

COVID-19 Youth Behavioral Health Impact Situation Report

This situation report presents the potential behavioral health impacts of the COVID-19 pandemic on Washington youth¹ to inform planning efforts. 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 on youth in Washington.

Purpose

On March 15, 2021, Governor Jay Inslee signed an [emergency proclamation](#)² recognizing the current mental and behavioral health emergency among Washington’s children and youth. The proclamation directs the Department of Health (DOH) and other state agencies to “identify and provide appropriate personnel for conducting necessary and ongoing incident related assessments.”

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

¹ Youth: Individuals ages 18 years and younger

² https://www.governor.wa.gov/sites/default/files/proclamations/21-05_Children%27s_Mental_Health_Crisis_%28tmp%29.pdf

Key Takeaways

- Youth behavioral health is of particular concern as family, school, and social interactions continue to be affected by the COVID-19 pandemic.
- The rate of emergency department (ED) visits for two syndromic indicators (psychological distress and suicidal ideation) for Washington youth increased from the previous reporting period, while the rates for suspected suicide attempts and drug-related ED visits decreased from the previous reporting period.
 - **Caution should be taken when examining these data as the steep drop in ED visits starting in March 2020 could skew data for any type of ED visit, including behavioral health.**
 - For inpatient community hospital discharges for mental, behavioral, and neurodevelopmental disorders, the most recent reporting period (August 2021) showed a 7.3% decrease for youth, compared to the previous month.
 - For monthly juvenile offender filings, there was a year-over-year percent decrease in September 2021 for all monthly juvenile offender filings with a 5% decrease in sex crimes, 10% decrease in robberies, an 18% decrease in assaults, a 29% decrease in thefts/burglaries, and an 88% decrease in motor vehicle thefts

Impact Assessment

This section summarizes data analyses that show the likely current and future impacts of the COVID-19 pandemic on mental health and potential for substance use issues among youth in Washington.

Syndromic Surveillance

The Department of Health collects syndromic surveillance data in near real time from hospitals and clinics across Washington. Key data elements reported include patient demographic information, chief complaint, and coded diagnoses. This [data collection system](#)³ is the only source of ED data for Washington. Statistical warnings and alerts are raised when a CDC algorithm detects a weekly count at least three standard deviations⁴ above a 28-day average count, ending three weeks prior to the week with a

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

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

warning or alert. While both warnings and alerts indicate more visits than expected, an alert indicates more caution may be warranted.⁵ These warnings or alerts will be mentioned within each respective syndrome section.

This report summarizes data for four syndromic surveillance indicators:

- 1) Psychological distress
- 2) Suicidal ideation
- 3) Suspected suicide attempts
- 4) Suspected overdoses

The graphs provide insight into behavioral health impacts of COVID-19 on Washington youth, as well as changes in care-seeking behavior. It is important to consider the changes in the overall number of ED visits, beginning with the implementation of the “Stay Home, Stay Healthy” order on March 23, 2020 ([CDC Week⁶ 13, 2020](#)).

Because the volume of visits across care settings varied widely during 2020 and to date in 2021, rates presented in this report may not reflect the true magnitude and direction of trends for behavioral health conditions and should be interpreted cautiously. Caution should be taken as the steep drop in total ED visits could skew data for any type of ED visit. While the number of ED visits is increasing, visits have not returned to pre-March 2020 ED numbers. In addition, ED visit counts for suicidal ideation, suspected suicide attempts, psychological distress, and suspected overdoses might show an increase in awareness of mental health experiences, thus taking a larger share of the total ED visits.

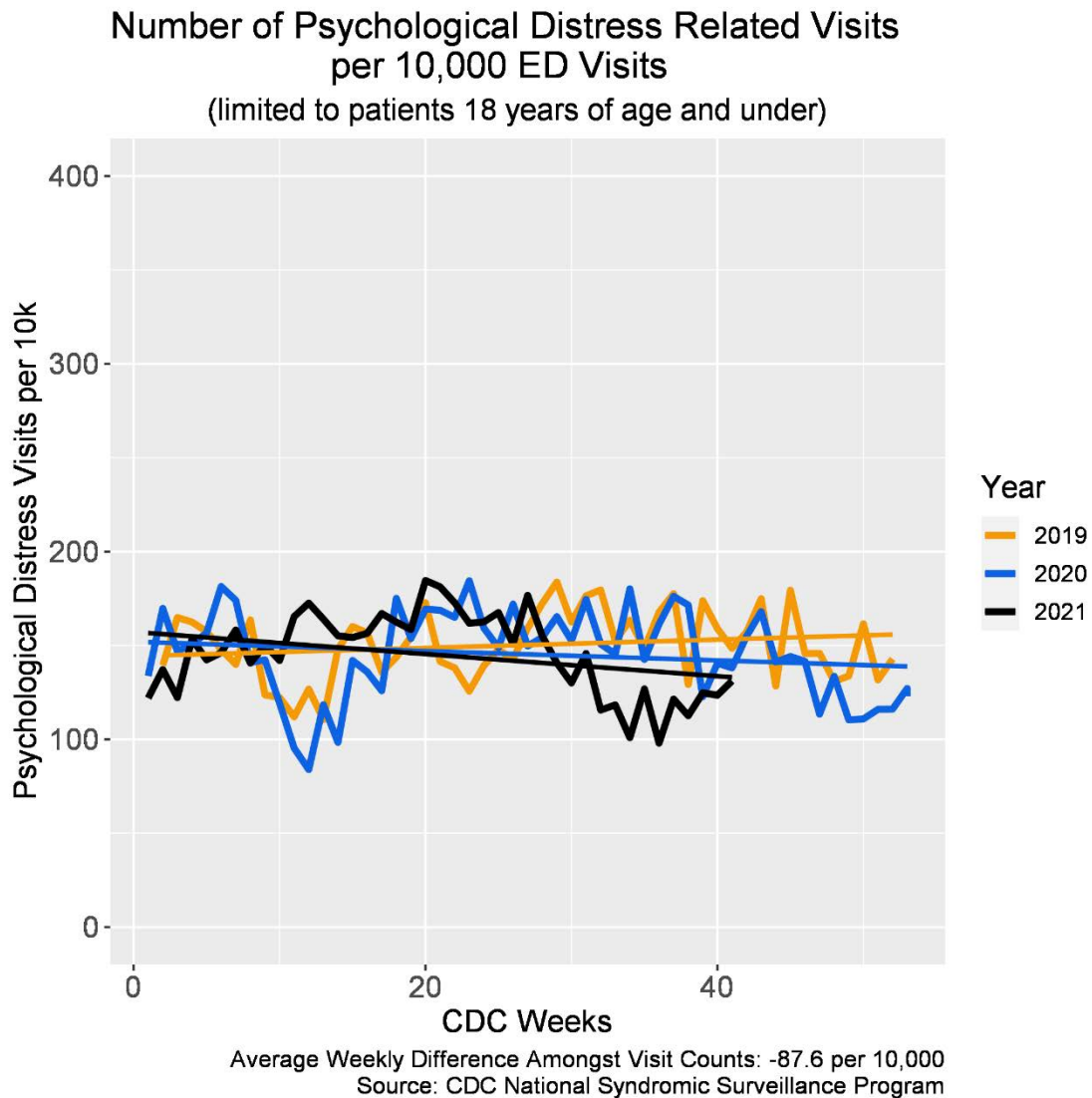
⁵ A warning is determined by statistical analysis using p-values from 0.01 – 0.05, while an alert is determined by statistical analysis using p-values of less than 0.01.

⁶ <https://wwwn.cdc.gov/nndss/document/2020.pdf>

Psychological Distress

CDC Week 40 (week of October 3) the relative reported ED visits for psychological distress⁷ among youth **increased from the previous reporting period** and is lower than rates in the corresponding week of 2019 and 2020 (Graph 1). No statistical warnings or alerts were issued.

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



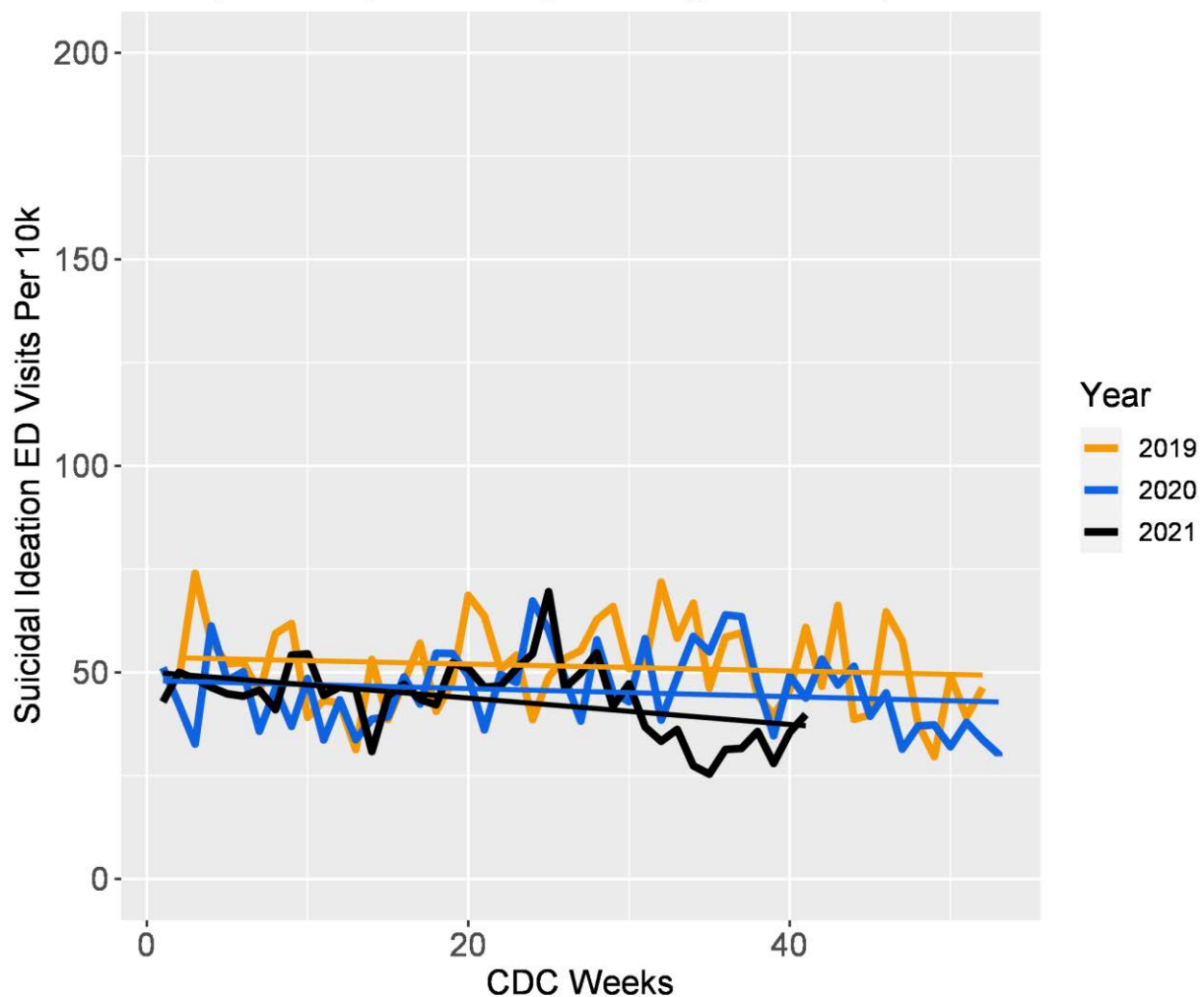
⁷ Psychological distress in this context is considered a disaster-related syndrome comprised of panic, stress, and anxiety. It is indexed in the Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE) platform as Disaster-related Mental Health v1. Full details are available at <https://knowledgerepository.syndromicsurveillance.org/disaster-related-mental-health-v1-syndrome-definition-subcommittee>.

Suicidal Ideation and Suspected Suicide Attempts

During **CDC Week 40 (week of October 3)**, the **relative reported rate of ED visits for suicidal ideation** among youth **increased from the previous reporting period** and is lower than the rates in the corresponding week of 2019 and 2020 (Graph 2). Statistical alerts for ages 18 years and under was issued for CDC Week 38 (week of September 19), CDC Week 39 (week of September 26), and CDC Week 40.

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

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

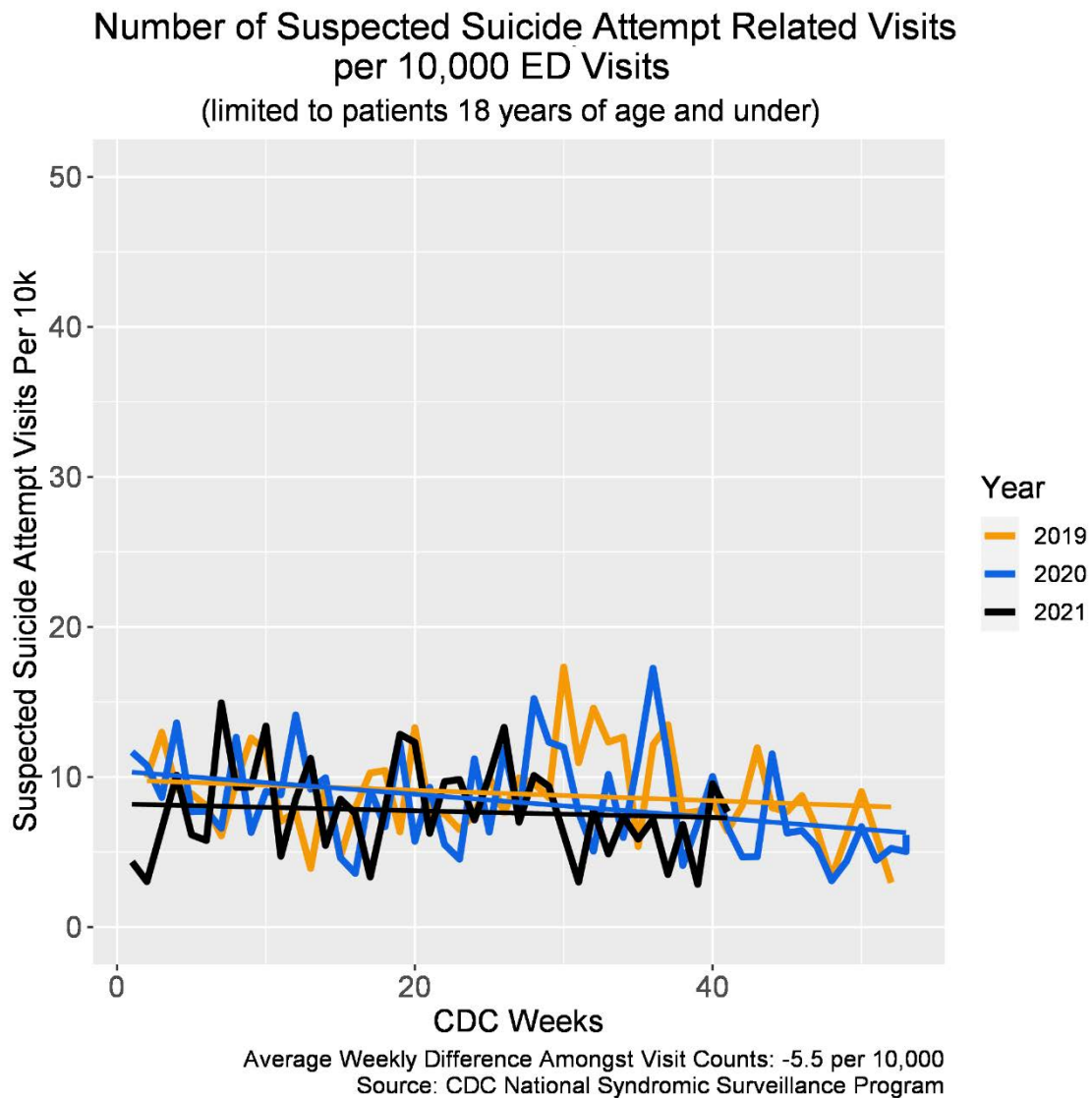


Average Weekly Difference Amongst Visit Counts: -30.8 per 10,000
Source: CDC National Syndromic Surveillance Program

During **CDC Week 40 (week of October 3)**, the **relative reported rate of ED visits for suspected suicide attempts** among youth **decreased from the previous reporting period** and has converged with the corresponding week of 2020 but lower than the corresponding week of 2019 (Graph 3). Statistical alerts for ages 18 years and under was issued for CDC Week 38 (week of September 19) and CDC Week 39 (week of September 26).

The current CDC definition for suspected suicide attempt, due to its broad inclusion of intentional self-harm behaviors that may or may not be interpreted as a suicidal act, could artificially inflate both the count and rate of such visits.⁸

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

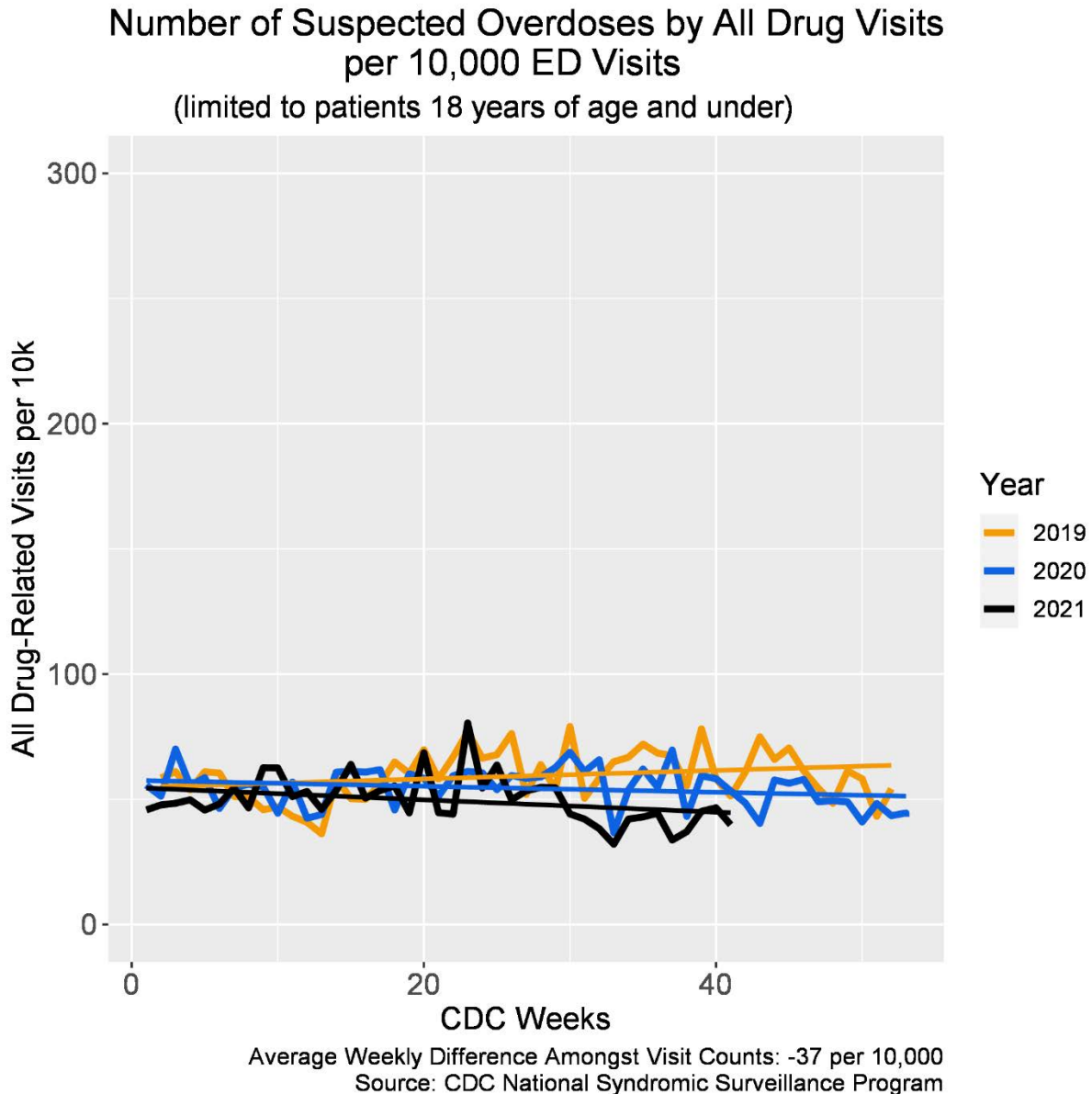


⁸ <https://knowledgerepository.syndromicsurveillance.org/disaster-related-mental-health-v1-syndrome-definition-subcommittee>

Substance Use – Suspected Drug Overdose

During **CDC Week 40 (week of October 3)**, the **relative reported rate of ED visits for suspected drug overdose** among youth **decreased from the previous reporting period** and is lower than rates in the corresponding week of 2019 and 2020 (Graph 4). No statistical warnings or alerts were issued.

Graph 4: Relative ED count for all drug⁹-related visits among youth in Washington, by week: 2019, 2020, and 2021 to date (Source: CDC ESSENCE)



⁹ 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 12-17

[Survey data](#)¹⁰ collected by the U.S. Census Bureau for July 21 – October 11, 2021 show that the greatest number of respondents (who are Washington adults with children ages 12 to 17) indicated that, in the most recent reporting period (September 29 – October 11, 2021) children ages 12 to 17 have received the COVID-19 vaccine (64.6%), a 5.4% decrease from the last reporting period (September 15 – 27, 2021). 22.8% of respondents (who are Washington adults with children ages 12 to 17) who did not receive a COVID-19 vaccine reported that they will definitely not get a vaccine (an 83.4% increase from the last reporting period), while 5.3% of respondents (who are Washington adults with children ages 12 to 17) who did not receive a COVID-19 vaccine reported that they will probably not get a vaccine (a 180.3% increase from the last reporting period). 26.3% and 5.8% of respondents (who are Washington adults with children ages 12 to 17) who did not receive a COVID-19 vaccine reported that they will definitely get a vaccine (an 80.7% decrease from the last reporting period) or probably get a vaccine (a 39.3% decrease from the last reporting period), respectively (Graph 5).

For respondents (who are Washington adults with children ages 12 to 17) or household members who experienced loss of employment income in the last four weeks, 8% of those individuals reported that they will probably not get a vaccine, 31% of those individuals reported that they will definitely not get a vaccine, and 13% of those individuals reported that they will definitely get a vaccine.

In terms of “definitely” getting a vaccine:

- Highest rate is with respondents in households earning \$35,000 - \$50,000 per year (9%),
- while the second highest rate is with respondents in households who did not report earning (8%).

In terms of “probably” getting a vaccine:

- Highest rate is with respondents in households earning less than \$25,000 per year (29%),
- while the second highest rate is with respondents in households earning \$35,000 - \$50,000 (9%).

In terms of “unsure” getting a vaccine:

- Highest rate is with respondents in households earning less than \$25,000 per year (54%),

¹⁰ <https://www.census.gov/programs-surveys/household-pulse-survey.html>

- while the second highest rate is with respondents in households earning \$25,000 - \$35,000 (21%).

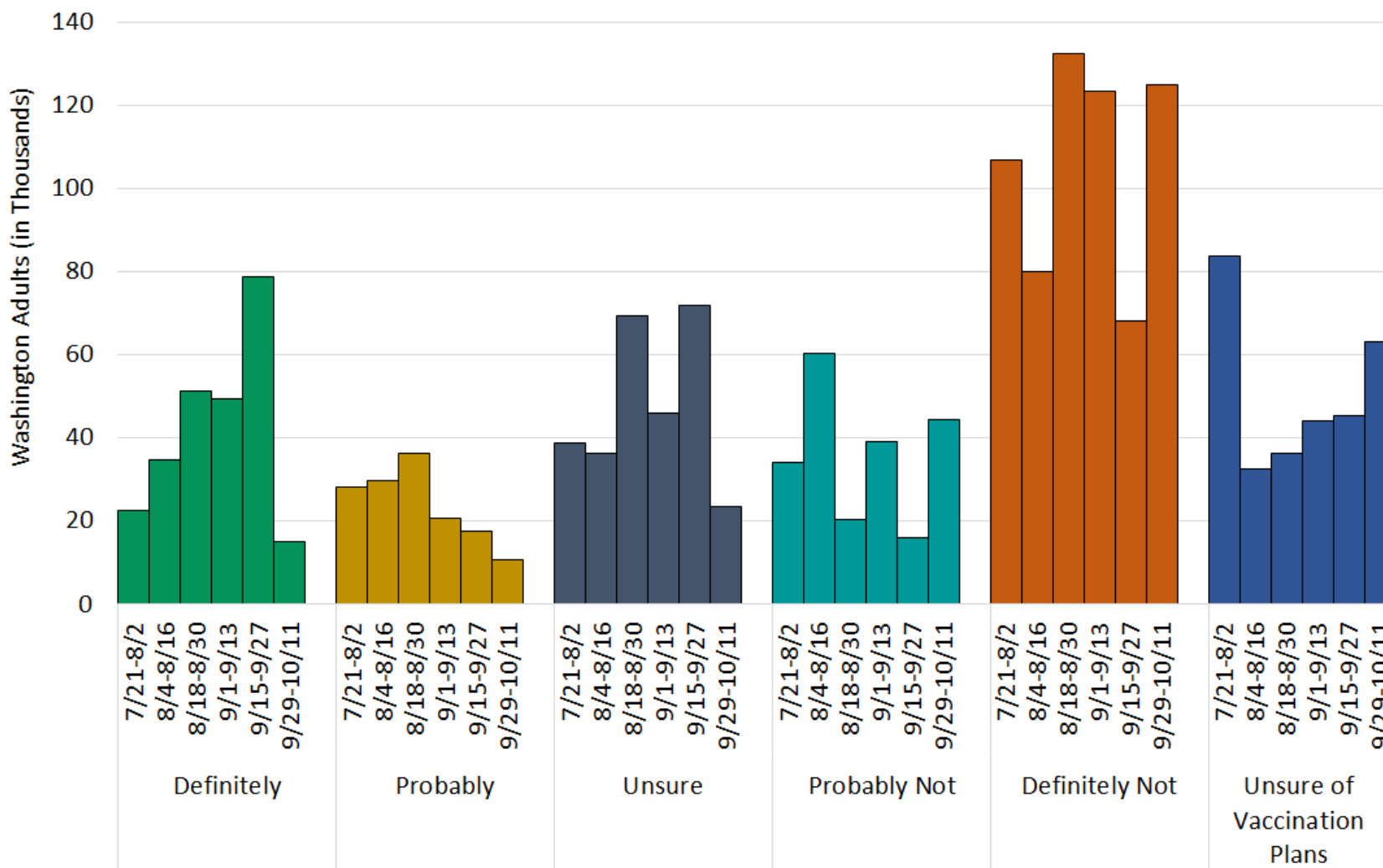
In terms of “probably not” getting a vaccine:

- Highest rate is with respondents in households earning \$100,000 - \$150,000 per year (44%),
- while the second highest rate is with respondents in households earning \$50,000 - \$75,000 per year (31%).

In terms of “definitely not” getting a vaccine:

- Highest rate is with respondents in households earning \$150,000 - \$200,000 per year (100%),
- while the second highest rate is with respondents in households earning \$50,000 - \$75,000 (69%).

**Graph 5: Count of Washington adults reporting children’s vaccination plans, by week:
July 21 – October 11, 2021 (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 to 17 who received a COVID-19 vaccine are not graphically included.

Reasons for children (ages 12 to 17) not receiving or planning to receive a COVID-19 vaccine

[Survey data](#)¹⁰ further show reasons for children (ages 12 to 17) not receiving or planning to receive a COVID-19 vaccine from July 21 – October 11, 2021 (Graph 6). In the most recent reporting period (September 29 – October 11, 2021), 17% of Washington adults with children (ages 12 to 17) reported being concerned about possible side effects for children, compared to 22% in the previous reporting period (September 15 – 27, 2021), 11% of Washington adults with children (ages 12 to 17) reported not believing children need a vaccine, compared to 10% in the previous reporting period (September 15 – 27, 2021), 14% of Washington adults with children (ages 12 to 17) reported not trusting the government, compared to 12% in the previous reporting period (September 15 – 27, 2021), 16% of Washington adults with children (ages 12 to 17) reported not trusting the COVID-19 vaccine, compared to 14% in the previous reporting period (September 15 – 27, 2021), and 10% of Washington adults with children (ages 12 to 17) reported planning to wait and see if the vaccines are safe, compared to 14% in the previous reporting period (September 15 – 27, 2021).

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

- Highest rate is with respondents in households earning \$200,000 and above per year (23%),
- while the second highest rate is with respondents in households earning less than \$25,000 (20%).

In terms of “planning to wait and see if it is safe”:

- Highest rate is with respondents in households earning \$25,000 - \$35,000 per year (11%),
- while the second highest rate is with respondents in households with earnings not reported (6%).

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

- Highest rate is with respondents in households earning \$100,000 - \$150,000 per year (18%),
- while the second highest rate is with respondents in households earning \$35,000 and \$50,000 and \$75,000 - \$100,000 per year (16%).

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

- Highest rate is with respondents in households with earnings not reported (19%),
- while the second highest rate is with respondents in households earning less than \$25,000 per year (9%).

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

- Highest rate is with respondents in households earning \$150,000 - \$200,000 per year (21%),
- while the second highest rate is with respondents in households earning 50,000 - \$75,000 per year (19%).

In terms of “not trusting the government”:

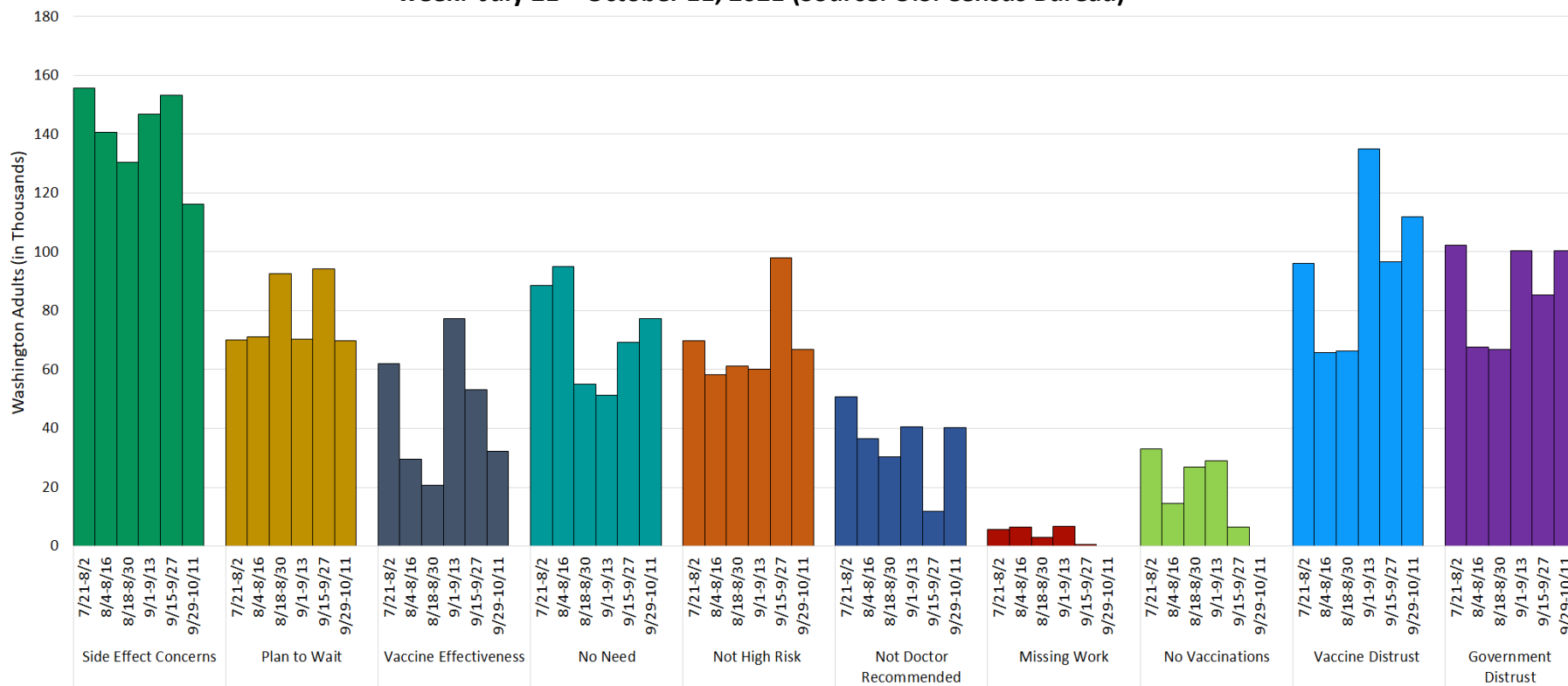
- Highest rate is with respondents in households earning \$200,000 and above per year (9%),
- while the second highest rate is with respondents in households earning \$25,000 - \$35,000 per year (3%).

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

- Highest rate is with respondents in households earning \$200,000 and above per year (29%),
- while the second highest rate is with respondents in households earning \$50,000 - \$75,000 per year (12%).
- [Note, COVID-19 vaccines are provided at no cost. The federal government will cover the cost of the COVID-19 vaccine.](#)¹¹

¹¹ <https://www.doh.wa.gov/Emergencies/COVID19/VaccineInformation/VaccineCost>

Graph 6: Count of Washington adults reporting reasons for children not receiving or planning to receive a COVID-19 vaccine, by week: July 21 – October 11, 2021 (Source: U.S. Census Bureau)

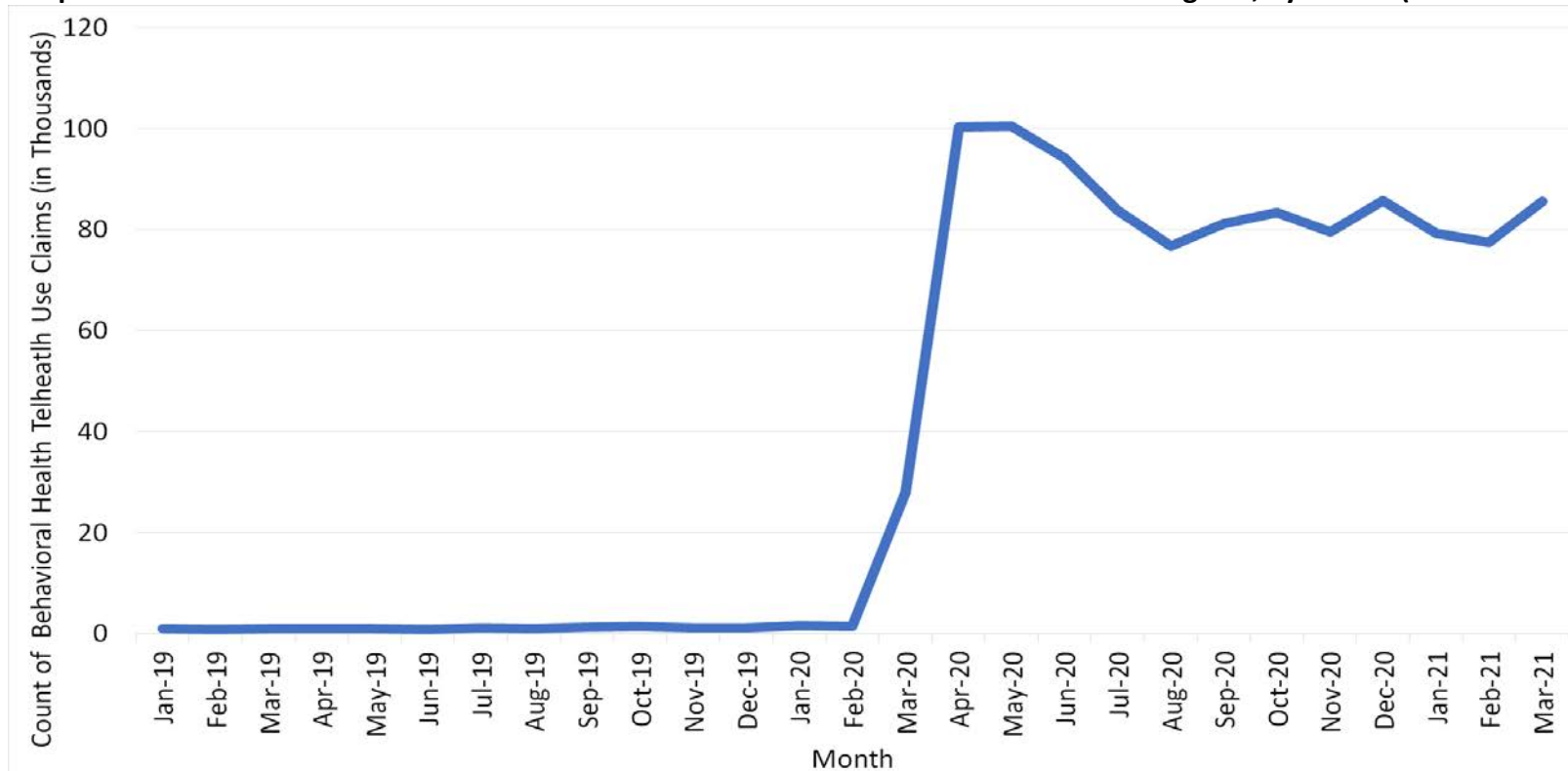


Note: **Side Effect Concerns** (concerned about possible side effects for children); **Plan to Wait** (plan to wait and see if it is safe); **Vaccine Effectiveness** (not sure if vaccine will work for children); **No Need** (don't believe children need a vaccine); **Not High Risk** (children in household not members of a high risk group); **Not Doctor Recommended** (children's doctor has not recommended a vaccine); **Missing Work** (concerned about missing work to have children vaccinated); **No Vaccinations** (parents or guardians do not vaccinate their children); **Vaccine Distrust** (don't trust COVID-19 vaccines); **Government Distrust** (don't trust the government). Responses also included "Other people need it more than children right now," "Unable to get a vaccine for children," "Other," and "Concerned about cost of vaccine" but due to low numbers, these responses were not graphically included. Please note that 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). Graph 7 provides a count of telehealth behavioral health services use claims. It is important to note the limited use of telehealth in Medicaid clients prior to COVID-19 (March 2020), which could explain the significant increase in March and April 2020. Caution should be taken when reviewing data as the “Stay Home, Stay Healthy” order may have impacted telehealth use. Additionally, due to the significant need for telehealth, several changes were made to policies, coverage, and implementation that could impact this data. The most recent reporting period (March 2021) showed an 11% increase in telehealth behavioral health service claims for individuals 18 and younger.

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

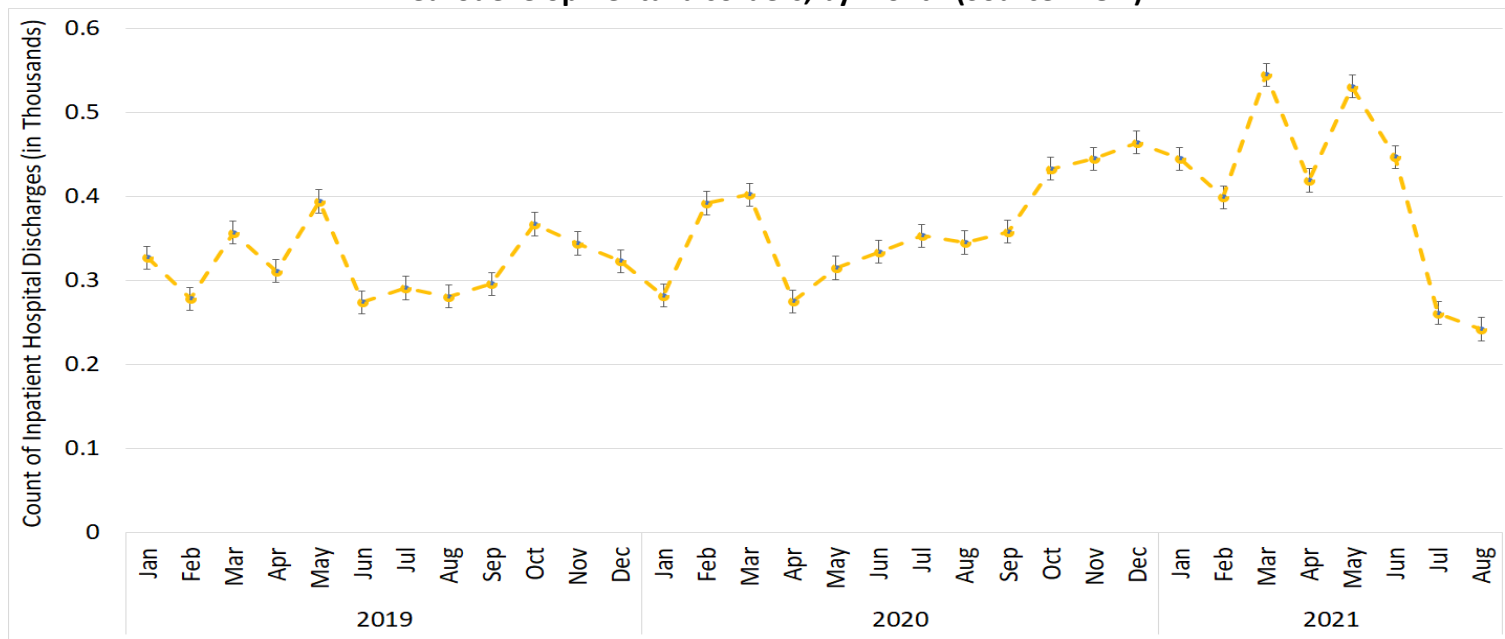


Note: Due to missing or suppressed data, results may be underreported.

Inpatient Community Hospital Discharges

The [Comprehensive Hospital Abstract Reporting System \(CHARS\)](#)¹² collects record level information on inpatient community hospital stays. Caution should be taken when reviewing data as the “Stay Home, Stay Healthy” order (March 2020) may have impacted hospital discharge data. Only mental, behavioral, and neurodevelopmental disorders were evaluated (i.e., primary diagnoses included only ICD-10 F-codes¹³). Graph 8 shows the count of youth inpatient community hospital discharges for mental, behavioral, and neurodevelopmental disorders. The most recent reporting period (August 2021) showed a 7.3% decrease for youth, compared to the previous month.

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



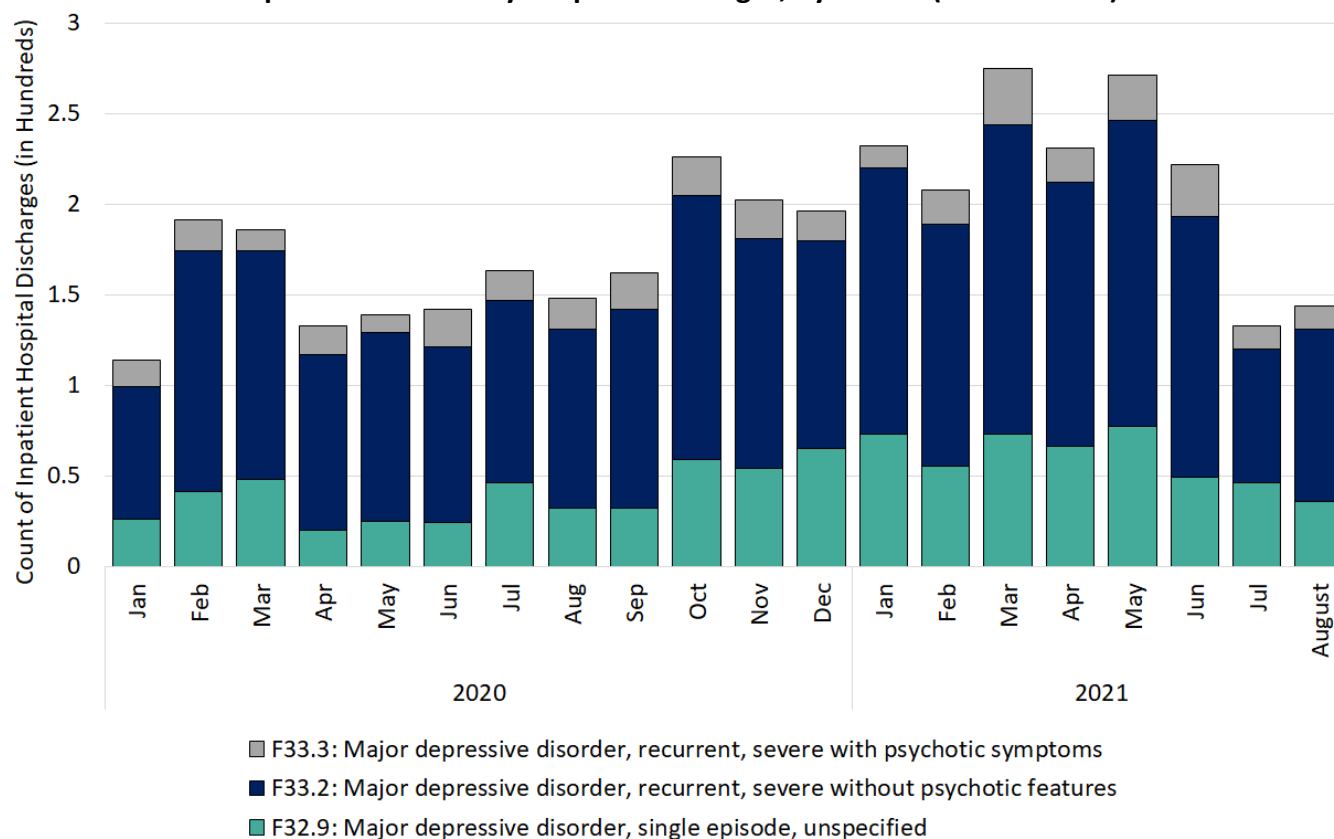
Note: Due to time lag, data might not be fully mature. While non-WA residents can discharge from a WA community hospital, only WA youth residents were included in the analysis. Only F-codes as primary diagnoses were included in the analysis.

¹² <https://www.doh.wa.gov/dataandstatisticalreports/healthcareinwashington/hospitalandpatientdata/hospitaldischargedatachars>

¹³ ICD-10 is the Tenth Revision of the International Classification of Disease and Related Health Problems published by the World Health Organization (WHO). F-codes are specifically related to mental, behavioral, and neurodevelopmental disorders.

Graph 9 shows the count of the top four mental, behavioral, and neurodevelopmental disorders in terms of inpatient community hospital discharges. The most recent reporting period showed a decrease in all four mental, behavioral, and neurodevelopmental disorders. There was a 21.7% decrease in “major depressive disorder, single episode, unspecified” inpatient community hospital discharges; a 28.4% increase in “major depressive disorder, recurrent, severe without psychotic features” inpatient community hospital discharges; and virtually no percent change in “major depressive disorder, recurrent, severe with psychotic symptoms” inpatient community hospital discharges.

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



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

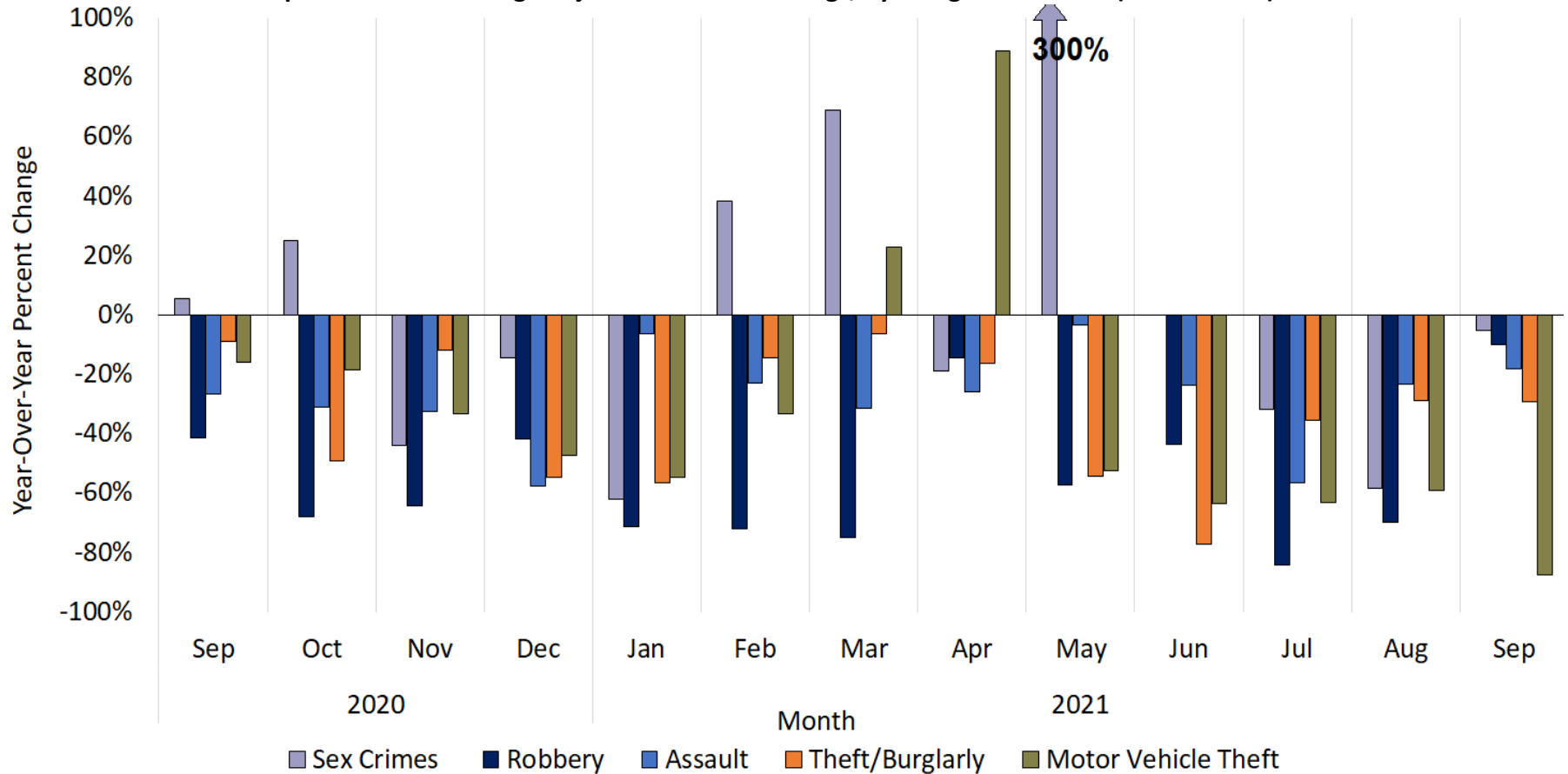
Court Reporting

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

Juvenile Offender Filings

Monthly filings from the Washington State Administrative Office of the Courts (AOC) show the initiation of a court case by formal submission. Case filings occur for each juvenile offender and are categorized by the primary (i.e., most serious) charge (e.g., homicide, sex crime, robbery, assault, theft/burglary, and motor vehicle theft). Year-over-year percent change of monthly juvenile offender filings (regardless of most serious charge) decreased from March 2020 – May 2020. Most recently, there was a year-over-year percent decrease in September 2021 for all monthly juvenile offender filings with a 5% decrease in sex crimes, 10% decrease in robberies, an 18% decrease in assaults, a 29% decrease in thefts/burglaries, and an 88% decrease in motor vehicle thefts (Graph 10).

Graph 10: Percent change of juvenile offender filings, by charge and month (Source: AOC)

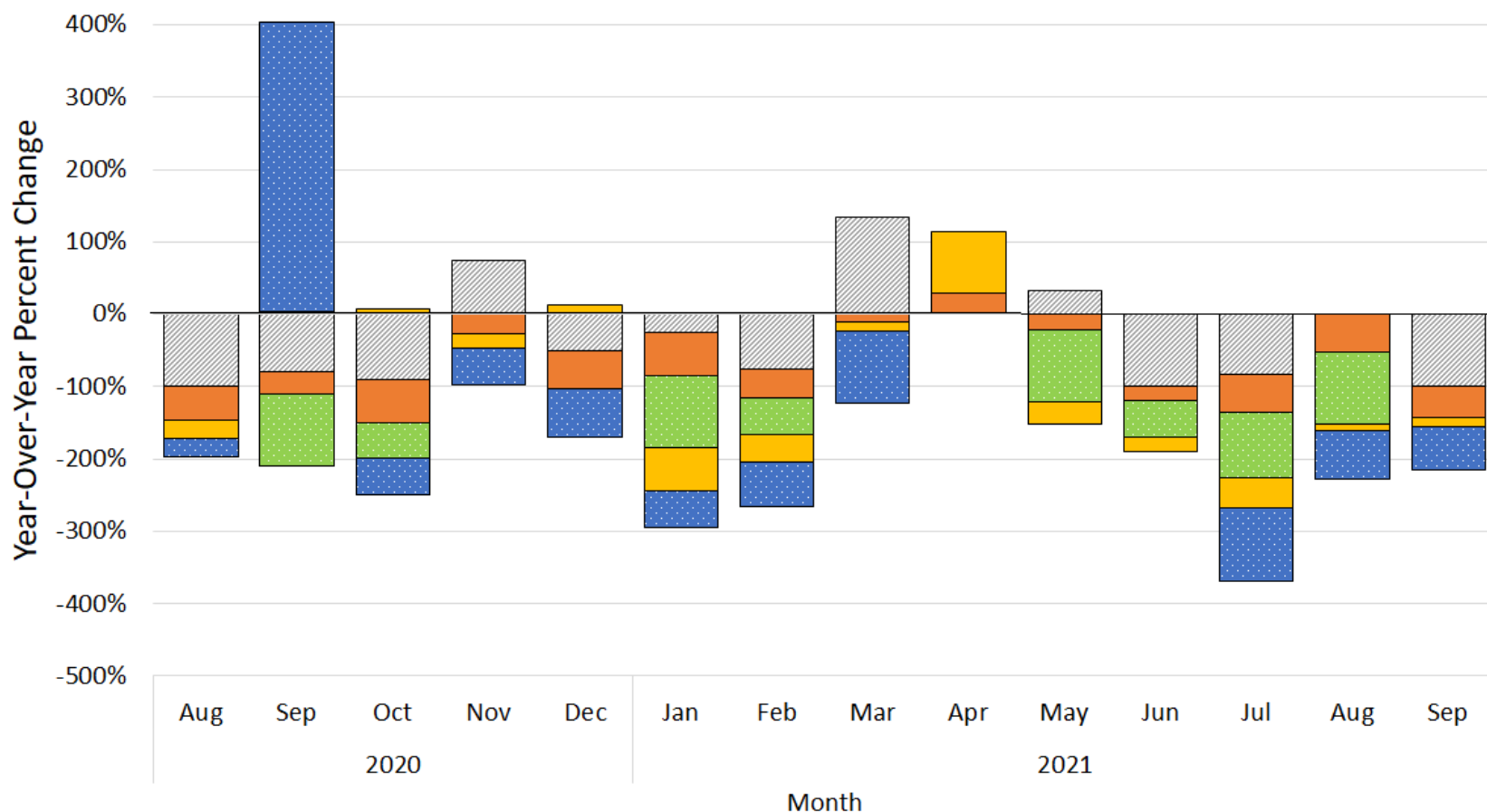


Note: **Sex crimes** involve sexual exploitation of a minor, incest, rape, statutory rape, or indecent liberties. **Robbery** involves theft of property by the use of force, violence, or fear of injury to a person or their property. **Assault** involves assault or intent to cause another person physical 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. Year-over-year percent change of monthly juvenile offender case completions and sentences decreased from March 2020 – May 2020. Most recently, there was a year-over-year percent decrease in September 2021 for state commitment (-13%), local commitment (-60%), community supervision (-100%), and detention only (-42%). (Graph 11).

Graph 11: Percent change of juvenile offender case completions and sentences, by type and month (Source: AOC)



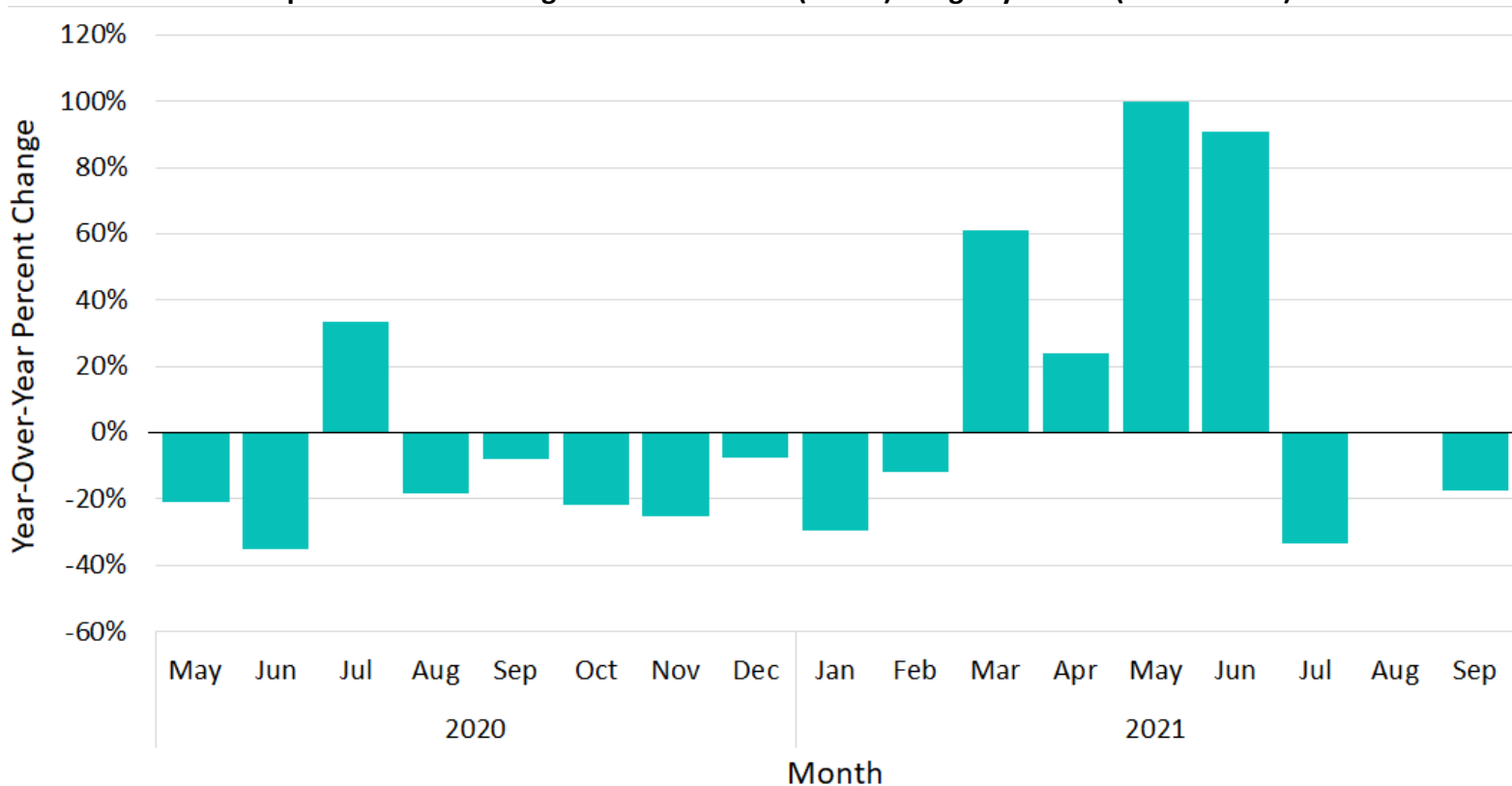
Community Supervision Only
 Detention only
 Detention/Community Supervision
 State Commitment
 Local Commitment

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.

Mental Illness (Minor) Filings

Monthly filings from the AOC show the initiation of a court case by formal submission for mental illness (minor) cases. Year-over-year percent change of monthly mental illness (minor) case filings decreased from March 2020 – June 2020. There was a year-over-year percent decrease change in September 2021 for monthly mental illness (minor) case filings (-17%), compared to the previous year (Graph 12).

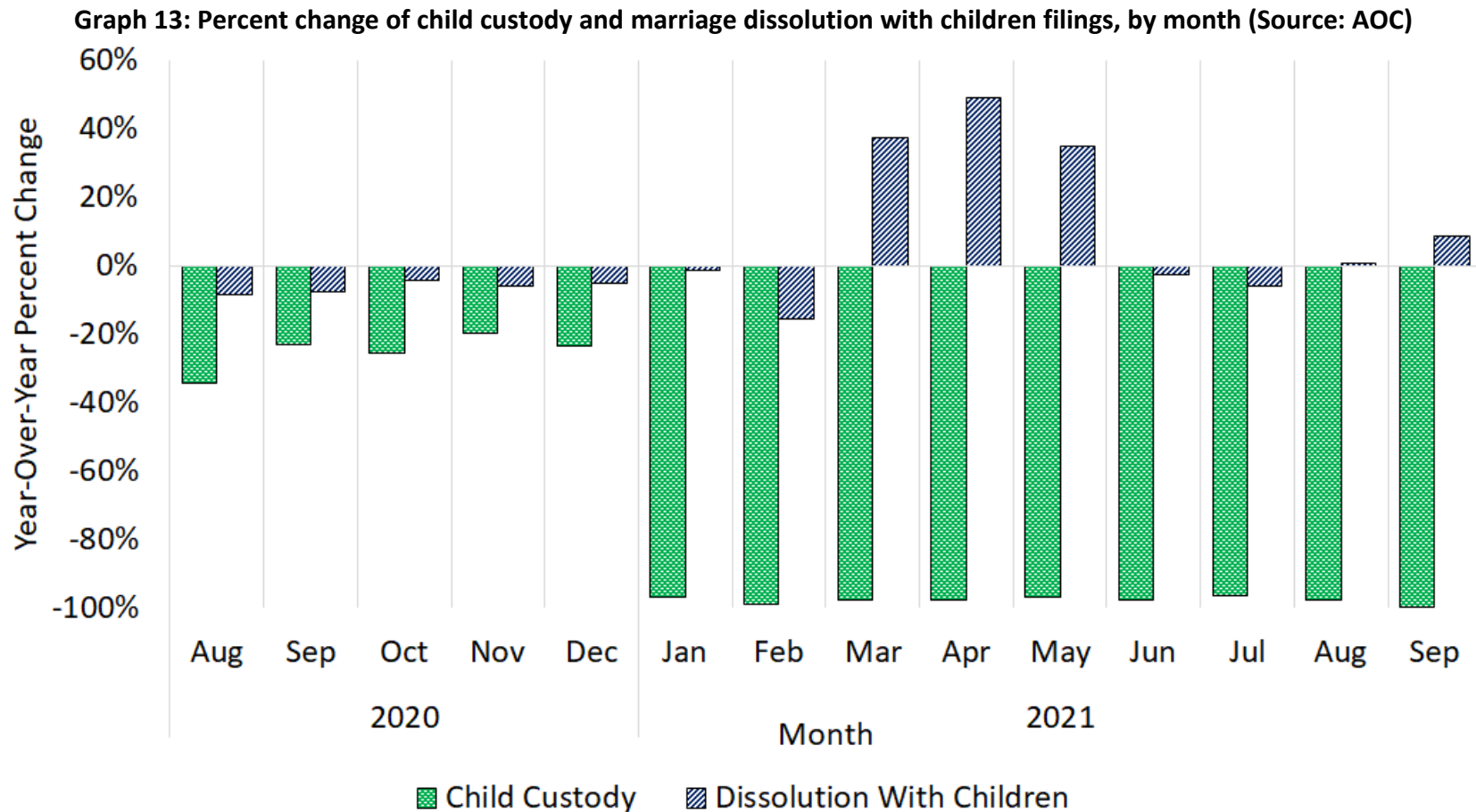
Graph 12: Percent change of mental illness (minor) filings by month (Source: AOC)



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

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. There was a year-over-year percent change in September 2021 for monthly child custody case filings (-100%) and dissolution with children (9%) (Graph 13).



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).

Acknowledgements

This document was developed by the Washington State Department of Health's Behavioral Health Epidemiology Team. Lead authors are Vasiliki Georgoulas-Sherry, PhD and Mary Franzen, MPH.

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