



May 2022

DOH 821-135-14

COVID-19 Youth Behavioral Health Impact Situation Report

Purpose

On March 15, 2021, Governor Jay Inslee signed an [emergency proclamation](#)¹ recognizing the current mental and behavioral health emergency among Washington’s children and youth. The proclamation directs the Department of Health (DOH) and other state agencies to “identify and provide appropriate personnel for conducting necessary and ongoing incident related assessments.”

This report summarizes data analyses conducted by the COVID-19 Behavioral Health Group’s Impact & Capacity Assessment Task Force on the potential behavioral health impacts of the COVID-19 pandemic on Washington youth². These analyses assess the likely current and future impacts of the COVID-19 pandemic on mental health and potential for substance use issues among Washington youth.

Key Takeaways

- The rate of emergency department (ED) visits for all four syndromic indicators (Psychological Distress, Suspected Suicide Attempt, Suicidal Ideation, and Suspected Drug Overdose) for Washington youth decreased from the previous reporting period.
- Survey data collected by the U.S. Census Bureau for March 20 – April 11, 2022 show that the greatest number of respondents (who are Washington adults with children ages 5 to 17) indicated that, in the most recent reporting period, 52% of children ages 5 – 17 have received the COVID-19 vaccine.
- Monthly filings from the Administrative Office of the Courts (AOC) show a year-over-year percent change in March 2022 for monthly juvenile offender filings with a 32% decrease in sex crimes, a 100% increase in robberies, a 108% increase in assaults, a 32% decrease in thefts/burglaries, and a 50% decrease in motor vehicle thefts as compared to the previous year.

¹ https://www.governor.wa.gov/sites/default/files/proclamations/21-05_Children%27s_Mental_Health_Crisis_%28tmp%29.pdf

² Youth: Individuals ages 18 years and younger

Impact Assessment

Syndromic Surveillance

The Department of Health collects syndromic surveillance data in near real-time from hospitals and clinics across Washington. The data are always subject to updates. Key data elements reported include patient demographic information, chief complaint, and coded diagnoses. This [data collection system](#)³ 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 deviations⁴ above a 28-day average count, ending three weeks prior to the week with a warning or alert. These warnings or alerts are indicated, as needed, within each respective syndrome section. Alerts indicate more caution is needed than a warning. Additionally, “average weekly difference” is a measure of the variation in the weekly volume of ED visits across Washington.

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

Because the volume of visits across care settings varied widely during 2020, 2021, and 2022 to date, rates presented in this report may not reflect the true magnitude and direction of trends for behavioral health conditions and should be interpreted cautiously.

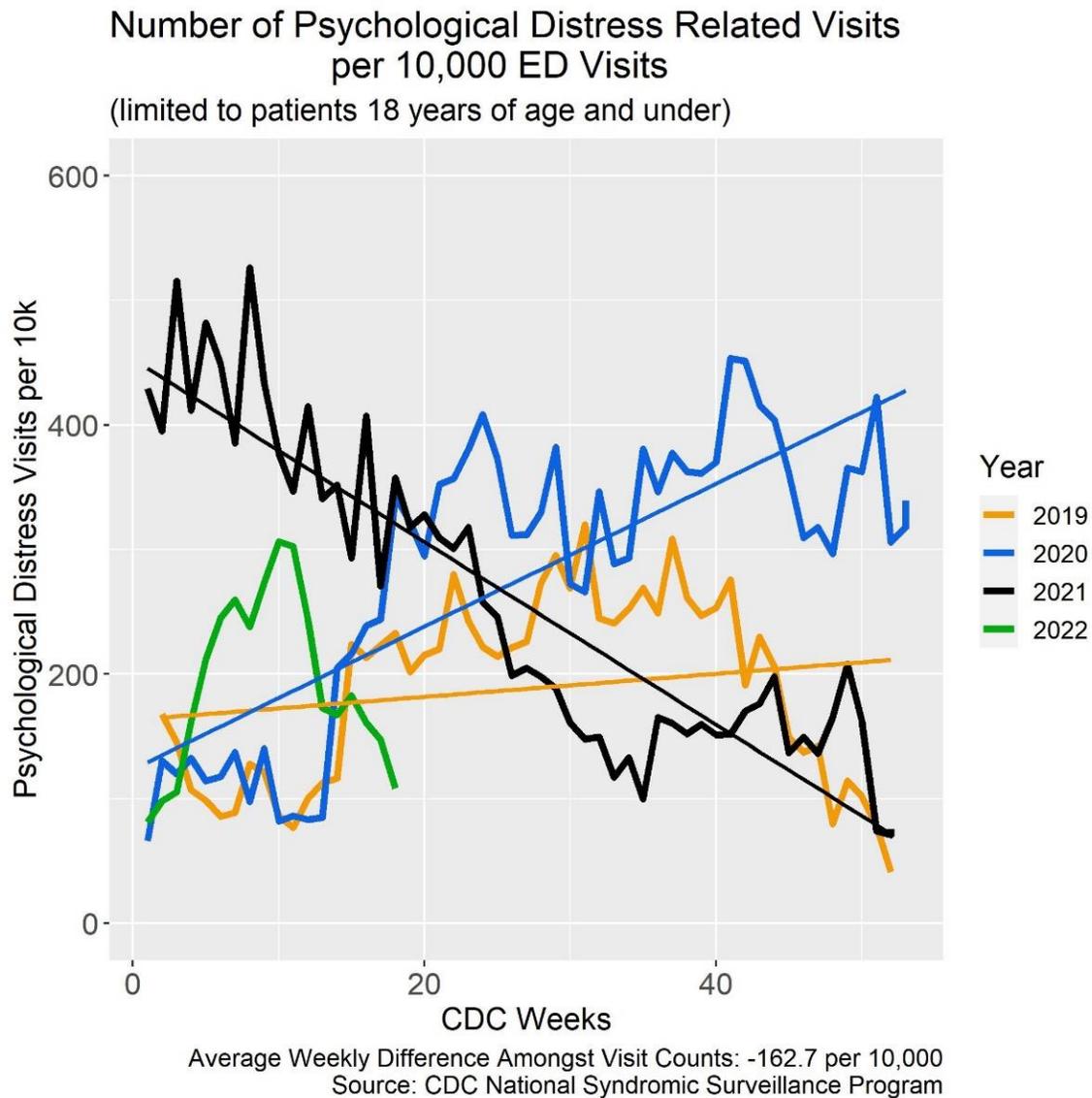
³ <https://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/HealthcareProfessionsandFacilities/PublicHealthMeaningfulUse/RHINO>

⁴ Standard deviation: A measure of the amount of variation or dispersion of a set of values. Standard deviation is often used to measure the distance of a given value from the average value of a data set.

Psychological Distress

During **CDC Week 13 – 17 (weeks of April 2 – 30, 2022)** the **relative reported rate of ED visits for psychological distress⁵** among youth **decreased from the previous reporting period** and is lower than the rate in the corresponding weeks of 2019, 2020, and 2021 (Graph 1). No statistical alert was issued.

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



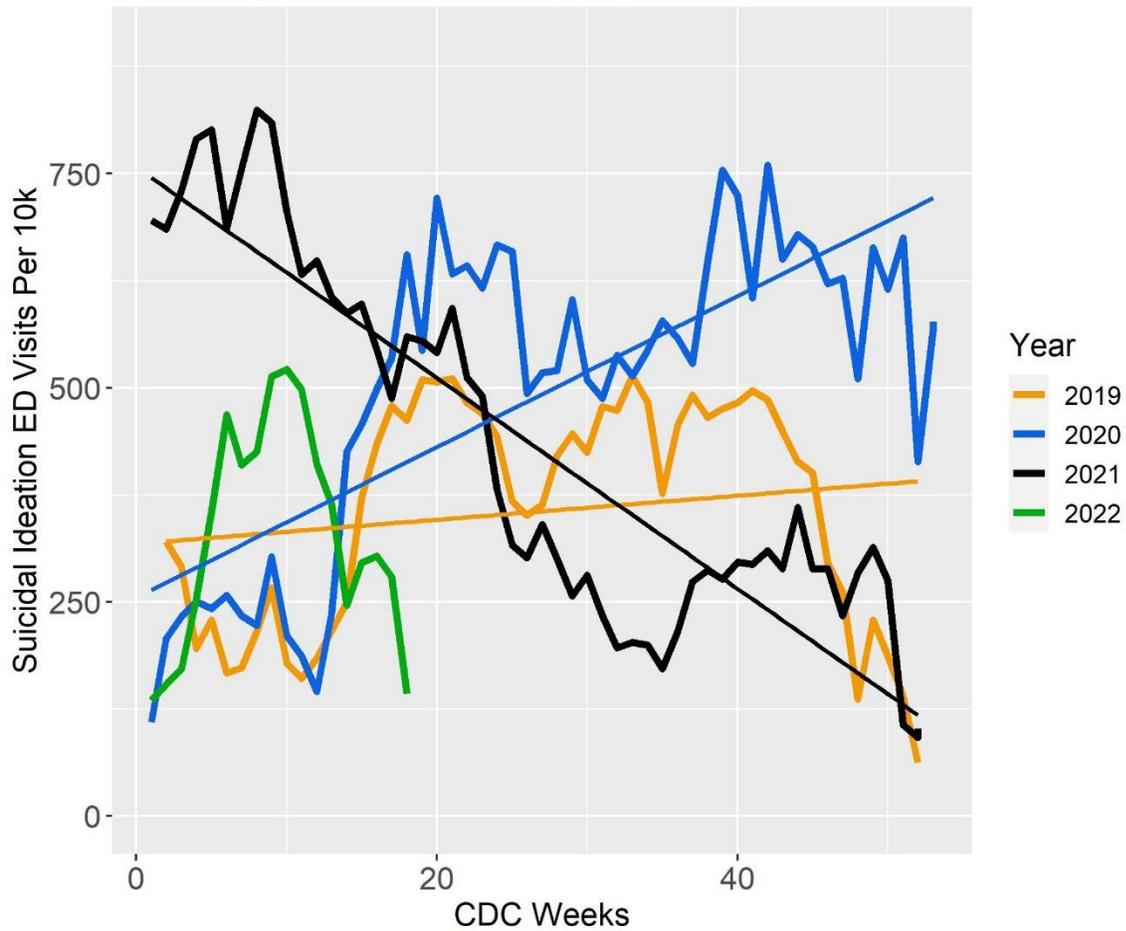
⁵ Psychological distress in this context is considered a disaster-related syndrome comprised of panic, stress, and anxiety. It is indexed in the Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE) platform as Disaster-related Mental Health v1. Full details are available at <https://knowledgerepository.syndromicsurveillance.org/disaster-related-mental-health-v1-syndrome-definition-subcommittee>.

Suicidal Ideation and Suspected Suicide Attempt

During **CDC Week 13 – 17 (weeks of April 2 – 30, 2022)** the **relative reported rate of ED visits for suicidal ideation** among youth **decreased from the previous reporting period** and is lower than the rate in 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 among youth in Washington, by week: 2019, 2020, 2021, and 2022 to date (Source: CDC ESSENCE)

Number of Suicidal Ideation Related Visits
per 10,000 ED Visits
(limited to patients 18 years of age and under)

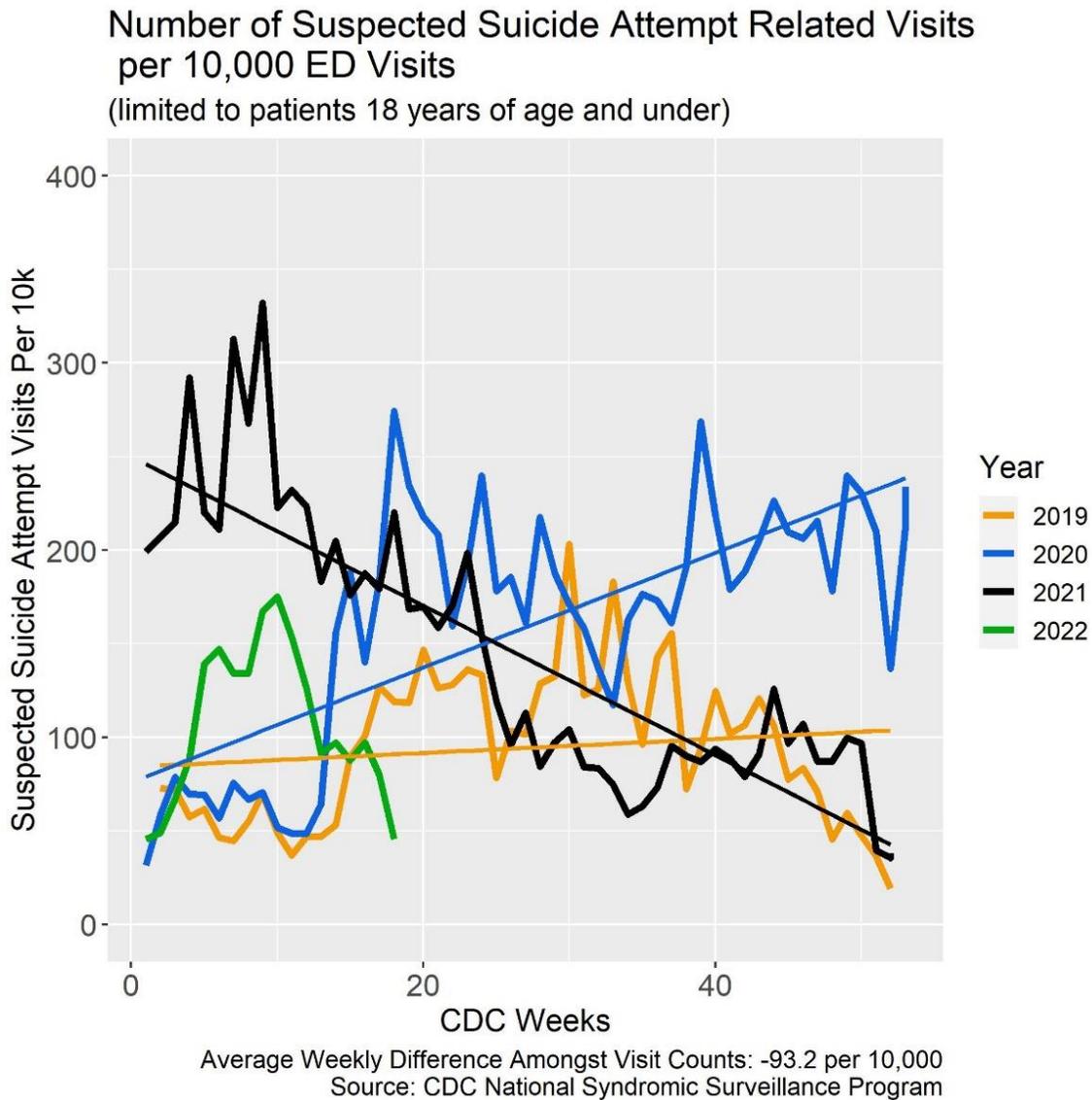


Average Weekly Difference Amongst Visit Counts: -282.3 per 10,000
Source: CDC National Syndromic Surveillance Program

During **CDC Week 13 – 17 (weeks of April 2 – 30, 2022)** the relative reported rate of ED visits for suspected suicide attempt among youth decreased from the previous reporting period and is lower than the rate in the corresponding weeks of 2019, 2020, and 2021. No statistical warnings or alerts were issued.

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.⁶

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

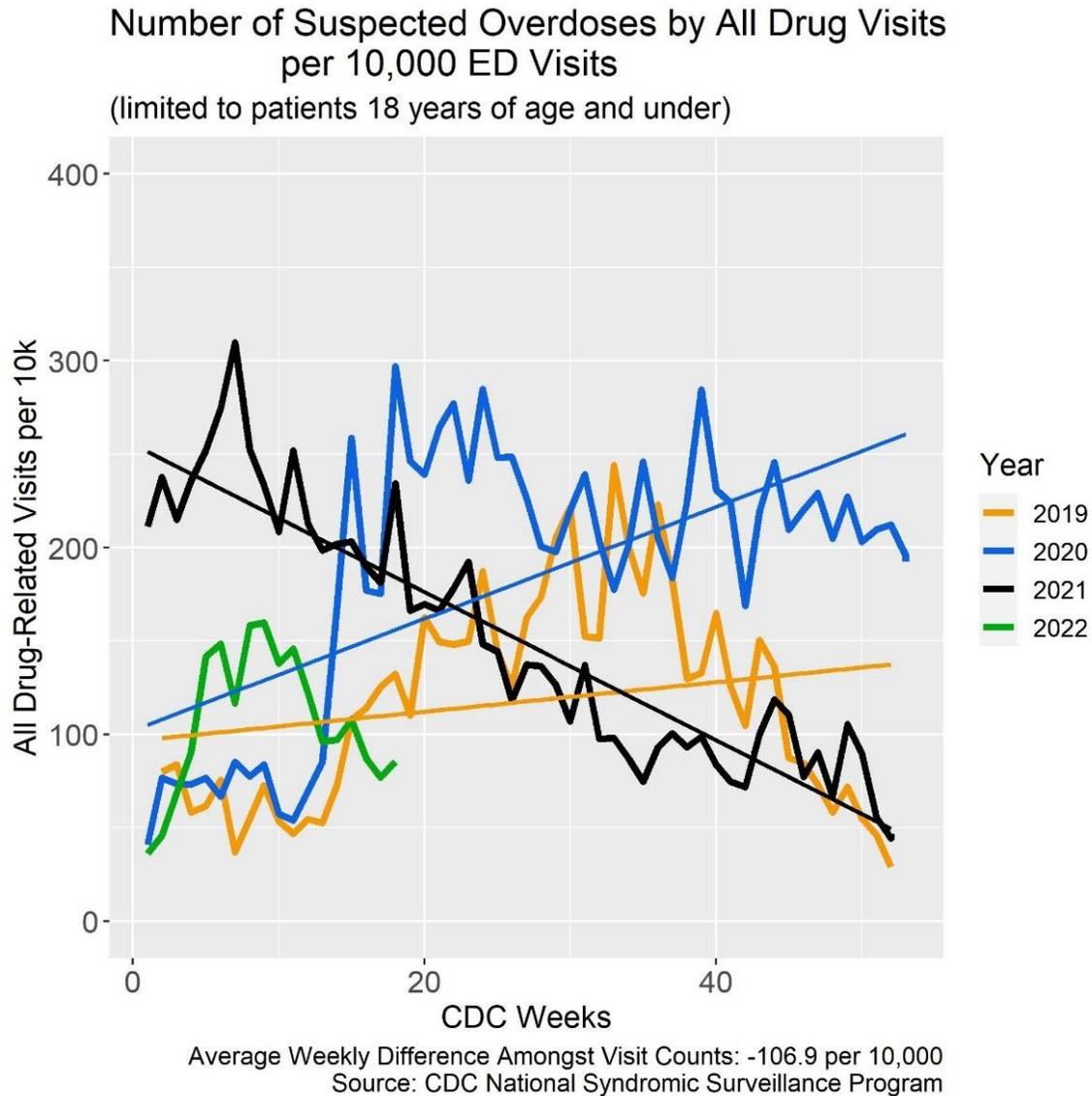


⁶ <https://knowledgerepository.syndromicsurveillance.org/disaster-related-mental-health-v1-syndrome-definition-subcommittee>

Substance Use – Suspected Drug Overdose

During **CDC Week 13 – 17 (weeks of April 2 – 30, 2022)** the relative reported rate of ED visits for suspected drug overdose among youth **decreased from the previous reporting period, is increasing**, but is lower than the rate in the corresponding weeks of 2019, 2020, and 2021 (Graph 4). No statistical warnings or alerts were issued.

Graph 4: Relative ED count for all drug⁷-related visits among youth 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>.

General Surveillance

COVID-19 Vaccinations for Children Ages 5 – 17

[Survey data](#)⁸ collected by the U.S. Census Bureau for January 26 – April 11, 2022 show that the greatest number of respondents (who are Washington adults with children ages 5 – 17) indicated that in the most recent reporting period (**March 30 – April 11, 2022**) 52% of children ages 5 – 17 have received the COVID-19 vaccine.

Just over half (54%) of respondents who did not receive a COVID-19 vaccine reported that they will **definitely not** get a vaccine for their children, while 18% of respondents who did not receive a COVID-19 vaccine reported that they will **probably not** get a vaccine for their children. For respondents who did not receive a COVID-19 vaccine, 2.97% and 5.78% indicated they will **definitely get** a vaccine or **probably get** a vaccine for their child (Graph 5).

For respondents or household members who experienced loss of employment income in the last four weeks, 53% of those individuals reported that they will **probably not** get a vaccine for their children, 12.74% of those individuals reported that they will **definitely not** get a vaccine for their children, and 3.61% of those individuals reported that they will **definitely** get a vaccine for their children.

In terms of “definitely” getting a vaccine for their children ages 5 – 17:

- Highest rate is with respondents in households earning \$150,000 - \$199,999 per year (19.22%),
 - Only respondents with children ages 5 – 11 answered this question.
- Second highest rate is with respondents in households earning \$200,000 and above per year (9.47%).
 - Only respondents with children ages 5 – 11 answered this question.

In terms of “probably” getting a vaccine for their children ages 5 – 17:

- Highest rate is with respondents in households earning \$150,000 - \$199,999 per year (6.50%),
 - Only respondents with children ages 12 – 17 answered this question.
- Second highest rate is with respondents in households earning \$25,000 - \$39,999 per year (3.88%),
 - Only respondents with children ages 12 – 17 answered this question.

In terms of “unsure” getting a vaccine for their children ages 5 – 17:

- Highest rate is with respondents in households earning \$ 25,000 - \$39,999 per year (23.00%) and \$50,000 - \$74,999 per year (23.90%),
- Third highest rate is with respondents in households earning less than \$25,000 per year (13.50%).

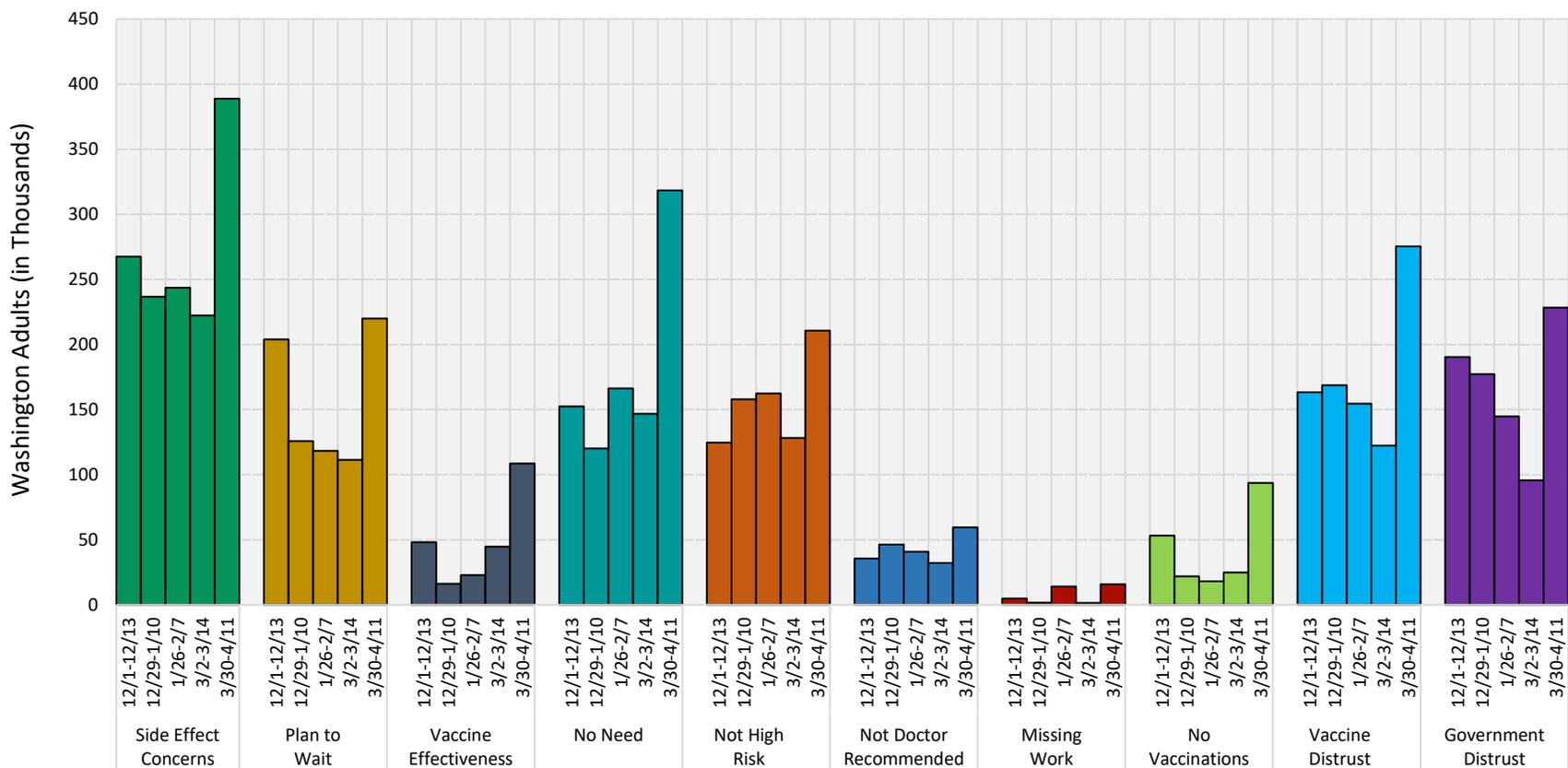
In terms of “probably not” getting a vaccine for their children ages 5 – 17:

- Highest rate is with respondents in households earning \$200,000 and above per year (52.07%),
 - Only respondents with children ages 5 – 11 answered this question.

⁸ <https://www.census.gov/programs-surveys/household-pulse-survey.html>

- Second highest rate is with respondents in households earning \$35,000 - \$49,999 per year (45.66%).
- In terms of “definitely not” getting a vaccine for their children ages 5 – 17:
- Highest rate is with respondents in households earning less than \$25,000 (70.98%),
 - Second highest rate is with respondents in households earning \$75,000 - \$99,999 (64.21%).

**Graph 5: Count of Washington adults reporting children’s vaccination plans:
December 29, 2021 – April 11, 2022 (Source: U.S. Census Bureau)**



Note: **Definitely** (will definitely get a vaccine); **Probably** (will probably get a vaccine); **Unsure** (unsure about getting a vaccine); **Probably Not** (will probably not get a vaccine); **Definitely Not** (will definitely not get a vaccine); **Unsure of Vaccination Plan** (do not know the vaccination plans of children). Children ages 12 – 17 who received a COVID-19 vaccine are not graphically included.

Reasons for children (ages 5 – 17) not receiving or planning to receive a COVID-19 vaccine

[Survey data](#)⁸ further show reasons for children (ages 5 – 17) not receiving or planning to receive a COVID-19 vaccine from January 26 – April 11, 2022 (Graph 6). In the most recent reporting period (**March 30 – April 11, 2022**), 21.57% of Washington adults with children ages 5 – 17 reported being “concerned about possible side effects for children,” 2.41% of Washington adults with children reported “not believing children need a vaccine,” 9.28% of Washington adults with children reported “not trusting the government,” 11.86% of Washington adults with children reported “not trusting the COVID-19 vaccine,” 12.44% of Washington adults with children reported that their “children were not members of a high risk group,” and 10.80% of Washington adults with children reported “planning to wait and see if the vaccines are safe.”

In terms of “being concerned about possible side effects for children”:

- Highest rate is with respondents in households earning less than \$25,000 per year (17.76%),
- Second highest rate is with respondents in households earning \$50,000 - \$75,000 per year (11.85%).

In terms of “being unsure if the vaccines will work for children”:

- Highest rate is with respondents in households earning \$50,000 - \$75,000 per year (24.62%),
- Second highest rate is with respondents in households earning \$100,000 - \$150,000 per year (16.52%).

In terms of “not believing children need a vaccine”:

- Highest rate is with respondents in households earning \$100,000 - \$150,000 per year (16.11%),
- Second highest rate is with respondents in households earning \$200,000 and above per year (15.24%).

In terms of “not trusting the COVID-19 vaccines”:

- Highest rate is with respondents in households earning \$150,000 - \$200,000 per year (27.38%),
- Second highest rate is with respondents in households earning \$25,000 - \$35,000 per year (16.24%).

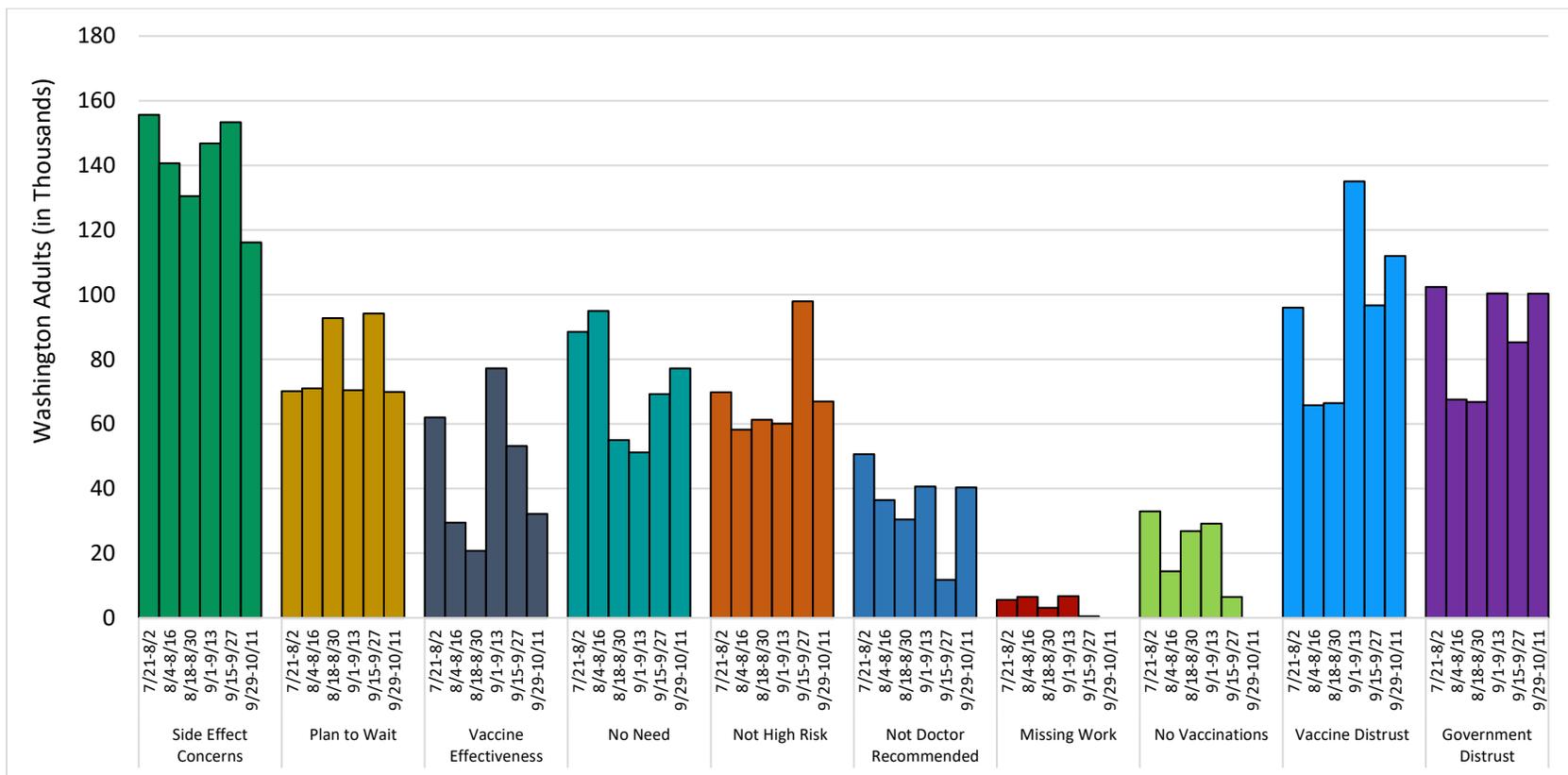
In terms of “parents or guardians do not vaccinate their children”:

- Highest rate is with respondents in households earning \$50,000 - \$75,000 per year (23.03%),
- Second highest rate is with respondents in households earning \$25,000 - \$35,000 per year (16.24%).

In terms of “concern about the cost of vaccines”:

- Highest rate is with respondents in households earning \$200,000 and above per year (22.53%),
- Second highest rate is with respondents in households earning \$100,000 - \$150,000 per year (10.17%).

Graph 6: Count of Washington adults reporting reasons for children not receiving or planning to receive a COVID-19 vaccine: December 29, 2021 – April 11, 2022 (Source: U.S. Census Bureau)



Note: Side Effect Concerns (concerned about possible side effects for children); Plan to Wait (plan to wait and see if it is safe); Vaccine Effectiveness (not sure if vaccine will work for children); No Need (don't believe children need a vaccine); Not High Risk (children in household not members of a high risk group); Not Doctor Recommended (children's doctor has not recommended a vaccine); Missing Work (concerned about missing work to have children vaccinated); No Vaccinations (parents or guardians do not vaccinate their children); Vaccine Distrust (don't trust COVID-19 vaccines); Government Distrust (don't trust the government). Responses also included "Other people need it more than children right now," "Unable to get a vaccine for children," "Other," and "Concerned about cost of vaccine" but due to low numbers, these responses were not graphically included. Note, survey respondents could choose more than one reason.

Telehealth Use Claims for Washington Medicaid Clients

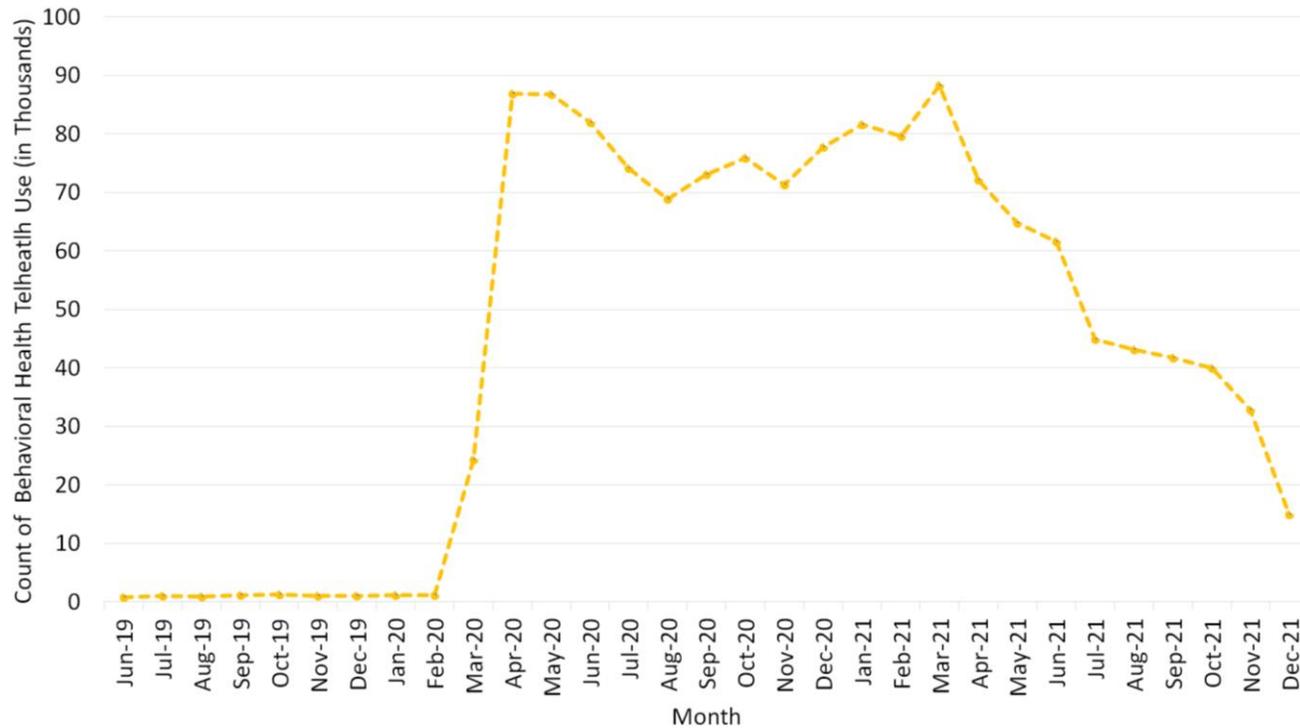
Telehealth (phone and videoconferencing) claims use for Washington Medicaid clients is collected by the Washington State Health Care Authority (HCA).

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

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

The most recent reporting period (December 2021) showed a 55% decrease in telehealth behavioral health service claims for individuals 18 and younger.

Graph 7: Count of behavioral health telehealth use claims for WA Medicaid clients under age 18, by month (Source: HCA)



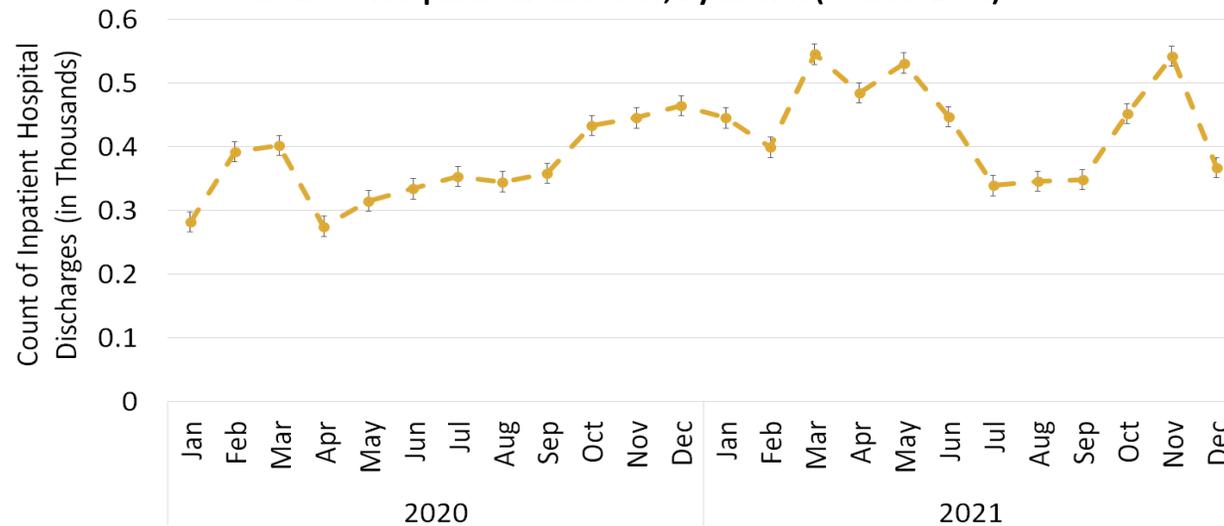
Inpatient Community Hospital Discharges

The [Comprehensive Hospital Abstract Reporting System \(CHARS\)](#)⁹ collects record level information on inpatient 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. Only mental, behavioral, and neurodevelopmental disorders were evaluated (based on the individuals primary diagnoses included only ICD-10 F-codes)¹⁰ for this report.

Graph 8 shows the count of youth inpatient community hospital discharges for mental, behavioral, and neurodevelopmental disorders. The most recent reporting period (December 2021) showed a 32% decrease for youth, compared to the previous month.

Graph 8: Count of youth inpatient community hospital discharges for mental, behavioral, and neurodevelopmental disorders, by month (Source: DOH)



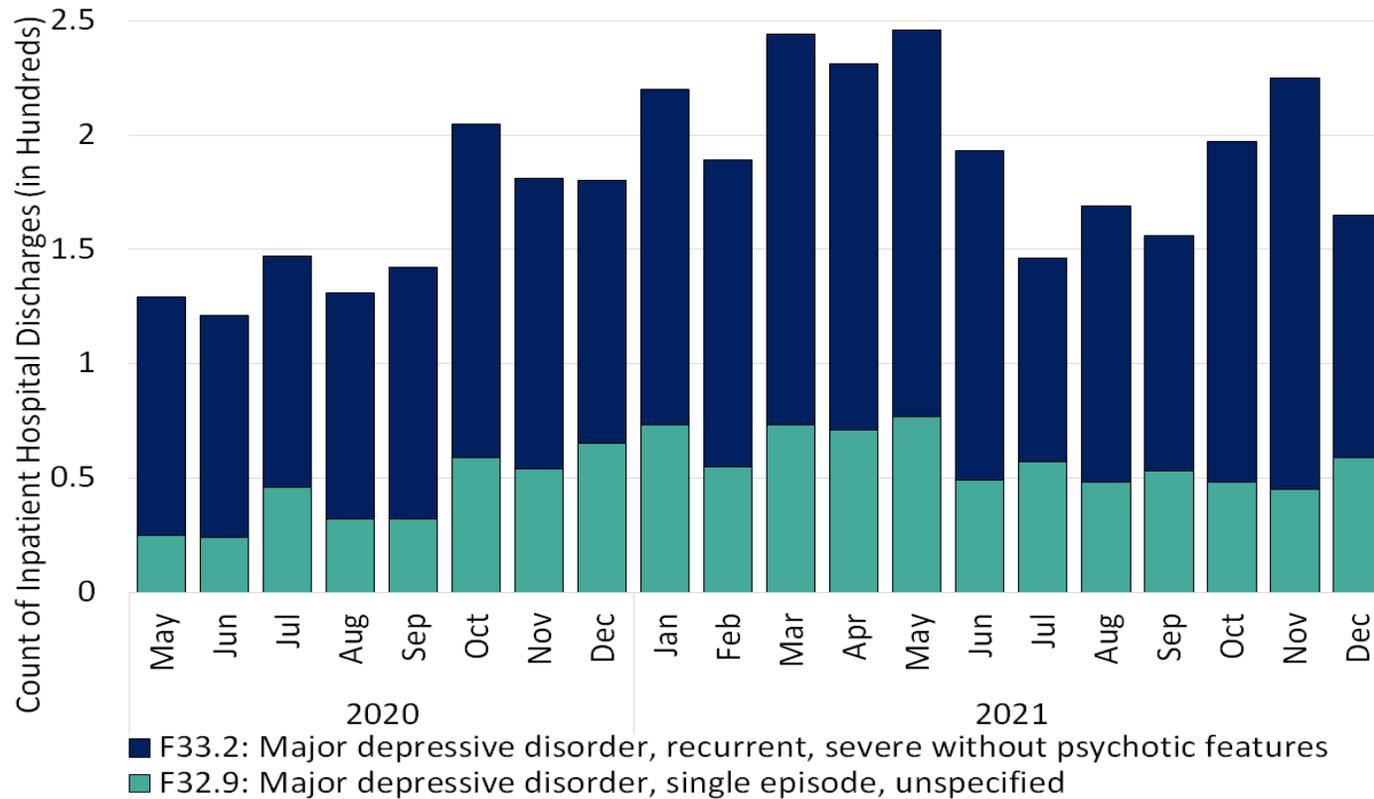
Note: Due to time lag, data might not be fully mature. While non-WA residents can discharge from a WA community hospital, only WA youth residents were included in the analysis. Only F-codes as primary diagnoses were included in the analysis.

⁹<https://www.doh.wa.gov/dataandstatisticalreports/healthcareinwashington/hospitalandpatientdata/hospitaldischargedatachars>

¹⁰ 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 9 shows the count of the top two mental, behavioral, and neurodevelopmental disorders in terms of inpatient community hospital discharges. The most recent reporting period showed a 31% increase in “major depressive disorder, single episode, unspecified” inpatient community hospital discharges and a 41% decrease in “major depressive disorder, recurrent, severe without psychotic features” inpatient community hospital discharges.

Graph 9: Count of top mental, behavioral, and neurodevelopmental disorders for youth inpatient community hospital discharges, by month (Source: DOH)



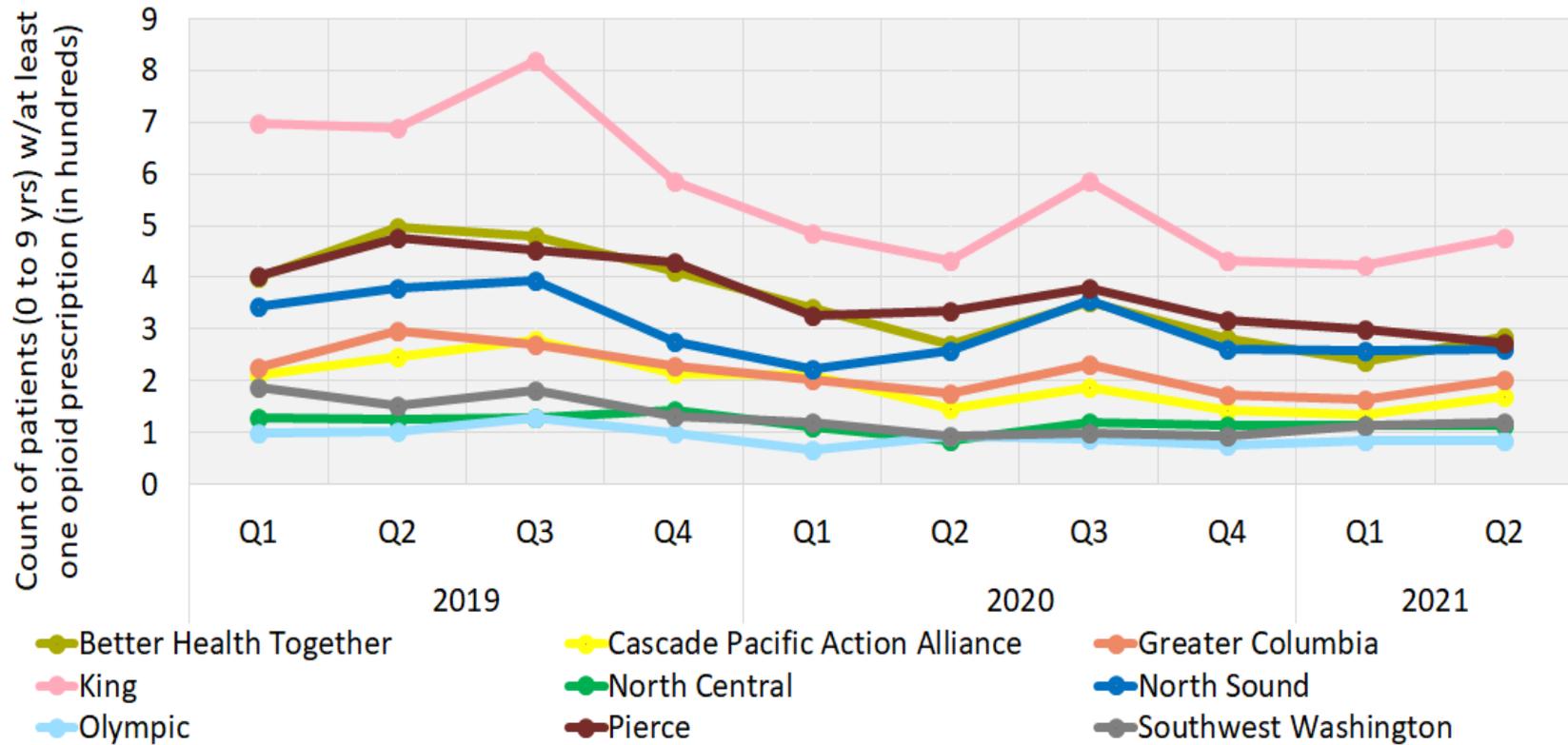
Note: Due to time lag, data might not be fully mature. While non-WA residents can discharge from a WA community hospital, only WA youth residents were included in the analysis. Only F-codes as primary diagnoses were included in the analysis. Due to low numbers, previously reported disorders are not further assessed.

Prescription Opioids Usage

DOH's Prescription Monitoring Program (PMP) collects the prevalence of prescription opioid use. For the overall Washington population ages 0 – 9, the most recent reporting period (Quarter 2 of 2021) showed a 8.19% 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 10 provides a count of patients ages 0 – 9, 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 **18.83% increase** of patients ages 0 – 9 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 **26.12% increase** of patients ages 0 – 9 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 **23.03% increase** of patients ages 0 – 9 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 **12.26% increase** of patients ages 0 – 9 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 **0.88% decrease** of patients ages 0 – 9 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 **1.17% increase** of patients ages 0 – 9 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 **1.18% decrease** of patients ages 0 – 9 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 **9.30% decrease** of patients ages 0 – 9 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 **6.19% increase** of patients ages 0 – 9 with at least one opioid prescription submitted to the PMP as compared to the previous calendar quarter (Quarter 1 of 2021)

Graph 10: Count of patients ages 0 – 9 with at least one opioid prescription, by calendar quarter and ACHs (Source: DOH)

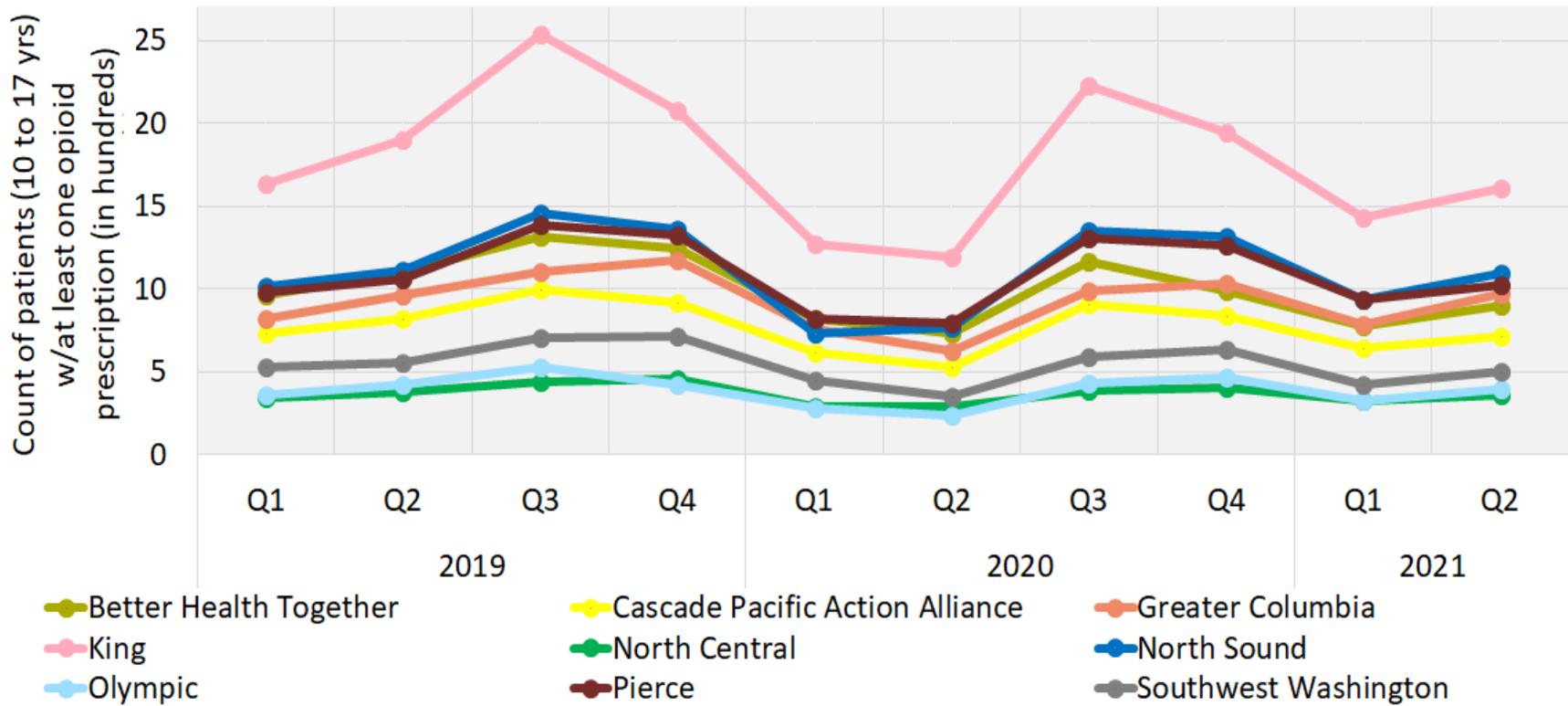


Note: Caution should be taken when examining these data; for Quarter 2 of 2021, 95% CI [2.04, 2.22] with a state population of 930,802 and state rate of 2.13 while Quarter 1 of 2021 presented with a 95% CI [1.88, 2.06] with a state population of 930,802 and state rate of 1.97. 2021 population estimates 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](#)

For the overall Washington population ages 10 – 17, the most recent reporting period (Quarter 2 of 2021) showed a 14.95% 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 11 provides a count of patients ages 10 – 17, broken down by calendar quarter and 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 **15.42% increase** of patients **ages 10 – 17** 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 **10.09% increase** of patients **ages 10 – 17** 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 **22.87% increase** of patients **ages 10 – 17** 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 **12.54% increase** of patients **ages 10 – 17** 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 **11.53% increase** of patients **ages 10 – 17** 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 **17.01% increase** of patients **ages 10 – 17** 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 **19.57% increase** of patients **ages 10 – 17** 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 **10.22% increase** of patients **ages 10 – 17** 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 **19.76% increase** of patients **ages 10 – 17** with at least one opioid prescription submitted to the PMP as compared to the previous calendar quarter (Quarter 1 of 2021)

Graph 11: Count of patients ages 10 – 17 with at least one opioid prescription, by calendar quarter and ACHs (Source: DOH)



Note: For Quarter 2 of 2021, 95% CI [9.63, 10.07] with a state population of 766,613 and state rate of 9.85 while Quarter 1 of 2021 presented with a 95% CI [8.36, 8.78] with a state population of 766,613 and state rate of 8.57. 2021 population estimates are based on the 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](#)

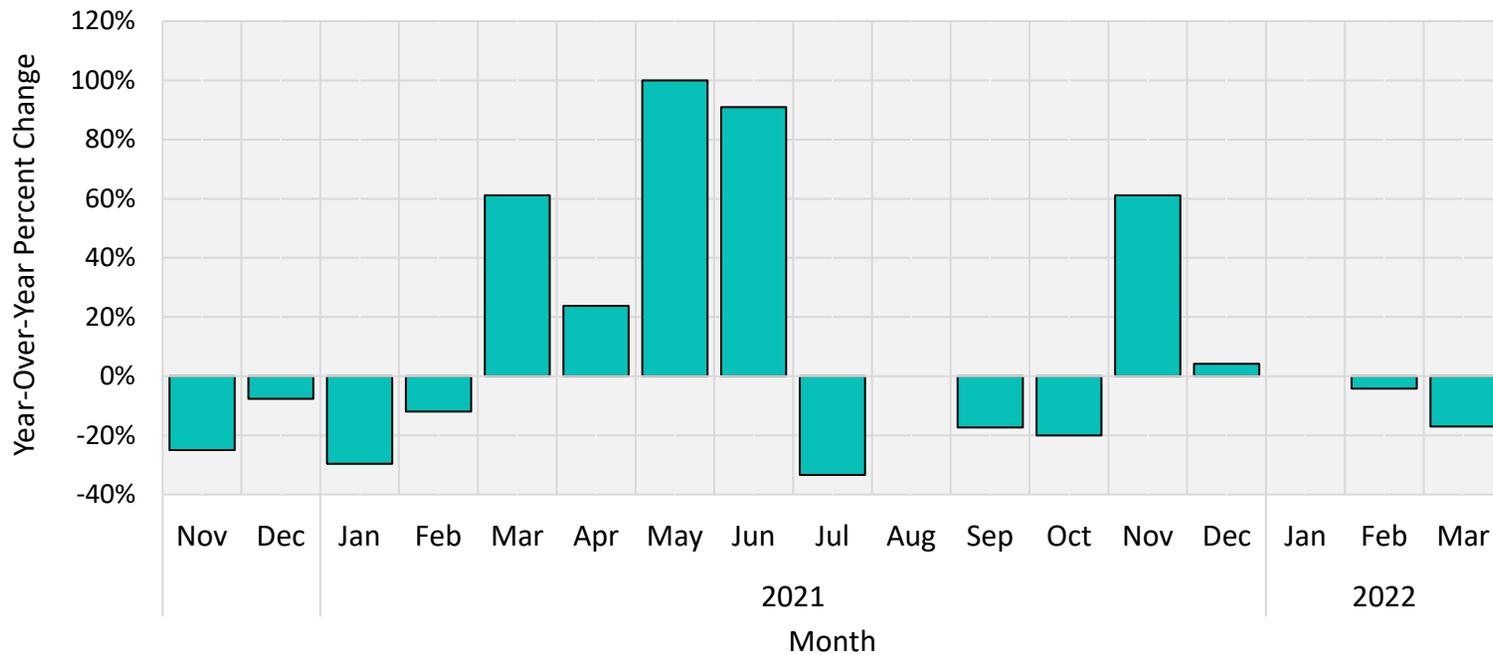
Court Reporting

For this reporting area, note that the “Stay Home, Stay Healthy” order and associated court closures may impact court filing data.

Mental Illness (Minor) Filings

Monthly filings from the Administrative Office of the Courts (AOC) show the initiation of a court case by formal submission for mental illness (minor) cases. Most recently, there was a year-over-year¹¹ percent change in March 2022 for monthly mental illness (minor) case filings (-17.24%), compared to the previous year (Graph 12).

Graph 12: Percent change of mental illness (minor) filings by month (Source: AOC)



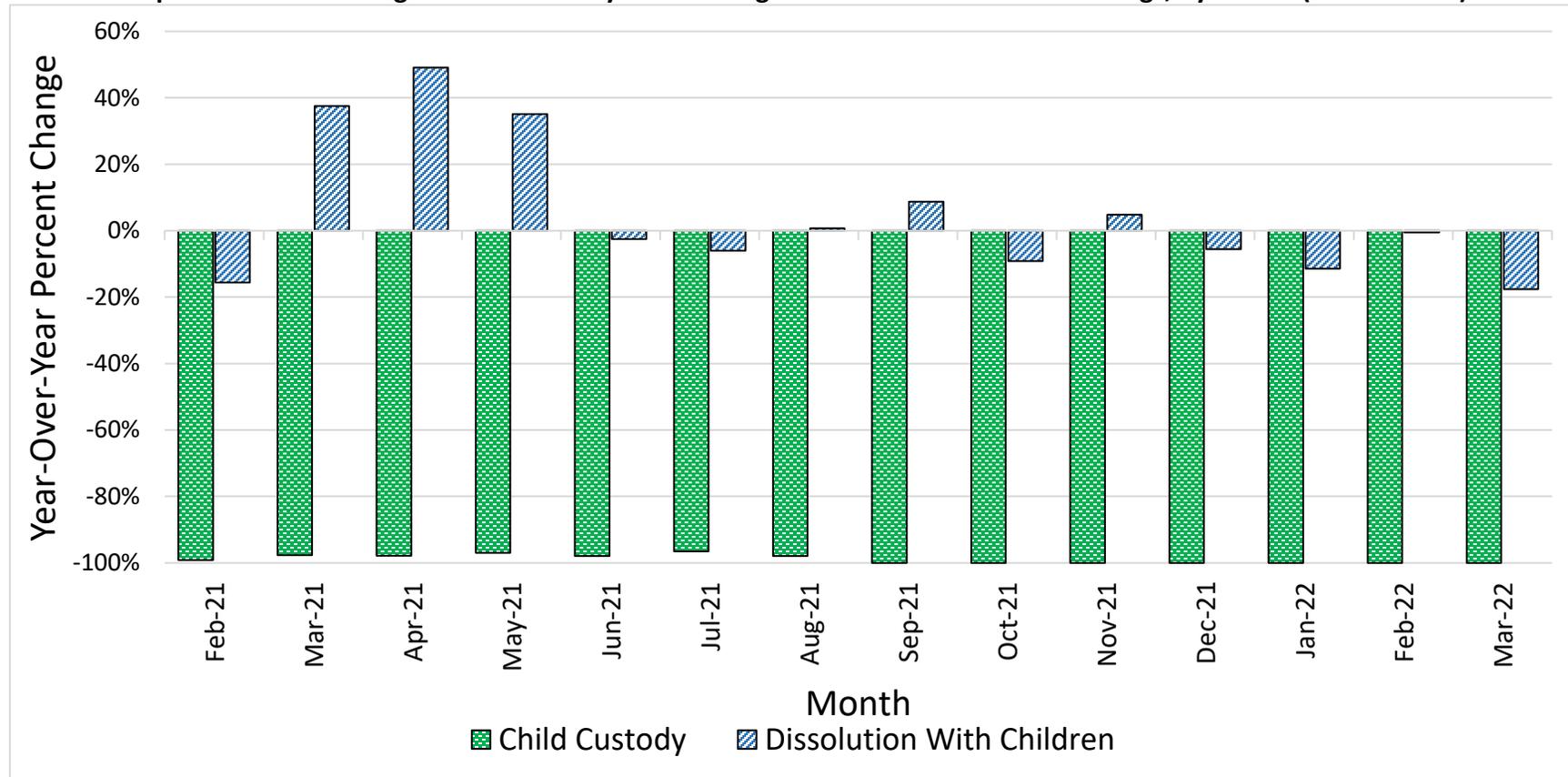
Note: Each unique mental illness case number is reported as a single filing, no matter how many subsequent petitions are filed during the life of a case. A case reopened for subsequent adjudication after the initial judgment is not considered a new filing unless there is a new case number. Mental illness (minor) cases involve the determination as to whether an individual is mentally ill or incapacitated and should be placed in or remain under care, custody, and treatment.

¹¹ Year-over-year: a comparison of data between multiple years, specifically 2020 to 2021 and 2022.

Child Custody and Marriage Dissolution with Children Filings

Monthly filings from the AOC show the initiation of a court case by formal submission for child custody and marriage dissolution with children. In March 2022, there was a year-over-year percent decrease in for monthly child custody case filings (-100%) and in dissolution with children (-17.61%) (Graph 13).

Graph 13: Percent change of child custody and marriage dissolution with children filings, by month (Source: AOC)

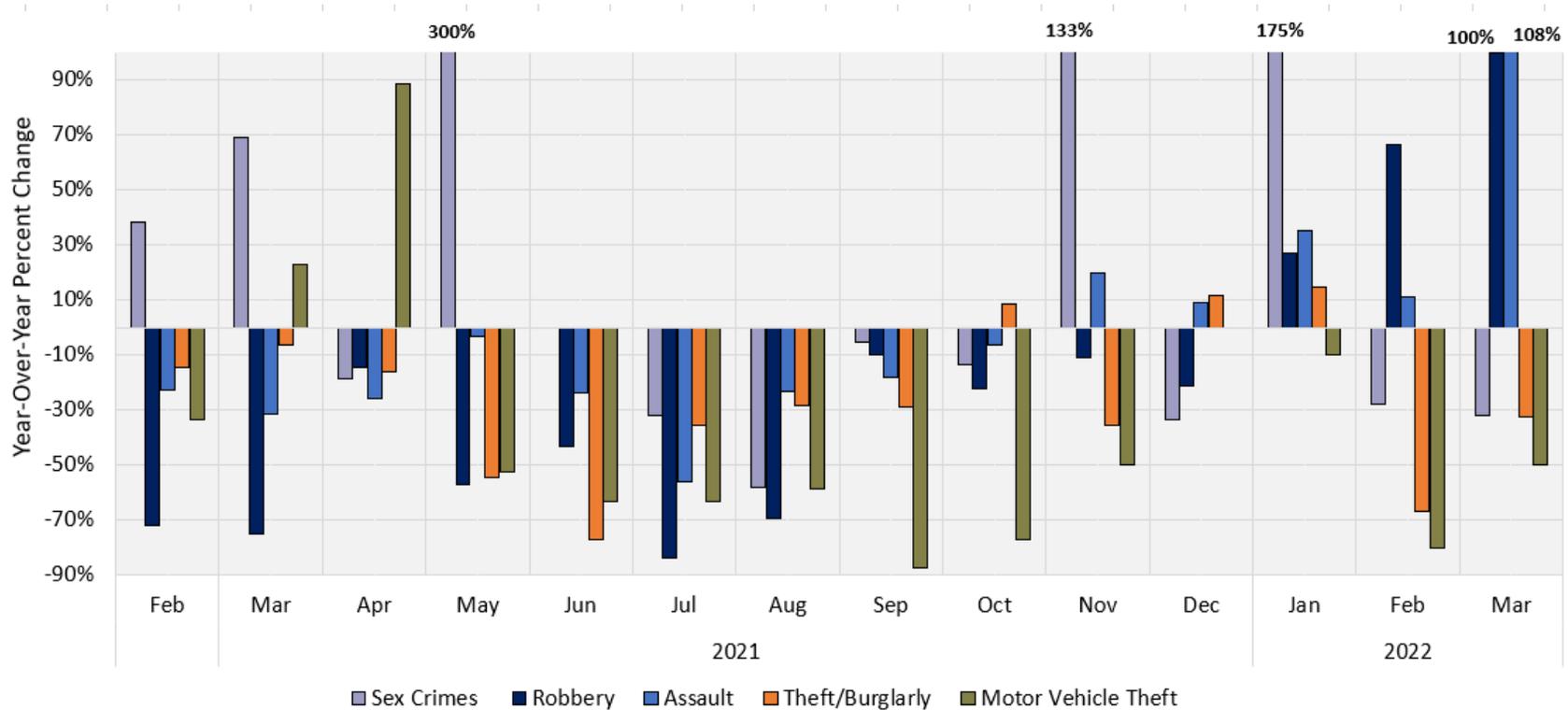


Note: Monthly filings from the AOC show the initiation of a court case by formal submission for child custody (i.e., dispute involving immediate charge and control of a child) and dissolution with children of the marriage (i.e., termination of a marriage other than by annulment, with dependent children of that marriage).

Juvenile Offender Filings

Monthly filings from the Washington State Administrative Office of the Courts (AOC) show the initiation of a court case by formal submission. Case filings occur for each juvenile offender and are categorized by the primary (i.e., most serious) charge. Most recently, there were year-over-year percent changes in March 2022 for monthly juvenile offender filings with a 32% decrease in sex crimes, a 100% increase in robberies, a 108% increase in assaults, a 32% decrease in thefts/burglaries, and a 50% decrease in motor vehicle thefts (Graph 14).

Graph 14: Percent change of juvenile offender filings, by charge and month (Source: AOC)

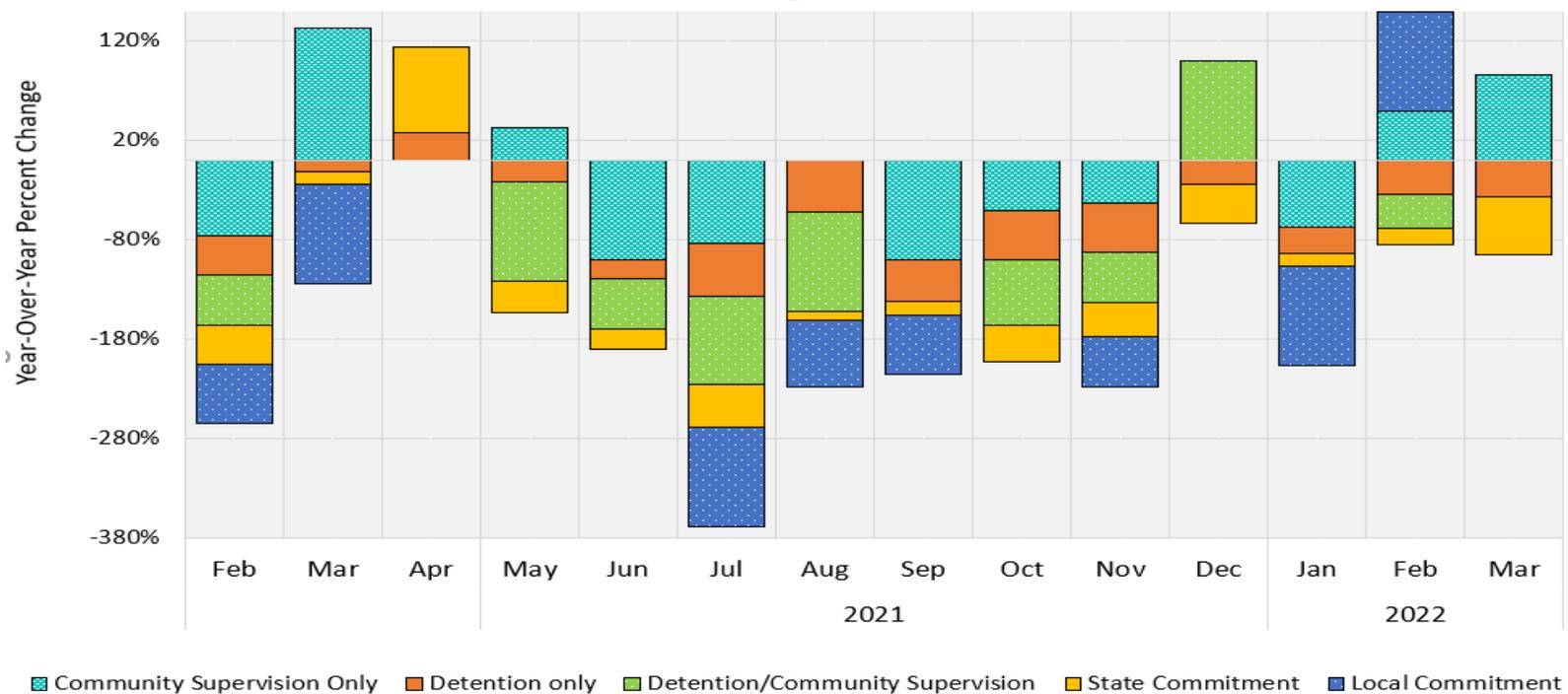


Note: **Sex crimes** involve sexual exploitation of a minor, incest, rape, statutory rape, or indecent liberties. **Robbery** involves theft of property by the use of force, violence, or fear of injury to a person or their property. **Assault** involves assault or intent to cause another person physical harm, including malicious harassment and coercion. **Theft/burglary** involves theft of property (other than a motor vehicle), possession of stolen property, extortion, burglary, or criminal trespass. **Motor vehicle theft** involves taking a motor vehicle without permission of the owner.

Juvenile Offender Case Completions and Sentences

AOC reports monthly juvenile offender case completions and sentences (counted only for defendants with a judgment of guilty) for sentences with conclusions that end with some form of institutionalization. Note that the length in criminal justice proceedings impacts timeliness of resolution. Most recently, there were year-over-year percent changes in February 2022 for state commitment (-17%), detention only (-35%), local commitment (+100%), detention/community supervision (-33%), and community supervision only (+50%) (Graph 15).

Graph 15: Percent change of juvenile offender case completions and sentences, by type and month (Source: AOC)



Note: **Community supervision** means sentenced to community supervision without being sentenced to spend time in detention or in a state or local institution. **Detention** means sentenced to detention without being sentenced to community supervision or to spend time in a state or local institution. **Detention and community supervision** mean sentenced to detention and community supervision service without being sentenced to spend time in a state or local institution. **State commitment** means committed to the Juvenile Rehabilitation Administration (JRA) for placement in a state juvenile institution. **Local commitment** means committed to the JRA for placement in a local institution and not sentenced to the JRA for placement in a state juvenile institution.

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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