments, as well as develop an evidenced-based bereavement care response system, the CDC should partner with the Social Security Administration and state jurisdictions to collect bereavement data pertaining to children and families.

Congress should direct the National Institutes of Health to establish a National Center of Excellence in Bereavement Care.

Bereavement is a multidimensional problem requiring a multidimensional solution. Limited investments in understanding bereavement have been made, but no coordinated research agenda has been developed to address our most pressing priorities. In the \$45 billion annual budget of the National Institutes of Health (NIH),⁵⁵ bereavement is not ranked among the top 309 research areas.⁵⁶ One possible reason for the lack of federal investment is that no national data source provides accurate estimates of how far-reaching familial bereavement is and whether certain subgroups are particularly vulnerable to losses.⁵⁷ Instead, bereavement is often viewed as a mental health challenge or a temporary distressing condition. Indeed, grief itself is an individual and iterative process, but bereavement's exogenous shock irrevocably alters lifelong health development pathways as well as the social and economic aspects of individual lives. Given the ubiquity of bereavement and the significant poor outcomes bereaved individuals face, the NIH should establish a National Center of Excellence in Bereavement Care, which would translate research into applied science and establish a national research agenda, outlining common goals, objectives, and priorities. It would also coordinate investments aimed at achieving the most positive outcomes.

The Centers for Disease Control and Prevention should expand the definitions of adverse childhood experiences (ACEs) and social determinants of health (SDOH) to include bereavement.



Bereaved children are more likely to suffer from psychiatric disorders, behavior problems, low self-esteem, difficulty sleeping, and problems in school than their nonbereaved counterparts.⁵⁸ Longitudinal studies have found that children who experience the death of a parent are at heightened risk for depression and post-traumatic stress disorder; the risk is particularly high during the first two years after the death.⁵⁹ Bereaved children are also at risk of functional impairment, or the inability to carry out certain day-to-day activities.⁶⁰ Researchers theorize that functional impairment results from a combination of preexisting vulnerabilities, loss of family resources, and the development of maladaptive coping styles. The emotional, mental, and physical effects stemming from the death of a loved one can have serious and long-lasting consequences, including an increased risk of involvement with the justice system. Despite the evidence, the CDC does not consider bereavement to be an ACE unless the child is related to or close to someone who has completed or attempted suicide. Given the large-scale mortality crisis throughout the United States, children are exposed to death and bereavement far beyond suicide, and the scientific evidence is clear that bereavement is a demonstrated hardship that can follow a child for a lifetime.

Further, bereavement affects each of the CDC's five domains of SDOH—including economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context—and disproportionately affects people of color. Black Americans are more likely to experience the death of children, spouses, siblings, and parents than White Americans are. They are also three times as likely as White Americans to have two or more family members die by the time they reach the age of thirty.⁶¹

Black Americans are exposed to death at a younger age and more frequently than White Americans. Individuals who are exposed to death when they're young are extremely vulnerable to negative social and health outcomes for the rest of their lives. These experiences cause cumulative disadvantages, induce high levels of stress, and deplete financial resources.⁶² In addition, this report should raise alarm and a sense of urgency regarding the disproportionately high burden of childhood bereavement among historically marginalized populations, particularly Indigenous children.

Congress should adopt the Senate appropriations language for fiscal year 2023, encouraging the Office of the Assistant Secretary for Planning and Evaluation, in collaboration with key divisions of the Department of Health and Human Services, to study the scope of need and best practices for high-quality evidence-based bereavement and grief services for youths and adults.

To better understand bereavement and what can be done to improve our nation's response to it, the Office of the Assistant Secretary for Planning and Evaluation should conduct a robust review of the literature with an eye toward developing strategies for (1) mediating the consequences of bereavement, (2) improving policies and systems that support families and communities during and after a death event, (3) coordinating training and workforce needs, and (4) identifying research gaps. This report, which would provide a contextual overview of the topic, should be prepared by experts from a variety of disciplines who gather preliminary and published research, including but not limited to

- current data and forthcoming research on such subjects as variations in causes of death by age, race, and geography as well as differentials in expected versus unexpected, or traumatic, deaths;
- studies of the scope of individual hardship, including bereavement's health, social, and economic ramifications as well as the unique stressors surviving children confront;
- early-stage analytics regarding the economic consequences of a death and related opportunity indicators that may be lost in the aftermath of death;
- state-of-the-science systems modeling key intervention and program points that may produce large-scale positive outcomes for families; and
- studies connecting the human toll of bereavement to policy and systems change.

The report should explore the extent of the problem, its implications on family function, its impact on health, its differential impact on communities, and its economic ramifications for families. It should also propose new methods for addressing family stability, function, and well-being from a systems perspective.

The best way to initiate the report is for Congress to adopt the Senate appropriations language for fiscal year 2023, encouraging the Office of the Assistant Secretary for Planning and Evaluation, in collaboration with key divisions of the Department of Health and Human Services, to begin the process.



The Growing Burden of Bereavement: Facts and Figures

In the United States in 2021, the rate at which children were being parentally bereaved was higher than at any time in the last twenty years, in every state in the nation but two, and in every racial and ethnic category. And right now, our nation's leadership has a unique opportunity to foster strong futures for America's 2.2 million bereaved and orphaned children. Attending to these children is not only the right and humane thing to do but also the strategy that carries the greatest economic and social benefit for the country.

Unequivocally, COVID-19 continues to be a global threat. It has also exacerbated preexisting racial disparities in health and longevity. As a result, Congress and the Biden administration are considering a singular national strategy to attend to children who have lost a parent or caregiver to COVID-19.

The problem is that a singular national COVID-19 strategy will leave behind more than 95 percent of all bereaved and orphaned children in America.

In the United States, the annual rate of parentally bereaved children was higher in 2021 than it has been for more than twenty years. But the uptick was not just the result of the COVID-19 pandemic; there were also related increases in mortality from other causes.⁶³ Beyond heart disease and cancer, the leading causes of death in the United States, these other epidemics have robbed the lives of millions of Americans in their prime childbearing and caretaking years.

Consider the following statistics:

- homicide rates rose more than 35 percent from 2019 to 2020;⁶⁴
- overdose deaths rose 30 percent from 2019 to 2020⁶⁵ but fell between 2020 and 2021 by only 15 percent, resulting in a net increase;⁶⁶
- traffic fatalities increased to more than 40,000 in 2020;⁶⁷ and
- suicide remains one of the top ten leading causes of death among people between the ages of ten and sixty-four and the second-leading cause of death among people between the ages of ten and fourteen and twenty-five and thirty-four.⁶⁸

Regardless of geography and race—**and regardless of the cause**—Americans are being affected by concerning public health trends that spill over to children, resulting in their experiencing the death of a co-resident parent. These troubling statistics reflect the plight of real bereaved children—not just a set of numbers—who face a cascading set of social, psychological, and economic complications that compound their other hardships, including poverty, food insecurity, and housing insecurity, among others.

TABLE 1. NUMBER OF CHILDREN UNDER AGE EIGHTEEN WHO HAVE EXPERIENCED THE DEATH OF A CO-RESIDENT PARENT DURING THEIR LIFETIMES BY RACE AND STATE, 2020

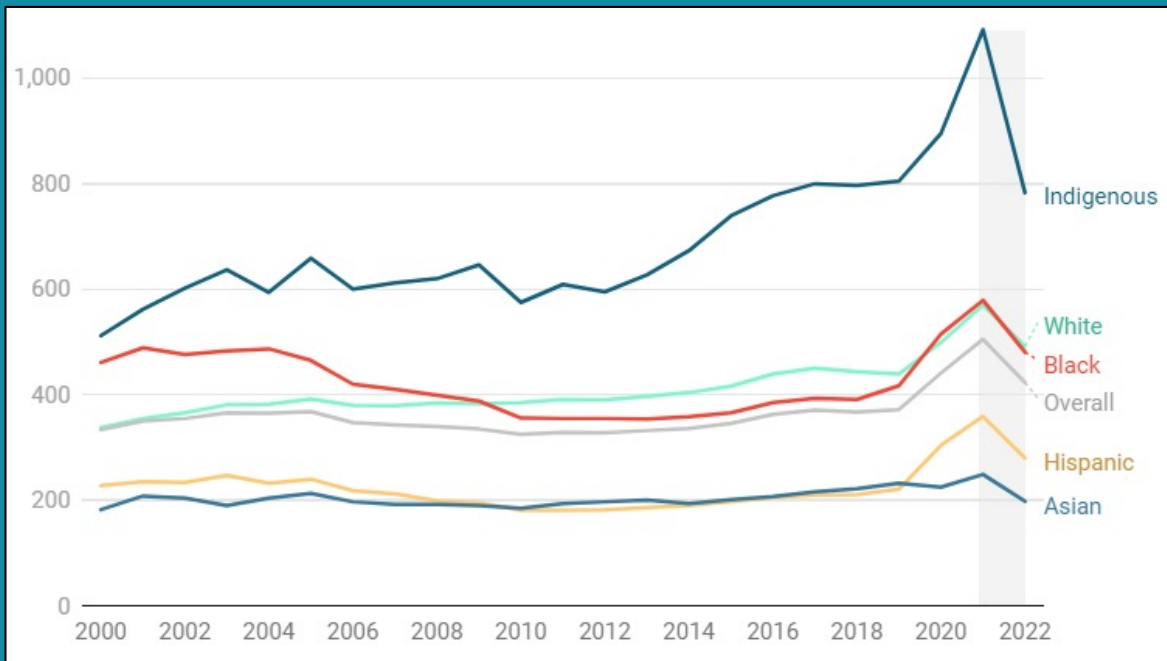
Location	Rank	Total	Black	Indigenous	Asian	Hispanic	White
United States	N/A	2,201,611	392,628	37,442	75,127	382,162	1,314,251
Alabama	4	43,878	11,893	182	361	2,125	29,317
Alaska	2	7,392	156	3,263	260	164	3,549
Arizona	29	49,771	3,432	5,719	818	17,059	22,743
Arkansas	9	25,808	4,896	203	562	1,629	18,519
California	46	229,147	23,319	1,899	21,854	97,973	84,101
Colorado	42	34,404	2,209	446	832	9,496	21,421
Connecticut	33	21,561	3,299	41	594	3,467	14,160
Delaware	15	7,079	1,848	0	190	549	4,493
District of Columbia	27	3,930	2,948	12	57	330	583
Florida	22	136,995	30,758	344	2,873	26,083	76,936
Georgia	25	77,861	29,097	244	1,786	6,127	40,607
Hawaii	41	8,249	249	13	5,119	1,129	1,739
Idaho	44	12,009	195	387	239	1,634	9,555
Illinois	36	81,797	17,988	181	2,237	15,172	46,219
Indiana	19	51,924	7,909	189	515	4,191	39,119
Iowa	50	17,763	1,194	122	264	1,318	14,866
Kansas	31	20,936	2,340	336	510	2,680	15,070
Kentucky	5	40,226	3,585	36	557	1,069	34,979
Louisiana	8	40,276	14,687	185	458	1,886	23,061
Maine	13	8,607	266	115	181	80	7,964
Maryland	21	43,134	16,877	214	1,406	3,482	21,155
Massachusetts	37	38,225	3,810	91	1,235	4,306	28,784
Michigan	20	70,654	15,894	537	1,277	4,164	48,782
Minnesota	51	29,900	4,480	1,437	1,381	1,675	20,927
Mississippi	6	26,552	10,943	162	219	524	14,704
Missouri	16	47,126	8,795	190	619	2,611	34,911
Montana	11	8,118	53	2,052	56	243	5,714
Nebraska	48	11,960	1,645	366	252	1,125	8,573
Nevada	28	20,995	3,227	315	1,351	5,437	10,664
New Hampshire	23	8,230	72	17	151	229	7,762
New Jersey	30	58,394	11,093	98	2,633	10,573	33,997
New Mexico	3	19,467	370	3,619	204	10,686	4,589
New York	40	111,472	25,636	435	5,378	19,739	60,284
North Carolina	26	70,774	17,379	1,089	1,397	6,719	44,190
North Dakota	35	5,171	270	1,149	24	185	3,544
Ohio	14	89,384	14,422	240	1,229	3,520	69,972

Location	Rank	Total	Black	Indigenous	Asian	Hispanic	White
Oklahoma	12	33,401	3,464	4,403	442	3,961	21,131
Oregon	47	22,230	1,051	421	888	3,392	16,478
Pennsylvania	18	88,055	15,266	255	1,670	6,825	64,039
Rhode Island	32	6,019	884	18	275	748	4,094
South Carolina	17	37,948	11,297	164	406	1,954	24,127
South Dakota	38	6,051	122	1,886	0	183	3,859
Tennessee	10	54,856	11,128	357	785	2,527	40,058
Texas	45	192,141	29,594	757	5,404	75,813	80,573
Utah	34	27,431	558	559	865	3,239	22,210
Vermont	24	3,578	135	0	51	83	3,309
Virginia	39	51,754	13,000	70	1,789	3,969	32,926
Washington	49	41,517	3,388	1,547	2,503	6,260	27,820
West Virginia	1	18,507	761	76	67	481	17,123
Wisconsin	43	33,946	4,667	501	876	2,564	25,338
Wyoming	7	5,007	81	500	26	786	3,613

NOTE: See Appendix 5 for methodology; DATA SOURCE: Estimates produced using modeling and data from Steven Ruggles, Sarah Flood, Ronald Goeken, Megan Schouweiler, and Matthew Sobek. IPUMS USA: Version 12.0 [American Community Survey (ACS) 2000–2019]. Minneapolis, MN: IPUMS, 2022. <https://doi.org/10.18128/D010.V12.0>; Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 1999–2020 on CDC WONDER Online Database, released in 2021. Data are from the Multiple Cause of Death Files, 1999–2020, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at <http://wonder.cdc.gov/ucd-icd10.html> on July 1, 2022, 4:46:34 p.m.

FIGURE 1.

ANNUAL RATE (PER 100,000) OF CHILDREN UNDER AGE EIGHTEEN NEWLY BEREAVED BY THE DEATH OF A CO-RESIDENT PARENT IN THE PREVIOUS YEAR BY RACE, 2000–2022*



NOTE: See Appendix 5 for methodology; DATA SOURCE: Estimates produced using modeling and data from Steven Ruggles, Sarah Flood, Ronald Goeken, Megan Schouweiler, and Matthew Sobek. IPUMS USA: Version 12.0 [American Community Survey (ACS) 2000–2019]. Minneapolis, MN: IPUMS, 2022. <https://doi.org/10.18128/DD10.V12.0>; Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System, Mortality 1999–2020 on CDC WONDER Online Database, released in 2021. Data are from the Multiple Cause of Death Files, 1999–2020, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at <http://wonder.cdc.gov/ucd-icd10.html> on July 1, 2022, 4:46:34 p.m.

*Figure made using datawrapper.de. Shaded portion denotes provisional data. Estimates pertain to children residing in each of the fifty states and Washington, DC, as shown in appendix 4, table 4D.



Racial Differences in Childhood Bereavement



Of the 2.2 million parentally bereaved children in the United States in 2020, more than 1.3 million were White, nearly 400,000 were Black, nearly 400,000 were Hispanic, approximately 75,000 were Asian, and approximately 37,000 were Indigenous (see table 1).^{*69-73} The annual rates are disproportionately high for Indigenous and Black children (see Figure 1). Indigenous children experienced the death of a parent at a rate of 1,092 per 100,000 (2.2 times higher than the national rate of childhood bereavement of 505 per 100,000 in 2021), and Black children experienced the death of a parent at a rate of 579 per 100,000 (1.15 times the national rate).

In 2021, the number of parentally bereaved children reached a twenty-year high of 370,000, rising significantly in nearly every state and in every racial and ethnic group (see appendix 4, table 4B). In absolute numbers, the highest increase was from 2019 to 2020—50,000, more than four times the previous high of 12,000, between 2015 and 2016 (see appendix 4, table 4B).

In figure 1, the area related to 2021 and 2022 is shaded because the estimates are based on provisional data from CDC WONDER. Recognizing the provisional nature of these estimates, we included them to show likely patterns through 2022. The 2021 estimates are the highest of any period for each race or ethnicity, while 2022 returns to levels similar to those of 2020. These massive per capita numbers mean that more than 300,000 children were parentally bereaved each year from 2020 through 2022, reaching a high of nearly 370,000 in 2021—a 20 percent increase over 2020, during which there was a similar increase over 2019 (see appendix 4 for specific values).

* For the purposes of this study, the White, Black, Asian, and Indigenous classifications do not include Hispanic children. For example, “Black children” means non-Hispanic Black children; “White children” means non-Hispanic White children. Children of Hispanic ethnicity are included in the Hispanic classification. Evermore analysis uses the CDC WONDER classifications of races and ethnicities, in which people who are identified as Hispanic and any other race are recorded as Hispanic. Otherwise, respondents are recorded as White, Black, Asian, or Indigenous. The demographic survey data from the American Community Survey via IPUMS USA are recorded slightly differently, because the survey includes the option for respondents to identify themselves as being of more than one race. To align these demographic data with the mortality data, Evermore recorded people who identify themselves as being of more than one race as a member of the race of greatest disadvantage (e.g., if a respondent identified himself or herself as both White and Black, he or she was recorded as Black).

Black Children

- The rate of childhood bereavement for Black children has increased by nearly 20 percent since 2000 and 51 percent since 2013. The 2020 rate of 579 newly bereaved children per 100,000 is second only to that of Indigenous children.
- Racial inequities in bereavement are magnified across the lives of Black Americans, who are more likely than White Americans to experience the deaths of children, siblings, spouses, and parents.
- As of 2020, approximately 3.5 percent of Black children—nearly 400,000—have experienced the loss of a co-resident parent during their lifetimes.
- The annual rate of parentally bereaved Black children declined from 2000 through 2013.
- The increase in the rate of childhood bereavement in Black children since the 2010s is the second highest of any race, behind only that of Indigenous children.

Indigenous Children

- Since 2000, Indigenous children have experienced higher rates of parental death than every other racial group, reaching a high of 2.2 times the national rate in 2020, up from 1.4 times the national rate in 2000. Any successful national strategy must address the disproportionate burden that bereaved and orphaned Indigenous children continue to experience.
- More than one in every 100 Indigenous children experienced the death of a parent in 2021, more than double the rate in 2000.
- Nearly seven in 100 Indigenous children under age eighteen have experienced the death of a co-resident parent during their lifetimes.

Asian Children

- From 2000 to 2021, the rate of childhood bereavement among Asian children increased by more than 35 percent (rising from 183 to 249 per 100,000).
- The rate of childhood bereavement among Asian children remained comparable with that of Hispanic children until 2020, when the Hispanic rate surged ahead of the Asian rate.
- Childhood bereavement is lowest among Asian children, with 2 percent having been bereaved at some point in their lifetimes, slightly lower than the percentage of Hispanic children.

Hispanic Children

- The annual rate of childhood bereavement Hispanic children rose by 40 percent between 2000 and 2020, from 222 to 304 per 100,000.
- By the end of 2020, around 2.1 percent of Hispanic children had experienced the loss of a co-resident parent in their lifetimes. This figure of nearly 400,000 children is comparable in raw numbers to that of Black children, despite their lower per capita numbers.
- The annual rate of childhood bereavement among Hispanic children was relatively stable from 2000 to 2019, though it decreased to a low of 181 per 100,000 between 2010 and 2012 before gradually increasing to 221 per 100,000 in 2019, similar to the per capita numbers in 2000.
- Between 2019 and 2020, the annual rate of childhood bereavement increased by 40 percent among Hispanic children, the greatest single-year percentage increase in the past twenty years.

White Children

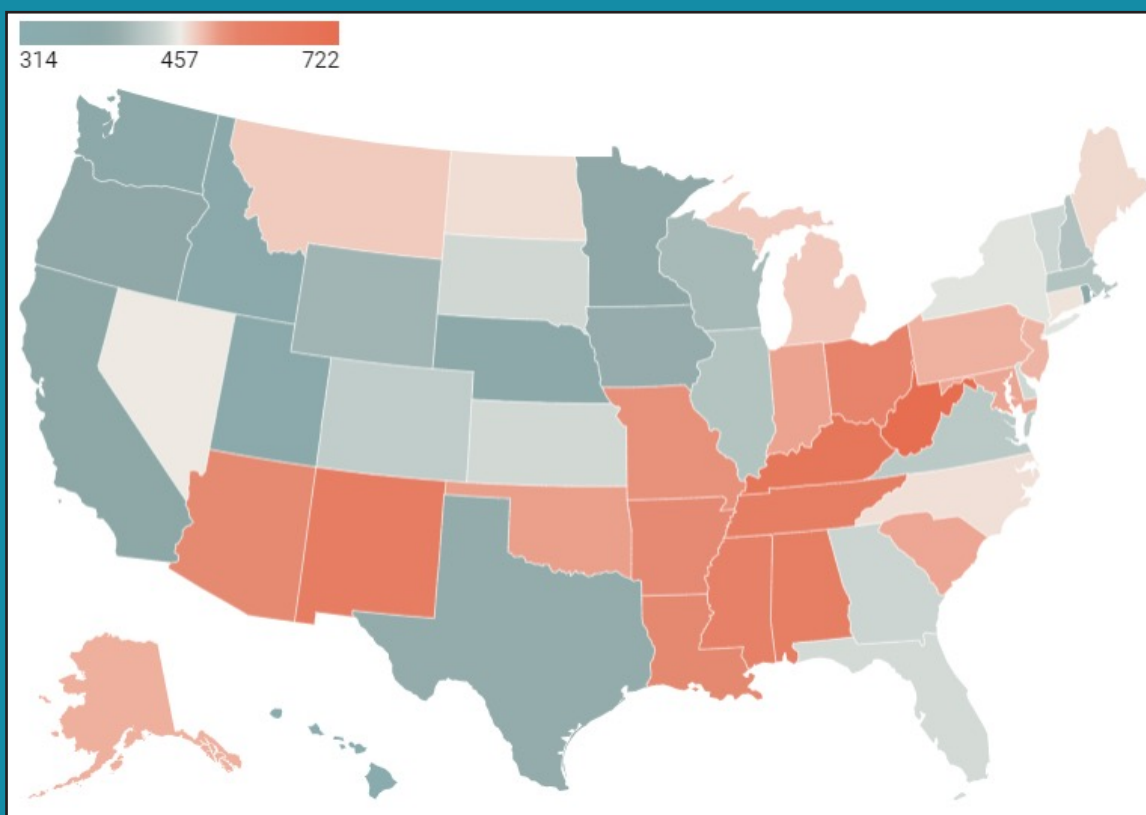
- Between 2000 and 2020, the annual rate of parentally bereaved White children has steadily increased, from 341 to 499 per 100,000—a 50 percent rise.
- Even prior to the COVID-19 pandemic, between 2000 and 2019, the rate of parental death rose by 30 percent.
- At the end of 2020, more than 1.3 million White children—nearly 3.5 percent of the nation's total of 38.8 million White children—had experienced the loss of a co-resident parent.
- In the early 2000s, White children had lower rates of parental loss than Black children; in the late 2010s, the rates of parental death for Black and White children were comparable; subsequently, in 2020, the rate experienced by Black children surged ahead again.



Analyzing Trends by State

In 2020, twenty-five states had rates of parental bereavement higher than the national rate, while twenty-six states had lower rates (see figure 2). Hawaii had the lowest rate of parentally bereaved children, at 325 per 100,000, less than three-quarters of the national rate. West Virginia had the highest rate of parentally bereaved children, at 722 per 100,000, 65 percent higher than the national rate.

FIGURE 2. ANNUAL RATE (PER 100,000) OF CHILDREN UNDER AGE EIGHTEEN BEREAVED BY THE DEATH OF A CO-RESIDENT PARENT BY STATE, 2020*



NOTE: See Appendix 5 for methodology; DATA SOURCE: Estimates produced using modeling and data from Steven Ruggles, Sarah Flood, Ronald Goeken, Megan Schouweiler, and Matthew Sobek. IPUMS USA: Version 12.0 [American Community Survey (ACS) 2000–2019]. Minneapolis, MN: IPUMS, 2022. <https://doi.org/10.18128/D010.V12.0>; Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 1999–2020 on CDC WONDER Online Database, released in 2021. Data are from the Multiple Cause of Death Files, 1999–2020, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at <http://wonder.cdc.gov/ucd-icd10.html> on July 1, 2022, 4:46:34 p.m.

*Rates are expressed in terms of the number of bereaved children per 100,000 in their populations. That is, the child bereavement rate was calculated by dividing the number of bereaved children by the total number of children and then multiplying the resulting number by 100,000. The website datwrpper.de was used to generate this figure.



All-Cause Bereavement Between 2020 and 2021

Across the nation, the annual rate of childhood bereavement—from all causes—increased significantly among all racial and ethnic groups from 2020 to 2021 (see figure 1).

Black Children

- The rate of bereavement among Black children increased by 28 percent from 2019 to 2020 and an additional 13 percent from 2020 to 2021.

Indigenous Children

- The rate of Indigenous bereavement increased 1.5 times faster than the rate of White bereavement—the highest increase of any racial or ethnic group.

Asian Children

- The number of bereaved Asian children increased by 10 percent, half the increase of Indigenous children.

Hispanic Children

- Hispanic children experienced a 20 percent increase in the rate of childhood bereavement, the second-highest increase behind that of Indigenous children.

White Children

- The absolute number of bereaved White children increased by nearly 30,000, from 190,000 to 220,000.



Assessing the Impact of Covid-19

Unequivocally, COVID-19 has reshaped our nation's health, disaster preparedness, and political priorities. More than one million people have died in the United States from the disease, leaving behind an estimated eight to nine million individuals who have lost a loved one.⁷⁰ The bereavement associated with these deaths is profound.

We estimate that 25,500 children were parentally bereaved by COVID-19 in 2020 and more than 93,000 were bereaved from 2020 to 2022. Approximately 38,600 White children, 15,300 Black children, 2,800 Indigenous children, 4,300 Asian children, and 32,300 Hispanic children will have experienced the death of a co-resident parent from the disease by the end of 2022 (see table 2). State variations range from 40 children in Vermont to 3,400 children in Texas in 2020 (see table 3).*

Yet in 2020, the total parentally bereaved child population was 2.2 million, including the children who lost a co-resident parent to COVID-19 (see table 4). Just in 2020–2022 alone, around 93,000 out of one million children who lost a parent did so because of COVID-19—that's fewer than 10 percent. In other words, more than 900,000 children were bereaved by other causes. This figure includes 160,000 Black, 13,000 Indigenous, 20,000 Asian, 140,000 Hispanic, and 570,000 White children. The point is that **these are huge numbers of children—many of whom are recently bereaved—to leave behind when formulating a national strategy and making decisions about resource allocation (see table 4).**

*The CDC mortality data for 2021 and 2022 are provisional, and 2022 data are partial. As the CDC finalizes its mortality data, Evermore will update these calculations.

TABLE 2. NUMBER OF CHILDREN UNDER AGE EIGHTEEN WHO EXPERIENCED THE DEATH OF A CO-RESIDENT PARENT BY CAUSE AND RACE, 2020–2022

Cause	Black	Indigenous	Asian	Hispanic	White	Total
Bereaved by COVID-19	15,335	2,829	4,299	32,289	38,614	93,364
Bereaved by other causes	161,388	12,662	20,351	143,258	567,406	905,067
Bereaved by all causes	176,723	15,491	24,650	175,547	606,020	998,431

*NOTE: See Appendix 5 for methodology. DATA SOURCE: Estimates produced using modeling and data from Steven Ruggles, Sarah Flood, Ronald Goeken, Megan Schouweiler, and Matthew Sobek. IPUMS USA: Version 12.0 [American Community Survey (ACS) 2000–2019]. Minneapolis, MN: IPUMS, 2022. <https://doi.org/10.18128/D010.V12.0>.

TABLE 3. NUMBER OF CHILDREN UNDER AGE EIGHTEEN WHO EXPERIENCED THE DEATH OF A CO-RESIDENT PARENT BY CAUSE AND STATE, 2020–2022

Location	Bereaved by COVID-19			Bereaved by All Other Causes		
	2020	2021	2022	2020	2021	2022
United States	25,483	50,333	17,548	295,762	318,115	291,190
Alabama	359	1,127	306	5,580	6,089	5,420
Alaska	170	187	139	680	896	678
Arizona	823	1,705	470	7,352	8,089	7,044
Arkansas	294	577	213	3,627	4,146	3,574
California	3,475	6,509	2,015	29,989	32,372	30,280
Colorado	285	608	231	4,977	5,561	4,755
Connecticut	284	298	196	2,780	2,790	2,633
Delaware	129	152	99	677	828	655
District of Columbia	55	52	37	318	297	243
Florida	955	3,969	695	17,583	18,813	17,504
Georgia	661	2,234	487	10,423	11,343	9,995
Hawaii	112	127	82	386	373	391
Idaho	168	276	122	1,443	1,740	1,561
Illinois	964	1,183	613	10,605	10,864	10,464
Indiana	358	801	410	7,362	7,814	7,078
Iowa	215	298	191	2,527	2,706	2,124
Kansas	254	406	215	2,642	2,971	2,772
Kentucky	243	759	335	5,963	6,380	5,456
Louisiana	336	710	206	5,110	5,741	4,726
Maine	122	115	82	980	1,206	1,213
Maryland	446	567	295	6,099	6,000	5,448

Location	Bereaved by COVID-19			Bereaved by All Other Causes		
	2020	2021	2022	2020	2021	2022
Massachusetts	322	343	224	5,036	5,205	5,021
Michigan	519	1,351	476	9,383	9,921	9,202
Minnesota	325	442	225	4,578	5,165	4,450
Mississippi	244	627	236	3,659	3,780	3,286
Missouri	301	775	399	6,693	7,143	6,127
Montana	114	151	77	992	1,191	1,051
Nebraska	208	198	131	1,446	1,653	1,376
Nevada	300	565	187	2,506	2,782	2,594
New Hampshire	167	170	142	850	955	955
New Jersey	1,266	858	366	7,795	7,817	7,331
New Mexico	291	563	209	2,764	3,184	2,801
New York	2,714	1,669	736	14,786	14,890	14,505
North Carolina	492	1,553	530	10,151	11,209	10,646
North Dakota	139	153	107	570	599	546
Ohio	427	1,653	720	13,077	13,673	12,284
Oklahoma	315	810	279	4,155	4,670	4,312
Oregon	211	348	155	2,967	3,699	3,357
Pennsylvania	515	1,407	691	11,814	12,322	11,402
Rhode Island	109	120	74	545	593	597
South Carolina	274	930	277	5,406	5,849	5,418
South Dakota	202	200	160	689	868	693
Tennessee	398	1,427	414	8,586	9,511	8,524
Texas	3,437	8,463	1,961	26,342	28,123	27,027
Utah	264	422	199	2,994	3,303	3,046
Vermont	41	49	26	427	476	509
Virginia	58	842	408	7,271	7,761	6,211
Washington	237	601	211	5,502	6,289	6,112
West Virginia	173	359	164	2,525	2,809	2,486
Wisconsin	286	477	236	4,780	5,184	4,951
Wyoming	128	147	90	370	470	356

NOTE: See Appendix 5 for methodology. Also note that approximately one-fourth of COVID-19 deaths occurred in 2020; thus a slightly higher proportion of children would be classified as being bereaved by COVID-19 if data from 2021–2022 were analyzed. Note that the CDC has released only provisional data for 2021 and 2022 and partial data for 2022. DATA SOURCE: Estimates produced using modeling and data from Steven Ruggles, Sarah Flood, Ronald Goeken, Megan Schouweiler, and Matthew Sobek. IPUMS USA: Version 12.0 [American Community Survey (ACS) 2000–2019]. Minneapolis, MN: IPUMS, 2022. <https://doi.org/10.18128/D010.V12.0>; Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 1999–2022 on CDC WONDER Online Database, released in 2021. Data are from the Multiple Cause of Death Files, 1999–2022, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at <http://wonder.cdc.gov/ucd-icd10.html> on July 1, 2022, 4:46:34 p.m.

*Note that approximately one-fourth of COVID-19 deaths occurred in 2020; thus a slightly higher proportion of children would be classified as being bereaved by COVID-19 if data from 2021–2022 were analyzed. Note that the CDC has released only provisional data for 2021 and 2022 and partial data for 2022.

TABLE 4. PERCENTAGE OF CHILDREN UNDER AGE EIGHTEEN WHO EXPERIENCED THE DEATH OF A CO-RESIDENT PARENT DURING THEIR LIFETIMES WHO WILL BE LEFT BEHIND BY A COVID-ONLY NATIONAL STRATEGY, 2020

Location	Children Bereaved by COVID-19	Children Bereaved by All Causes	Percentage of Children Left Behind
United States	25,483	2,176,163	98.8
Alabama	359	43,473	99.2
Alaska	170	7,387	97.7
Arizona	823	48,767	98.3
Arkansas	294	25,573	8.9
California	3,475	225,341	98.5
Colorado	285	34,137	99.2
Connecticut	284	21,359	98.7
Delaware	129	7,050	98.2
District of Columbia	55	3,877	98.6
Florida	955	135,869	99.3
Georgia	661	77,039	99.1
Hawaii	112	8,244	98.6
Idaho	168	11,964	98.6
Illinois	964	80,653	98.8
Indiana	358	51,566	99.3
Iowa	215	17,612	98.8
Kansas	254	20,758	98.8
Kentucky	243	40,089	99.4
Louisiana	336	39,887	99.2
Maine	122	8,601	98.6
Maryland	446	42,610	99.0
Massachusetts	322	37,919	99.2
Michigan	519	70,059	99.3
Minnesota	325	29,639	98.9
Mississippi	244	26,231	99.1
Missouri	301	46,833	99.4
Montana	114	8,048	98.6
Nebraska	208	11,857	98.2
Nevada	300	20,698	98.6
New Hampshire	167	8,220	98.0
New Jersey	1,266	56,978	97.8
New Mexico	291	19,136	98.5
New York	2,714	108,552	97.5

Location	Children Bereaved by COVID-19	Children Bereaved by All Causes	Percentage of Children Left Behind
North Carolina	492	70,264	99.3
North Dakota	139	5,131	97.3
Ohio	427	88,868	99.5
Oklahoma	315	33,114	99.0
Oregon	211	22,152	99.0
Pennsylvania	515	87,464	99.4
Rhode Island	109	5,991	98.2
South Carolina	274	37,685	99.3
South Dakota	202	5,995	96.6
Tennessee	398	54,441	99.3
Texas	3,437	188,298	98.2
Utah	264	27,265	99.0
Vermont	41	3,578	98.9
Virginia	358	51,418	99.3
Washington	237	41,308	99.4
West Virginia	173	18,452	99.1
Wisconsin	286	33,713	99.2
Wyoming	128	4,999	97.4

NOTE: See Appendix 5 for methodology. Also note that Evermore focuses on 2020 for these estimates, given the provisional nature of CDC mortality data for 2021 and 2022. DATA SOURCE: Estimates produced using modeling and data from Steven Ruggles, Sarah Flood, Ronald Goeken, Megan Schouweiler, and Matthew Sobek. IPUMS USA: Version 12.0 [American Community Survey (ACS) 2000–2019]. Minneapolis, MN: IPUMS, 2022. <https://doi.org/10.18128/D010.V12.0>; Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 1999–2020 on CDC WONDER Online Database, released in 2021. Data are from the Multiple Cause of Death Files, 1999–2020, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at <http://wonder.cdc.gov/ucd-icd10.html> on July 1, 2022, 4:46:34 p.m.

A person is seen from behind, holding a large, glowing paper lantern. The lantern is illuminated from within, casting a warm, orange and yellow light. The person's hands are visible at the top of the lantern's frame. The background is a soft, hazy sky with a gradient of colors from light blue to a pale orange, suggesting a sunset or sunrise. The overall mood is peaceful and contemplative.

Part II
Appendixes

Appendix 1: National Fact Sheet

Childhood Bereavement National Fact Sheet

In the United States, 2,200,000 parentally bereaved and orphaned children account for 3 percent of the total child population in the United States.

More than 2.2 million US children (under age eighteen) have experienced the death of a parent or caregiver. These children are at higher risk of academic failure, substance misuse, suicide attempts, suicide, and premature death from any cause than their nonbereaved peers.

In the United States in 2021, the rate at which children were being parentally bereaved was higher than at any time in the last twenty years, in every state in the nation but two, and in every racial and ethnic category. The time to act is now.

Of the 2,200,000 parentally bereaved children in the United States, 30,000 have had a parent die from COVID-19. This means that as of 2020 in the United States, 2,170,000 parentally bereaved children, or *approximately 99 percent of parentally bereaved children in all racial and ethnic groups*, will be left behind if the federal government pursues a COVID-only national response.

**NUMBER OF PARENTALLY BEREAVED CHILDREN
UNDER AGE EIGHTEEN IN THE UNITED STATES BY CAUSE AND RACE, 2020**

	Black	Indigenous	Asian	Hispanic	White	Total
Total number of children	11,225,599	559,275	3,671,974	18,617,684	38,840,398	72,911,930
Number of children who have been parentally bereaved in their lifetimes	392,628	37,442	75,127	382,162	1,314,251	2,201,611
Percentage of child population that is parentally bereaved	3.5%	6.7%	2.0%	2.1%	3.4%	3.0%
Number of children parentally bereaved in the previous year by all causes	57,763	5,005	8,224	56,608	193,625	321,245
Number of children parentally bereaved in the previous year by COVID-19	4,918	1,256	1,775	11,631	5,905	25,483
Percentage of bereaved children excluded in a COVID-only national strategy	98.7%	96.6%	97.6%	97.0%	99.6%	98.8%

SOURCE: Estimates produced using modeling and data from Steven Ruggles, Sarah Flood, Ronald Goeken, Megan Schouweiler, and Matthew Sobek. IPUMS USA: Version 12.0 [American Community Survey (ACS) 2000–2019]. Minneapolis, MN: IPUMS, 2022. <https://doi.org/10.18128/D010.V12.0>; Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics. source: Estimates produced using modeling and data from Steven Ruggles, Sarah Flood, Ronald Goeken, Megan Schouweiler, and Matthew Sobek. IPUMS USA: Version 12.0 [American Community Survey (ACS) 2000–2019]. Minneapolis, MN: IPUMS, 2022. <https://doi.org/10.18128/D010.V12.0>; Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 1999–2020 on CDC WONDER Online Database, released in 2021. Data are from the Multiple Cause of Death Files, 1999–20210, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at <http://wonder.cdc.gov/ucd-icd10.html> on July 1, 2022, 4:46:34 p.m.

*Because of modeling differences between analyses and the fact that underlying data from CDC WONDER are based on provisional versus final numbers, Evermore caps COVID-specific estimates at previous-year estimates when there are differences in race-specific estimates between the two rows.

ROAD MAP TO A HEALTHY AND PROSPEROUS FUTURE FOR ALL CHILDREN

Evermore's policy recommendations fall into four broad categories.

PROVIDE ECONOMIC SECURITY FOR FAMILIES

1. The Social Security Administration should ensure that all bereaved children receive the Social Security benefits to which they are entitled yet which they often do not access.
2. Congress should reinstate and expand the Social Security student benefit program to provide postsecondary education benefits for all bereaved and orphaned children.
3. The Federal Trade Commission should regulate pricing practices among funeral providers and pass protections that require price transparency for consumers.
4. Congress should amend the Family and Medical Leave Act to include bereavement as an eligible event for job protection and study the feasibility of offering financial incentives to employers that provide five days of paid bereavement leave to their employees.
5. Congress should give states an incentive to ease enrollment in and increase service coordination among existing federal economic, social, and health programs that buffer vulnerable children from the shock of bereavement.

PROVIDE ACCESS TO HEALTH CARE

1. As it does for children in the foster care system, the Centers for Medicare and Medicaid Services should extend automatic Medicaid eligibility to all bereaved and orphaned children below the age of eighteen and offer means testing and other eligibility pathways to individuals up to the age of twenty-six.
2. The Center for Medicare and Medicaid Innovation should develop reimbursement payment structures that support and promote qualified bereavement care and bereavement care systems outside the medical-industrial complex.
3. Congress should adopt the Senate appropriations language for fiscal year 2023, encouraging the Agency for Healthcare Research and Quality to develop evidence-based credentialing standards for therapeutic providers who serve as frontline bereavement responders.
4. The Health Resources and Services Administration and the Community Oriented Policing Services should institute training and support programs to prevent burnout among healthcare workers, first responders, law enforcement personnel, and others who are routinely exposed to intense death events and grief in their occupations.
5. The Health Resources and Services Administration should expand the Title V Maternal and Child Health Block Grant program to include bereavement services for families in addition to child death reviews.

DEVELOP SUPPORTIVE COMMUNITY-BASED PROGRAMS

1. The Agency for Healthcare Research and Quality should partner with the Department of Education to optimize telehealth availability for grieving children within school settings, which are increasingly important centers of health care for school-age children.
2. The Department of Education should work with states and school districts to develop bereavement policies that support students who are grieving and mourning their losses.
3. The Department of Health and Human Services and the Department of Justice should commit resources to highly affected jurisdictions, ensuring that bereavement care for at-risk youth is a tenet of community-based programs aimed at reducing gang affiliation, criminal activities, and imprisonment.
4. The Department of Health and the Department of Justice should pilot new and evidence-based programs that nurture bereaved children and families.

INVEST IN DATA COLLECTION AND RESEARCH

1. The Centers for Disease Control and Prevention and the Social Security Administration should partner with state associations to collect bereavement data on children and families.
2. Congress should direct the National Institutes of Health to establish a National Center of Excellence in Bereavement Care.
3. The Centers for Disease Control and Prevention should expand the definitions of adverse childhood experiences (ACEs) and social determinants of health (SDOH) to include bereavement.
4. Congress should adopt the Senate appropriations language for fiscal year 2023, encouraging the Office of the Assistant Secretary for Planning and Evaluation, in collaboration with key divisions of the Department of Health and Human Services, to study the scope of need and best practices for high-quality evidence-based bereavement and grief services for youths and adults.

Appendix 2: State Fact Sheets

For more information on parentally bereaved children in each state, follow the links below.

1. [Alabama](#)
2. [Alaska](#)
3. [Arizona](#)
4. [Arkansas](#)
5. [California](#)
6. [Colorado](#)
7. [Connecticut](#)
8. [Delaware](#)
9. [District of Columbia](#)
10. [Florida](#)
11. [Georgia](#)
12. [Hawaii](#)
13. [Idaho](#)
14. [Illinois](#)
15. [Indiana](#)
16. [Iowa](#)
17. [Kansas](#)
18. [Kentucky](#)
19. [Louisiana](#)
20. [Maine](#)
21. [Maryland](#)
22. [Massachusetts](#)
23. [Michigan](#)
24. [Minnesota](#)
25. [Mississippi](#)
26. [Missouri](#)
27. [Montana](#)
28. [Nebraska](#)
29. [Nevada](#)
30. [New Hampshire](#)
31. [New Jersey](#)
32. [New Mexico](#)
33. [New York](#)
34. [North Carolina](#)
35. [North Dakota](#)
36. [Ohio](#)
37. [Oklahoma](#)
38. [Oregon](#)
39. [Pennsylvania](#)
40. [Rhode Island](#)
41. [South Carolina](#)
42. [South Dakota](#)
43. [Tennessee](#)
44. [Texas](#)
45. [Utah](#)
46. [Vermont](#)
47. [Virginia](#)
48. [Washington](#)
49. [West Virginia](#)
50. [Wisconsin](#)
51. [Wyoming](#)

Appendix 3: How Many Parentally Bereaved Children Live in Your Community?

To calculate how many parentally bereaved children live in your community, first determine how many children reside in your jurisdiction (e.g., city, school district, or political district). Then multiply that number by the state-specific multiplier in the table below.

It is very important to note that the smaller the total child population, the less reliable this estimate will be. The larger the population, the more reliable the estimate.

EXAMPLE: ESTIMATE OF PARENTALLY BEREAVED CHILDREN IN ARLINGTON, TEXAS

Total child population	100,700
Texas childhood bereavement multiplier	0.026
Estimate of total number of parentally bereaved children	2,618

State	Childhood bereavement multiplier, 2020
Alabama	0.040
Alaska	0.041
Arizona	0.030
Arkansas	0.037
California	0.026
Colorado	0.027
Connecticut	0.030
Delaware	0.035
District of Columbia	0.031
Florida	0.032
Georgia	0.031
Hawaii	0.028
Idaho	0.027
Illinois	0.029
Indiana	0.033
Iowa	0.025
Kansas	0.030
Kentucky	0.040
Louisiana	0.037
Maine	0.035
Maryland	0.032
Massachusetts	0.028
Michigan	0.033
Minnesota	0.023

State	Childhood bereavement multiplier, 2020
Mississippi	0.038
Missouri	0.034
Montana	0.036
Nebraska	0.025
Nevada	0.030
New Hampshire	0.032
New Jersey	0.030
New Mexico	0.041
New York	0.028
North Carolina	0.031
North Dakota	0.029
Ohio	0.035
Oklahoma	0.035
Oregon	0.026
Pennsylvania	0.034
Rhode Island	0.030
South Carolina	0.034
South Dakota	0.028
Tennessee	0.036
Texas	0.026
Utah	0.030
Vermont	0.032
Virginia	0.028
Washington	0.025
West Virginia	0.052
Wisconsin	0.027
Wyoming	0.037

NOTE: See Appendix 5 for methodology; DATA SOURCE: Estimates produced using modeling and data from Steven Ruggles, Sarah Flood, Ronald Goeken, Megan Schouweiler, and Matthew Sobek. IPUMS USA: Version 12.0 [American Community Survey (ACS) 2000–2019]. Minneapolis, MN: IPUMS, 2022. <https://doi.org/10.18128/D010.V12.0>; Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 1999–2020 on CDC WONDER Online Database, released in 2021. Data are from the Multiple Cause of Death Files, 1999–2020, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at <http://wonder.cdc.gov/ucd-icd10.html> on July 1, 2022, 4:46:34 p.m.

Appendix 4: Data Tables

TABLE 4A: ESTIMATES OF PARENTALLY BEREAVED CHILDREN BY STATE AND CAUSE, 2020

State	Rank (percentage of child population ever bereaved by any cause)	Number of children parentally bereaved in childhood by any cause in their lifetimes	Number of children parentally bereaved by any cause in 2020	Number of children parentally bereaved by COVID-19 in 2020	Total child population
United States	N/A	2,201,611	321,247	25,483	72,911,928
Alabama	4	43,878	5,939	359	1,086,191
Alaska	2	7,392	850	170	178,374
Arizona	29	49,771	8,175	823	1,638,489
Arkansas	9	25,808	3,921	294	698,580
California	46	229,147	33,464	3,475	8,879,864
Colorado	42	34,404	5,262	285	1,253,572
Connecticut	33	21,561	3,064	284	727,424
Delaware	15	7,079	806	129	203,953
District of Columbia	27	3,930	373	55	127,682
Florida	22	136,995	18,538	955	4,230,542
Georgia	25	77,861	11,084	661	2,502,012
Hawaii	41	8,249	498	112	299,909
Idaho	44	12,009	1,611	168	449,415
Illinois	36	81,797	11,569	964	2,815,256
Indiana	19	51,924	7,720	358	1,570,036
Iowa	50	17,763	2,742	215	721,021
Kansas	31	20,936	2,896	254	700,401
Kentucky	5	40,226	6,206	243	1,000,197
Louisiana	8	40,276	5,446	336	1,085,203
Maine	13	8,607	1,102	122	246,348
Maryland	21	43,134	6,545	446	1,331,209
Massachusetts	37	38,225	5,358	322	1,350,229
Michigan	20	70,654	9,902	519	2,139,769
Minnesota	51	29,900	4,903	325	1,304,810
Mississippi	6	26,552	3,903	244	698,345
Missouri	16	47,126	6,994	301	1,369,358
Montana	11	8,118	1,106	114	227,442
Nebraska	48	11,960	1,654	208	473,990
Nevada	28	20,995	2,806	300	690,646
New Hampshire	23	8,230	1,017	167	256,762
New Jersey	30	58,394	9,061	1,266	1,932,681
New Mexico	3	19,467	3,055	291	473,701
New York	40	111,472	17,500	2,714	4,017,665
North Carolina	26	70,774	10,643	492	2,293,400
North Dakota	35	5,171	709	139	177,211

State	Rank (percentage of child population ever bereaved by any cause)	Number of children parentally bereaved in childhood by any cause in their lifetimes	Number of children parentally bereaved by any cause in 2020	Number of children parentally bereaved by COVID-19 in 2020	Total child population
Ohio	14	89,384	13,504	427	2,571,440
Oklahoma	12	33,401	4,470	315	950,362
Oregon	47	22,230	3,178	211	862,749
Pennsylvania	18	88,055	12,329	515	2,626,979
Rhode Island	32	6,019	654	109	202,225
South Carolina	17	37,948	5,680	274	1,110,262
South Dakota	38	6,051	891	202	215,236
Tennessee	10	54,856	8,984	398	1,510,670
Texas	45	192,141	29,779	3,437	7,394,731
Utah	34	27,431	3,258	264	929,592
Vermont	24	3,578	468	41	112,889
Virginia	39	51,754	7,629	358	1,856,489
Washington	49	41,517	5,739	237	1,661,312
West Virginia	1	18,507	2,698	173	358,681
Wisconsin	43	33,946	5,066	286	1,261,838
Wyoming	7	5,007	498	128	134,788

NOTE: See Appendix 5 for methodology; DATA SOURCE: Estimates produced using modeling and data from Steven Ruggles, Sarah Flood, Ronald Goeken, Megan Schouweiler, and Matthew Sobek. IPUMS USA: Version 12.0 [American Community Survey (ACS) 2000–2019]. Minneapolis, MN: IPUMS, 2022. <https://doi.org/10.18128/D010.V12.0>; Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 1999–2020 on CDC WONDER Online Database, released in 2021. Data are from the Multiple Cause of Death Files, 1999–2020, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at <http://wonder.cdc.gov/ucd-icd10.html> on July 1, 2022, 4:46:34 p.m..

TABLE 4B: NUMBER OF NEWLY BEREAVED CHILDREN UNDER AGE EIGHTEEN IN THE UNITED STATES BY YEAR, REGARDLESS OF CAUSE, 2000–2022

Year	Total
2000	240,745
2001	252,609
2002	257,338
2003	266,280
2004	265,716
2005	269,016
2006	256,192
2007	253,452
2008	250,934
2009	249,559
2010	241,102
2011	242,640
2012	241,212
2013	243,749
2014	247,162
2015	254,219
2016	267,062
2017	272,971
2018	269,223

Year	Total
2018	269,223
2019	271,512
2020	321,247
2021 (preliminary estimate)	368,448
2022 (preliminary estimate)	308,738

NOTE: See Appendix 5 for methodology; DATA SOURCE: Estimates produced using modeling and data from Steven Ruggles, Sarah Flood, Ronald Goeken, Megan Schouweiler, and Matthew Sobek. IPUMS USA: Version 12.0 [American Community Survey (ACS) 2000–2019]. Minneapolis, MN: IPUMS, 2022. <https://doi.org/10.18128/D010.V12.0>; Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 1999–2020 on CDC WONDER Online Database, released in 2021. Data are from the Multiple Cause of Death Files, 1999–2020, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at <http://wonder.cdc.gov/ucd-icd10.html> on July 1, 2022, 4:46:34 p.m.

TABLE 4C: CHANGE IN THE NUMBER OF NEWLY BEREAVED CHILDREN UNDER AGE EIGHTEEN IN THE UNITED STATES BY STATE, REGARDLESS OF CAUSE, 2019–2022

State	Year	Number	Percent change
Alabama	2019	5,055	
Alabama	2020	5,939	17%
Alabama	2021	7,216	22%
Alabama	2022	5,726	-21%
Alaska	2019	850	
Alaska	2020	850	0%
Alaska	2021	1,083	27%
Alaska	2022	817	-25%
Arizona	2019	6,486	
Arizona	2020	8,175	26%
Arizona	2021	9,794	20%
Arizona	2022	7,514	-23%
Arkansas	2019	3,227	
Arkansas	2020	3,921	22%
Arkansas	2021	4,723	20%
Arkansas	2022	3,787	-20%
California	2019	26,841	
California	2020	33,464	25%
California	2021	38,881	16%
California	2022	32,295	-17%
Colorado	2019	4,479	
Colorado	2020	5,262	17%
Colorado	2021	6,169	17%
Colorado	2022	4,986	-19%
Connecticut	2019	2,614	
Connecticut	2020	3,064	17%
Connecticut	2021	3,088	1%

NOTE: See Appendix 5 for methodology; DATA SOURCE: Estimates produced using modeling and data from Steven Ruggles, Sarah Flood, Ronald Goeken, Megan Schouweiler, and Matthew Sobek. IPUMS USA: Version 12.0 [American Community Survey (ACS) 2000–2019]. Minneapolis, MN: IPUMS, 2022. <https://doi.org/10.18128/D010.V12.0>; Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 1999–2020 on CDC WONDER Online Database, released in 2021. Data are from the Multiple Cause of Death Files, 1999–2020, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at <http://wonder.cdc.gov/ucd-icd10.html> on July 1, 2022, 4:46:34 p.m.

State	Year	Number	Percent change
Delaware	2019	873	
Delaware	2020	806	-8%
Delaware	2021	980	22%
Delaware	2022	754	-23%
District of Columbia	2019	353	
District of Columbia	2020	373	6%
District of Columbia	2021	349	-6%
District of Columbia	2022	280	-20%
Florida	2019	15,831	
Florida	2020	18,538	17%
Florida	2021	22,782	23%
Florida	2022	18,199	-20%
Georgia	2019	9,142	
Georgia	2020	11,084	21%
Georgia	2021	13,577	22%
Georgia	2022	10,482	-23%
Hawaii	2019	995	
Hawaii	2020	498	-50%
Hawaii	2021	500	0%
Hawaii	2022	473	-5%
Idaho	2019	1,438	
Idaho	2020	1,611	12%
Idaho	2021	2,016	25%
Idaho	2022	1,683	-17%
Illinois	2019	9,825	
Illinois	2020	11,569	18%
Illinois	2021	12,047	4%
Illinois	2022	11,077	-8%
Indiana	2019	6,546	
Indiana	2020	7,720	18%
Indiana	2021	8,615	12%
Indiana	2022	7,488	-13%
Iowa	2019	2,507	
Iowa	2020	2,742	9%
Iowa	2021	3,004	10%
Iowa	2022	2,315	-23%
Kansas	2019	2,596	
Kansas	2020	2,896	12%
Kansas	2021	3,377	17%
Kansas	2022	2,987	-12%
Kentucky	2019	5,098	

State	Year	Number	Percent change
Kentucky	2020	6,206	22%
Kentucky	2021	7,139	15%
Kentucky	2022	5,791	-19%
Louisiana	2019	4,533	
Louisiana	2020	5,446	20%
Louisiana	2021	6,451	18%
Louisiana	2022	4,932	-24%
Maine	2019	1,107	
Maine	2020	1,102	0%
Maine	2021	1,321	20%
Maine	2022	1,295	-2%
Maryland	2019	5,608	
Maryland	2020	6,545	17%
Maryland	2021	6,567	0%
Maryland	2022	5,743	-13%
Massachusetts	2019	4,878	
Massachusetts	2020	5,358	10%
Massachusetts	2021	5,548	4%
Massachusetts	2022	5,245	-5%
Michigan	2019	8,574	
Michigan	2020	9,902	15%
Michigan	2021	11,272	14%
Michigan	2022	9,678	-14%
Minnesota	2019	4,200	
Minnesota	2020	4,903	17%
Minnesota	2021	5,607	14%
Minnesota	2022	4,675	-17%
Mississippi	2019	3,281	
Mississippi	2020	3,903	19%
Mississippi	2021	4,407	13%
Mississippi	2022	3,522	-20%
Missouri	2019	6,164	
Missouri	2020	6,994	13%
Missouri	2021	7,918	13%
Missouri	2022	6,526	-18%
Montana	2019	1,009	
Montana	2020	1,106	10%
Montana	2021	1,342	21%
Montana	2022	1,128	-16%
Nebraska	2019	1,634	
Nebraska	2020	1,654	1%

State	Year	Number	Percent change
Nebraska	2021	1,851	12%
Nebraska	2022	1,507	-19%
Nevada	2019	2,367	
Nevada	2020	2,806	19%
Nevada	2021	3,347	19%
Nevada	2022	2,781	-17%
New Hampshire	2019	1,077	
New Hampshire	2020	1,017	-6%
New Hampshire	2021	1,125	11%
New Hampshire	2022	1,097	-2%
New Jersey	2019	7,198	
New Jersey	2020	9,061	26%
New Jersey	2021	8,675	-4%
New Jersey	2022	7,697	-11%
New Mexico	2019	2,563	
New Mexico	2020	3,055	19%
New Mexico	2021	3,747	23%
New Mexico	2022	3,010	-20%
New York	2019	12,818	
New York	2020	17,500	37%
New York	2021	16,559	-5%
New York	2022	15,241	-8%
North Carolina	2019	9,029	
North Carolina	2020	10,643	18%
North Carolina	2021	12,762	20%
North Carolina	2022	11,176	-12%
North Dakota	2019	658	
North Dakota	2020	709	8%
North Dakota	2021	752	6%
North Dakota	2022	653	-13%
Ohio	2019	11,925	
Ohio	2020	13,504	13%
Ohio	2021	15,326	13%
Ohio	2022	13,004	-15%
Oklahoma	2019	4,113	
Oklahoma	2020	4,470	9%
Oklahoma	2021	5,480	23%
Oklahoma	2022	4,591	-16%
Oregon	2019	2,979	
Oregon	2020	3,178	7%
Oregon	2021	4,047	27%

State	Year	Number	Percent change
Oregon	2022	3,512	-13%
Pennsylvania	2019	11,130	
Pennsylvania	2020	12,329	11%
Pennsylvania	2021	13,729	11%
Pennsylvania	2022	12,093	-12%
Rhode Island	2019	720	
Rhode Island	2020	654	-9%
Rhode Island	2021	713	9%
Rhode Island	2022	671	-6%
South Carolina	2019	4,843	
South Carolina	2020	5,680	17%
South Carolina	2021	6,779	19%
South Carolina	2022	5,695	-16%
South Dakota	2019	854	
South Dakota	2020	891	4%
South Dakota	2021	1,068	20%
South Dakota	2022	853	-20%
Tennessee	2019	7,406	
Tennessee	2020	8,984	21%
Tennessee	2021	10,938	22%
Tennessee	2022	8,938	-18%
Texas	2019	23,651	
Texas	2020	29,779	26%
Texas	2021	36,586	23%
Texas	2022	28,988	-21%
Utah	2019	3,048	
Utah	2020	3,258	7%
Utah	2021	3,725	14%
Utah	2022	3,245	-13%
Vermont	2019	409	
Vermont	2020	468	14%
Vermont	2021	525	12%
Vermont	2022	535	2%
Virginia	2019	6,338	
Virginia	2020	7,629	20%
Virginia	2021	8,603	13%
Virginia	2022	6,619	-23%
Washington	2019	5,329	
Washington	2020	5,739	8%
Washington	2021	6,890	20%
Washington	2022	6,323	-8%

State	Year	Number	Percent change
West Virginia	2019	2,354	
West Virginia	2020	2,698	15%
West Virginia	2021	3,168	17%
West Virginia	2022	2,650	-16%
Wisconsin	2019	4,391	
Wisconsin	2020	5,066	15%
Wisconsin	2021	5,661	12%
Wisconsin	2022	5,187	-8%
Wyoming	2019	568	
Wyoming	2020	498	-12%
Wyoming	2021	617	24%
Wyoming	2022	446	-28%

NOTE: See Appendix 5 for methodology; DATA SOURCE: Estimates produced using modeling and data from Steven Ruggles, Sarah Flood, Ronald Goeken, Megan Schouweiler, and Matthew Sobek. IPUMS USA: Version 12.0 [American Community Survey (ACS) 2000–2019]. Minneapolis, MN: IPUMS, 2022. <https://doi.org/10.18128/D010.V12.0>; Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 1999–2020 on CDC WONDER Online Database, released in 2021. Data are from the Multiple Cause of Death Files, 1999–2020, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at <http://wonder.cdc.gov/ucd-icd10.html> on July 1, 2022, 4:46:34 p.m.

TABLE 4D: PARENTALLY BEREAVED CHILDREN PER 100,000 BY RACE AND YEAR, 2000–2022

Year	White	Black	Indigenous	Asian	Hispanic	Total
2000	341	444	478	183	222	332
2001	358	474	549	213	231	349
2002	369	459	569	207	229	353
2003	385	471	617	193	245	366
2004	386	477	572	208	229	365
2005	395	452	654	218	236	367
2006	382	406	584	202	212	345
2007	382	397	586	196	207	341
2008	386	389	606	197	194	338
2009	386	376	636	196	192	334
2010	387	345	549	190	177	324
2011	393	343	592	197	178	327
2012	392	343	594	202	179	326
2013	399	341	613	205	183	330
2014	406	347	669	200	187	335
2015	417	353	721	206	194	344
2016	439	370	753	213	201	360
2017	450	379	769	222	206	368
2018	444	378	773	229	207	365
2019	439	403	777	239	217	370
2020	499	515	895	225	304	441
2021	570	579	1092	249	359	505
2022	492	481	783	198	280	423

NOTE: See Appendix 5 for methodology; DATA SOURCE: Estimates produced using modeling and data from Steven Ruggles, Sarah Flood, Ronald Goeken, Megan Schouweiler, and Matthew Sobek. IPUMS USA: Version 12.0 [American Community Survey (ACS) 2000–2019]. Minneapolis, MN: IPUMS, 2022. <https://doi.org/10.18128/D010.V12.0>; Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 1999–2020 on CDC WONDER Online Database, released in 2021. Data are from the Multiple Cause of Death Files, 1999–2020, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at <http://wonder.cdc.gov/ucd-icd10.html> on July 1, 2022, 4:46:34 p.m.

Appendix 5: Methodology

Five general calculations are made in this report: **(1)** the number of newly bereaved children, defined as the number of children under age eighteen who experienced the death of a co-resident parent in a given year, regardless of cause; **(2)** the total number of bereaved children, defined as the number of children under age eighteen who have experienced the death of a co-resident parent during their lifetimes, regardless of when they experienced it and regardless of cause; **(3)** the rate of childhood bereavement as a result of COVID-19, defined as the number of children under age eighteen who experienced the death of a co-resident parent as a result of COVID-19; **(4)** the number and percentage of children left behind by a COVID-only strategy, defined as the percentage of children parentally bereaved as a result of causes other than COVID-19; and **(5)** the rankings of each state plus the District of Columbia along several bereavement measures, in which 1 has the highest rate of bereaved children per 100,000 and 51 has the lowest rate of bereaved children per 100,000. A co-resident parent is defined using the [American Community Survey \(ACS\) definition](#) of “own children,” which includes biological parents, adoptive parents, and stepparents, as long as they live in the same homes as their children.

Mortality

[CDC WONDER Underlying Cause of Death](#) is the source used for 2000–2022 mortality rates. The data were coded into five racial groups: non-Hispanic White, non-Hispanic Black, non-Hispanic Indigenous, non-Hispanic Asian, and Hispanic.

Population

[ACS data \(via IPUMS USA\)](#) were used to estimate population sizes and co-resident compositions. To merge the population and mortality data for the purpose of generating estimates, the data were coded to correspond with the [mortality data from CDC WONDER](#). Datasets were joined using age, gender, race, state, and year combinations. Although gender-specific findings are not presented, information about mortality patterns and population composition by gender improves estimates because gender plays such a prominent demographic role in the United States.

Estimates of the Number of Parentally Bereaved Children in a Given Year

The joined mortality and population data were used to estimate the number of bereaved children per racial group per state per year. The number of deaths was multiplied by the average number of co-resident children in each age, gender, race, state, and year grouping. Estimates were calculated by race, state, and year. These estimates constitute the annual rates of bereaved children.

Estimates of the Number of Children Parentally Bereaved in Their Lifetimes

Evermore calculated the number of children parentally bereaved in their lifetimes using a method similar for estimating bereavement in a given year. Mortality rates were based on age, gender, race, ethnicity, and state. For example, if a parent dies in simulation in any year from 2003 to 2020, all co-resident children under age eighteen in 2020 are categorized as bereaved. This does not include children who turned eighteen before the end of 2020. For example, if a fifteen-year-old child suffered the death of a co-resident parent in 2015, that child would not count toward the total in 2020 because he or she would have turned eighteen in 2018.

COVID-19 Bereavement

Using the same method it used to calculate annual rates, Evermore employed [COVID-only mortality data](#) to estimate COVID-19 bereavement. Once final CDC data are available for 2021 and 2022, we may find that the percentage of children newly bereaved as a result of COVID-19 in these years constitutes a slightly higher proportion of all bereaved children; however, even a substantial increase in the percentage of COVID-19-related deaths would not change the fact that COVID-19 is responsible for only a small segment of the total number of parentally bereaved children. Evermore findings indicate that over the three-year span between 2020 and 2022, around 10 percent of childhood bereavement was attributable to COVID-19: that is, around 93,000 parentally bereaved children had a co-resident parent whose death certificate lists COVID-19 as a cause, whereas approximately one million children had a co-resident parent die from other causes during those years. Based on these estimates, the total number of children who have had a co-resident parent die during their lifetimes would reach

perhaps 2.3 or 2.4 million by the end of 2022, and of those, around 4 percent would be bereaved as a result of COVID-19. Making a liberal upward adjustment on this bereavement number would result in the same conclusion: a COVID-19-focused approach to bereavement leaves out the vast majority of bereaved children. Evermore uses data through August 20, 2022, the latest available as of our analysis.

State Rankings

A state ranking is always based on rates of children parentally bereaved at any point during childhood as of 2020. A ranking of 1 indicates the highest level of bereavement, whereas a ranking of 51 indicates the lowest level of bereavement. For example, if a state ranks first in the rate of childhood bereavement, then it has the highest number of children per capita who lost a co-resident parent. If a state ranks fifty-first, then it has the lowest number of bereaved children per capita.

Sensitivity Checks, Strengths, and Limitations

Estimates of the total number of children who were bereaved at some point during their lifetimes were supplemented using [Survey of Income and Program Participation \(SIPP\) data, the same data](#) used by other scholars of the topic (see note 17). Estimates using SIPP suggest that roughly 3.1 percent of children under age eighteen experienced the death of a biological parent (regardless of residence) from 2017 to 2019. Evermore includes any co-resident parent, including biological parents, adoptive parents, and stepparents, in its calculations, which results in estimates comparable to those of Verdery et al. (see note 70). The COVID-19 estimates are dissimilar to those of Hillis et al. (see note 71) because Hillis's calculations used total excess deaths during the pandemic (that is, deaths in excess of expectations) and included caregivers in some analyses, whereas Evermore focused specifically on death certificates with COVID-19 indicated and co-resident parents.

Despite this distinction, general assumptions made in the report align with previous research (see note 71). The estimates used in this report assume that parents and nonparents are equally vulnerable to all-cause and COVID-19 mortality. This assumption is driven by the inability to match CDC mortality records with ACS population records. Notably, research suggests that households with children were more likely to contract COVID-19 early in the pandemic than households without children, given children's greater extra-household contact (e.g., school attendance). Although we do not anticipate that this significantly biases our estimates, any bias would lead to an underestimate of COVID-19 bereavement in 2020. While the report focuses on co-resident parent mortality, it is important to note that children have critical relationships with parents outside their households and with other caregivers. The focus on co-resident parents disproportionately affects Black, Hispanic, and Indigenous children because, relative to White and Asian children, a greater percentage of them live in single-parent households.

Evermore extended estimates of the number of newly bereaved children through 2022 to understand bereavement patterns after 2020. These estimates are based on provisional data (2021–2022) and data that are not yet complete (2022). In doing so, we also estimated COVID-specific bereavement through this period. However, these estimates are based on ACS data for 2019. While the underlying population characteristics are not likely to change much during the period, updated population characteristics could slightly change bereavement estimates. We accounted for CDC WONDER–censored COVID-19 mortality data by imputing estimates for subgroups with fewer than ten deaths. Evermore imputes these estimates using subgroup characteristics (e.g., population size, age, race, gender, state, year). This imputation approach accounts for some forty thousand deaths that are otherwise censored in the disaggregated CDC WONDER mortality data. Evermore will reestimate bereavement to attend to these limitations as CDC WONDER finalizes data for 2021 and 2022.

Notes

- ¹ Dan Treglia et al., “Hidden Pain: Children Who Lost a Parent or Caregiver to COVID-19 and What the Nation Can Do to Help Them,” COVID Collaborative, December 2021, https://www.covidcollaborative.us/initiatives/hidden-pain_.
- ² The White House, “National COVID-19 Preparedness Plan,” March 2022, <https://www.whitehouse.gov/wp-content/uploads/2022/03/NAT-COVID-19-PREPAREDNESS-PLAN.pdf>.
- ³ Lisa Berg et al., “Parental Death During Childhood and Subsequent School Performance,” *Pediatrics* 133, no. 4 (April 2014): 682–89, <https://pubmed.ncbi.nlm.nih.gov/24616354/>.
- ⁴ John R. Jacobs and Gregory B. Bovasso, “Re-Examining the Long-Term Effects of Experiencing Parental Death in Childhood on Adult Psychopathology,” *Journal of Nervous and Mental Disease* 197, no. 1 (January 2009): 24–27, https://journals.lww.com/jonmd/Abstract/2009/01000/Re_Examining_the_Long_Term_Effects_of_Experiencing.5.aspx.
- ⁵ Sami Hamdan et al., “Alcohol and Substance Abuse in Parentally Bereaved Youth,” *Journal of Clinical Psychiatry* 74, no. 8 (August 2013): 828–33, <https://psycnet.apa.org/record/2013-30914-008>.
- ⁶ Holly C. Wilcox et al., “Psychiatric Morbidity, Violent Crime, and Suicide Among Children and Adolescents Exposed to Parental Death,” *Journal of the American Academy of Child and Adolescent Psychiatry* 49, no. 5 (May 2010): 514–23, <https://pubmed.ncbi.nlm.nih.gov/20431471/>.
- ⁷ Ida Skytte Jakobsen and Erik Christiansen, “Young People’s Risk of Suicide Attempts in Relation to Parental Death: A Population-Based Register Study,” *Journal of Child Psychology and Psychiatry* 52, no. 2 (February 2011): 176–83, <https://acamh.onlinelibrary.wiley.com/doi/10.1111/j.1469-7610.2010.02298.x>.
- ⁸ Mai-Britt Guldin et al., “Incidence of Suicide Among Persons Who Had a Parent Who Died During Their Childhood: A Population-Based Cohort Study,” *JAMA Psychiatry* 72, no. 12 (December 2015): 1227–34, <https://jamanetwork.com/journals/jamapsychiatry/article-abstract/2469106>.
- ⁹ Guldin et al., “Incidence of Suicide.”
- ¹⁰ Julie Laken Harnisher et al., “Loss Due to Death and Its Association with Mental Disorders in Juvenile Detainees,” *Juvenile Family Court Journal* 66, no. 3 (Summer 2015): 1–18, <https://onlinelibrary.wiley.com/doi/abs/10.1111/jfcj.12029>.
- ¹¹ Steven Pham et al., “The Burden of Bereavement: Early-Onset Depression and Impairment in Youths Bereaved by Sudden Parental Death in a 7-Year Prospective Study,” *American Journal of Psychiatry* 175, no. 9 (September 2018): 887–96, <https://ajp.psychiatryonline.org/doi/10.1176/appi.ajp.2018.17070792>.
- ¹² Elizabeth Arias et al., “Provisional Life Expectancy Estimates for 2021,” National Vital Statistics System, August 2022, <https://www.cdc.gov/nchs/data/vsrr/vsrr023.pdf>.
- ¹³ Steven H. Woolf, Ryan K. Masters, and Laudan Y. Aron, “Effect of the COVID-19 Pandemic in 2020 on Life Expectancy Across Populations in the USA and Other High Income Countries: Simulations of Provisional Mortality Data,” *The BMJ* 373 (June 2021), <https://www.bmj.com/content/bmj/373/bmj.n1343.full.pdf>.
- ¹⁴ Woolf, Masters, and Aron, “Effect of the COVID-19 Pandemic.”
- ¹⁵ Magali Barbieri, “COVID-19 and the Growing Disadvantage in US Life Expectancy,” *The BMJ* 373 (June 2021), <https://www.bmj.com/content/373/bmj.n1530>.
- ¹⁶ Katherine M. Keyes et al., “The Burden of Loss: Unexpected Death of a Loved One and Psychiatric Disorders Across the Life Course in a National Study,” *American Journal of Psychiatry* 171, no. 8 (August 2014): 864–71, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4119479/>.
- ¹⁷ David Weaver, “Parental Mortality and Outcomes Among Minor and Adult Children,” *Population Review* 58, no. 2 (September 2019), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3471209.
- ¹⁸ Weaver, “Parental Mortality.”
- ¹⁹ Weaver, “Parental Mortality.”
- ²⁰ David Koitz, “Social Security Student Benefits: Issue Brief Number IB81030,” Library of Congress Congressional Research Service, February 1981, https://www.everycrsreport.com/files/19831018_IB81030_8034b8b4d238e7e94a058487b9ced4ebaa3e5d2d.pdf.

²¹ Koitz, “Social Security Student Benefits.”

²² Weaver, “Parental Mortality.”

²³ Federal Trade Commission, “Funeral Industry Practices; Trade Regulation Rule,” Federal Register 47, no. 186 (September 1982): 42260, <https://www.govinfo.gov/content/pkg/FR-1982-09-24/pdf/FR-1982-09-24.pdf>.

²⁴ Sara Marsden-Illie, “Federal Trade Commission ‘Funeral Law’ Conducts Undercover Investigations,” US Funerals Online, April 27, 2020, <https://www.us-funerals.com/ftc-undercover-investigations-funeral-law/#.YydYVezMIb1>.

²⁵ Federal Trade Commission, “FTC Undercover Investigations of Funeral Homes in Nine States Test Compliance with Funeral Rule Disclosure Requirements,” press release, March 11, 2014, <https://www.ftc.gov/news-events/news/press-releases/2014/03/ftc-undercover-inspections-funeral-homes-nine-states-test-compliance-funeral-rule-disclosure>.

²⁶ Federal Trade Commission, “Funeral Industry Practices Rule,” request for comment, https://www.ftc.gov/system/files/ftc_gov/pdf/P034410FuneralRuleANPR.pdf.

²⁷ Code of Federal Regulations, title 16, chapter 1, subchapter D, part 453 (“Funeral Industry Practices”), section 453.2(a), <https://www.law.cornell.edu/cfr/text/16/453.2>.

²⁸ Code of Federal Regulations, title 16, chapter 1, subchapter D, part 453 (“Funeral Industry Practices”), section 453.4(b), <https://www.law.cornell.edu/cfr/text/16/453.4>.

²⁹ Code of Federal Regulations, title 16, chapter 1, subchapter D, part 453 (“Funeral Industry Practices”), section 453.5(a), <https://www.law.cornell.edu/cfr/text/16/453.5>.

³⁰ Bureau of Labor Statistics, National Compensation Survey, Employee Benefits Survey, table 31, “Leave Benefits: Access, Civilian Workers,” March 2020, <https://www.bls.gov/ncs/ebs/benefits/2020/employee-benefits-in-the-united-states-march-2020.pdf>.

³¹ [Name redacted], “The ‘Superwaiver’ Proposal and Service Integration: A History of Federal Initiatives,” Congressional Research Service, April 13, 2005, https://www.everycrsreport.com/files/20050413_RL32859_3a03d353829a2ff2f23b68f4c529dcc68e8461cc.pdf.

³² General Accounting Office, “Means-Tested Programs: Determining Financial Eligibility Is Cumbersome and Can Be Simplified,” November 2, 2001, <https://www.gao.gov/products/gao-02-58#:~:text=While%20GAO's%20review%20covered%2011,these%20programs%20or%20exclude%20others>.

³³ Weaver, “Parental Mortality.”

³⁴ Weaver, “Parental Mortality.”

³⁵ Debra Umberson, “Black Deaths Matter: Race, Relationship Loss, and Effects on Survivors,” *Journal of Health and Social Behavior* 58, no. 4 (December 2017): 405–20, <https://pubmed.ncbi.nlm.nih.gov/29172766/>.

³⁶ M. Trent, D.G. Dooley, and J. Dougé, “The Impact of Racism on Child and Adolescent Health,” *Section on Adolescent Health, Council on Community Pediatrics, Committee on Adolescence, Pediatrics*, 144, no.#2 (August 2019):e20191765.

³⁷ M. Katherine Shear, “Complicated Grief,” *New England Journal of Medicine* 372 (January 2015): 153–60, <https://www.nejm.org/doi/full/10.1056/NEJMcp1315618>.

³⁸ George A. Bonanno et al., “Resilience to Loss in Bereaved Spouses, Bereaved Parents, and Bereaved Gay Men,” *Journal of Personality and Social Psychology* 88, no. 5 (May 2005): 827–43, <https://pubmed.ncbi.nlm.nih.gov/15898878/>.

³⁹ “Explanatory Statement for Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Bill, 2023: Summary of Budget Estimates and Committee Recommendations,” United States Senate Committee on Appropriations, <https://www.appropriations.senate.gov/imo/media/doc/LHHSFY23REPT.pdf>.

⁴⁰ “Addressing Health Worker Burnout: The U.S. Surgeon General’s Advisory on Building a Thriving Health Workforce,” Department of Health and Human Services, 2022, <https://www.hhs.gov/sites/default/files/health-worker-wellbeing-advisory.pdf>.

⁴¹ Frédéric Duthéil et al., “Suicide Among Physicians and Healthcare Workers: A Systematic Review and Meta-Analysis,” *PloS One* 14, no. 12 (December 2019), <https://doi.org/10.1371/journal.pone.0226361>.

⁴² Jan M. Shoenberger et al., “Death Notification in the Emergency Department: Survivors and Physicians,” *Western Journal of Emergency Medicine* 14, no. 2 (March 2013): 181–85, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3628479/>.

- ⁴³ Emily Fay et al., “Teaching the Unteachable: Educating Obstetrics and Gynecology Residents About the Patient Experience of Stillbirth,” *Obstetrics & Gynecology* 130 (October 2017), https://journals.lww.com/greenjournal/Abstract/2017/10001/Teaching_the_Unteachable__Educating_Obstetrics.44.aspx.
- ⁴⁴ Health Resources and Services Administration, “Title V Maternal and Child Health Block Grant,” <https://mchb.hrsa.gov/programs-impact/title-v-maternal-child-health-mch-block-grant>.
- ⁴⁵ National Center for Education Statistics, “Back-to-School Statistics,” <https://nces.ed.gov/fastfacts/display.asp?id=372#PK12-enrollment>.
- ⁴⁶ National Center for Education Statistics, “Back-to-School Statistics.”
- ⁴⁷ Bradley E. Cox, Jessica G. Dean, and Robin Kowalski, “Hidden Trauma, Quiet Drama: The Prominence and Consequence of Complicated Grief Among College Students,” *Journal of College Student Development* 56, no. 3 (April 2015): 280–85, https://www.researchgate.net/publication/277921722_Hidden_Trauma_Quiet_Drama_The_Prominence_and_Consequence_of_Complicated_Grief_Among_College_Students.
- ⁴⁸ Chris Cousins, Heather L. Servaty-Seib, and Jennifer Lockman, “College Student Adjustment and Coping: Bereaved and Nonbereaved Students,” *Omega—Journal of Death and Dying* 74, no. 4: 386–409, <https://journals.sagepub.com/doi/10.1177/0030222815598911>.
- ⁴⁹ Chye Hong Liew and Heather L. Servaty-Seib, “College Students’ Feedback on a Student Bereavement Leave Policy,” *Journal of Student Affairs Research and Practice* 57, no. 1 (2020): 55–68, <https://www.tandfonline.com/doi/abs/10.1080/19496591.2019.1614940?journalCode=uarp20>.
- ⁵⁰ Berg et al., “Parental Death During Childhood.”
- ⁵¹ Michelle Livings et al., “Bereavement & Mental Health: The Generational Consequences of a Grandparent’s Death,” *SSM—Mental Health* 2 (2022), <https://doi.org/10.1016/j.ssmmh.2022.100100>.
- ⁵² Amy E. Lansing et al., “Loss and Grief Among Persistently Delinquent Youth: The Contribution of Adversity Indicators and Psychopathy-Spectrum Traits to Broadband Internalizing and Externalizing Psychopathology,” *Journal of Child and Adolescent Trauma* 11, no. 8 (September 2018): 375–89, https://www.researchgate.net/publication/324063386_Loss_and_Grief_Among_Persistently_Delinquent_Youth_The_Contribution_of_Adversity_Indicators_and_Psychopathy-Spectrum_Traits_to_Broadband_Internalizing_and_Externalizing_Psychopathology.
- ⁵³ Harnisher et al., “Loss Due to Death and Its Association with Mental Disorders.”
- ⁵⁴ Lansing et al., “Loss and Grief Among Persistently Delinquent Youth”; Harnisher et al., “Loss Due to Death and Its Association with Mental Disorders.”
- ⁵⁵ National Institutes of Health budget, <https://www.nih.gov/about-nih/what-we-do/budget#:~:text=Reflects%20the%20Enacted%20FY%202022,authority%3B%20and%20%24141.5%20million%20in>.
- ⁵⁶ National Institutes of Health, “Estimates of Funding for Various Research, Condition, and Disease Categories,” May 16, 2022, [https://report.nih.gov/funding/categorical-spending#/.](https://report.nih.gov/funding/categorical-spending#/)
- ⁵⁷ Joyal Mulheron and Sharon K. Inouye, “Bereavement Care in America Is Broken: A Call to Action,” *NAM Perspectives*, January 21, 2020, <https://nam.edu/bereavement-care-in-america-is-broken-a-call-to-action/>.
- ⁵⁸ Ann-Sofie Bergman, Ulf Axberg, and Elizabeth Hanson, “When a Parent Dies—A Systematic Review of the Effects of Support Programs for Parentally Bereaved Children and Their Caregivers,” *BMC Palliative Care* 16, no. 1 (August 2017), <https://pubmed.ncbi.nlm.nih.gov/28797262/>.
- ⁵⁹ Pham et al., “The Burden of Bereavement.”
- ⁶⁰ Pham et al., “The Burden of Bereavement.”
- ⁶¹ Debra Umberson et al., “Death of Family Members as an Overlooked Source of Racial Disadvantage in the United States,” *Proceedings of the National Academy of Sciences of the United States of America* 114, no. 5 (January 2017): 915–20, <https://pubmed.ncbi.nlm.nih.gov/28115712/>.

⁶² Umberson, “Black Deaths Matter.”

⁶³ Rachel Kidman et al., “Estimates and Projections of COVID-19 and Parental Death in the US,” JAMA Pediatrics 175, no. 7 (April 2021): 745–46, <https://jamanetwork.com/journals/jamapediatrics/fullarticle/2778229>.

⁶⁴ CDC Newsroom, “Firearm Deaths Grow, Disparities Widen,” May 10, 2022, <https://www.cdc.gov/media/releases/2022/s0510-vs-firearm-deathrates.html>.

⁶⁵ National Center for Health Statistics, “Drug Overdose Deaths in the U.S. Top 100,000 Annually,” press release, November 17, 2021, https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2021/20211117.htm.

⁶⁶ National Center for Health Statistics, “U.S. Overdose Deaths in 2021 Increased Half as Much as in 2020—but Are Still Up 15%,” press release, May 11, 2022, https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2022/202205.htm.

⁶⁷ Centers for Disease Control and Prevention, “Transportation Safety,” <https://www.cdc.gov/transportationsafety/index.html>.

⁶⁸ Centers for Disease Control and Prevention, “Department of Health and Human Services Fiscal Year 2023: Centers for Disease Control and Prevention Justification of Estimates for Appropriation Committees,” 290, <https://www.cdc.gov/budget/documents/fy2023/FY-2023-CDC-congressional-justification.pdf>.

⁶⁹ Umberson et al., “Death of Family Members as an Overlooked Source of Racial Disadvantage.”

⁷⁰ Ashton M. Verdery et al., “Tracking the Reach of COVID-19 Kin Loss with a Bereavement Multiplier Applied to the United States,” Proceedings of the National Academy of Sciences of the United States of America 117, no. 30 (July 2020): 17695–701, <https://www.pnas.org/doi/full/10.1073/pnas.2007476117>.

⁷¹ Susan D. Hillis et al., “COVID-19–Associated Orphanhood and Caregiver Death in the United States,” Pediatrics 148, no. 6 (December 2021), <https://publications.aap.org/pediatrics/article/148/6/e2021053760/183446/COVID-19-Associated-Orphanhood-and-Caregiver-Death?autologincheck=redirected?nfToken=00000000-0000-0000-0000-000000000000>; Susan Hillis et al., “Orphanhood and Caregiver Loss Among Children Based on New Global Excess COVID-19 Death Estimates,” JAMA Pediatrics 176, no. 11 (November 2022): 1145–48, <https://jamanetwork.com/journals/jamapediatrics/fullarticle/2795650>.

⁷² Shamez N. Ladhani, “Children and COVID-19 in Schools,” Science 374, no. 6568 (November 2021): 680–2, <https://www.science.org/doi/10.1126/science.abj2042>; Justin Lessler et al., “Household COVID-19 Risk and In-Person Schooling,” Science 372, no. 6546 (April 2021): 1092–97, <https://www.science.org/doi/10.1126/science.abh2939>.

⁷³ Annie E. Casey Foundation Kids Count Data Center, “Children in Single-Parent Families by Race and Ethnicity in the United States,” <https://datacenter.kidscount.org/data/tables/107-children-in-single-parent-families-by-race#detailed/1/any/false/1729,37,871,870,573,869,36,868,867,133/10,11,9,12,1,185,13/432,431>.



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