

MAY 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.
- The second quarter of 2021 continues our progression into reconstruction and recovery. Data indicates there is an increasing divergence between specific groups and populations in Washington in terms of the recovery pathways and behavioral health experiences. The speed and process of recovery varies significantly among communities (Figure 1), and it is likely that behavioral health symptoms will also begin to vary widely among groups within our population. Those who have experienced significant primary and secondary effects of the pandemic are likely to progress more slowly into reconstruction and recovery than others and experience more severe behavioral health symptoms (Figure 2). This path is represented by the *disaster cascade pathway* (dotted line) in Figure 1.
 - Risk factors that predict a longer recovery cycle (along the disaster cascade pathway) with more severe behavioral health symptoms are also higher for individuals who identify as being part of marginalized social or ethnic groups, families and communities of lower socioeconomic status, and children and youth.^{1,2,3,4,5}
- Governor Inslee's announcement on May 13, 2021 regarding the Washington's reopening plans is likely to provide a strong sense of hope for many and anxiety for others. Guidance updates from the Centers for Disease Control and Prevention (CDC) on the same day about



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recommended changes in mask use requirements for those who are fully vaccinated may also contribute to mixed reactions – on one end, excitement and relief for those who are eager for the pandemic to end and, on the other end, increased apprehension about the extent to which the pandemic is (and will be) under control.

- From a behavioral health perspective, dynamics associated with full reopening plans and the discontinuation of universal masking guidelines after such a long period of time are likely to be complicated and may cause unexpected reactions from many people who are concerned about trust related to the vaccination status of others.
- The COVID-19 variants and their effects continue to influence the likelihood of a disaster cascade. These variants may create widespread health and social impacts with the potential for additional infection waves.
- Remaining uncertainty about the future potential for reopening phase rollbacks may increase the likelihood of frustration, anxiety, anger, and depression. Please see [Coping with the Behavioral Health Impacts of Roadmap to Recovery Phase Changes during COVID-19^a](#) for information on managing behavioral health challenges associated with reopening phase changes.
- **The risk of suicide, depression, hopelessness, and substance use will continue to remain high through the second quarter of 2021, particularly for populations experiencing effects related to a disaster cascade.** Risk factors associated with the experience of a disaster cascade pathway include being a member of a marginalized social group, those experiencing the effects of racism and discrimination, and those with fewer economic resources.^{6,7,8,9}
- **Children, youth, and young adults are a demographic group at significant risk for challenging behavioral health outcomes and experiences.**¹⁰ The effects of isolation, combined with shifting educational and social opportunities and experiences, have contributed to behavioral health challenges for many individuals ages 6 – 25.¹⁰ See the [May Youth Behavioral Health Impact Situation Report^b](#) for more information on behavioral health impacts to youth in Washington.
- We expect behavioral health issues related to isolation, stress, and fear to trend relative to COVID-19 cases, COVID-19 hospitalization rates, and reopening plans.^{11,12,13,14} In addition, even with increased COVID-19 vaccine availability and eligibility, situations of varying vaccine access and confidence could escalate medical risks for some people, contributing to subsequent behavioral health impacts. To mitigate these risks, the Washington State Department of Health (DOH) developed and implemented eight [strategies for equitable vaccine distribution^c](#) based on extensive feedback from the communities, sectors, and partners most impacted by COVID-19.

Phase-Related Behavioral Health Considerations

Behavioral health symptoms will continue to present in phases.^{15,16} 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 DOH, which are available on the

^a <https://www.doh.wa.gov/Portals/1/Documents/1600/coronavirus/821-138-BHImpactsToPhaseChanges.pdf>

^b <https://www.doh.wa.gov/Portals/1/Documents/1600/821-135-YouthBehavioralHealthSitRep-May2021.pdf>

^c <https://www.doh.wa.gov/Emergencies/COVID19/VaccineInformation/Engagement>

[Behavioral Health Resources & Recommendations webpage](#).^d Behavioral health symptoms of anxiety, impulsivity, decreased frustration tolerance, anger, depression, and post-traumatic stress disorder (PTSD) are likely to increase with any significant increases in infection and hospitalization rates or reopening plan changes.^{17,18}

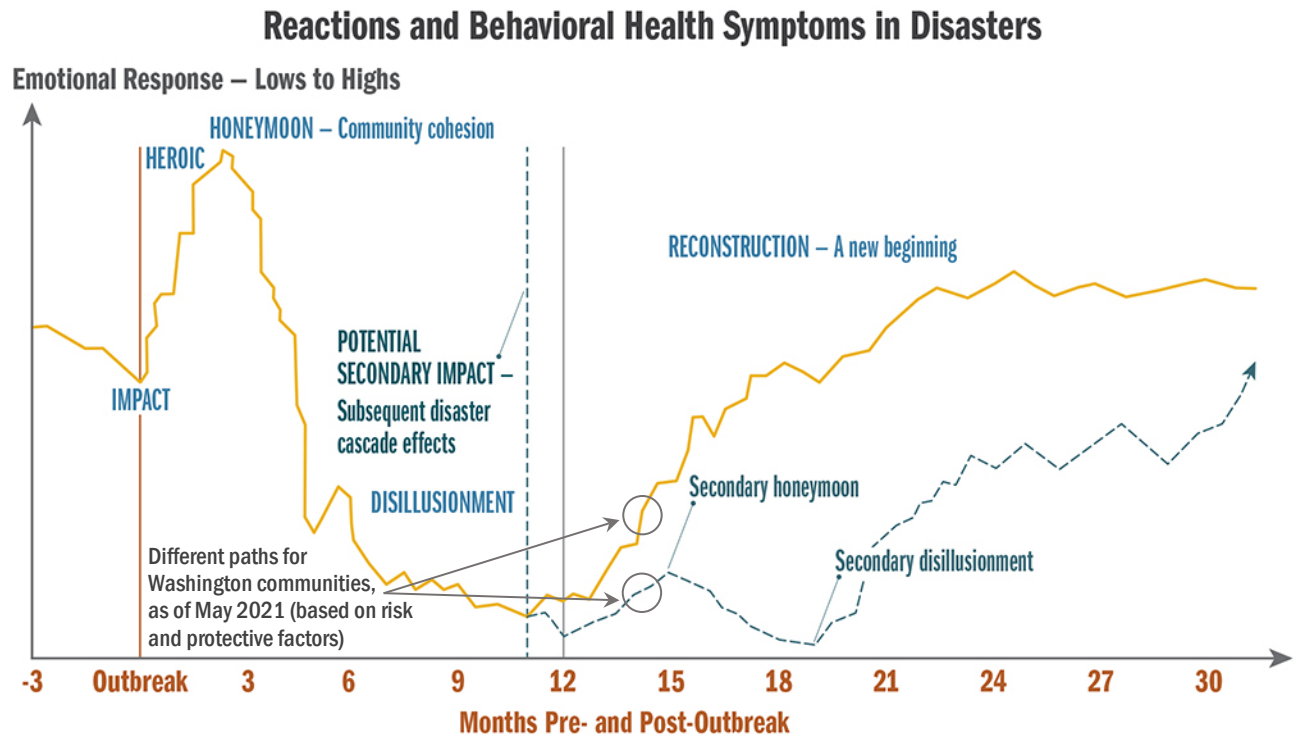


Figure 1: Phases of reactions and behavioral health symptoms in disasters. The dotted graph line represents the response and recovery pattern that may occur if the full force of a disaster cascade is experienced by a majority of the population (i.e., the *disaster cascade pathway*). *Protective factors* are characteristics, conditions, or behaviors that reduce the effects of stressful life events. They also increase a person’s ability to avoid risks or hazards, recover, and grow stronger. Adapted from the Substance Abuse and Mental Health Services Administration (SAMHSA).¹⁹

COVID-19 Variants

The concerns about a **disaster cascade** have been previously discussed in this forecast, and it is possible that the arrival and spread of COVID-19 variants could cause such an event. The CDC has identified five variants of concern:^e B.1.1.7 (first found in the United Kingdom), B.1.351 (first found in South Africa), P.1 (first found in Brazil), and B.1.427 and B.1.429 (originated in California).^{20,21} To date, these five [variants of concern have been detected in Washington](#).^f There are also eight variants of interest^g that have been identified by the CDC which are being

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

^e Variant of concern: A variant for which there is evidence of an increase in transmissibility, more severe disease (increased hospitalizations or deaths), significant reduction in neutralization by antibodies generated during previous infection or vaccination, reduced effectiveness of treatments or vaccines, or diagnostic detection failures. See the CDC *SARS-CoV-2 Variant Classifications and Definitions* page (<https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/variant-surveillance/variant-info.html>) for additional information.

^f <https://www.doh.wa.gov/Emergencies/COVID19/Variants>

^g Variant of interest: A variant with specific genetic markers that have been associated with changes to receptor binding, reduced neutralization by antibodies generated against previous infection or vaccination, reduced efficacy of treatments, potential diagnostic impact, or predicted increase in transmissibility or disease severity.

monitored and characterized. For the latest information on variants in Washington, see the weekly [SARS-CoV-2 Sequencing and Variants in Washington State report](#).^h

A *disaster cascade* could occur with any new rise in infections, which may prompt a secondary disaster impact (as represented by the dotted line in Figure 1). The secondary impact may be a result of the pandemic itself (infections and hospitalizations) or an indirect impact of the pandemic (economic hardship, social and political unrest, reopening plan changes, etc.). There remains some concern that the variants, some of which spread more easily and quickly, may lead to an increase in COVID-19 cases.

Immunity through vaccination is helping slow the spread of the virus and reduce its impact on the healthcare system. Many people may be experiencing *pandemic apathy* (an experience where general exhaustion manifests in the form of apathy about the pandemic), but it is **essential** to continue vaccination efforts and other preventive measures (like wearing masks and maintaining distance if unvaccinated and following local guidelines).

Behavioral health concerns related to the many unknowns associated with the variants include the risks of additional anxiety, issues with excessive use of media to seek information and answers, and additional risks of depression for those already experiencing many negative outcomes related to the pandemic or a *disaster cascade*.

Phase Divergence within Washington

As we progress into the *reconstruction phase* of the typical disaster recovery cycle, communities, families, and individuals in Washington will diverge more distinctly from each other in terms of behavioral health experiences. Factors, such as economic security, social marginalization, and race and ethnicity continue to play a role in the experience of both physical and behavioral health risks and symptoms throughout the pandemic.^{6,7,8,9} Disparities throughout the last year will tend to be magnified and worsened in the next several months as we move further through the recovery cycle.

Those who have had more economic, social, educational, and occupational opportunities in the first quarter of 2021 will tend to climb more rapidly into the *reconstruction phase* and recovery, while those who have experienced more direct primary and secondary impacts from the pandemic (e.g., illness, hospitalization, job loss, eviction) (Figure 2) will likely endure a repetition of the recovery cycle as is consistent with the disaster cascade pathway (Figure 1).

^h <https://www.doh.wa.gov/Portals/1/Documents/1600/coronavirus/data-tables/420-316-SequencingAndVariantsReport.pdf>

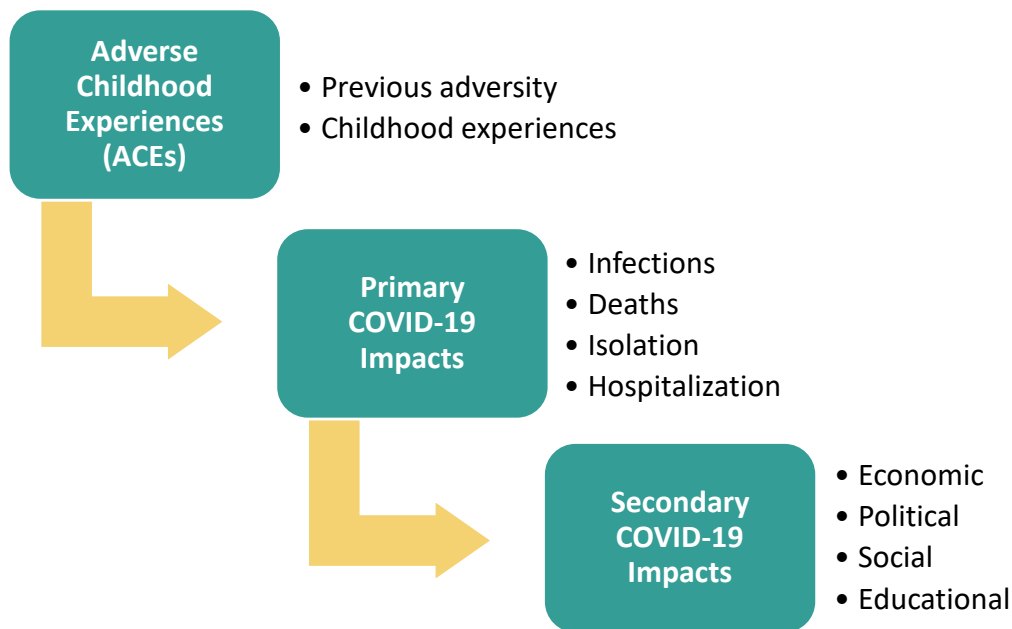


Figure 2: Disaster and Trauma Cascade Potential. The figure displays the range of factors (ACEs,¹ primary COVID-19 impacts, and secondary COVID-19 impacts) which may alter the *reconstruction phase* and recovery for individuals based on their experiences.

Typical Disaster Response and Recovery Pathway Considerations

Workplace Changes

As we move forward in the disaster recovery cycle, some employees who were previously working remotely may begin to transition back to in-person work. This transition may bring with it a variety of emotional and behavioral responses that range from excitement and happiness to anxiety and fear. It may be beneficial for supervisors, managers, and leaders within organizations and businesses to address these transitions and the associated reactions about workplace unknowns and the new normal as directly and transparently as possible. When possible, safety protocol information should be clearly provided, and well-defined expectations about working hours, shifts, and locations should be set at all levels in order to alleviate anxiety and reduce the likelihood of misinterpretation. Within teams, it may be helpful for managers and supervisors to recognize that team members may have very different experiences and reactions about returning to the workplace. *Active listening*, a form of healthy communication that can support team building, is recommended as an intervention that can help address workplace issues that may arise during these transitions.

As workplace expectations and challenges evolve over the next several months, there may be ongoing questions and concerns about managing childcare, distance learning requirements, and work-life balance. For women in the workforce, these issues are likely to be particularly problematic. There are additional burdens related to caregiving, less secure employment, and the wage gap that may create more stresses for women compared with their male counterparts.^{22,23,24,25} For more information, please see the later sections on social marginalization (page 7) and socioeconomic status (page 8).

¹ Adverse childhood experience (ACE): A traumatic experience in a person's life occurring before the age of 18 that the person remembers as an adult.

Social and Recreational Factors, Risk Taking

As more people in Washington get vaccinated and plans move toward a full reopening of the state by June 30, 2021, there will be additional opportunities for social and recreational activities that were previously unavailable due to pandemic-associated safety restrictions. The need for patience and diligence remains high as the weather improves and pandemic apathy continues to wear on everyone. One area of attention in the spring and summer months of 2021 is the potential likelihood of a *rebound effect* from the pandemic that may include people acting “out” in ways that are consistent with highly expressive, thrill-seeking, or pleasure-oriented behavior (e.g., partying, substance use, risk taking, aggressive or illegal behavior) as a response to the perception that things are returning to the way they were before the pandemic.

The likelihood of risk-taking behavior increases as the more opportunities for social connection with peers and a sense of freedom from pandemic-related restrictions begins to emerge, particularly for youth and young adults.^{26,27} In addition to the ways in which the neurological consequences of general pandemic apathy may influence decision making, as the weather changes and temperatures increase, generally risky behavior and the likelihood of aggression and violence also increase.^{26,28,29}

Vaccine Confidence

Vaccine confidence is a concern in some communities and groups. Efforts by medical and behavioral health providers should be focused on providing scientifically accurate, consistent, straightforward messaging for clients and patients about potential benefits and risks of the vaccine. Simple, consistent information about vaccine development, testing, and distribution should be made available for patients and clients who are interested. Anxiety about potential side effects can also be alleviated by sharing accurate information on what is known to date for those who have already received the vaccine. See the [Health Care Provider Discussion Guide^j](#) for tips on building confidence in COVID-19 mRNA vaccines and the [Behavioral Health Tips for Getting the COVID-19 Vaccine^k](#) handout for tips on staying relaxed and communicating effectively when getting the vaccine. Additional information for providers can be found on DOH’s [Vaccine Information for Healthcare Providers webpage^l](#).

Disaster Cascade Pathway Considerations

Increases in Stigma

As the recovery process diverges among groups, we are likely to see an increase in stigma toward members of our communities who are experiencing ongoing or worsening behavioral health symptoms over the summer months. Under conditions where a large number of the population is feeling better, social norms may shift to reflect that it appears to be less acceptable to struggle with behavioral health-related concerns. As the pandemic continues – even with long-term recovery in sight – it is important for everyone to try maintaining and reinforcing their sense of empathy for the experiences of others. In any group, there is likely to

^j <https://www.doh.wa.gov/Portals/1/Documents/1600/coronavirus/820-130-ProviderMRNAVaccinesDiscussionGuide.pdf>

^k <https://www.doh.wa.gov/Portals/1/Documents/1600/coronavirus/821-133-BehavioralHealthTipsGettingTheVaccine.pdf>

^l <https://www.doh.wa.gov/Emergencies/COVID19/HealthcareProviders/VaccineInformationforHealthcareProviders>

be a highly varied experience of behavioral health needs and concerns. Keeping this in mind while practicing and encouraging active listening to understand more fully the perspectives of others will be helpful for all social and workplace environments.

Social Marginalization, Racism, and Discrimination

There are a number of groups and communities that have experienced significant social marginalization throughout the pandemic. Several studies have found that across the United States, members of ethnic minority groups have been disproportionately negatively affected by COVID-19, sometimes at rates two or three times higher than their representation in the larger population.^{30,31,32} There is also a corresponding increase in behavioral health concerns related to historical negative medical experiences, direct medical impacts of the pandemic, and grief and isolation.³³ In terms of behavioral health outcomes, 61% of Black adults and 60% of Hispanic adults reported that the COVID-19 pandemic has impacted their mental health, in comparison with 55% of white adults.³⁴

Risks related to underlying social or systemic factors are exacerbated by historical trauma and anxiety related to discrimination and prejudice.³⁵ These risks can result in higher levels of PTSD, as well as a variety of other mental health concerns, including substance use issues. There has been a significant increase in crimes against members of Asian communities related to COVID-19 as a result of misconceptions and misinformation about the source of the virus that causes COVID-19 and the tendency to seek a source of blame for the pandemic.^{36,37,38} There have been reports of hate crimes directly associated with racism, such as harassment and discrimination, with Asian Americans being shunned, verbally abused, coughed and spat on, and physically assaulted. These experiences have significant negative impacts to behavioral health, as social isolation and perceived separation from the community escalates.²²

Violence against women increases both during and after every type of large-scale emergency or disaster, and increases during the COVID-19 pandemic have been documented across multiple countries, including the United States.^{39,40} Violence against women can result in serious physical, psychological, and sexual and reproductive health problems, including sexually transmitted infections, HIV, and unplanned pregnancies.³⁹ Increased stress due to COVID-19, reduced peer support, increased substance use issues, and decreased access to services may all contribute to a significant increase of gender-based violence.⁴¹ Business closures and the need to stay home to control the spread of COVID-19 contributed to an environment where some victims of intimate partner violence had to shelter in place with their abusers. There has also been a significant increase in housing-related sexual harassment from landlords demanding “sex-for-rent” from both female and male renters who are falling behind on rent payments.⁴²

The uneven division of labor in the household also significantly burdens women. Women are doing more unpaid labor in the home than men, such as educating children at home due to school closures, caring for ill family members, and daily household chores.^{39,43,44,45} Additionally, closures of schools and daycare centers significantly increased child care needs, which has a particularly large impact on working mothers.⁴⁴ In the United States, among all married couples with children, husbands provide 7.4 hours of child care per week on average, versus the 13.3 hours for wives. Single mothers make up the majority of single-parent households, accounting for just under 70 percent of all single-parent households.⁴³ In the United States, that amounts to 15 million single mothers. Combined with the economic disadvantages of identifying as female as outlined above, women who are single parents experience even larger financial impacts related to the COVID-19 pandemic.

Individuals in the LGBTQ+ community are also at increased risk of behavioral health, medical, and economic impacts due to COVID-19.^{39,46} LGBTQ+ youth are particularly vulnerable to

negative mental health impacts due to COVID-19.⁴⁷ Prior to COVID-19, LGBTQ+ youth were disproportionately impacted by housing instability – a trend that is likely to significantly worsen with the pandemic.⁴⁷ LGBTQ+ youth were at significantly increased risk for depression, anxiety, substance use, and suicidality before COVID-19.⁴⁴ These risks are highest among youth who identify as transgender, non-binary, or both.⁴³ Safe, supportive social connections are essential protective factors against depression and suicide among LGBTQ+ youth.^{47,48}

With school closures and the need to stay home to control the spread of COVID-19, many youth in the LGBTQ+ community lost access to trusted allies and safe adults, such as coaches, teachers, and school counselors, as well as LGBTQ+ community groups, including Gender and Sexualities Alliances (GSAs).⁴⁷ Physical distancing measures may have an additional negative impact on LGBTQ+ youth as only 30% report living in a home where they are accepted by their parents.¹ LGB young adults who experience high levels of parental rejection are eight times more likely to die by suicide and are six times more likely to experience severe depression.² LGBTQ+ youth are at extremely high risk for sexual, physical, and psychological abuse.^{44,47} Intimate partner violence is also prevalent in the LGBTQ+ community, even in youth.⁴⁹ Social isolation is a difficult aspect of the COVID-19 pandemic among older adults and is particularly challenging for members of the aging LGBTQ+ population who also deal with various forms of systemic discrimination, including those in employment, medical care, and housing.⁴⁴

Socioeconomic Status

Disasters may affect all people, but those of lower socioeconomic status are usually much more negatively impacted than other groups.³³ For example, individuals and families in lower socioeconomic groups are 52% more likely to lose their job or experience a significant reduction in their income than individuals in middle or upper socioeconomic groups.⁵⁰ Only 23% of individuals in lower socioeconomic groups have enough money saved to cover expenses for three months in case of a sudden loss of income, compared to their middle (48%) and upper (75%) socioeconomic counterparts. Additionally, 53% of individuals with lower socioeconomic status will struggle to pay all their bills in any given month, compared to 25% of individuals with middle socioeconomic status and 11% of individuals with upper socioeconomic status.⁵⁰

In general, women tend to have less stable employment than their male counterparts.³⁹ This means there may be an increased economic impact of COVID-19 for women who are earning less, saving less, and have less secure employment than men.^{39,43} Unemployment rates related to physical distancing measures have had a large impact on sectors with high female employment, such as restaurants and hospitality.⁵¹ Additionally, though women make up a majority of the healthcare workforce (67%),^{36,52} the overall pay gap between men and women in the field is 28%.⁴⁴

Individuals in the LGBTQ+ community are more likely to work jobs with high rates of exposure to illness (e.g., essential jobs), as well as higher risk of economic impact (i.e., sudden loss of income or layoffs).⁵³ Approximately 30% of individuals in the LGBTQ+ community, compared to 22% of the general population, have experienced a sudden loss of income.² Individuals in the LGBTQ+ community are more likely to live in poverty than their cisgender counterparts.⁴⁴ Already, 20% of LGBTQ+ individuals describe their personal finances as “much worse off” than they were a year ago, compared to 11% of the general population. LGBTQ+ individuals are less likely to have access to health insurance.⁴⁴ Prior to the pandemic, 17% of LGBTQ+ adults had no access to health insurance, compared to 12% of non-LGBTQ+ adults.⁴⁴ When broken down more specifically, 23% of LGBTQ+ adults of color, 22% of transgender adults, and 32% of transgender adults of color have no form of health insurance coverage.

The following concerns related to socioeconomic status are things that directly and indirectly influence behavioral health symptoms for members of this group throughout the COVID-19 pandemic:

- Those without a four-year college degree (46%) are more likely than their counterparts with a bachelor's degree (37%) to lose their job or experience a reduction in income.⁵⁰
- When looking at the impact of ethnicity on loss of income, 61% of Hispanic adults report that someone in their household lost a job or experienced a pay cut due to the COVID-19 pandemic, compared with 44% of Black adults and 38% of white adults.⁵⁰
- Overall, more than 26% of individuals have lost their job due to the COVID-19 pandemic. Also, 21% have had their hours reduced, 13% have experienced a pay cut, and 7% have been furloughed.³⁴ Approximately 65% of these individuals are from low-income households earning less than \$40,000 annually.
- Almost 30% of adults are struggling to pay monthly bills or afford household expenses, such as food or health insurance, due to COVID-19.³⁴ This increases to 40% among 18 – 29 year-olds, those with annual household incomes of \$40,000 or less, and Hispanic adults. Additionally, Black adults are disproportionately struggling to pay monthly bills or afford household expenses, with 56% of Black adults reporting these impacts.
- Individuals in lower socioeconomic groups are at higher risk for having their mental health negatively impacted due to COVID-19.⁵⁴ For example, 26% of individuals with an annual income of less than \$40,000 report experiencing a significant negative mental health impact, compared to 17% of those with an annual income between \$40,000 and \$89,000 and 14% of those with an annual income of \$90,000 or more.
- Individuals in lower socioeconomic groups are also at a higher risk for developing PTSD after a disaster.^{55,56}

Unemployment

Suicide and drug overdose death rates are both highly influenced by unemployment.^{57,58,59,80} For every 1% increase in the unemployment rate, there is a corresponding 1.6% increase in the suicide rate⁵⁸ and an increase of one drug overdose death per 300,000 people.⁵⁷ Additionally, a recent study from the National Bureau of Economic Research reported, “the size of the COVID-19-related unemployment to be between 2 and 5 times larger than the typical unemployment shock, depending on race [and] gender, resulting in a 3.0% increase in mortality rate and a 0.5% drop in life expectancy over the next 15 years for the overall American population. We also predict that the shock will disproportionately affect African Americans and women [in the short term] while white men might suffer large consequences [in the long term]. These figures translate in a staggering 0.89 million additional deaths [nationally] over the next 15 years.”⁶⁰

The U.S. Bureau of Labor Statistics (BLS) regularly reports unemployment data, which is based on labor market activity, working conditions, and price changes in the U.S. economy. BLS measured the national unemployment rate to be 6.0% in March 2021. After a significant amount of research, the Ludwig Institute for Shared Economic Prosperity (LISEP) began using a new measure to calculate what is called the True Rate of Unemployment (TRU).^{61,62} This rate is defined as the percentage of the U.S. labor force that is *functionally unemployed*.⁶³ TRU uses data from BLS and also tracks the percentage of the U.S. labor force that does not have a full-time job (35+ hours a week) but wants one, has no job, or does not earn a living wage (which is marked at \$20,000 annually before taxes). Thus, any individual who wants full-time work but can only find part-time work, as well as those working full-time but earning too little to climb

above the poverty line, are considered *functionally unemployed*. Based on the inclusion of these additional factors related to unemployment, the TRU in March 2021 was 24.7% nationally. Further analysis shows significant disparities related to race and sex. Specifically, in March 2021 the TRU for Black Americans was 58.5%, compared to 53.6% for Hispanic Americans and 53.2% for white Americans. This disparity becomes even greater when evaluated by sex. The TRU for female Americans was 60.5% in March 2021, compared to 46.2% for male Americans.

Individuals in Washington who are experiencing functional unemployment are at higher risk of facing a disaster cascade, even as we move into the early summer months. In Washington, approximately 1,231 people die from suicide annually, and 1,173 people die from drug overdose annually.⁶⁴ The unemployment rate in Washington was 6.1% in March 2021, 1 percentage point higher than March 2020.⁶⁵ Given the increase in unemployment, it is possible that the suicide rate will increase by 1.6%.

Depression and Suicide

Depression is a common response throughout the disaster recovery cycle. Many children, teens, and young adults are experiencing significant symptoms of depression during the pandemic.^{10,66} Older adults are also a group of concern due to isolation and lack of social connection.⁷⁵ First responders, healthcare professionals, and behavioral health providers are also experiencing emotional impacts of the pandemic as more patients and clients need treatment, support, and preventive care.

As the risk of depression increases, so does the risk of suicide. Active suicide prevention should be promoted through sharing information on recognizing [warning signs](#)^m and other related resources, and checking in with colleagues, friends, family members, and neighbors. When someone is expressing thoughts of self-harm, [access to dangerous means of harm should be removed](#),ⁿ and medications, poisons, and firearms should be stored safely. Suicides consistently account for approximately 75% of all firearm-related fatalities in Washington.⁶⁷ [Storing firearms safely](#)^o and [temporarily removing them from the home](#)^p 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](#)^q: Call 833-681-0211 to talk to a support specialist who will listen and help you cope with the stress of COVID-19.
- **Health Care Authority:** [Mental health crisis lines](#)^r
- [National Suicide Prevention Lifeline](#):^s Call 800-273-8255 (English) or 1-888-628-9454 (Español).

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

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

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

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

^q <https://www.walistsens.org/>

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

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

- [Crisis Connections](#):^t Call 866-427-4747.
- [Crisis Text Line](#):^u Text HEAL to 741741.
- **Department of Health**: [Crisis lines for specific groups](#)^v
- [TeenLink](#):^w Call or text 866-833-6546.
- [Washington Warm Line](#):^x Call 877-500-9276.
- **Washington State COVID-19 Response**: [Mental and emotional well-being webpage](#)^y

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.⁶⁸ Families experiencing hardship are also reporting navigating their child’s disruptive or uncooperative behavior and anxiety. Mental health-related visits to emergency departments for children ages 5 – 17 between April and October 2020 increased by 24% – 31%, compared with the same time period in 2019.⁶⁹ When children go through a hard time, such as living through a disaster, they will need extra attention and comfort from their parents. It’s important to try to be patient with children who are 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 normal for children to be having trouble during this time. However, if there are concerns about safety, seek 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](#).^z 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. Parents and caregivers can also use the [National Parent Helpline](#)^{aa} to access telephone support (1-855-427-2736) and additional resources.

Suicidal Ideation and Suicide Attempts in Youth

We are continuing to monitor rates of emergency department visits for psychological distress, suicidal ideation, and suspected suicide attempts for children, teens, and young adults.^{bb,cc} The convergence of factors that may be uniquely affecting the psychological health of these groups

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

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

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

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

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

^y coronavirus.wa.gov/wellbeing

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

^{aa} <https://www.nationalparenthelpline.org/>

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

^{cc} <https://knowledgerepository.syndromicsurveillance.org/disaster-related-mental-health-v1-syndrome-definition-subcommittee>

in the later months of 2020 into the early months of 2021 is **very concerning**. Several factors, including the current *disillusionment phase* of disaster, the extreme difficulty with access to behavioral healthcare and resources, and the unique challenges faced by young people this year, will likely contribute to an increase in distress.

A recent [emergency proclamation](#)^{dd} by Governor Inslee states that “hospitals and health professionals who specialize in the treatment of children indicate that many of Washington’s children and youth are experiencing a significant mental and behavioral health crisis as a result of the ongoing pandemic,” and “the children and adolescents presenting in mental health crises to hospitals or emergency rooms are the most severe cases and represent just a small portion of the entire population of youth in Washington who are suffering from increased mental and behavioral health needs, educational setbacks, and developmental concerns.”

We strongly recommend 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.

Potential for Violence and Aggression

While potential for violence and aggression remain a possibility, the likelihood of a large-scale event rooted in violence or extremist behavior is likely to decrease as the pandemic is controlled and a return to “normal” is on the horizon. Factors related to risks in these areas of human behavior include hope and false hope,⁷⁰ subjective well-being,⁷¹ family stress,^{72,73} and social learning,⁷³ among others.

It is important that messaging and information provided to clients and patients about the course of the pandemic, such as where we are collectively, as well as realistic behavioral health concerns, be accurate, consistent, straightforward, and clear in order to minimize risks related to misinterpretation or misguided enthusiasm for the pandemic being “over.” Highlighting consistent and gradual progress during the summer months rather than large-scale jumps in expectation will help to mitigate risks associated with false hope.

Behavioral Health Outcomes Associated With COVID-19

As the number of people infected with the virus continues to increase nationally, so does the number of survivors. Concerning research, provider bulletins, anecdotal accounts, and case studies have documented specific behavioral health symptoms and diagnoses which seem to occur in those who have survived COVID-19.^{74,75,76,77,78,79} Treatment providers and behavioral health systems should be aware of these findings, which include new instances of anxiety disorders and PTSD, as well as a new diagnosis identified as **post-COVID-19 psychosis**.⁸⁰

In addition to increased risks for a *new* psychological disorder after a positive COVID-19 diagnosis, research shows that individuals who had a pre-COVID-19 psychiatric diagnosis were associated with a 65% increased risk of confirmed COVID-19 infection, compared to individuals who only had a pre-COVID-19 diagnosis of a physical health issue and no psychiatric history.⁷⁷ These researchers also found an increased risk for first-time experiences of psychotic symptoms in individuals that tested positive for COVID-19.^{77,78} The individuals who had a new onset of

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

psychosis related to COVID-19 infections tended to have features of disorganized thinking and confusion and were less likely to experience paranoia and delusions as part of their psychosis.^{77,78} The individuals who developed this post-COVID-19 psychosis are also less likely to have a family history of psychosis and more likely to present with mild to moderate (i.e., less severe) symptoms of psychosis.⁷⁷ Individuals experiencing this type of post-COVID-19 psychosis are typically recovering quickly with the use of low-dose antipsychotic medications.^{77,78}

Additional research has identified a post-COVID-19 group that are referred to as “long-haulers” or as experiencing “long COVID,” in which individuals experience symptoms related to COVID-19 for more than six weeks. Many of these individuals only experienced mild respiratory symptoms and never developed pneumonia or hypoxemia (having a below-normal level of oxygen in the blood) requiring hospitalization. It is estimated that 87% of hospitalized COVID-19 patients continue to have symptoms 60 days after COVID-19 onset, and app-based symptom trackers estimate that 4.5% of patients have mild COVID-19 symptoms lasting more than 8 weeks. Accordingly, several million people in the world may already suffer from “long COVID.”

The ten most common neurologic symptoms experienced by “long haulers” are *brain fog* (81%), *headache* (68%), *numbness/tingling* (60%), *dysgeusia* (loss of taste) (59%), *anosmia* (loss of smell) (55%), *myalgia* (muscle pain) (55%), *dizziness* (47%), *pain* (43%), *blurred vision* (30%), and *tinnitus* (ringing in the ears) (29%). The most frequent non-neurologic symptoms include *fatigue* (85%), *depression/anxiety* (47%), *shortness of breath* (46%), *chest pain* (37%), *insomnia* (33%), *variation of heart rate and blood pressure* (30%), and *gastrointestinal symptoms* (29%). The constellation of “long hauler” symptoms, particularly fatigue and a sense of cognitive dysfunction (e.g., memory impairment and problems with attention and concentration), in patients resembles the prominent fatigue and cognitive complaints seen in those after mild traumatic brain injury (TBI).⁷⁹

For adults over 65 years, there seems to be a slight increase in diagnoses of dementia in the first 14 – 90 days after a COVID-19 diagnosis.⁷⁴ Research indicates that individuals who have been hospitalized for COVID-19 or developed encephalopathy (any brain disease that impacts brain function) due to their illness are more likely to experience neurological complications, a psychotic disorder, mood disorder, anxiety disorder, substance use disorder, and insomnia.⁸¹ Although the estimated incidence is modest in the whole COVID-19 cohort (0.67%), 1.46% of hospitalized cases and 4.72% of those who had neurological symptoms related to their COVID-19 infection received a first diagnosis of dementia within six months.

Individuals with even mild cases of COVID-19 are at higher risk for depression and anxiety.

This research is congruent with earlier research on COVID-19 which demonstrated evidence that survivors are at increased risk for mood and anxiety disorders and dementia in the three months following infection.⁷⁴

Key Things to Know

- **Medical and specialty providers,**^{ee} organizations, and facilities should continue developing resources and staffing to address behavioral health impacts of the pandemic that are likely to remain significant particularly under circumstances where individuals, families, and communities are affected by a disaster cascade. Support strategies need to be tailored based on the current phase of the incident and the target population, group, or individual.

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

- The risk of suicide will likely continue to be high throughout the first half of 2021. Data suggest that young adults (ages 18 – 29) and older adults (60+) are particularly vulnerable.⁸² 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](#)^{ff} can be used for patients ages 10 – 24.
- It is anticipated that rates of depression and anxiety for certain at-risk groups (e.g., those identifying as multiracial or LGBTQ+) in the general population during this pandemic are likely to be much higher than is typical after a natural disaster where there is a single impact. Clinically significant symptoms of anxiety or depression are likely to occur in 30% – 60% of the general population (equivalent to 2.25 million – 4.5 million people in Washington, including children and youth) due to the chronic and ongoing social and economic disruption in people’s lives as a result of the COVID-19 pandemic.⁸¹
- Weekly survey data suggest that approximately 1.1 million Washington adults are experiencing symptoms of anxiety on at least most days and just over 800,000 are experiencing symptoms of depression on at least most days (Figure 4).⁷

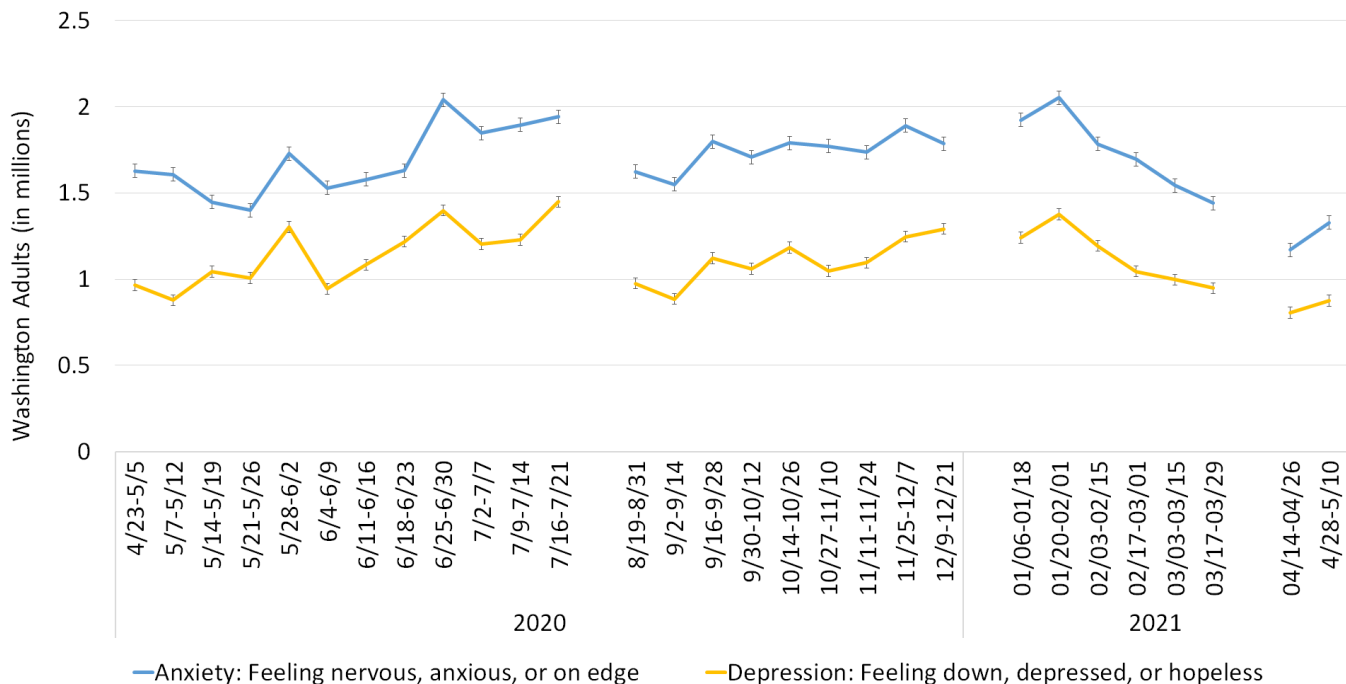


Figure 3: Estimated Washington adults experiencing symptoms of anxiety and depression at least most days, by week: April 23, 2020 – May 10, 2021 (Source: U.S. Census Bureau).

Note: Census data is unavailable for the periods of July 22, 2020 – August 18, 2020, December 21, 2020 – January 6, 2021, and March 30 – April 14, 2021.

- Survey data collected by the U.S. Census Bureau for August 19, 2020 – May 10, 2021 show the number of adults in Washington who received medical care and counseling, as well as the number who delayed or did not receive care (Figure 5).⁷ Among those who responded to the survey, those ages 18 – 29 were the most likely to report that they needed counseling or therapy but did not receive it (18%), and those ages 30 – 39 were the second most likely (16%). Survey respondents were not asked why they were unable to receive behavioral healthcare.

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

- 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](#).^d 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.
- An eventual return to pre-pandemic baseline levels of functioning is anticipated for many people during the summer months of 2021.

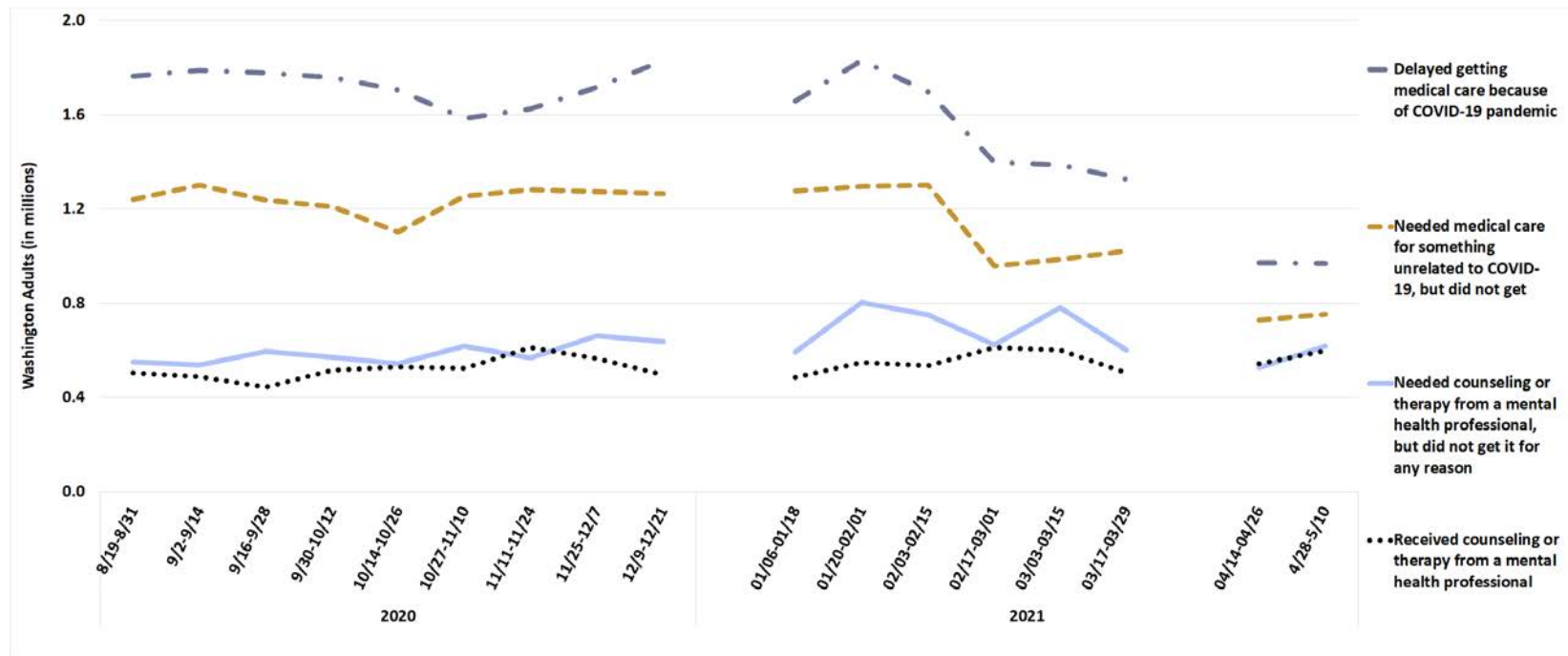


Figure 4: Estimated Washington adults who received or delayed medical care or counseling, by week: August 19, 2020 – May 10, 2021 (Source: U.S. Census Bureau).

Note: The U.S. Census Bureau began this data collection in August 2020 and paused briefly for the period of December 23, 2020 – January 3, 2021 and March 30 – April 14, 2021.

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