Washington State Department of Health

Updated April 16th, 2020

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

SUMMARY

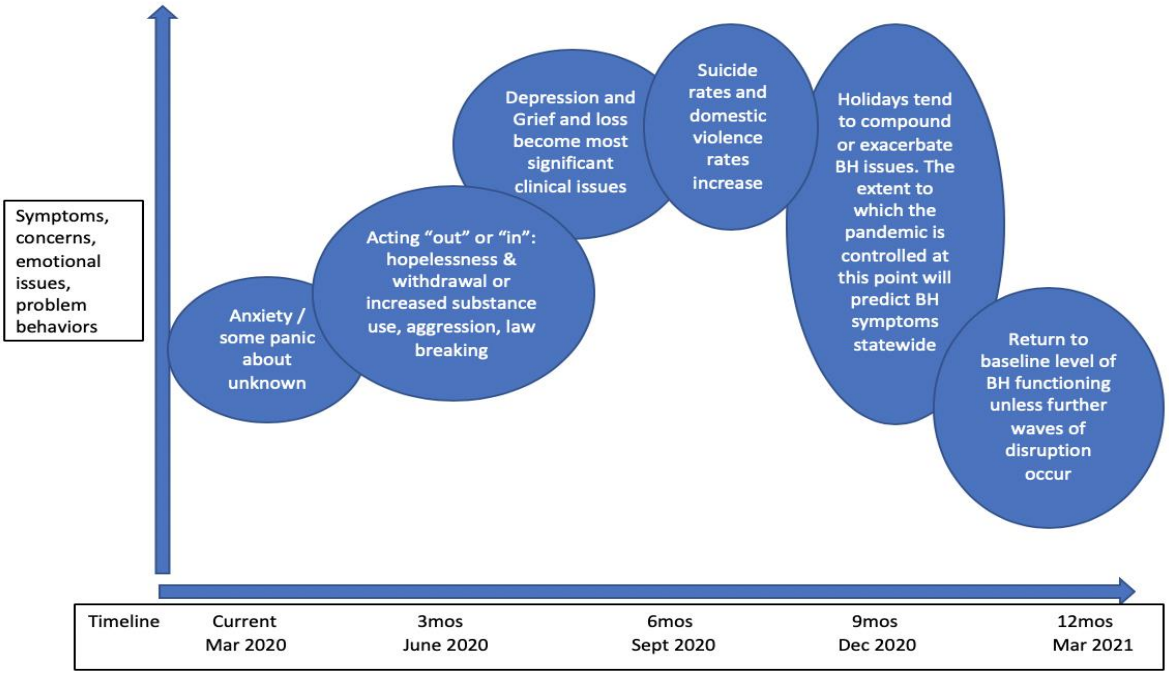
Purpose

This document provides a brief overview of the potential statewide, behavioral health impacts from COVID-19. The intent of this document is to communicate the potential impacts of the outbreak to response planners and behavioral health organizations so they can adequately prepare.

Bottom Line Up Front

- The behavioral health impacts from the COVID-19 outbreak and related government actions will likely cause a surge in behavioral health symptoms across the state. This surge will present differently based on the stage of the pandemic, the effectiveness of the overall response effort, and the populations being impacted. In particular, a second pandemic wave would dramatically change this forecast. This forecast will be updated during summer months based on new data.
- These impacts will likely be seen in phases with anxiety related issues becoming prevalent immediately through the next 2 to 3 months, followed by an increase in depressive symptoms over 2 to 6 months, peaking around 9 months (around November / December 2020). [8,9] This could potentially coincide with a second wave of infections, a pattern consistent with previous pandemics.
- In Washington, the highest risk of suicide will likely occur between October and December 2020. This is consistent with known cycles of disaster response patterns. Seasonal affective disorder also increases at our latitude at that time of year.
- Outreach and support strategies need to be tailored based on the current phase of the incident and the target population. Population specific impacts can be found in the companion document: *COVID-19: Forecasted Behavioral Health Impacts Guide for Specific Groups*.
- Efforts should focus on activating/augmenting existing community supports to increase social connections, which reduces behavioral health symptoms, and encouraging active coping skills among target audiences.
- An eventual return to baseline levels of functioning for **most** people should occur around February 2021, *assuming the pandemic does not enter an additional disruptive (social and economic) wave*.

Forecasted Behavioral Health Symptoms from COVID-19 Over Time



NOTE: Where people start on this chart is strongly predicted by their baseline level of functioning BEFORE the outbreak / pandemic, and the degree to which they have SOCIAL SUPPORT and use ACTIVE COPING SKILLS.
If the situation comes to a resolvable level after 12 months, the VAST majority of people will return to their baseline level of functioning. If the situation cascades, then the emotional and behavioral responses become compounded over time.

Key Things to Know

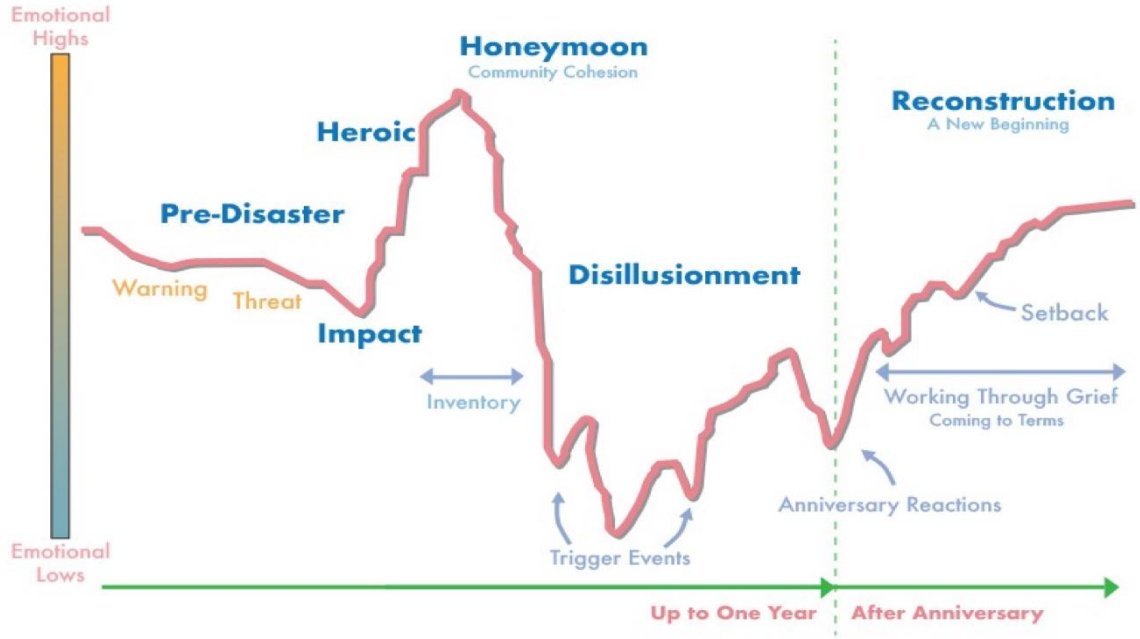
1. Approximately 650,000 Washingtonians were receiving treatment for behavioral health needs prior to the COVID19 outbreak.
2. Approximately 700,000 Washingtonians have mental health concerns, but were NOT receiving services prior to the outbreak.
3. Approximately 10% to 33% of individuals experience symptoms of acute stress (such as negative thoughts, sadness, intrusive dreams or memories, avoidance, insomnia or hypersomnia, headaches & stomach aches) within one month after the impact phase of a disaster or critical incident. In Washington, that timeline begins mid-March 2020. [10, 11, 12]
4. Based on population data for Washington, and known cycles of common psychological responses to disasters, **we can reasonably expect that approximately TWO MILLION Washingtonians could experience behavioral health symptoms consistent with acute stress, anxiety, or increasing depression from the present time to over the next two to six months.** These symptoms will likely be strong enough to cause significant distress or impairment for most people in this group.
5. Only 4% to 6% of people typically develop symptoms of PTSD after a disaster (equivalent to 380,000 individuals in Washington). This number can vary quite a bit depending on the type of disaster, and is often higher amongst first responders and medical personnel if the disaster is more chronic, widespread, children are hurt or injured, and burnout is likely. [10,11, 12]
6. **Behavioral health symptoms will likely present in phases:** [8,9]
   a. We can reasonably expect that behavioral health symptoms including anxiety, trouble sleeping, stomach aches, and headaches will increase dramatically amongst the general population in the next one to two months (April – May 2020).

b. Behavioral symptoms associated with "acting out": (aggression, law breaking, increased substance use) or "acting in" (voluntary isolation, non-participation, blunted emotional expression) may increase in the next three to six months (June - Sept 2020).
c. Depression rates and symptoms, along with suicides, could increase dramatically in the fall and winter of 2020, with November and December likely being the most difficult. This is due to a particularly hard combination of the experience for the general population of:
    i. The Disillusionment phase of disaster recovery (when people recognize that things will not be returning to the way they once were)
    ii. The season (holidays as well as limited daily sunlight)
    iii. Long term effects of financial losses or concerns on sense of hope
d. An eventual return to premorbid baseline levels of functioning by February or March 2021 is anticipated for most people, assuming that the pandemic does not enter an additional disruptive (social and economic) wave before December 2020. [8,9]

7. Behavioral health systems, providers, and public messaging teams should be mindful of the following strategies to maximize the impact of their efforts:
    a. Primary efforts for the next 6 to 9 months should be focused on activating community supports to increase social connections (and thus reducing behavioral health symptoms) and encouraging the development of ACTIVE coping skills amongst the general public to reduce symptoms of depression.
    b. There should be a psychoeducational emphasis on the disaster response cycle so that people are informed about what they may expect, and they do not pathologize a normal response to an abnormal situation.
8. The typical response to disaster is RESILIENCE, rather than disorder. [8,10] Resiliency can be increased by: [13]
    a. Focus on developing social CONNECTIONS big or small
    b. Reorienting and developing a sense of PURPOSE
    c. Becoming adaptive and psychologically FLEXIBLE
    d. Focusing on HOPE
9. Resilience is something that can be intentionally taught, practiced, and developed for people across all age groups.
10. Community support groups, lay volunteers, and all manner of social organizations and clubs are resources that can be developed to help reduce behavioral health symptoms for the general population, and should be leveraged to take pressure off depleted or unavailable professional medical and therapeutic resources throughout 2020.
11. **Approximately half of the individuals who experience a behavioral health diagnosis will develop a substance-related disorder, and vice versa.** [6]
    a. As a result, we can expect <u>substance-related symptoms and disorders to increase</u> as behavioral health symptoms and disorders increase.
12. During disasters, individuals may have difficulty accessing their prescribed medication, which could lead them to seek alternatives. Relatedly, the *Stay Home, Stay Healthy* policy means that peer support groups for both substance-related disorders and behavioral health disorders and are inaccessible via traditional means.
    a. Healthcare providers should anticipate an increase in substance-use as a possible disaster reaction, and should suggest both healthy alternatives for coping, and sources of support.

Background and Analysis

Reactions and Behavioral Symptoms in Disasters: SAMHSA



https://www.samhsa.gov/dtac/recovering-disasters/phases-disaster

Mental Illness, Behavioral Health Diagnoses, and Demographics

National prevalence rates for mental and behavioral health diagnoses[2,4]

Generalized Anxiety Disorder = approximately 1% of adolescents, 2.9% adults (6.06 million nationally)

Panic Attacks = 11.2% of adults (23.40 million)

Panic Disorder = approximately 2-3% of adolescents and adults (4.18 million)

Mood Disorders = approximately 9.7% of adults[4] (20.27 million)

Depression = 12.7% in WA, 41.1% of whom received mental health services[1]

Annual suicide rates: approximately 17 per 100,000[3]

Post-Traumatic Stress Disorder: 3.5% of adults nationally[2]

Substance-Related Disorder prevalence:

National prevalence rates for substance-related disorders:[2, 4, 5]

Alcohol Use Disorder = approximately 4.6% of adolescents, 8.5% of adults

Cannabis Use Disorder = approximately 2.3% of adolescents, 5% of young adults, and 0.8% of adults

Opioid Use Disorder = approximately 0.6% of adolescents, 1.1% of young adults, and 0.8% of adults

Population of WA: Approx. 7.5488 Million

Percentages with baseline Serious Mental Illness (2017 most recent):

Young adults from 18-25 = 6.2%[1] (or 467,976 people)

Adults 18 and over = 5.3%[1] (or 400,044 people)

Percentage of adults 18 and over with ANY mental illness who received treatment in Washington (2017 most recent): = 45.6% (approximately 650,000 people or 8% of the total population of WA)[1]

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