

Week of May 23, 2022

COVID-19 Behavioral Health Impact Situation Report

Purpose

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

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

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

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

Key Takeaways

For the most recent reporting period ([CDC Week¹ 20](#): week of May 21, 2022), all six syndromic indicators decreased from the previous reporting period (CDC week 18, week of May 7, 2022). Five of the syndromic indicators are currently increasing (Psychological Distress, Suicidal Ideation, Suspected Suicide Attempt, Drug Overdose, and Alcohol-Related emergency department [ED] visits), but are lower than corresponding weeks for 2019, 2021, and 2022 to date. Homelessness ED visits are decreasing and are lower than corresponding weeks for 2019 and 2020, but higher than the corresponding week of 2021. Current trends for all syndromic indicators are increasing.

- An alert was issued for **Suspected Suicide Attempt for individuals who reported their race as Asian.**

Survey data collected by the U.S. Census Bureau for **April 27 - May 9, 2022** shows an increase in **both anxiety (8.20%) and depression (14.14%)** among adults in Washington. Additionally, more people reported needing therapy or counseling but not receiving it for any reason (**14%**) and

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

more people reported that they received counseling or therapy from a mental health professional such as a psychiatrist, psychologist, psychiatric nurse, or clinical social worker **(36%)**.

Impact Assessment

Syndromic Surveillance

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

Statistical warnings and alerts are raised when a CDC algorithm detects a weekly count at least three standard deviations³ 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 period.

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

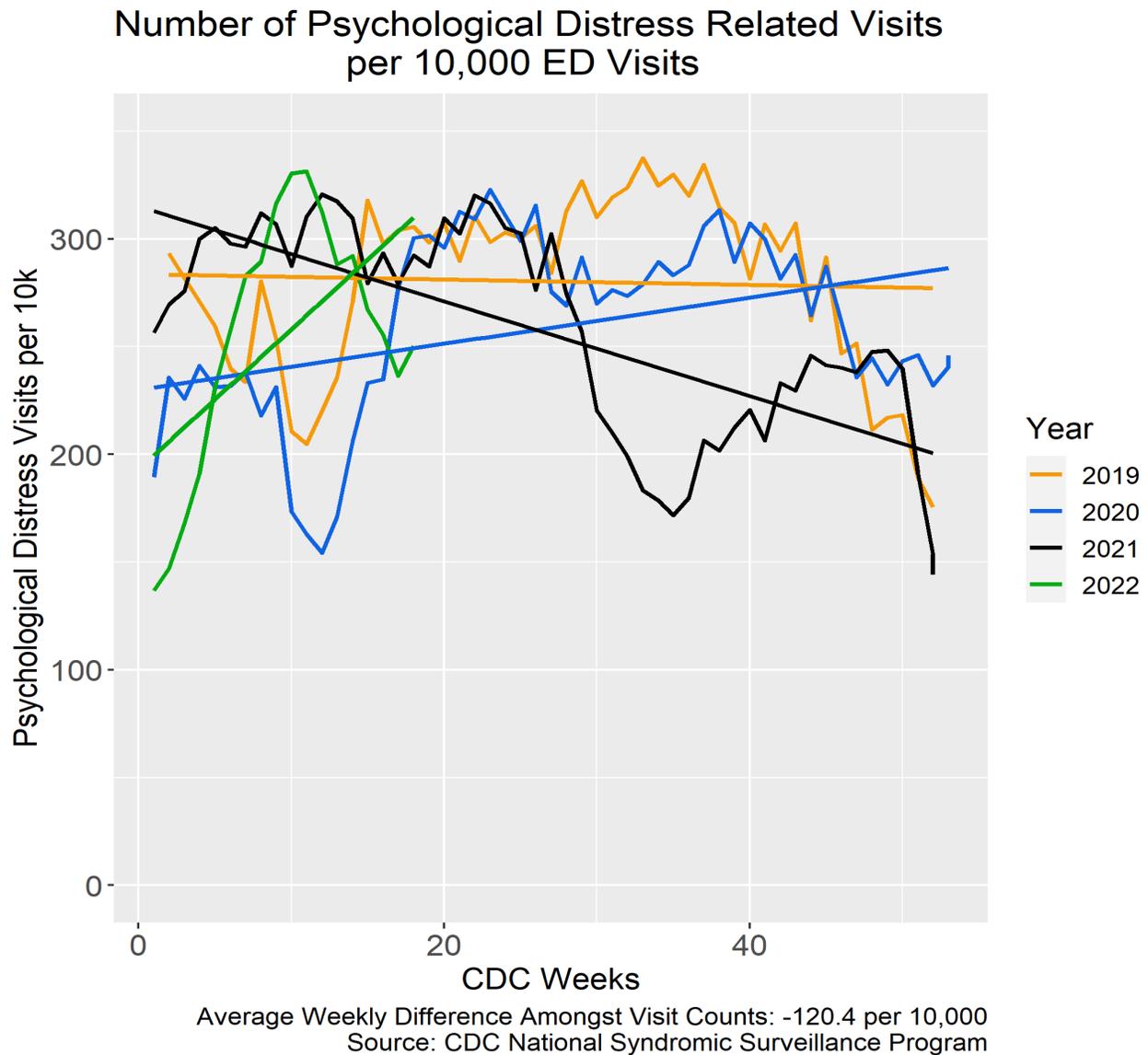
² <https://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/HealthcareProfessionsandFacilities/PublicHealthMeaningfulUse/RHINO>

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.

Psychological Distress

During **CDC Week 20 (week of May 21, 2022)**, the relative reported rate of ED visits for psychological distress⁴ **decreased from the previous reporting period (CDC week 18)**, is currently increasing, but is lower than rates in the corresponding weeks of 2019, 2020 and 2021 (Graph 1). **No statistical alert or warnings 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)

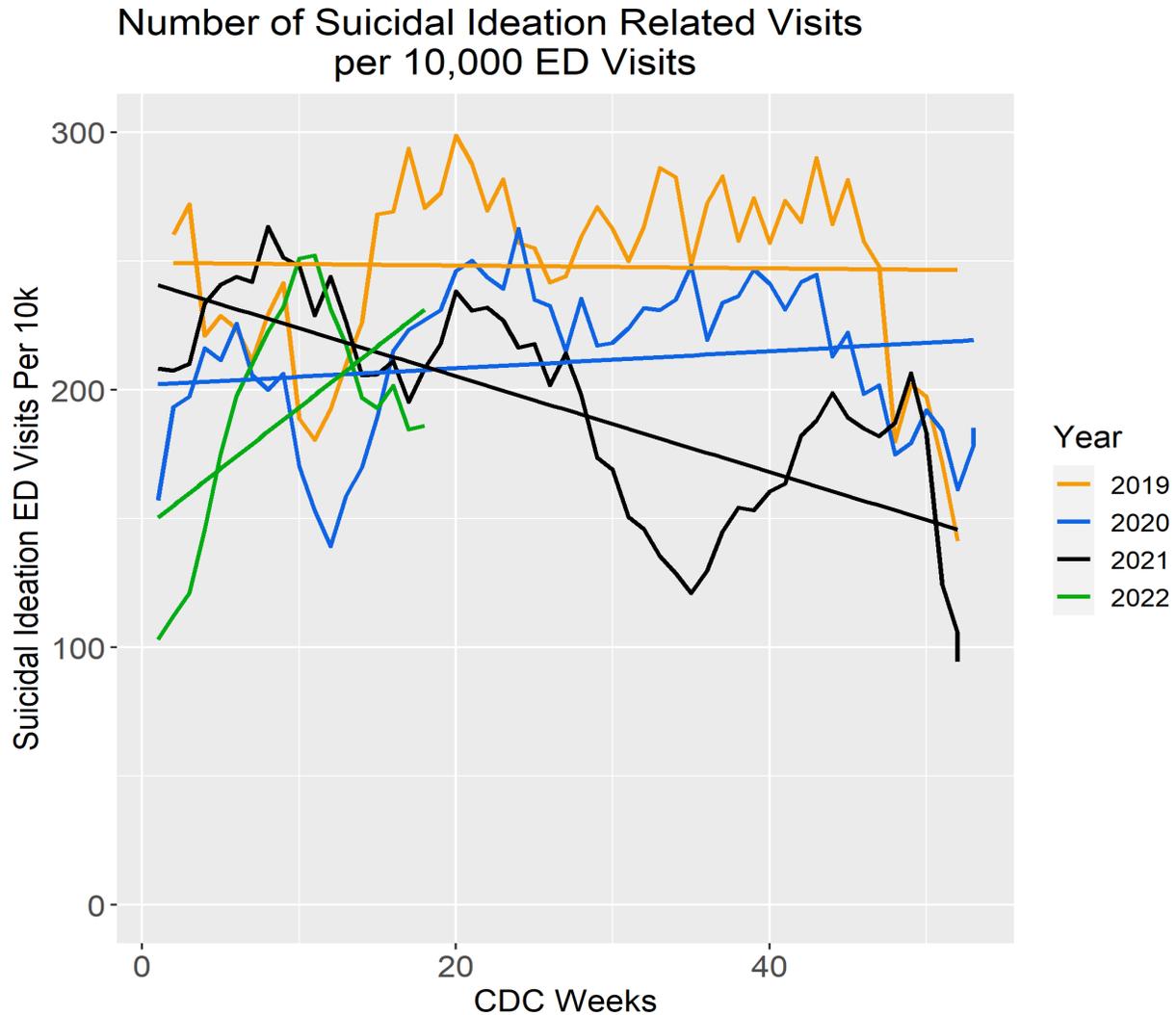


⁴ Psychological distress in this context is considered a disaster-related syndrome comprised of panic, stress, and anxiety. It is indexed in the Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE) platform as Disaster-related Mental Health v1. Full details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

Suicidal Ideation and Suspected Suicide Attempts

During **CDC Week 20 (week of May 21, 2022)**, the relative reported rate of ED visits for suicidal ideation **decreased from the previous reporting period (CDC week 18)**, is currently increasing, but is lower than the corresponding weeks in 2019, 2020, and 2021 (Graph 2). **No statistical alert or warnings 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)

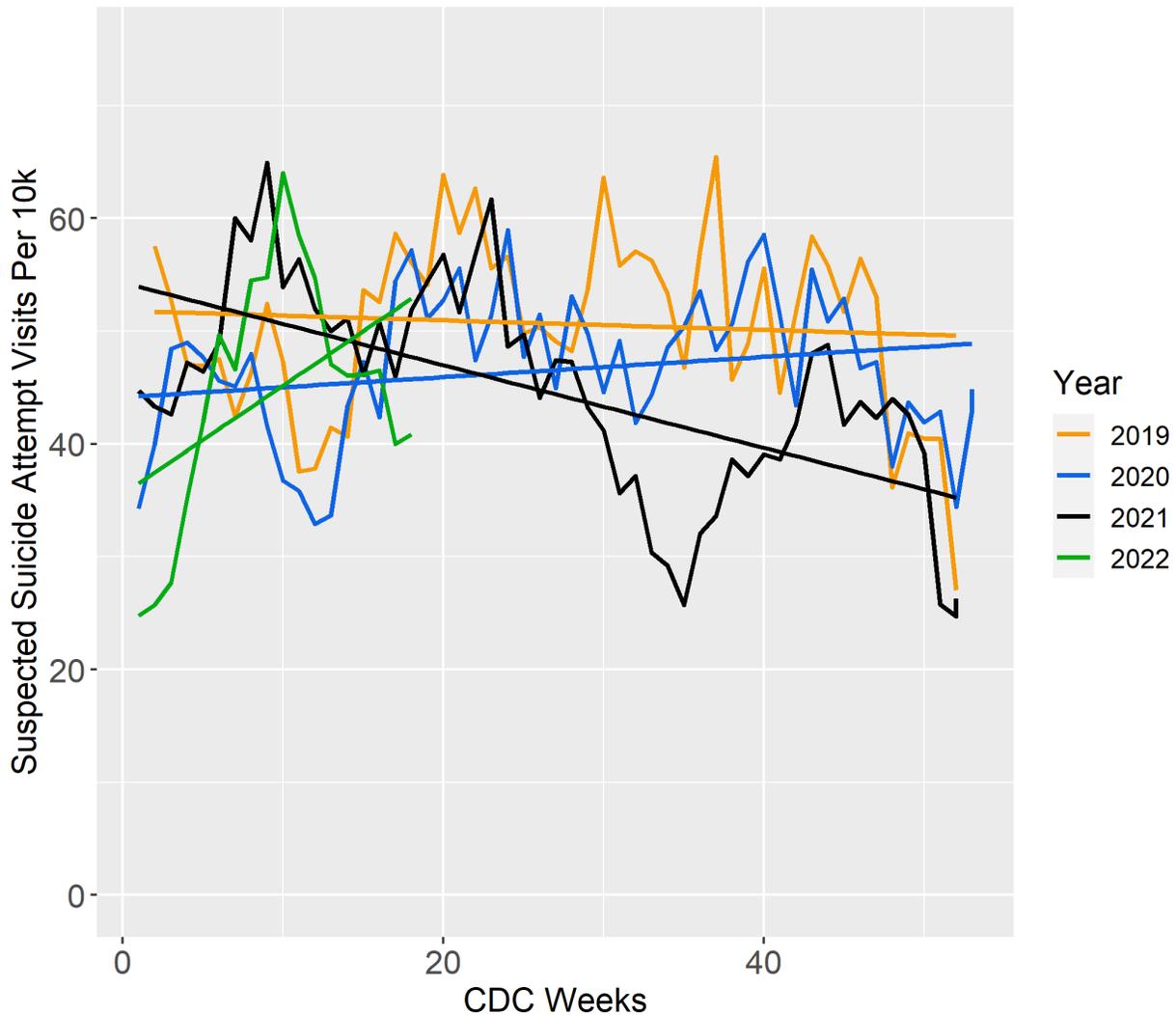


Average Weekly Difference Amongst Visit Counts: -98.8 per 10,000
Source: CDC National Syndromic Surveillance Program

During **CDC Week 20 (week of May 21, 2022)**, the relative reported rate of ED visits for suspected suicide attempt **decreased from the previous reporting period (CDC week 18)**, is currently increasing, but is lower than the corresponding weeks of 2019, 2020, and 2021 (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. **A statistical alert was issued for individuals who reported their race as Asian.**

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

Number of Suspected Suicide Attempt Related Visits per 10,000 ED Visits

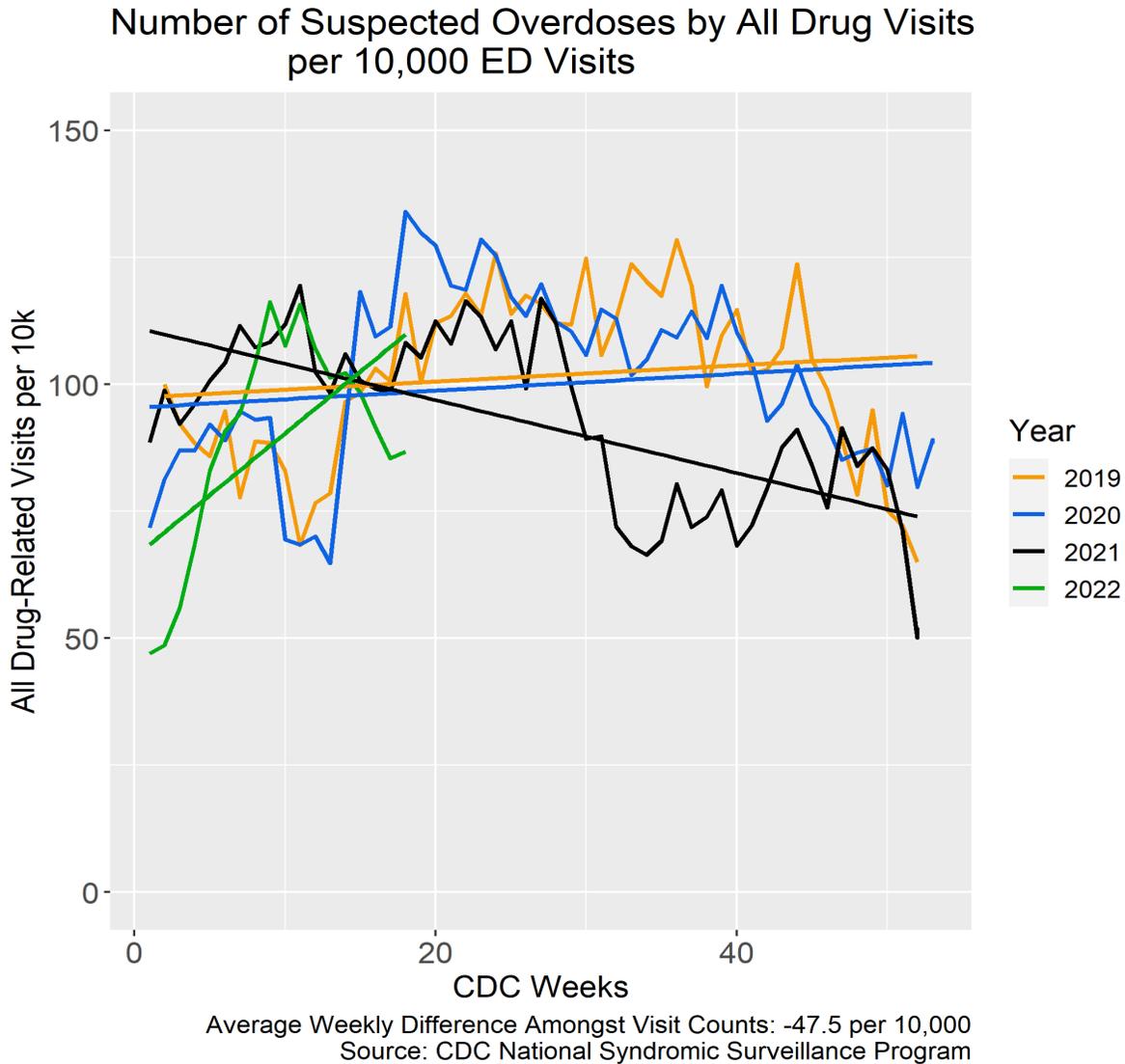


Average Weekly Difference Amongst Visit Counts: -21.4 per 10,000
 Source: CDC National Syndromic Surveillance Program

Substance Use – Drug Overdose and Alcohol-Related Emergency Visits

During **CDC Week 20 (week of May 21, 2022)**, the relative reported rate of all drug⁵-related ED visits **decreased from the previous reporting period (CDC week 18)**, is currently increasing, but is lower than the corresponding weeks of 2019, 2020, and 2021 (Graph 4). **No statistical alert or warnings were issued.**

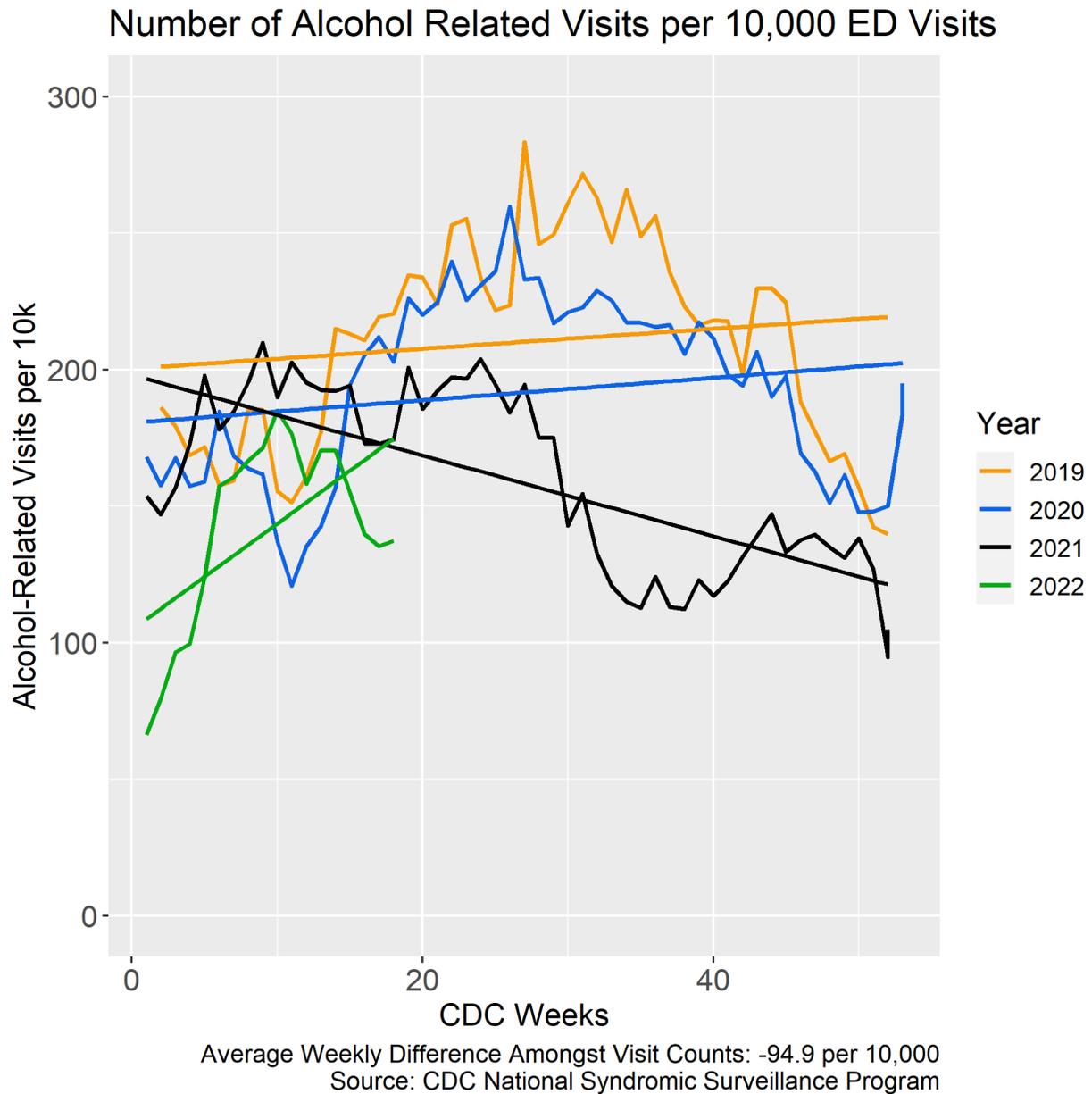
Graph 4: Relative count of all drug-related ED visits in Washington, by week: 2019, 2020, 2021, and 2022 to date (Source: CDC ESSENCE)



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

During **CDC Week 20 (week of May 21, 2022)**, the relative reported rate of alcohol-related ED visits **decreased from the previous reporting period (CDC week 18)**, is currently increasing, but is lower than the rate in the corresponding week of 2019, 2020, and 2021 (Graph 5). **No statistical alert or warnings were issued.**

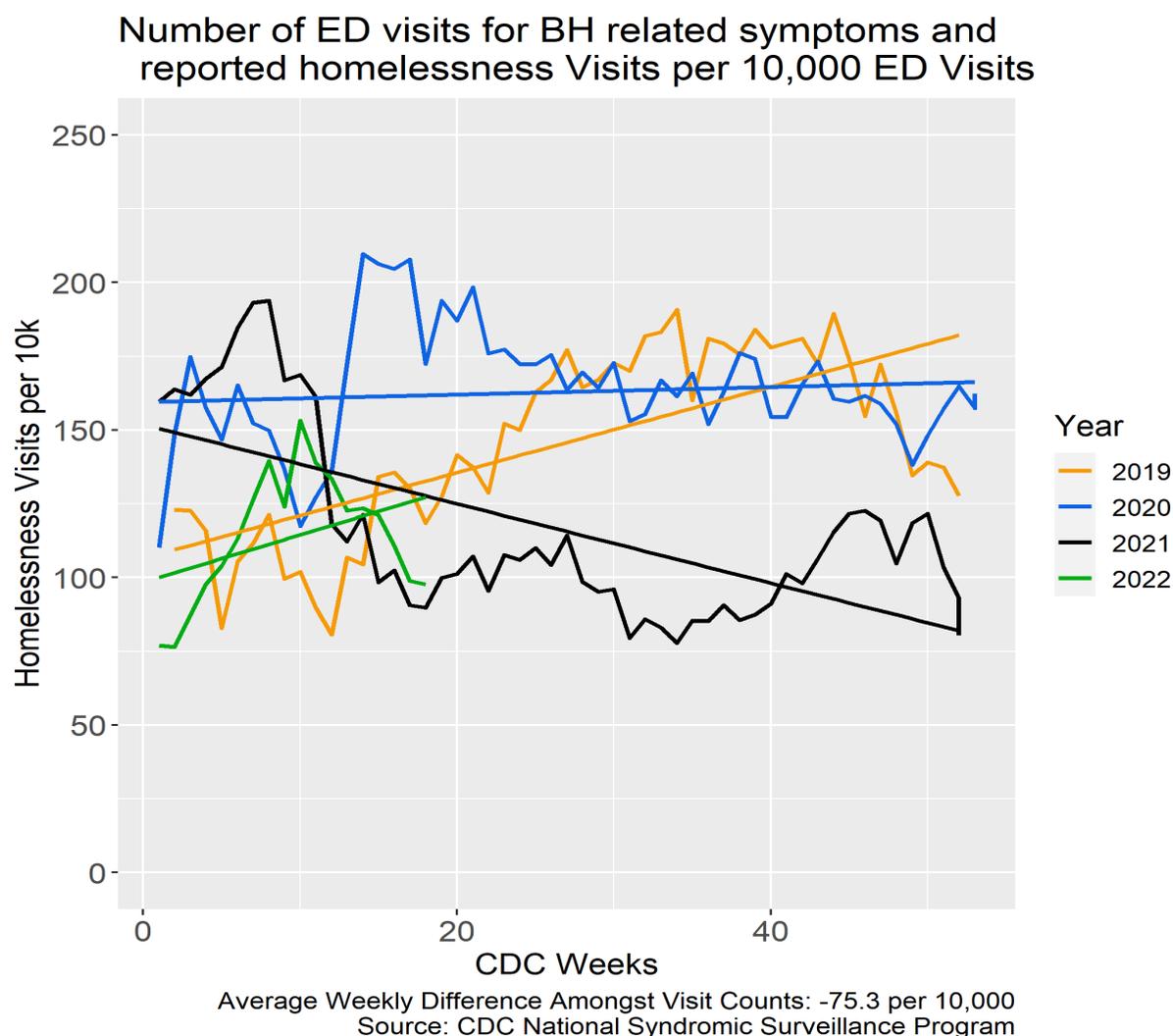
Graph 5: Relative count of alcohol-related ED visits in Washington, by week: 2019, 2020, 2021, and 2022 to date (Source: CDC ESSENCE)



Behavioral Health (BH)-Related and Reported Homelessness

During **CDC Week 20 (week of May 21, 2022)**, the relative reported rate of ED visits for homelessness⁶ decreased from the previous reporting period (CDC week 18), is currently decreasing, is lower than the rate in the corresponding weeks of 2019, and 2020, but is higher than 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. The current trend is increasing. No **statistical alert or warnings were issued**.

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



⁶ 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 **April 27 - May 9, 2022**, shows **an increase in both anxiety** (i.e., feeling nervous, anxious, or on edge) **(8.20%) and depression** (i.e., feeling down, depressed, or hopeless) **(14.14%)** among adults in Washington compared to the previous reporting period of **March 30 – April 11 2022** (Graph 7).⁷ In the most recent reporting period represented below, **approximately 1.38 million adults in Washington reported symptoms of anxiety** on all or most days of the previous week, while **approximately 978 thousand adults reported the same frequency of symptoms of depression**.

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

In the **April 27 - May 9, 2022**, survey data, respondents ages 18 – 29 reported the highest rate of symptoms of anxiety (41%), followed by those ages 30 – 39 (38%). Those ages 30 – 39 reported the highest rate of symptoms of depression (32%) followed by those ages 18 – 29 (25%).

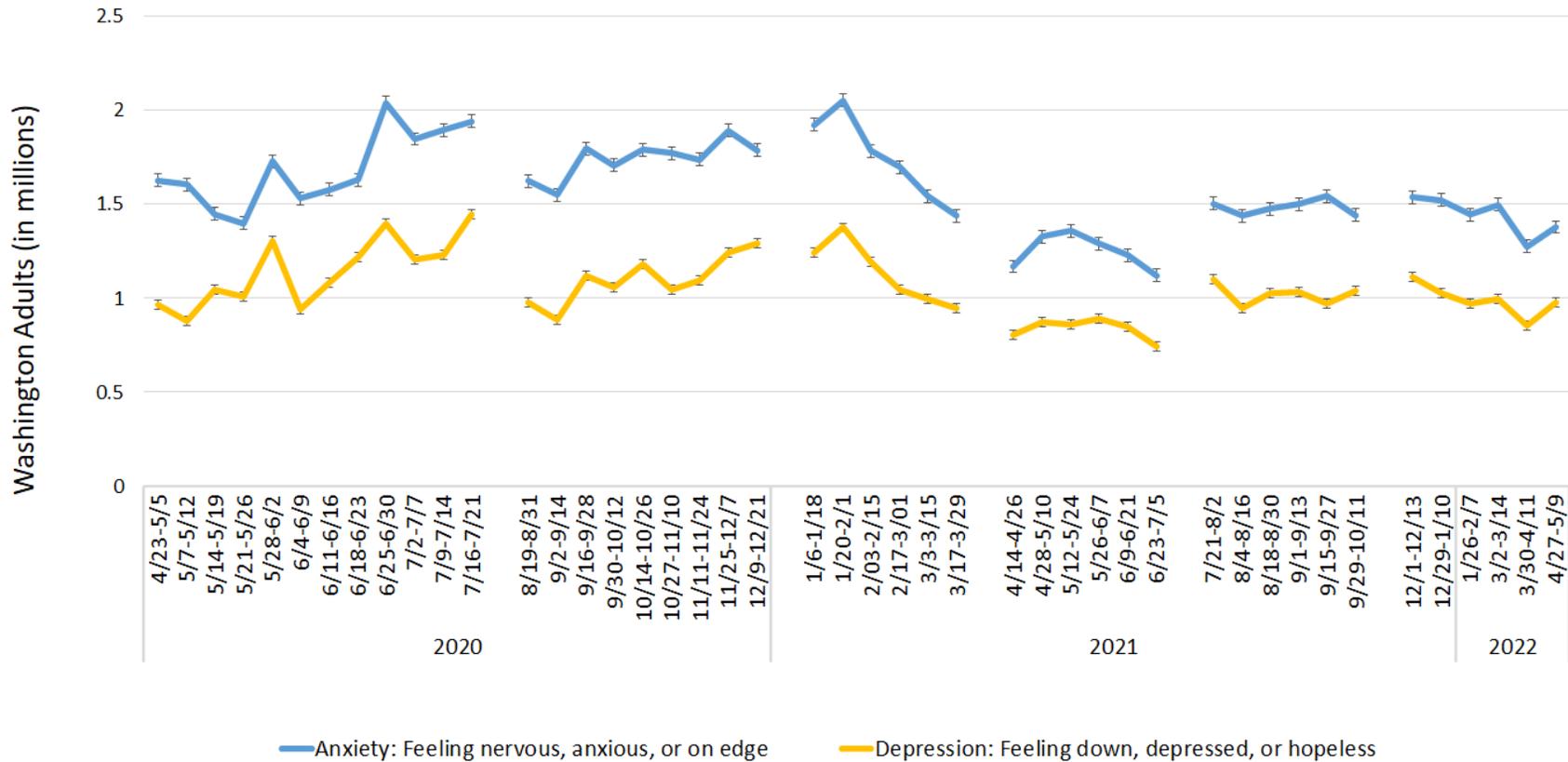
Those who live in households earning \$25,000 - \$34,000 per year were the most likely to report frequent symptoms of **anxiety** (48%), followed by those in households earning less than \$25,000 (36%) and \$35,000 - \$50,000 per year (34%).

Additionally, respondents in households earning \$25,000- \$34,000 per year reported the highest rate of frequent symptoms of **depression** (39%), followed by those in households earning less than \$25,000 per year (30%).

Those who identified as female at birth have an increased symptom reporting rate for **anxiety** as those who identify as male at birth (32% for females, compared to 23% for males) and those who identified as female at birth have similar reporting rate for **depression** as those who identify as male at birth (22% for females and 17% for males).

⁷ 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 who reported feelings of anxiety or depression “at least most days,” by week: April 23, 2020 – May 9, 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](#)⁸ collected by the U.S. Census Bureau for **April 27 – May 9, 2022**, shows 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 of **March 30 – April 11 2022**, **more people reported needing therapy or counseling but not receiving it for any reason (14%) and more people reported that they received counseling or therapy from a mental health professional such as a psychiatrist, psychologist, psychiatric nurse, or clinical social worker (36%).**

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

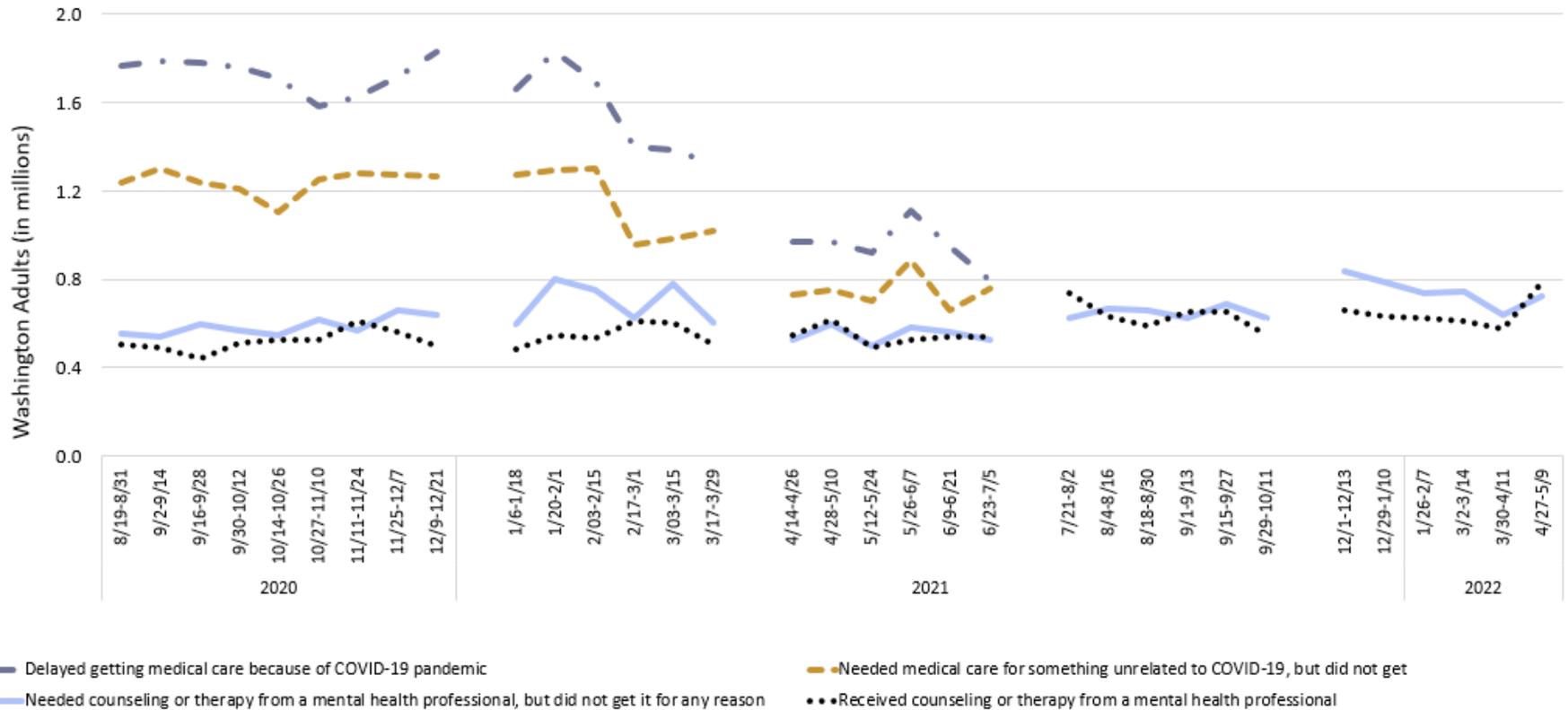
Those who live in households earning over \$200,000 were the most likely to report they **received** counseling or therapy from a mental health professional such as a psychiatrist, psychologist, psychiatric nurse, or clinical social worker (29%), followed by those in households earning \$25,000 - \$34,000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

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

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

⁸ <https://www.cdc.gov/nchs/covid19/pulse/mental-health-care.htm>

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



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

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

Telehealth Use for Washington Medicaid Clients

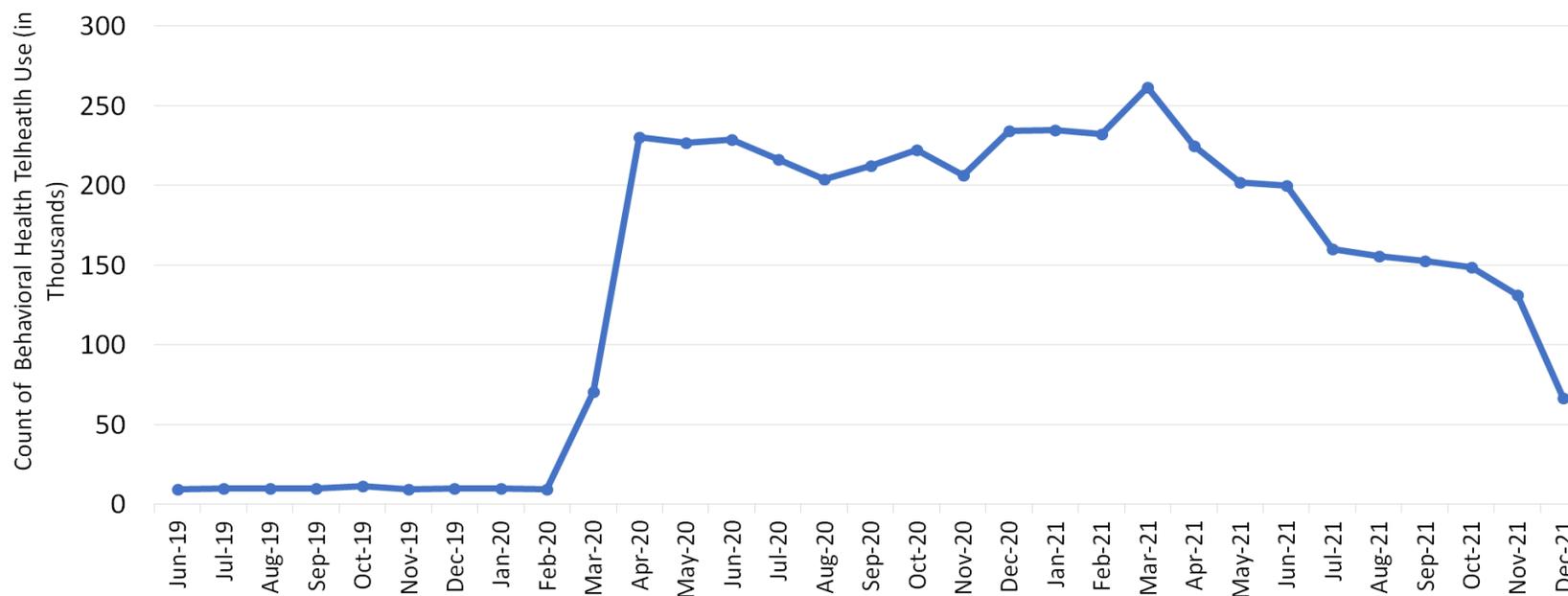
Telehealth (phone and videoconferencing) claims use for Washington Medicaid clients is collected by the Washington State Health Care Authority (HCA).

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

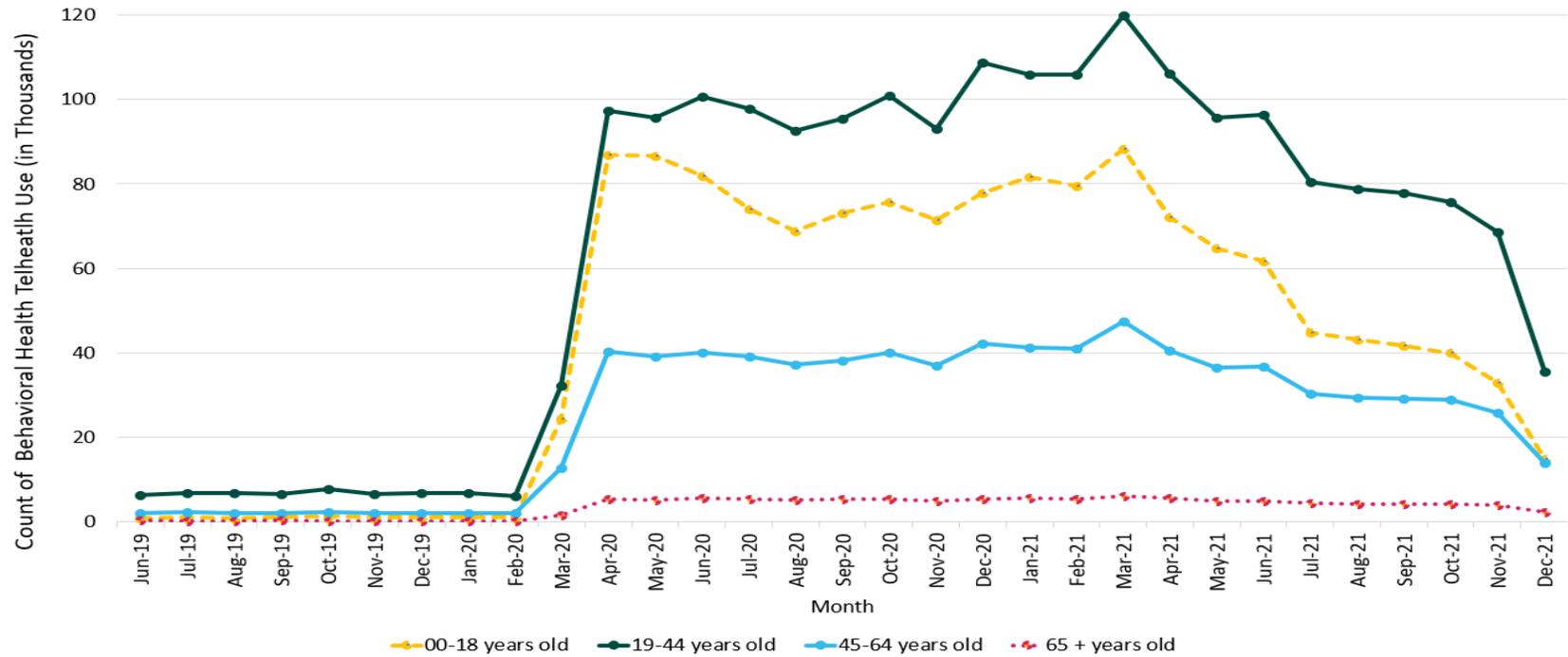
Due to the significant demand for telehealth, several changes were made to policies, coverage, and implementation that could impact this data. Results may be underreported due to missing, changed, or suppressed data.

The most recent reporting period (December 2021) showed a 49% decrease of telehealth behavioral health services **use (Medicaid) claims** compared to the previous month (graph 9). Graph 10 showed decreased claims of telehealth behavioral health services **by age group**, compared to the previous month: individuals ages 18 and younger (-55%), ages 19 – 44 (-48%), ages 45 – 64 (-47%), and ages 65 and older (-41%).

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



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



Inpatient and Observational Community Hospital Discharges

The [Comprehensive Hospital Abstract Reporting System \(CHARS\)](#)⁹ collects information on inpatient and observation patient community hospital stays.

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

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

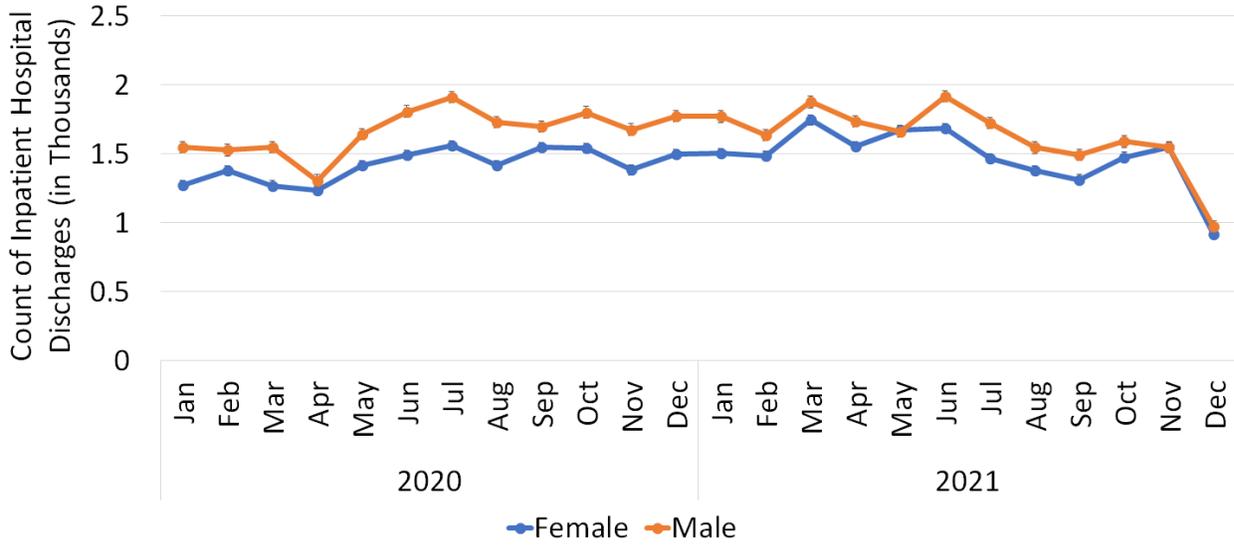
The most recent reporting period (December 2021) **showed a 39% decrease of discharges with a diagnosis of mental, behavioral, and neurodevelopmental disorders from inpatient care from community hospitals** and a **32.3% decrease of discharges with diagnoses of mental, behavioral, and neurodevelopmental disorders from observational care from community hospitals**, compared to the previous month.

Graphs 11 and 12 show the count of inpatient and observational community hospital discharges for mental, behavioral, and neurodevelopmental disorders stratified by gender. For **inpatient** community hospital discharges for mental, behavioral, and neurodevelopmental disorders, the most recent reporting period (December 2021) showed a **41% decrease for females** and a **37% decrease for males**. For **observational** community hospital discharges for mental, behavioral, and neurodevelopmental disorders, the most recent reporting period (December 2021) showed a **50% decrease for females** and a **12% decrease for males**.

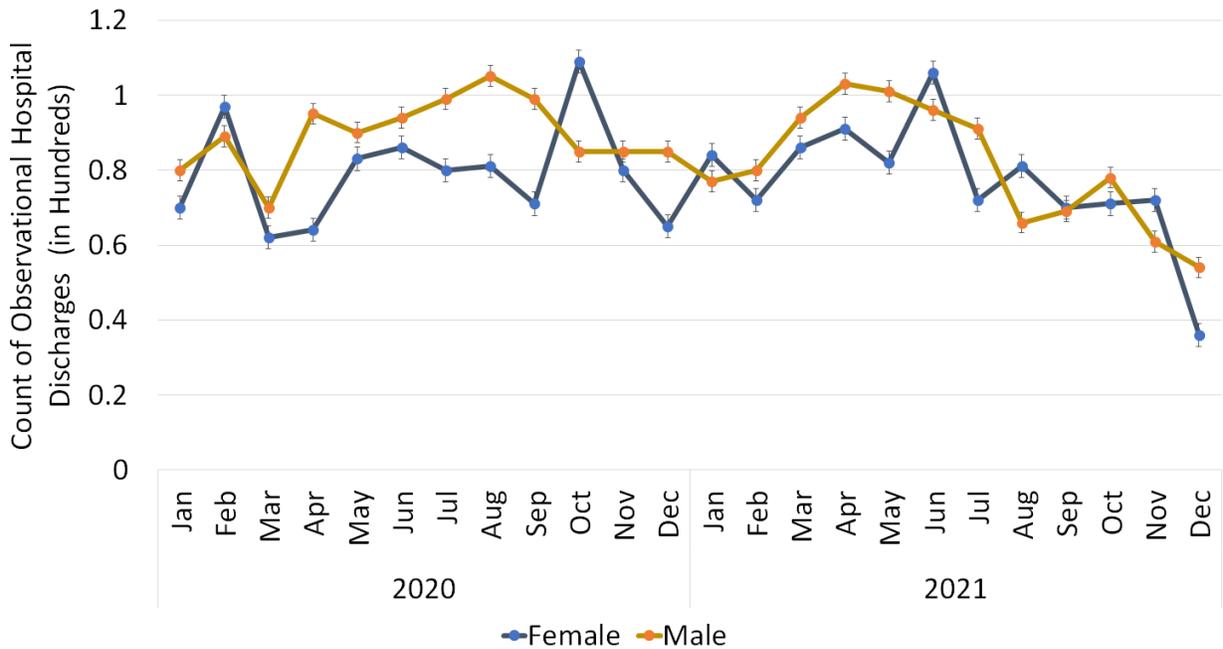
⁹<https://www.doh.wa.gov/dataandstatisticalreports/healthcareinwashington/hospitalandpatientdata/hospitaldischargedatachars>

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

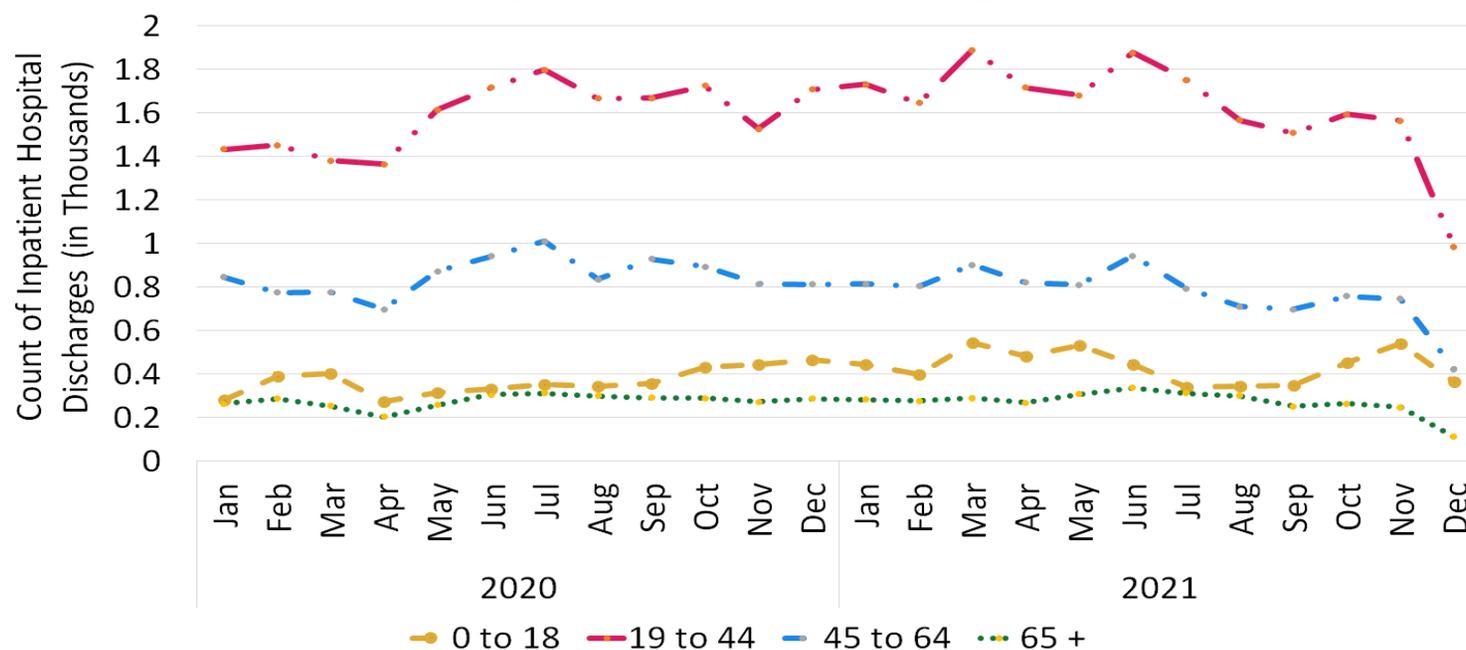


Graph 12: Count of observational community hospital discharges for mental, behavioral, and neurodevelopmental disorders, by month and gender (Source: DOH)



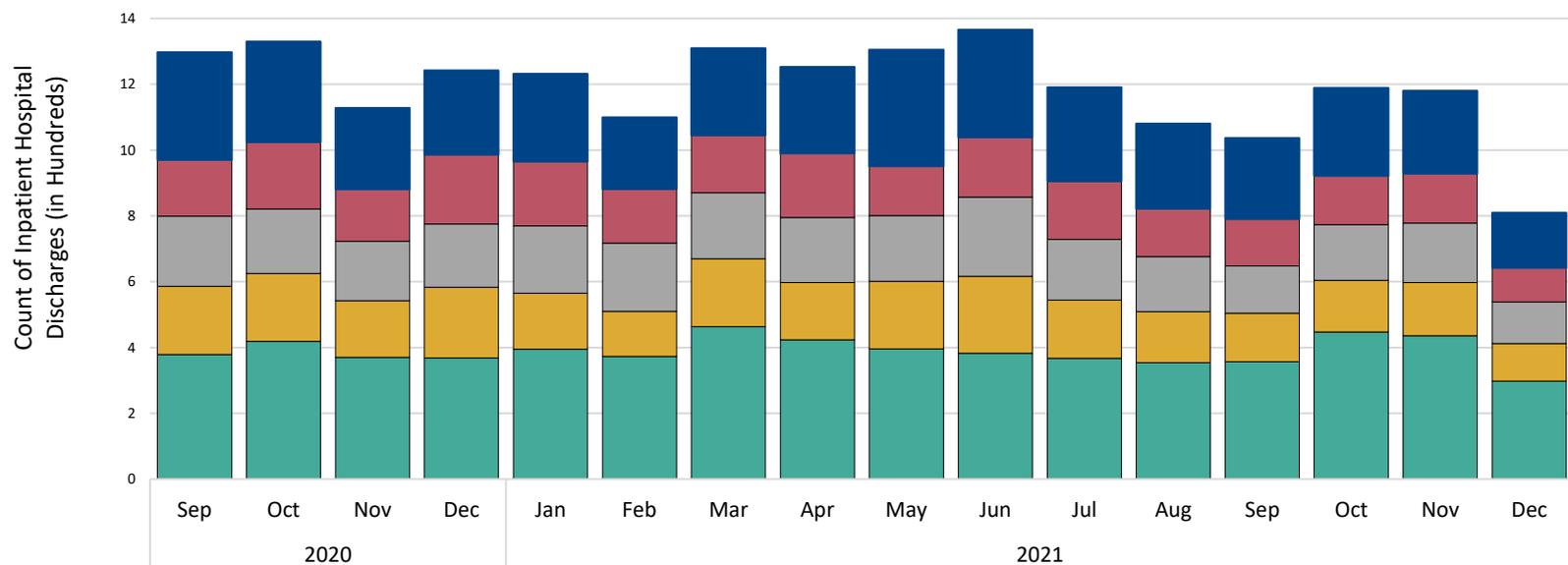
Graph 13 shows counts of inpatient community hospital discharges for mental, behavioral, and neurodevelopmental disorders separated by age. Compared to the previous month, the most recent reporting period (December 2021) showed a 32% decrease for those ages 0 – 18, a 37% decrease for individuals ages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

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



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

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



- F10.239: Alcohol dependence with withdrawal, unspecified
- F20.9: Schizophrenia, unspecified
- F25.0: Schizoaffective disorder, bipolar type
- F29.0: Unspecified psychosis not due to a substance or known physiological condition
- F33.2: Major depressive disorder, recurrent severe without psychotic features

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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