Washington State Department of Health

DOH 821-102-92

Week of August 15, 2022 COVID-19 Behavioral Health Impact Situation Report

Purpose

This report summarizes data analyses conducted by the COVID-19 Behavioral Health Group's Impact & Capacity Assessment Task Force. These analyses assess the likely current impact of the COVID-19 pandemic on mental health and potential for substance use issues.

Please note this report is based on the most recent available data from various sources. As such, different sections may present information for different reporting periods.

The intended audience for this report includes response planners and any organization that is responding to or helping to mitigate the behavioral health impacts of the COVID-19 pandemic.

As of May 8, 2022, this report has been updated to remove data that are no longer beneficial to the COVID-19 Behavioral Health Group's Impact & Capacity Assessment Task Force. If there is mission critical information that has been removed, please contact Alaine Ziegler at Alaine.Ziegler@doh.wa.gov to address the data.

Key Takeaways

For the most recent reporting period (CDC Week[1] 32, week of August 13, 2022), all five syndromic indicators (psychological distress, suicidal ideation, suspected suicide attempt, drug overdose, and alcohol-related emergency department (ED) visits) **decreased** from the previous reporting period (CDC week 30). For the current reporting period, all the indicators are **decreasing.**

- Alerts were issued for Native Hawaiian or Other Pacific Islander, individuals who did not report their race, and individuals who did not report their ethnicity.
- A statistical warning was issued for those who identified as Black or African American.

Survey data collected by the U.S. Census Bureau for June 30 – July 11, 2022, show a **decrease** in anxiety (-7.05%) and a **decrease** in depression (-3.27%) among adults in Washington. Additionally, more people reported **needing** therapy or counseling but not receiving it for any reason (14%), and more people reported **receiving** counseling or therapy from a mental health professional (36%).

[1] https://ndc.services.cdc.gov/wp-content/uploads/W2021-22.pdf

Impact Assessment

Syndromic Surveillance

The Department of Health collects syndromic surveillance data in near real-time from hospitals and clinics across Washington. The data are always subject to updates. Key data elements reported include patient demographic information, chief complaint, and coded diagnoses. This data collection system[2] is the only source of ED data for Washington.

The Behavioral Health Team along with the Rapid Health Information Network (RHINO) data team have identified discrepancies within the codes used to generate the Behavioral Health Team Situation Report Syndromic graphs. Specifically, individuals who were seen in the Emergency Department (ED) may have been counted more than once during one ED visit based on the individual's diagnosis and how the diagnosis was categorized. For example, if an individual presents to the ED for a Heroin Overdose this visit could be classified as both a CDC Heroin Overdose and a CDC All Drug (overdose) resulting in the same visit being counted twice.

While the overall trend in the data remains the same, the number of visits and therefore the data represented in the graphs may have calculated incorrectly, causing a misrepresentation of what was actually happening. After a careful review of the data, the Behavioral Health Team has decided to use Syndromic graphs generated by the Electronic Surveillance System for the Early Notification of Community-based Epidemics (Essence) which is managed by Johns Hopkins and the CDC.

These graphs better represent the corrected data and remove any discrepancies within the codes. They also allow for increased ease of readability and better identification of long-term trends. Data represented with a blue dot are an expected or normal value. Data represented with a yellow dot are a warning and a red dot is an alert, both of which are related to how the CDC algorithms detect data.

Statistical warnings and alerts are raised when a CDC algorithm detects a weekly count at least three standard deviations[3] above a 28-day average count, ending three weeks prior to the week with a warning or alert. These warnings or alerts are indicated, as needed, within each respective syndrome section. Alerts indicate more caution is needed than a warning.

Analysis conducted by the Washington State Department of Health and the Northwest Tribal Epidemiology Center found 9,443 misclassified visits in Washington hospitals from May 15 – September 15, 2020. The visits in question should have been classified as American Indian/Alaska Native and represent a 27% misclassification percent during that period.

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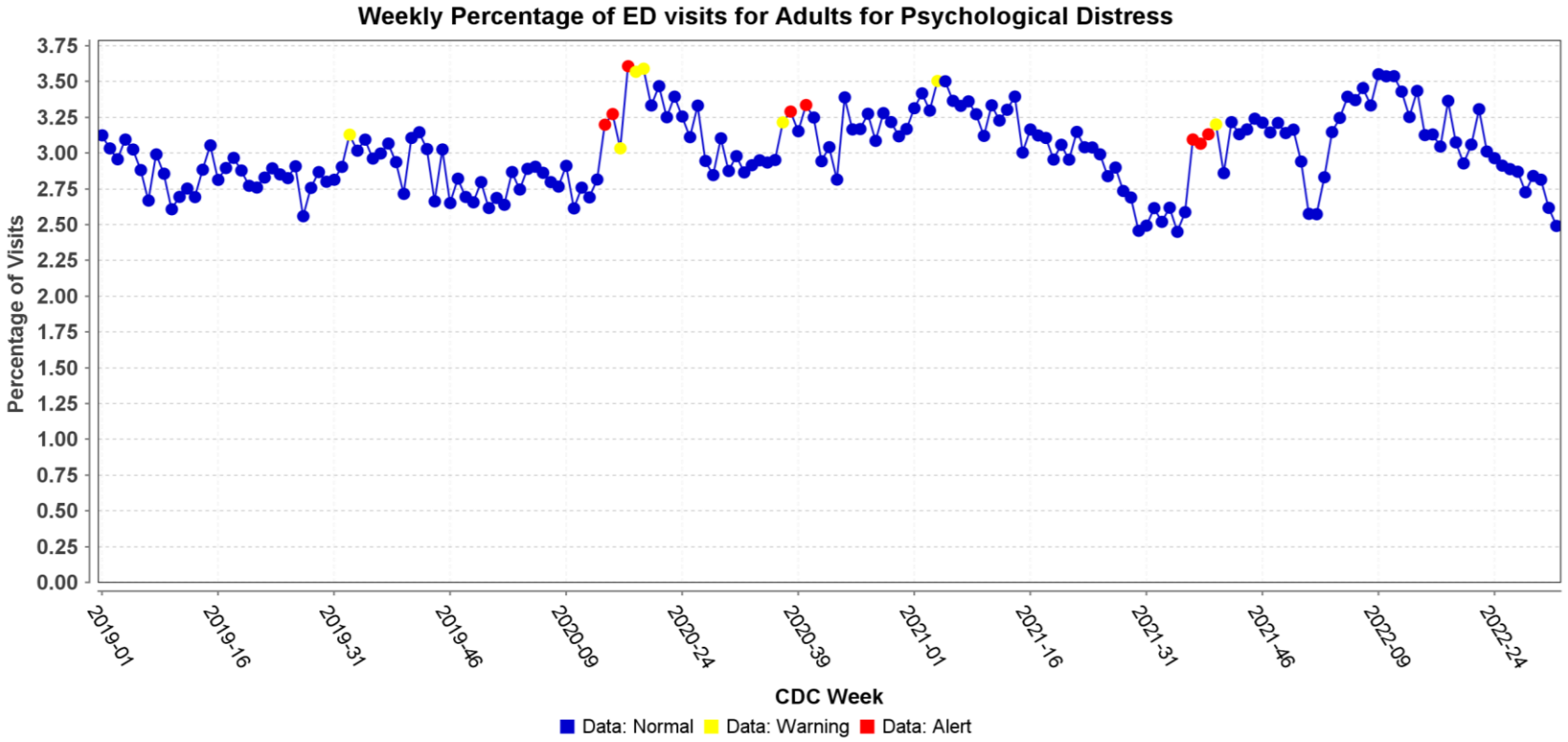
[2] https://doh.wa.gov/public-health-healthcare-providers/healthcare-professions-and-facilities/data-exchange-0/syndromic-surveillance-rhino

[3] Standard deviation: A measure of the amount of variation or dispersion of a set of values. Standard deviation is often used to measure the distance of a given value from the average value of a data set.

Psychological Distress

During CDC Week 32 (week of August 13, 2022), the reported relative percent of ED visits for psychological distress[4] **decreased** from the previous reporting period (CDC week 30), and the current week is **decreasing** (Graph 1). No statistical alert or warning was issued.

Graph 1: Percent change of ED visits for psychological distress in Washington, by week: 2019, 2020, 2021, and 2022 to date (Source: CDC ESSENCE)

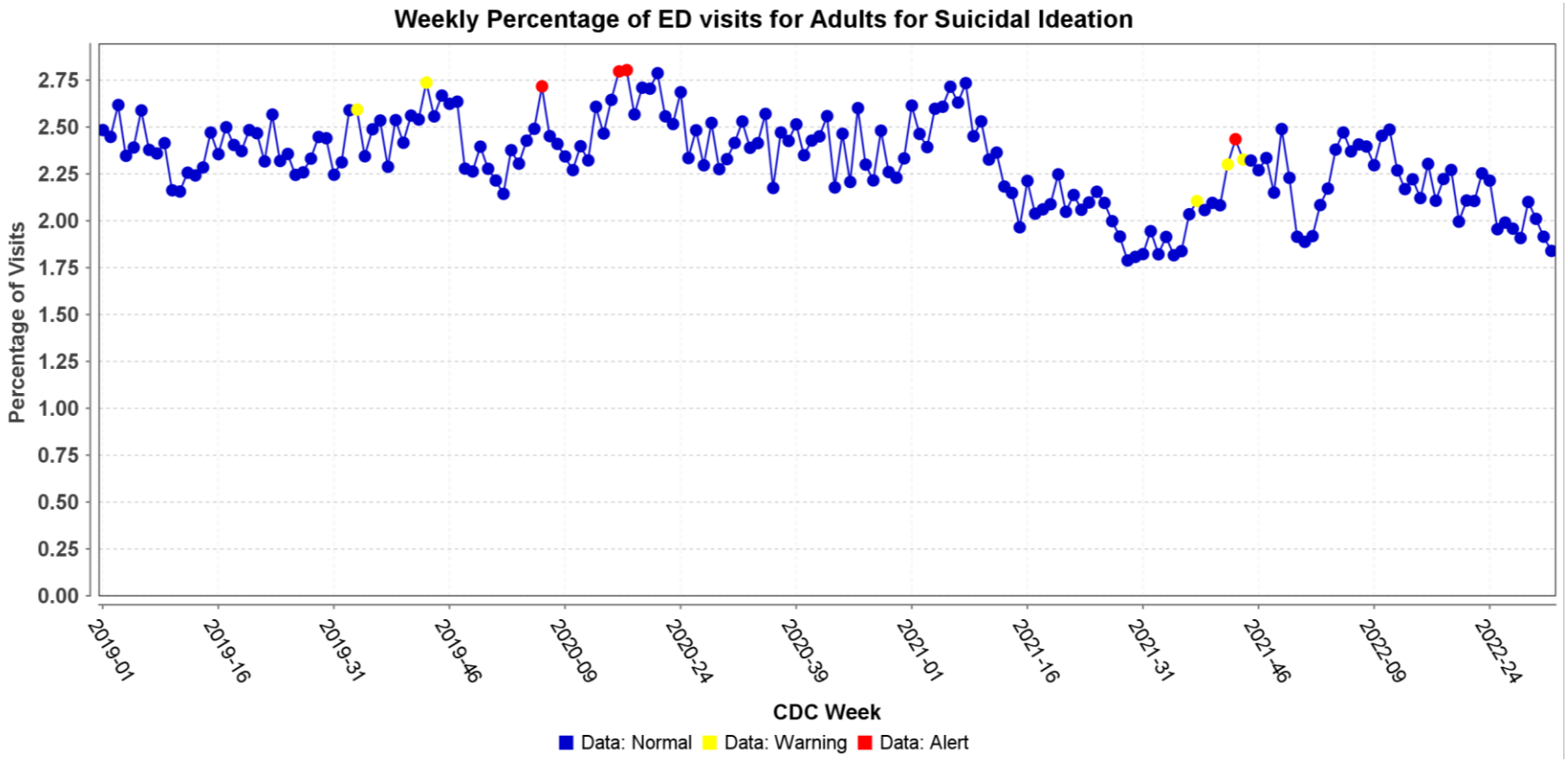


[4] Psychological distress in this context is considered a disaster-related syndrome comprised of panic, stress, and anxiety. It is indexed in the Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE) platform as Disaster-related Mental Health v1. Full details are available at https://knowledgerepository. syndromicsurveillance.org/disaster-related-mental-health-v1-syndrome-definition-subcommittee.

Suicidal Ideation and Suspected Suicide Attempt

During CDC Week 32 (week of August 13, 2022), the reported relative percent of ED visits for suicidal ideation **decreased** from the previous reporting period (CDC week 30), and the current week is **decreasing** (Graph 2). No statistical alert or warning was issued.

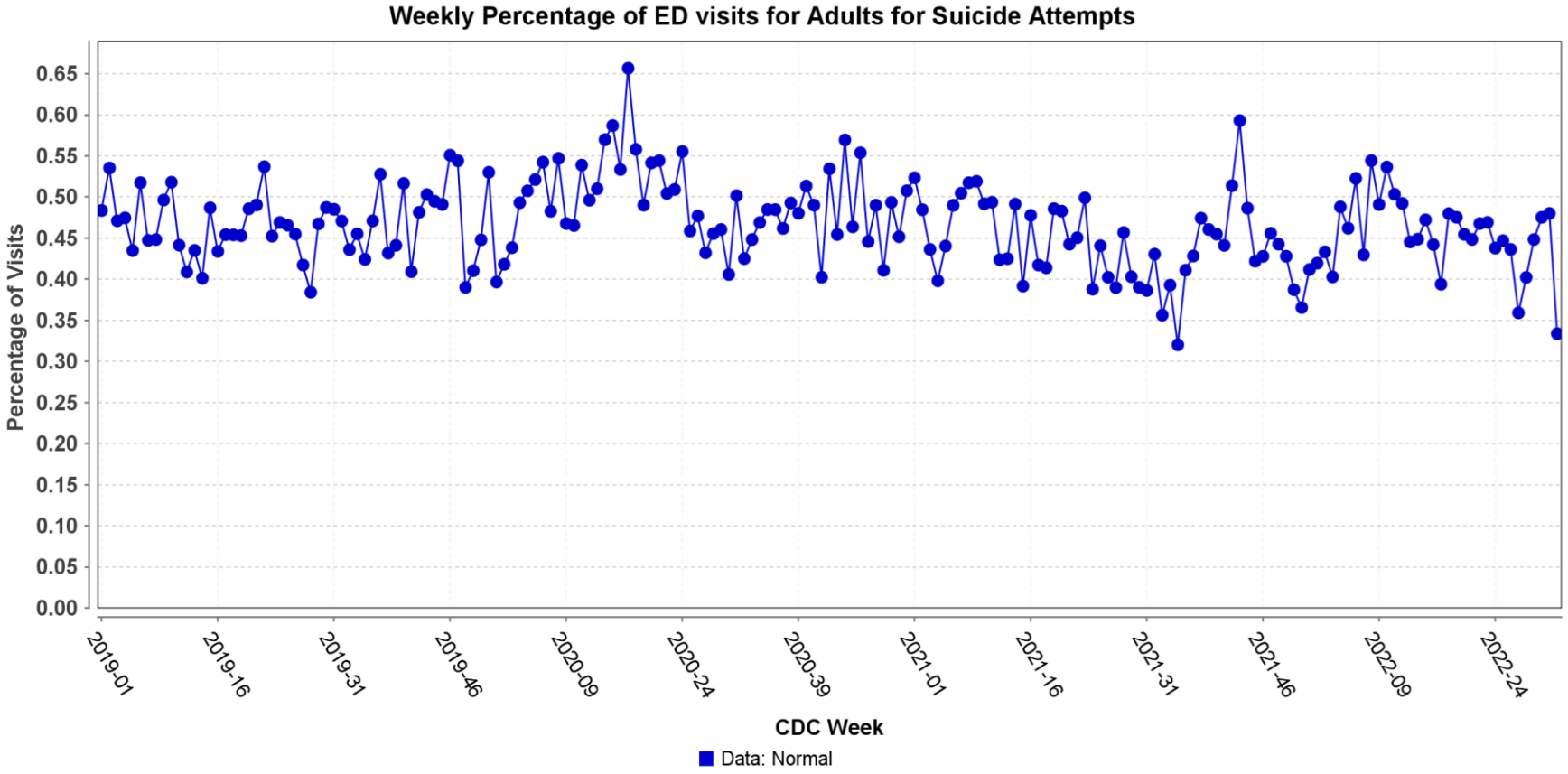
Graph 2: Percent change of ED visits for suicidal ideation in Washington, by week: 2019, 2020, 2021, and 2022 to date (Source: CDC ESSENCE)



During CDC Week 32 (week of August 13, 2022), the reported relative percent of ED visits for suspected suicide attempt **decreased** from the previous reporting period (CDC week 30), and the current week is **decreasing** (Graph 3). A statistical warning was issued for those who identified as Black or African American.

Data regarding suspected suicide attempt should be interpreted with caution. The current CDC definition for suspected suicide attempt, due to its broad inclusion of intentional self-harm behaviors that may or may not be interpreted as a suicidal act, could artificially inflate both the count and percentage of such visits.

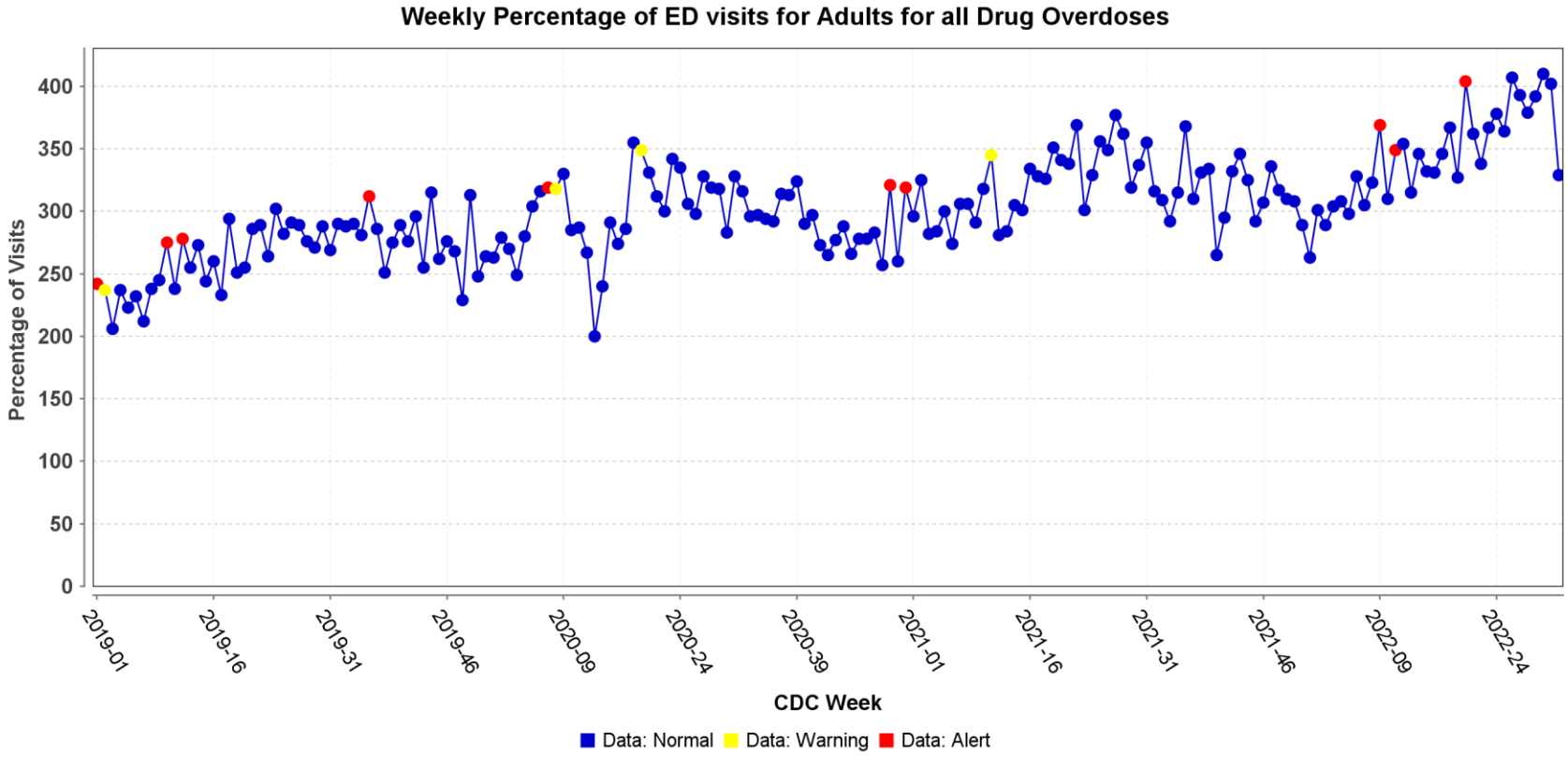
Graph 3: Percent change of ED visits for suspected suicide attempt in Washington, by week: 2019, 2020, 2021, and 2022 to date (Source: CDC ESSENCE)



Substance Use – Drug Overdose and Alcohol-Related Emergency Visits

During CDC Week 32 (week of August 13, 2022), the reported relative percent of all drug[5]-related ED visits **decreased** from the previous reporting period (CDC week 30), and the current week is **decreasing** (Graph 4). No statistical alert or warning was issued.

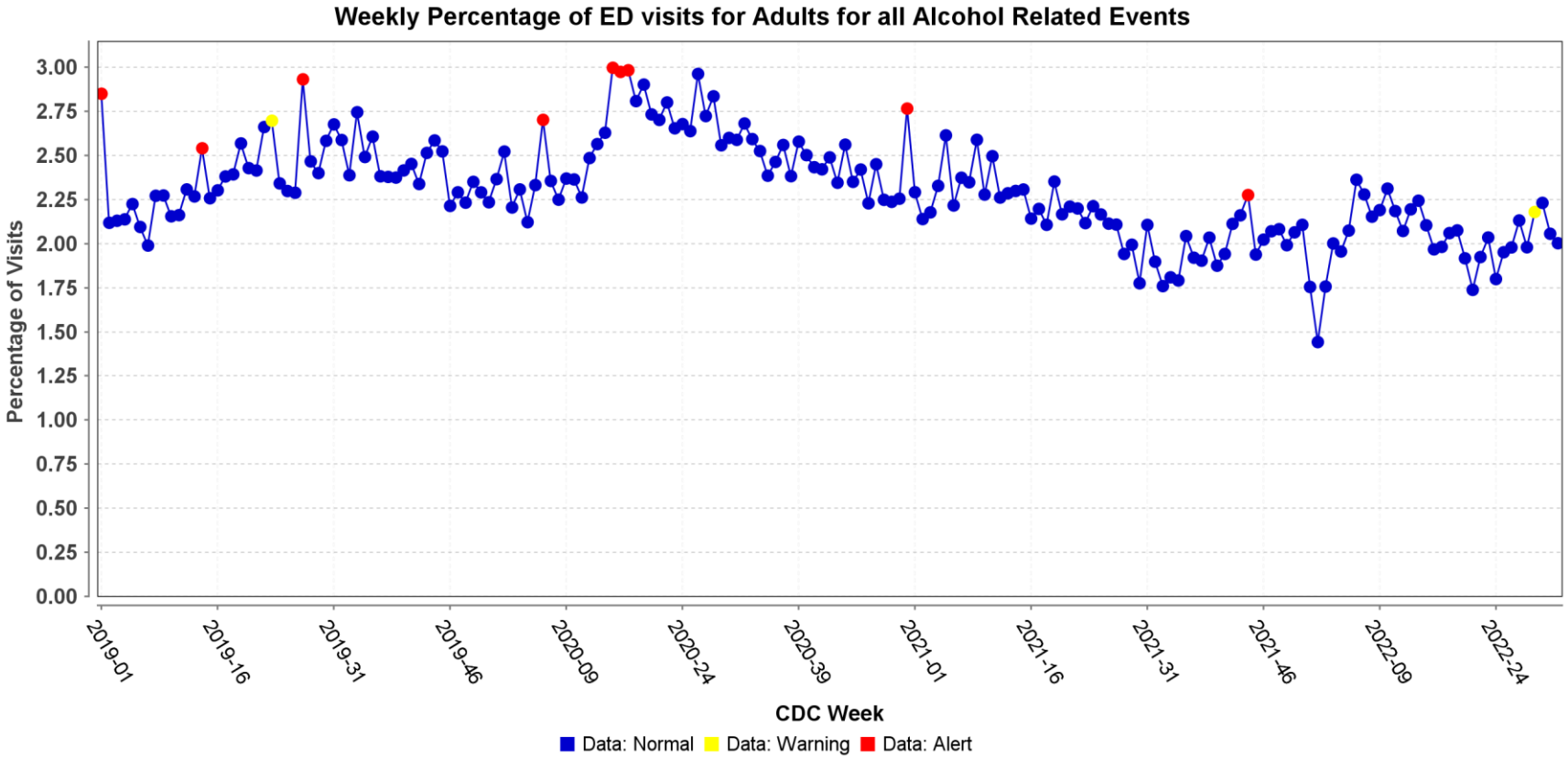
Graph 4: Percent change of all drug-related ED visits in Washington, by week: 2019, 2020, 2021, and 2022 to date (Source: CDC ESSENCE)



[5] All drug: This definition specifies overdoses for any drug, including heroin, opioid, and stimulants. It is indexed in the Electronic Surveillance System for the Early Notification of Community-Based Epidemics (ESSENCE) platform as CDC All Drug v1. Full details available at https://knowledgerepository.syndromicsurveillance.org/cdc-all-drug-v1

During CDC Week 32 (week of August 13, 2022), the reported relative percent of alcohol-related ED visits **decreased** from the previous reporting period (CDC week 30), and the current week is **decreasing** (Graph 5). Alerts were issued for Native Hawaiian or Other Pacific Islander, individuals who did not report their race, and individuals who did not report their ethnicity.

Graph 5: Percent change of alcohol-related ED visits in Washington, by week: 2019, 2020, 2021, and 2022 to date (Source: CDC ESSENCE)



Emergency Department visits for Behavioral Health Related and Reported Homelessness

The syndromic indicator **Behavioral Health Related and Reported Homelessness** has been removed from this document until the Essence codes can be updated to reflect only homelessness for individuals with behavioral health concerns.

General Surveillance

Symptoms of Anxiety and Depression

Survey data collected by the U.S. Census Bureau for June 29 – July 11, 2022, show a **decrease** in anxiety -- feeling nervous, anxious, or on edge -- (-7.05%), and a **decrease** in depression -- feeling down, depressed, or hopeless -- (-3.27%) among adults in Washington, compared to the previous reporting period of June 1 – 13, 2022 (Graph 7).

In the most recent reporting period represented below, approximately 1.22 million adults in Washington reported symptoms of anxiety on all or most days of the previous week, while approximately 799 thousand adults reported the same frequency of symptoms of depression.

The same respondent may report symptoms of both anxiety and depression at the same time, and these numbers are not cumulative. These survey data are independent to the data presented in previous sections.

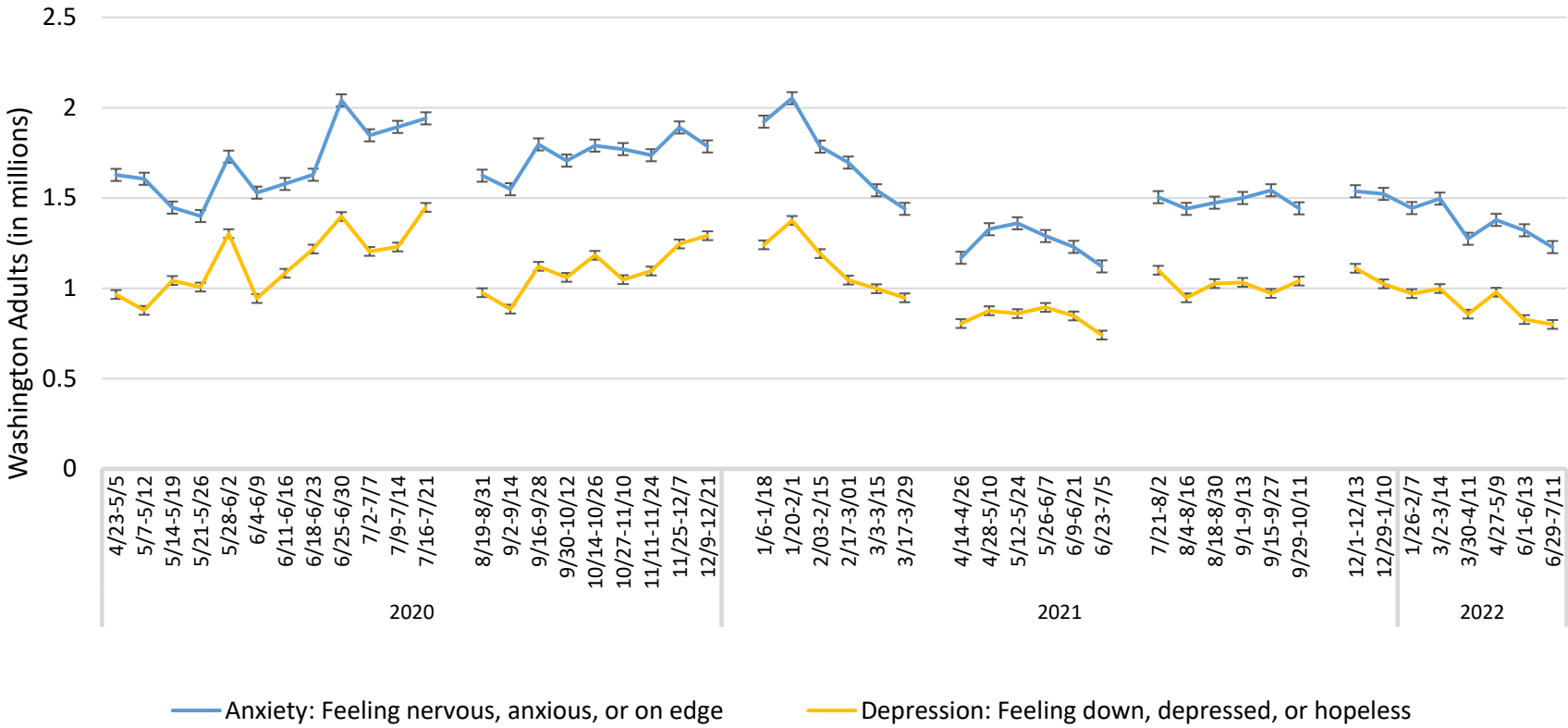
In the June 29 – July 11, 2022, survey data, respondents ages 18 – 29 reported an identical percentage of symptoms of **anxiety** (34%), followed by those ages 40 – 49 (30%). Those ages 40 – 49 reported the highest percent of symptoms of **depression** (23%) followed by those ages 18 – 29 (19%).

Those who live in households earning $75,000 - $99,999 per year were the most likely to report frequent symptoms of **anxiety** (28%), followed by those in households earning $35,000 - $39,999 per year (25%).

Additionally, respondents in households earning $75,000 - $99,999 per year reported the highest percent of frequent symptoms of **depression** (30%), followed by those in households earning $25,000 - $34,999 per year (21%).

Those who identified as female at birth have an **increased** symptom reporting percentage for **anxiety,** as compared to those who identified as male at birth (25% for females, 16% for males), and those who identified as female at birth have a **similar** reporting percentage for **depression** as those who identified as male at birth (15% for females, 12% for males).

Graph 7: Estimated number of Washington adults who reported feelings of anxiety or depression "at least most days," by week: April 23, 2020 – June 13, 2022 (Source: U.S. Census Bureau)



Note: For the period of July 21 – August 19, 2020, census data were not available and thus, any trends during this point are an artifact of analysis. Additionally, the U.S. Census Bureau briefly paused data collection for the periods of December 23, 2020 – January 3, 2021; March 30 – April 14, 2021; The U.S. Census Bureau briefly paused data collection for the period of December 23, 2020 – January 3, 2021, March 30, 2021 – April 13, 2021, July 6 – 20, 2021, and October 12– November 31, 2021.

Note, for Phase 3.3 has shifted to a two-weeks on, two-weeks off collection and dissemination approach, although previous phases of the survey collected and disseminated data every two weeks.

Care-Seeking Behavior

Survey data collected by the U.S. Census Bureau for April 27 – May 9, 2022, show the number of adults in Washington who received medical care and counseling, as well as the number who delayed or did not receive care (Graph 8). No new data were released for mental health and care-seeking behaviors in the most recent data set.

Compared to the previous reporting period of March 30 – April 11, 2022, **more** people reported needing therapy or counseling but not receiving it for any reason (14%) and **more** people reported that they received counseling or therapy from a mental health professional, such as a psychiatrist, psychologist, psychiatric nurse, or clinical social worker (36%).

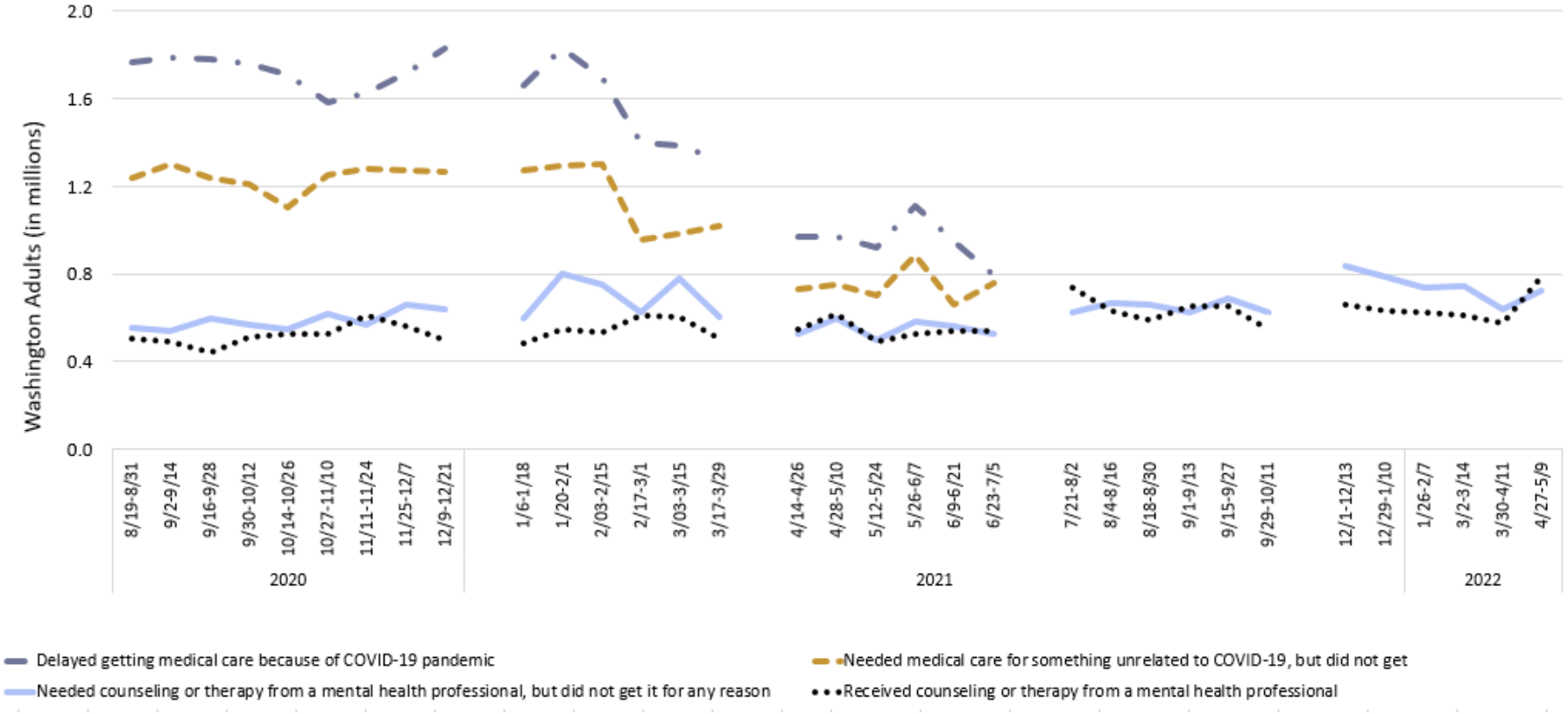
In the April 27 – May 9, 2022 survey data, respondents ages 30 – 39 (19%) reported **receiving** counseling or therapy from a mental health professional, such as a psychiatrist, psychologist, psychiatric nurse, or clinical social worker followed by those ages 18 – 29 (18%). Those ages 30 – 39 also reported the highest percentage of **needing** therapy or counseling but not receiving it for any reason (18%), followed by those ages 18 – 29 (16%).

Those who live in households earning over $200,000 were the most likely to report that they **received** counseling or therapy from a mental health professional, such as a psychiatrist, psychologist, psychiatric nurse, or clinical social worker (29%), followed by those in households earning $25,000-$34,000 per year (21%).

Additionally, respondents in households earning less than $25,000 per year reported the highest percentage for **needing** therapy or counseling but not receiving it for any reason (25%), followed by those in households earning $75,000 - $99,000 per year (20%).

Those who identified as female at birth have an increased reporting percentage for **receiving** counseling or therapy from a mental health professional such as a psychiatrist, psychologist, psychiatric nurse, or clinical social worker (16% for females, compared to 11% for males), and those who identified as female at birth have an increased reporting percentage for **needing** therapy or counseling but not receiving it for any reason (16% for females and 8% for males).

Graph 8: Estimated number of Washington adults who received or delayed medical care or counseling, by week: August 19, 2020 – May 9, 2022 (Source: U.S. Census Bureau)



Note: The U.S. Census Bureau briefly paused data collection for the period of December 23, 2020 – January 3, 2021, March 30, 2021 – April 13, 2021, July 6 – 20, 2021, and October 12 – November 31, 2021. Data collection for Phase 3.2 of the Household Pulse Survey impacted survey methodology, questions related to "delayed getting medical care because of COVID-19 pandemic" and "needed medical care for something unrelated to COVID-19, but did not get" were removed and will not be included in further analyses.

Note, for Phase 3.3 has shifted to a two-weeks on, two-weeks off collection and dissemination approach, although previous phases of the survey collected and disseminated data every two weeks.

Telehealth Use for Washington Medicaid Clients

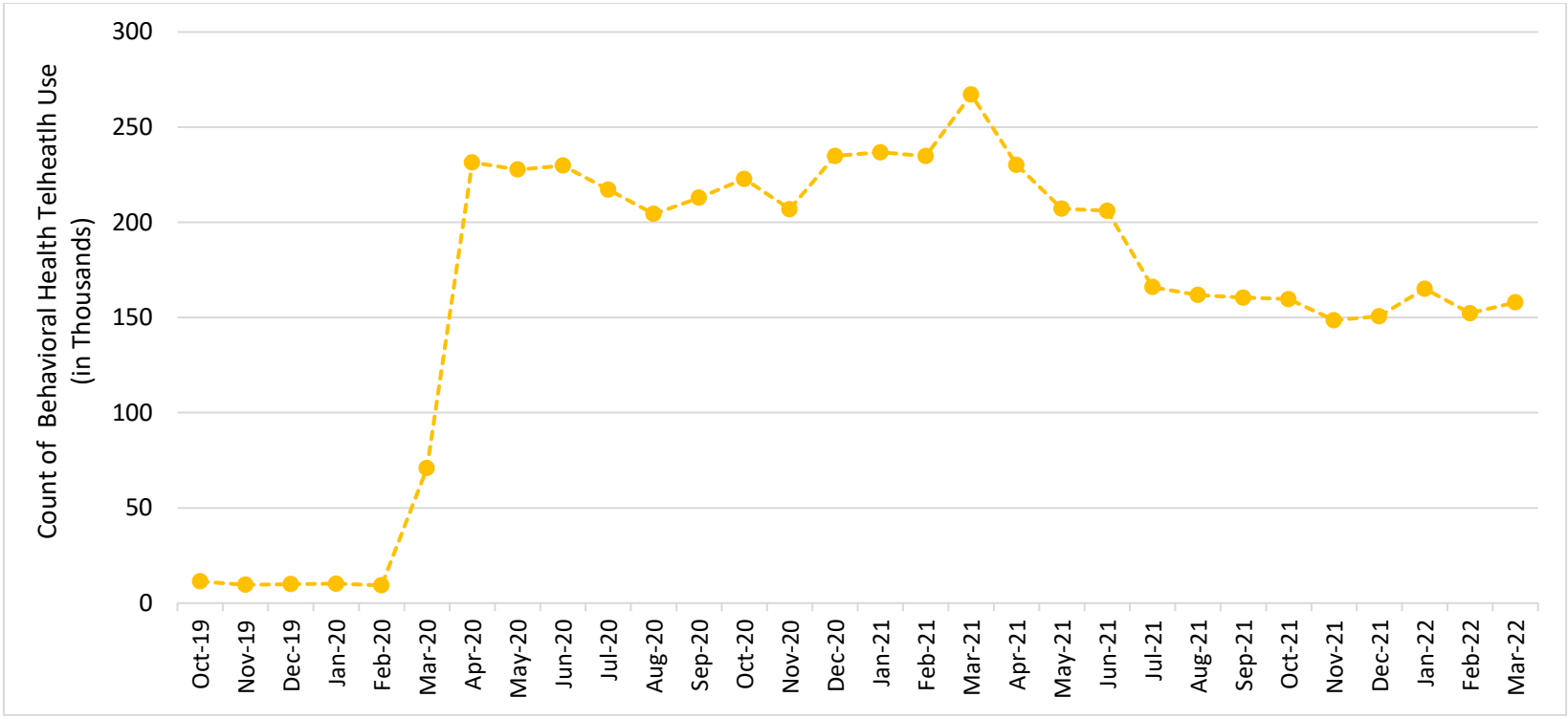
Telehealth (phone and videoconferencing) claims use for Washington Medicaid clients is collected by the Washington State Health Care Authority (HCA).

It is important to note the limited use of telehealth in Medicaid clients prior to the COVID-19 pandemic (March 2020), which could explain the significant increase in March and April 2020 (237%) after the implementation of the "Stay Home, Stay Healthy" order in March 2020.

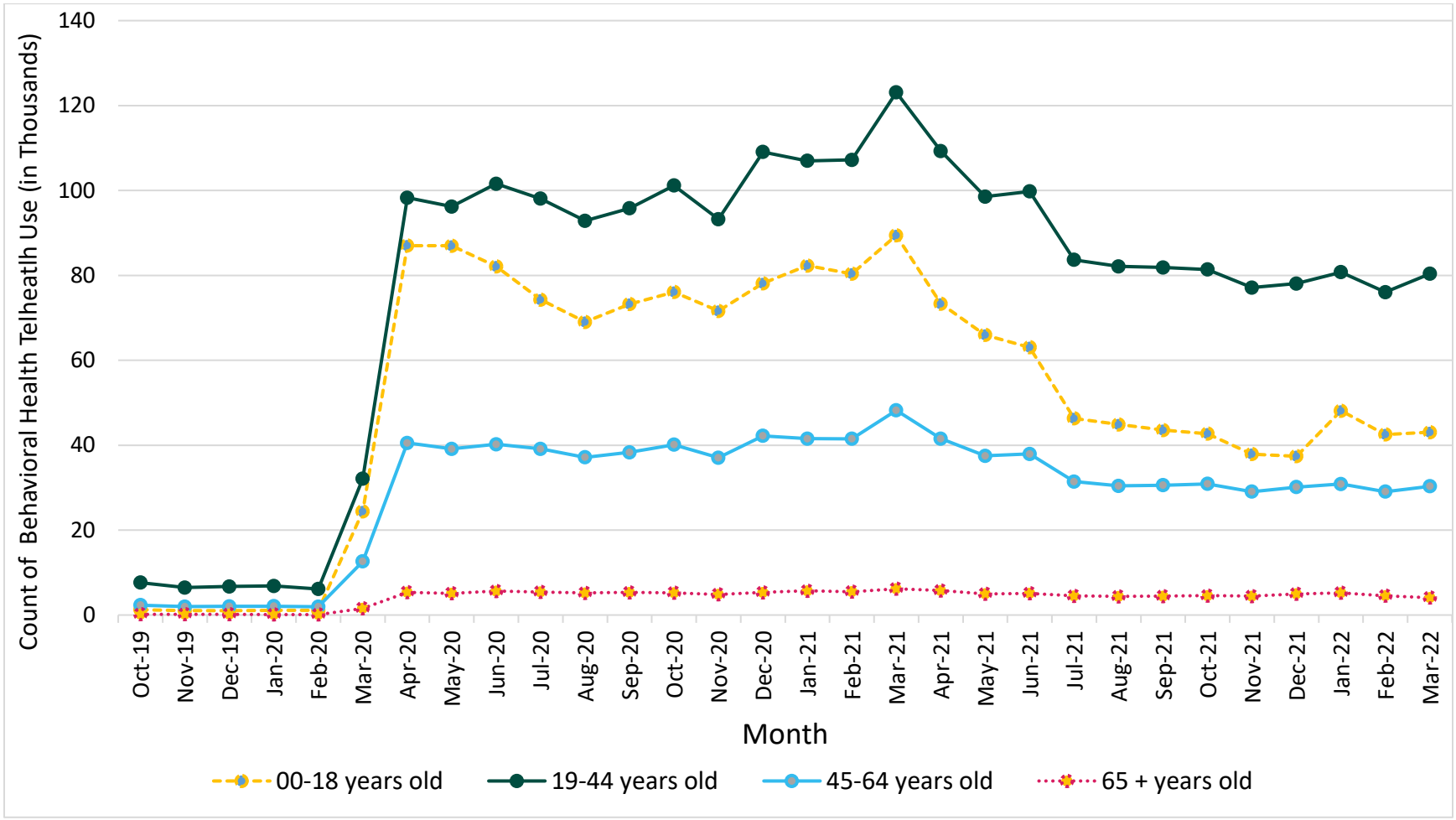
Due to the significant demand for telehealth, several changes were made to policies, coverage, and implementation that could impact these data. Results may be underreported due to missing, changed, or suppressed data.

The most recent reporting period (March 2022) showed a 4% **increase** of telehealth behavioral health services use (Medicaid) claims compared to the previous month (Graph 9). Graph 10 showed **decreased** claims of telehealth behavioral health services by age group, compared to the previous month: individuals ages 18 and younger (1.28%), ages 19 – 44 (5.69%), ages 45 – 64 (4.32%), and ages 65 and older (-9.72%).

Graph 9: Number of telehealth behavioral health use claims for Washington Medicaid clients, by month (Source: HCA)



Graph 10: Number of telehealth behavioral health use claims for Washington Medicaid clients, by month and age (Source: HCA)



Inpatient and Observational Community Hospital Discharges

The Comprehensive Hospital Abstract Reporting System (CHARS)[6] collects information on inpatient and observation patient community hospital stays.

Caution should be taken when reviewing data, as the "Stay Home, Stay Healthy" order (March 2020) may impact hospital discharge data for both inpatient and observation patients. Only mental, behavioral, and neurodevelopmental disorders were evaluated (based on the individuals primary diagnoses included only ICD-10 F-codes)[7] for this report.

Due to time lag, data may not be complete. While non-Washington residents can be discharged from a Washington community hospital, only Washington residents were included in the analysis. Because of low numbers (>10), no further separation was conducted for discharges for either age or specific mental, behavioral, or neurodevelopmental disorders.

The most recent reporting period (December 2021) showed a 39% **decrease** of discharges with a diagnosis of mental, behavioral, and neurodevelopmental disorders from inpatient care at community hospitals, and a 32% **decrease** of discharges with diagnoses of mental, behavioral, and neurodevelopmental disorders from observational care from community hospitals, compared to the previous reporting period.

Graphs 11 and 12 show the count of inpatient and observational community hospital discharges for mental, behavioral, and neurodevelopmental disorders stratified by gender.

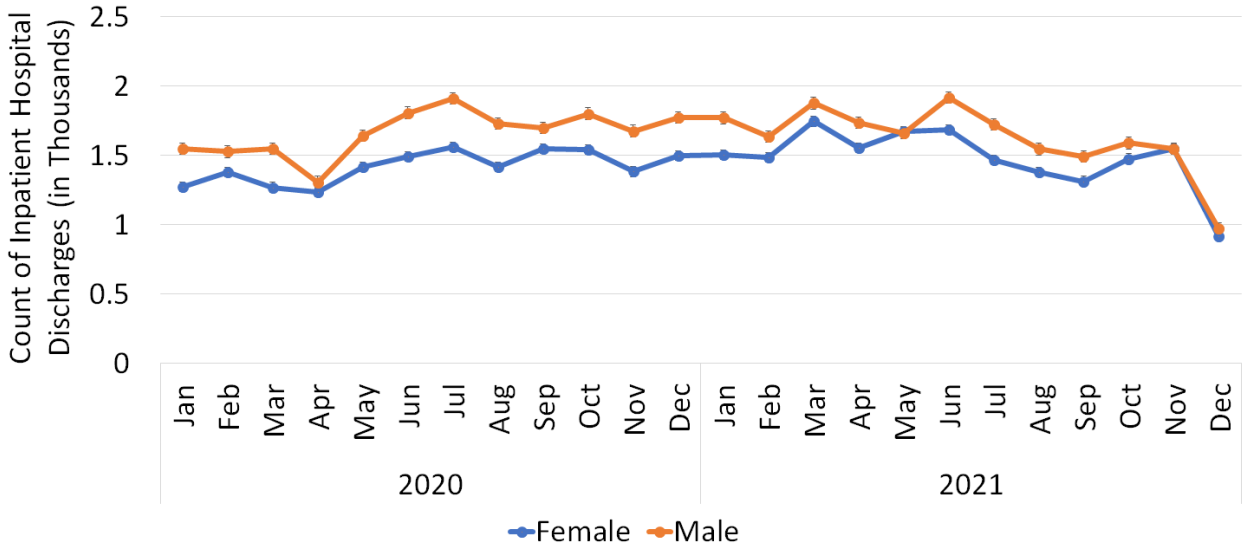
For inpatient community hospital discharges for mental, behavioral, and neurodevelopmental disorders, the most recent reporting period (December 2021) showed a 41% **decrease** for females and a 37% **decrease** for males.

For observational community hospital discharges for mental, behavioral, and neurodevelopmental disorders, the most recent reporting period (December 2021) showed a 50% **decrease** for females and a 12% **decrease** for males.

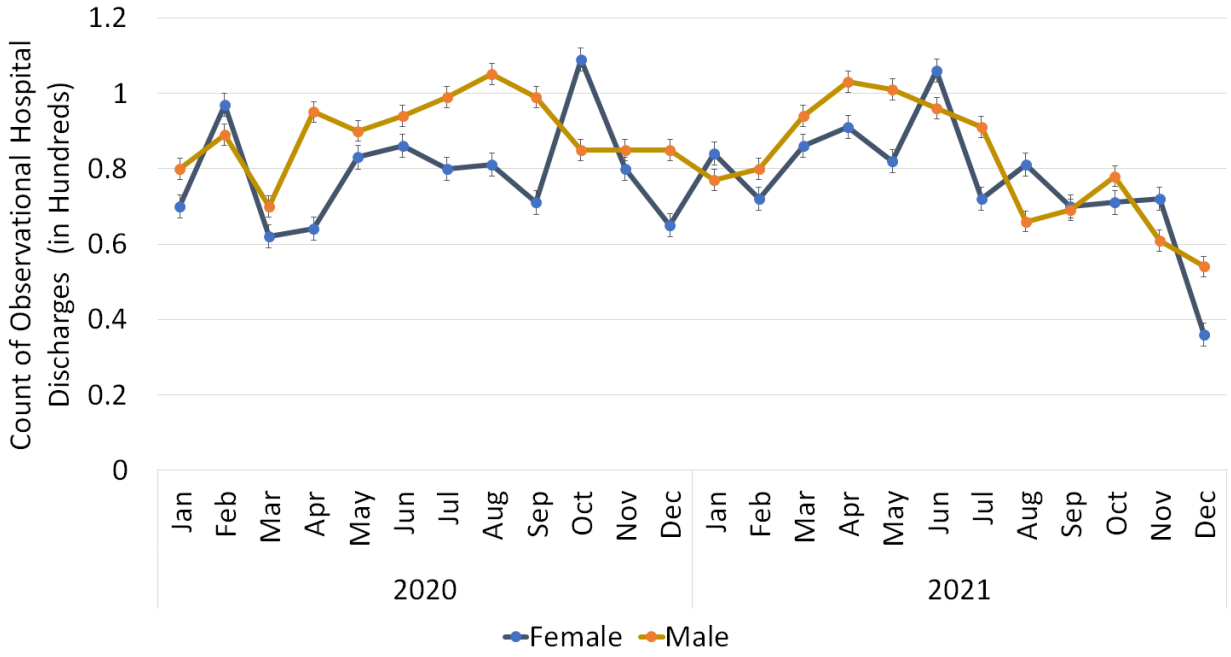
[6]https://www.doh.wa.gov/dataandstatisticalreports/healthcareinwashington/hospitalandpatientdata/hospitaldischargedatachars

[7] ICD-10 is the Tenth Revision of the International Classification of Disease and Related Health Problems published by the World Health Organization (WHO). F-codes are specifically related to mental, behavioral, and neurodevelopmental disorders.

Graph 11: Count of inpatient community hospital discharges for mental, behavioral, and neurodevelopmental disorders, by month and gender (Source: DOH)

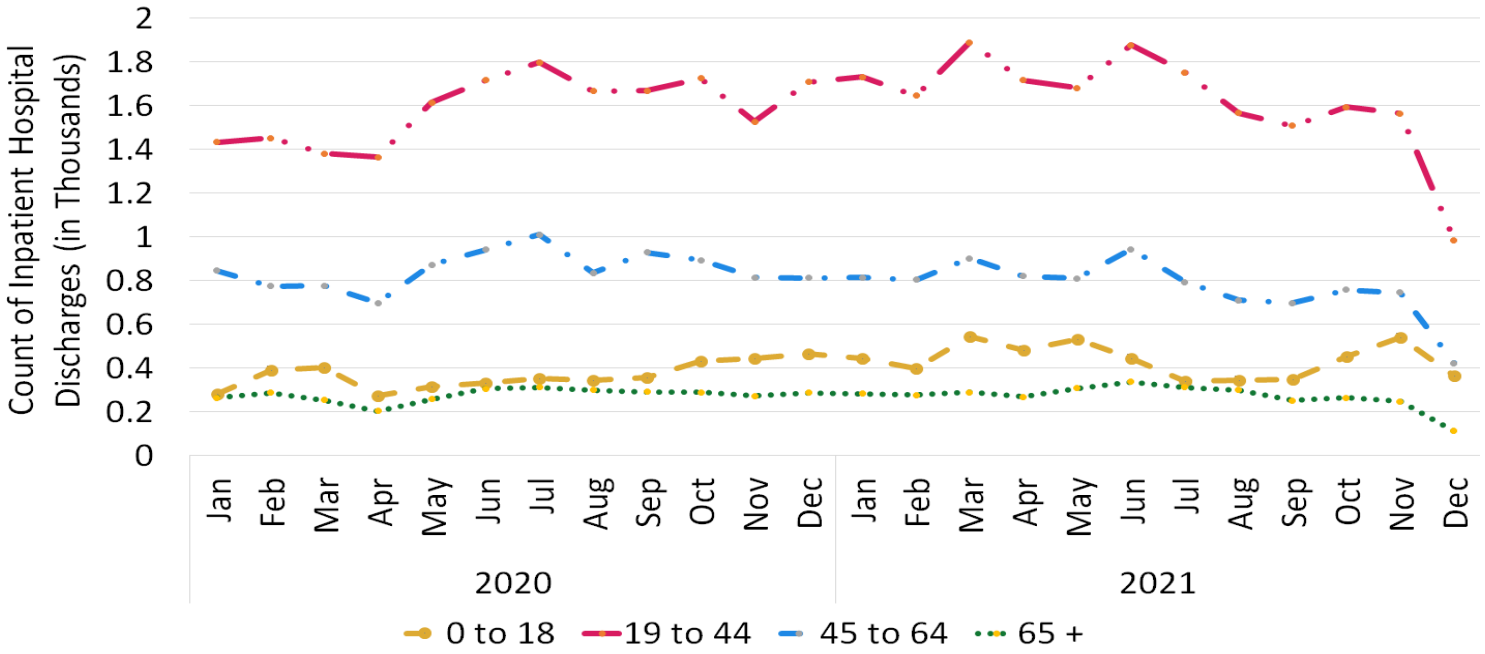


Graph 12: Count of observational community hospital discharges for mental, behavioral, and neurodevelopmental disorders, by month and gender (Source: DOH)



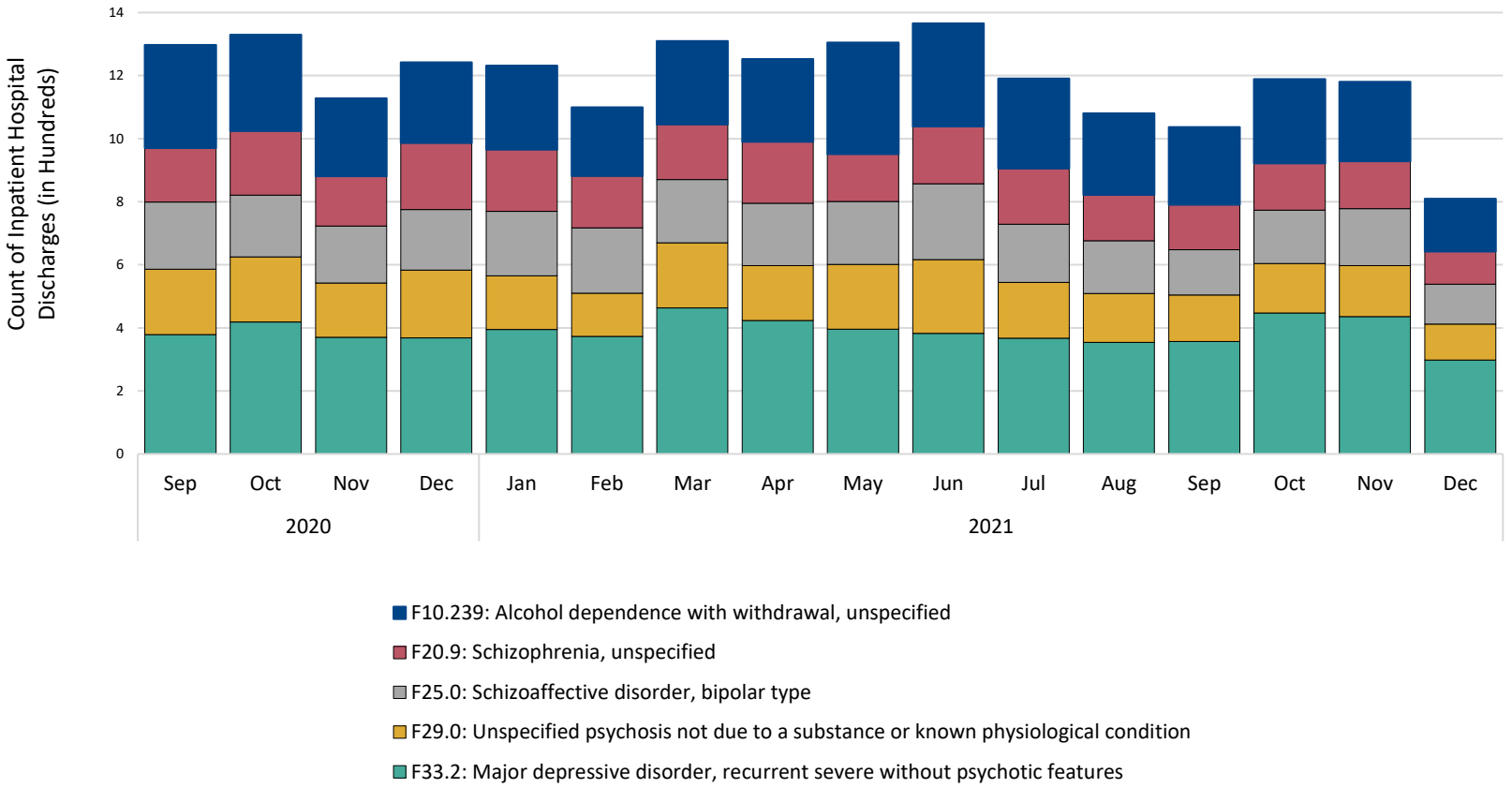
Graph 13 shows counts of inpatient community hospital discharges for mental, behavioral, and neurodevelopmental disorders separated by age. Compared to the previous month, the most recent reporting period (December 2021) showed a 32% **decrease** for those 0 – 18 years old, a 37% **decrease** for individuals ages 19 – 44 years, a 43% **decrease** for individuals ages 45 – 64 years, and a 54% **decrease** for individuals ages 65 years and older.

Graph 13: Count of inpatient community hospital discharges for mental, behavioral, and neurodevelopmental disorders, by month and age (Source: DOH)



Graph 14 shows the count of the top five mental, behavioral, and neurodevelopmental disorders in terms of inpatient community hospital discharges. The most recent reporting period showed a decrease in four of five disorders. Compared to the previous month, there was a 34% **decrease** in "alcohol dependence with withdrawal, unspecified," a 30% **decrease** in "schizoaffective disorder, bipolar type," a 29% **decrease** in "unspecified psychosis not due to a substance or known physiological condition," in inpatient community hospital discharges, a 31% **decrease** in "schizophrenia, unspecified," and a 32% **decrease** in "major depressive disorder, recurrent severe without psychotic features."

Graph 14: Count of the top mental, behavioral, and neurodevelopmental disorders for inpatient community hospital discharges, by month (Source: DOH)



Acknowledgements

This document was developed by the Washington State Department of Health's Behavioral Health Epidemiology Team. Lead author is Alaine Ziegler, MPH.

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