Washington State Department of Health

DOH 821-102-47

Week of June 28, 2021
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] 24: week of June 13), **all five syndromic indicators decreased from the previous reporting period. No statistical warnings or alerts were issued**.
- According to a survey conducted by the U.S. Census Bureau, the number of Washington **adults reporting frequent symptoms of anxiety (1.3 million)** decreased from the previous reporting period, and the number of **adults reporting frequent symptoms of depression (890,000)** increased from the previous reporting period.
- The most recent reporting period (March 2021) **showed a 6.7% increase of discharges with a diagnosis of mental, behavioral, and neurodevelopmental disorders from inpatient care of community hospitals** and an **11.1% increase of discharges with diagnoses of mental, behavioral, and neurodevelopmental disorders from observational care of community hospitals** compared to the previous month.

[1] https://wwwn.cdc.gov/nndss/document/2020.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 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.

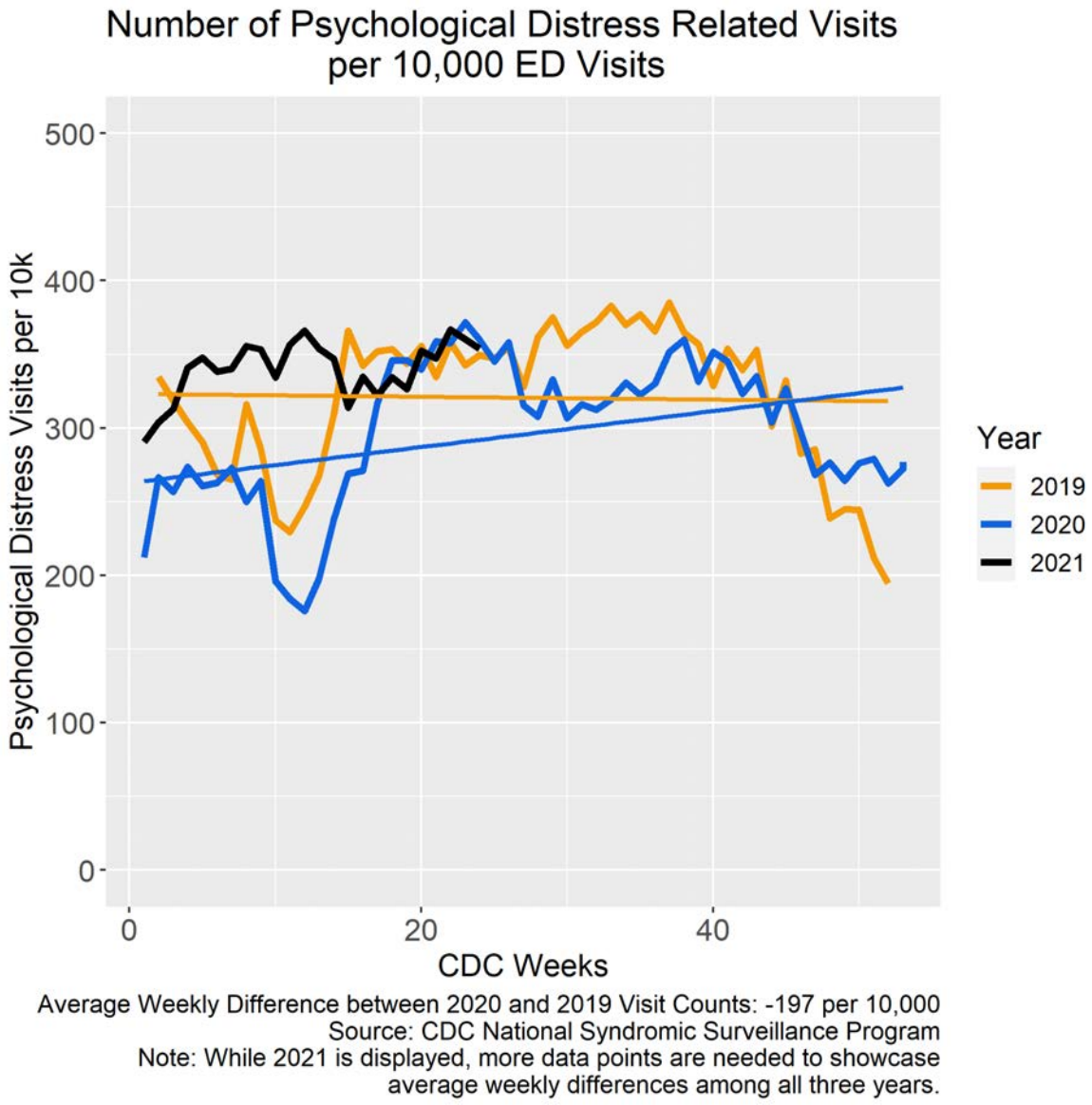
[4] A warning is determined by statistical analysis using p-values from 0.01 – 0.05, while an alert is determined by statistical analysis using p-values of less than 0.01.

[5] Year-over-year: The comparison of two or more years, specifically 2021 to 2019 and 2020.

Psychological Distress

During **CDC Week 24 (week of June 13)**, the relative reported rate of ED visits for psychological distress[6] **decreased from the previous reporting period** and falls between the rates in the corresponding weeks of 2019 and 2020 (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, and 2021 to date (Source: CDC ESSENCE)

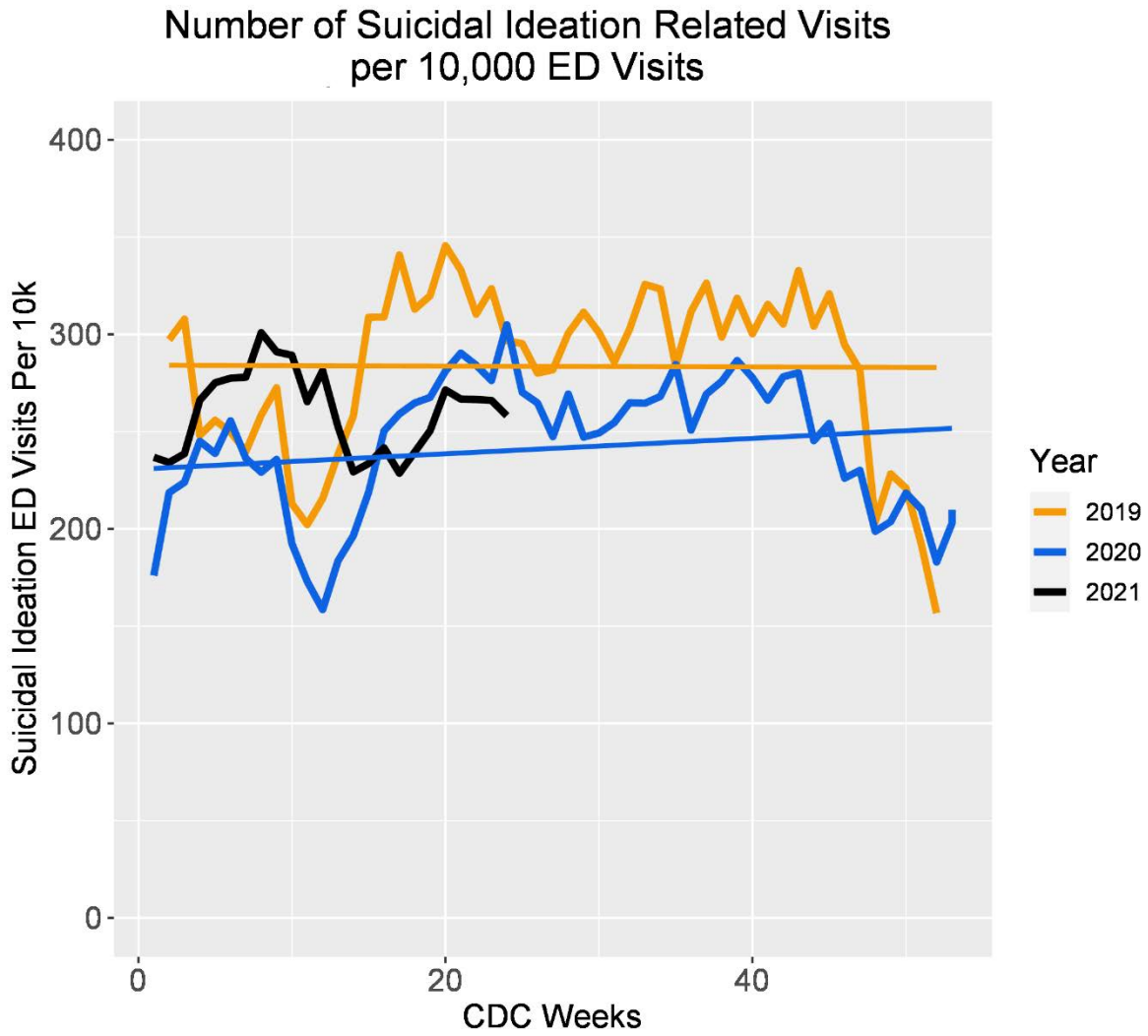


[6] Psychological distress in this context is considered a disaster-related syndrome comprised of panic, stress, and anxiety. It is indexed in the Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE) platform as Disaster-related Mental Health v1. Full details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

Suicidal Ideation and Suspected Suicide Attempts

During **CDC Week 24 (week of June 13)**, the relative reported rate of ED visits for suicidal ideation **decreased from the previous reporting period** and remains lower than rates in the corresponding weeks of 2019 and 2020 (Graph 2). **No statistical warnings or alerts were issued.**

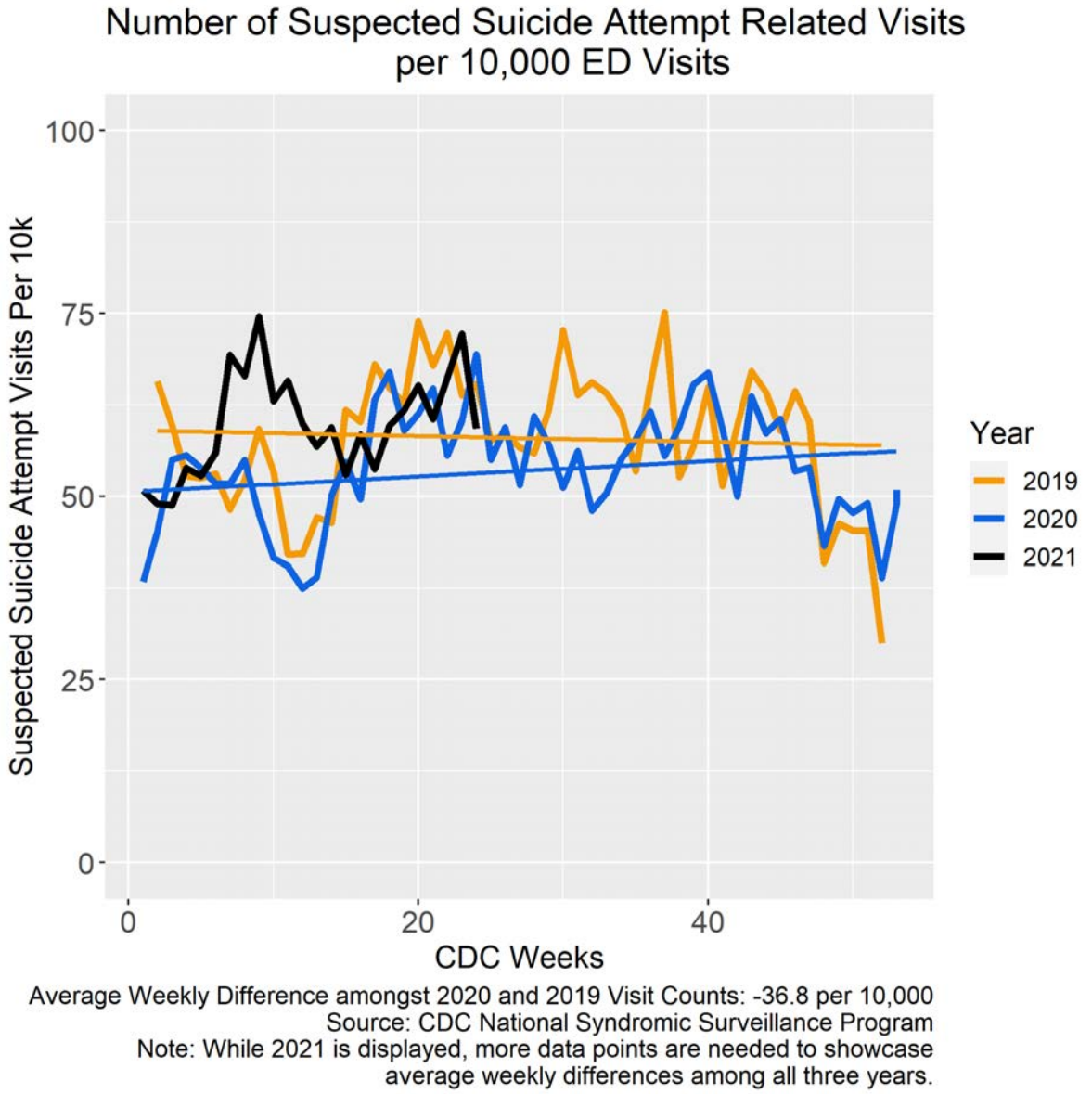
Graph 2: Relative count of ED visits for suicidal ideation in Washington, by week: 2019, 2020, and 2021 to date (Source: CDC ESSENCE)



Average Weekly Difference between 2020 and 2019 Visit Counts: -188 per 10,000
Source: CDC National Syndromic Surveillance Program
Note: While 2021 is displayed, more data points are needed to showcase average weekly differences among all three years.

During **CDC Week 24 (week of June 13)**, the relative reported rate of ED visits for suspected suicide attempts **decreased from the previous reporting period** and is lower than rates in the corresponding weeks of 2019 and 2020 (Graph 3). 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 rate of such visits. **No statistical warnings or alerts were issued.**

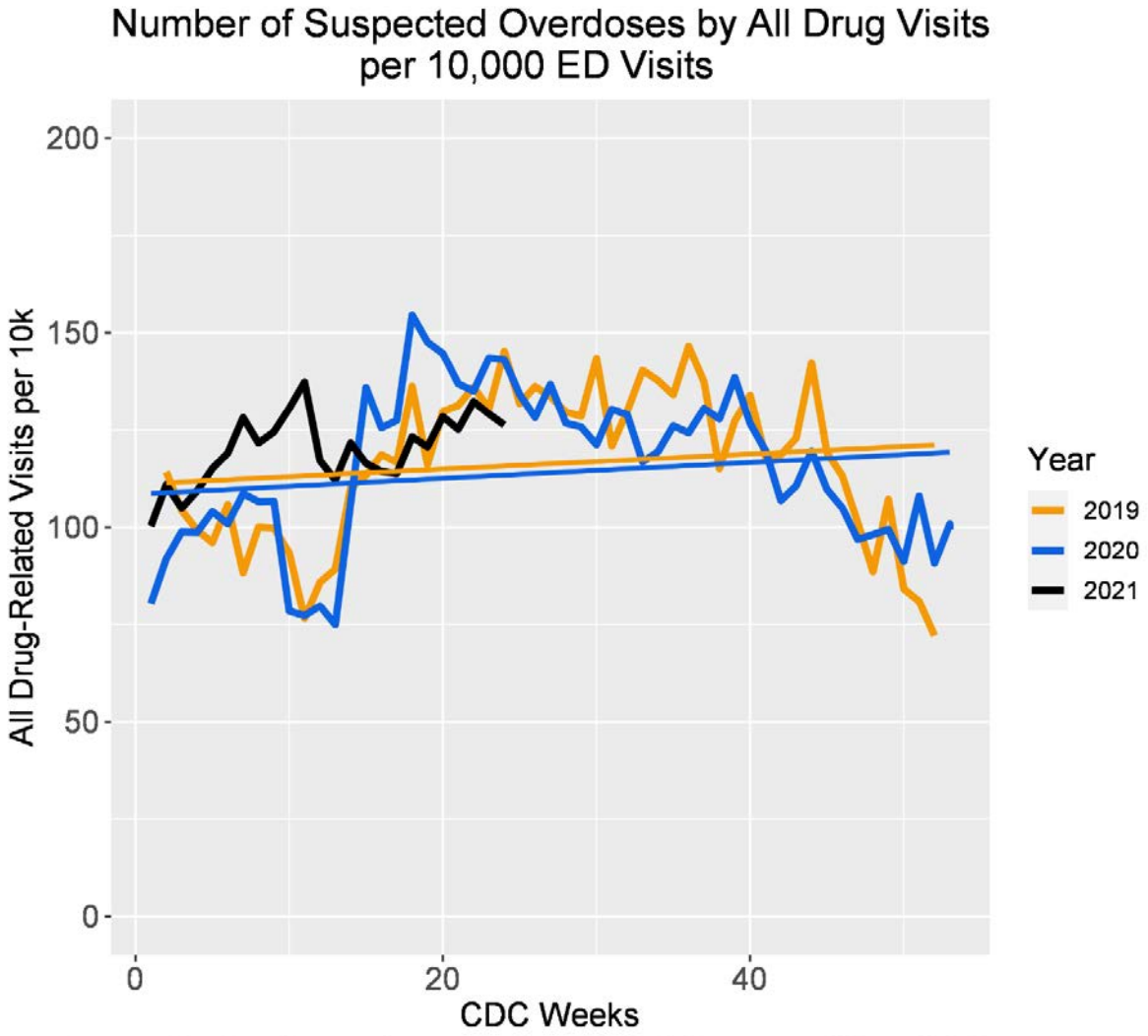
Graph 3: Relative count of ED visits for suspected suicide attempt in Washington, by week: 2019, 2020, and 2021 to date (Source: CDC ESSENCE)



Substance Use – Drug Overdose and Alcohol-Related Emergency Visits

During **CDC Week 24 (week of June 13)**, the relative reported rate of all drug[7]-related ED visits **decreased from the previous reporting period** and is lower than rates in the corresponding weeks of 2019 and 2020 (Graph 4). **No statistical warnings or alerts were issued.**

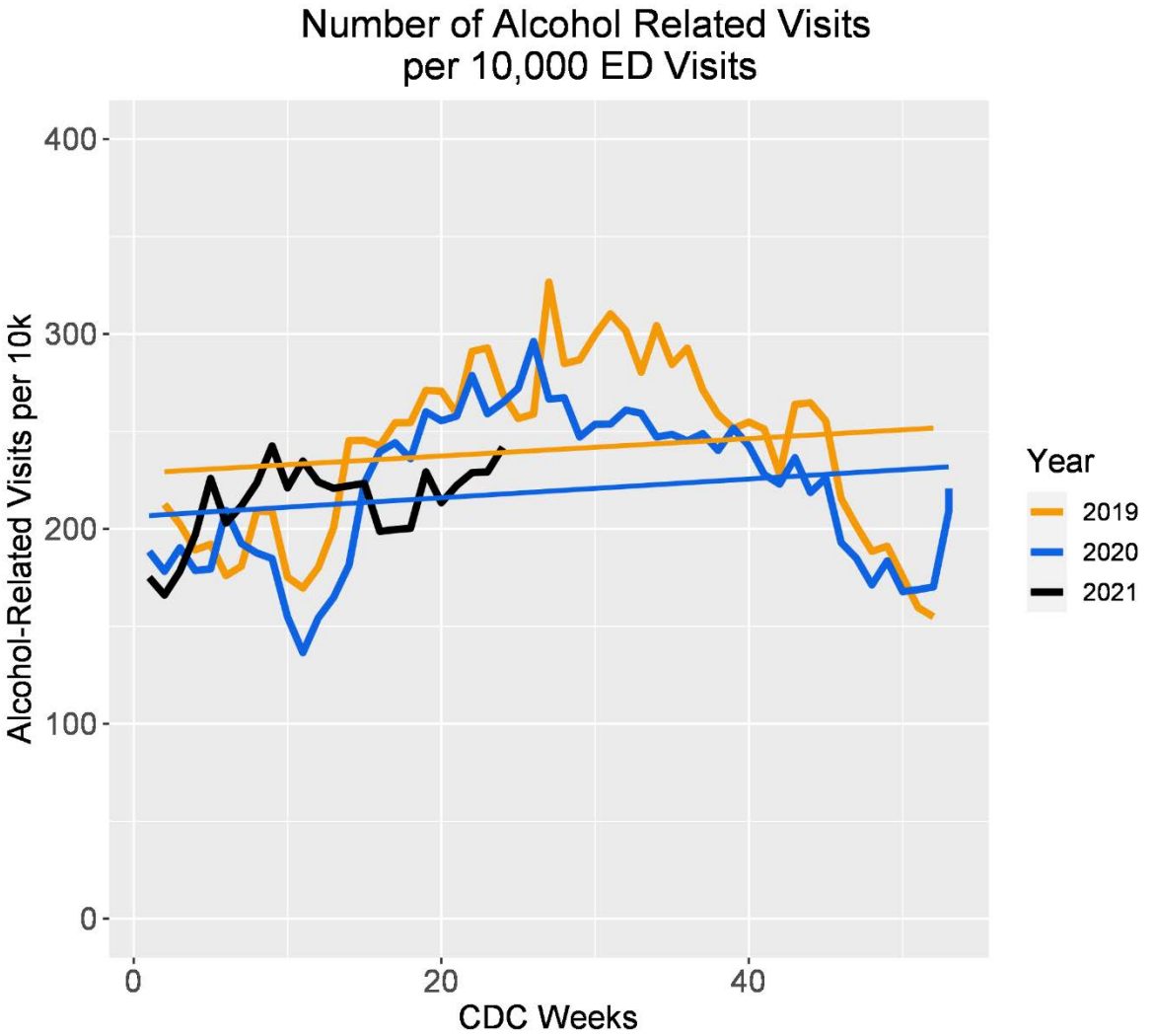
Graph 4: Relative count of all drug-related ED visits in Washington, by week: 2019, 2020, and 2021 to date (Source: CDC ESSENCE)



[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 24 (week of June 13)**, the relative reported rate of alcohol-related ED visits **increased slightly from the previous reporting period** and is lower than the rates in the corresponding weeks of 2019 and 2020 (Graph 5). **No statistical warnings or alerts were issued.** It should be noted that ED visits per 10,000 for alcohol remained somewhat stable in 2020, while there was a several week period of sustained decreases in visits in 2019. This has resulted in a slight convergence in visit counts between 2019 and 2020 data.

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



Average Weekly Difference between 2020 and 2019 Visit Counts: -172.2 per 10,000
Source: CDC National Syndromic Surveillance Program
Note: While 2021 is displayed, more data points are needed to showcase average weekly differences among all three years.

General Surveillance

Symptoms of Anxiety and Depression

Survey data collected by the U.S. Census Bureau for May 26 – June 7, 2021 show **a decrease in anxiety (-5%) and an increase in depression (+4%)** among adults in Washington, compared to the previous reporting period of May 12 – 24, 2021 (Graph 6).[8] In the most recent reporting period represented below, **approximately 1.3 million adults in Washington reported symptoms of anxiety** on all or most days of the previous week, while **approximately 890,000 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. For these measures, the standard error suggests that the inaccuracy of estimates may be around 7.9% above or below the numbers previously mentioned. This survey data is not in any way related to the data presented in previous sections.

Additionally, the May 26 – June 7, 2021 survey data on anxiety and depression measures continue to indicate an inverse relationship between age and frequency of symptoms. In other words, **the younger someone is, the greater their frequency of reporting anxiety and depression symptoms**. Respondents ages 18 – 29 reported the highest rate of frequent symptoms of anxiety (42%) and depression (31%). The next highest rates of anxiety (30%) and depression (31%) were reported by respondents ages 30 – 39.

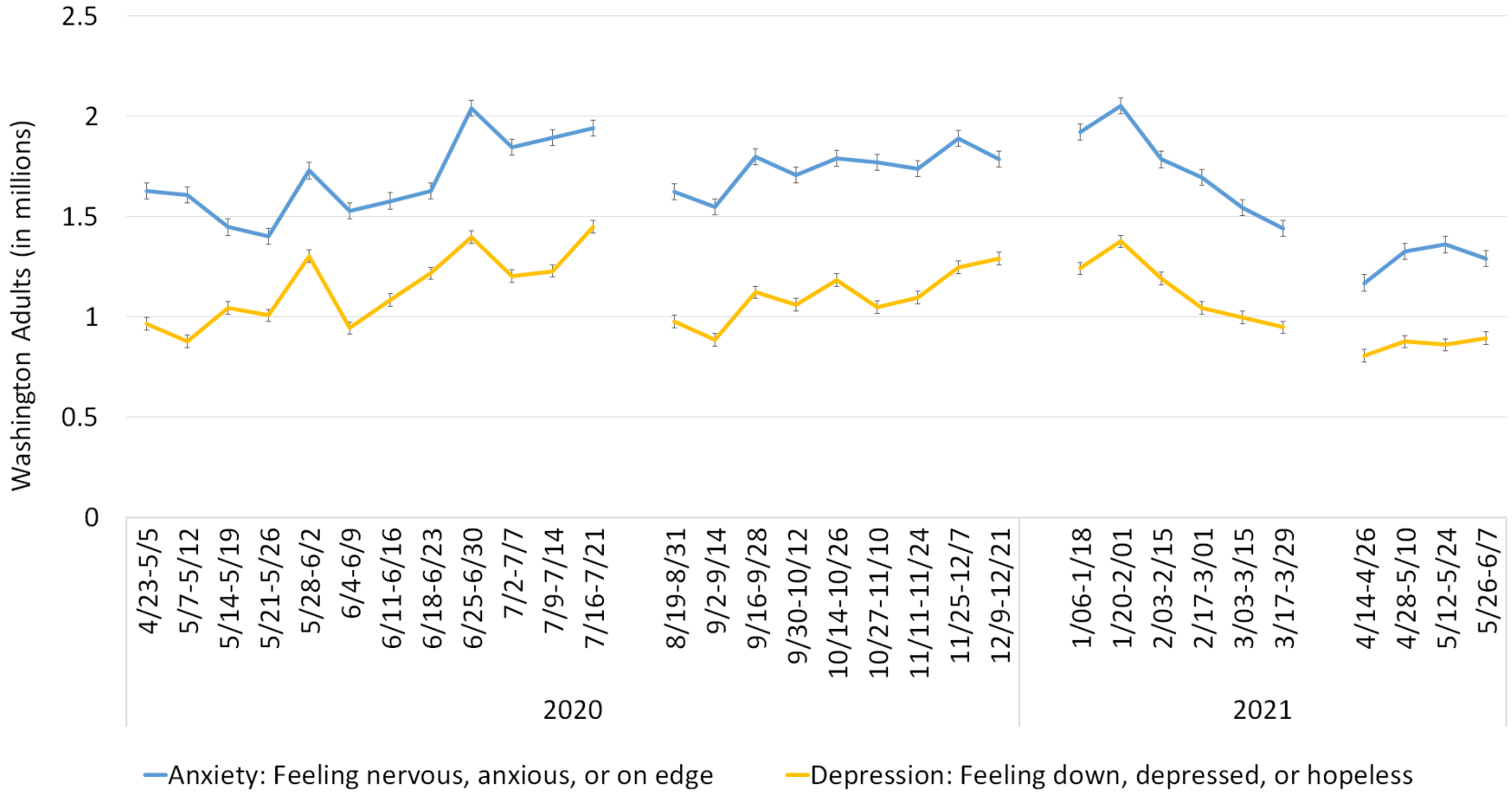
Those who live in households earning up to $50,000 per year were most likely to report frequent symptoms of anxiety, with the highest rates among those in households earning less than $25,000 per year (53%), followed by those in households earning $35,000 – $50,000 per year (37%) and those in households earning $25,000 – $35,000 per year (37%).

A similar pattern emerged for frequent symptoms of depression, with those in households earning less than $25,000 per year reporting the highest rate (37%), followed by those in households earning $35,000 – $50,000 per year (27%).

Those who identified as female have an increased symptom reporting rate for anxiety (29% for females, compared to 23% for males) and depression (20% for females, compared to 18% for males).

[8] 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 6: Estimated Washington adults with feelings of anxiety and depression at least most days, by week: April 23, 2020 – June 7, 2021 (Source: U.S. Census Bureau)



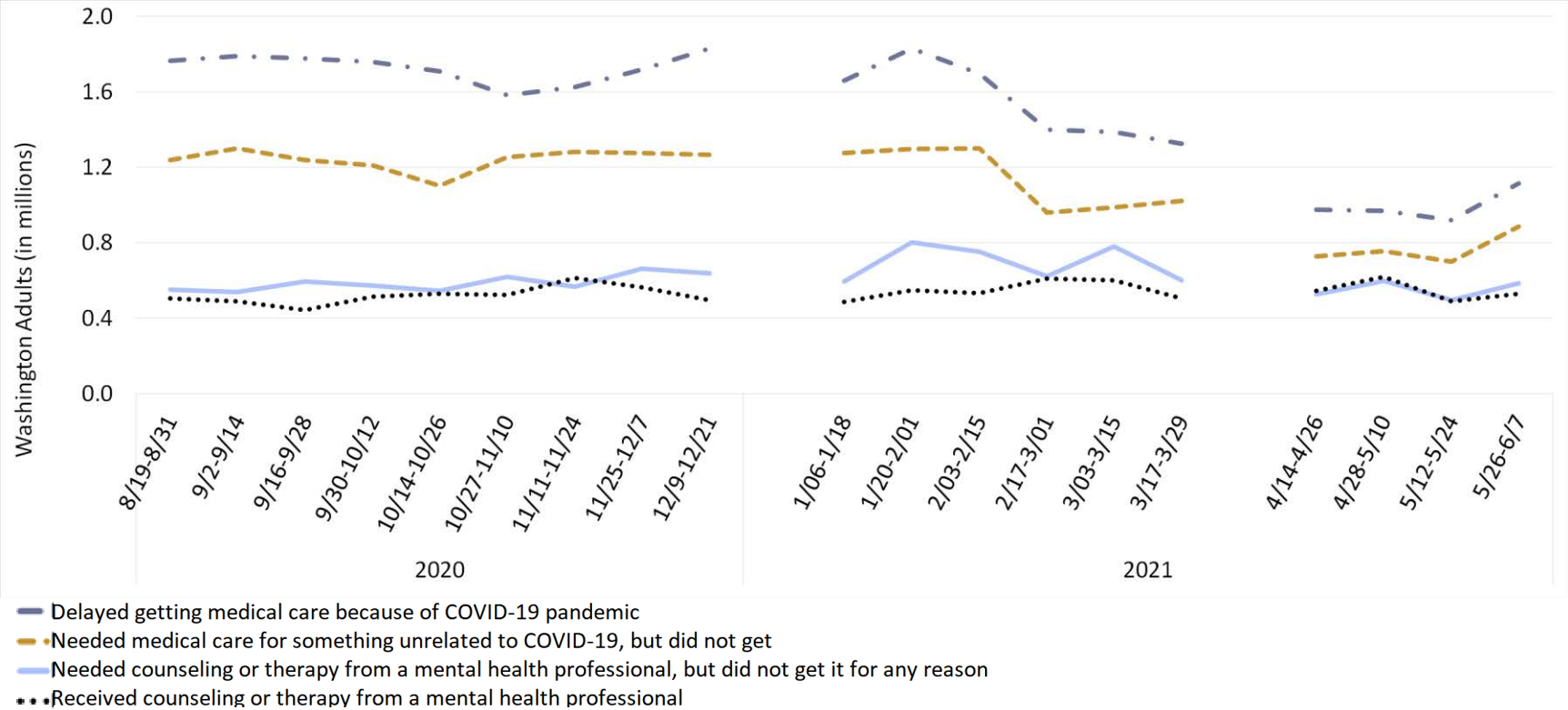
Note: For the period of July 21 – August 19, 2020, census data was not available and thus, any trends during this point are an artifact of analysis. Additionally, the U.S. Census Bureau briefly paused data collection for the periods of December 23, 2020 – January 3, 2021 and March 30 – April 14, 2021.

Care-Seeking Behavior

Survey data[9] collected by the U.S. Census Bureau for August 19, 2020 – June 7, 2021 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 7). Compared to the previous reporting period of May 12 – 24, 2021, **more people reported needing therapy or counseling but not receiving it for any reason (+17%)**. For these measures, the standard error suggests that the inaccuracy of estimates may be around 6% above or below the numbers previously mentioned.

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

Graph 7: Estimated Washington adults who received or delayed medical care or counseling, by week: August 19, 2020 – June 7, 2021 (Source: U.S. Census Bureau)

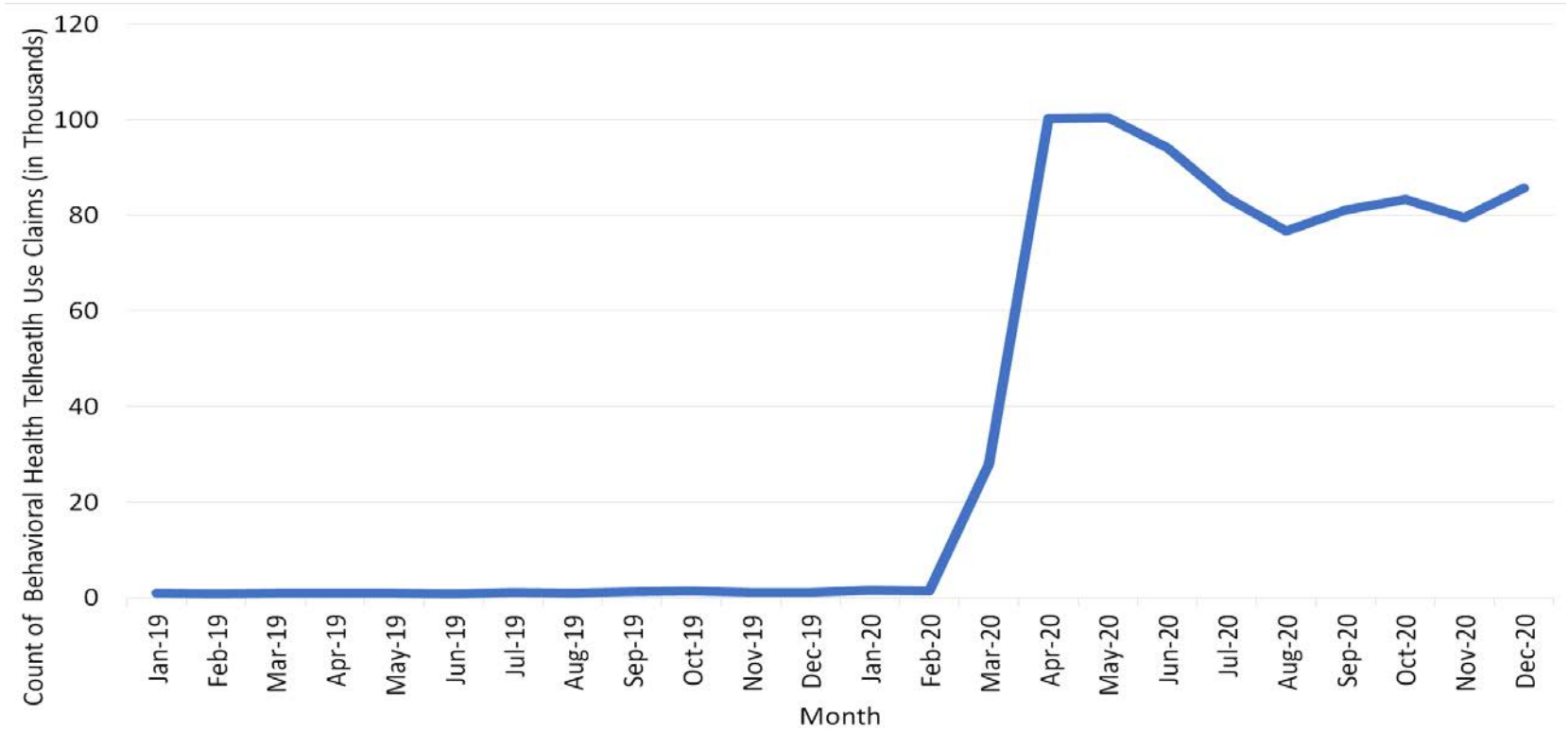


Note: The U.S. Census Bureau began this data collection in August 2020 and paused briefly for the periods of December 23, 2020 – January 3, 2021 and March 30 – April 14, 2021.

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 8 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 2020) showed a 12% increase of telehealth behavioral health services use claims compared to the previous month.

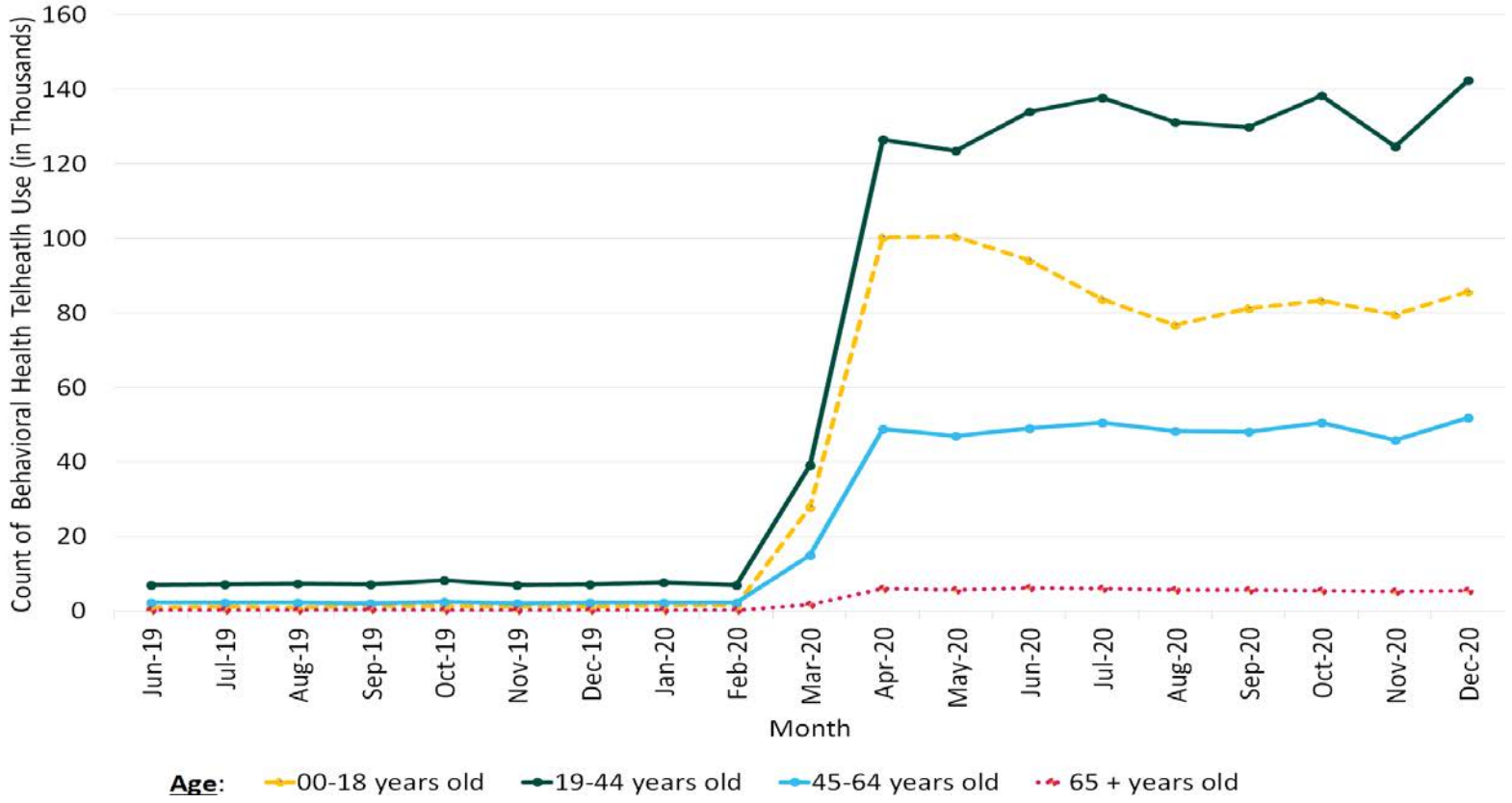
Graph 8: Count of telehealth behavioral health use claims for Washington Medicaid clients, by month (Source: HCA)



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

Graph 9 shows the count of claims for telehealth behavioral health services use stratified (or arranged) by age. Similar to 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 2020) showed increased claims of telehealth behavioral health services (by age group), compared to the previous month: individuals ages 18 and younger (8%), ages 19 – 44 (14%), ages 45 – 64 (13%), and ages 65 and older (5%).

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

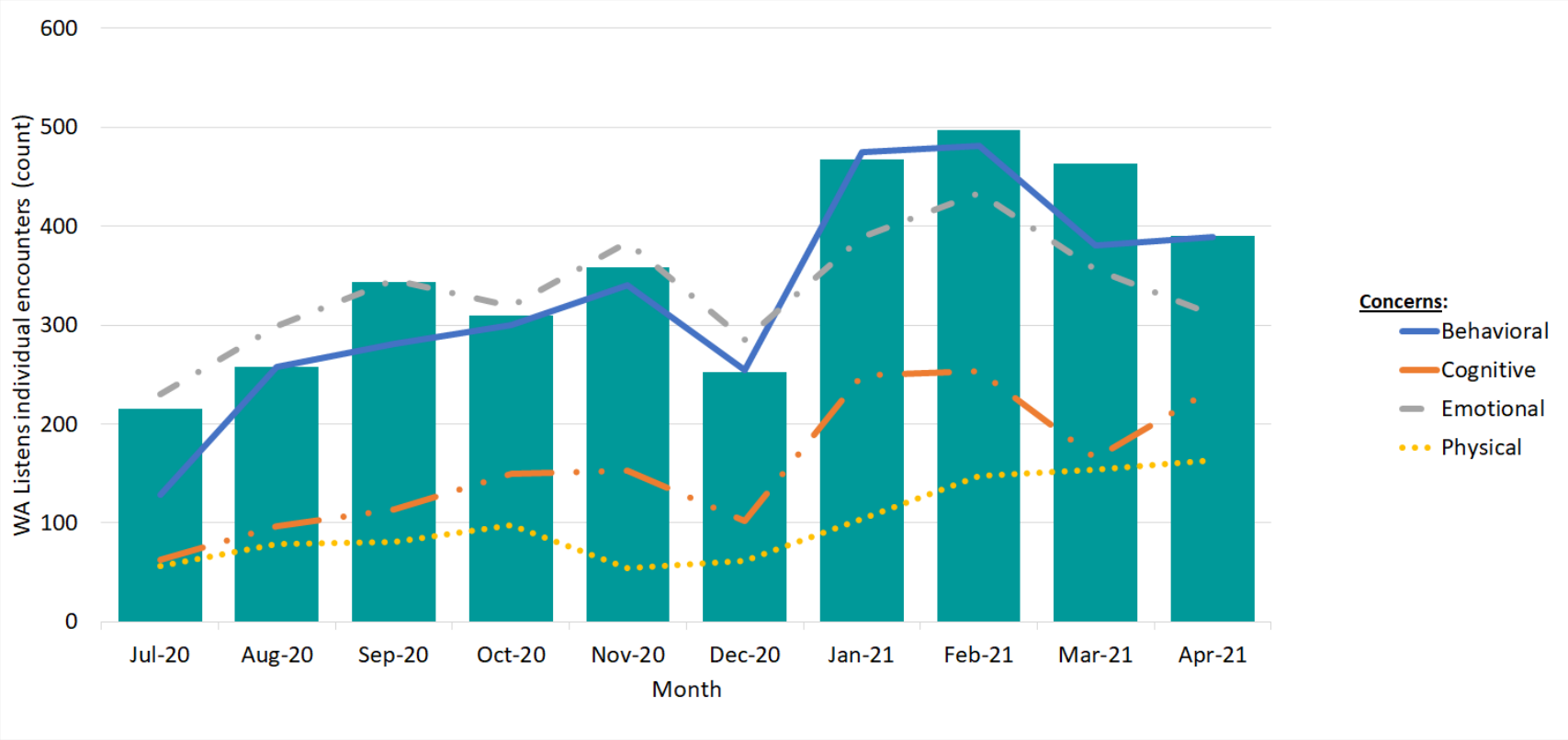


Note: Due to missing or suppressed data, results may be underreported.

Telephonic Support Lines – Service Volume

Washington (WA) Listens[10] 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 3,554 WA Listens individual encounters have been completed (Graph 10). For **gender, age, and race** information on **individual encounters** in April 2021, see Table 1.

Graph 10: 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.

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

Table 1: Gender, age, and race of April 2021 WA Listens survivors (Source: HCA)

Gender	Count (%)
Female	240 (61.5%)
Male	152 (39.0%)

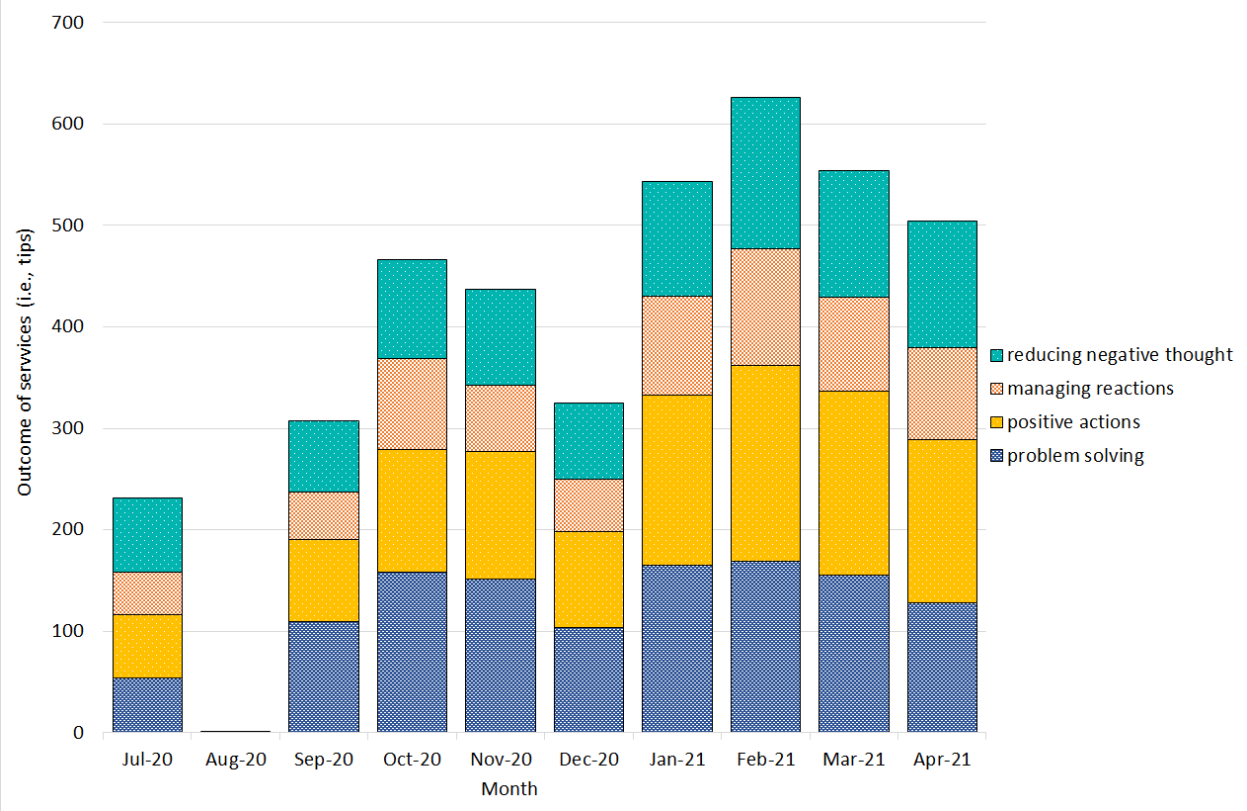
Age	Count (%)
< = 17	-- (--%)
18 – 39	121 (30.7%)
40 – 64	133 (33.8%)
> = 65	140 (35.5%)

Race	Count (%)
Other	27 (6.9%)
White	251 (64.4%)
Did not report	112 (28.7%)

Note: Gender, age, and race are not mutually exclusive (i.e., individuals can report more than one gender, age, and race).

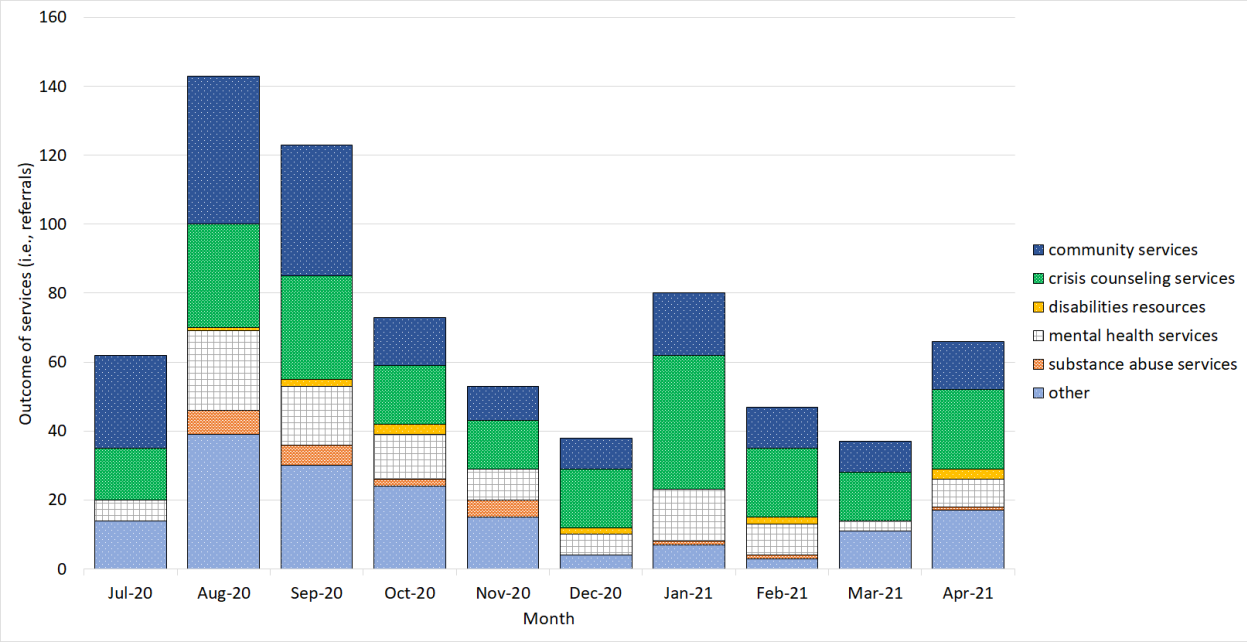
In April 2021, calls for **behavioral concerns** increased by 2.1%, **cognitive concerns** increased by 42.2%, **emotional concerns** decreased by 12.6%, and **physical concerns** increased by 5.8% (Graph 10). For **risk factors**, 26.4% focused on prolonged separation from family, 21.8% on past substance use and mental health problems, and 21.3% on sheltering in place or seeking shelter due to immediate threat of danger. For **outcomes from services** (e.g., tips and referrals), see Graphs 11 and 12.

Graph 11: Outcome of services (i.e., tips) for WA Listens, by month (Source: HCA)



Note: Tips are not mutually exclusive (i.e., individuals can receive more than one tip).

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

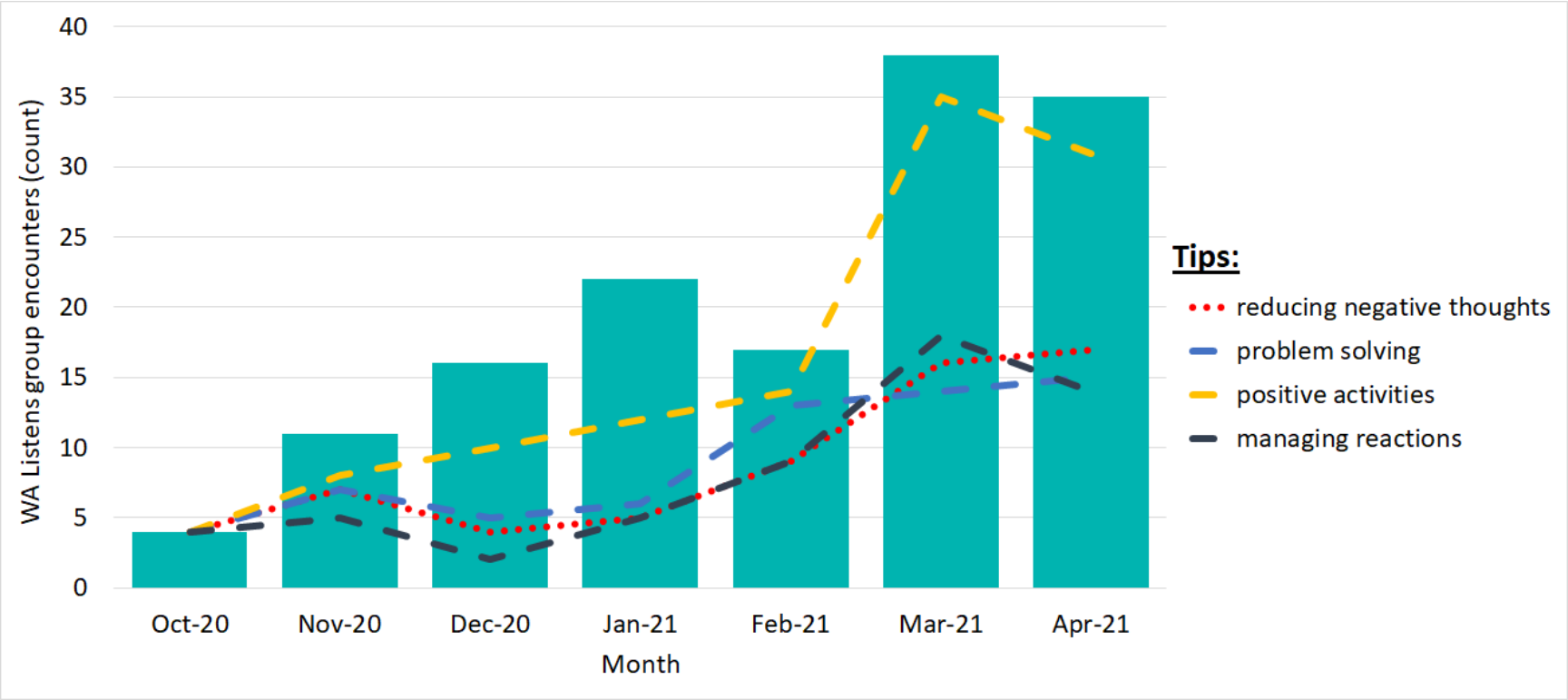


Note: Referrals are not mutually exclusive (i.e., individuals can receive more than one referral).

Since the start of WA Listens, a total of 143 **group encounters** (2 or more people) have been completed (Graph 13). Due to the group environment, gender, age, and race were not collected in a standardized method. In April 2021, most group encounters (68.6%) occurred in a virtual setting, 11.4% occurred at a public place/event, 11.4% occurred at a workplace, and 8.6% occurred in a temporary home.

For **outcomes from services** in April 2021, 8.6% of group sessions provided no type of information, while 5.7% of group sessions provided all three types of information (i.e., information on reactions to disasters, community resources, and the crisis counseling program). All group sessions in April provided at least one tip (25.7%), while 17.1% provided all four types of tips (Graph 13).

Graph 13: WA Listens group encounters and outcome of services, by month (Source: HCA)

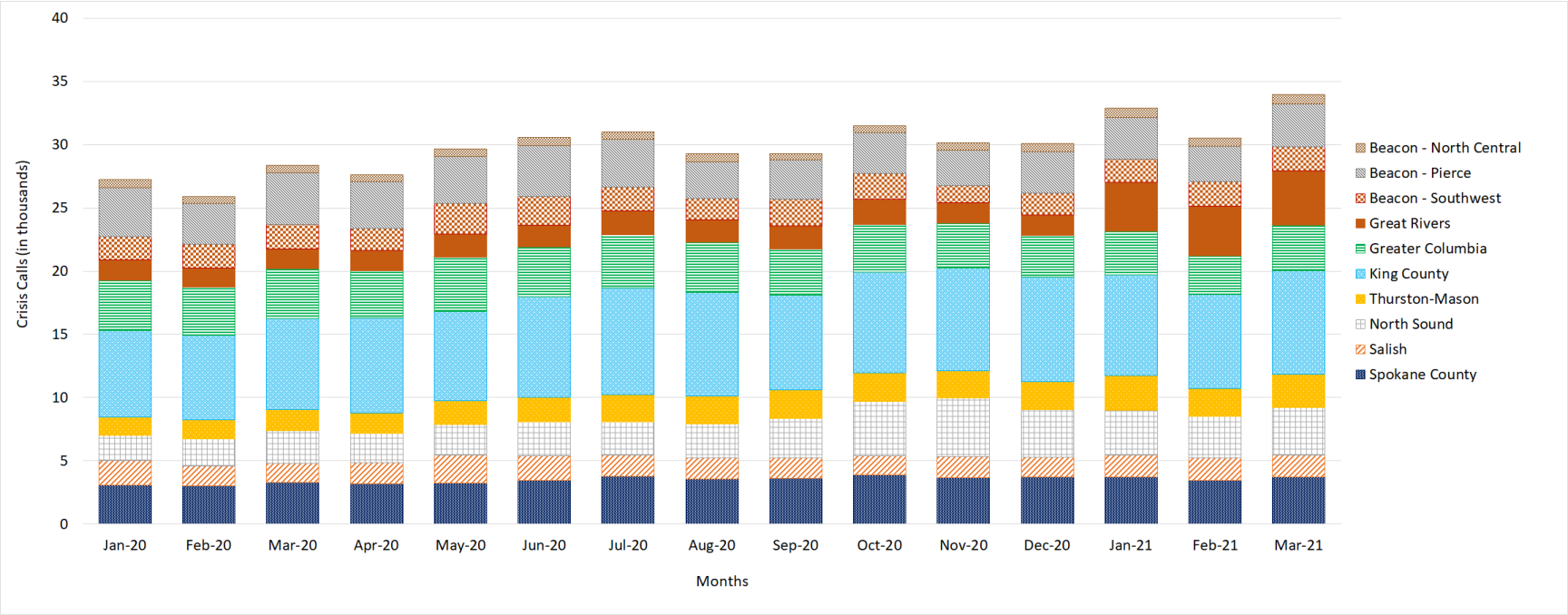


Note: Tips are not mutually exclusive (i.e., individuals can receive more than one tip).

Crisis System of Care

The crisis system of care completed by behavioral health administrative service organizations[11] (BH-ASOs) provides regional crisis line[12] support that serves as the entry point or *front door* to crisis services (Graph 14). This includes support, initial risk assessment, and referral to appropriate follow up services, if needed. Graph 14 shows data on crisis system utilization for 2020 and 2021 to date.

Graph 14: Total count of individual encounter crisis calls, by month and BH-ASO (Source: HCA)



In 2020, the average monthly call volume (excluding hang ups, wrong number, and messages) was 29,218. During 2020, there was an increase in call trend in the beginning of the year (outside of February and April), but a stable trend at the end of 2020 (with a peak in October). Most recently, March 2021 presented with an 11.3% increase of all individual crisis calls.

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

Inpatient and Observational Community Hospital Discharges

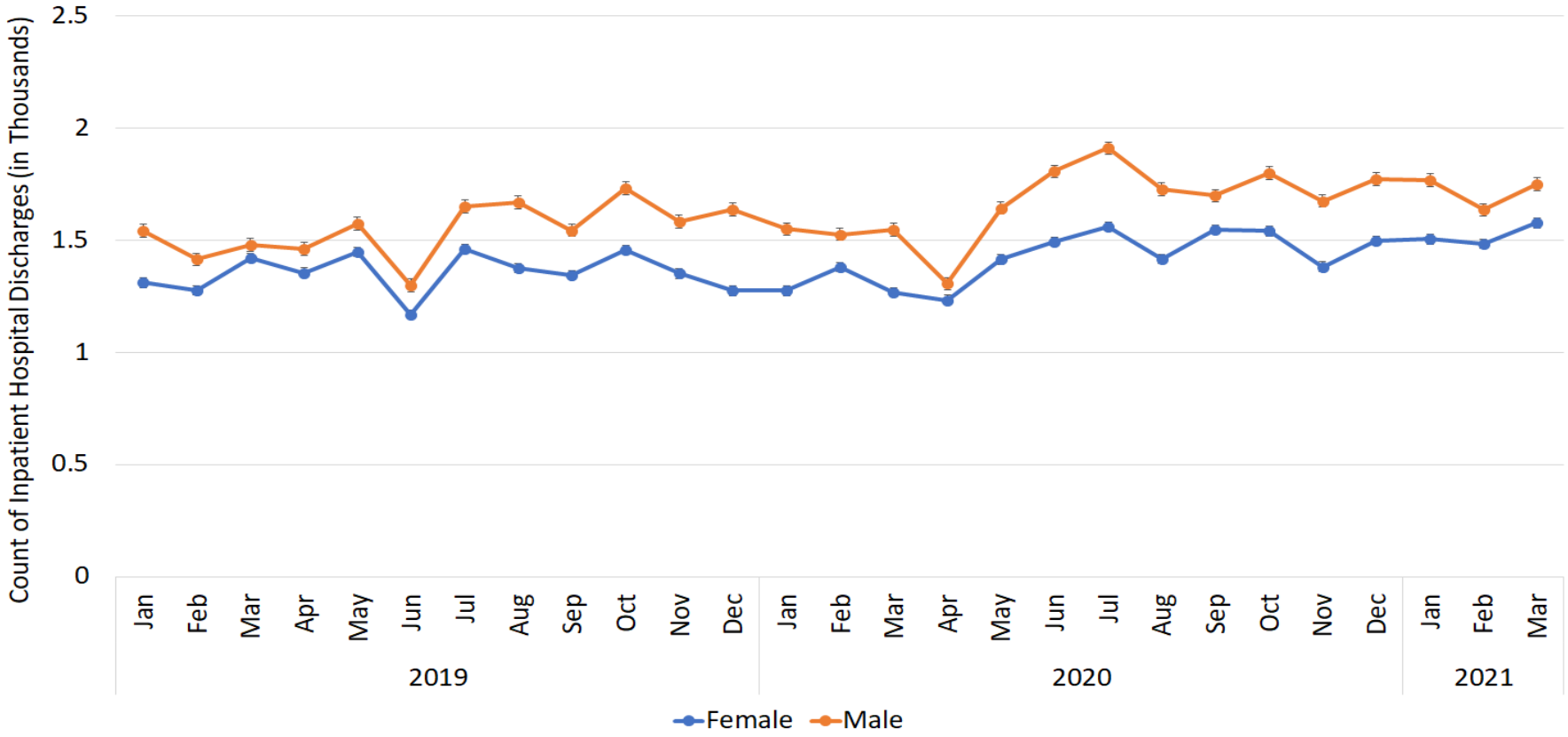
The Comprehensive Hospital Abstract Reporting System (CHARS)[13] collects information on inpatient and observation patient community hospital stays. Caution should be taken when reviewing data, as the "Stay Home, Stay Healthy" order (March 2020) may have impacted hospital discharge data for both inpatient and observation patients. Only mental, behavioral, and neurodevelopmental disorders were evaluated (i.e., primary diagnoses included only ICD-10 F-codes).[14] The most recent reporting period (March 2021) **showed a 6.7% increase of discharges with a diagnosis of mental, behavioral, and neurodevelopmental disorders for inpatient care from community hospitals** and an **11.1% increase of discharges with diagnoses of mental, behavioral, and neurodevelopmental disorders for observational care from community hospitals** compared to the previous month.

Graphs 15 and 16 show the count of inpatient and observational community hospital discharges for mental, behavioral, and neurodevelopmental disorders stratified by gender, respectively. Caution should be taken when reviewing data, as the "Stay Home, Stay Healthy" order (March 2020) may have impacted hospital discharges. For **inpatient** community hospital discharges for mental, behavioral, and neurodevelopmental disorders, the most recent reporting period (March 2021) showed a 6.1% increase for females and 7.1% increase for males compared to the previous month. For **observational** community hospital discharges for mental, behavioral, and neurodevelopmental disorders, the most recent reporting period showed a 6.7% increase for females and 15.4% for males compared to the previous month.

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

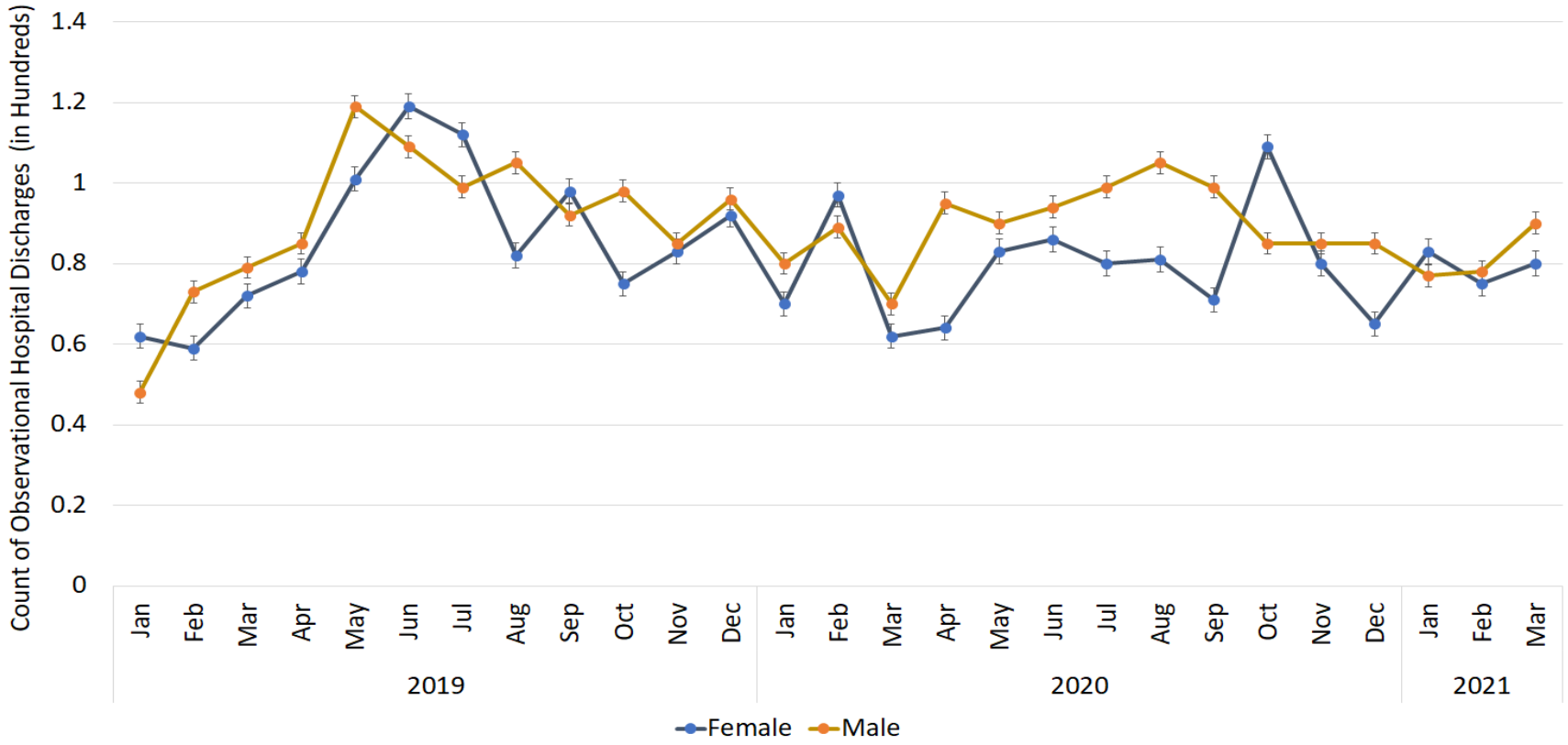
[14] ICD-10 is the Tenth Revision of the International Classification of Disease and Related Health Problems published by the World Health Organization (WHO). F-codes are specifically related to mental, behavioral, and neurodevelopmental disorders.

Graph 15: 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.

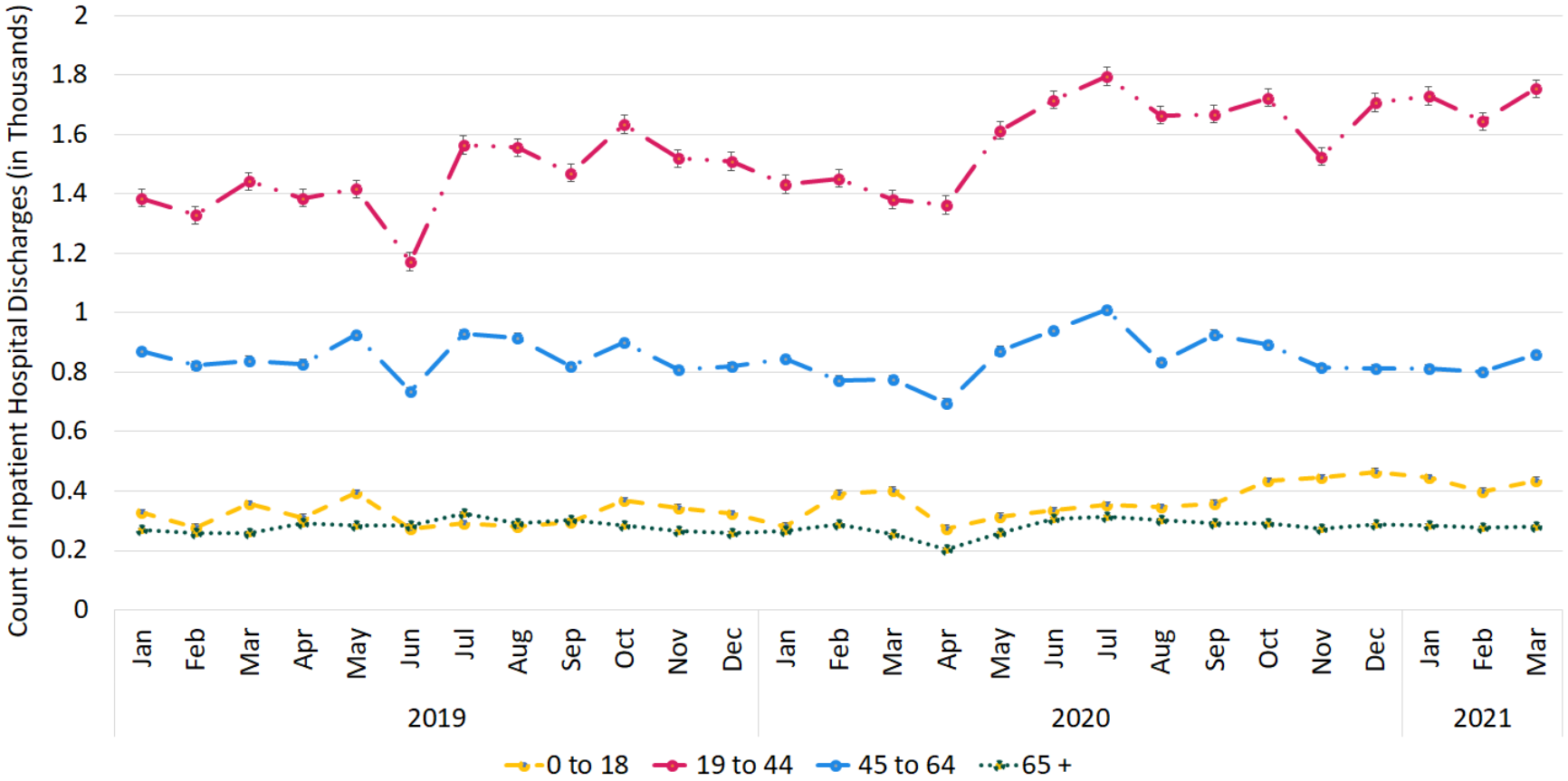
Graph 16: Count of observational community hospital discharges for mental, behavioral, and neurodevelopmental disorders, by month and gender (Source: DOH)



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 17 shows counts of inpatient community hospital discharges for mental, behavioral, and neurodevelopmental disorders separated by age. The most recent reporting period showed an increase in all ages: 9.3% increase for individuals who were 0 – 18 years old, 6.7% increase for individuals who were 19 – 44 years old, 7.2% increase for individuals who were 45 – 64 years old, and 1.4% increase for individuals who were 65 years and older compared to the previous month.

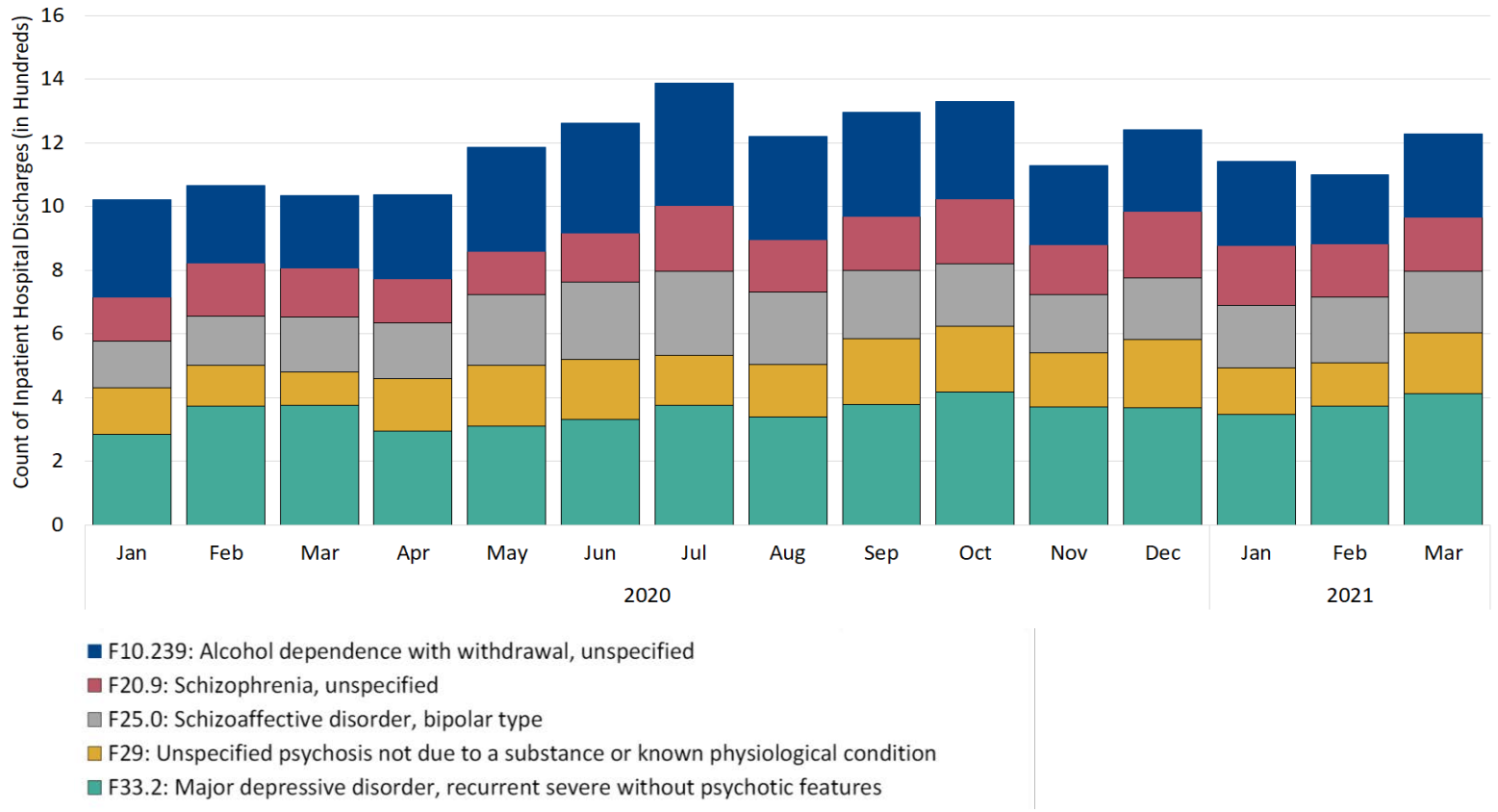
Graph 17: Count of inpatient community hospital discharges for mental, behavioral, and neurodevelopmental disorders, by month and age (Source: DOH)



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 18 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 an increase in four of the five mental, behavioral, and neurodevelopmental disorders. There was a 21.2% increase in "alcohol dependence with withdrawal, unspecified" inpatient community hospital discharges; a 1.8% increase in "schizophrenia, unspecified" inpatient community hospital discharges; a 38.7% increase in "unspecified psychosis not due to a substance or known physiological condition" inpatient community hospital discharges; and a 10.7% increase in "major depressive disorder, recurrent severe without psychotic features" inpatient community hospital discharges. There was a 5.8% decrease in "schizoaffective disorder, bipolar type" inpatient community hospital discharges.

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

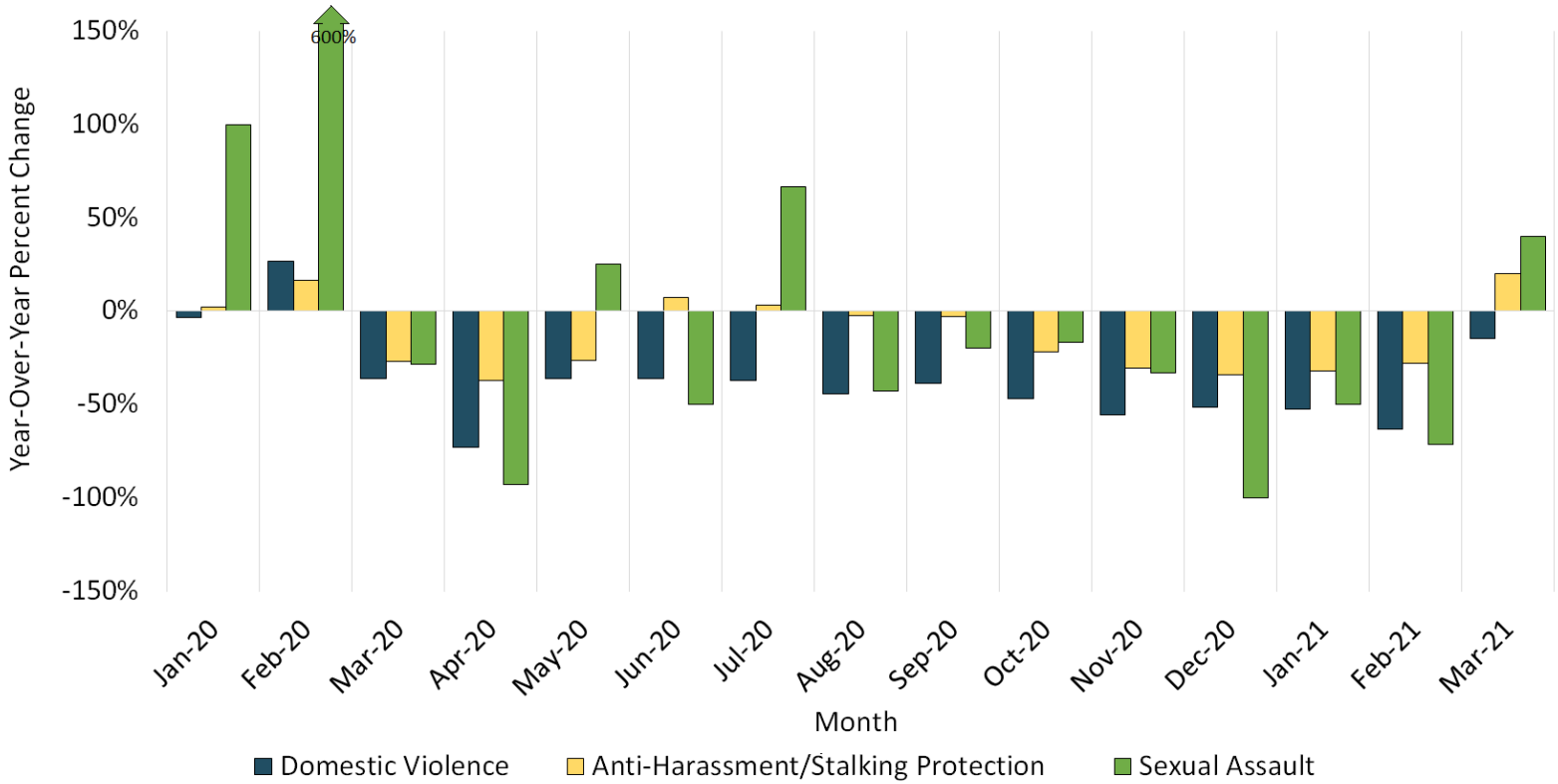


Court Reporting

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. Year-over-year percent change of monthly juvenile offender filings (regardless of most serious charge) decreased from March 2020 – May 2020. Note that the "Stay Home, Stay Healthy" order and associated court closures may impact court filing data. While monthly filings of protection orders for anti-harassment and sexual assault fluctuated from May 2020 to July 2020, a consistent decrease for monthly filings of protection orders was present from August 2020 to February 2021. Most recently, March 2021 presented an increase in the year-over-year percent change for anti-harassment/stalking protection (20%) and sexual assault (40%).There was a consistent decrease of monthly filings of protection orders for domestic violence, with a 15% decrease most recently in March 2021 (Graph 19).

Graph 19: Protection orders filed, by month: 2019, 2020, and 2021 to date (Source: AOC)

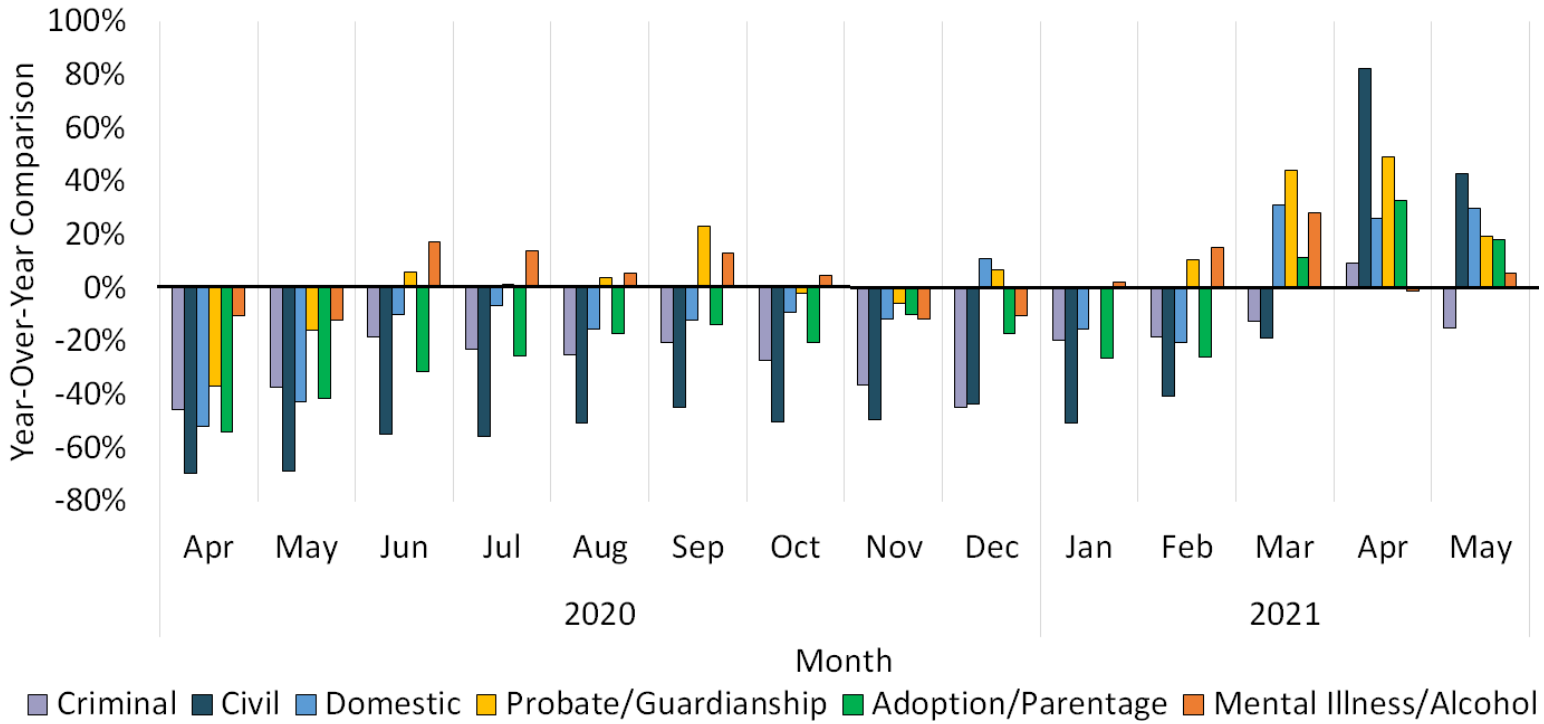


Note: For civil case protection orders, a petition for an order of protection is filed by a person seeking relief from an allegedly violent person, either related to or living with the petitioner. Anti-harassment petitions included in this category began to be processed by district courts effective July 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 court closures associated with the "Stay Home, Stay Healthy" order may have impacted court filing data. The most recent reporting period (May 2021) presented with year-over-year percent increases for all but criminal court case filings (-15%) (Graph 20).

Graph 20: Superior court cases filed, by month: 2019, 2020, and 2021 to date (Source: AOC)

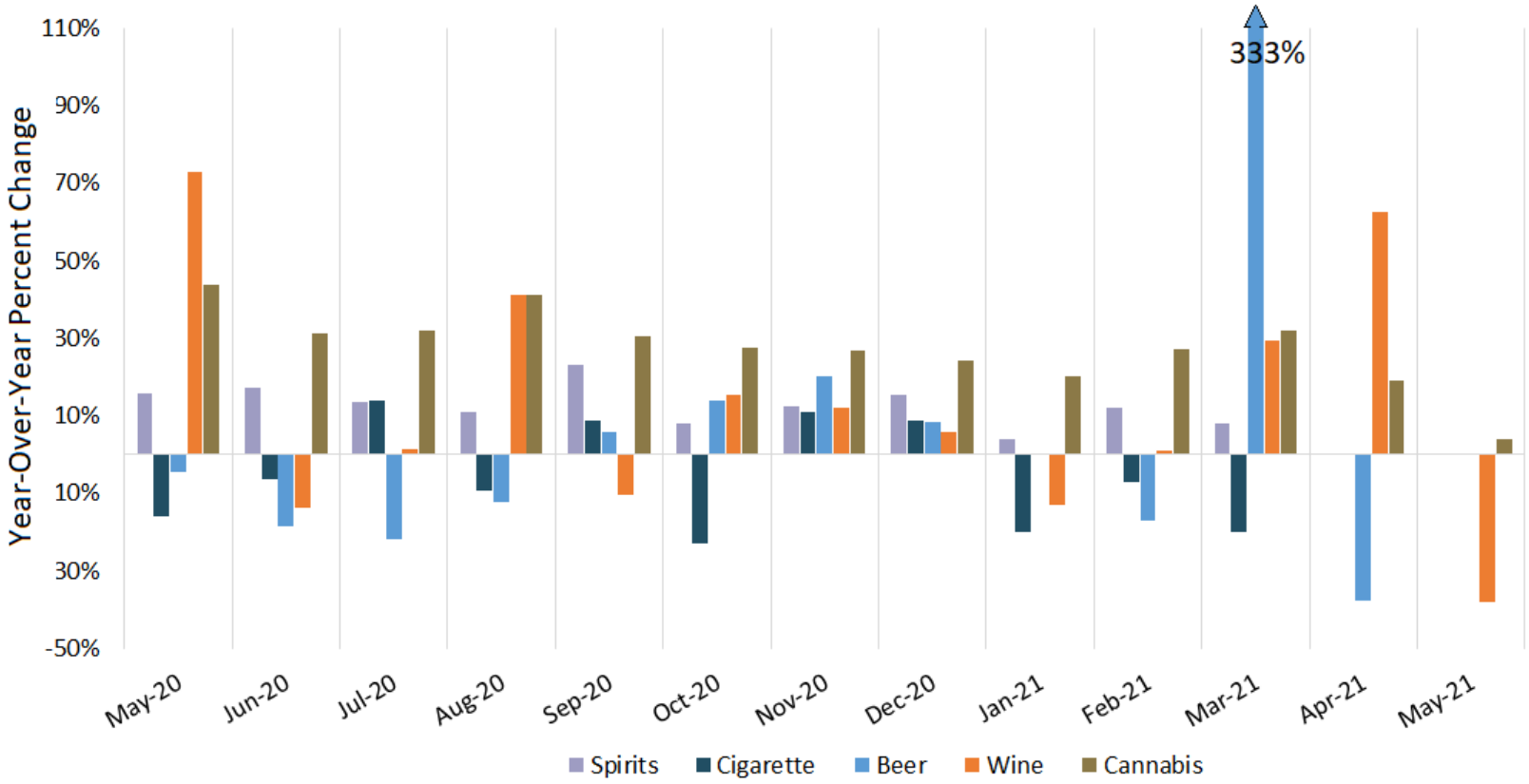


Note: **Criminal cases** are categorized by the primary (i.e., most serious) original charge in the following order: homicide, sex crime, robbery, assault, theft/burglary, motor vehicle theft, controlled substances, other felony, and misdemeanors. **Civil cases** pertain to the settlement of disputes 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 the month of May, beer tax collections showed no change (0%) in 2021 as compared to 2020, while monthly wine tax collections showed a decrease (-38%) in 2021 as compared to 2020 (Graph 21). Note that on January 1, 2021, the legal age to purchase cigarettes in Washington increased from 18 to 21.

Graph 21: Year-over-year percent change in select product sales indicators, by month: May 2020 – May 2021 (Source: LCB, DOR)



Note: Timing of LCB revenue collection can impact LCB data. Vertical axis has been decreased to provide better detailed presentation.

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.[15,16,17,18] 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 April and May 2021, Washington showed a year-over-year increase in the number of background checks, similar to the rest of the United States (Graph 22).

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 March, April, and May 2021, there was a year-over-year decrease at both the state and national levels (Graph 23).

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, July 2020 introduced legislative updates on firearm regulations, such as new limitations on where firearms may be carried or stored.

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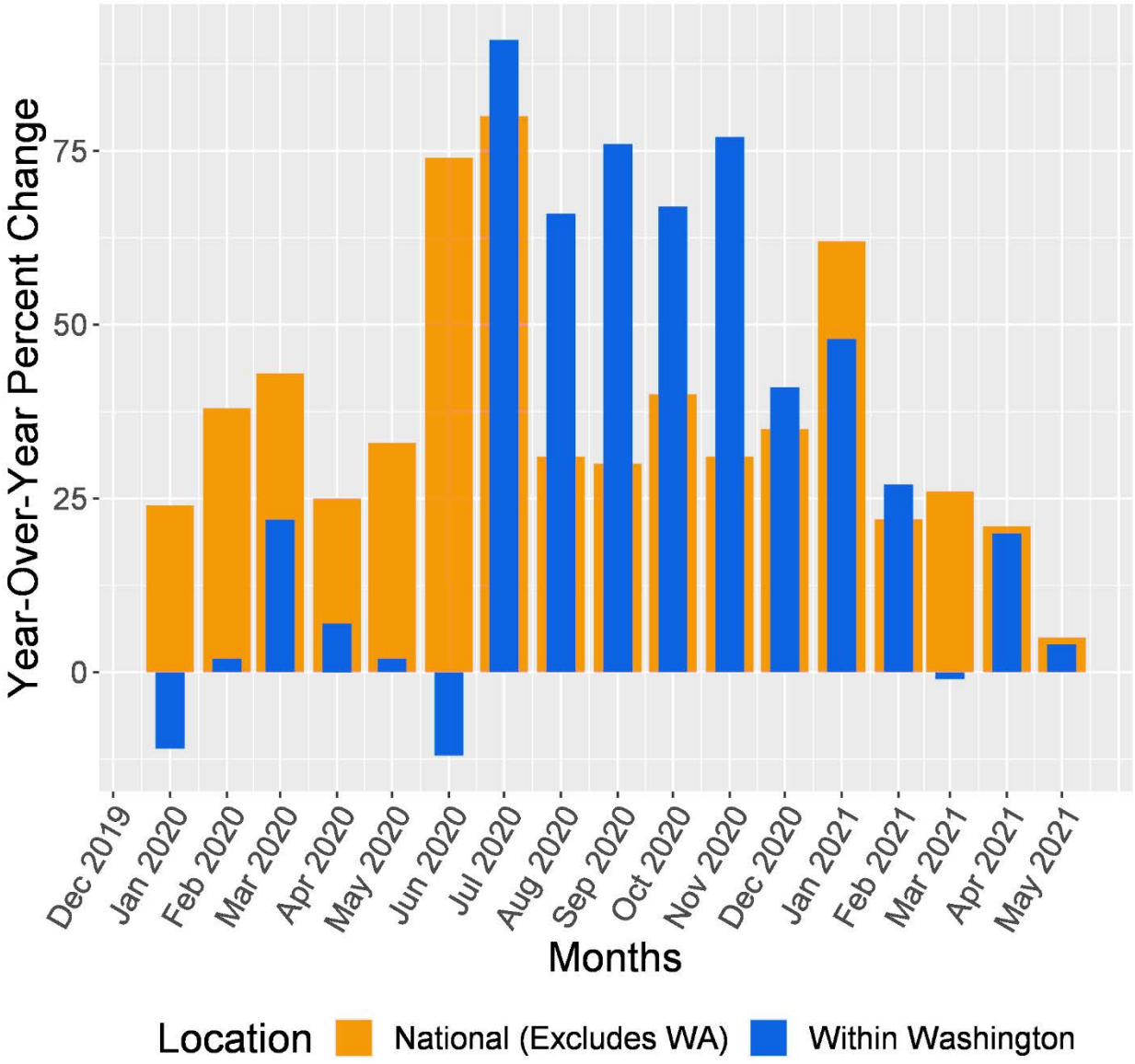
[15] From the Federal Bureau of Investigation: "It is important to note that the statistics within this chart represent the number of firearm background checks initiated through the NICS [National Instant Criminal Background Check System]. They do not represent the number of firearms sold. Based on varying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

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

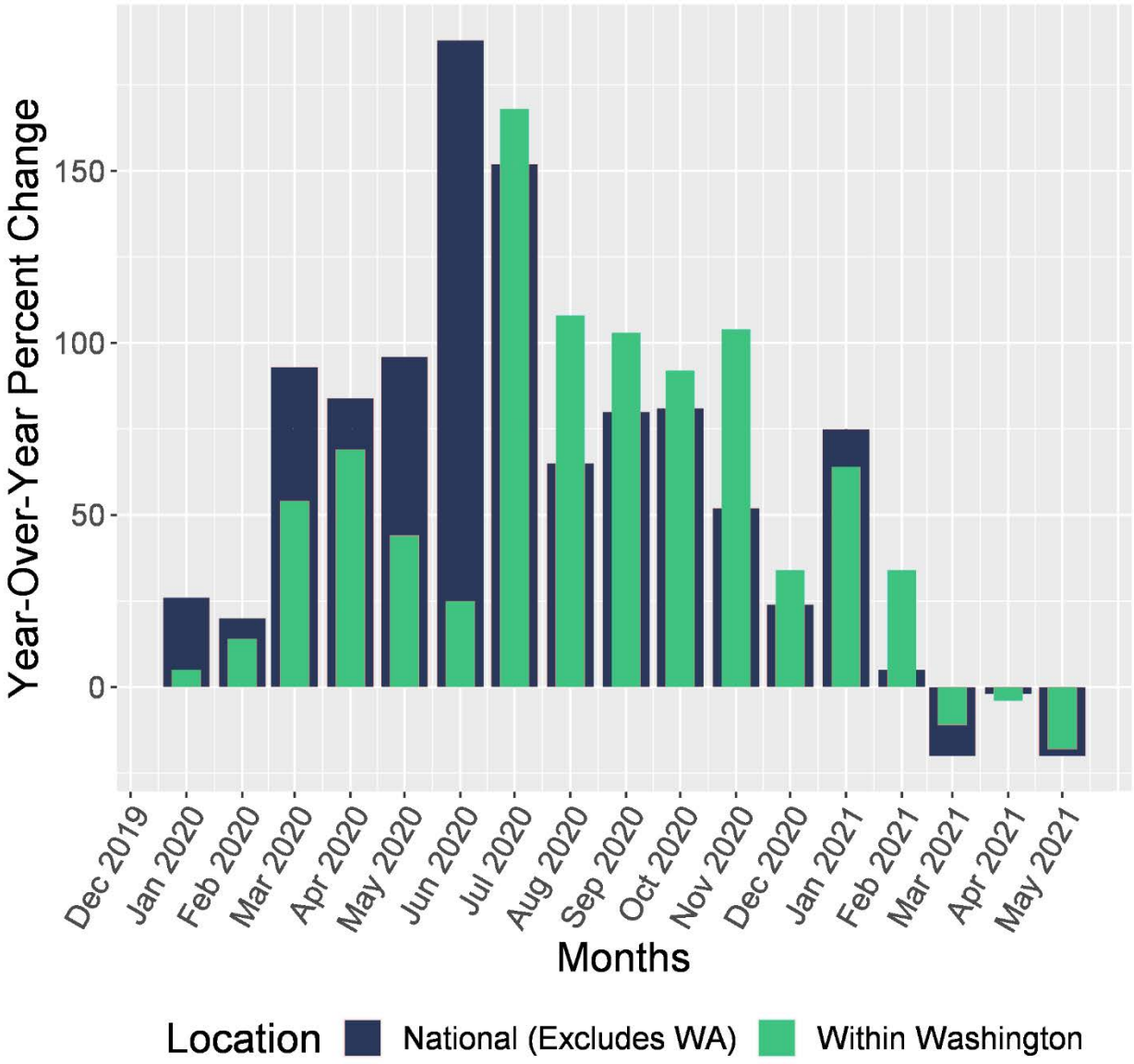
[17] Anglemyer, A., Horvath, T., & Rutherford, G. (2014). The accessibility of firearms and risk for suicide and homicide victimization among household members: a systematic review and meta-analysis [published correction appears in Ann Intern Med. 2014 May 6. 160(9), 658-9]. *Ann Intern Med, 160*(2),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

[18] 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.

Graph 22: Percent change of NICS firearm background checks, by month: 2019, 2020, and 2021 to date (Source: FBI)



Graph 23: Percent change of NICS handgun background checks, by month: 2019, 2020, and 2021 to date (Source: FBI)



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