

Week of October 31, 2022

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 October 31, 2022, this report has been updated to remove data that are no longer beneficial to the COVID-19 Behavioral Health Group's Impact & Capacity Assessment Task Force. If there is mission critical information that has been removed, please contact Alaine Ziegler at Alaine.Ziegler@doh.wa.gov to address the data.

Key Takeaways

For the most recent reporting period ([CDC Week](#)¹ 43, week ending October 29, 2022), three of the five syndromic indicators (psychological distress, suspected suicide attempt, and drug overdose) **decreased** from the previous reporting period (CDC week 35). Suicidal ideation and alcohol-related emergency department (ED) visits **increased** from the previous reporting period (CDC week 35). For the current reporting period, psychological distress, suspected suicide attempt, drug overdose, and alcohol-related ED visits are **decreasing**, and suicidal ideation is **increasing**.

- Alerts were issued for individuals of unknown race or sex for the week of October 23, 2022

Survey data collected by the U.S. Census Bureau for October 5 – 17, 2022, show an **increase** in anxiety (7.45%), and an **increase** in depression (18.63%) among adults in Washington.

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

Impact Assessment

Syndromic Surveillance

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

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

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

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

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

The Syndromic Data represented in the most recent situation report is incomplete due to interface and data uploading issues for two hospital systems within Washington to ESSENCE. The affected systems account for approximately 10% of the reported data tracked within ESSENCE. Syndromic Data previously shown using the ESSENCE surveillance system is complete and accurate.

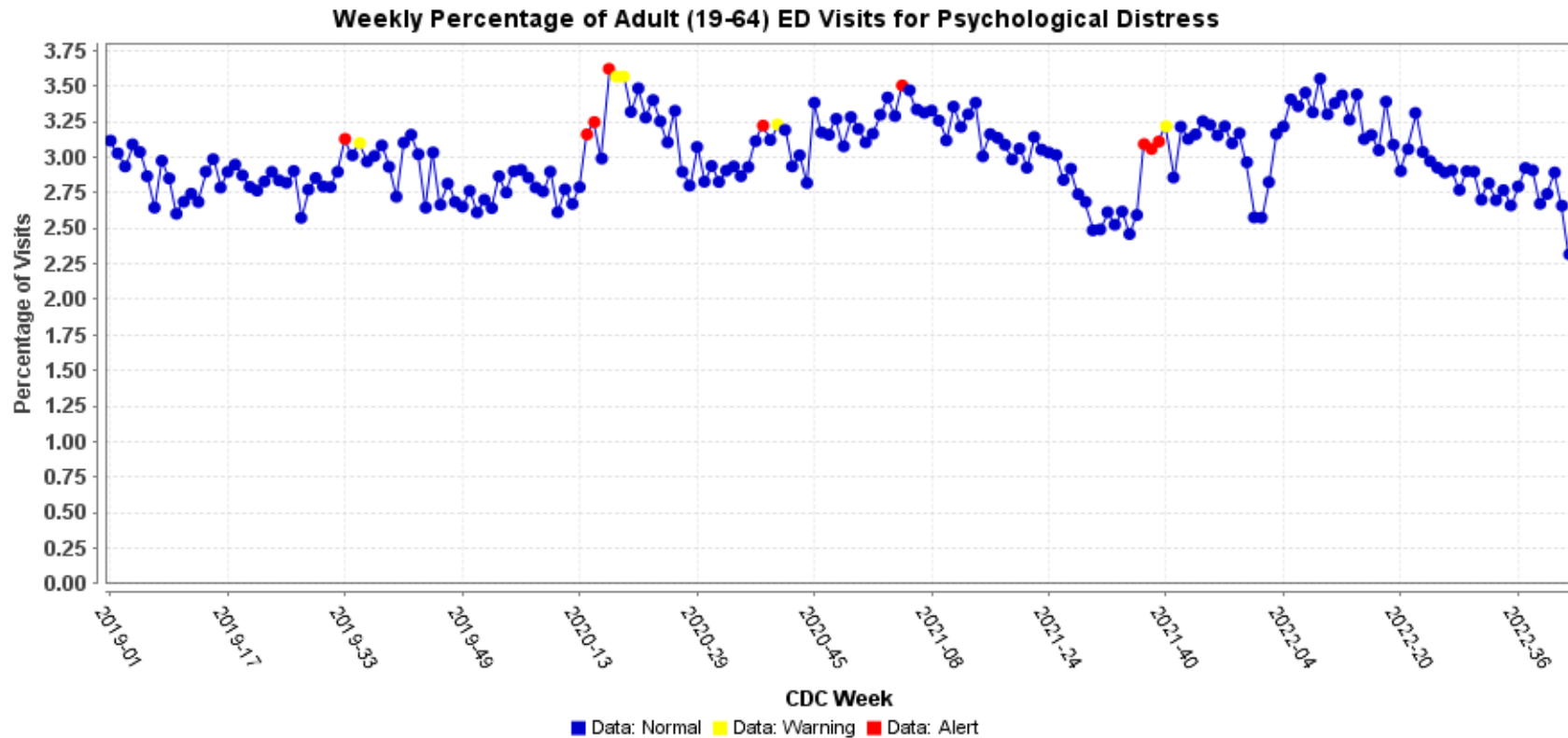
² <https://doh.wa.gov/public-health-healthcare-providers/healthcare-professions-and-facilities/data-exchange-0/syndromic-surveillance-rhino>

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

Psychological Distress

During CDC Week 43 (week of October 22, 2022), the reported relative percentage of ED visits for psychological distress⁴ **decreased** from the previous reporting period (CDC week 35), and the current week is **decreasing** (Graph 1). No statistical alert or warning was issued.

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

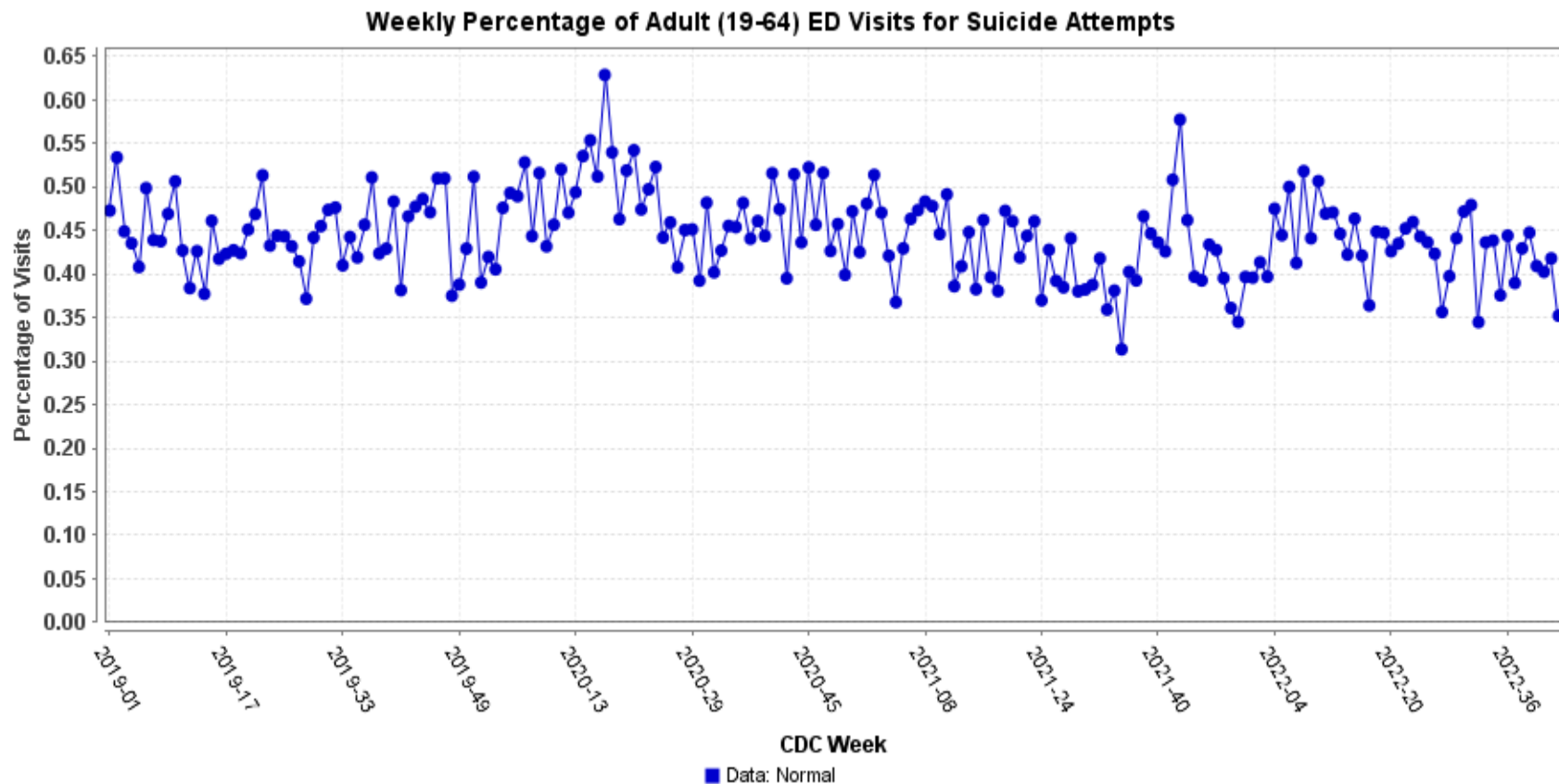


⁴ Psychological distress in this context is considered a disaster-related syndrome comprised of panic, stress, and anxiety. It is indexed in the Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE) platform as Disaster-related Mental Health v1. Full details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

During CDC Week 43 (week of October 22, 2022), the reported relative percentage of ED visits for suspected suicide attempt **increased** from the previous reporting period (CDC week 35), and the current week is **decreasing** (Graph 3). An alert was issued for individuals with unknown race for the week of October 22, 2022.

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

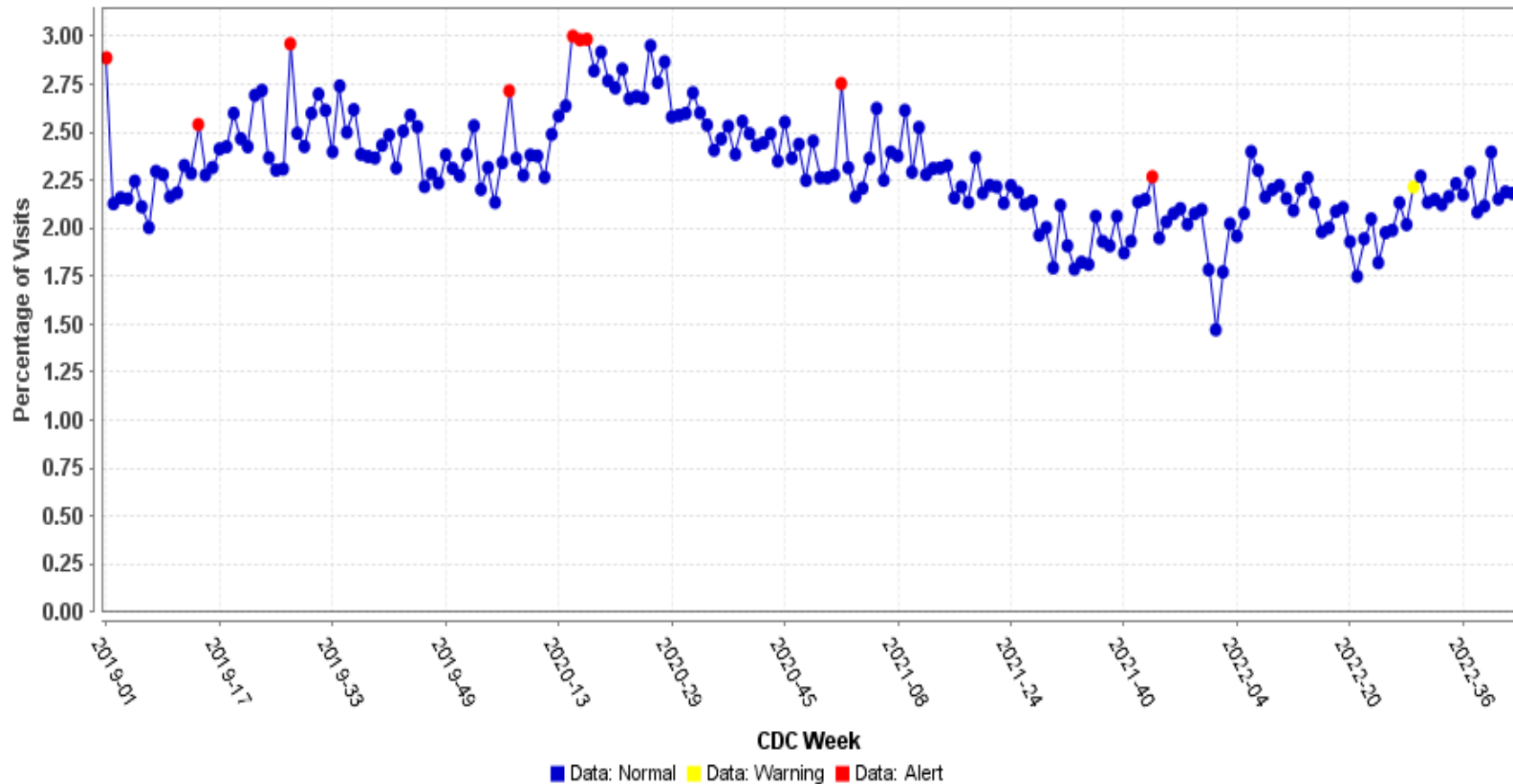
Graph 3: Percentage change of ED visits for suspected suicide attempt in Washington, by week: 2019, 2020, 2021, and 2022 to date (Source: CDC ESSENCE)



During CDC Week 43 (week of October 22, 2022), the reported relative percentage of alcohol-related ED visits **increased** from the previous reporting period (CDC week 35), and the current week is **decreasing** (Graph 5). An alert was issued for individuals with unknown sex for the week of October 22, 2022.

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

Weekly Percentage of Adult (19-64) ED Visits for Alcohol



Emergency Department visits for Behavioral Health Related and Reported Homelessness

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

General Surveillance

Symptoms of Anxiety and Depression

[Survey data](#) collected by the U.S. Census Bureau for October 5 – 17, 2022, show an **increase** in anxiety – feeling nervous, anxious, or on edge – (7.45%), and an **increase** in depression -- feeling down, depressed, or hopeless – (18.63%) among adults in Washington, compared to the previous reporting period of September 14 – 26, 2022 (Graph 7).

In the most recent reporting period represented below, approximately 1.66 million adults in Washington reported symptoms of anxiety on all or most days of the previous week, while approximately 1.16 million adults reported the same frequency of symptoms of depression.

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

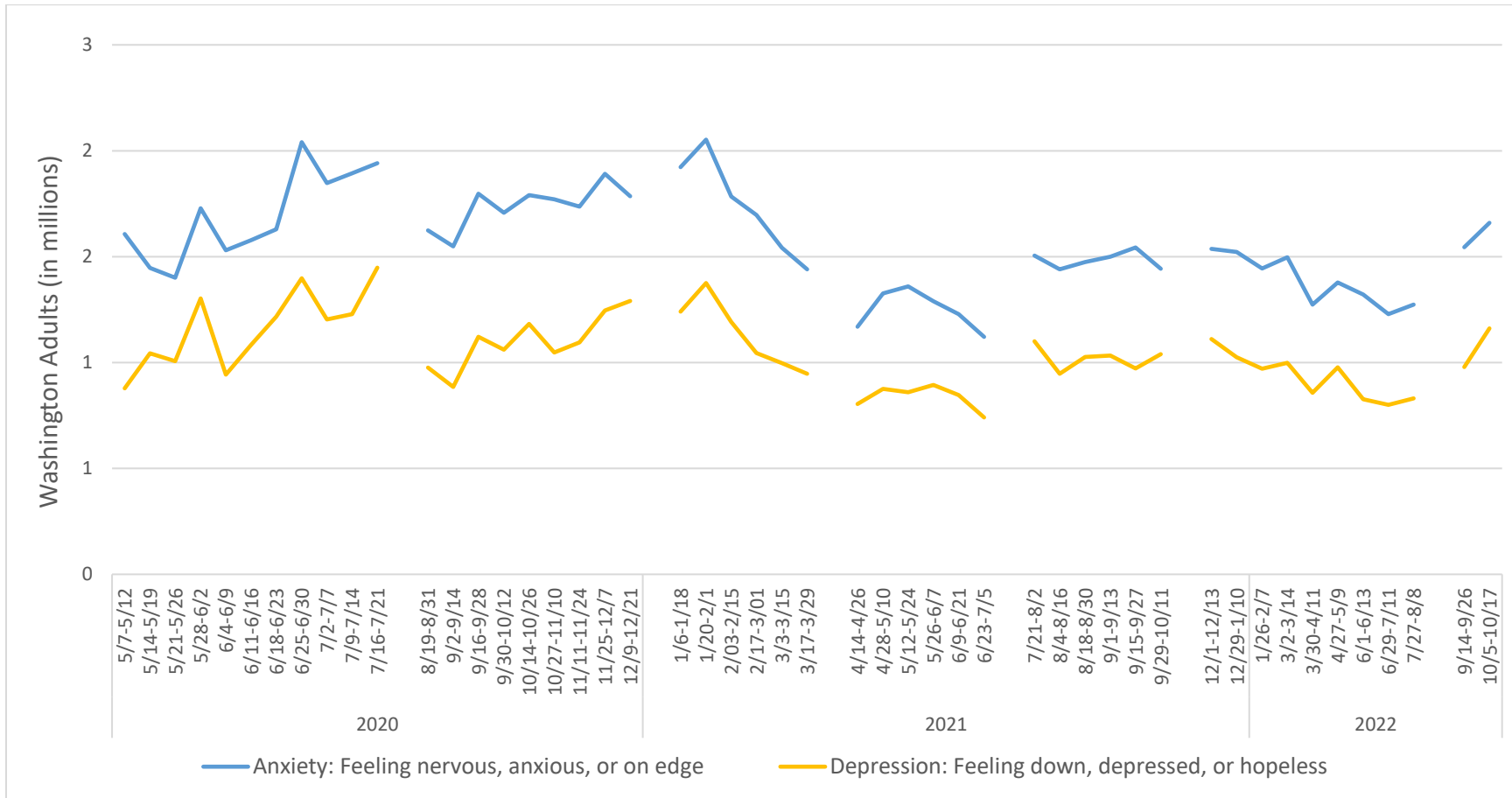
In the October 5 – 17, 2022 survey data, respondents ages 18 – 29 reported an identical percentage of symptoms of **anxiety** (50%), followed by those ages 30 – 39 (37%). The highest percentage of symptoms of **depression** were reported by those ages 18 – 29 (41%) followed by those ages 80 and above (29%).

Those who live in households earning \$25,000 - \$34,999 per year were the most likely to report frequent symptoms of **anxiety** (42%), followed by those in households earning \$50,000 - \$74,999 per year (32%).

Additionally, respondents in households earning \$25,000 - \$34,999 per year reported the highest percentage of frequent symptoms of **depression** (40%), followed by those in households earning less than \$25,000 per year (35%).

Those who identified as female at birth have an **increased** symptom reporting percent for **anxiety**, as compared to those who identified as male at birth (30% for females, 25% for males), and those who identified as female at birth have a **similar** reporting percentage for **depression** as those who identified as male at birth (21% for females, 18% for males).

Graph 7: Estimated number of Washington adults who reported feelings of anxiety or depression “at least most days,” by week (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, August 13 – September 14, 2022. For Phase 3.3, data collection and release has shifted to a two-weeks on, two-weeks off collection and dissemination approach.

Telehealth Use for Washington Medicaid Clients

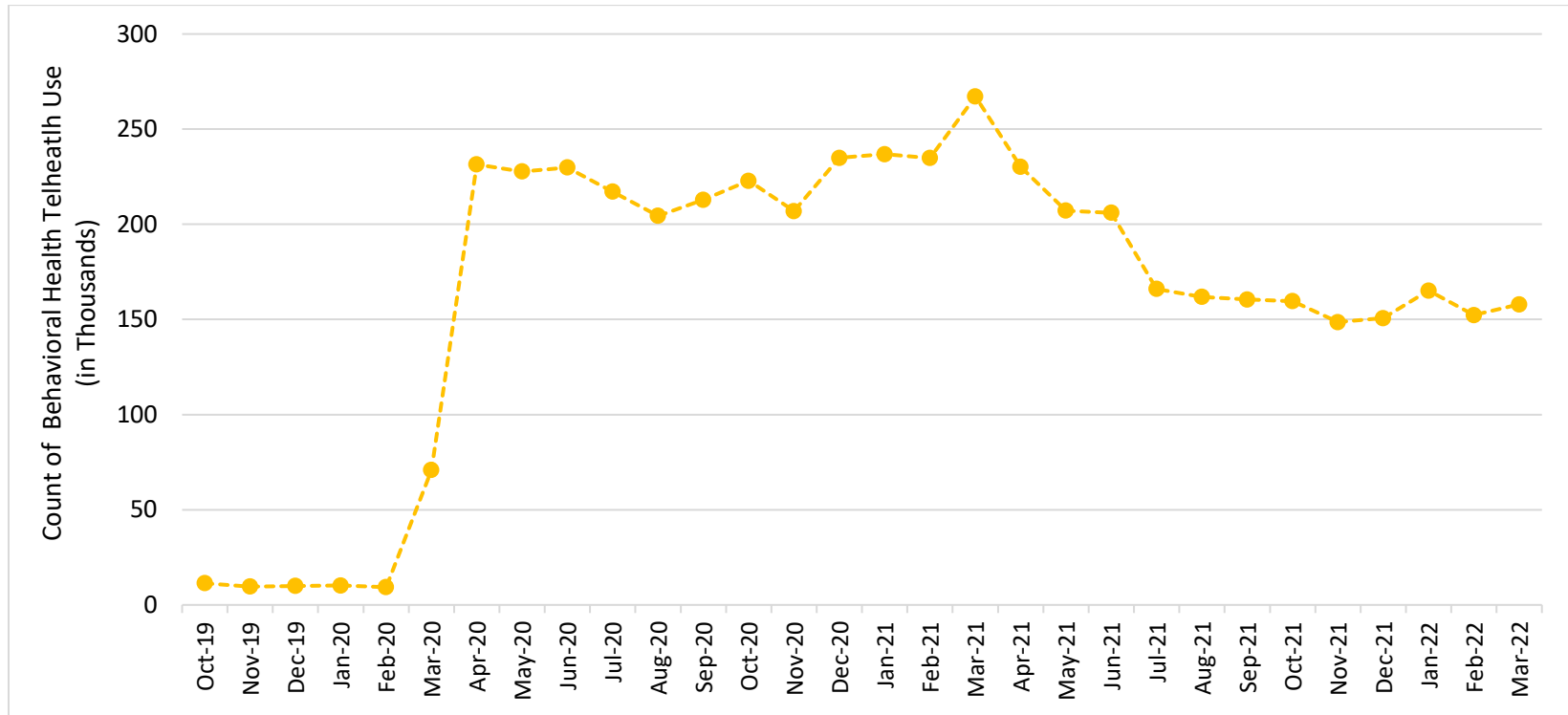
Telehealth (phone and videoconferencing) claims use for Washington Medicaid clients is collected by the Washington State Health Care Authority (HCA).

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

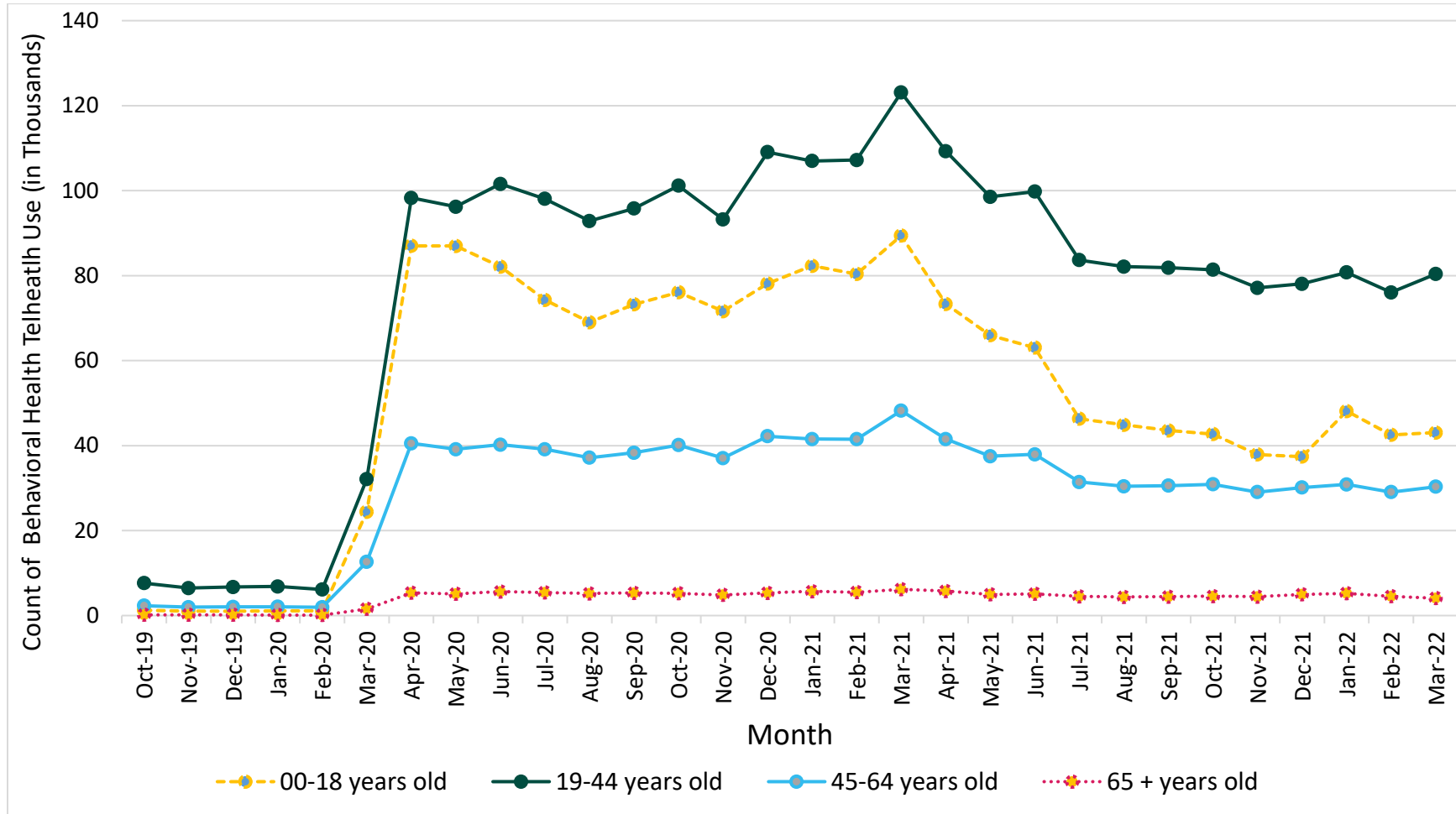
Due to the significant demand for telehealth, several changes were made to policies, coverage, and implementation that could impact these data. Results may be underreported due to missing, changed, or suppressed data.

The most recent reporting period (March 2022) showed a 4% **increase** of telehealth behavioral health services use (Medicaid) claims compared to the previous month (Graph 8). Graph 9 showed **decreased** claims of telehealth behavioral health services by age group, compared to the previous month: individuals ages 18 and younger (1.28%), ages 19 – 44 (5.69%), ages 45 – 64 (4.32%), and ages 65 and older (-9.72%).

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



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



Toxic Exposure

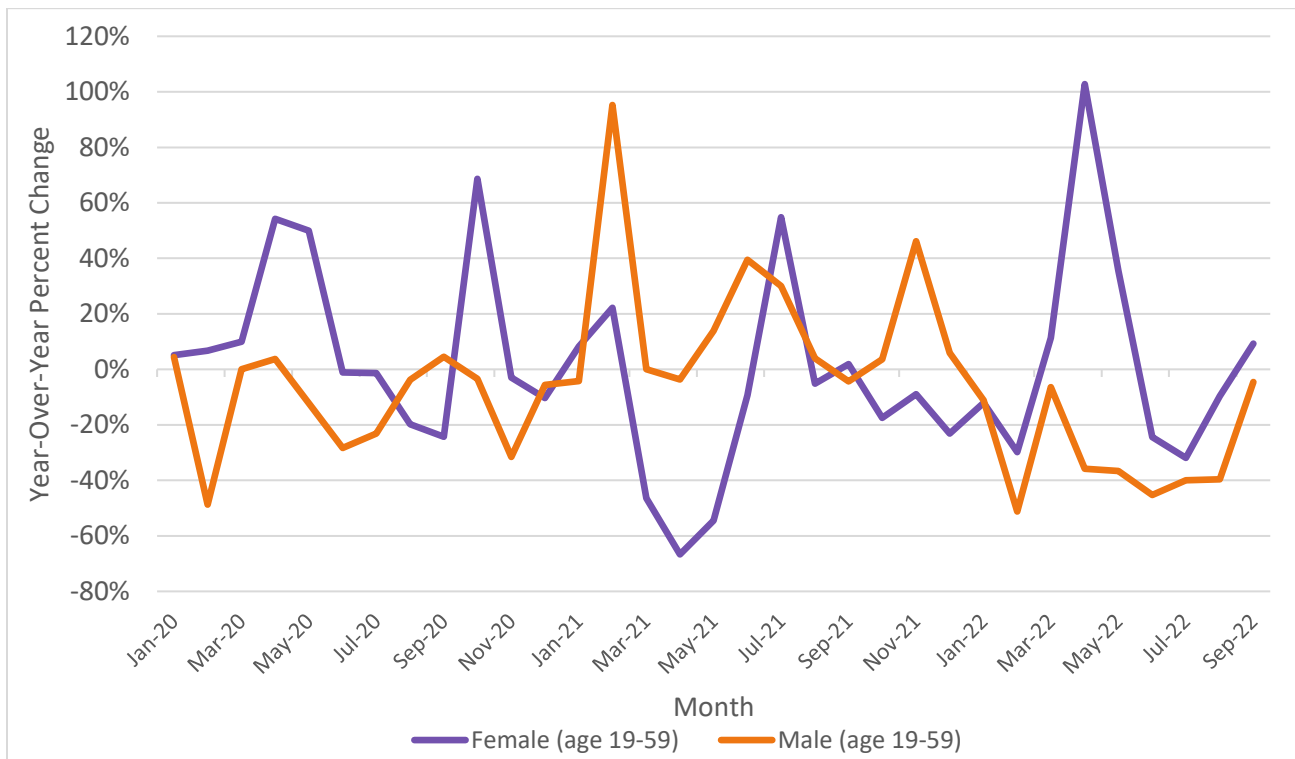
The [National Capital Poison Control](#) (NCPC) tracks human exposures to any substance that could harm the body. This is often by swallowing, splashing to the eyes, nose, mouth, or skin, inhalation, or injection. All reported exposures to the NCPC are done voluntarily so data collected is probably an underrepresentation of true occurrences.

Exposure to a substance does not represent a poisoning or overdose, intentional or otherwise. The NCPC does not track self-harm, suicidal ideation, suicide attempts, or suicides that use a substance to perform the act.

For data collected for September 2022, there was an **increase** (7.98%) in total reported exposures compared to the previous reporting period of August 2022 per 100,000 Washingtonians of all ages.

Graph 10 shows the year-over-year percent change in exposure reporting for adults ages 19 – 59. There was an **increase** in all reported exposures for males (31%) and a **decrease** in all reported exposures for females (10.61%) compared to the previous reporting period.

Graph 10: Percent change of Washington adults who reported an exposure to any substance, in Washington, by month and gender (Source: NCPC)



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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