Washington State Department of Health

DOH 821-102-86

Week of April 25, 2022
COVID-19 Behavioral Health Impact Situation Report

This situation report presents the potential behavioral health impacts of the COVID-19 pandemic for Washington to inform planning efforts. 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.

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 and future impacts of the COVID-19 pandemic on mental health and potential for substance use issues among Washingtonians.

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.

Key Takeaways

- **For the most recent reporting period** (CDC Week[1] 14: week of April 9, 2022), **all six syndromic indicators** increased from the previous reporting period**.** It is important to note that the large spike in COVID-19 Emergency Department (ED) visits and significant adverse weather conditions could impact behavioral health ED visits.
    - There were no alerts issued for the reporting period of CDC Week 14
- Survey data collected by the U.S. Census Bureau for **March 30 – April 11, 2022** show **a decrease in anxiety (-15%) and a decrease in depression (-14%)** among adults in Washington. Additionally, more people reported needing therapy or counseling but not receiving it for any reason (+1%) and less people reported that they received counseling or therapy from a mental health professional such as a psychiatrist, psychologist, psychiatric nurse, or clinical social worker (-2%).

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

Impact Assessment

This section summarizes data analyses that show the likely current and future impacts of the COVID-19 pandemic on mental health and potential for substance use issues among Washingtonians.

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 emergency department (ED) data for Washington. 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. While both statistical warnings and alerts indicate more visits than expected, an alert indicates more caution may be warranted.[4] These warnings or alerts will be mentioned within each respective syndrome section.

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 26.8% misclassification rate during that time period.

As of the Week of October 12, 2020 Situation Report (Situation Report 13), ***visits of interest per 10,000 ED visits*** **replaced** ***visit count*** **graphs.** This new measure can help provide insights into: behavioral health impacts since the implementation of the "Stay Home, Stay Healthy" order from March 23, 2020 (CDC Week 13), seasonal shifts year-over-year[5], new visit trends due to COVID-19 symptoms and diagnosis, perceptions of disease transmission and risk, as well as the relative frequency of these indicators for 2019 and 2020. An additional feature of these graphs is the "average weekly difference" in the lower right-hand corner. This feature is a measure of the variation in the weekly volume of visits and allows readers to compare both the year-over-year averages for a particular week, along with the weekly visit fluctuations, to better assess demand for care and care-seeking behaviors.

Because the volume of visits across care settings varied widely during 2020 and to date in 2021, rates presented in this report may not reflect the true magnitude and direction of trends for behavioral health conditions and should be interpreted cautiously.

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[2] https://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/HealthcareProfessionsandFacilities/PublicHealthMeaningfulUse/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.

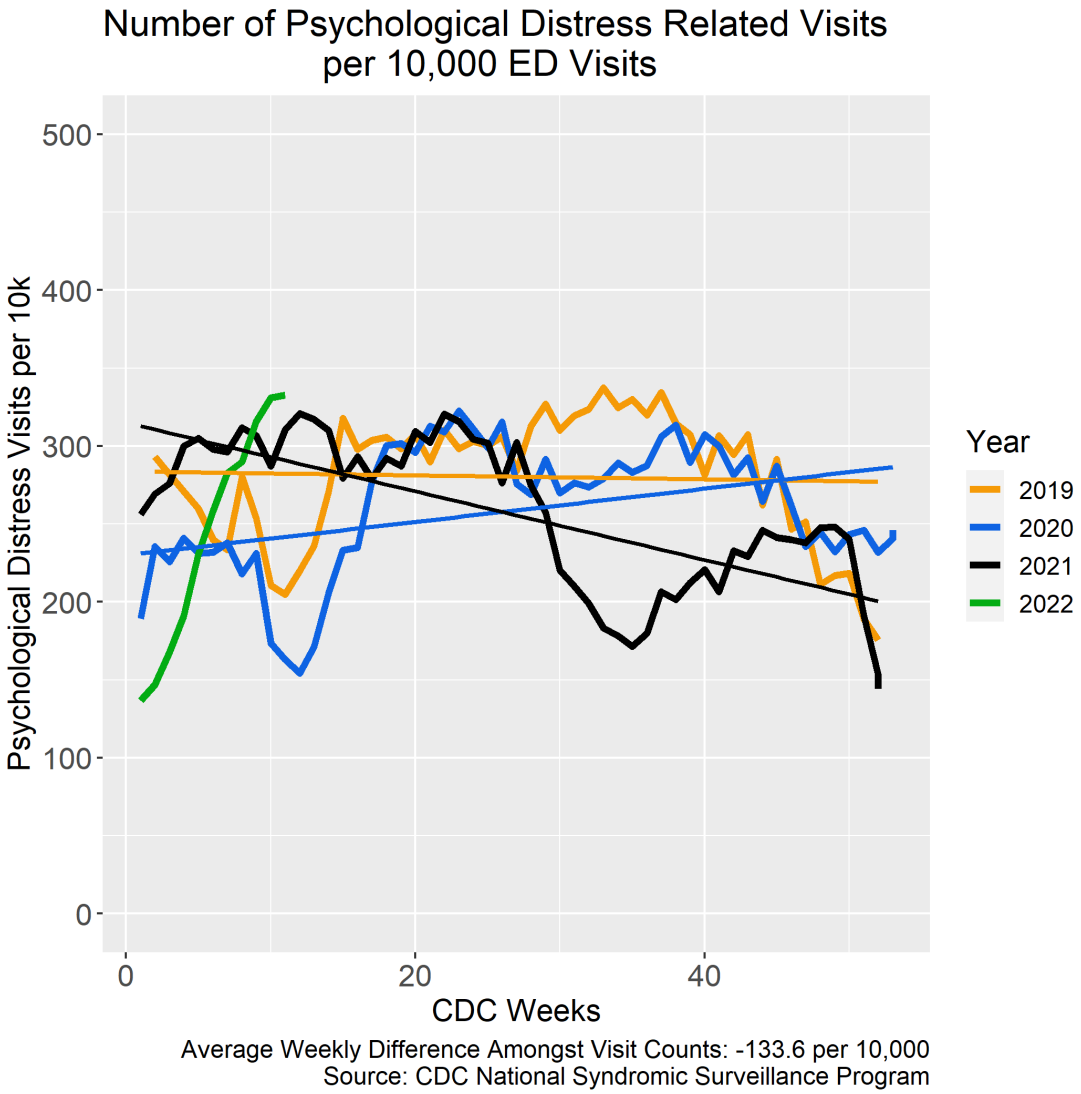
[4] A warning is determined by statistical analysis using p-values from 0.01 – 0.05, while an alert is determined by statistical analysis using p-values of less than 0.01.

[5] Year-over-year: a comparison of two or more years, for example, 2022 compared to 2021, 2020, and 2019.

Psychological Distress

During **CDC Week 14 (week of April 9, 2022)**, the relative reported rate of ED visits for psychological distress[6] **increased from the previous reporting period,** is higher than rates in the corresponding weeks of 2019, 2020, and 2021 (Graph 1). **No statistical warnings or alerts were issued.**

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

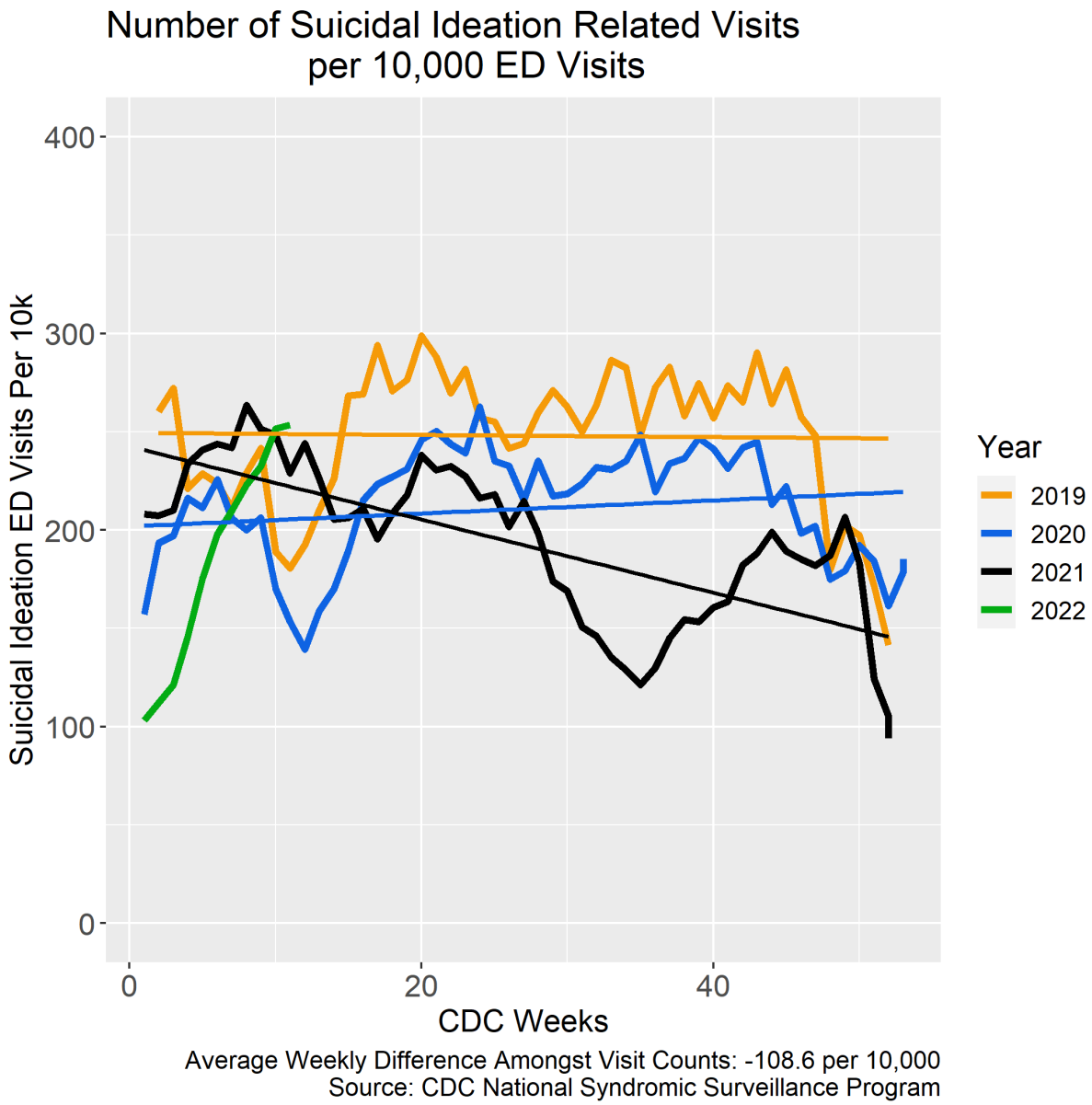


[6] Psychological distress in this context is considered a disaster-related syndrome comprised of panic, stress, and anxiety. It is indexed in the Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE) platform as Disaster-related Mental Health v1. Full details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

Suicidal Ideation and Suspected Suicide Attempts

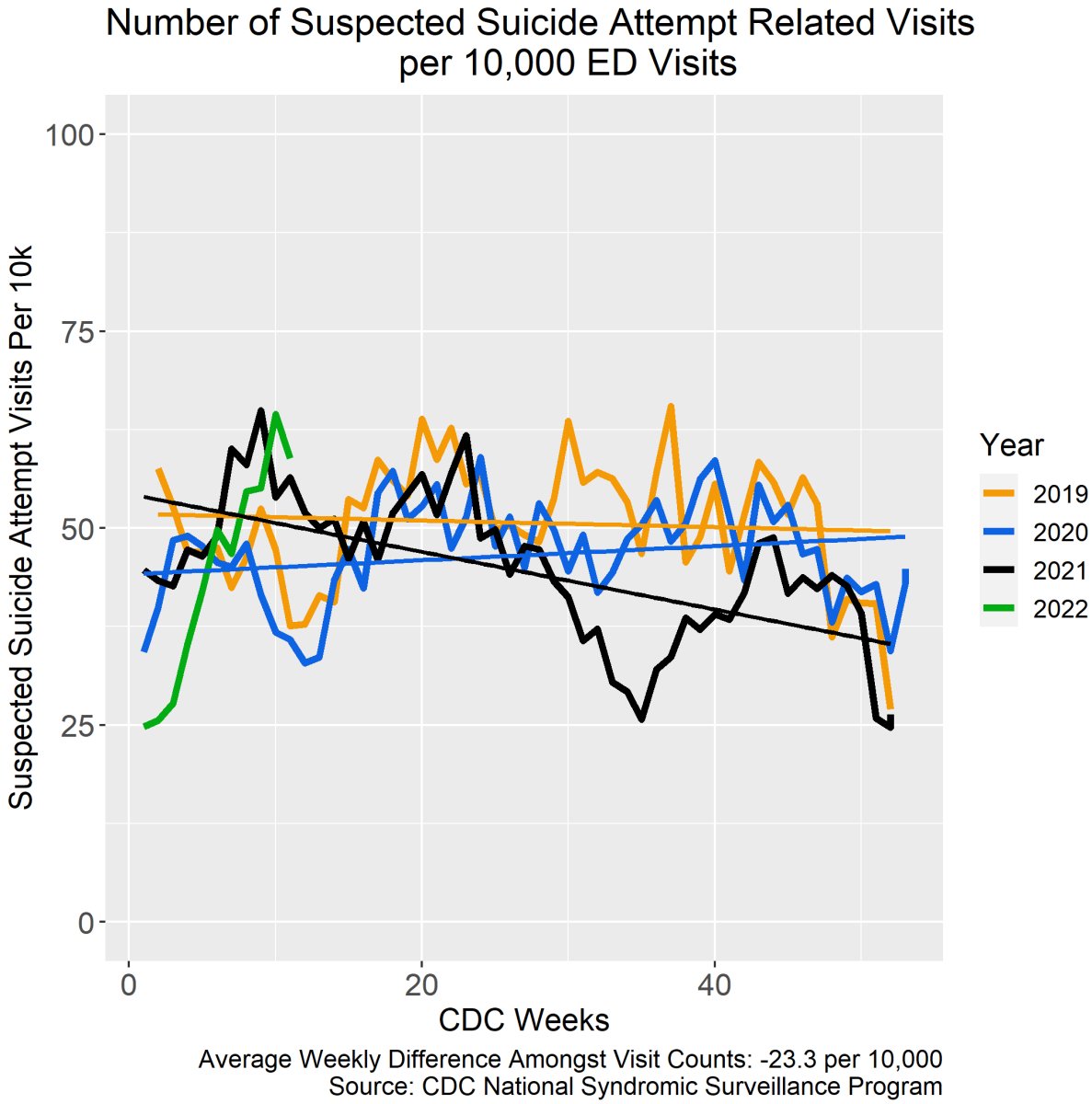
During **CDC Week 14 (week of April 9, 2022)**, the relative reported rate of ED visits for suicidal ideation **increased from the previous reporting period,** is higher than the corresponding weeks of 2019, 2020, and 2021 (Graph 2). **No statistical warnings or alerts were issued.**

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



During **CDC Week 14 (week of April 9, 2022)**, the relative reported rate of ED visits for suspected suicide attempts **increased from the previous reporting period** and is higher than the corresponding weeks of 2019, 2020, and 2021 (Graph 3). Data regarding suspected suicide attempts 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 rate of such visits. **No statistical warnings or alerts were issued.**

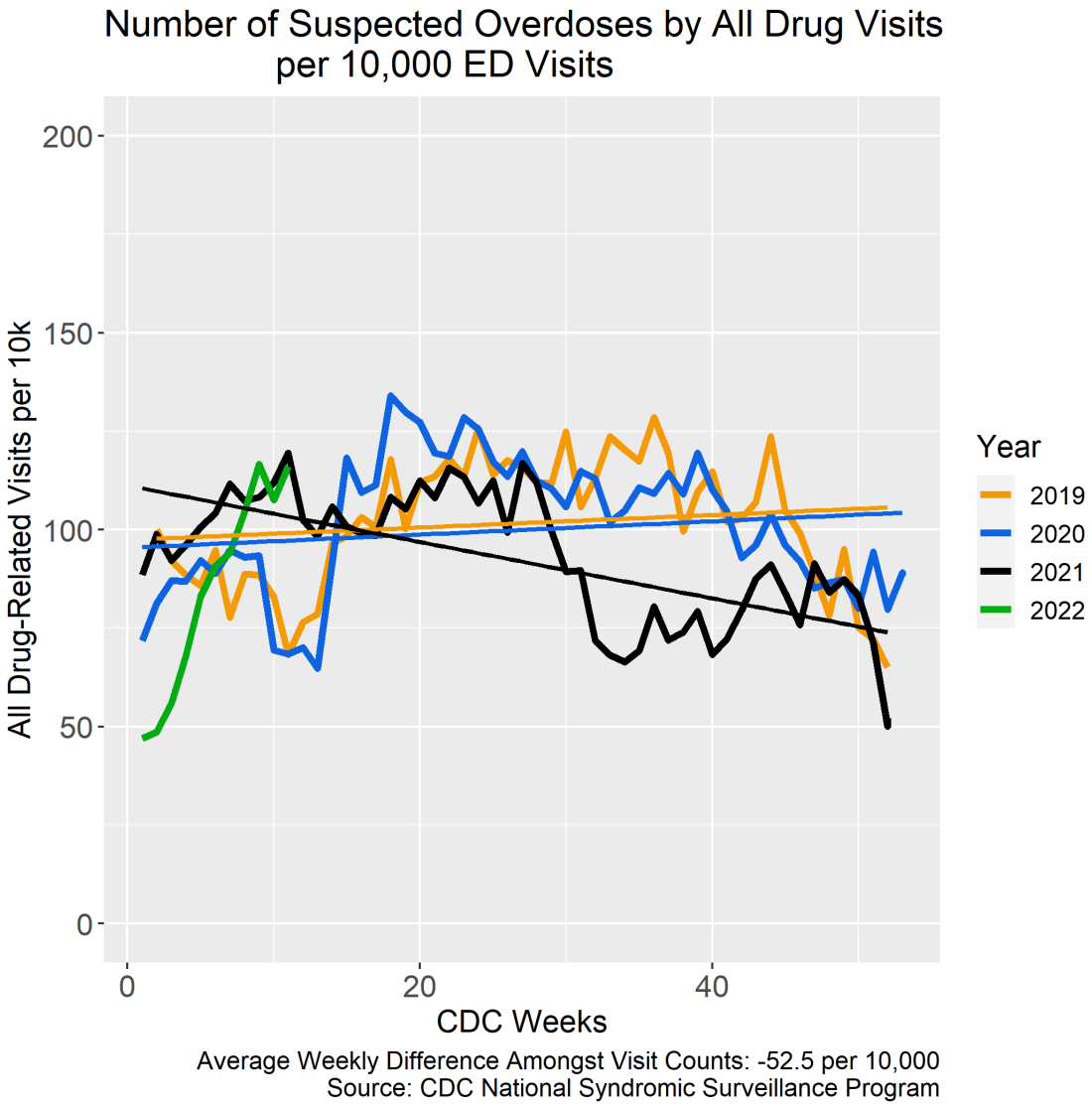
Graph 3: Relative count of ED visits for suspected suicide attempts in Washington, by week: 2019, 2020, 2021, and 2022 to date (Source: CDC ESSENCE)



Substance Use – Drug Overdose and Alcohol-Related Emergency Visits

During **CDC Week 14 (week of April 9, 2022)**, the relative reported rate of all drug[7]-related ED visits **increased from the previous reporting period,** is higher than the corresponding weeks of 2019 and 2020, and has merged with the rate in the corresponding week of 2021 (Graph 4). **No statistical warnings or alerts were issued.**

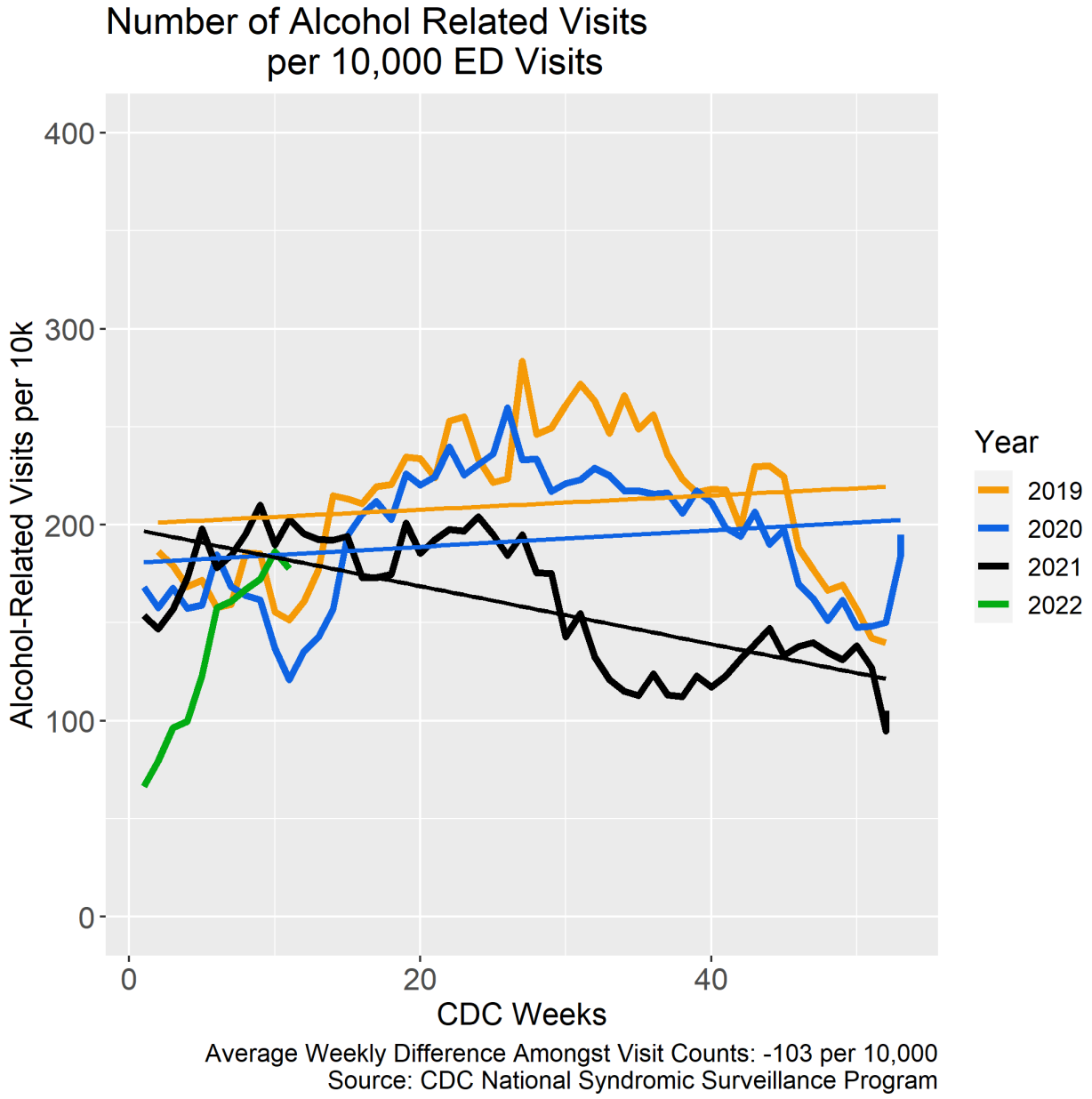
Graph 4: Relative count of all drug-related ED visits in Washington, by week: 2019, 2020, 2021, and 2022 to date (Source: CDC ESSENCE)



[7] 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 14 (week of April 9, 2022)**, the relative reported rate of alcohol-related ED visits **increased from the previous reporting period,** is higher than the rate in the corresponding week of 2019 and 2020, and is lower than the rate in the corresponding week of 2021 (Graph 5). **No statistical warnings or alerts were issued.**

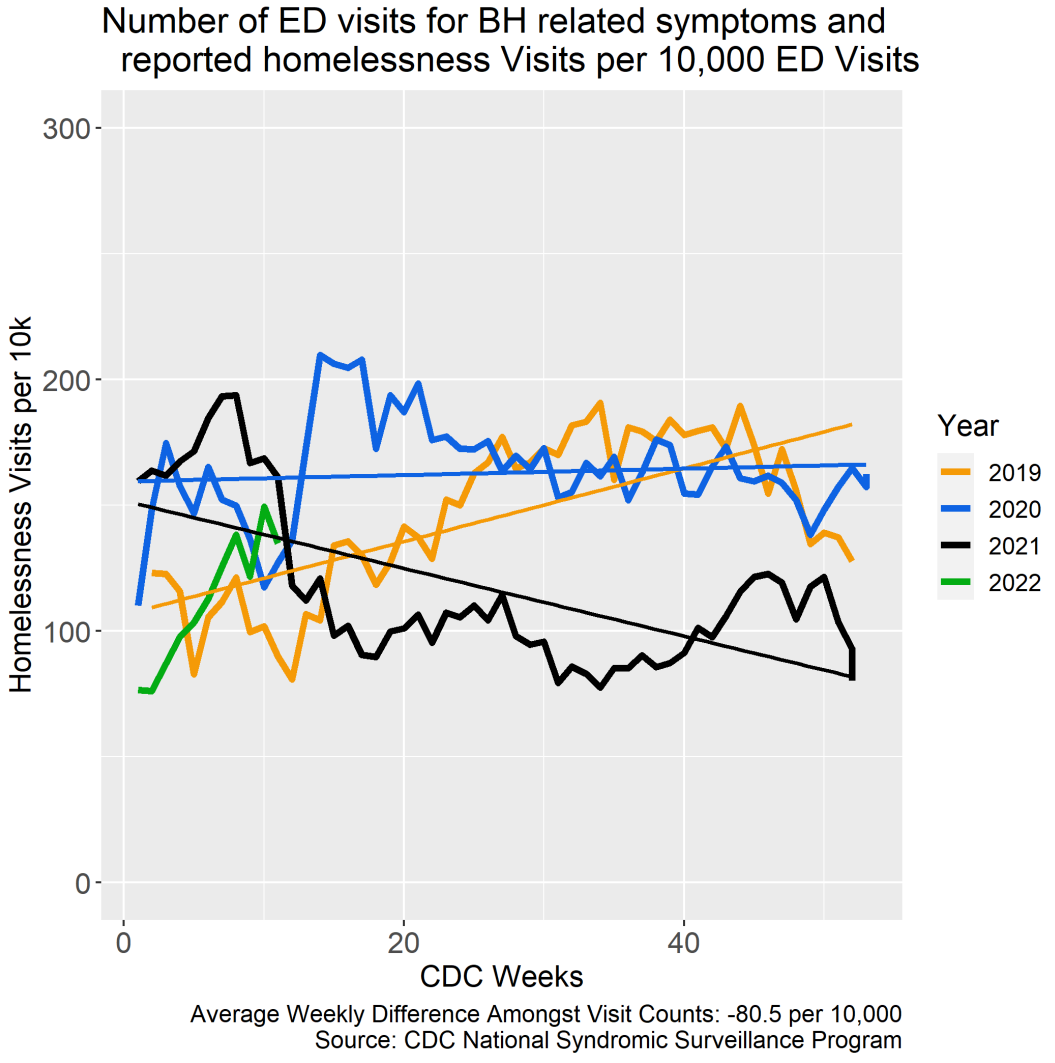
Graph 5: Relative count of alcohol-related ED visits in Washington, by week: 2019, 2020, 2021, and 2022 to date (Source: CDC ESSENCE)



Behavioral Health (BH)-Related and Reported Homelessness

During **CDC Week 14 (week of April 9, 2022)**, the relative reported rate of ED visits for homelessness[8] **increased from the previous reporting period,** is higher than the rate in the corresponding weeks of 2019 and 2020, and is lower than rates in the corresponding week of 2021 (Graph 6). Data regarding ED visits for homelessness should be interpreted with caution; the current CDC definition incorporates patients experiencing homelessness or housing insecurity and behavioral health concerns which has yielded to an ED visit. **No statistical warnings or alerts were issued.**

Graph 6: Relative count of ED visits for behavioral health (BH)-related and reported homelessness in Washington, by week: 2019, 2020, 2021, and 2022 to date (Source: CDC ESSENCE)



[8] The homelessness syndrome identifies emergency department visits for patients who are experiencing homelessness or housing insecurity. For more information: https://knowledgerepository.syndromicsurveillance.org/syndrome-categories/behavioral-health

General Surveillance

Symptoms of Anxiety and Depression

Survey data collected by the U.S. Census Bureau for **March 30 – April 11, 2022** show **a decrease in anxiety (-15%) and a decrease in depression (-14%)** among adults in Washington compared to the previous reporting period of **March 2 – 14, 2022** (Graph 7).[9] In the most recent reporting period represented below, **approximately 1.27 million adults in Washington reported symptoms of anxiety** on all or most days of the previous week, while **approximately 857.9 thousand adults reported the same frequency of symptoms of depression**. Please note that the same respondent may have reported frequent symptoms of both anxiety and depression, and these numbers are not cumulative. These survey data are not in any way related to the data presented in previous sections.

In the March 30 – April 11, 2022 survey data, respondents age 18 – 29 reported the highest rate of frequent symptoms of anxiety (44%), followed by those aged 30 – 39 (28%). Those aged 18 – 29 reported the highest rate of frequent symptoms of depression (38%) followed by those aged 30 – 39 (22%).

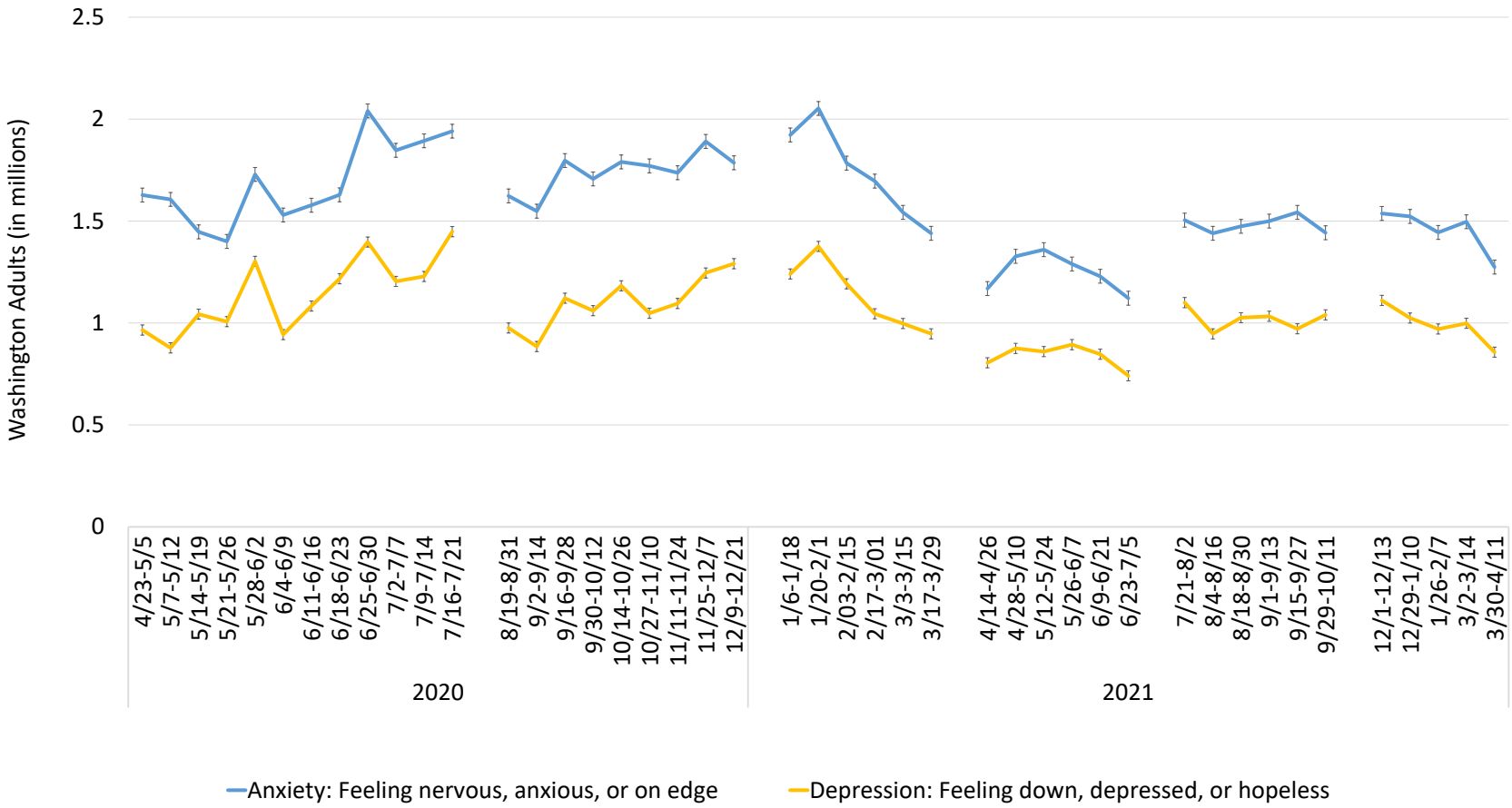
Those who lived in households earning $25,000 - $34,000 per year were the most likely to report frequent symptoms of anxiety (42%), followed by those in households earning $35,000 - $50,000 per year (35%) and less than $25,000 (34%).

Additionally, respondents in households earning less than $25,000 per year reported the highest rate of frequent symptoms of depression (30%), followed by those in households earning $25,000 - $34,000 per year (28%).

Those who identified as female at birth had an increased symptom reporting rate for anxiety as compared to those who identified as male at birth (35% for females, 22% for males) and those who identified as female at birth had a similar reporting rate for depression as those who identified as male at birth (18% for females, 18% for males).

[9] In May, the U.S. Census Bureau began measuring the social and economic impacts of the COVID-19 pandemic with a weekly Household Pulse survey of adults across the country. The survey asks questions related to various topics, such as how often survey respondents have experienced specific symptoms associated with diagnoses of generalized anxiety disorder or major depressive disorder over the past week, as well as services sought. Additional details about the survey can be found at https://www.cdc.gov/nchs/covid19/pulse/mental-health.htm.

Graph 7: Estimated Washington adults with feelings of anxiety and depression at least most days, by week: April 23, 2020 – April 18, 2022 (Source: U.S. Census Bureau)



Note: For the period of July 21 – August 19, 2020, census data was 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[10] collected by the U.S. Census Bureau for **March 2 – 14, 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). Compared to the previous reporting period, **more people reported needing therapy or counseling but not receiving it for any reason (+1%)** and **less people reported that they received counseling or therapy from a mental health professional such as a psychiatrist, psychologist, psychiatric nurse, or clinical social worker (-2%).** For these measures, the standard error suggests the inaccuracy of estimates may be around 3.4% above or below the numbers previously mentioned.

In the March 2 – 14, 2022 survey data, respondents ages 18 – 29 reported the highest percent for needing therapy or counseling but not receiving it for any reason (19%), followed by those ages 30 – 39 (16%). Those ages 18 – 29 reported the highest percent for received counseling or therapy from a mental health professional such as a psychiatrist, psychologist, psychiatric nurse, or clinical social worker (15%) followed by those ages 30 – 39 (14%).

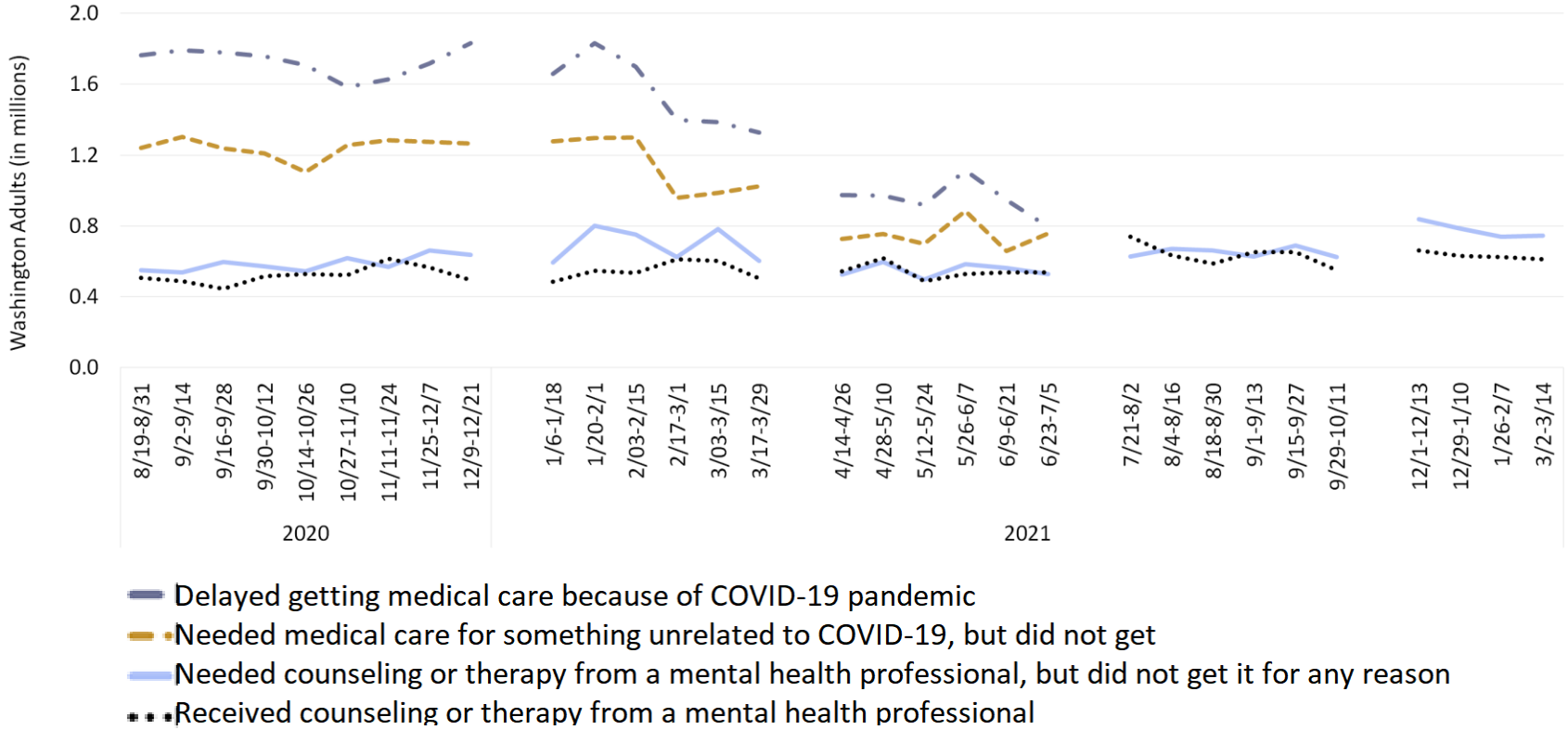
Those who live in households earning less than $25,000 were the most likely to report that they received counseling or therapy from a mental health professional such as a psychiatrist, psychologist, psychiatric nurse, or clinical social worker (18%), followed by those in households earning $50,000 - $75,000 per year (14%).

Additionally, respondents in households earning less than $25,000 per year reported the highest rate for needing therapy or counseling but not receiving it for any reason (25%), followed by those in households earning $25,000 – $35,000 per year (22%).

Those who identified as female at birth had an increased reporting rate for received counseling or therapy from a mental health professional such as a psychiatrist, psychologist, psychiatric nurse, or clinical social worker (14% for females, compared to 7% for males) and those who identified as female at birth had an increased reporting rate for needing therapy or counseling but not receiving it for any reason (16% for females and 9% for males).

[10] https://www.cdc.gov/nchs/covid19/pulse/mental-health-care.htm

Graph 8: Estimated Washington adults who received or delayed medical care or counseling, by week: August 19, 2020 – March 14, 2022 (Source: U.S. Census Bureau)

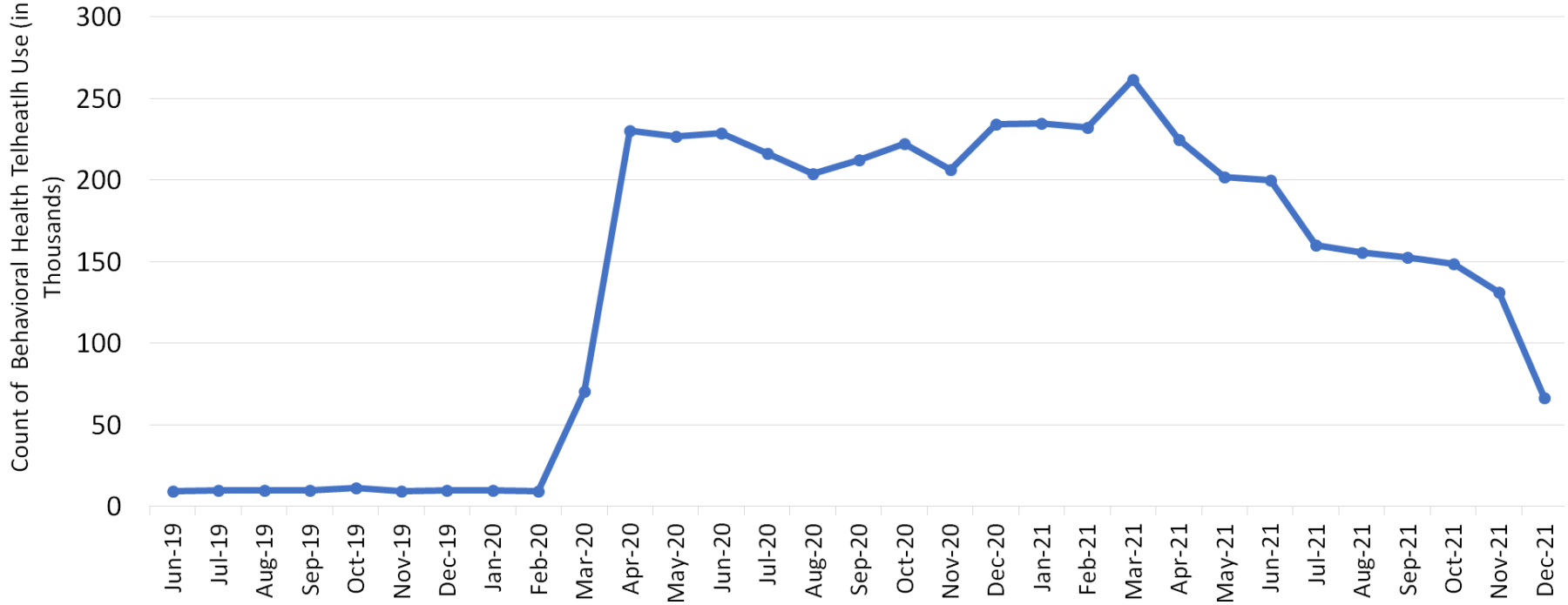


Note: The U.S. Census Bureau briefly paused data collection for the period of December 23, 2020 – January 3, 2021, March 30, 2021 – April 13, 2021, July 6 – 20, 2021, and October 12 – November 31, 2021. Data collection for Phase 3.2 of the Household Pulse Survey impacted survey methodology, questions 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). Graph 9 provides a count of telehealth behavioral health services use claims. 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 (237.6%). Caution should be taken when reviewing data as the "Stay Home, Stay Healthy" order may have impacted telehealth use. Additionally, due to the significant demand for telehealth, several changes were made to policies, coverage, and implementation that could impact this data. The most recent reporting period (December 2021) showed a 49% decrease of telehealth behavioral health services use claims compared to the previous month.

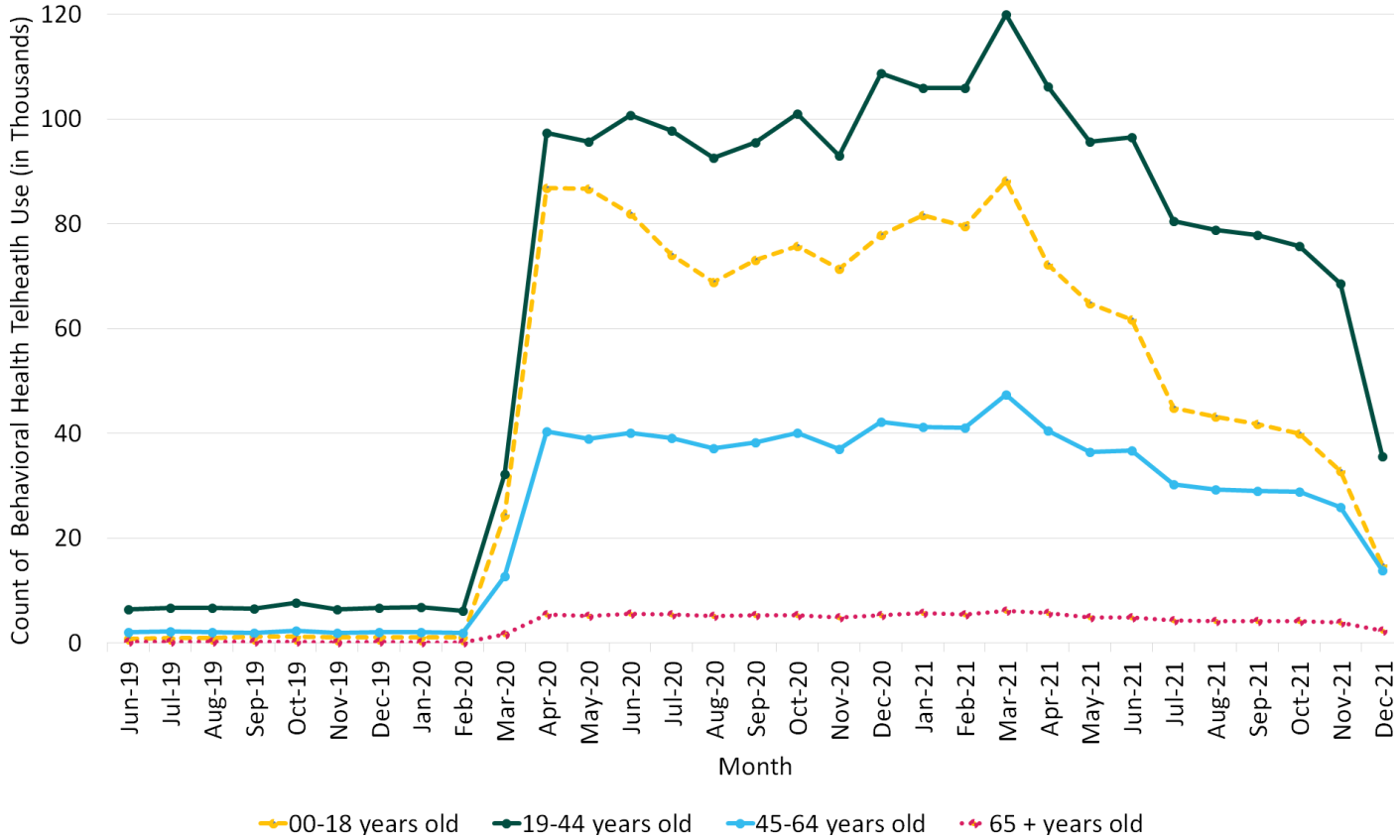
Graph 9: Count of telehealth behavioral health use claims for Washington Medicaid clients, by month (Source: HCA)



Note: Due to missing or suppressed data, results may be underreported.

Graph 10 shows the count of claims for telehealth behavioral health services use stratified (or arranged) by age. Like the non-stratified data, 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. Caution should be taken when reviewing data, as the "Stay Home, Stay Healthy" order may have impacted telehealth use. Additionally, due to the significant need for telehealth, several changes were made to policies, coverage, and implementation that could impact this data. The most recent reporting period (December 2021) showed decreased claims of telehealth behavioral health services (by age group), compared to the previous month: individuals ages 18 and younger (-55%), ages 19 – 44 (-48%), ages 45 – 64 (-47%), and ages 65 and older (-41%).

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

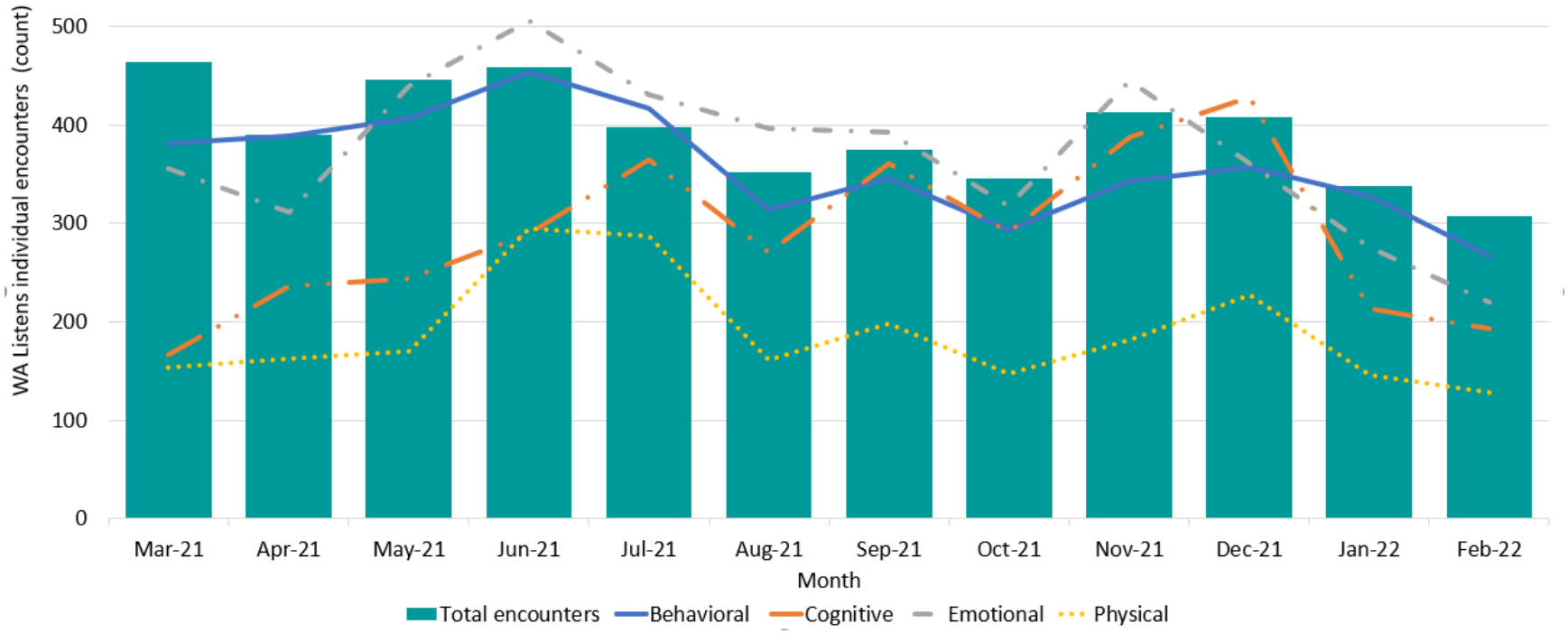


Note: Due to missing or suppressed data, results may be underreported.

Telephonic Support Lines – Service Volume

Washington (WA) Listens[11] is a free, anonymous service that offers non-clinical behavioral health support for both individual and group encounters. Additionally, WA Listens provides referral information to local resources based on the needs expressed. Since its inception in July 2020, a total of 7,415 WA Listens individual encounters have been completed – 338 encounters in the month of January and 307 encounters for the month of February (Graph 11). For **gender, age, and race** information on **individual encounters** in December 2021, see Table 1.

Graph 11: Total count of WA Listens individual calls and concerns, by month (Source: HCA)



Note: Individuals can call about more than one concern, including multiple of the same type. Due to data collection issues, data might be underreported by approximately 5-10%.

[11] https://waportal.org/partners/home/WaListens

Table 1a: Gender, age, and race of January 2022 WA Listens survivors (Source: HCA)

Gender	Count (%)
Female	166 (48.5%)
Male	169 (49.4%)
Transgender	7 (2.1%)

Age	Count (%)
< = 17	1 (0.3%)
18 – 39	141 (41.2%)
40 – 64	130 (38.0%)
> = 65	70 (20.5%)

Race	Count (%)
Other	28 (11.7%)
White	212 (88.3%)

Table 1b: Gender, age, and race of February 2022 WA Listens survivors (Source: HCA)

Gender	Count (%)
Female	123 (39.9%)
Male	183 (54.4%)
Transgender	2 (0.6%)

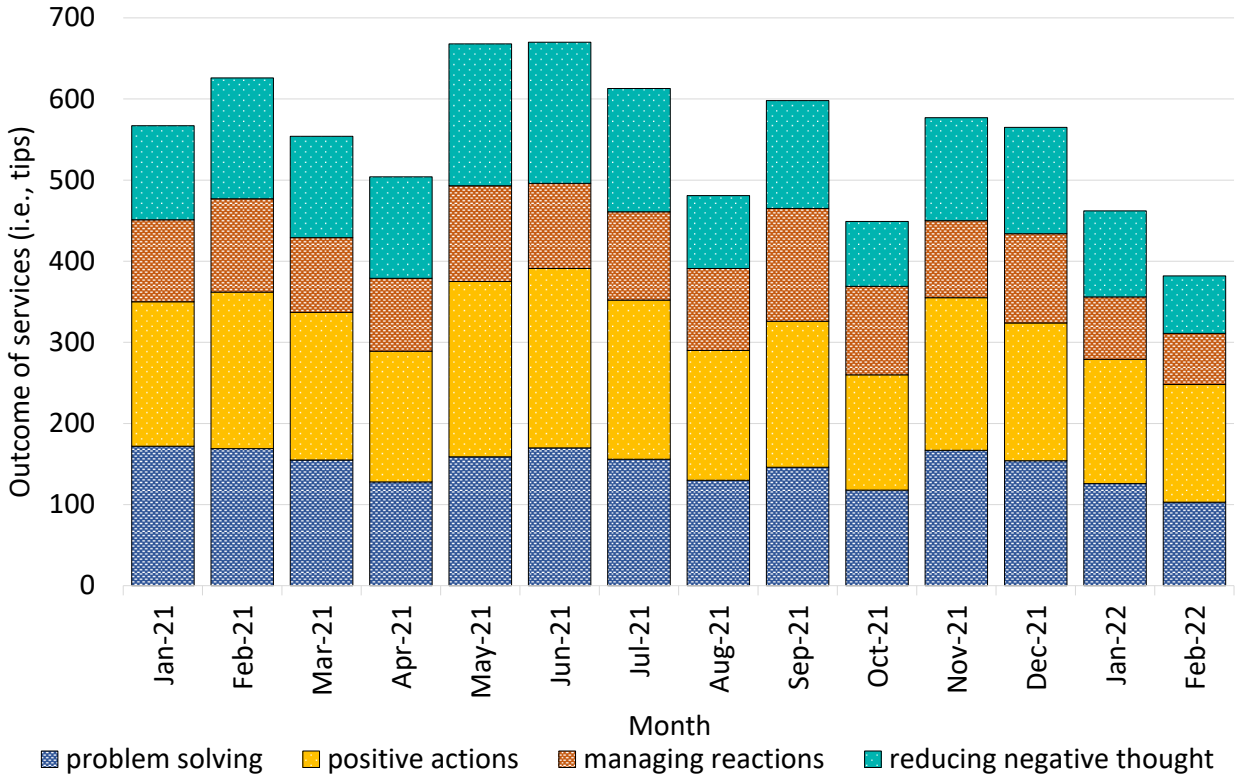
Age	Count (%)
< = 17	1(0.3%)
18 – 39	119 (38.6%)
40 – 64	121 (39.3%)
> = 65	67 (21.8%)

Race	Count (%)
Other	39 (16.3%)
White	200 (83.7%)

Note: Gender, age, and race are not mutually exclusive (i.e., individuals can report more than one gender, age, and race). Due to data collection issues, data might be underreported by approximately 5-10%.

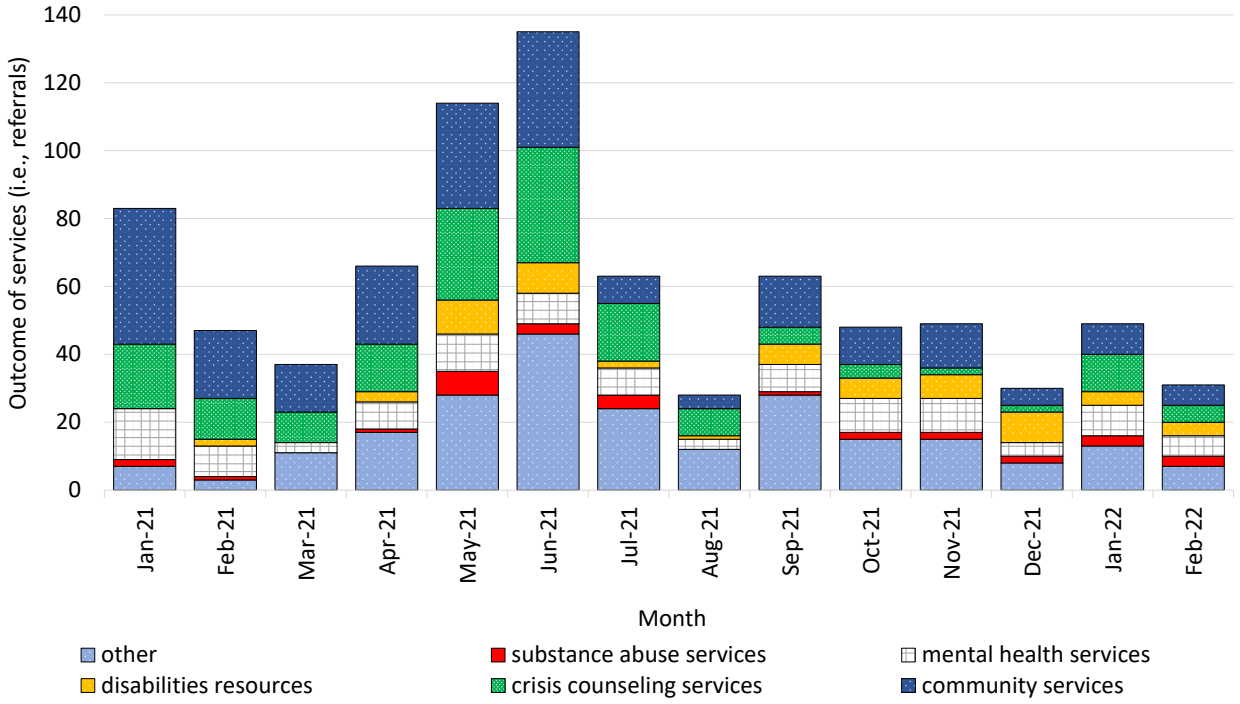
In January 2022, calls for **behavioral concerns** decreased by 8.4%, **cognitive concerns** decreased by 50.23%, **emotional concerns** decreased by 23.61%, and **physical concerns** decreased by 35.68% (Graph 11). In February 2022, calls for **behavioral concerns** decreased by 18.3%, **cognitive concerns** decreased by 9.4%, **emotional concerns** decreased by 20.0%, and **physical concerns** decreased by 12.3%; these data are not mutually exclusive (Graph 11). For **outcomes from services**, see Graph 12 for **tip** outcomes and Graph 13 for **referral** outcomes.

Graph 12: Outcome of services (i.e., tips) for WA Listens individual encounters, by month (Source: HCA)



Note: Tips are not mutually exclusive (i.e., individuals can receive more than one tip). Due to data collection issues, data might be underreported by approximately 5-10%.

Graph 13: Outcome of services (i.e., referrals) for WA Listens individual encounters, by month (Source: HCA)

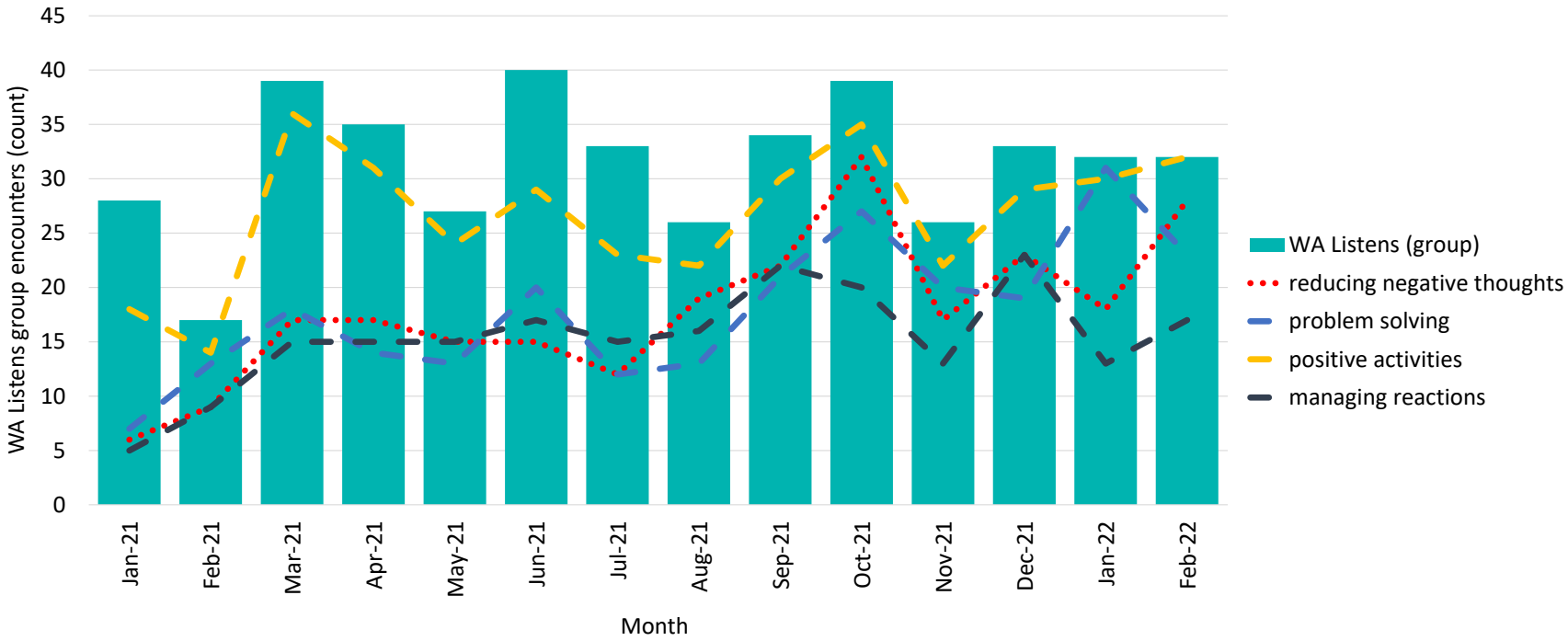


Note: Referrals are not mutually exclusive (i.e., individuals can receive more than one referral). Due to data collection issues, data might be underreported by approximately 5-10%.

Since the start of WA Listens, a total of 474 **group encounters** (2 or more people) have been completed. Graph 14 shows the type of **tip** provided (reducing negative thoughts, managing physical and emotional reactions [e.g., breathing techniques], doing positive things, and problem solving). Due to the group environment, gender, age, and race were not collected in a standardized method.

For **outcomes from services** in January 2022, 96.9% of all group sessions provide at least one **type of information**, while 28.1% of group sessions provided all three **types of information** (i.e., information on reactions to disasters, community resources, and the crisis counseling program). For **outcomes from services** in February 2022, 96.9% of all group sessions provide at least one **type of information**, while 62.5% of group sessions provided all three **types of information**.

Graph 14: WA Listens group encounters and outcome of services, by month (Source: HCA)

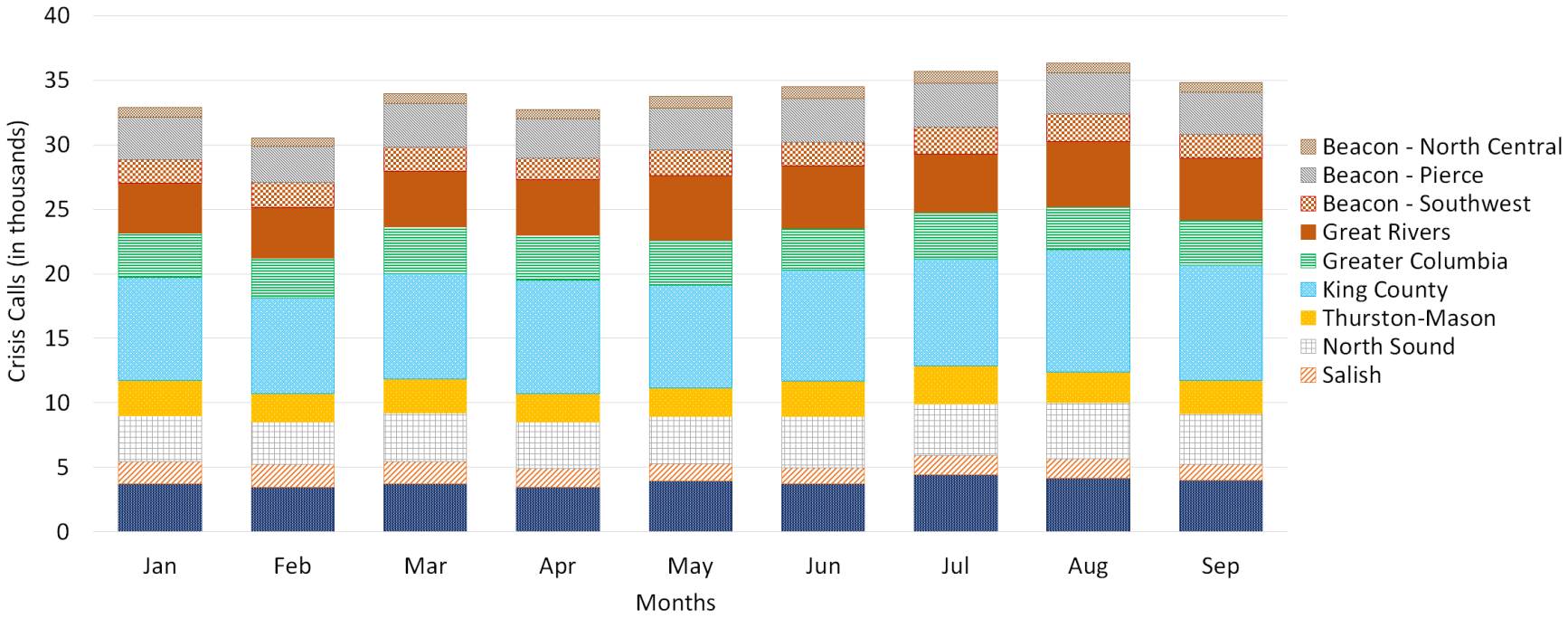


Note: Tips are not mutually exclusive (i.e., individuals can receive more than one tip). Due to data collection issues, data might be underreported by approximately 5-10%.

Crisis System of Care

The crisis system of care completed by behavioral health administrative service organizations[12] (BH-ASOs) provides regional crisis line[13] support that serves as the entry point or *front door* to crisis services (Graph 15). This includes support, initial risk assessment, and referral to appropriate follow up services, if needed. Graph 15 shows data on crisis system utilization for January – September 2021.

Graph 15: Total count of individual encounter crisis calls, by month and BH-ASO (Source: HCA)



In 2021, the average monthly call volume (excluding hang ups, wrong number, and messages) was 33,939. Most recently, September 2022 presented with a 4% decrease of all individual crisis calls as compared to the previous month (August 2021).

[12] https://www.hca.wa.gov/assets/free-or-low-cost/19-0040-bh-aso-map.pdf
[13] https://www.hca.wa.gov/health-care-services-supports/behavioral-health-recovery/mental-health-crisis-lines

Inpatient and Observational Community Hospital Discharges

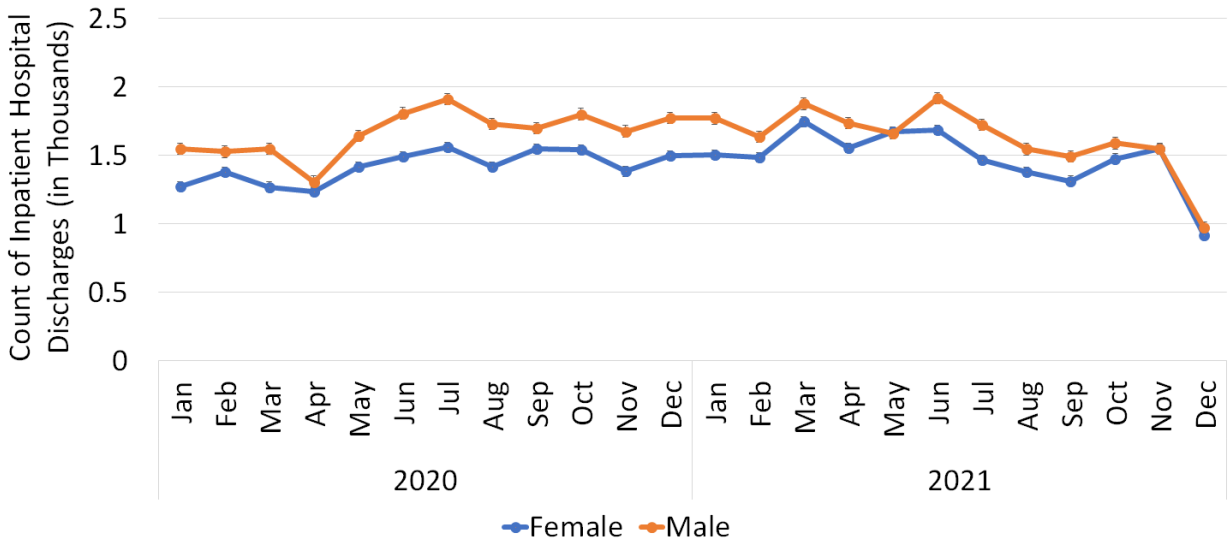
The Comprehensive Hospital Abstract Reporting System (CHARS)[14] collects information on inpatient and observation patient community hospital stays. Caution should be taken when reviewing data, as the "Stay Home, Stay Healthy" order (March 2020) may have impacted hospital discharge data for both inpatient and observation patients. Only mental, behavioral, and neurodevelopmental disorders were evaluated (i.e., primary diagnoses included only ICD-10 F-codes).[15] The most recent reporting period (December 2021) **showed a 39.0% decrease of discharges with a diagnosis of mental, behavioral, and neurodevelopmental disorders from inpatient care from community hospitals** and a **32.3% decrease of discharges with diagnoses of mental, behavioral, and neurodevelopmental disorders from observational care from community hospitals**, compared to the previous month.

Graphs 16 and 17 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 **40.9% decrease for females** and a **37.1% decrease for males**. For **observational** community hospital discharges for mental, behavioral, and neurodevelopmental disorders, the most recent reporting period (December 2021) showed a **50.0% decrease for females** and a **11.5% decrease for males**.

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

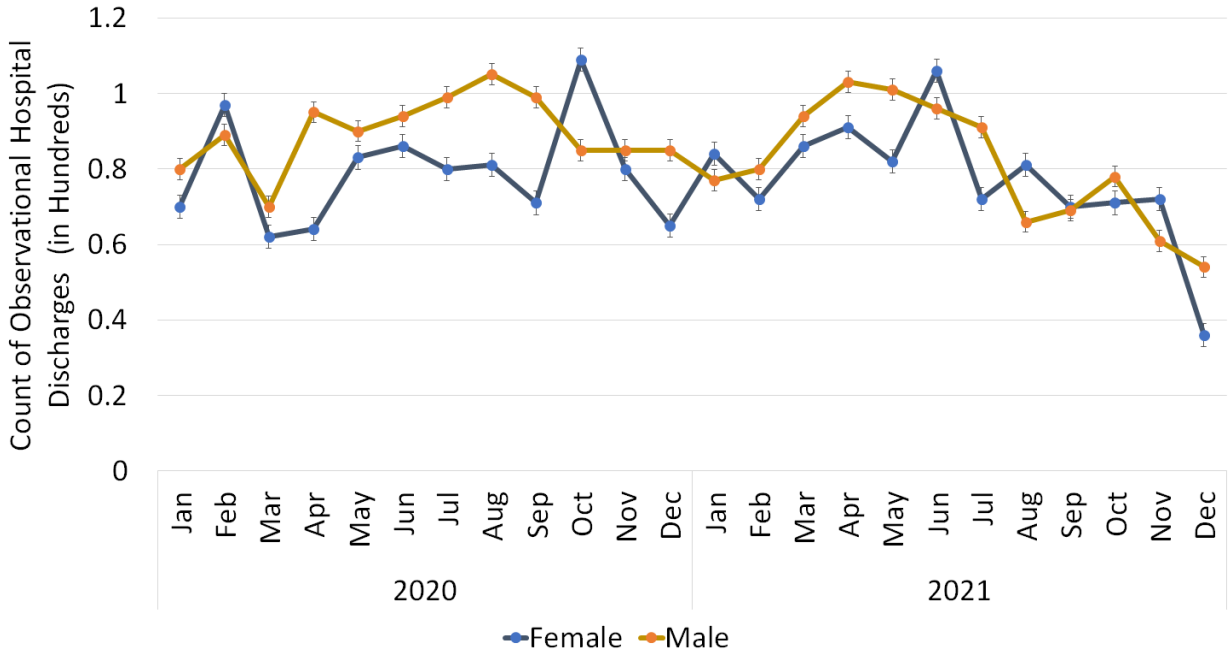
[15] ICD-10 is the Tenth Revision of the International Classification of Disease and Related Health Problems published by the World Health Organization (WHO). F-codes are specifically related to mental, behavioral, and neurodevelopmental disorders.

Graph 16: Count of inpatient community hospital discharges for mental, behavioral, and neurodevelopmental disorders, by month and gender (Source: DOH)



Note: Due to time lag, data might not be complete. While non-Washington residents can discharge from a Washington community hospital, only Washington residents were included in the analysis. Only F-codes as primary diagnoses were included in the analysis, and due to limitation, results may be underreported.

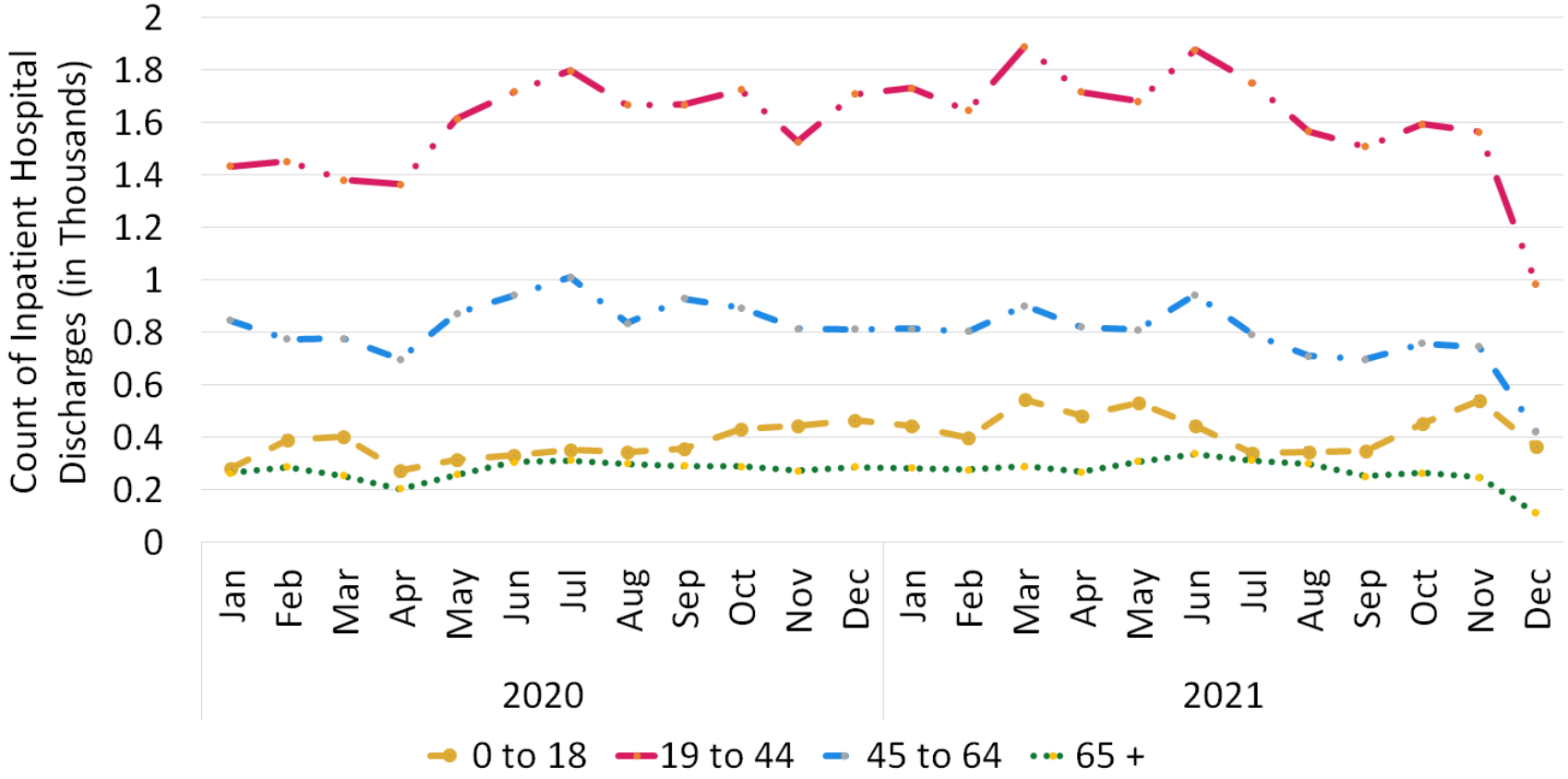
Graph 17: Count of observational community hospital discharges for mental, behavioral, and neurodevelopmental disorders, by month and gender (Source: DOH)



Note: Due to time lag, data might not be complete. While non-Washington residents can discharge from a Washington community hospital, only Washington residents were included in the analysis. Only F-codes as primary diagnoses were included in the analysis, and due to limitation, results may be underreported.

Graph 18 shows counts of inpatient community hospital discharges for mental, behavioral, and neurodevelopmental disorders separated by age. Due to low numbers, no further separation was conducted for observational community hospital discharges. Compared to the previous month, the most recent reporting period (December 2021) showed a 32.3% decrease for those 0 – 18 years old, a 37.0% decrease for individuals ages 19 – 44 years, a 43.3% decrease for individuals ages 45 – 64 years, and a 54.0% decrease for individuals ages 65 years and older.

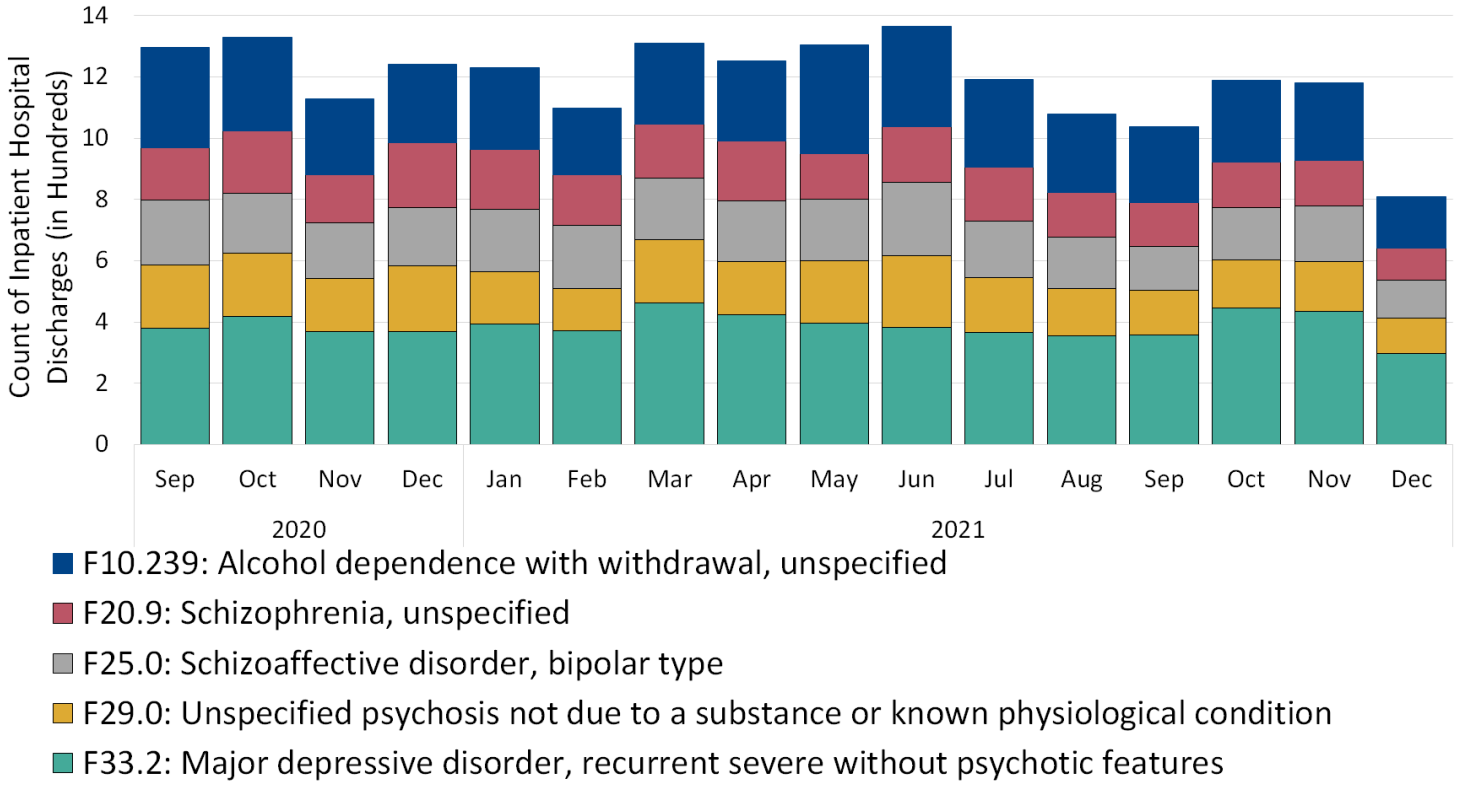
Graph 18: Count of inpatient community hospital discharges for mental, behavioral, and neurodevelopmental disorders, by month and age (Source: DOH)



Note: Due to time lag, data might not be complete. While non-Washington residents can discharge from a Washington community hospital, only Washington residents were included in the analysis. Only F-codes as primary diagnoses were included in the analysis, and due to limitation, results may be underreported.

Graph 19 shows the count of the top five mental, behavioral, and neurodevelopmental disorders in terms of inpatient community hospital discharges. Due to low numbers, no further separation was conducted for observational community hospital discharges. The most recent reporting period showed a decrease in four of five mental, behavioral, and neurodevelopmental disorders. Compared to the previous month, there was a 33.7% decrease in "alcohol dependence with withdrawal, unspecified," a 30.4% decrease in "schizoaffective disorder, bipolar type," a 29.2% decrease in "unspecified psychosis not due to a substance or known physiological condition," in inpatient community hospital discharges, a 30.7% decrease in "schizophrenia, unspecified," and a 31.7% decrease in "major depressive disorder, recurrent severe without psychotic features" in inpatient community hospital discharges.

Graph 19: Count of the top mental, behavioral, and neurodevelopmental disorders for inpatient community hospital discharges, by month (Source: DOH)

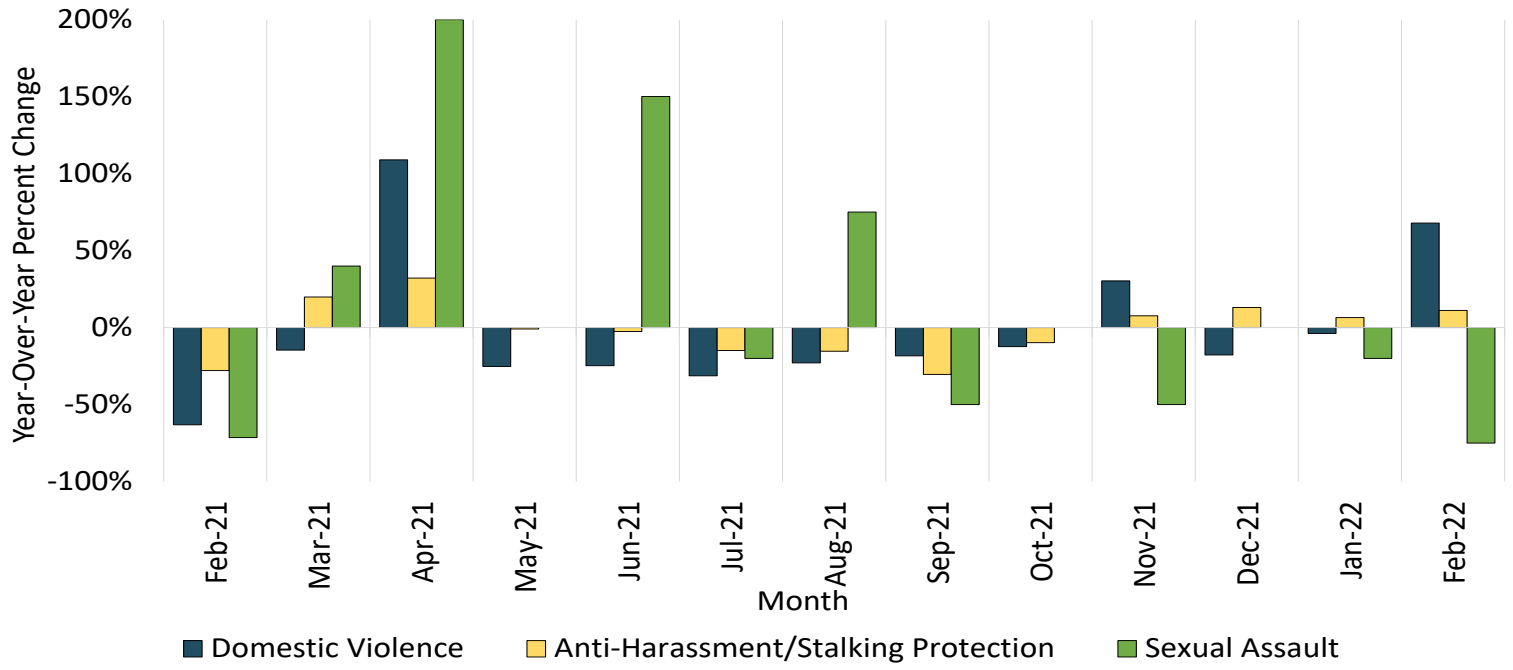


Note: Due to time lag, data might not be complete. While non-Washington residents can discharge from a Washington community hospital, only Washington residents were included in the analysis. Only F-codes as primary diagnoses were included in the analysis, and due to limitation, results may be underreported.

Protection Order Filings

Monthly protection order (for domestic violence, anti-harassment, and sexual assault) filings from the Washington Administrative Office of the Courts (AOC) show the initiation of a court case by formal submission. Note that the "Stay Home, Stay Healthy" order and associated court closures may impact court filing data. February 2022 presented a year-over-year (i.e., February 2022 compared to February 2021) percent change for protection orders for anti-harassment/stalking (+11%), domestic violence (+68%), and sexual assault (-75%) protection orders (Graph 20). For February, there was an increase in domestic violence (24%) and anti-harassment/stalking protection (4%), and a decrease in sexual assault compared to the previous month (75%).

Graph 20: Protection orders filed, in Washington, by month (Source: AOC)

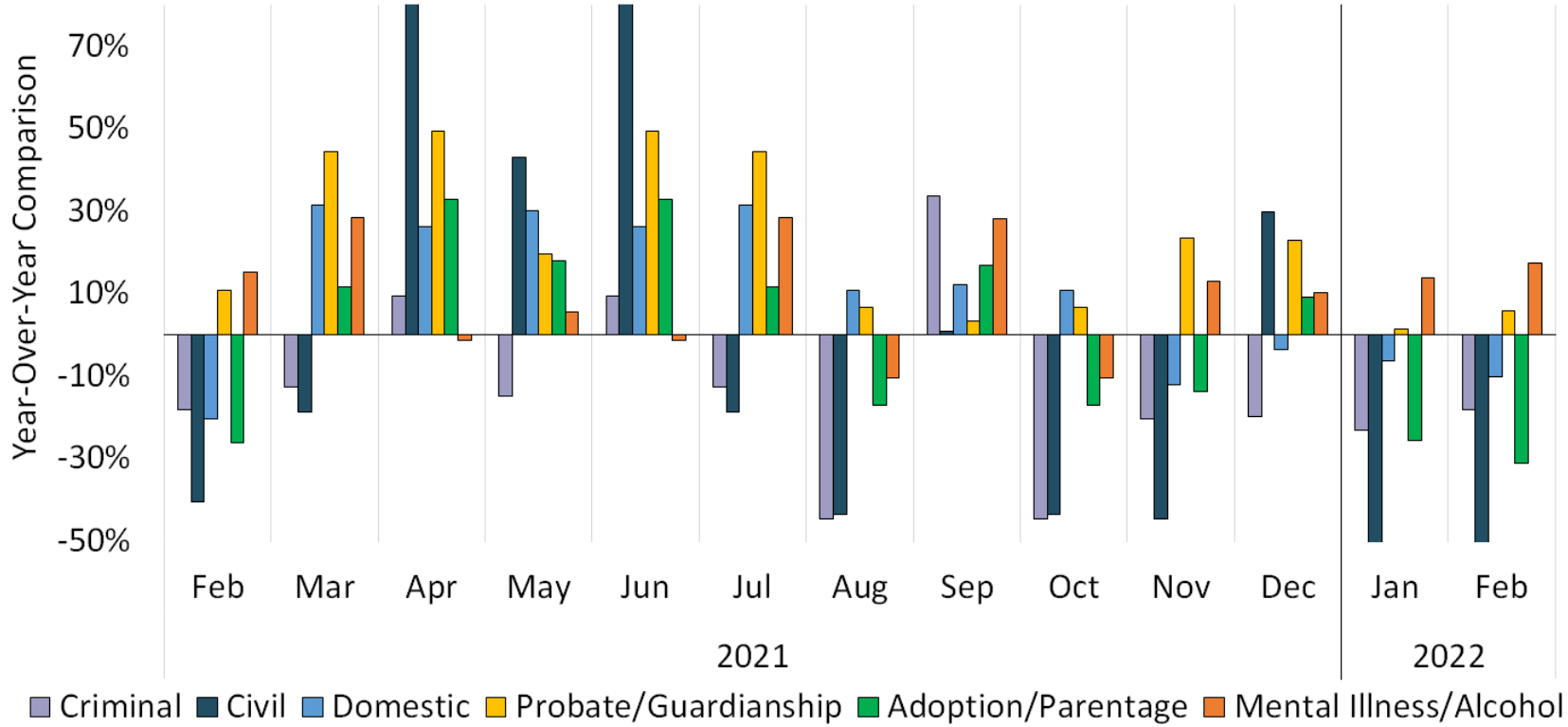


Note: For civil case protection orders, a petition for an order of protection is filed by a person seeking relief from an allegedly violent person, either related to or living with the petitioner. Anti-harassment petitions included in this category began to be processed by district courts effective July 1, 1991. Stalking protection order petitions began reporting in this category effective July 28, 2013.

Superior Court Case Filings

Monthly superior court case filings (e.g., criminal, civil, domestic, probate or guardianship, adoption or parentage, and mental illness and alcohol) are recorded by AOC. The total count of superior court case filings decreased from March 2020 to May 2020. Note that the court closures associated with the "Stay Home, Stay Healthy" order may have impacted court filing data. The most recent reporting period (February 2022) presented with year-over-year percent changes in criminal (-18%), civil (-55%), domestic (-10%), adoption/parentage (-31%), mental illness/alcohol (+17%), and probate/guardianship (+6%) court case filings (Graph 21).

Graph 21: Superior court cases filed, in Washington, by month (Source: AOC)



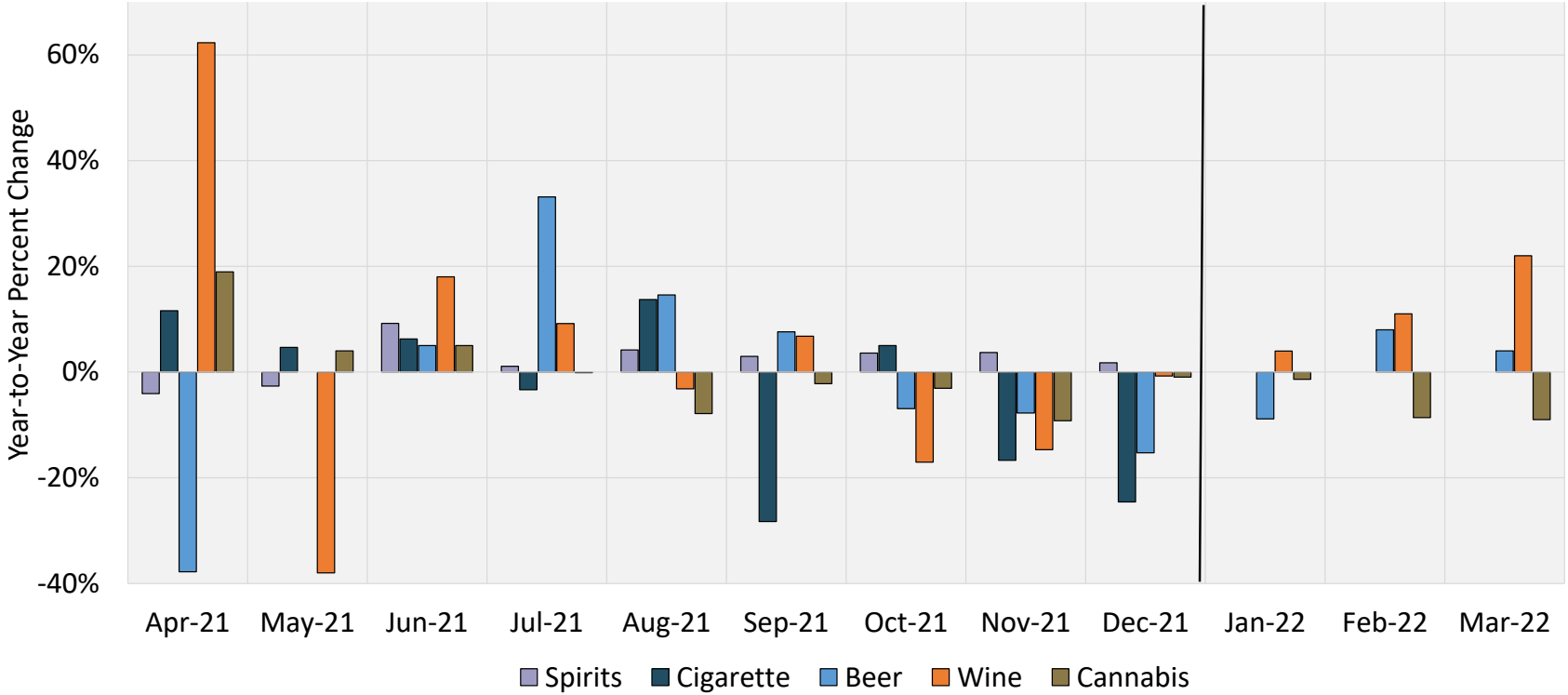
Note: **Criminal cases** are categorized by the primary (i.e., most serious) original charge in the following order: homicide, sex crime, robbery, assault, theft/burglary, motor vehicle theft, controlled substances, other felony, and misdemeanors. **Civil cases** pertain to the settlement of disputes between and among individuals, organizations, or groups and have to do with the establishment, recovery, or redress of private and civil rights. **Domestic cases** include child custody, committed intimate relationships, dissolution with children (and no children) of the marriage, annulment/invalidity, out-of-state-child custody, and

legal separation. **Probate cases** pertain to registering a will, determining whether a will is a valid instrument, the statutory method of establishing a will's proper execution, or the disposition of an estate in the absence of a will. **Guardianship cases** pertain to the relationship between a person lawfully invested with the power and charged with the duty of taking care of the rights of another person who is considered by the court to be incapable of caring for themself. **Adoption/parentage cases** pertain to the establishment of a new, permanent relationship of a parent and child between persons not having that relationship (this includes adoption petitions filed in relation to actions of relinquishment or termination of parental rights) and to determine the legal status of an alleged biological parent. **Mental illness cases** involve the determining whether an individual is mentally ill or incapacitated and should be placed in or remain under care, custody, and treatment. **Alcohol cases** involve determining whether an individual is incapacitated by alcohol and should be committed to an institution for treatment.

Product Sales – Alcohol, Cannabis, and Cigarette Taxes

The Washington State Liquor and Cannabis Board (LCB) and the Washington State Department of Revenue (DOR) summarize monthly tax collections, which may be used as a representation of sales of legal recreational substances and by extension, potential for substance use issues. For January 2022, beer and cannabis tax collections showed year-over-year percent decreases while wine tax collections showed year-over-year percent increases (Graph 22). Note that on January 1, 2021, the legal age to purchase cigarettes in Washington increased from 18 to 21.

Graph 22: Year-over-year percent change in select product sales indicators, by month: from April 2021 – March 2022 (Source: LCB, DOR)



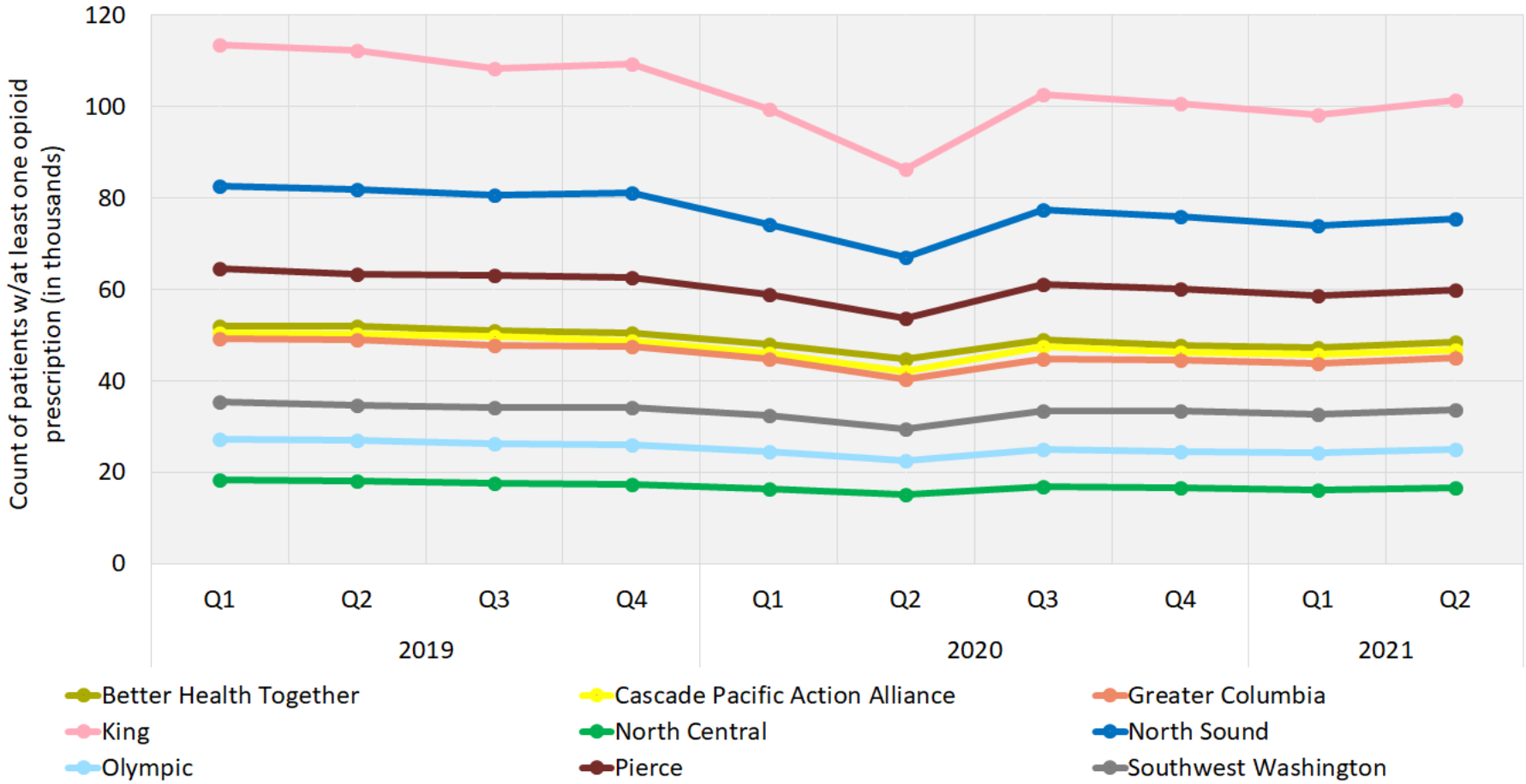
Note: Timing of LCB revenue collection can impact LCB data. Vertical axis has been decreased to provide better detailed presentation.
Note 2: Spirit tax and cigarette tax for January – March 2022 was unavailable.

Prescription Opioids Usage

DOH's Prescription Monitoring Program (PMP) collects the prevalence of prescription opioid use. **For the overall Washington population,** the most recent reporting period (Quarter 2 of 2021) showed a **3% increase** of patients with at least one opioid prescription submitted to the PMP as compared to the previous calendar quarter (Quarter 1 of 2021). Graph 23 provides a count of patients, broken down by calendar quarter and Accountable Communities of Health (ACHs), with at least one opioid prescription submitted to the PMP. Stratifying by ACHs:

- For **Better Health Together ACH**, the most recent reporting period (Quarter 2 of 2021) showed a **3% increase** of patients with at least one opioid prescription submitted to the PMP as compared to the previous calendar quarter (Quarter 1 of 2021).
- For **Cascade Pacific Action Alliance ACH**, the most recent reporting period (Quarter 2 of 2021) showed a **2% increase** of patients with at least one opioid prescription submitted to the PMP as compared to the previous calendar quarter (Quarter 1 of 2021).
- For **Greater Columbia ACH**, the most recent reporting period (Quarter 2 of 2021) showed a **2% increase** of patients with at least one opioid prescription submitted to the PMP as compared to the previous calendar quarter (Quarter 1 of 2021).
- For **King ACH**, the most recent reporting period (Quarter 2 of 2021) showed a **3% increase** of patients with at least one opioid prescription submitted to the PMP as compared to the previous calendar quarter (Quarter 1 of 2021).
- For **North Central ACH**, the most recent reporting period (Quarter 2 of 2021) showed a **3% increase** of patients with at least one opioid prescription submitted to the PMP as compared to the previous calendar quarter (Quarter 1 of 2021).
- For **North Sound ACH**, the most recent reporting period (Quarter 2 of 2021) showed a **2% increase** of patients with at least one opioid prescription submitted to the PMP as compared to the previous calendar quarter (Quarter 1 of 2021).
- For **Olympic ACH**, the most recent reporting period (Quarter 2 of 2021) showed a **3% increase** of patients with at least one opioid prescription submitted to the PMP as compared to the previous calendar quarter (Quarter 1 of 2021).
- For **Pierce ACH**, the most recent reporting period (Quarter 2 of 2021) showed a **2% increase** of patients with at least one opioid prescription submitted to the PMP as compared to the previous calendar quarter (Quarter 1 of 2021).
- For **Southwest Washington ACH**, the most recent reporting period (Quarter 2 of 2021) showed a **3% increase** of patients with at least one opioid prescription submitted to the PMP as compared to the previous calendar quarter (Quarter 1 of 2021).

Graph 23: Count of patients with at least one opioid prescription, by calendar quarter and ACHs (Source: DOH)



Note: Caution should be taken when examining these data. For overall Washington population, for Quarter 2 of 2021, 95% Confidence Interval (CI) [121.70, 123.26] with a state population of 779,842 and state rate of 122.48. For 2021, population estimates are based on the Office of Financial Management (OFM)'s 2020 population estimates; data can be potentially impacted when OFM releases the 2021 population estimates. Please refer to link, opioid data technical notes (PDF) (wa.gov), for technical details and limitations about the data and the metrics utilized including CI, ACH populations, and ACH state rate. For more information, please refer to link: dashboard: Opioid Prescriptions and Drug Overdoses

NICS Background Checks – Firearms and Handguns

The National Instant Criminal Background Check System (NICS), operated by the FBI, requires a national namecheck system for federal firearms licensees (FFL). Federal background checks for gun sales may represent access to firearms, which is a risk factor for suicide and other gun violence.[16,17,18,19] Nationally and in Washington, the year-over-year percent change of **firearm background checks** fluctuated in the first half of 2020 but maintained an increase from July 2020 to February 2021. In the same time period, Washington showed a higher percent change of firearm background checks compared to the rest of the United States in all but one month. In February 2022, Washington showed a year-over-year percent decrease (-9%) in the number of background checks, similar to the rest of the United States (-26%) (Graph 24).

Overall, the year-over-year percent change of **handgun background checks** has been higher in 2020 than in 2019, with June and July showing the greatest year-over-year monthly increases. Similar to firearms, Washington showed a higher percent change of handgun background checks from July to December 2020 as compared to the rest of the United States, and again showed a greater percent change in February 2021. While this does not account for a higher absolute number of handgun background checks, this finding reveals an increase of background checks from 2019 to early 2021. In February 2022, there was a year-over-year percent decrease at both the state (-12%) and national (-3%) levels (Graph 25).

Potential social and political impacts, such as protests in the spring and summer of 2020 and contentious federal elections and subsequent election-related events (November 2020 through January 2021), could be affecting the number of firearm and handgun background checks. Specific to Washington, since July 2020 legislative updates on firearm regulations[20] have been introduced such as new limitations on where firearms may be carried or stored.

[16] From the Federal Bureau of Investigation: "It is important to note that the statistics within this chart represent the number of firearm background checks initiated through the NICS [National Instant Criminal Background Check System]. They do not represent the number of firearms sold. Based on varying state laws and purchase scenarios, a one-to-one correlation cannot be made between a firearm background check and a firearm sale."

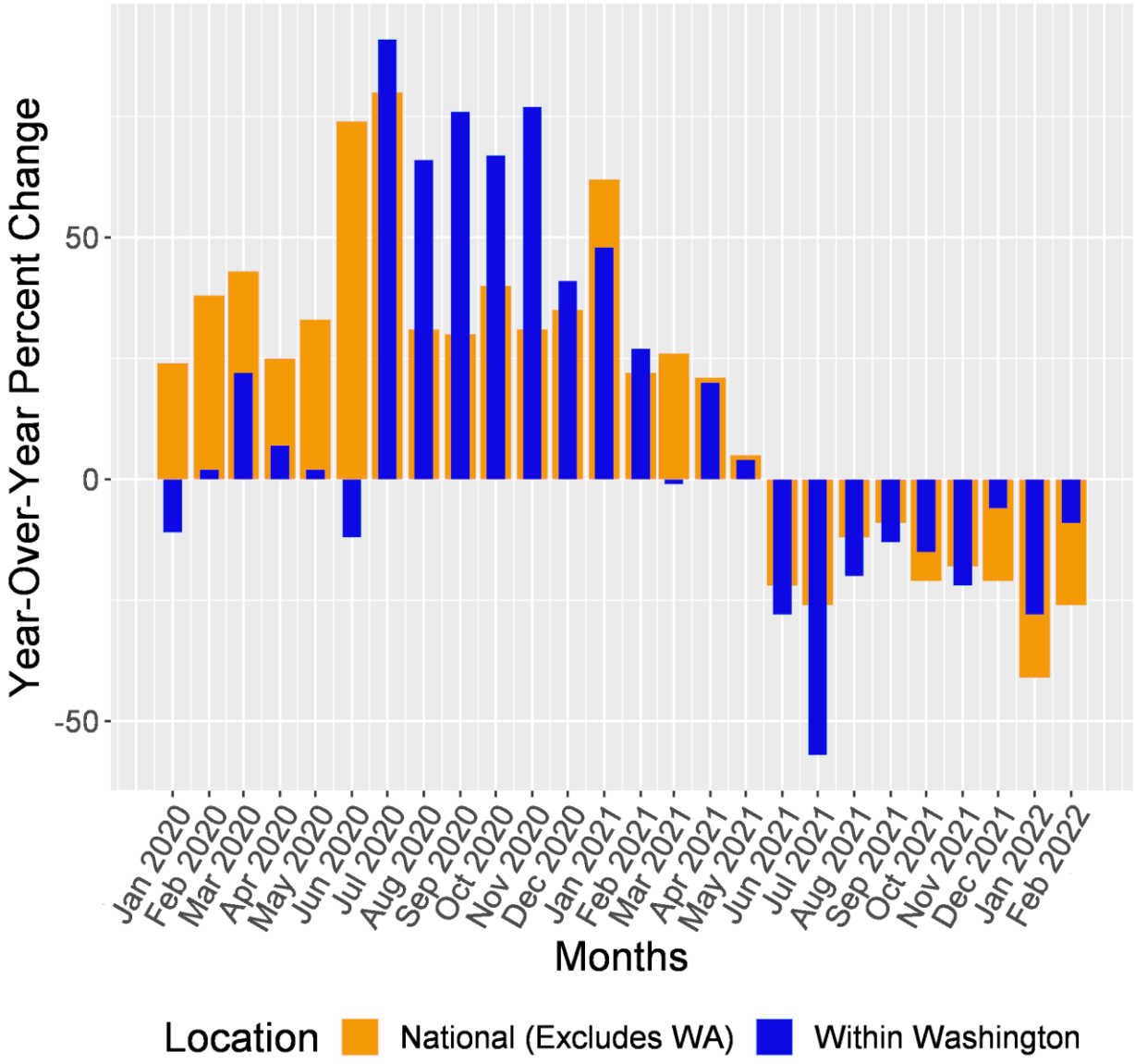
[17] Nemerov, H. R. (2018). Estimating Guns Sold by State. SSRN: http://dx.doi.org/10.2139/ssrn.3100289

[18] Anglemyer, A., Horvath, T., & Rutherford, G. (2014). The accessibility of firearms and risk for suicide and homicide victimization among household members: a systematic review and meta-analysis [published correction appears in Ann Intern Med. 2014 May 6. 160(9), 658-9]. *Ann Intern Med, 160*(2), 101-110. doi:10.7326/M13-1301

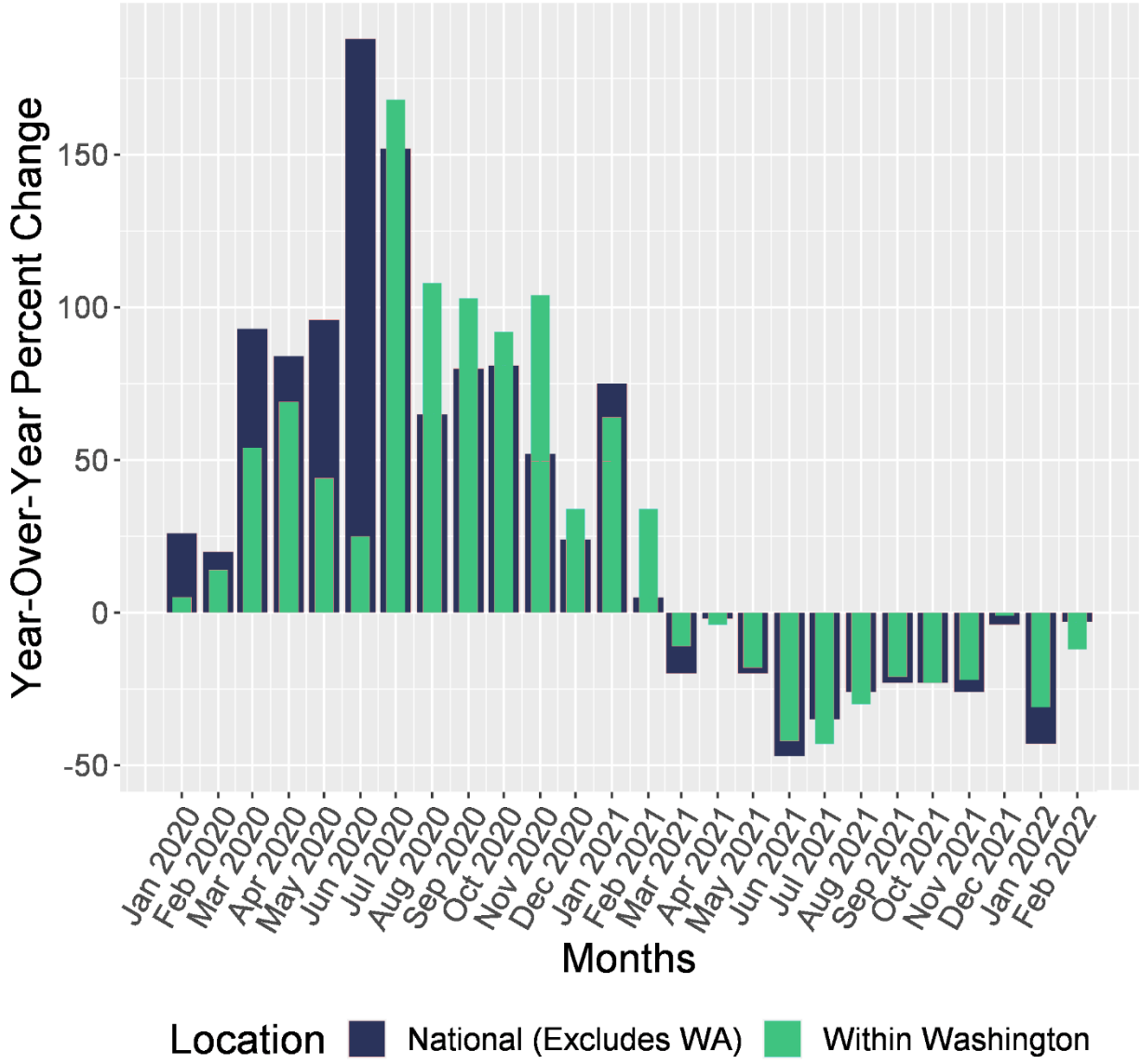
[19] Saadi, A., Choi, K. R., Takada, S., & Zimmerman, F. J. (2020). The impact of gun violence restraining order laws in the US and firearm suicide among older adults: a longitudinal state-level analysis, 2012–2016. *BMC Public Health,* 20, 1-8.

[20] Final Bill Report ESSB 5078: https://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bill%20Reports/Senate/5078-S.E%20SBR%20FBR%2022.pdf?q=20220323105509

Graph 24: Percent change of NICS firearm background checks, by month (Source: FBI)



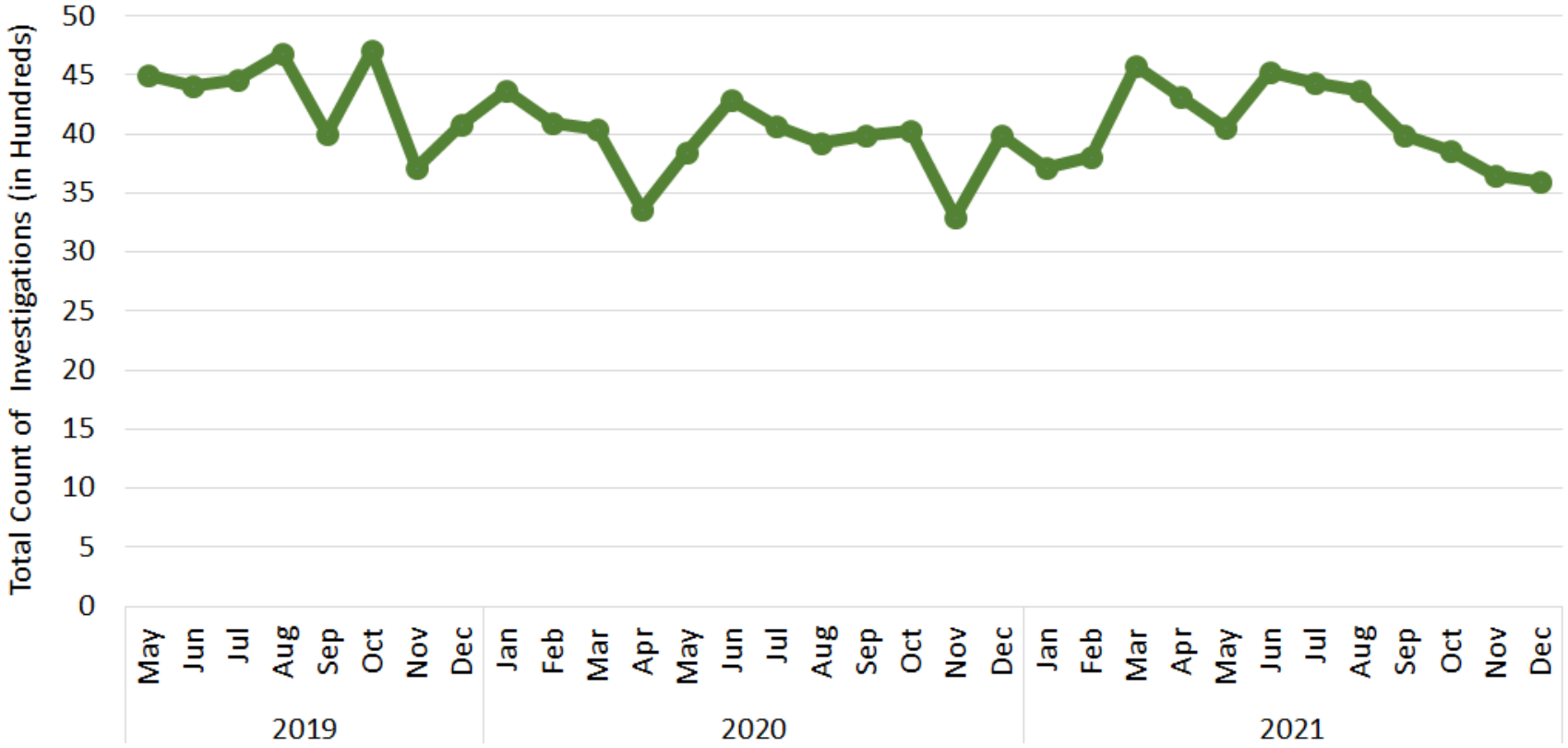
Graph 25: Percent change of NICS handgun background checks, by month (Source: FBI)



Adult Protective Services Investigations

The Department of Social and Health Services' (DSHS) Adult Protective Services (APS) receives and investigates reports of abuse, abandonment, neglect, exploitation and self-neglect of vulnerable adults in Washington. Graph 26 shows the count of total Washington State APS investigations. The most recent reporting period (December 2021) showed a 1.4% decrease in investigations, compared to the previous month.

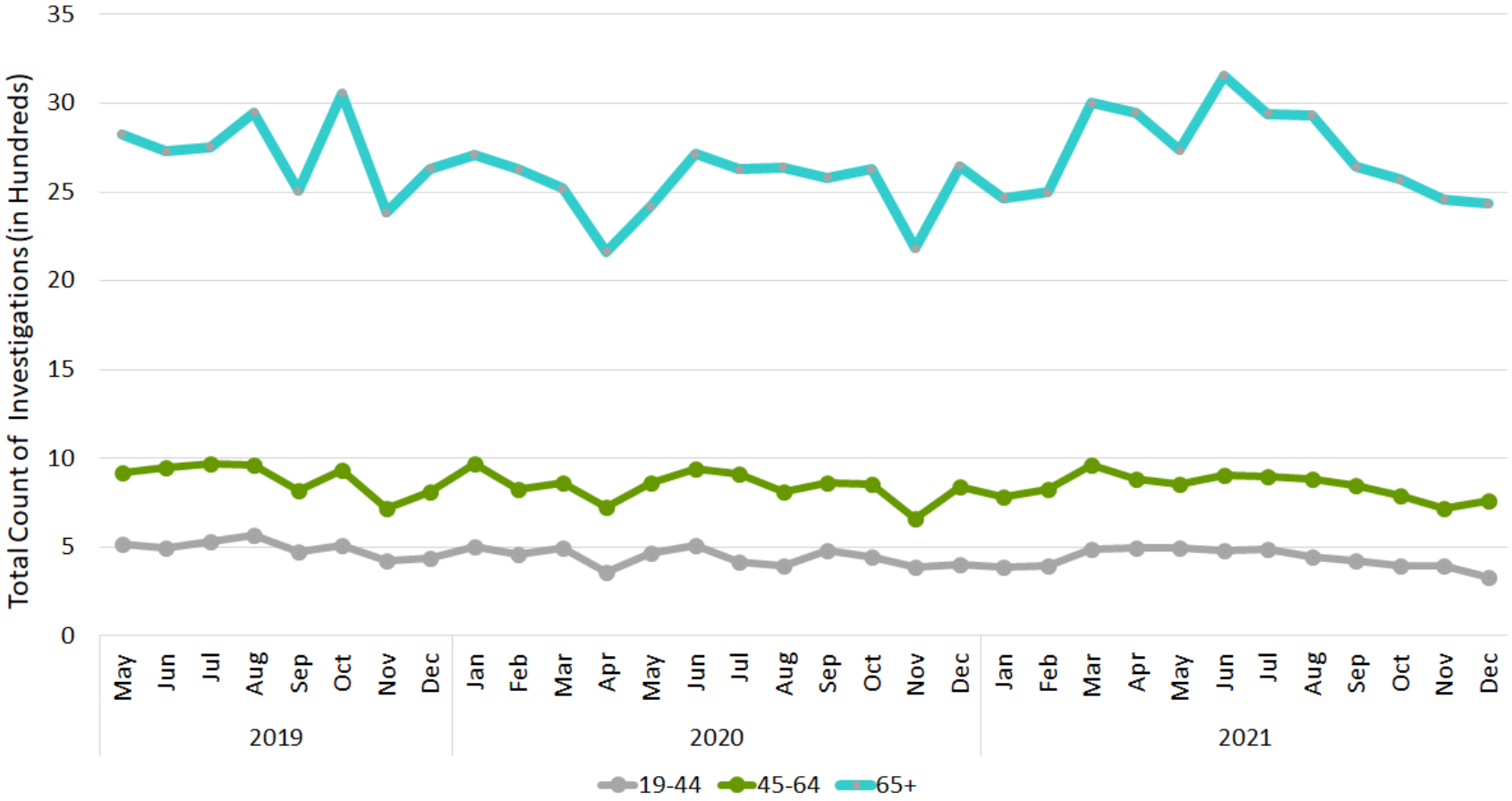
Graph 26: Count of total Washington State Adult Protective Services investigations, by month (Source: DSHS)



Note: Data is limited following intake report to determine if APS has jurisdiction. Investigations include thorough interviews, observations, record reviews and coordination with law enforcement and other agencies as needed.

Graph 27 shows counts of total Washington State investigations stratified (or separated) by age. The most recent reporting period (December 2021) showed both increases and decreases APS investigations (by age group), compared to the previous month: individuals ages 19 – 44 (-17%), ages 45 – 64 (+7%), and ages 65 and older (-1%).

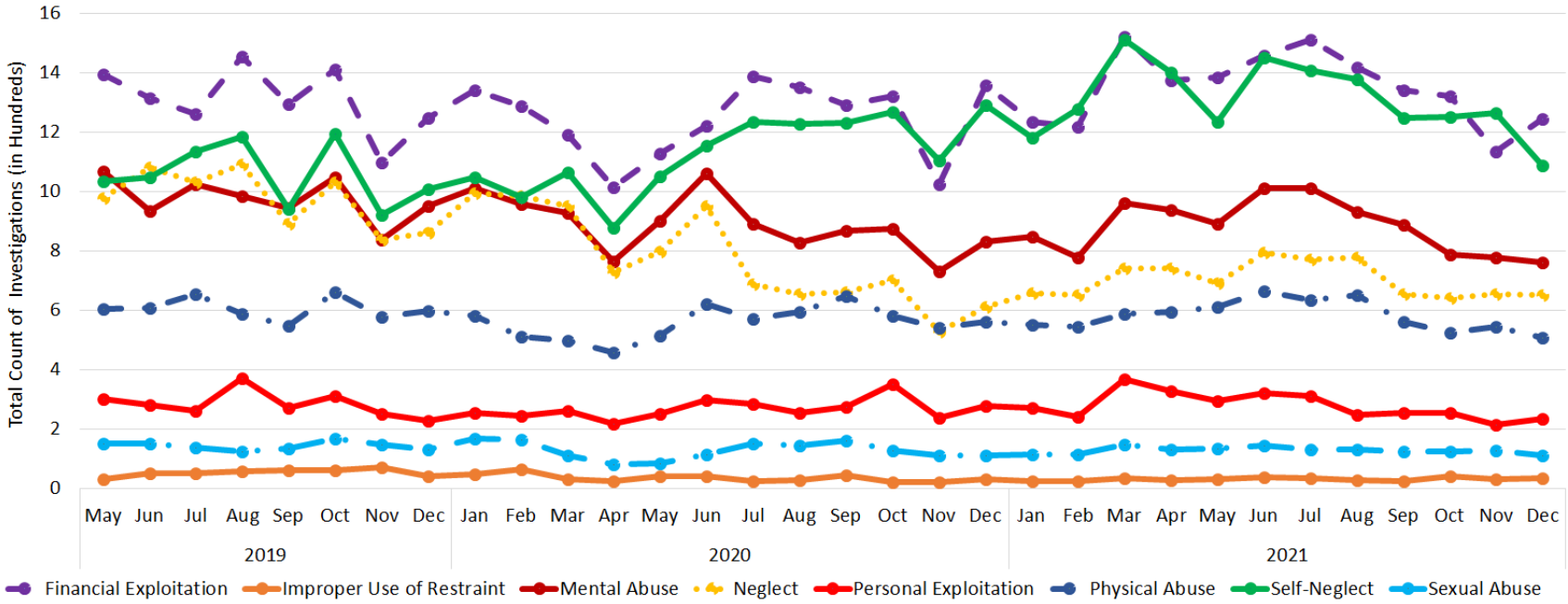
Graph 27: Count of total Washington State investigations, by month and age (Source: DSHS)



Note: Data is limited following intake report to determine if APS has jurisdiction. Investigations include thorough interviews, observations, record reviews, and coordination with law enforcement and other agencies as needed.

Graph 28 shows the count of the APS investigations by type of investigation. The most recent reporting period showed both increases and decreases in different types of APS investigations: 9.7% increase in financial exploitation, 3.2% increase improper use of restraint, 2.1% decrease in mental abuse, -0.2% decrease in neglect, 8.4% increase in personal exploitation, 7.0% decrease in physical abuse, 13.9% decrease in self-neglect, and 14.2% decrease in sexual abuse APS investigations.

Graph 28: Count of total Washington State investigations, by month and type (Source: DSHS)



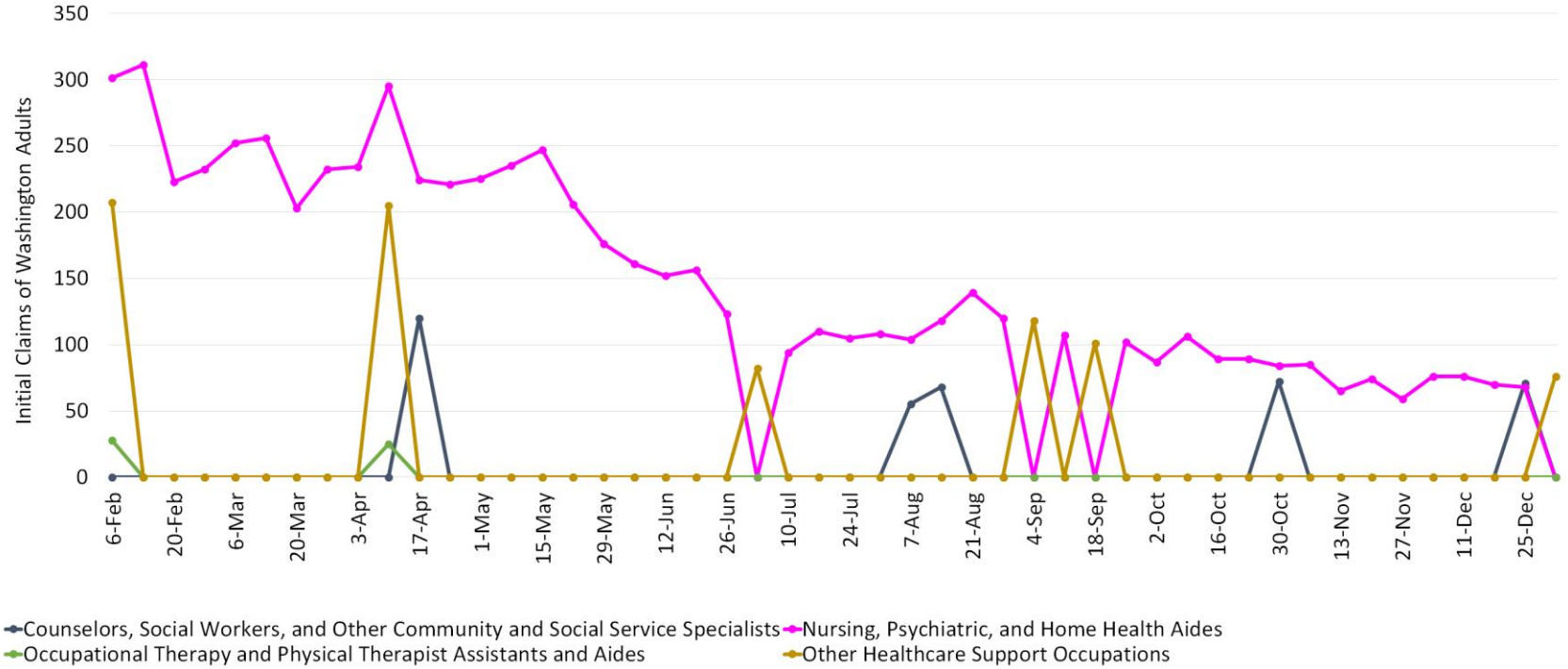
Note: **Financial exploitation** means the illegal or improper use, control over, or withholding of the property, income, resources, or trust funds of the vulnerable adult by any person or entity for any person's or entity's profit or advantage other than for the vulnerable adult's profit or advantage. **Improper use of restraint** means the inappropriate use of chemical, physical, or mechanical restraints for convenience or discipline or in a manner that: (i) Is inconsistent with federal or state licensing or certification requirements for facilities, hospitals, or programs authorized under chapter 71A.12 RCW; (ii) is not medically authorized; or (iii) otherwise constitutes abuse under this section. **Mental abuse** means a willful verbal or nonverbal action that threatens, humiliates, harasses, coerces, intimidates, isolates, unreasonably confines, or punishes a vulnerable adult. Mental abuse may include ridiculing, yelling, or swearing. **Neglect** means (a) A pattern of conduct or inaction by a person or entity with a duty of care that fails to provide the goods and services that maintain physical or mental health of a vulnerable adult, or that fails to avoid or prevent physical or mental harm or pain to a vulnerable adult, or (b) An act or omission by a person or entity with a duty of care that demonstrates a serious disregard of consequences of such a magnitude as to constitute a clear and present danger to the vulnerable adult's health, welfare, or safety, including but not limited to conduct prohibited under RCW 9A.42.100. **Personal exploitation** means an act of forcing, compelling, or exerting undue influence over a vulnerable adult causing the vulnerable adult to act in a way that is inconsistent with relevant past

behavior or causing the vulnerable adult to perform services for the benefit of another. **Physical abuse** means the willful action of inflicting bodily injury or physical mistreatment. Physical abuse includes, but is not limited to: striking with or without an object, slapping, pinching, choking, kicking, shoving, prodding, or the use of chemical restraints or physical restraints unless the restraints are consistent with licensing requirements, and includes restraints that are otherwise being used inappropriately. **Self-neglect** means the failure of a vulnerable adult, not living in a facility, to provide for himself or herself the goods and services necessary for the vulnerable adult's physical or mental health, and the absence of which impairs or threatens the vulnerable adult's well-being. This definition may include a vulnerable adult who is receiving services through home health, hospice, or a home care agency, or an individual provider when the neglect is not a result of inaction by that agency or individual provider. **Sexual abuse** means any form of nonconsensual sexual contact including, but not limited to, unwanted or inappropriate touching, rape, sodomy, sexual coercion, sexually explicit photographing, and sexual harassment. Sexual abuse includes any sexual contact between a staff person, who is not also a resident or client, of a facility or a staff person of a program authorized under Chapter 71A.12 RCW, and a vulnerable adult living in that facility or receiving service from a program authorized under Chapter 71A.12 RCW, whether or not it is consensual.

Initial Claims of Washington Adults

The Employment Security Department (ESD) provides unemployment benefits to eligible workers who become unemployed through no fault of their own and meet certain other eligibility requirements. The most recent reporting period (January 1, 2022) showed an increase of 76 initial claims for occupations under Other Healthcare Support Occupations as compared to the previous reporting period (December 25, 2021); in the previous reporting period (December 25, 2021, there were 71 initial claims for occupations under Counselors, Social Workers, and Other Community and Social Service Specialists and 68 initial claims of occupations under Nursing, Psychiatric, and Home Health Aides – there were 0 initial claims for both occupations for the most recent reporting period (January 1, 2022) (Graph 29).

Graph 29: Count of Initial Claims of Washington Adults, by week (Source: ESD)



Note: Initial claims are defined/measured as an event in which an individual is seeking to receive unemployment benefits. Initial claims included in the analysis contain 2 types of initial claims events: (1) New Claim. The first initial claim filed in person, by mail, by internet, telephone or other means to request a determination of entitlement to and eligibility for compensation which results in an agency generated document of an appealable monetary determination provided to the potential claimant (2) Additional Claim. A subsequent initial claim filed during an existing benefit year due to new unemployment and when a break of one week or more has occurred in the claim series due to intervening employment.

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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