

Month of September 2022

COVID-19 Youth 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 Washington youth (individuals 18 years and younger unless otherwise noted).

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 September 2, 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 31 – 35 weeks of August 6 – September 3, 2022) three of the four syndromic indicators **increased** (psychological distress, suicidal ideation, and suspected drug overdose) from the previous reporting period (CDC weeks 27 – 30). Suspected suicide attempt **decreased** from the previous reporting period. For the current week, psychological distress, suicidal ideation, and suspected drug overdose are **decreasing** and suspected suicide attempt **increased**.

- For the week of August 14, 2022, a statistical warning was issued for those age 0 – 18 for psychological distress.
- For the week of August 28, 2022, a statistical warning was issued for individuals who did not report their ethnicity.

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

Survey data collected by the U.S. Census Bureau for July 27 – August 8, 2022 show that respondents who make \$75,000 - \$99,999 per year (54%) and \$200,000 and above per year (45%) indicated they will “Definitely not get the vaccine for their child.” The “definitely not” category is 14.82% of all respondents surveyed.

Filings from the Administrative Office of the Courts (AOC) shows the year-over-year² percent changes for July 2022 for these filings show sex crimes **decreased** 32%, robberies **increased** 58%, assaults **increased** 3%, thefts/burglaries **increased** 3%, and motor vehicle thefts **decreased** 31% compared to the previous year.

Impact Assessment

Syndromic Surveillance

The Department of Health collects syndromic surveillance data in near real-time from hospitals and clinics across Washington. The data are always subject to updates. Key data elements reported include patient demographic information, chief complaint, and coded diagnoses. This [data collection system](#)³ is the only source of emergency department (ED) data for Washington.

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 calculated incorrectly, causing a misrepresentation of what was actually 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 are 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 deviations⁴ above a 28-day average count, ending three weeks prior to the week

² Year-over-year: a comparison of data between multiple years, specifically 2019 to 2020, 2021, and 2022.

³ <https://doh.wa.gov/public-health-healthcare-providers/healthcare-professions-and-facilities/data-exchange-0/syndromic-surveillance-rhino>

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

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.

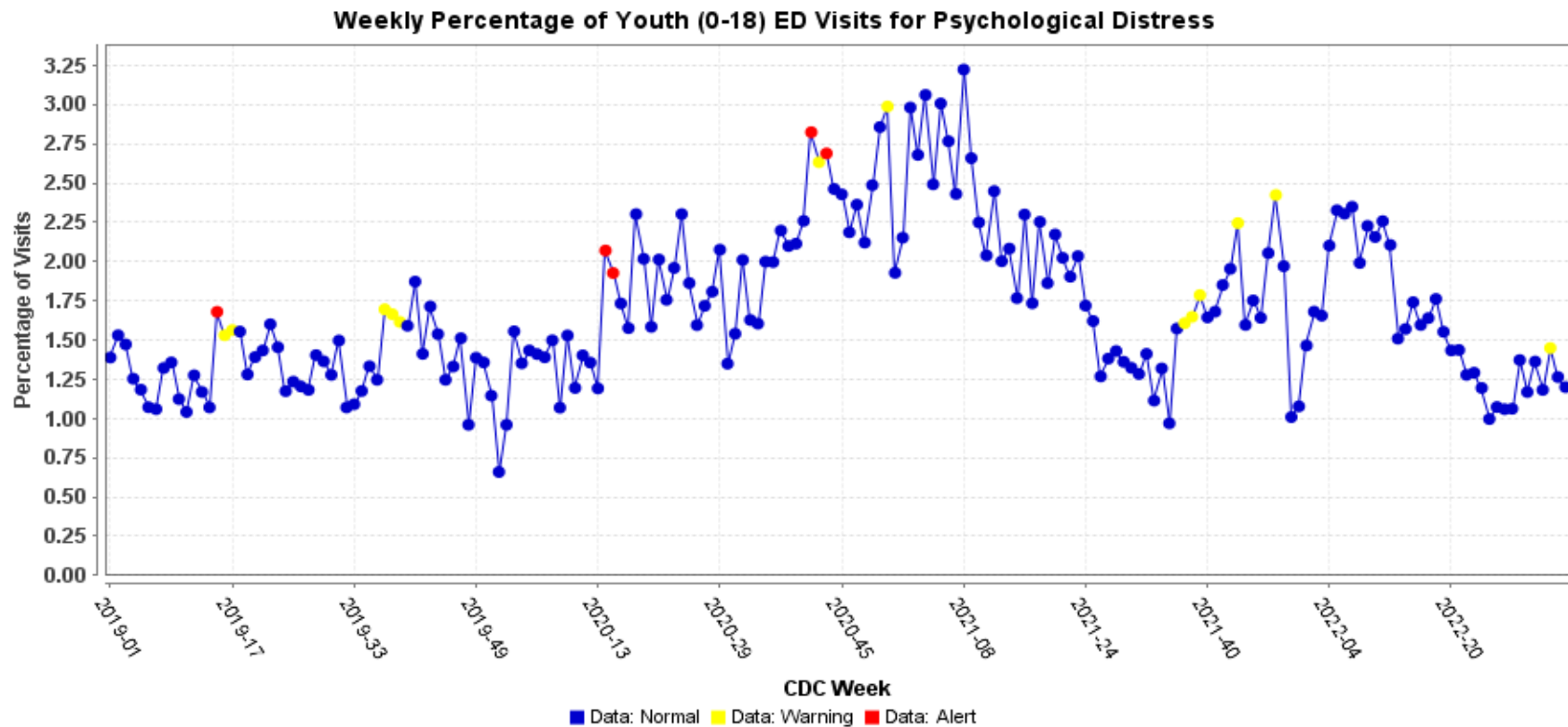
Analysis conducted by the Washington State Department of Health and the Northwest Tribal Epidemiology Center found 9,443 misclassified visits in Washington hospitals from May 15 – September 15, 2020. The visits in question should have been classified as American Indian/Alaska Native and represent a 27%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

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

Psychological Distress

During CDC Week 31 – 35 (weeks of August 6 – September 3, 2022) the reported relative percent of ED visits for psychological distress⁵ among youth **increased** from the previous reporting period (CDC weeks 27 – 30), and the current week is **decreasing** (Graph 1). For the week of August 14, 2022, a statistical warning was issued for those age 0 – 18.

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

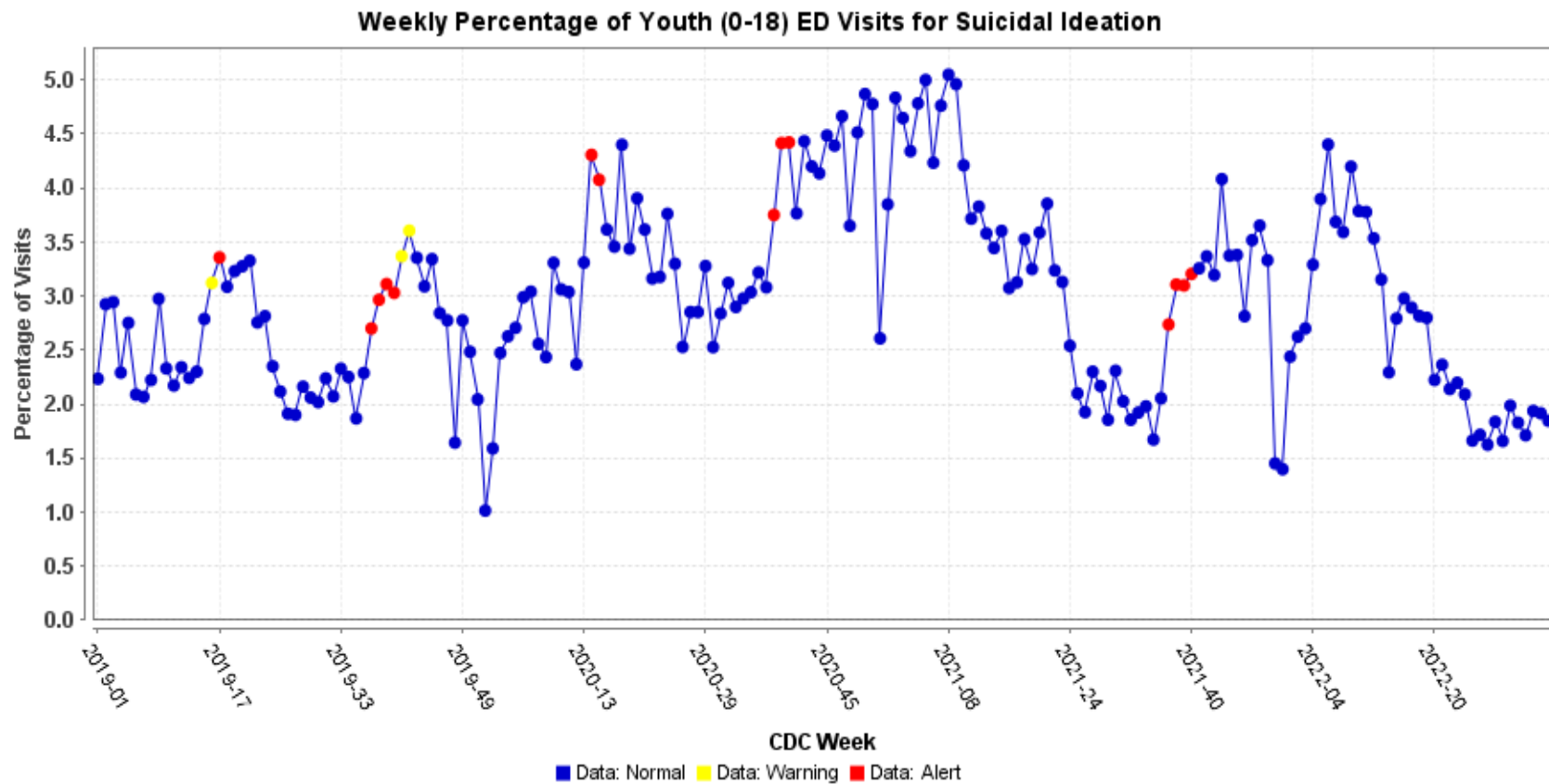


⁵ Psychological distress in this context is considered a disaster-related syndrome comprised of panic, stress, and anxiety. It is indexed in the Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE) platform as Disaster-related Mental Health v1. Full details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

Suicidal Ideation and Suspected Suicide Attempt

During CDC Week 31 – 35 (weeks of August 6 – September 3, 2022) the reported relative percent of ED visits for suicidal ideation among youth **increased** from the previous reporting period (CDC weeks 27 – 30), and the current week is **decreasing** (Graph 2). No statistical warning or alert were issued. For the week of August 28, 2022, a statistical warning was issued for individuals who did not report their ethnicity.

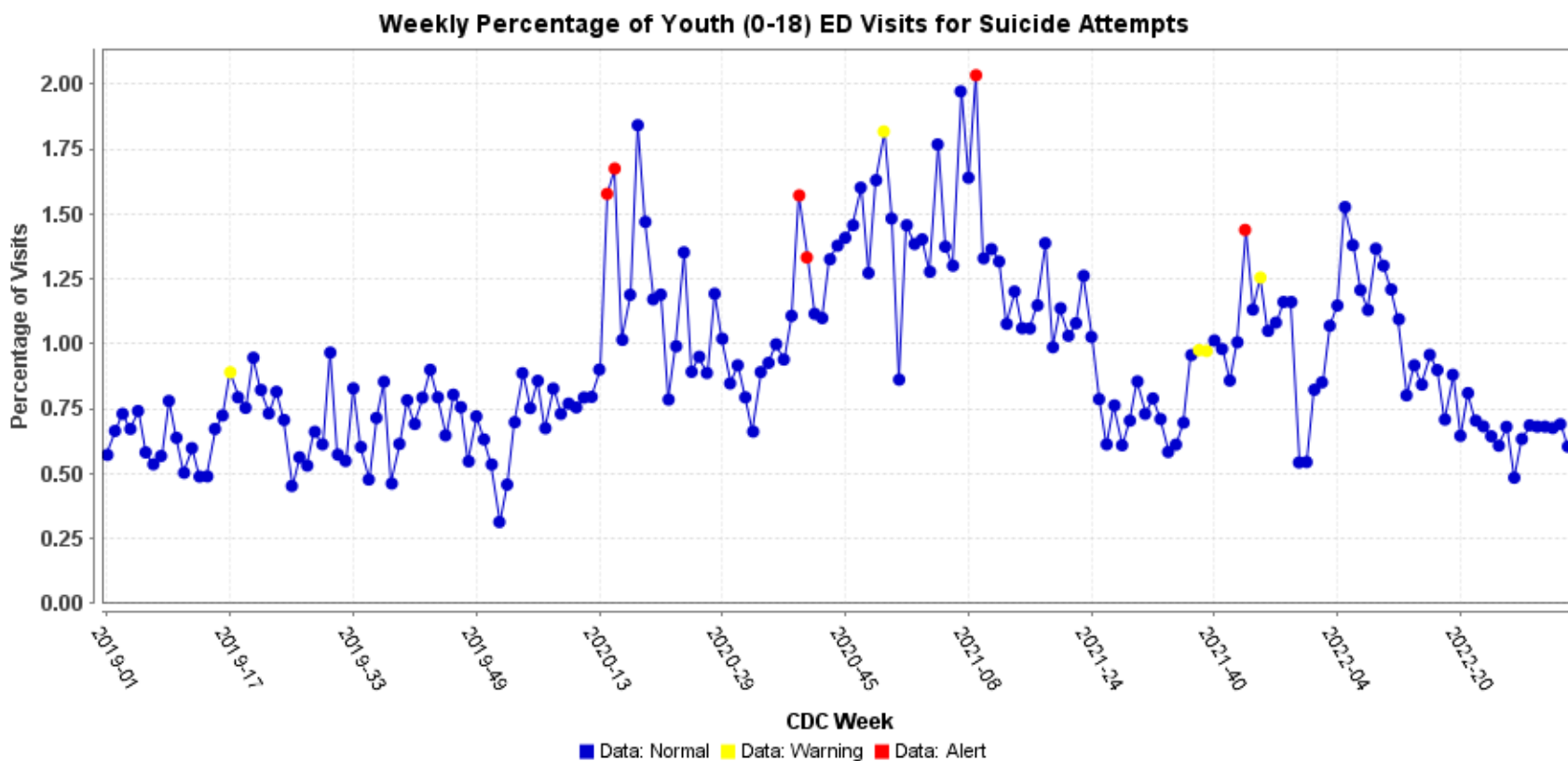
Graph 2: Percent change of ED visits for suicidal ideation among youth in Washington, by week: 2019, 2020, 2021, and 2022 to date (Source: CDC ESSENCE)



During CDC Week 31 – 35 (weeks of August 6 – September 3, 2022) the reported relative percent of ED visits for suspected suicide attempt among youth **decreased** from the previous reporting period (CDC weeks 27 – 30), and the current week is **increasing** (Graph 3). No statistical warning or alert was issued.

The current CDC definition for suspected suicide attempt, due to its broad inclusion of intentional self-harm behaviors that may or may not be interpreted as a suicidal act, could artificially inflate both the count and percent of such visits.⁶

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



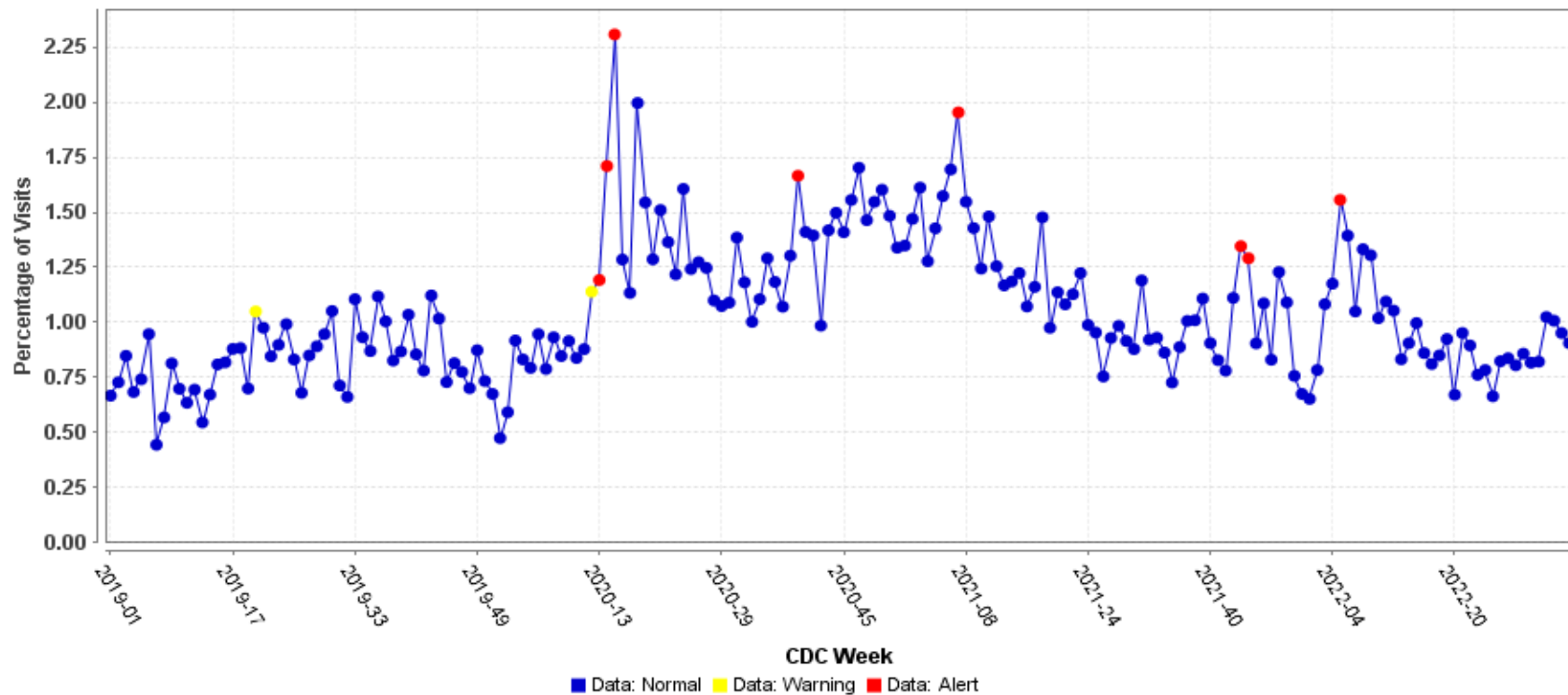
⁶ <https://knowledgerepository.syndromicsurveillance.org/disaster-related-mental-health-v1-syndrome-definition-subcommittee>

Substance Use – Suspected Drug Overdose

During CDC Week 31 – 35 (weeks of August 6 – September 3, 2022) the reported relative percent of ED visits for suspected drug overdose among youth **increased** from the previous reporting period (CDC weeks 27 – 30), and the current week is **decreasing** (Graph 4). No statistical warning or alert was issued.

Graph 4: ED percent change for all drug⁷-related visits among youth in Washington, by week: 2019, 2020, 2021, and 2022 to date (Source: CDC ESSENCE)

Weekly Percentage of Youth (0-18) ED Visits for All Drug Overdoses



⁷ All drug: This definition specifies overdoses for any drug, including heroin, opioid, and stimulants. It is indexed in the Electronic Surveillance System for the Early Notification of Community-Based Epidemics (ESSENCE) platform as CDC All Drug v1. Full details available at <https://knowledgerepository.syndromicsurveillance.org/cdc-all-drug-v1>

General Surveillance

COVID-19 Vaccinations for Children Ages 5 – 17

[Survey data](#) collected by the U.S. Census Bureau for January 26 – August 8, 2022, show that the greatest number of respondents (who are Washington adults with children ages 5 – 17) indicated that in the most recent reporting period (July 27 – August 8, 2022) 56% of children ages 5 – 17 have received the COVID-19 vaccine.

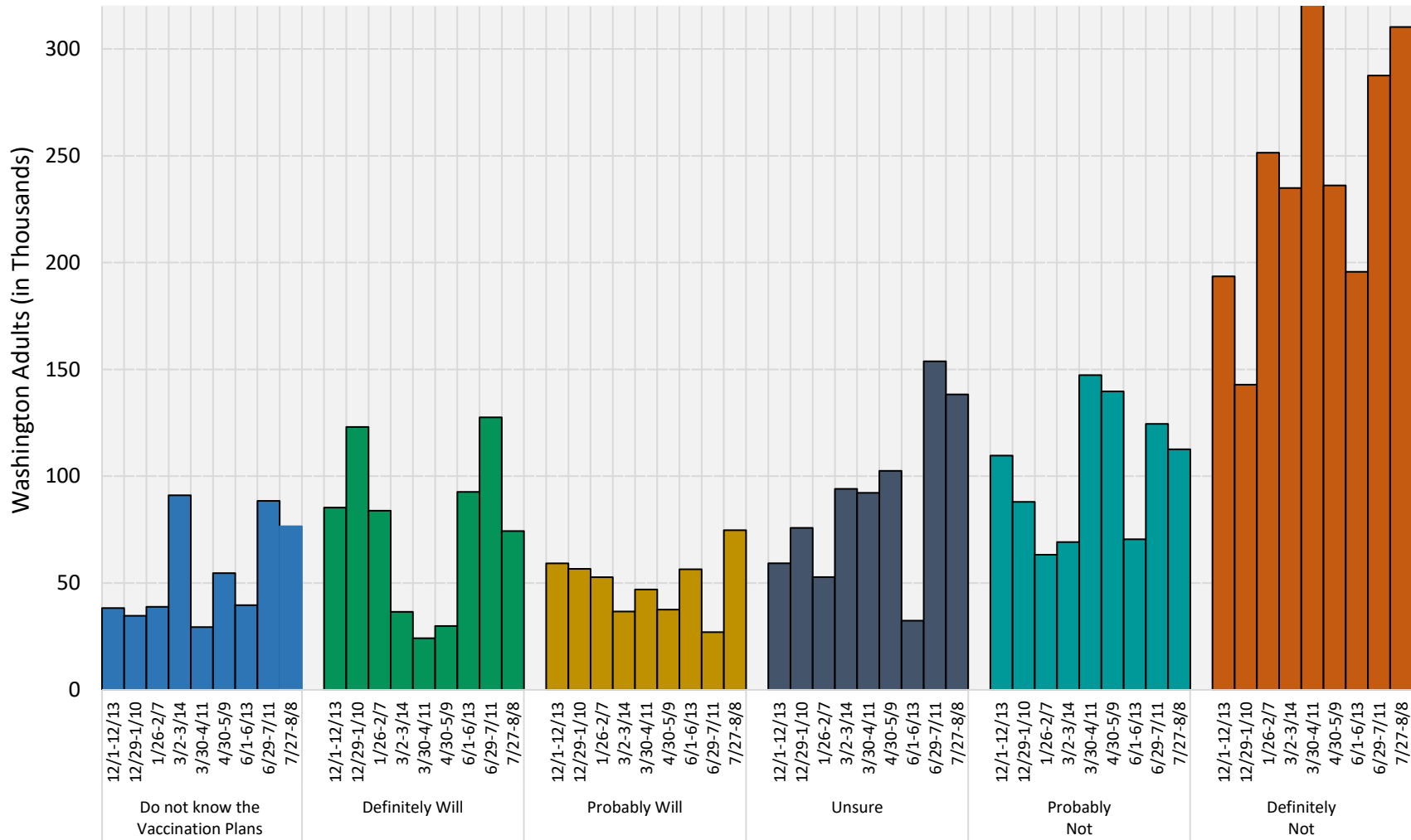
Table 1 and Graph 5 show the plans respondents have given for whether they will get their child vaccinated (based on income), and the total percentage of respondents to the survey.

For respondents or household members who have experienced loss of employment income in the last four weeks and not vaccinated their child, 39% of those individuals reported they will **probably not** get a vaccine for their children, 13% of those individuals reported that they will **definitely not** get a vaccine for their children, and 10% reported that they will **definitely** get a vaccine for their children.

Table 1: Percentage of Washington adults reporting children’s vaccination plans by income: December 29, 2021 – May 9, 2022 (Source: U.S. Census Bureau)

Vaccination Plan for Child age 5 – 17	Definitely will get the vaccine for their child	Probably will get the vaccine for their child	Unsure about the vaccine for their child	Probably will not get the vaccine for their child	Definitely will not get the vaccine for their child
Highest percentage (%)	\$150,000 - \$199,999 per year (20.01%)	\$100,000 - \$149,999 per year (23.85%)	Less than \$25,000 per year(40%)	Less than \$25,000 per year(41%)	\$75,000 - \$99,999 per year (54%)
Second highest percentage (%)	\$35,000 - \$49,999 per year (14.32%)	\$150,000 - \$199,999 per year (21.06%)	\$50,000 - \$74,999 per year (37%)	\$25,000 - \$39,999 per year (24%)	\$200,000 and above per year (45%)
Total percent of respondents plans for their child’s vaccination	3.55%	3.57%	6.61%	5.38%	14.82%

**Graph 5: Count of Washington adults reporting children’s vaccination plans:
December 29, 2021 – June 13, 2022 (Source: U.S. Census Bureau)**



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

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

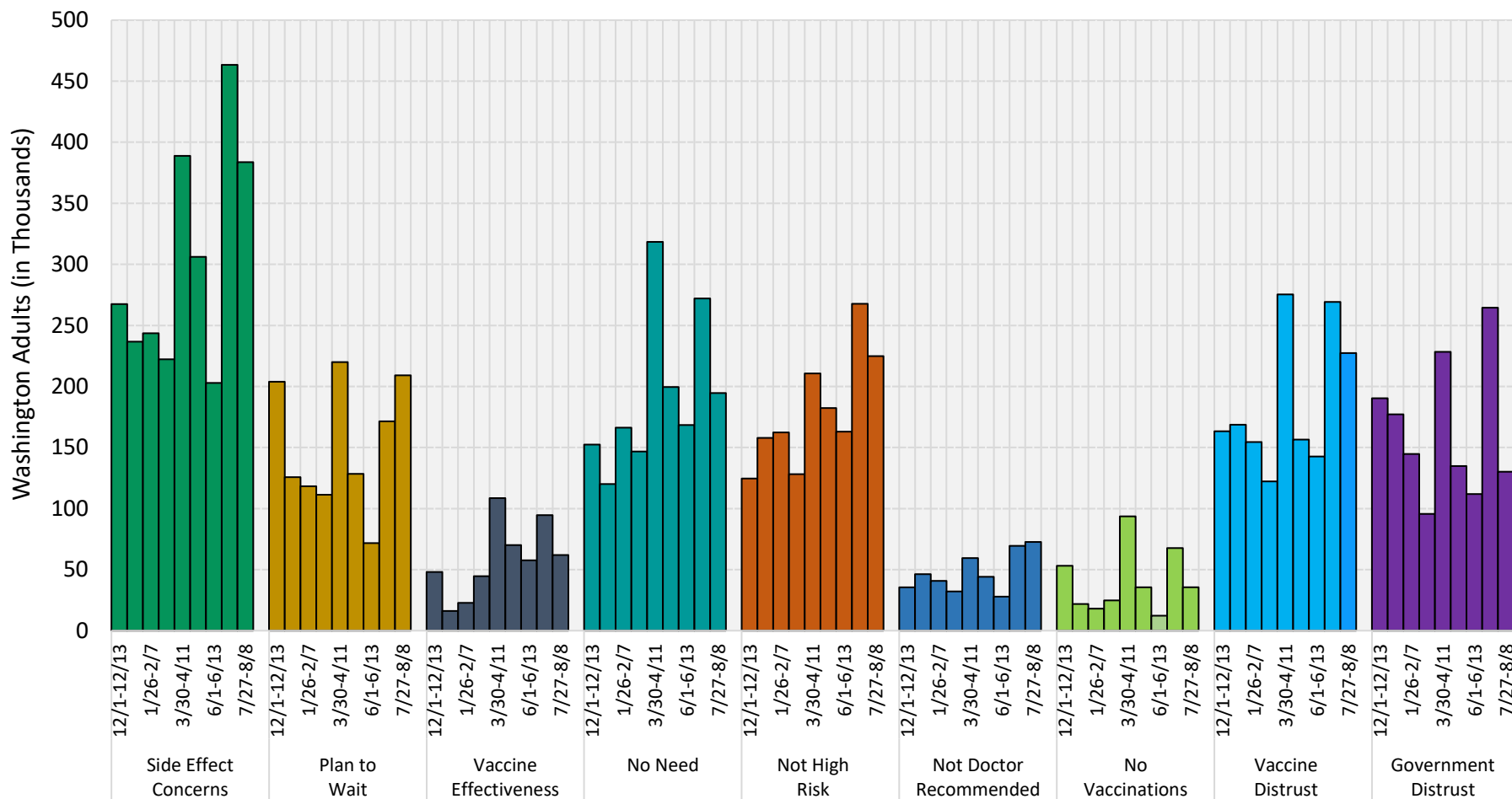
[Survey data](#)**Error! Bookmark not defined.** further show reasons for children (ages 5 – 17) not receiving or planning to receive a COVID-19 vaccine from January 26 – August 8, 2022 (Graph 6). Table 2 shows breakdown of the reasons why respondents with children ages 5 – 17 reported the child has not received the vaccine for the most recent reporting period (July 27 – August 8, 2022).

Table 2 and Graph 6 show the reason respondents have given for why they have not vaccinated their child (based on income), and the total percentage of respondents to the survey.

Table 2: Percentage of Washington adults reporting reasons for children not receiving or planning to receive a COVID-19 vaccine (based on income): December 29, 2021 – June 13, 2022 (Source: U.S. Census Bureau)

Reason for not receiving or planning to receive a vaccine	Concern about side effects	Plan to wait and see if it is safe	Not sure if vaccine will work	Don't believe child need a vaccine	Child not member of a high-risk group	Child's doctor has not recommended a vaccine	Respondents do not vaccinate their child	Don't trust COVID-19 vaccines
Highest percentage (%)	Less than \$25,000 per year (42%)	\$25,000 - \$34,999 per year (23%)	\$25,000 - \$34,999 per year (17%)	\$200,000 and above per year (20%)	\$200,000 and above per year (23%)	\$ 150,000 - \$199,999 per year (11.07%)	\$ 100,000 - \$149,999 per year (4.35%)	\$35,000 - \$49,999 per year (21%)
Second highest percentage (%)	\$25,000 - \$34,999 per year (31%)	\$50,000 - \$74,999 per year (21%)	\$50,000 - \$74,999 per year (8.15%)	\$100,000 - \$149,999 per year (15%)	\$75,000 - \$99,999 per year (17%)	\$75,000 - \$99,999 per year (6.07%)	\$35,000 - \$49,999 per year (4.02%)	\$50,000 - \$74,999 per year (19%)
Total Respondents reasons for not vaccinating their child	61%	33%	9.89%	31%	36%	11.60%	5.68%	36%

Graph 6: Count of Washington adults reporting reasons for children not receiving or planning to receive a COVID-19 vaccine: December 29, 2021 – August 8, 2022 (Source: U.S. Census Bureau)



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

Telehealth Use Claims for Washington Medicaid Clients

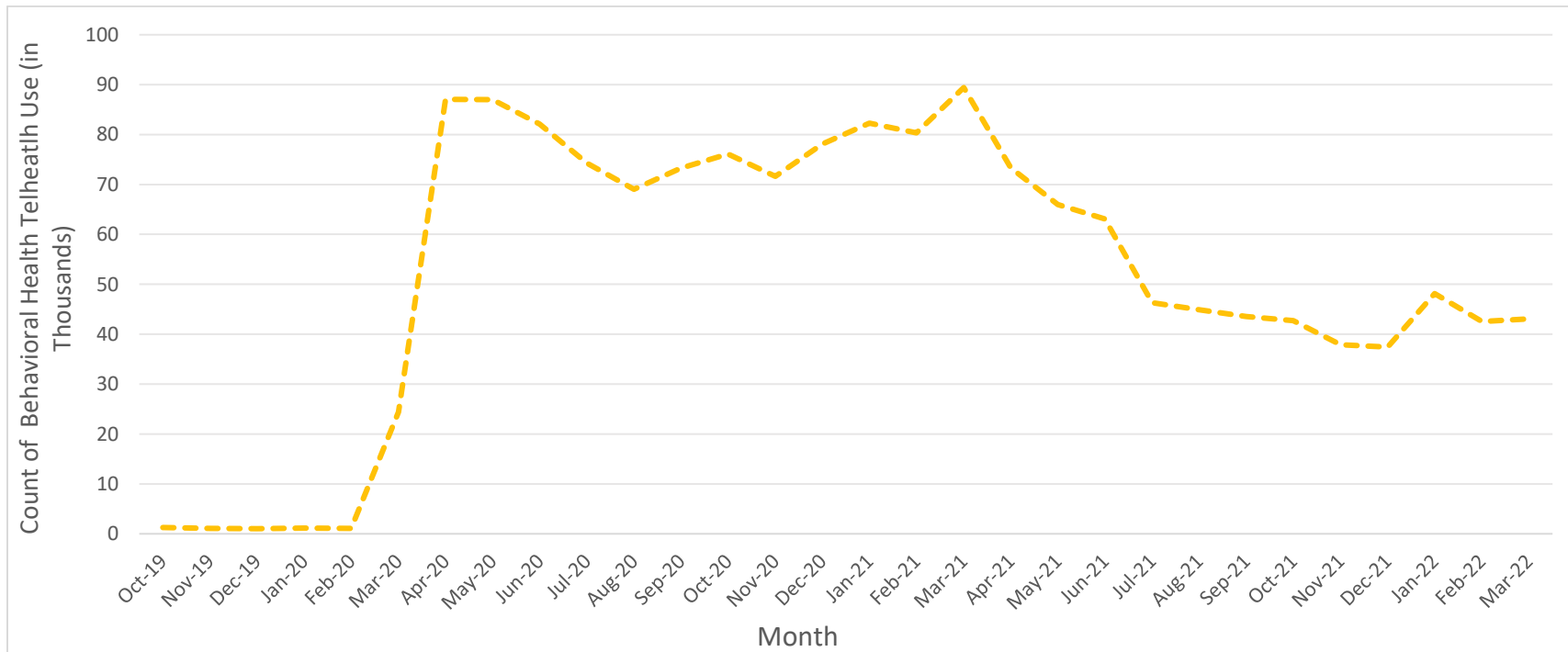
Telehealth (phone and videoconferencing) claims use for Washington Medicaid clients is collected by the Washington State Health Care Authority (HCA).

It is important to note the limited use of telehealth in Medicaid clients prior to the COVID-19 pandemic (March 2020), which could explain the significant increase in March and April 2020 (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 (March 2022) showed a 1.28% increase in telehealth behavioral health service claims for individuals 18 and younger (Graph 7).

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



Inpatient Community Hospital Discharges

The [Comprehensive Hospital Abstract Reporting System \(CHARS\)](#)⁸ collects record level information on inpatient and observation patient community hospital stays.

Caution should be taken when reviewing data as the “Stay Home, Stay Healthy” order (March 2020) may have impacted hospital discharge data. Only mental, behavioral, and neurodevelopmental disorders were evaluated (based on the individuals primary diagnoses included only ICD-10 F-codes)⁹ for this report.

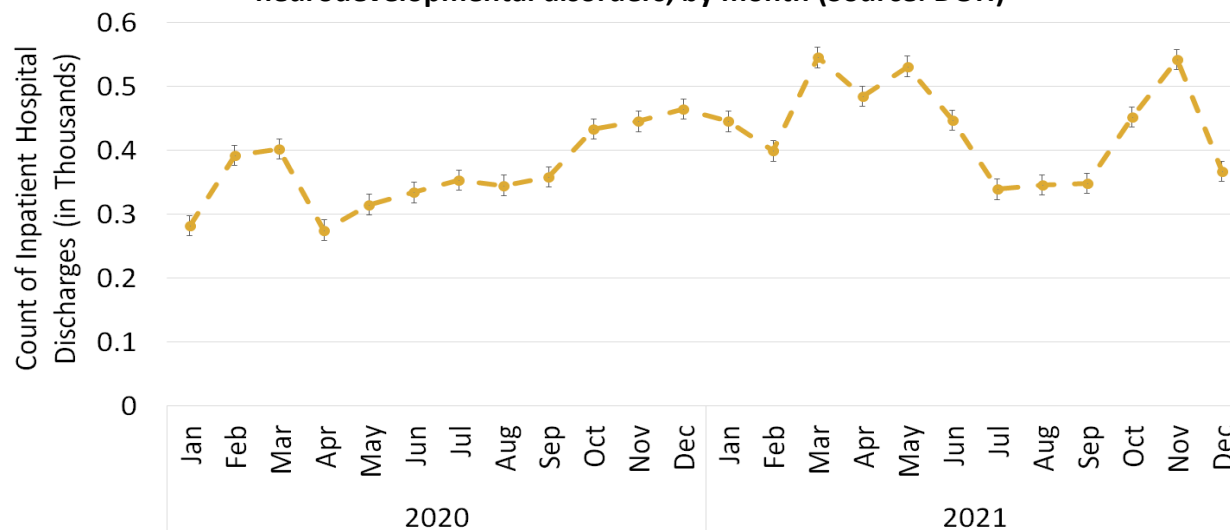
Due to time lag, data may not be complete. While non-Washington residents can be discharged from a Washington community hospital, only Washington residents were included in the analysis

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

⁸<https://www.doh.wa.gov/dataandstatisticalreports/healthcareinwashington/hospitalandpatientdata/hospitaldischargedatachars>

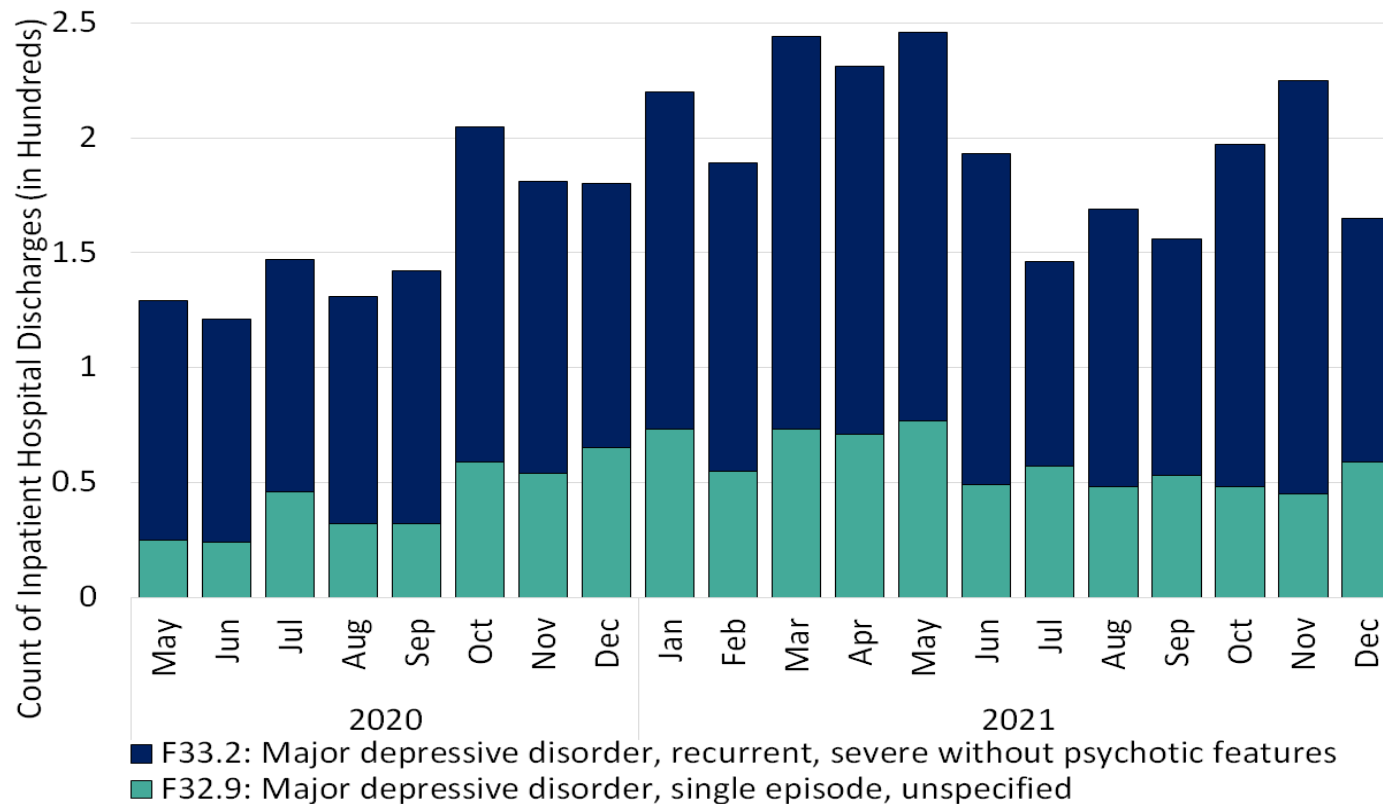
⁹ ICD-10 is the Tenth Revision of the International Classification of Disease and Related Health Problems published by the World Health Organization (WHO). F-codes are specifically related to mental, behavioral, and neurodevelopmental disorders.

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



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

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

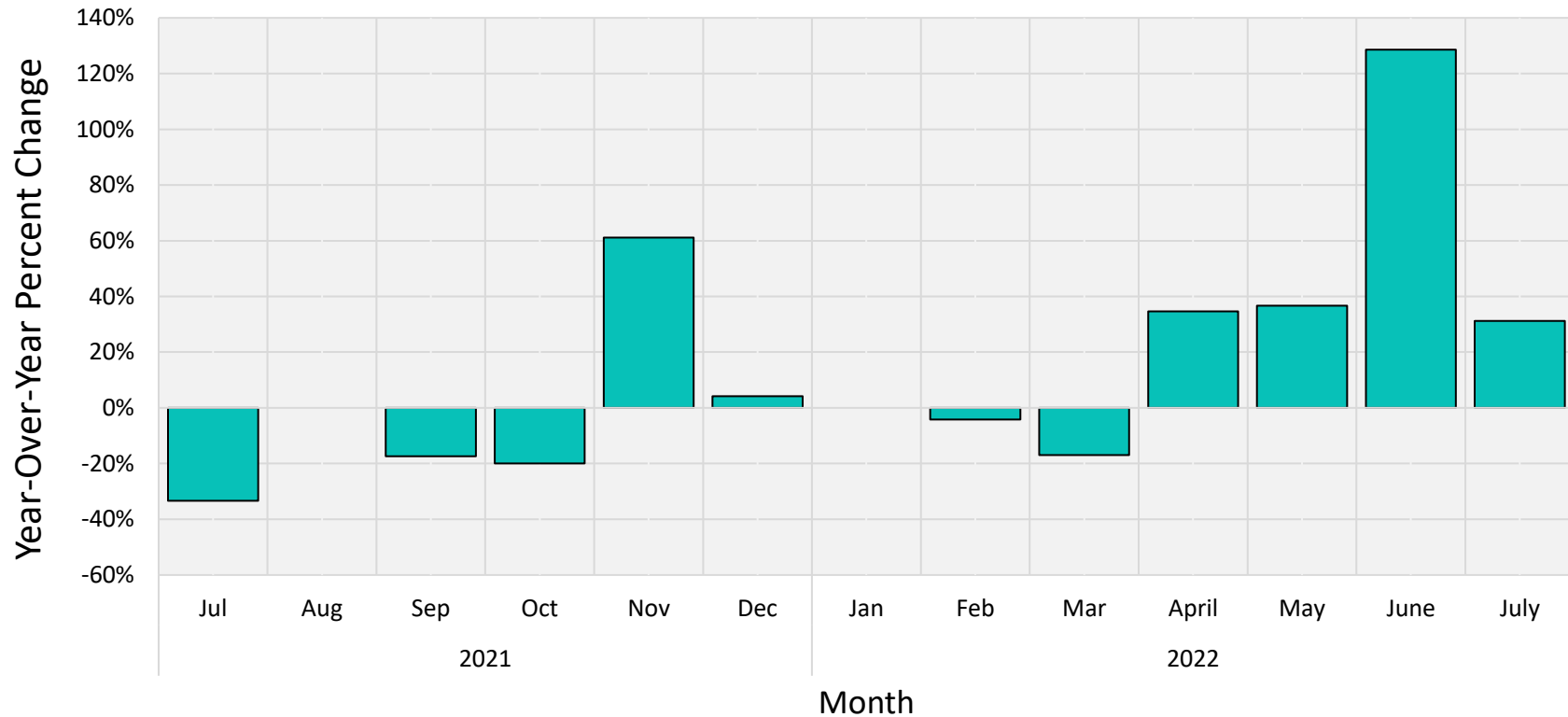


Court Reporting

Mental Illness (Minor) Filings

Monthly filings from the Administrative Office of the Courts (AOC) show the initiation of a court case by formal submission for mental illness (minor) cases. The year-over-year percent change in July 2022 for monthly mental illness (minor) case filings **increased 31%**, compared to the previous year (Graph 10).

Graph 10: Percent change of mental illness (minor) filings by month (Source: AOC)

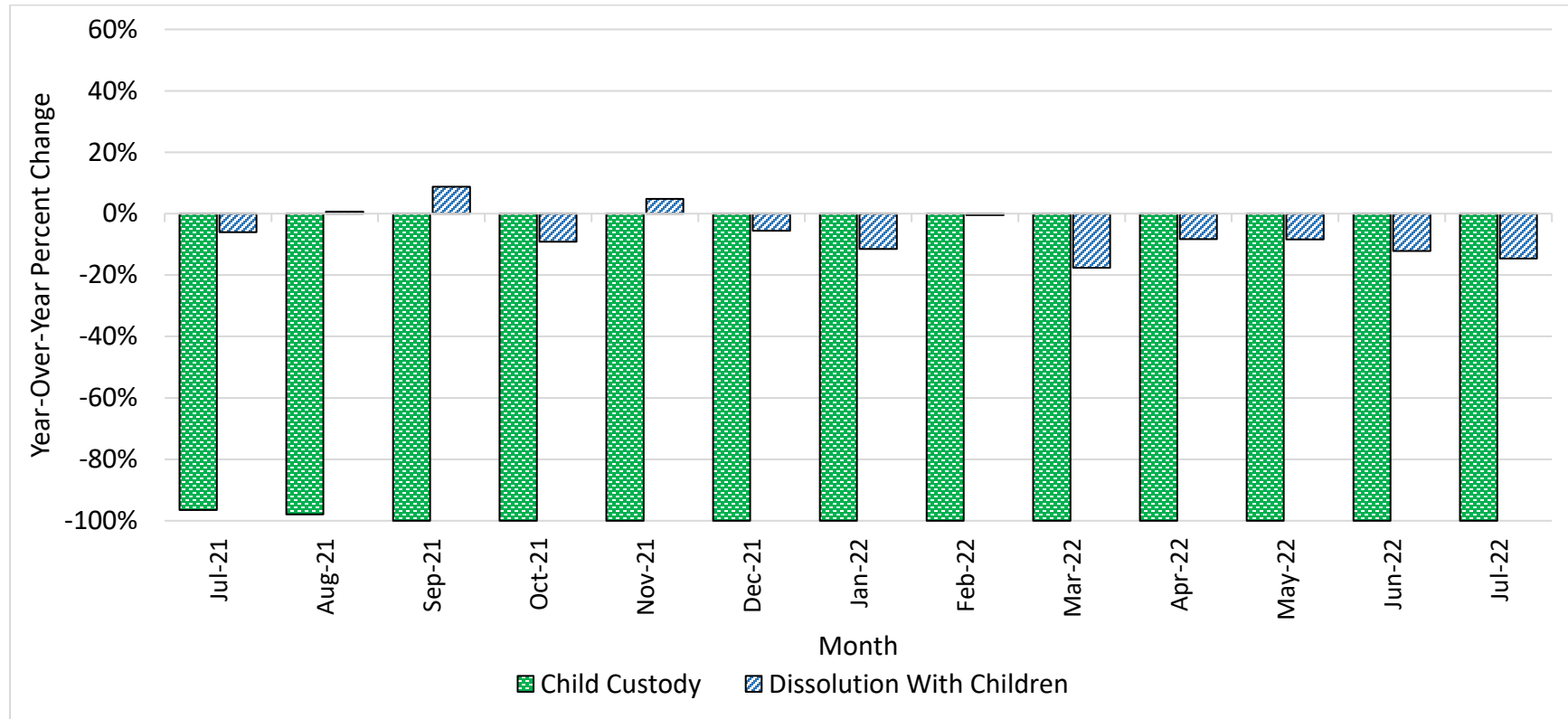


Note: Each unique mental illness case number is reported as a single filing, no matter how many subsequent petitions are filed during the life of a case. A case reopened for subsequent adjudication after the initial judgment is not considered a new filing unless there is a new case number. Mental illness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

Child Custody and Marriage Dissolution with Children Filings

Monthly filings from the AOC show the initiation of a court case by formal submission for child custody and marriage dissolution with children. The year-over-year¹⁰ percent change in July 2022 for monthly child custody case filings **decreased** 100% and dissolution with children **decreased** 14.63% compared to the previous year (Graph 11).

Graph 11: Percent change of child custody and marriage dissolution with children filings, by month (Source: AOC)



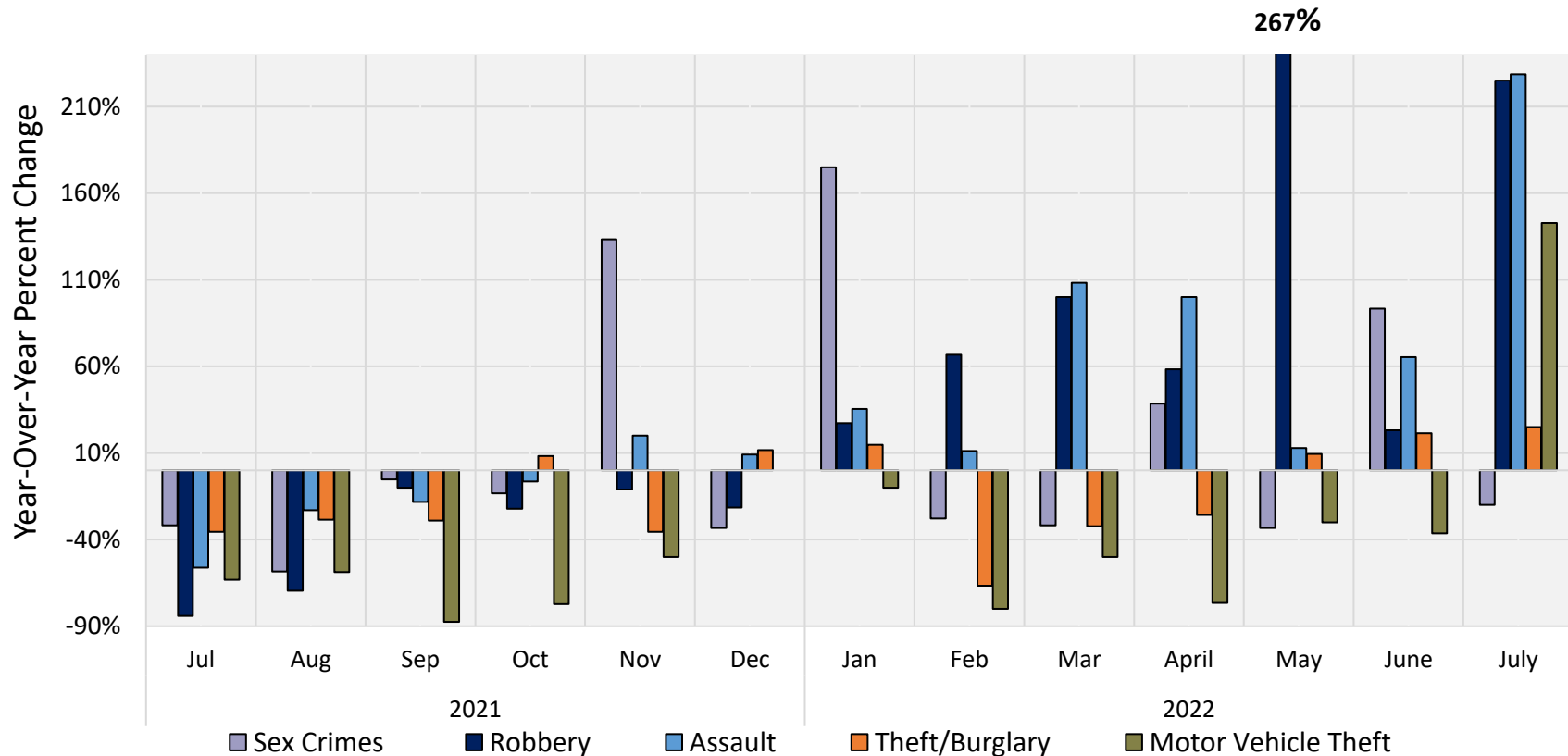
Note: Monthly filings from the AOC show the initiation of a court case by formal submission for child custody (i.e., dispute involving immediate charge and control of a child) and dissolution with children of the marriage (i.e., termination of a marriage other than by annulment, with dependent children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

¹⁰ Year-over-year: a comparison of data between multiple years, specifically 2021 to 2022.

Juvenile Offender Filings

Filings from the Washington State Administrative Office of the Courts (AOC) show the initiation of a court case by formal submission. Case filings occur for each juvenile offender and are categorized by the primary (i.e., most serious) charge. The year-over-year percent changes for July 2022 for these filings show sex crimes **decreased** 32%, robberies **increased** 58%, assaults **increased** 3%, thefts/burglaries **increased** 3%, and motor vehicle thefts **decreased** 31% compared to the previous year (Graph 12).

Graph 12: Percent change of juvenile offender filings, by charge and month (Source: AOC)

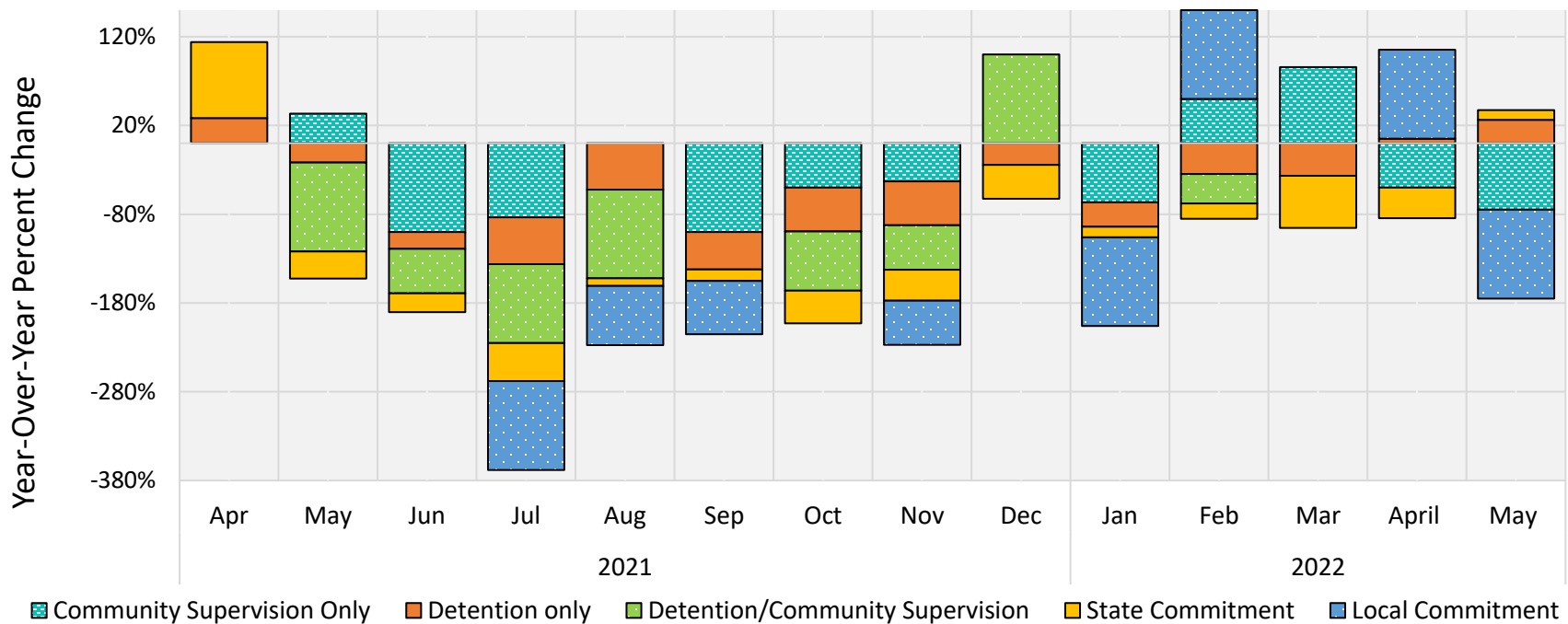


Note: **Sex crimes** involve sexual exploitation of a minor, incest, rape, statutory rape, or indecent liberties. **Robbery** involves theft of property by the use of force, violence, or fear of injury to a person or their property. **Assault** involves assault or intent to cause another person physical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

Juvenile Offender Case Completions and Sentences

AOC reports monthly juvenile offender case completions and sentences (counted only for defendants with a judgment of guilty) for sentences with conclusions that end with some form of institutionalization. Note that the length in criminal justice proceedings impacts timeliness of resolution. The year-over-year percent changes for May 2022 for state commitment **increased** 11%, detention-only **increased** 26%, local commitment **decreased** 100%, detention/community supervision **did not change** (0%), and community supervision only **decreased** 75% compared to the previous year (Graph 13). No updates were provided in the July data release.

Graph 13: Percent change of juvenile offender case completions and sentences, by type and month (Source: AOC)



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

Toxin Exposures

The National Capital for Poison Control (NCPC) tracks human exposures to any substance that could harm the body. This is often by swallowing, splashes 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.

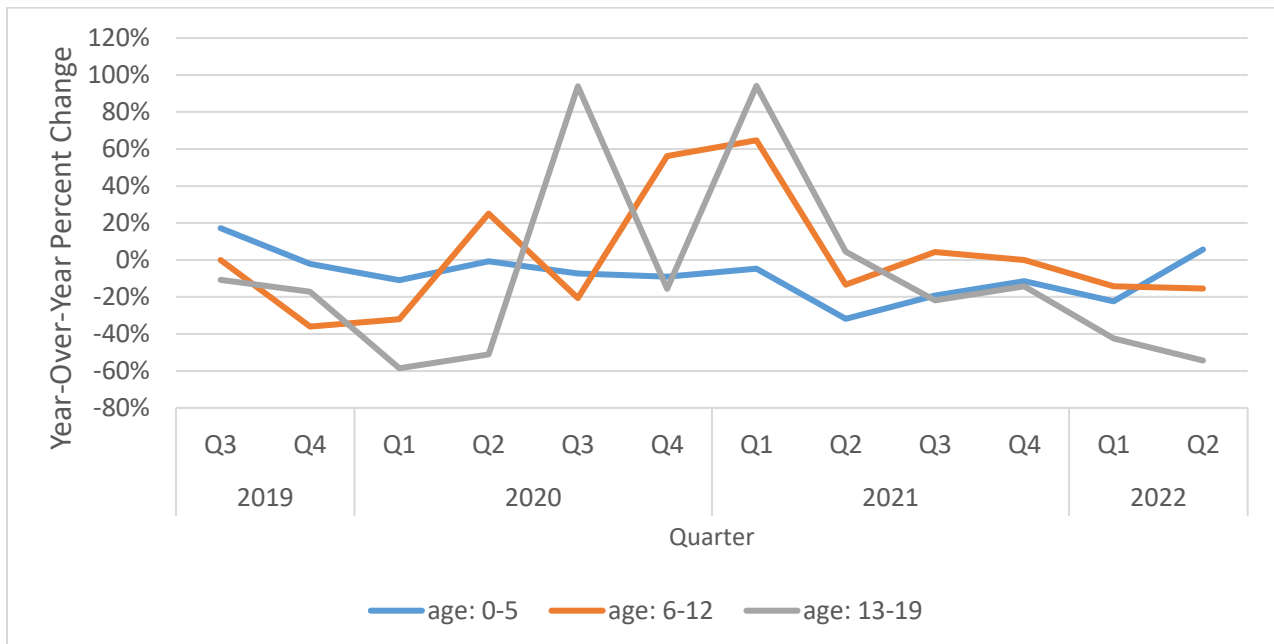
Exposure to a substance does not represent a poisoning or overdose, intentional or otherwise. The NCPC does not track self-harm, suicidal ideation, suicide attempts, or suicides that use a substance to perform the act.

For youth data (ages 0 – 19) collected for Quarter 2, 2022, there was an **increase** (11.33%) in total reported exposures compared to the previous reporting period (Quarter 1, 2022) per 100,000 individuals. There was an **increase** (13.27%) in exposures for youth ages 0 – 5, an **increase** (31.25%) in exposures for youth ages 6 – 12 and a **decrease** (-26.23%) in exposures for youth ages 13 – 19.

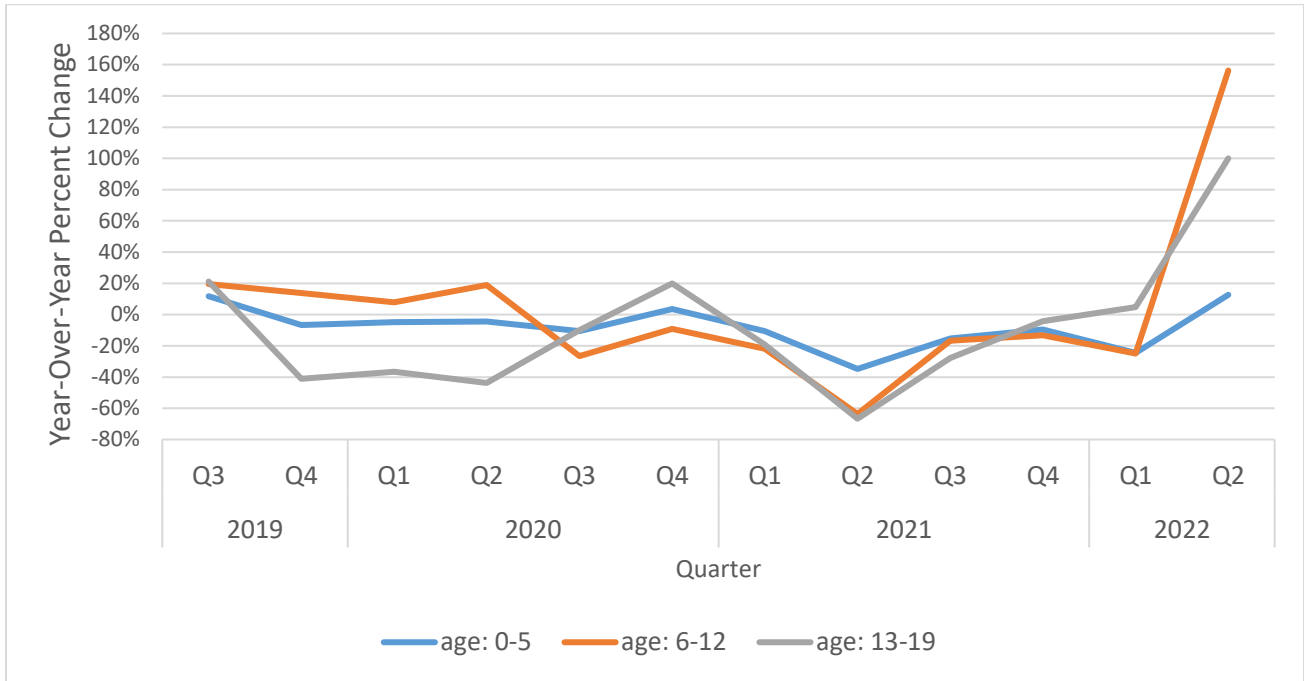
Graph 14 shows the year-over-year percent change in exposure reporting for females ages 0 – 19. Compared to the previous reporting period there was an **increase** (6.74%) in exposures for females ages 0 – 5, a **decrease** (-8.33%) in exposures for females ages 6 – 12, and a **decrease** (44.74%) in exposures for females ages 13 – 19.

Graph 15 shows the year-over-year percent change in exposure reporting for males ages 0 – 19. Compared to the previous reporting period there was an **increase** (20.46%) in exposures for males ages 0 – 5, an **increase** (70.83%) in exposures for males ages 6 – 12, and an **increase** (9.09%) in exposures for males ages 13 – 19.

Graph 14: Percent change of female Washington youth who reported an exposure to any substance, by month and age (Source: NCPC)



Graph 15: Percent change of male Washington youth who reported an exposure to any substance, by month and age (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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