

DECEMBER UPDATE

Statewide High-Level Analysis of Forecasted Behavioral Health Impacts from COVID-19

Purpose

This document provides a brief overview of the potential statewide behavioral health impacts from the COVID-19 pandemic. The intent of this document is to communicate potential behavioral health impacts to response planners and organizations or individuals who are responding to or helping to mitigate the behavioral health impacts of the COVID-19 pandemic.

Bottom Line Up Front

- The COVID-19 pandemic strongly influences behavioral health symptoms and behaviors across the state due to far-reaching medical, economic, social, and political consequences. This forecast is heavily informed by disaster research and response, and the latest data and findings specific to this pandemic. Updates will be made monthly to reflect changes in baseline data.
- For the last several weeks, the risk of a *disaster cascade* (more than one disaster impact within a short period of time) has increased significantly. Secondary disaster impacts are often related to or triggered by the initial impact, and may include economic hardships (unemployment, bankruptcy, eviction, and food insecurity, etc.) and social and political disturbances (violence, civil unrest, protests, etc.). They can also be triggered by additional natural disasters, such as the wildfires that occurred during the summer months and impacted communities already struggling with the pandemic.
- Any secondary disaster impacts within the next few months will also be occurring during the height of the *disillusionment phase* of the initial disaster recovery cycle that began in March 2020. A *disaster cascade* extends response and recovery cycles and tends to increase both the severity and number of behavioral health symptoms many people experience.
- Ongoing behavioral health impacts in Washington continue to be seen in phases (Figure 1), with symptoms for most people peaking throughout the remainder of 2020 and into the first half of 2021.^{1,2} This coincides with significant increases in rates of infection and hospitalization in our state.³
- Early 2021 will likely be defined by an extension of the *disillusionment phase* of disaster recovery, with the potential for impacts of a disaster cascade. The risk of suicide, depression, hopelessness, and substance use historically are at their highest during this phase of any disaster, matching what we are currently seeing. The need for professional behavioral health

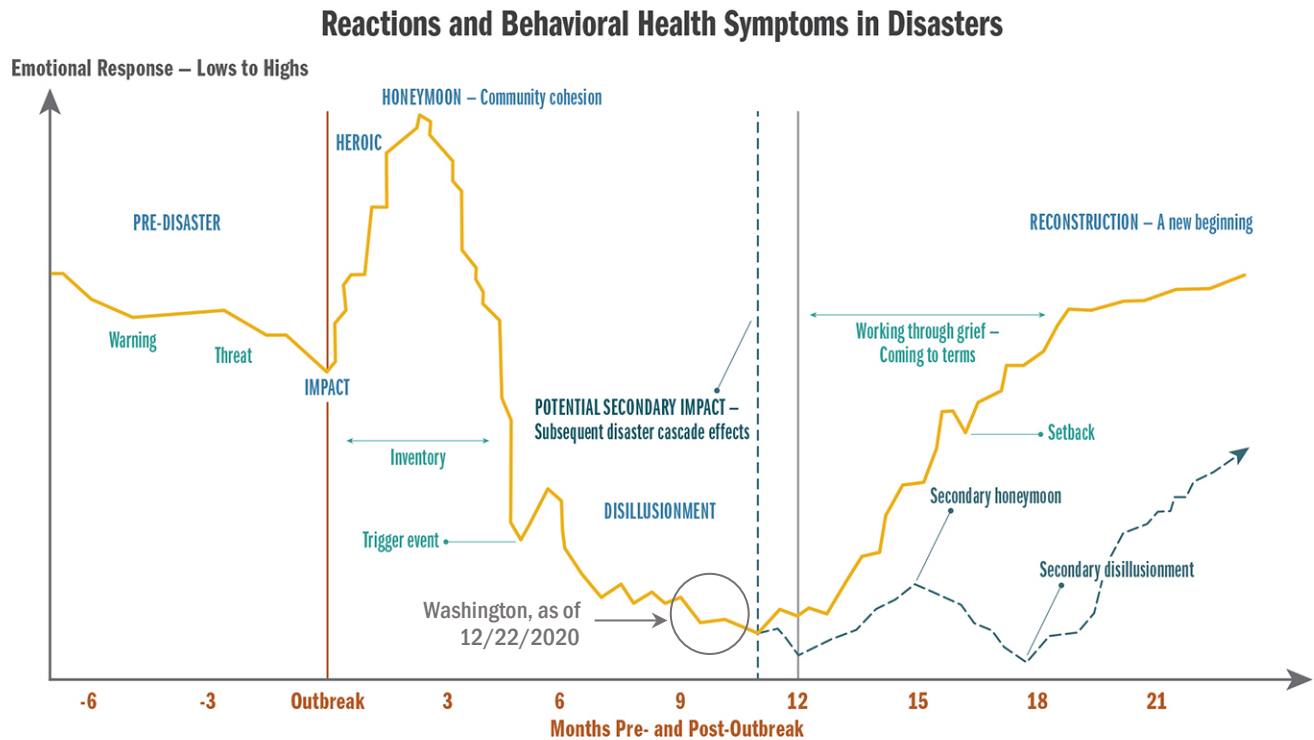


DOH 821-103-09 December 2020

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email civil.rights@doh.wa.gov.

support, as well as community resources, will likely be at their highest in the first few months of 2021. This will be occurring at a time when community resources – that are already stretched – will have even less ability to support the increased need.

- Behavioral health experiences at this phase of the COVID-19 pandemic typically include symptoms of depression and anxiety, trouble with cognitive functioning, exhaustion, and burnout. **Active resilience development remains an essential intervention for all groups in our state.**
- We expect behavioral health issues related to isolation, stress, and fears to worsen as COVID-19 cases increase, which could escalate medical risks for greater numbers of people.^{4,5,6,7}



*Figure 1: Phases of reactions and behavioral health symptoms in disasters. Adapted from the Substance Abuse and Mental Health Services Administration (SAMHSA)⁸

*The dotted graph line represents the response and recovery pattern that may occur if the full force of a disaster cascade is experienced by a majority of the population.

Phase-Related Behavioral Health Considerations

Behavioral health symptoms will continue to present in phases.^{1,2} The unique characteristics of this pandemic trend towards anxiety and depression as a significant behavioral health outcome for many in Washington. These outcomes have been shown throughout the Behavioral Health Impact Situation Reports published by the Washington State Department of Health, which are available on the [Behavioral Health Resources & Recommendations webpage](#).^a As infection and hospitalization rates continue to rise significantly, symptoms of anxiety and risk of post-traumatic stress disorder (PTSD) related to fears of illness or death from the virus, or direct experience of illness or death among family and friends are also likely to increase.^{9,10}

A **disaster cascade** is a circumstance in which multiple disasters occur with separate impacts, or a single disaster occurs with cascading outcomes over a relatively short timeframe.^{11,12} An additional consideration is the potential for a **disaster cascade**, which could occur if the current rise in infections continues at a rate which triggers a secondary disaster impact (as represented

^a <https://www.doh.wa.gov/Emergencies/COVID19/HealthcareProviders/BehavioralHealthResources>

by the dotted line in Figure 1). The secondary impact may be a result of the pandemic itself (illnesses and hospitalizations) or an indirect impact of the pandemic (economic hardship, social and political unrest, etc.).

In Washington, families who have been impacted by wildfires that occurred this year (and have been displaced or lost their homes) have already experienced a *disaster cascade* on an individual and community level. If the winter months (of 2020–2021) drive exponential infection rates, causing corresponding public health, economic, and personal losses or struggles, the consequences of a *disaster cascade* would be experienced widely. If this occurs, it is likely to happen when we are already in the *disillusionment phase*.^b The behavioral health issues common to that phase (depression, anxiety, and suicide risk) would then very likely be more severe for many, and extend the reconstruction and recovery process (i.e., return to baseline) by many months.^{11,13,14}

Certain populations, such as some ethnic and racial minorities, disadvantaged groups, those of lower socioeconomic status, and essential workers, continue to experience disproportionately more significant behavioral health impacts.^{15,16,17,18} Healthcare workers, law enforcement officers, educators, and people recovering from critical care may experience greater behavioral health impacts than those in the general population. The [COVID-19 Behavioral Health Group Impact Reference Guide](#),^c provides detailed information on how people in specific occupations and social roles are uniquely impacted.

Specific Areas of Focus for First Quarter (January, February, March) of 2021

Pandemic Apathy

For many people, the length of time that this pandemic has been influencing life has resulted in an experience where general exhaustion may be manifesting in the form of apathy about the pandemic. This seems to be characterized in a similar pattern to what is typically seen in disasters in terms of acting “out” and acting “in,” but unique in terms of apathy presenting on both ends of the spectrum. (Please see pages 3–4 of the [July forecast update](#)^d for more information about the concepts of acting “out” and acting “in.”)

On one end of the apathy spectrum, current anecdotal reports and examples suggest that acting “out” may manifest as behaviors consistent with denial of the pandemic. Acting “out” may also include being so tired of managing the consequences of the pandemic, leading some individuals to behave as if the current conditions don’t apply or exist (e.g., meeting with friends and family, refusing to comply with recommended and mandated public health guidelines, conducting “business as usual”). The other end of the apathy spectrum includes acting “in,” which seems to be manifesting in extreme hopelessness, not caring about other people, and not caring to engage or participate in much of anything at all (including work and daily tasks like child care, self-hygiene, etc.), and seems to be consistent with some symptoms of *major depressive disorder*.

^b For a description of each phase in the disaster timeline, refer to page 5 of the [COVID-19 Behavioral Health Group Impact Reference Guide](#).^c

^c <https://www.doh.wa.gov/Portals/1/Documents/1600/coronavirus/BHG-COVID19BehavioralHealthGroupImpactReferenceGuide.pdf>

^d <https://www.doh.wa.gov/Portals/1/Documents/1600/coronavirus/BHG-COVID19StatewideSummaryForecastofBHImpacts-July2020Update.pdf>

Depression and Suicide Risk

Depression is one of the most common emotional responses during the *disillusionment phase* of disaster response and recovery. In Washington, this phase coincides with seasonal changes, such as reduced daylight hours and fall/winter weather conditions. When weather conditions change and people are less likely to spend time outdoors for exercise or as part of a coping mechanism, mental health symptoms are likely to worsen. Many people relied on outdoor gatherings as a way to more safely interact with family and friends during the warmer months of 2020. Those options are far more limited during colder months with fewer daylight hours. The combination of these circumstances may result in an increase in symptoms of *seasonal affective disorder* (depression that tends to recur chiefly during the late fall and winter and is associated with shorter hours of daylight) beyond increases that are typical for this time of year.¹⁹

Many youth, teens, and young adults are experiencing significant symptoms of depression during the pandemic.²⁰ Older adults are also a group of concern due to isolation and lack of social connection. First responders, healthcare professionals, and behavioral health providers are also feeling emotional impacts of the pandemic as more patients and clients need treatment, support, and preventive care.

As the risk of depression increases throughout the *disillusionment phase* and the winter months, so too does the risk of suicide. Active suicide prevention should be promoted through the sharing of information about recognizing [warning signs](#);^e checking in with colleagues, friends, family members, and neighbors; and sharing resources. When someone is expressing thoughts of self-harm, [remove access to dangerous means of harm](#),^f and safely storing medications, poisons, and firearms. Suicides consistently account for approximately 75% of all firearm-related fatalities in Washington.²¹ [Storing firearms safely](#)^g and [temporarily removing them from the home](#)^h of an at-risk person during a crisis can save lives.

Additional Resources:

- Anyone concerned about depression or other behavioral health symptoms should talk with their healthcare provider.
- [Washington Listens](#)ⁱ (833-681-0211) is a hotline for people experiencing stress due to COVID-19.
- **Health Care Authority** – [Washington Mental Health Crisis Services](#)^j
- [National Suicide Prevention Lifeline](#):^k Call 800-273-8255 (English) or 1-888-628-9454 (Español).
- [Crisis Connections](#):^l Call 866-427-4747.
- [Crisis Text Line](#):^m Text HEAL to 741741.

^e <https://www.doh.wa.gov/YouandYourFamily/InjuryandViolencePrevention/SuicidePrevention/HelpSomeoneElse#common>

^f <https://www.seattlechildrens.org/health-safety/keeping-kids-healthy/prevention/home-checklist/>

^g <https://www.kingcounty.gov/depts/health/violence-injury-prevention/violence-prevention/gun-violence/LOCK-IT-UP.aspx>

^h <https://hiprc.org/firearm/firearm-storage-wa/>

ⁱ <https://www.walistens.org/>

^j <https://www.hca.wa.gov/health-care-services-supports/behavioral-health-recovery/mental-health-crisis-lines>

^k <https://suicidepreventionlifeline.org/>

^l <https://www.crisisconnections.org/24-hour-crisis-line/>

^m <https://www.crisistextline.org/>

- **Department of Health** – [Crisis Lines for Specific Groups](#)ⁿ
- [TeenLink](#):^o Call or text 866-833-6546.
- [Washington Warm Line](#):^p Call 877-500-9276.
- **Washington State COVID-19 Response** – [Mental and emotional well-being webpage](#)^q

Exhaustion

General fatigue, exhaustion, and feeling overwhelmed are common experiences in the disillusionment phase of disaster response and recovery.^{22,23,28} Feeling exhausted can be both caused *and* worsened by problems with sleep, which commonly is disrupted by prolonged periods of stress. Recognizing the need to engage in healthy sleep hygiene practices (going to sleep and waking around the same time each day), limiting blue light exposure (such as light from computer screens and other digital devices), physical exercise, and practicing healthy eating habits will help to mitigate this symptom for children and adults. Long term exhaustion may also contribute to other behavioral health symptoms, such as reduced or diminished cognitive and higher-level thinking capacity. This too is also likely to be impacted by increased stress in this phase. Exhaustion significantly worsens the personal impact of pre-existing behavioral health symptoms such as depression, anxiety, or trauma, and can make it much more difficult for individuals to deal with their mental health. As such, consistently working to practice self-care, particularly in the form of consistent and restorative rest, is a priority.

Workplace Burnout, Compassion Fatigue, and Moral Injury

Workplace burnout and similar phenomena for healthcare and human services workers have been increasing steadily in the last several months and will likely continue to do so for the remainder of 2020.^{24,25} Compounding this issue is the concern that some workers' concern that they may experience discrimination in the workplace for voicing concerns about mental health.

Burnout is defined as exhaustion of body and mind when there is an unequal balance between the demands of the job and the coping resources available to an employee. *Compassion fatigue* is emotional and physical tiredness leading to a decreased ability to empathize or feel compassion for others. It is also described as *secondary traumatic stress*.

Moral injury is defined as strong feelings of guilt, shame, and anger about the frustration that comes from not being able to give the kind of care or service that an employee wants and expects to provide. During disasters such as the COVID-19 pandemic, [healthcare workers](#)^r are frequently in situations where standards of care are altered due to patient surge and scarce resources, shifting from conventional care to contingency care or crisis standards of care. Having to practice outside of conventional care is an added psychological risk for healthcare workers.²² As infection rates rise throughout the state, potentially causing a strain on medical resources, issues of burnout and moral injury become increasingly likely for all types of healthcare workers in all care settings, including behavioral health providers.²⁶

We are likely to continue to see an increase in the experiences of burnout, compassion fatigue, and moral injury for all types of healthcare workers due to the length and pervasiveness of the pandemic. Additionally, there will likely be workplace stressors related to economic pressures

ⁿ <https://www.doh.wa.gov/YouandYourFamily/InjuryandViolencePrevention/SuicidePrevention/HotlinesTextandChatResources>

^o <https://www.crisisconnections.org/teen-link/>

^p <https://www.crisisconnections.org/wa-warm-line/>

^q coronavirus.wa.gov/wellbeing

^r <https://www.statnews.com/2018/07/26/physicians-not-burning-out-they-are-suffering-moral-injury/>

and divisiveness among people and groups. For information on mitigating these impacts, please see the [COVID-19 Guidance for Building Resilience in the Workplace](#).⁵

Cognitive and Emotional Disruptions

Cognitive concerns and the tendency to react emotionally are hallmarks of long-term stress and trauma, and are significant in the context of disaster response and recovery.^{27,28} Many people are experiencing problems with memory (such as tracking details, attention, planning, and organizational thinking) that impact the ability to function at home and at work. In addition to these cognitive issues—in part as a function of them—many people are reacting in a more emotional way than they otherwise might to neutral events and interactions.²⁷

Recognizing the way that the human brain functions in the context of a disaster and providing that information publicly may help reduce the stigma around these cognitive issues and provide opportunities for many people to learn how to manage them more effectively. Normalizing the experiences of stress and trauma affecting the brain, body, and functioning helps increase resilience.

Substance Use

According to the Washington Poison Center (WAPC), there are recent and concerning trends for adolescents and teens. Specifically, in children ages 6–12, 35% used cannabis in 2019 compared to 41% in 2020. For youth ages 13–20, those numbers jump from 63% in 2019 to 78% in 2020.²⁹ Relative to 2019, exposures to THC (delta-9-tetrahydrocannabinol, one of many chemical compounds in cannabis products) reported to WAPC increased 20% in adults ages 21–59 years.

There are similar concerns regarding adults over 60 years old related to medication errors and the misuse of household cleaning products and disinfectants.³⁰ There is also data to suggest a higher call volume to the WAPC about the intentional use of substances for self-harm or abuse. It is important to help older adults with medication management to avoid errors, and to encourage regular preventative care appointments in order to foster support and prevention related to self-harm or suicidal ideation.

Recent research has also identified a concerning trend around increased alcohol use in women. This may reflect the multitude of responsibilities that many working women have been faced with, such as managing home-schooling and trying to maintain employment throughout the pandemic.³¹ Substance use will likely continue to be a problematic coping choice for many, with the potential for further increases moving into 2021.³² Parenting in the context of work and other life demands can also be affected by substance use and misuse. Though substance use may be a coping tool for many, it could quickly contribute to an unhealthy environment for both children and adults. Individuals concerned about substance use are encouraged to talk with their healthcare provider. Visit the state's coronavirus response [well-being webpage](#)⁹ for resources to help with substance use.

Continued Efforts Toward Personal and Community Resilience

The continued development of *psychological resilience* (adaptability and flexibility, connection, purpose, and hope) should be strongly encouraged throughout the next several months. Please see the [Born resilient article](#),^t [The Ingredients of Resilience infographic](#),^u and the [COVID-19 Guidance for Building Resilience in the Workplace](#)^s for more information on resilience.

Encouraging people to engage in **healthy outdoor activities as a way of active coping is highly**

^s <https://www.doh.wa.gov/Portals/1/Documents/1600/coronavirus/COVID-19-BuildingWorkplaceResilience.pdf>

^t <https://medium.com/wadepthealth/born-resilient-5a20945356df>

^u <https://coronavirus.wa.gov/sites/default/files/2020-09/COVID-19%20Ingredients%20of%20Resilience.pdf>

recommended when group size is limited appropriately, and safe social or physical distancing can be maintained.

Community resilience is the capacity of individuals and households within a community to absorb, endure, and recover from the impacts of a disaster. Approximately 50% of Washington residents have one or two risk factors that can threaten resilience, including unemployment, single parenting, economic inequality, or pre-existing medical conditions.³³ Resilience can be actively developed both on individual and community levels. Creative social connection as a part of resilience building can also be encouraged and developed. It can be amplified to increase social connection. This helps reduce behavioral health symptoms and encourages development of active coping skills for the population at large.

The typical long-term response to disaster is **resilience**, rather than disorder.^{1,34} Resilience is something that can be intentionally taught, practiced, and developed for people across all groups. Resilience can be increased by:³⁵

- Becoming **adaptive** and psychologically **flexible**.
- Focusing on developing social **connections**, big or small.
- Reorienting and developing a sense of **purpose**.
- Focusing on **hope**.

Community support groups, lay volunteers, and social organizations and clubs are resources that can be developed to help reduce behavioral health symptoms for the general population. These should be leveraged to reduce demand on depleted or unavailable professional medical and therapeutic resources throughout 2021.

Organizational Resilience

Organizational resilience can be developed by focusing on the main elements of resilience and identifying some specific ways in which organizations can be successful in this phase of the COVID-19 pandemic. Recommendations include:

- Developing shared trust and interdependence among employers and employees.
- Enhancing the organization's ability to learn and adapt to lessons learned.
- Human Resources flexibility for work schedules and boundaries, time off, and job roles.
- Open, two-way communication among leadership and staff at all levels about expectations and goals.^{36,37}

For more detailed information on how to support and build workplace resilience, please see the [COVID-19 Guidance for Building Resilience in the Workplace](#).⁵

Potential for Violence and Aggression

Increases in handgun sales present more risk for gun violence.^{38,39} Most notably, handgun ownership is associated with a significantly increased and enduring risk of suicide by firearm.⁴⁰ The FBI has conducted 35,758,249 background checks nationwide for gun purchases and other related services from January–November 2020. 3,626,335 background checks occurred in November alone. In comparison, the FBI conducted a total of 28,369,750 background checks for gun purchases in the year 2000.⁴⁰ Some [ways to decrease risk](#)^v are to keep all firearms securely locked up, prevent unauthorized access by children, and ask a friend or relative to take firearms in an emergency transfer until the crisis is addressed.

^v <https://saferhomescoalition.org/what-is-a-safer-home/>

The combination of the COVID-19 pandemic and the election season has caused a significant increase in sociopolitical discord, extremist views, and extremist behaviors, according to a U.S. Department of Homeland Security threat assessment.⁴¹ Generally, there is a higher risk of violence related to political tension during election season. In the context of the COVID-19 pandemic, that risk of violence is elevated during this election season.⁴¹ With heightened emotions due to the pandemic, increased extremist behavior, and increased gun sales, it is more important than ever for people and communities to promote resilience, increase connection, be mindful of what others may be experiencing, and be intentional about practicing patience.

Children and Families

Almost 30% of parents are experiencing negative mood and poor sleep quality, with a 122% increase in reported work disruption and 86% of families experiencing hardships, such as loss of income, job loss, increased caregiving burden, and household illness. Families experiencing hardship are also reporting navigating their child's disruptive or uncooperative behavior and anxiety.⁴² When children go through a hard time, such as living through a disaster, they will need extra attention, comfort, and attention from their parents. It's important to try to be patient with the child who is upset and may be having tantrums or becoming withdrawn. It's also important to try to keep the family rules about behavior the same, if possible. When children don't have help with boundaries and limits on their behavior, it can make them feel less safe and more anxious.

It is also important to note that mental health-related visits to emergency departments for children ages 5–17 between April and October of 2020 increased by 24–31%, compared with the same time period in 2019.⁴³ It is normal for children to be experiencing difficulty during this time, but if you have concerns about safety, please reach out for professional support and assistance. For more detailed information on this topic, see the [Behavioral Health Toolbox for Families: Supporting Children and Teens During the COVID-19 Pandemic](#).^w This resource provides general information about common emotional reactions of children, teens, and families during disasters. It also has suggestions on how to help children, teens, and families recover from disasters and grow stronger.

Suicidal Ideation and Attempts in Youth

We are continuing to monitor rates of emergency department visits for psychological distress, suicidal ideation, and suicide attempts for adolescents, youth and young adults. The convergence of factors that may be uniquely affecting the psychological health of these groups in our state leading into 2021 is **very concerning**. There are a number of factors, including the current *disillusionment phase* of disaster, as well as the unique challenges faced by young people this year, that may contribute to an increase in distress.

We are strongly recommending continual monitoring and supporting of adolescents and youth. For parents and caregivers, this can include checking in and asking youth and teens about thoughts of self-harm or suicide. Asking about suicide does not increase risk and, in fact, increases safety and often helps lead to timely intervention. For medical and behavioral health providers, this includes screening for suicidal ideation and behaviors, and regularly checking in about access to means, such as substances or firearms, for inflicting self-harm of any kind.

^w <https://www.doh.wa.gov/Portals/1/Documents/1600/coronavirus/BHG-COVID19-FamilyToolbox.pdf>

Child Abuse

Child abuse and domestic violence often increase significantly in post-disaster settings, such as the COVID-19 pandemic.^{44,45,46} Traumatic brain injuries (TBIs) among very young children are the most commonly studied and among the most concerning form of injury due to child abuse after a disaster.⁴⁴ The national rate of emergency department (ED) visits related to child abuse and neglect resulting in hospitalization has increased among children across all ages, compared with 2019.⁴⁷ While we don't have clear evidence of increasing numbers of child abuse-related ED visits in Washington (yet), we are very concerned and want to make sure families have the support they need during these challenging times.⁴⁸

Due to school closures and social distancing measures, more children and youth are online and unsupervised than usual. Predators that are sexually interested in children are using this opportunity to entice children to produce sexually explicit material (i.e., online enticement).⁴⁹ National rates of online enticement of children have increased 98.66% – from 15,220 reports in 2019 to 30,236 in 2020 – during the January–September time period.

Additionally, as child traffickers have adjusted to the reluctance of buyers to meet in person to engage in commercial sex, some traffickers are now offering virtual subscription-based services in which buyers pay to access online images and videos of the child being sexually abused. Accordingly, compared to the January–September time period of 2019, there has been a 63.31% increase in National CyberTipline reports (i.e., reports of distribution of child pornography and child sexual abuse material) for the same time period in 2020 (11,286,674 reports in 2019 versus 18,423,495 in 2020).⁴⁹ According to Seattle Police Department's Internet Crimes Against Children (ICAC) Unit, which processes all statewide data of this nature, Washington CyberTips and online enticement reports are following the same trends as national-level data.

In an online setting, most educators and healthcare providers are asking for a parent or caregiver to be present during all the interactions between the child and educator or provider. This may change or limit the opportunities for an educator/provider to ask the child directly or inquire about the way things are going at home. Typical cues that educators/providers use to spot signs of abuse or neglect may not be applicable in an online environment.

Potential signs of child abuse or neglect that may be visible in an online setting:

- Changes in levels of participation in online classes (unusually vocal, disruptive, very withdrawn, frequently absent or late to class, leaving early without explanation or notice, not wanting to leave).
- Extremely blunted or heightened emotional expressions.
- Appearing frightened or shrinking at the approach of an adult in the home.
- Age-inappropriate or sexualized knowledge, language, drawings, or behavior.
- Observable bruising on face, head, neck, hands, or arms (that is atypical for an active child of that developmental age). Recognize that children can have bruises for many reasons (e.g., rough playing, climbing).
- A change in the child's general physical appearance or hygiene (e.g., a child that normally presents in weather-appropriate clothing is no longer doing so, or a child that normally appears clean begins to appear with consistently greasy hair).
- Indications that a young child may be home alone.

- Observable signs in the background of health or safety hazards, harsh discipline, violence, substance abuse, or accessible weapons. Keep in mind that substance misuse is not, by itself, reason for removing a child from the home.
- Parent or caregiver giving conflicting, unconvincing, or no explanation for a child’s injury.
- Parent or caregiver describing the child as bad, worthless, or burdensome.

Refer to DOH’s [COVID-19 Guidance for Educators: Recognizing and Reporting Child Abuse and Neglect in Online Education Settings](#)^x for more information.

It is important to recognize the challenges parents and caregivers are experiencing during this unprecedented time. Many parents and caregivers have the responsibility of balancing their work schedule with their child’s distance learning and limited child care options, or they may be experiencing job loss and financial instability. The [Washington State Resource Guide for Parents and Caregivers: Caring for Your Family During COVID-19](#)^y (available in multiple languages) is another resource to help strengthen the resilience of parents and families. Refer families in need of assistance to community supports, which can be found through state resources, such as [HelpMeGrow WA](#)^z and [WA Listens](#).ⁱ

Holidays and Family Gatherings

The upcoming holiday season presents a series of challenges for many people in the context of COVID-19 and family dynamics.⁵⁰ Members of the same extended family may have different ideas about health precautions, mask-wearing, and norms and safety around interactions (e.g., social distancing, time spent indoors, etc.). There may also be challenges around social and political ideology and conversation. The holidays tend to exacerbate anxiety and stress for many people generally, but under the conditions of the pandemic and the current social climate, that experience may be magnified. There also may be a sense of pressure or expectation on the part of many people to celebrate, party, or have a great time during this season as a means of ‘blowing off steam’ and trying to relax.

The combination of more stress and the expectation that the holidays should be more fun than the day-to-day may also contribute to problematic substance use for many. It is recommended that each person try to acknowledge and respect their own personal values, as well as physical and emotional boundaries with family gatherings, in order to mitigate behavioral health challenges that may develop (specifically anxiety, stress, and substance use). Managing appropriate expectations for events and gatherings at this time of year in the context of COVID-19 will be helpful in reducing symptoms.

Visit the state’s coronavirus response [gatherings webpage](#)^{aa} for guidelines on alternatives and risk reduction strategies for gatherings, as well as tips for navigating difficult conversations about gatherings. Refer to local health departments which may also have guidelines for gatherings and upcoming holidays.

^x <https://www.doh.wa.gov/Portals/1/Documents/1600/coronavirus/821-113-COVID19RecognizingReportingChildAbuse.pdf>

^y https://dcyf.wa.gov/publications-library?combine_1=fs_0039&combine=&field_program_topic_value=All&field_languages_available_value=All

^z <https://helpmegrowwa.org/>

^{aa} <https://coronavirus.wa.gov/gatherings>

Key Things to Know

There are a number of additional factors and considerations that impact behavioral health to take into account in the remaining months of 2020:

- [Medical and specialty providers](#),^{bb} organizations, and facilities should continue developing resources and staffing to address behavioral health impacts of the pandemic that are likely to increase significantly, particularly under circumstances where a disaster cascade may occur. Support strategies need to be tailored based on the current phase of the incident and the target population.
- With cold and flu season, many individuals will have difficulty determining whether their symptoms of illness are COVID-19 related or due to another virus. As such, employees may be required to isolate, quarantine, or follow other guidelines that restrict contact with others. In the case that specific companies, businesses, or occupational roles face mass isolation or quarantine, delays or disruptions in supply chains and services could occur.
- **In Washington, as infection rates have climbed throughout November and the possibility of a disaster cascade in the next few months remains high, the risk of suicide will continue to be high throughout the first quarter 2021.** *Seasonal affective disorder* worsens mental health challenges at this time of year due to increased hours of darkness and inclement weather. Winter holidays can also worsen mental health challenges for many people, as they are often an emotionally and financially difficult time of year. **Data suggest that young adults (18–29) and older adults (60+) are particularly vulnerable.**⁵¹ **We encourage healthcare providers to routinely screen and ask their patients about suicidal thoughts or plans.** The National Institute of Mental Health’s [Ask Suicide-Screening Questions \(ASQ\) Screening Tool](#)^{cc} can be used for patients ages 10–24.
- Rates of PTSD have been much higher (10–35%) in some places more directly impacted by a critical incident.⁵² Although rates of PTSD may not reach such critical levels in Washington, it is anticipated that **rates of depression are likely to be much higher (potentially 30–60% of the general population, which is equivalent to 2.25 million–4.5 million people in Washington⁵³) due to the chronic and ongoing social and economic disruption in people’s lives as a result of the COVID-19 pandemic.** This is a much higher rate than typical after a natural disaster where there is a single impact point in time.
- If we experience an additional significant increase of illness as a function of this pandemic, significant behavioral health reactions or functional impairments may be experienced by approximately 45% of the population.^{54,55}
- In the context of post-disaster recovery, individuals often utilize substances as a way to relieve psychological suffering. As such, disasters are linked to increased use of tobacco, cannabis, and alcohol.⁵⁶
- Healthcare providers and organizations should continue to suggest healthy alternatives for coping and sources of support for staff as well as patients and clients. For additional resources, visit [DOH's Behavioral Health Resources & Recommendations webpage](#)^a for providers. Planning should include creative and flexible behavioral health service provision, particularly within rural communities and underserved populations, with specific mindfulness around cost of services, access to technology (e.g., for telehealth), availability of services, and stigma related to behavioral health.

^{bb} <https://www.doh.wa.gov/Portals/1/Documents/1600/coronavirus/BHG-COVID19BehavioralHealthGroupImpactReferenceGuide.pdf#page=8>

^{cc} https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials/asq-tool/screening_tool_asq_nimh_toolkit_155867.pdf

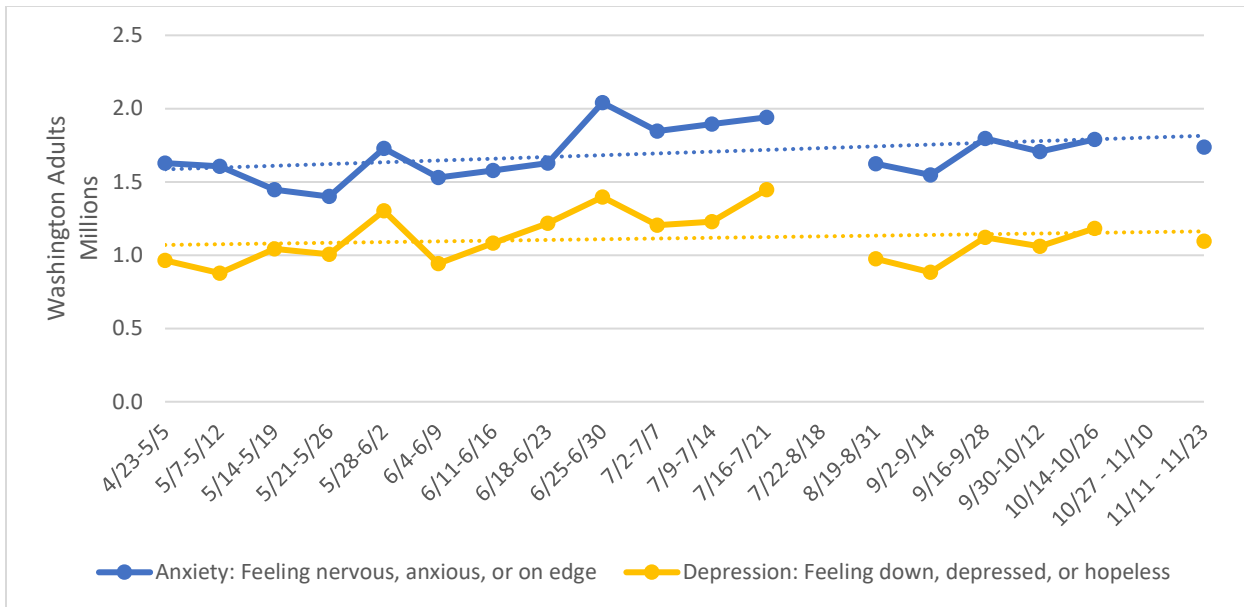


Figure 2: Estimated Washington adults experiencing symptoms of anxiety and depression at least most days, by week: April 23–Nov 23 (Source: U.S. Census Bureau).

Note: Census data is unavailable for the periods of July 22–August 18 and October 26–November 11.

- Based on population data for Washington and known cycles of common psychological responses to disasters, as well as the latest outcome data specific to COVID-19, **we can reasonably expect that more than three million Washingtonians will experience clinically significant behavioral health symptoms over the next two to five months. As we experience an additional impact from a winter surge in infections, this number may increase dramatically.**
 - **Symptoms of depression will likely be the most common, followed by anxiety and acute stress.** These symptoms will likely be strong enough to cause significant distress or impairment for most people in this group.
- Weekly survey data suggest that over 1.8 million Washington adults are experiencing symptoms of anxiety on at least most days, and over 1.2 million are experiencing symptoms of depression on at least most days (Figure 2).⁵⁷
- Suicide and drug overdose rates are both highly influenced by unemployment.^{15,58,59,60} For every 1% increase in the unemployment rate, there is a corresponding 1.6% increase in the suicide rate⁵⁹ and an increase of one drug overdose death per 300,000 people.⁵⁸
 - In Washington, approximately 1,231 people die from suicide annually, and 1,173 people die from drug overdose annually.
 - The unemployment rate in Washington was 6.0% in November 2020,⁶¹ 2.0 percentage points lower than November 2019. If economic impacts of the pandemic are sustained over a longer term, this could result in an additional 4,978 deaths annually by suicide, and drug overdose may also increase proportionally.
- An eventual return to pre-pandemic baseline levels of functioning in 2021 is anticipated for many people. However, this is dependent on the level of disruption caused by a potentially dramatic increase in infection rates throughout December and early 2021.^{1,2}

Acknowledgements

This document was developed by the Washington State Department of Health's Behavioral Health Strike Team for the COVID-19 response. The strike team is a group of clinical psychologists, psychiatrists, and therapists who are professionals in disaster relief and behavioral health. Lead authors from the Behavioral Health Strike Team are Kira Mauseth, Ph.D. and Stacy Cecchet, Ph.D., ABPP. Research support for this report was provided by undergraduate psychology students at Seattle University.

References

1. Substance Abuse and Mental Health Services Administration. (2015). Supplemental research bulletin - Issue 5: Traumatic stress and suicide after disasters. SAMHSA. https://www.samhsa.gov/sites/default/files/dtac/srb_sept2015.pdf
2. Centers for Disease Control and Prevention. (2018). The continuum of pandemic phases. CDC. <https://www.cdc.gov/flu/pandemic-resources/planning-preparedness/global-planning-508.html>
3. Washington State Department of Health (2020). *COVID-19 Data Dashboard*. <https://www.doh.wa.gov/Emergencies/COVID19/DataDashboard#dashboard>
4. Hossain, M. M., Sultana, A., & Purohit, N. (2020). *Mental health outcomes of quarantine and isolation for infection prevention: A systematic umbrella review of the global evidence*. <https://ssrn.com/abstract=3561265>
5. Johnson, B. R., Pagano, M. E., Lee, M. T., & Post, S. G. (2018). Alone on the Inside: The Impact of Social Isolation and Helping Others on AOD Use and Criminal Activity. *Youth & society*, 50(4), 529–550. <https://doi.org/10.1177/0044118X15617400>
6. Havassy, B. E., Hall, S. M., & Wasserman, D. A. (1991). Social support and relapse: Commonalities among alcoholics, opiate users, and cigarette smokers. *Addictive Behaviors*, 16(5), 235–246. [https://doi.org/10.1016/0306-4603\(91\)90016-B](https://doi.org/10.1016/0306-4603(91)90016-B)
7. Da, B. L., Im, G. Y., & Schiano, T. D. (2020). COVID-19 Hangover: A Rising Tide of Alcohol Use Disorder and Alcohol-Associated Liver Disease. *Hepatology*. Accepted Author Manuscript. <https://doi.org/10.1002/hep.31307>
8. SAMHSA. (2020). *Phases of Disaster*. <https://www.samhsa.gov/dtac/recovering-disasters/phases-disaster>
9. Anesi, G. L. & Manaker, S. (2020). *Coronavirus disease 2019 (COVID-19): Critical care issues*. <https://www.uptodate.com/contents/coronavirus-disease-2019-covid-19-critical-care-issues>
10. Bhatraju, P. K., Ghassemieh, B. J., Nichols, M., Kim, R., Jerome, K. R., Nalla, A. K., Greninger, A. L., Pipavath, S., Wurfel, M. M., Evans, L., Kritek, P. A., West, R. E., et al. (2020). Covid-19 in Critically Ill Patients in the Seattle Region. *New England Journal of Medicine*. 10.1056/NEJMoa2004500
11. Shultz, J. M., Espinola, M., Rechkemmer, A., Cohen, M. A., & Espinel, Z. (2017). Prevention of disaster impact and outcome cascades. In M. Israelashvili & J. L. Romano (Eds.), *The Cambridge handbook of international prevention science*. (pp. 492–519). Cambridge University Press. <https://doi-org.proxy.seattleu.edu/10.1017/9781316104453.022>
12. Pescaroli G. & Alexander D. (2015). A definition of cascading disasters and cascading effects: going beyond the “toppling dominos” metaphor. *Planet and Risk*, 2(3), 58–67.
13. Miller, J. L., & Pescaroli, G. (2018). Psychosocial capacity building in response to cascading disasters: A culturally informed approach. *International Journal of Disaster Risk Reduction*, 30, 164-171. <https://doi.org/10.1016/j.ijdr.2018.04.018>
14. Berariu, R., Fikar, C., Gronalt, M., & Hirsch, P. (2015). Understanding the impact of cascade effects of natural disasters on disaster relief operations. *International Journal of Disaster Risk Reduction*, 12, 350-356. <https://doi.org/10.1016/j.ijdr.2015.03.005>
15. Parker, K., Horowitz Menasce, J., & Brown, A. (2020). Pew Research Center. *About Half of Lower-Income Americans Report Household Job or Wage Loss Due to COVID-19*. <https://www.pewsocialtrends.org/2020/04/21/about-half-of-lower-income-americans-report-household-job-or-wage-loss-due-to-covid-19/>
16. Panchal, N., Kamal, R., Orgera, K., Cox, C., Garfield, R., Hamel, L., Muñana, C., & Chidambaram, P. (2020). *The Implications of COVID-19 for Mental Health and Substance Use*. Kaiser Family Foundation. <https://www.kff.org/health-reform/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use>
17. Liem, A., Wang, C., Wariyanti, Y., Latkin, C. A., & Hall, B. J. (2020). The neglected health of international migrant workers in the COVID-19 epidemic. *The Lancet Psychiatry*, 7(4), e20.

18. Garg, S., Kim, L., Whitaker, M., et al. (2020). Hospitalization Rates and Characteristics of Patients Hospitalized with Laboratory-Confirmed Coronavirus Disease 2019 — COVID-NET, 14 States, March 1–30, 2020. *MMWR Morb Mortal Wkly Rep*, 69, 458–464. <http://dx.doi.org/10.15585/mmwr.mm6915e3>
19. Targum, S. D., & Rosenthal, N. (2008). Seasonal affective disorder. *Psychiatry (Edgmont (Pa. : Township))*, 5(5), 31–33.
20. Czeisler, M. É., Lane, R. I., Petrosky, E., et al. (2020). Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic — United States, June 24–30, 2020. *MMWR Morb Mortal Wkly Rep*, 69, 1049–1057. <http://dx.doi.org/10.15585/mmwr.mm6932a1>
21. Washington State Department of Health. (2019). *Annual Report: Firearm Fatality and Suicide Prevention – A Public Health Approach*. <https://www.doh.wa.gov/Portals/1/Documents/8390/346-087-SuicideFirearmPrevention.pdf>
22. Mira, J. J., Carrillo, I., Guilabert, M., Mula, A., Martin-Delgado, J., Pérez-Jover, M. V., Vicente, M. A., & Fernández, C. (2020). Acute stress of the healthcare workforce during the COVID-19 pandemic evolution: a cross-sectional study in Spain. *BMJ Open*, 10(11), e042555. <https://doi-org.proxy.seattleu.edu/10.1136/bmjopen-2020-042555>
23. Center for Substance Abuse Treatment (US). (2014). Trauma-Informed Care in Behavioral Health Services. Rockville (MD). Substance Abuse and Mental Health Services Administration (US). (Treatment Improvement Protocol (TIP) Series, No. 57.) Chapter 3, *Understanding the Impact of Trauma*. <https://www.ncbi.nlm.nih.gov/books/NBK207191/>
24. American Psychiatric Association. (2020). *Moral Injury During the COVID-19 Pandemic*. <https://www.psychiatry.org/File%20Library/Psychiatrists/APA-Guidance-COVID-19-Moral-Injury.pdf>
25. Alharbi, J., Jackson, D., & Usher, K. (2020). The potential for COVID-19 to contribute to compassion fatigue in critical care nurses. *PubMed Central*. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7267232/>
26. Vyas, K. J., Delaney, E. M., Webb-Murphy, J. A., et al (2016). Psychological Impact of Deploying in Support of the U.S. Response to Ebola: A Systematic Review and Meta-Analysis of Past Outbreaks. *Military Medicine*, 181.11/12e1515.
27. Hayes, J. P., Vanelzakker, M. B., & Shin, L. M. (2012). Emotion and cognition interactions in PTSD: a review of neurocognitive and neuroimaging studies. *Frontiers in integrative neuroscience*, 6, 89. <https://doi.org/10.3389/fnint.2012.00089>
28. Centers for Disease Control and Prevention. (2013, December 30). *Traumatic Incident Stress*. The National Institute for Occupational Safety and Health (NIOSH). <https://www.cdc.gov/niosh/topics/traumaticincident/default.html>
29. Washington Poison Center. (2020, December 8). *Exposure Trends During the COVID-19 Pandemic, Special Focus: Cannabis (THC)*. https://www.wapc.org/wp-content/uploads/COVID-Snapshot-6_Cannabis.pdf
30. Washington Poison Center (2020). *Exposure Trends During the COVID-19 Pandemic. Special Focus: Adults 60 Years and Older*. https://www.wapc.org/wp-content/uploads/FINAL-COVID-Snapshot-4_Older-Adults.pdf
31. Pollard, M., Tucker, J., & Green, H. (2020). Changes in Adult Alcohol Use and Consequences During the COVID-19 Pandemic in the US. Author Affiliations Article Information *JAMA Network Open*, 3(9),e2022942. doi:10.1001/jamanetworkopen.2020.22942
32. Lebow, J. L. (2020). The Challenges of COVID-19 for Divorcing and Post-divorce Families. *Fam. Proc.*, 59, 967-973. 10.1111/famp.12574
33. U.S. Census Bureau. (2020). *Community Resilience Estimate June 17, 2020*. <https://www2.census.gov/data/experimental-data-products/community-resilience-estimates/2020/technical-document.pdf>
34. Bonanno, G. A. (2004). Loss, Trauma, and Human Resilience: Have We Underestimated the Human Capacity to Thrive After Extremely Aversive Events? *American Psychologist*, 59(1), 20–28. <https://doi.org/10.1037/0003-066X.59.1.20>

35. Hobfoll, S. E., Watson, P. J., Bell, C. C., Bryant, R., Brymer, M. J., Friedman, M. J., & Ursano, R. J. (2007). Five essential elements of immediate and mid-term mass trauma intervention: Empirical evidence. *Psychiatry Interpersonal & Biological Processes*, 70(4), 283-315.
36. Gittell, J. H., Cameron, K., Lim, S., & Rivas, V. (2006). Relationships, Layoffs, and Organizational Resilience: Airline Industry Responses to September 11. *The Journal of Applied Behavioral Science*, 42(3), 300-324.
37. Lengnick-Hall, C. A., Beck, T. E., & Lengnick-Hall, M. L. (2011). Developing a capacity for organizational resilience through strategic human resource management. *Human Resource Management Review*, 21, 243-255.
38. 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*, 160(9), 658-9]. *Ann Intern Med*, 160(2), 101-110. doi:10.7326/M13-1301
39. Studdert, D. M., Zhang, Y., Swanson, S. A, Prince, P., Rodden, J. A., Holsinger, E. E., Spittal, M. J., Wintemute, G. J., & Miller, M. M. (2020). Handgun Ownership and Suicide in California. *N Engl J Med*, 382, 2220-2229. doi: 10.1056/NEJMsa1916744
40. Federal Bureau of Investigation. (2019). National Instant Criminal Background Check System (NICS), Services: NICS. <https://www.fbi.gov/services/cjis/nics>
41. U.S. Department of Homeland Security. (2020). *Homeland Threat Assessment*. https://www.dhs.gov/sites/default/files/publications/2020_10_06_homeland-threat-assessment.pdf
42. Gassman-Pines, A., Oltmans Ananat, E., & Fitz-Henley, J. (2020). COVID-19 and Parent-Child Psychological Well-being. *Pediatrics*, 146(4), e2020007294. doi: 10.1542/peds.2020-007294
43. Leeb, R. T., Bitsko, R. H., Radhakrishnan, L., Martinez, P., Njai, R., Holland, K. M. (2020). *Mental Health–Related Emergency Department Visits Among Children Aged <18 Years During the COVID-19 Pandemic — United States, January 1–October 17, 2020*. *MMWR Morb Mortal Wkly Rep*, 69, 1675–1680. DOI: [http://dx.doi.org/10.15585/mmwr.mm6945a3external icon](http://dx.doi.org/10.15585/mmwr.mm6945a3external%20icon).
44. World Health Organization. (2005). *Violence and Disasters*. Department of Injuries and Violence Prevention. Geneva, Switzerland. https://www.who.int/violence_injury_prevention/publications/violence/violence_disasters.pdf
45. Rezaeian, M. (2013). The association between natural disasters and violence: A systematic review of the literature and a call for more epidemiological studies. *Journal of Research in Medical Sciences*, 18(12): 1103–1107.
46. Abramson, A. (2020). *How COVID-19 may increase domestic violence and child abuse. National crises ramp up stress among couples and families. Psychologists identify the risks and point to resources that can help.* American Psychological Association. <https://www.apa.org/topics/covid-19/domestic-violence-child-abuse>
47. Swedo, E., Idaikkadar, N., Leemis, R., et al. (2020). Trends in U.S. Emergency Department Visits Related to Suspected or Confirmed Child Abuse and Neglect Among Children and Adolescents Aged <18 Years Before and During the COVID-19 Pandemic — United States, January 2019–September 2020. *MMWR Morb Mortal Wkly Rep*, 69, 1841–1847. <http://dx.doi.org/10.15585/mmwr.mm6949a1>
48. Washington State Department of Social and Health Services. (2020, December 18). *Child Welfare and Health Service Trends in Washington State – Monitoring Child Protective Services Intakes and Medical Visits During the COVID-19 Pandemic*. <https://www.dshs.wa.gov/sites/default/files/rda/reports/DCYF-covid.pdf>
49. O'Donnell, B. (2020, July 16). COVID-19 and Missing & Exploited Children. *National Center for Missing & Exploited Children*. <https://www.missingkids.org/blog/2020/covid-19-and-missing-and-exploited-children>
50. Centers for Disease Control and Prevention. (2020, October 19). Holiday Celebrations, Coronavirus Disease 2019 (COVID-19), Your Health. <https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/holidays.html>
51. Washington State Department of Health. *Behavioral Health Impact Situation Report, Week of October 26, 2020*. 821-102-15.

52. Bonanno, G. A., Galea, S., Bucciarielli, A., & Vlahov, D. (2006). Psychological Resilience after disaster: New York City in the aftermath of the September 11th terrorist attack. *Psychological Science*, *17*(3): 181-6.
53. Fran H., Norris, Matthew J., Friedman & Patricia J., Watson. (2002). 60,000 Disaster Victims Speak: Part II. Summary and Implications of the Disaster Mental Health Research. *Psychiatry*, *65*(3), 240-260. 10.1521/psyc.65.3.240.20169
54. Bonanno, G. A., Brewin, C. R. Kaniasty, K. & LaGreca, A. M. (2010). Weighing the Costs of Disaster: Consequences, Risks, and Resilience in Individuals, Families, and Communities. *Psychological Science in the Public Interest*, *11*(1), 1–49. <https://doi.org/10.1177/1529100610387086>
55. Cerdá, M., Bordelois, P. M., Galea, S., Norris, F., Tracy, M., & Koenen, K. C. (2013). The course of posttraumatic stress symptoms and functional impairment following a disaster: what is the lasting influence of acute versus ongoing traumatic events and stressors? *Social psychiatry and psychiatric epidemiology*, *48*(3), 385–395. <https://doi.org/10.1007/s00127-012-0560-3>
56. Alexander, A. C., & Ward, K. D. (2018). Understanding post-disaster substance use and psychological distress using concepts from the self-medication hypothesis and social cognitive theory. *Journal of psychoactive drugs*, *50*(2), 177-186.
57. U.S. Census Bureau. *Household Pulse Survey Data Tables*. <https://www.census.gov/programs-surveys/household-pulse-survey/data.html>
58. Brown, E., & Wehby, G. L. (2019). Economic conditions and drug and opioid overdose deaths. *Medical Care Research and Review*, *76*(4), 462–477.
59. Phillips, J. A. (2014). Suicide and the Great Recession of 2007–2009: The Role of Economic Factors in the 50 U.S. States. *Social Science & Medicine*. 116, 22-31.
60. Meadows Mental Health Policy Institute (2020). *COVID-19 Response Briefing: Mental Health and Substance Use Disorder Impacts of a COVID-19 Economic Recession*. <https://www.texasstateofmind.org/uploads/whitepapers/COVID-MHSUDIImpacts.pdf>
61. Washington State Employment Security Department. *Facts and Figures Report – June 2020*. <https://esd.wa.gov/labormarketinfo/facts-and-figures-report>