Washington State Department of Health

March 2022

DOH 821-135-12

COVID-19 Youth Behavioral Health Impact Situation Report

This monthly situation report presents the potential behavioral health impacts of the COVID-19 pandemic on Washington youth[1] 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 all four syndromic indicators for Washington youth increased 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 (December 2021) showed a 32.3% decrease for youth, compared to the previous month.
    - The most recent reporting period (December 2021) showed a 55% decrease in telehealth behavioral health service claims for individuals 18 and younger.
    - Survey data collected by the U.S. Census Bureau for January 26 – February 7, 2022 show that the greatest number of respondents (who are Washington adults with children ages 5 to 17) indicated that, in the most recent reporting period (December 29, 2021 – January 10, 2022), 66.2% of children ages 5 to 17 have received the COVID-19 vaccine.

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 deviations[4] 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 Week[6] 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.

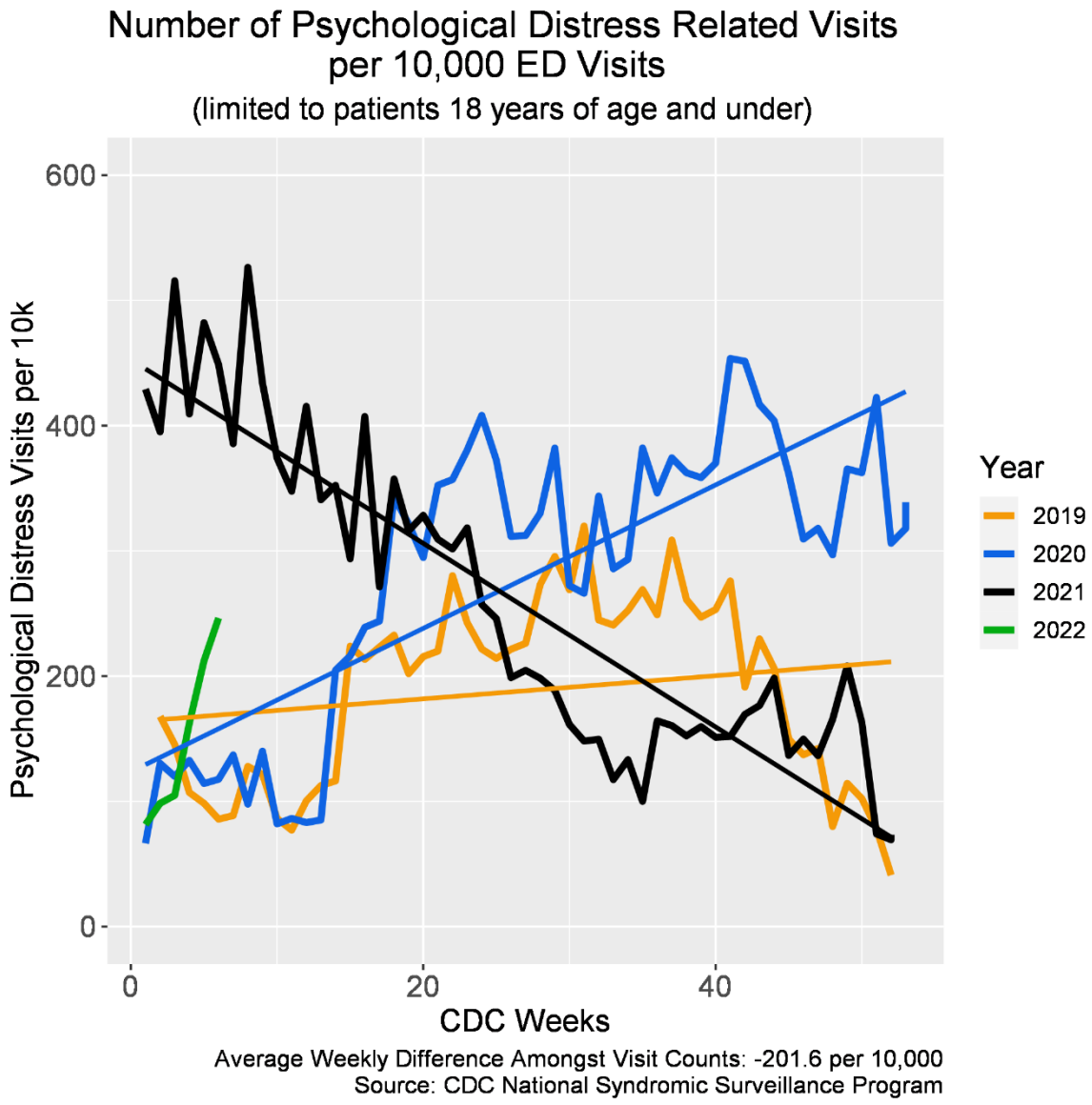
[5] A warning is determined by statistical analysis using p-values from 0.01 – 0.05, while an alert is determined by statistical analysis using p-values of less than 0.01.

[6] https://wwwn.cdc.gov/nndss/document/2020.pdf

Psychological Distress

During **CDC Week 4 (week of January 29, 2022)** the relative reported ED visits for psychological distress[7] among youth **increased from the previous reporting period** and is lower than rates in the corresponding week of 2021 but higher than rates in the corresponding weeks 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, 2021, and 2022 to date (Source: CDC ESSENCE)

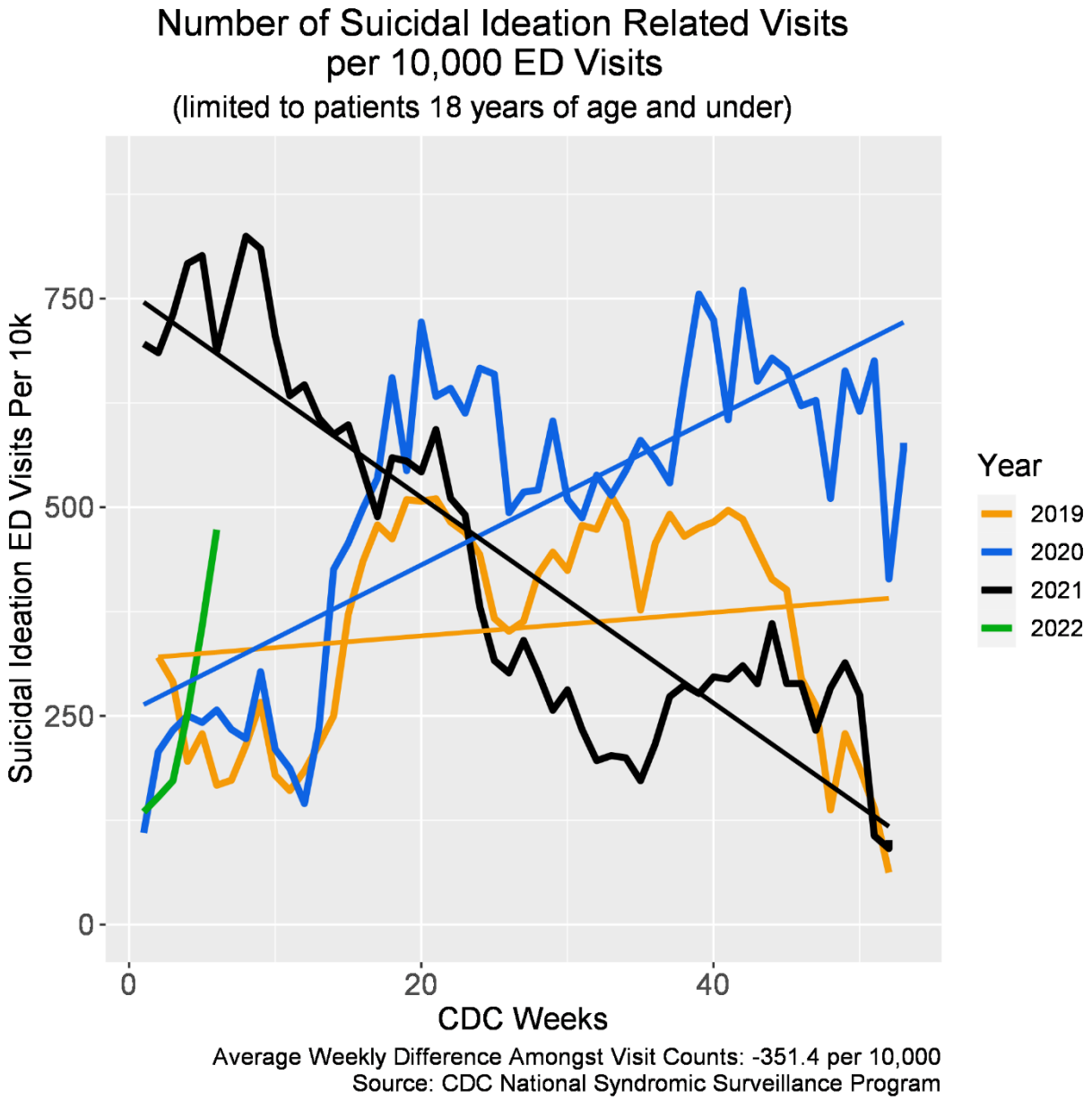


[7] Psychological distress in this context is considered a disaster-related syndrome comprised of panic, stress, and anxiety. It is indexed in the Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE) platform as Disaster-related Mental Health v1. Full details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

Suicidal Ideation and Suspected Suicide Attempts

During **CDC Week 4 (week of January 29, 2022)**, the **relative reported rate of ED visits for suicidal ideation** among youth **increased from the previous reporting period** and is lower than rates in the corresponding week of 2021 but higher than rates in the corresponding weeks of 2019 and 2020 (Graph 2). No statistical warnings or alerts were issued.

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

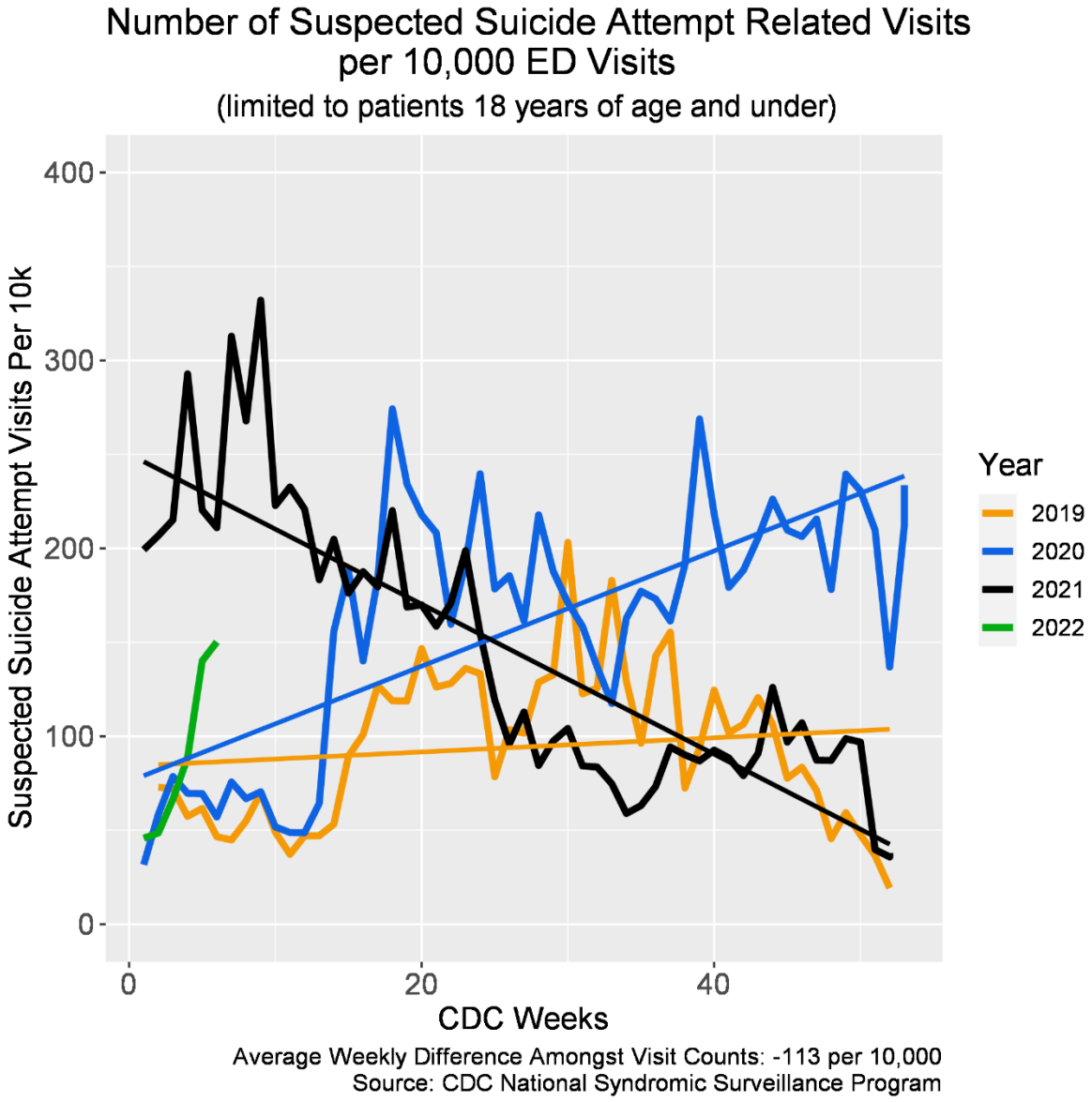


During **CDC Week 4 (week of January 29, 2022),** the **relative reported rate of ED visits for suspected suicide attempts** among youth **increased from the previous reporting period** and is

lower than rates in the corresponding week of 2021 but higher than rates in the corresponding weeks of 2019 and 2020 (Graph 3). No statistical warnings or alerts were 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 rate of such visits.[8]

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

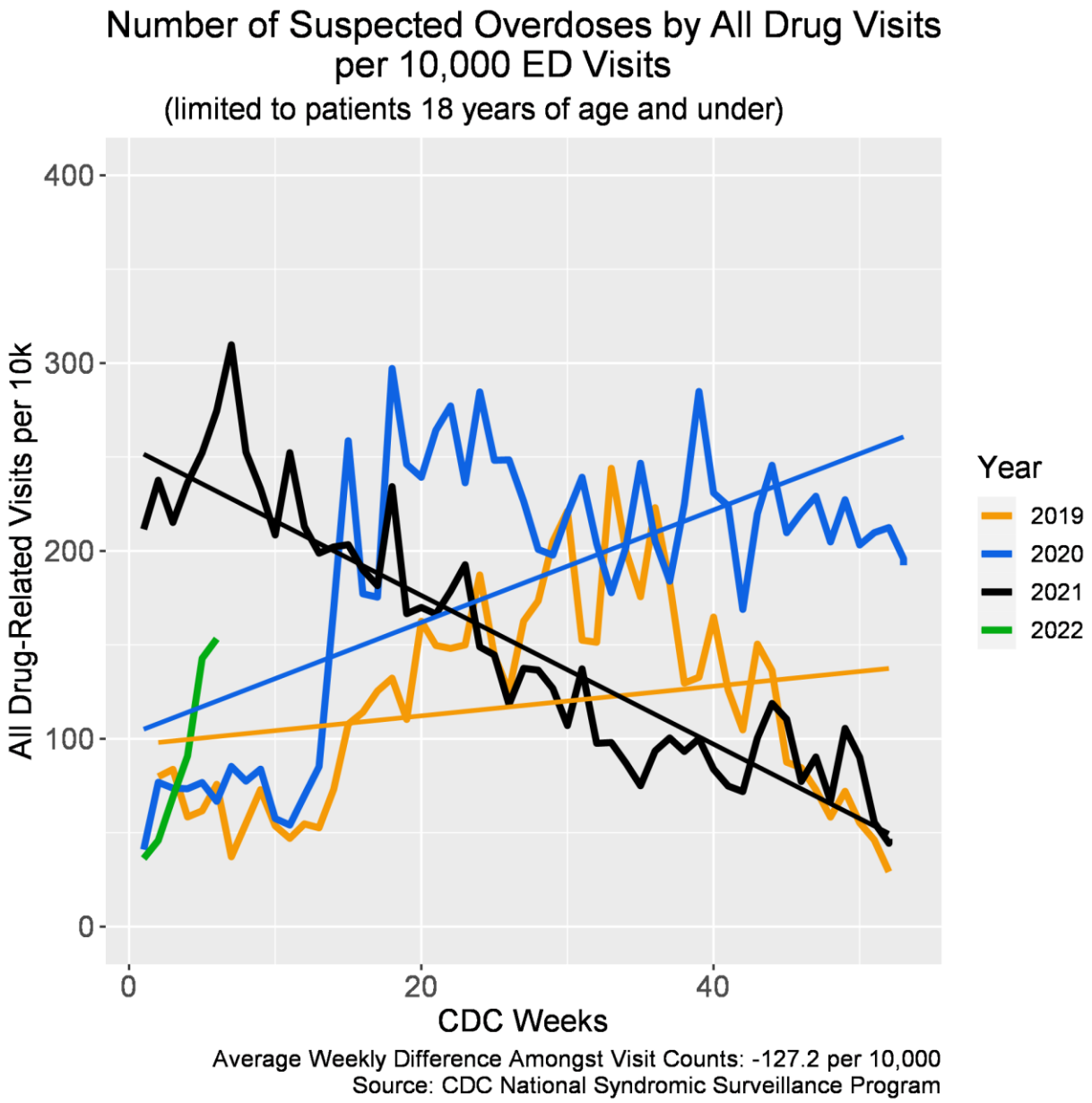


[8] https://knowledgerepository.syndromicsurveillance.org/disaster-related-mental-health-v1-syndrome-definition-subcommittee

Substance Use – Suspected Drug Overdose

During **CDC Week 4 (week of January 29, 2022),** the **relative reported rate of ED visits for suspected drug overdose** among youth **increased from the previous reporting period** and is lower than rates in the corresponding week of 2021 but higher than rates in the corresponding weeks of 2019 and 2020 (Graph 4). No statistical warnings or alerts were issued.

Graph 4: Relative ED count for all drug[9]-related visits among youth in Washington, by week: 2019, 2020, 2021, and 2022 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 5-17

Survey data[10] collected by the U.S. Census Bureau for January 26 – February 7, 2022 show that the greatest number of respondents (who are Washington adults with children ages 5 to 17) indicated that in the most recent reporting period (**December 29, 2021 – January 10, 2022**) 66.2% of children ages 5 to 17 have received the COVID-19 vaccine. Less than half (46.3%) of respondents (who are Washington adults with children ages 5 to 17) who did not receive a COVID-19 vaccine reported that they will *definitely* not get a vaccine for their children ages 5 to 17, while 11.6% of respondents (who are Washington adults with children ages 5 to 17) who did not receive a COVID-19 vaccine reported that they will *probably* not get a vaccine for their children ages 5 to 17. 15.4% and 9.7% of respondents (who are Washington adults with children ages 5 to 17) who did not receive a COVID-19 vaccine reported that they will definitely get a vaccine or probably get a vaccine, respectively, for their children ages 5 to 17 (Graph 5).

For respondents (who are Washington adults with children ages 5 to 17) or household members who experienced loss of employment income in the last four weeks, 3% of those individuals reported that they will probably not get a vaccine for their children ages 5 to 17, 46% of those individuals reported that they will definitely not get a vaccine for their children ages 5 to 17, and 26% of those individuals reported that they will definitely get a vaccine for their children ages 5 to 17.

In terms of "definitely" getting a vaccine for their children ages 5 to 17:

- Highest rate is with respondents in households earning $25,000 - $35,000 per year (52%),
- while the second highest rate is with respondents in households earning less than $25,000 per year (28%).

In terms of "probably" getting a vaccine for their children ages 5 to 17:

- Highest rate is with respondents in households earning $35,000 - $50,000 per year (28%),
- while the second highest rate is with respondents in households earning $150,000 - $200,000 per year (19%).

In terms of "unsure" getting a vaccine for their children ages 5 to 17:

- Highest rate is with respondents in households earning less than $25,000 per year (35%),
- while the second highest rate is with respondents in households earning $100,000 - $150,000 per year (8%).

In terms of "probably not" getting a vaccine for their children ages 5 to 17:

- Highest rate is with respondents in households earning $150,000 - $200,000 per year (37%),

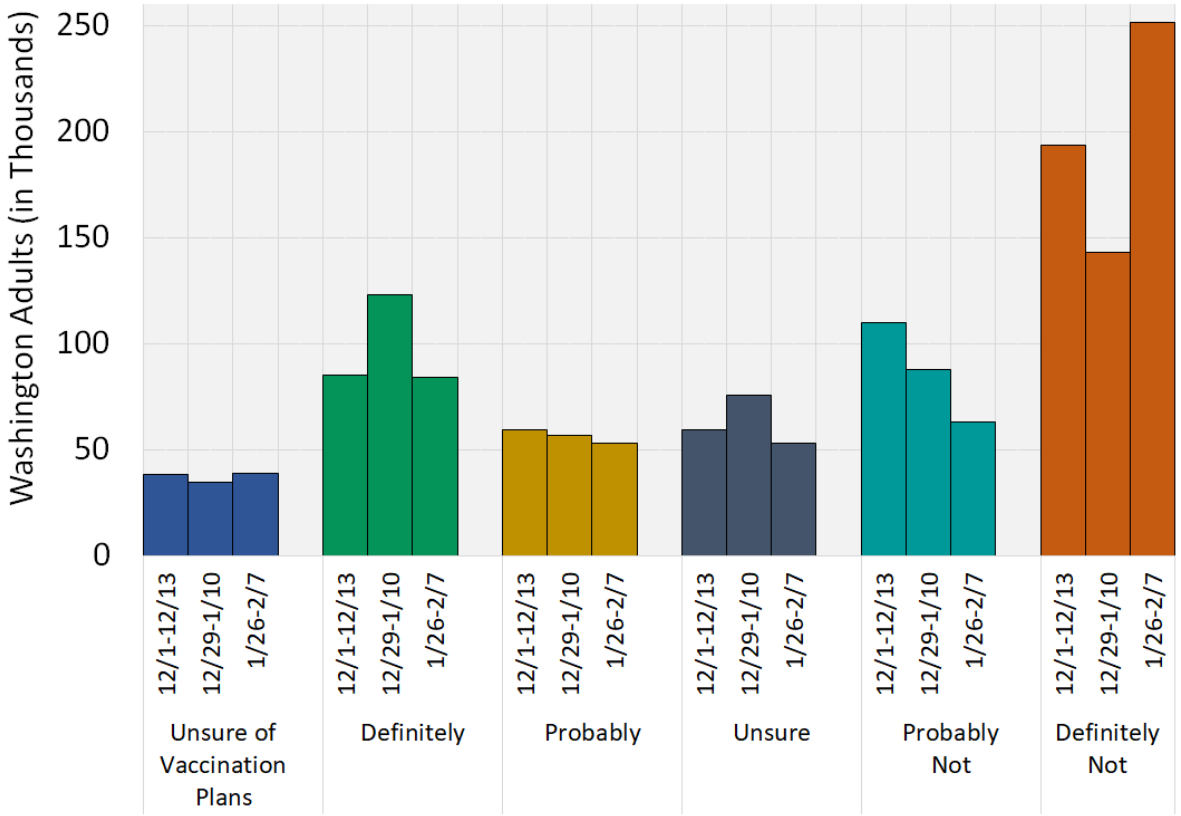
[10] https://www.census.gov/programs-surveys/household-pulse-survey.html

- while the second highest rate is with respondents in households earning $200,000 and above per year (21%).

In terms of “definitely not” getting a vaccine for their children ages 5 to 17:

- Highest rate is with respondents in households earning $75,000 - $100,000 per year (74%),
- while the second highest rate is with respondents in households earning $200,000 and above per year (73%).

Graph 5: Count of Washington adults reporting children’s vaccination plans: December 29, 2021 – February 7, 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 to17 who received a COVID-19 vaccine are not graphically included.

Reasons for children (ages 5 to17) not receiving or planning to receive a COVID-19 vaccine

Survey data[10] further show reasons for children (ages 5 to 17) not receiving or planning to receive a COVID-19 vaccine from January 26 – February 7, 2022 (Graph 6). In the most recent reporting period (January 26 – February 7, 2022), 19% of Washington adults with children ages 5 to 17 reported being concerned about possible side effects for children, 2% of Washington adults with children ages 5 to 17 reported not believing children need a vaccine, 11% of Washington adults with children ages 5 to 17 reported not trusting the government, 12% of Washington adults with children (ages 5 to 17) reported not trusting the COVID-19 vaccine, 13% of Washington adults with children (ages 5 to 17) reported that their children were not members of a high risk group, and 9% of Washington adults with children (ages 5 to 17) reported planning to wait and see if the vaccines are safe.

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

- Highest rate is with respondents in households earning $150,000 - $200,000 per year (16%),
- while the second highest rate is with respondents in households earning less than $25,000 (15%).

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

- Highest rate is with respondents in households earning $75,000 - $100,000 per year (17%),
- while the second highest rate is with respondents in households earning $200,000 and above per year (15%).

In terms of "not believing children need a vaccine":

- Highest rate is with respondents in households earning $75,000 - $100,000 per year (19%),
- while the second highest rate is with respondents in households earning $100,000 and $150,000 per year (18%).

In terms of "not trusting the COVID-19 vaccines":

- Highest rate is with respondents in households earning $25,000 and $35,000 per year (16%),
- while the second highest rate is with respondents in households earning $200,000 and above per year (15%).

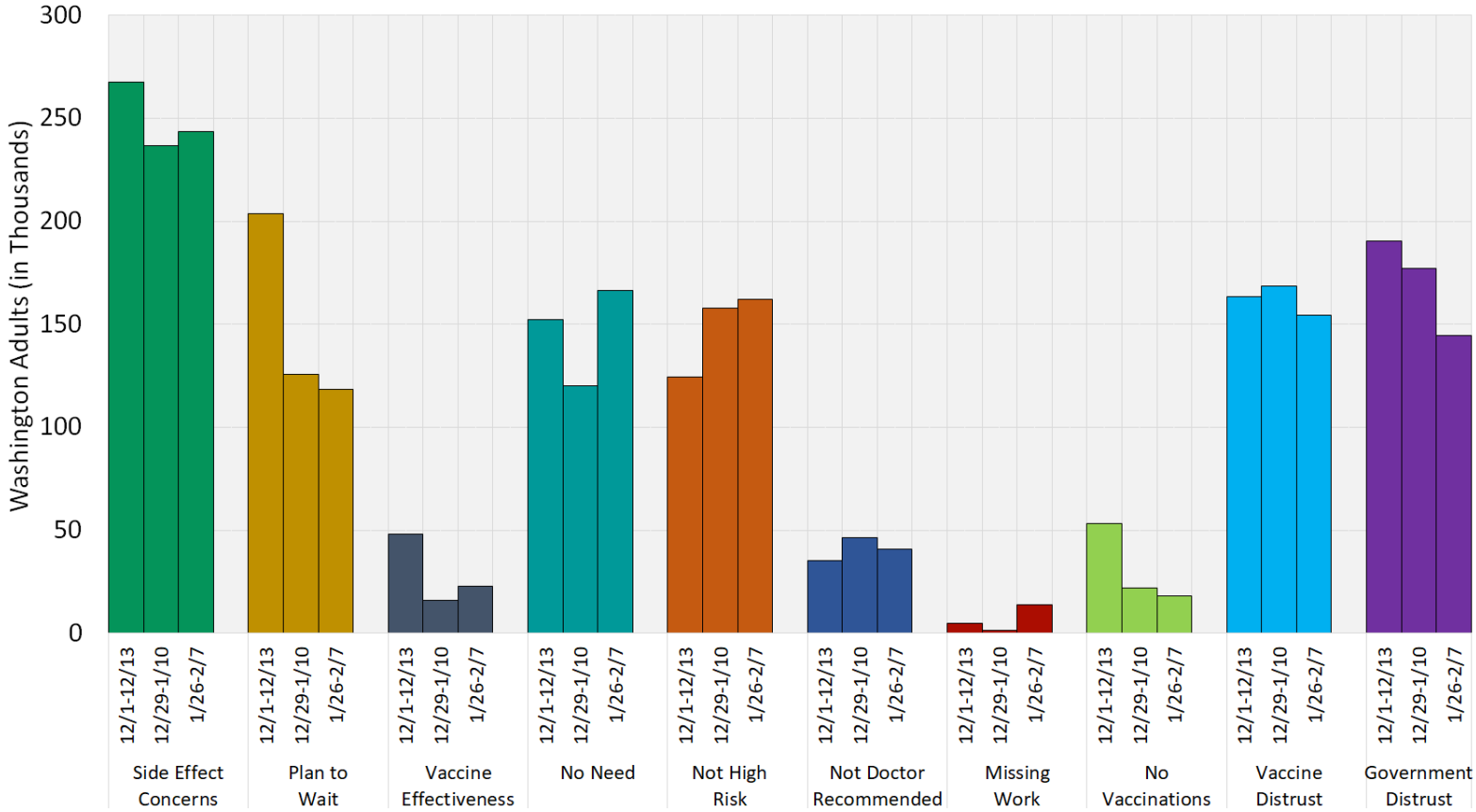
In terms of "parents or guardians do not vaccinate their children":

- Highest rate is with respondents in households earning $50,000 - $75,000 per year (16%),
- while the second highest rate is with respondents in households earning $25,000 - $35,000 per year (15%).

In terms of "concern about the cost of vaccines":

- Highest rate is with respondents in households earning $50,000 - $75,000 per year (19%),
- while the second highest rate is with respondents in households earning $200,000 and above per year (13%).
- Note, COVID-19 vaccines are provided at no cost. The federal government will cover the cost of the COVID-19 vaccine.

Graph 6: Count of Washington adults reporting reasons for children not receiving or planning to receive a COVID-19 vaccine: December 29, 2021 – February 7, 2022 (Source: U.S. Census Bureau)

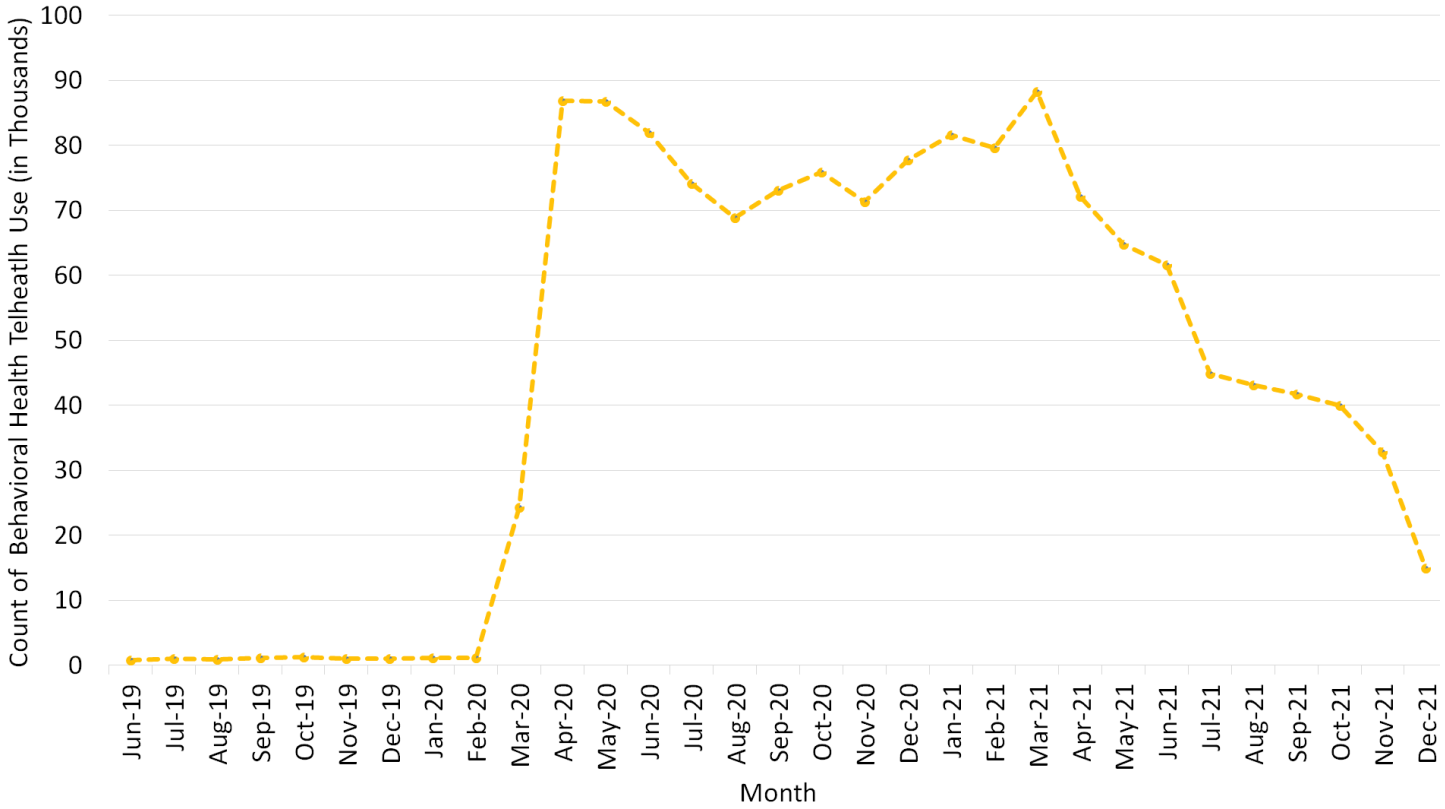


Note: Side Effect Concerns (concerned about possible side effects for children); **Plan to Wait** (plan to wait and see if it is safe); **Vaccine Effectiveness** (not sure if vaccine will work for children); **No Need** (don't believe children need a vaccine); **Not High Risk** (children in household not members of a high risk group); **Not Doctor Recommended** (children's doctor has not recommended a vaccine); **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. 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). 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 (December 2021) showed a 55% decrease 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)

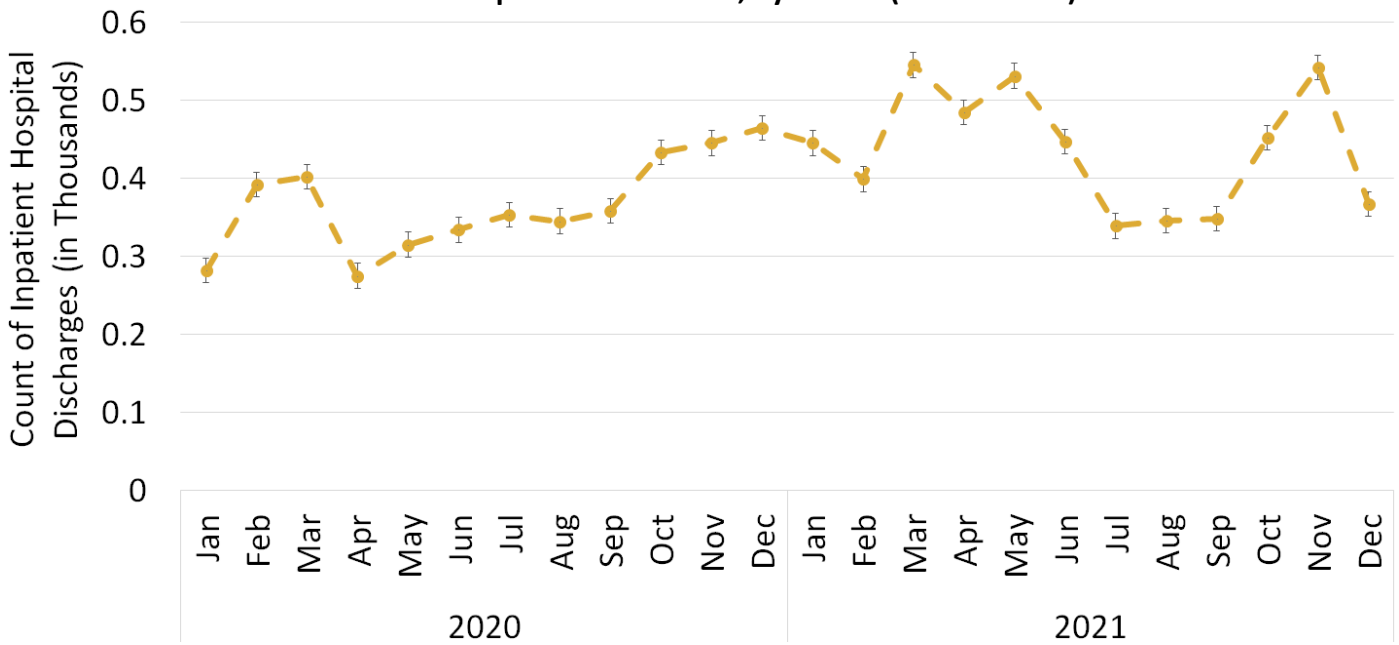


Note: Due to missing or suppressed data, results may be underreported.

Inpatient Community Hospital Discharges

The Comprehensive Hospital Abstract Reporting System (CHARS)[11] 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-codes[12]). Graph 8 shows the count of youth inpatient community hospital discharges for mental, behavioral, and neurodevelopmental disorders. The most recent reporting period (December 2021) showed a 32.3% 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)



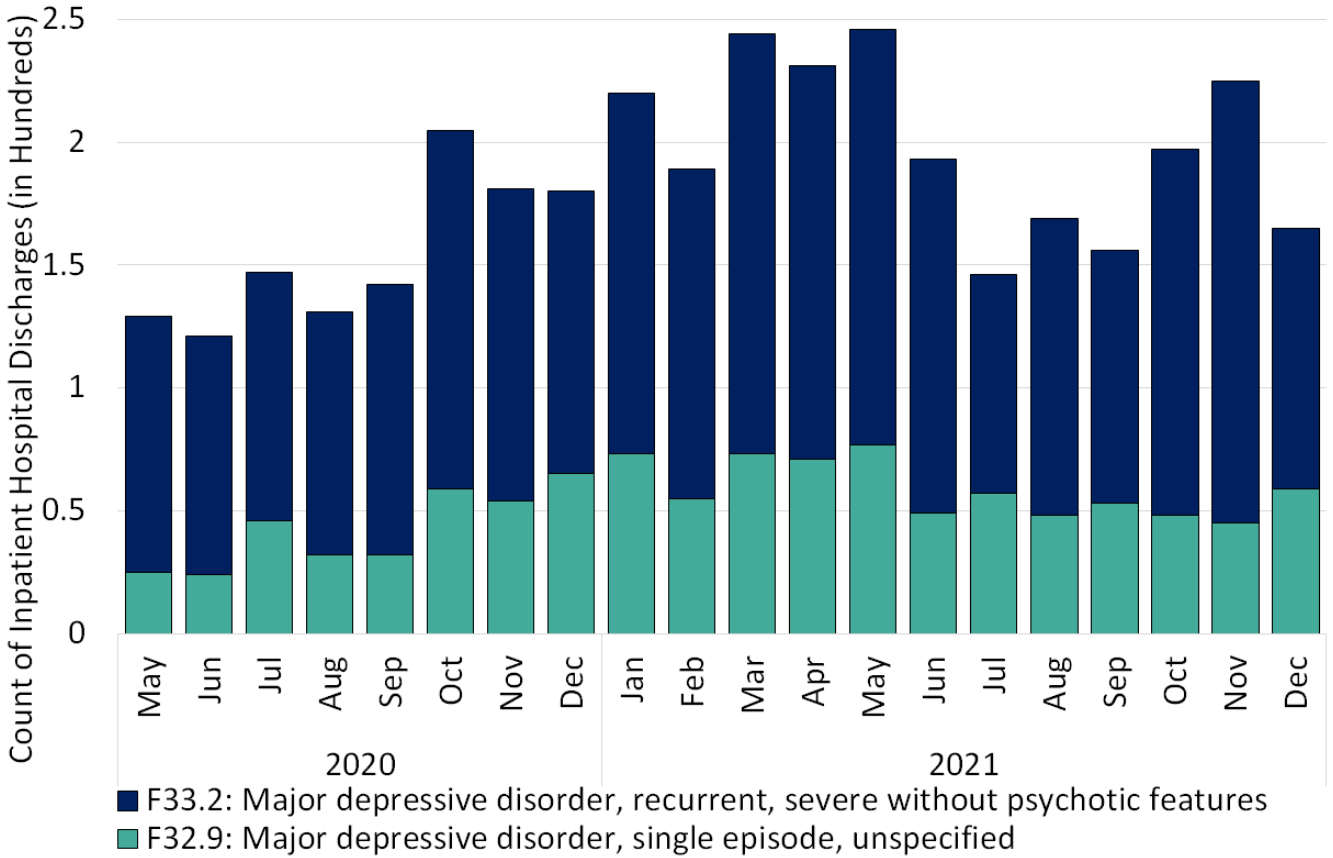
Note: Due to time lag, data might not be fully mature. While non-WA residents can discharge from a WA community hospital, only WA youth residents were included in the analysis. Only F-codes as primary diagnoses were included in the analysis.

[11] https://www.doh.wa.gov/dataandstatisticalreports/healthcareinwashington/hospitalandpatientdata/hospitaldischargedatachars

[12] 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 two mental, behavioral, and neurodevelopmental disorders in terms of inpatient community hospital discharges. The most recent reporting period showed a 31.1% increase in “major depressive disorder, single episode, unspecified” inpatient community hospital discharges and a 41.1% 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)



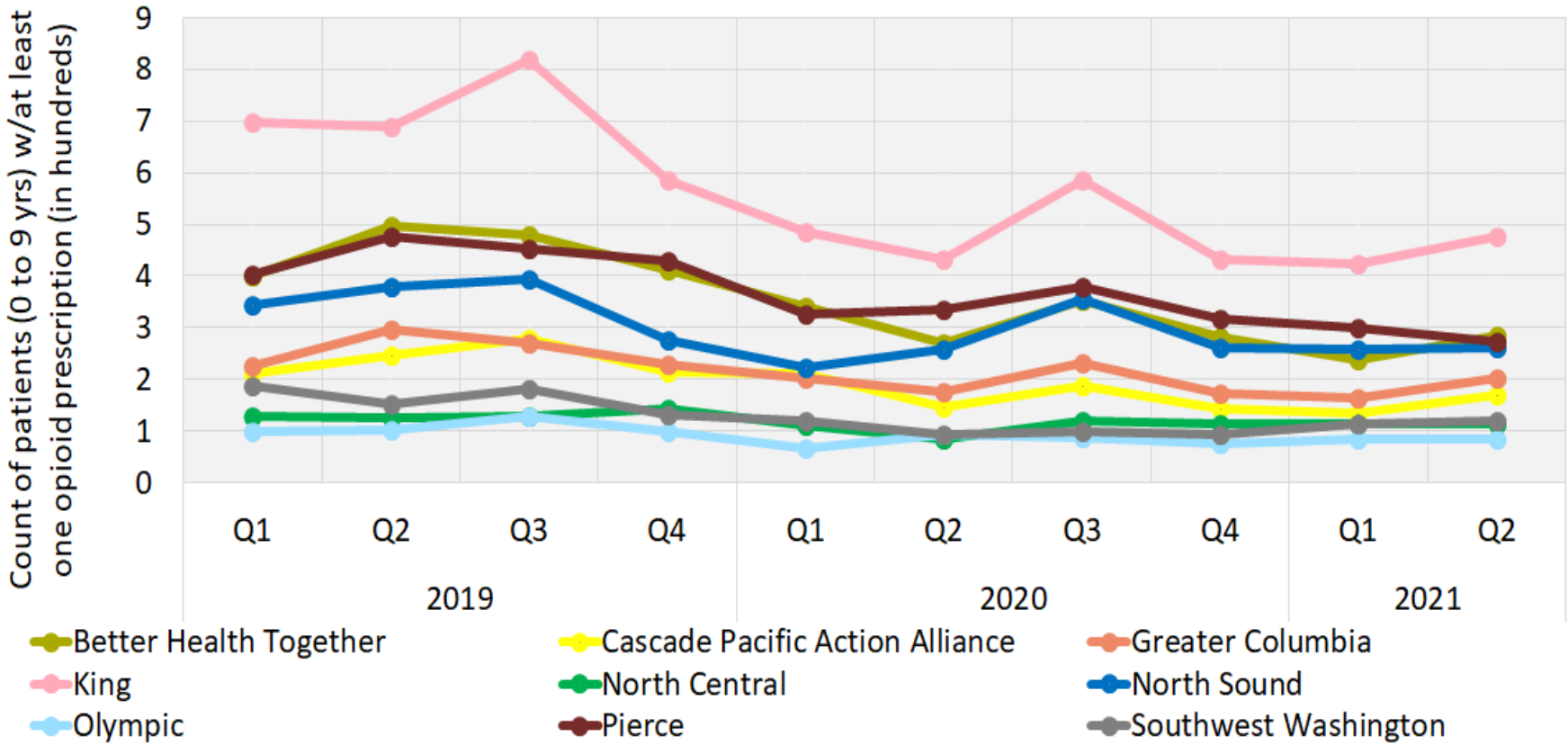
Note: Due to time lag, data might not be fully mature. While non-WA residents can discharge from a WA community hospital, only WA youth residents were included in the analysis. Only F-codes as primary diagnoses were included in the analysis. Due to low numbers, previously reported disorders are not further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

Prescription Opioids Usage

DOH's Prescription Monitoring Program (PMP) collects the prevalence of prescription opioid use. For the overall Washington population ages 0 to 9, the most recent reporting period (Quarter 2 of 2021) showed a 9% increase of patients with at least one opioid prescription submitted to the PMP as compared to the previous calendar quarter (Quarter 1 of 2021). Graph 10 provides a count of patients ages 0 to 9, broken down by calendar quarter and Accountable Communities of Health (ACHs), with at least one opioid prescription submitted to the PMP. Stratifying by ACHs:

- For **Better Health Together ACH**, the most recent reporting period (Quarter 2 of 2021) showed a **19% increase** of patients ages 0 to 9 with at least one opioid prescription submitted to the PMP as compared to the previous calendar quarter (Quarter 1 of 2021)
- For **Cascade Pacific Action Alliance ACH**, the most recent reporting period (Quarter 2 of 2021) showed a **26% increase** of patients ages 0 to 9 with at least one opioid prescription submitted to the PMP as compared to the previous calendar quarter (Quarter 1 of 2021)
- For **Greater Columbia ACH**, the most recent reporting period (Quarter 2 of 2021) showed a **23% increase** of patients ages 0 to 9 with at least one opioid prescription submitted to the PMP as compared to the previous calendar quarter (Quarter 1 of 2021)
- For **King ACH**, the most recent reporting period (Quarter 2 of 2021) showed a **12% increase** of patients ages 0 to 9 with at least one opioid prescription submitted to the PMP as compared to the previous calendar quarter (Quarter 1 of 2021)
- For **North Central ACH**, the most recent reporting period (Quarter 2 of 2021) showed a **1% decrease** of patients ages 0 to 9 with at least one opioid prescription submitted to the PMP as compared to the previous calendar quarter (Quarter 1 of 2021)
- For **North Sound ACH**, the most recent reporting period (Quarter 2 of 2021) showed a **1% increase** of patients ages 0 to 9 with at least one opioid prescription submitted to the PMP as compared to the previous calendar quarter (Quarter 1 of 2021)
- For **Olympic ACH**, the most recent reporting period (Quarter 2 of 2021) showed a **1% decrease** of patients ages 0 to 9 with at least one opioid prescription submitted to the PMP as compared to the previous calendar quarter (Quarter 1 of 2021)
- For **Pierce ACH**, the most recent reporting period (Quarter 2 of 2021) showed a **9% decrease** of patients ages 0 to 9 with at least one opioid prescription submitted to the PMP as compared to the previous calendar quarter (Quarter 1 of 2021)
- For **Southwest Washington ACH**, the most recent reporting period (Quarter 2 of 2021) showed a **6% increase** of patients ages 0 to 9 with at least one opioid prescription submitted to the PMP as compared to the previous calendar quarter (Quarter 1 of 2021)

Graph 10: Count of patients ages 0 to 9 with at least one opioid prescription, by calendar quarter and ACHs (Source: DOH)

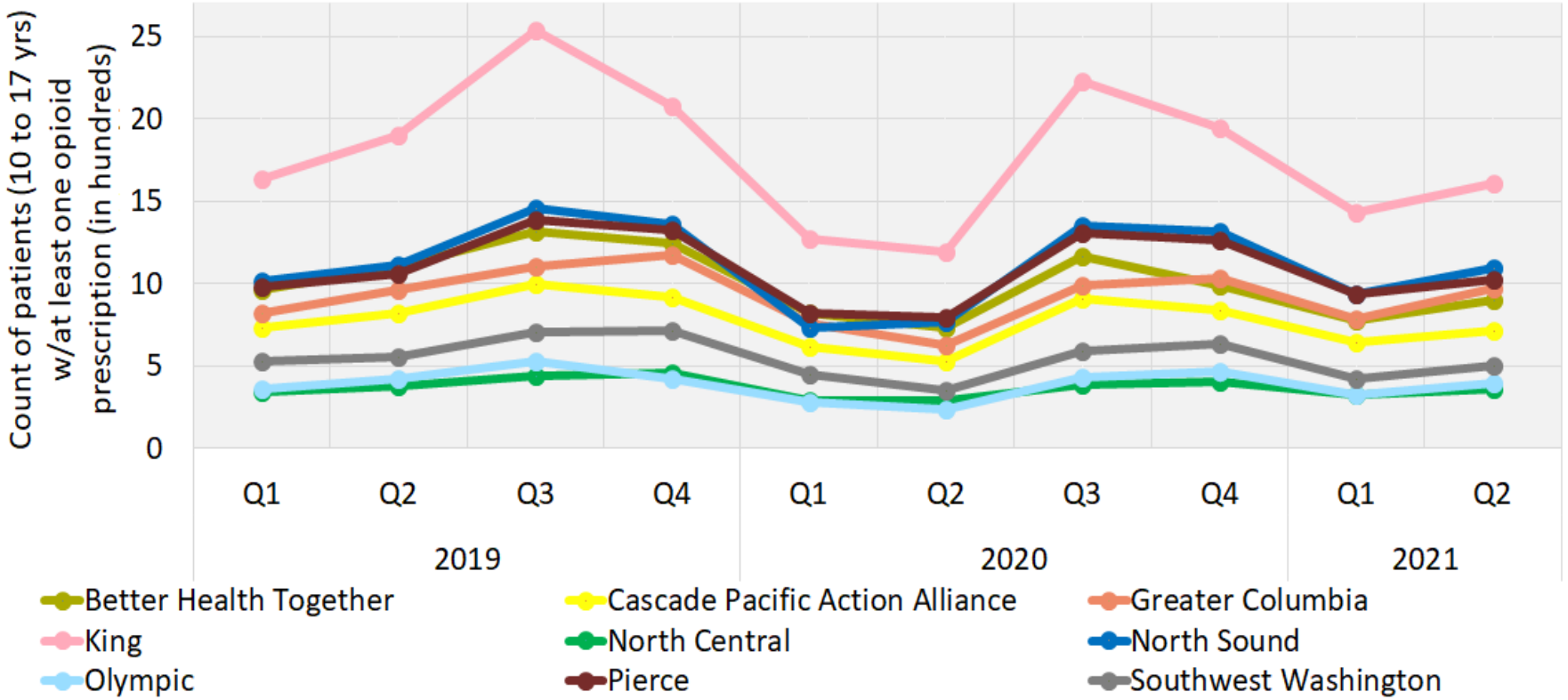


Note: Caution should be taken when examining these data; for Quarter 2 of 2021, 95% CI [2.04, 2.22] with a state population of 930,802 and state rate of 2.13 while Quarter 1 of 2021 presented with a 95% CI [1.88, 2.06] with a state population of 930,802 and state rate of 1.97. 2021 population estimates are based on the Office of Financial Management (OFM)'s 2020 population estimates; data can be potentially impacted when OFM releases the 2021 population estimates. Please refer to link, opioid data technical notes (PDF) (wa.gov), for technical details and limitations about the data and the metrics utilized including CI, ACH populations, and ACH state rate. For more information please refer to link: dashboard: Opioid Prescriptions and Drug Overdoses

For the overall Washington population ages 10 to 17, the most recent reporting period (Quarter 2 of 2021) showed a 15% increase of patients with at least one opioid prescription submitted to the PMP as compared to the previous calendar quarter (Quarter 1 of 2021). Graph 11 provides a count of patients ages 10 to 17, broken down by calendar quarter and ACHs, with at least one opioid prescription submitted to the PMP. Stratifying by ACHs:

- For **Better Health Together ACH**, the most recent reporting period (Quarter 2 of 2021) showed a **15% increase** of patients **ages 10 to 17** with at least one opioid prescription submitted to the PMP as compared to the previous calendar quarter (Quarter 1 of 2021)
- For **Cascade Pacific Action Alliance ACH**, the most recent reporting period (Quarter 2 of 2021) showed a **10% increase** of patients **ages 10 to 17** with at least one opioid prescription submitted to the PMP as compared to the previous calendar quarter (Quarter 1 of 2021)
- For **Greater Columbia ACH**, the most recent reporting period (Quarter 2 of 2021) showed a **23% increase** of patients **ages 10 to 17** with at least one opioid prescription submitted to the PMP as compared to the previous calendar quarter (Quarter 1 of 2021)
- For **King ACH**, the most recent reporting period (Quarter 2 of 2021) showed a **13% increase** of patients **ages 10 to 17** with at least one opioid prescription submitted to the PMP as compared to the previous calendar quarter (Quarter 1 of 2021)
- For **North Central ACH**, the most recent reporting period (Quarter 2 of 2021) showed a **12% increase** of patients **ages 10 to 17** with at least one opioid prescription submitted to the PMP as compared to the previous calendar quarter (Quarter 1 of 2021)
- For **North Sound ACH**, the most recent reporting period (Quarter 2 of 2021) showed a **17% increase** of patients **ages 10 to** 17 with at least one opioid prescription submitted to the PMP as compared to the previous calendar quarter (Quarter 1 of 2021)
- For **Olympic ACH**, the most recent reporting period (Quarter 2 of 2021) showed a **20% increase** of patients **ages 10 to 17** with at least one opioid prescription submitted to the PMP as compared to the previous calendar quarter (Quarter 1 of 2021)
- For **Pierce ACH**, the most recent reporting period (Quarter 2 of 2021) showed a **10% increase** of patients **ages 10 to 17** with at least one opioid prescription submitted to the PMP as compared to the previous calendar quarter (Quarter 1 of 2021)
- For **Southwest Washington ACH**, the most recent reporting period (Quarter 2 of 2021) showed a **20% increase** of patients **ages 10 to 17** with at least one opioid prescription submitted to the PMP as compared to the previous calendar quarter (Quarter 1 of 2021

Graph 11: Count of patients ages 10 to 17 with at least one opioid prescription, by calendar quarter and ACHs (Source: DOH)



Note: For Quarter 2 of 2021, 95% CI [9.63, 10.07] with a state population of 766,613 and state rate of 9.85 while Quarter 1 of 2021 presented with a 95% CI [8.36, 8.78] with a state population of 766,613 and state rate of 8.57. 2021 population estimates are based on the OFM's 2020 population estimates; data can be potentially impacted when OFM releases the 2021 population estimates. Please refer to link, opioid data technical notes (PDF) (wa.gov), for technical details and limitations about the data and the metrics utilized including CI, ACH populations, and ACH state rate. For more information please refer to link: dashboard: Opioid Prescriptions and Drug Overdoses

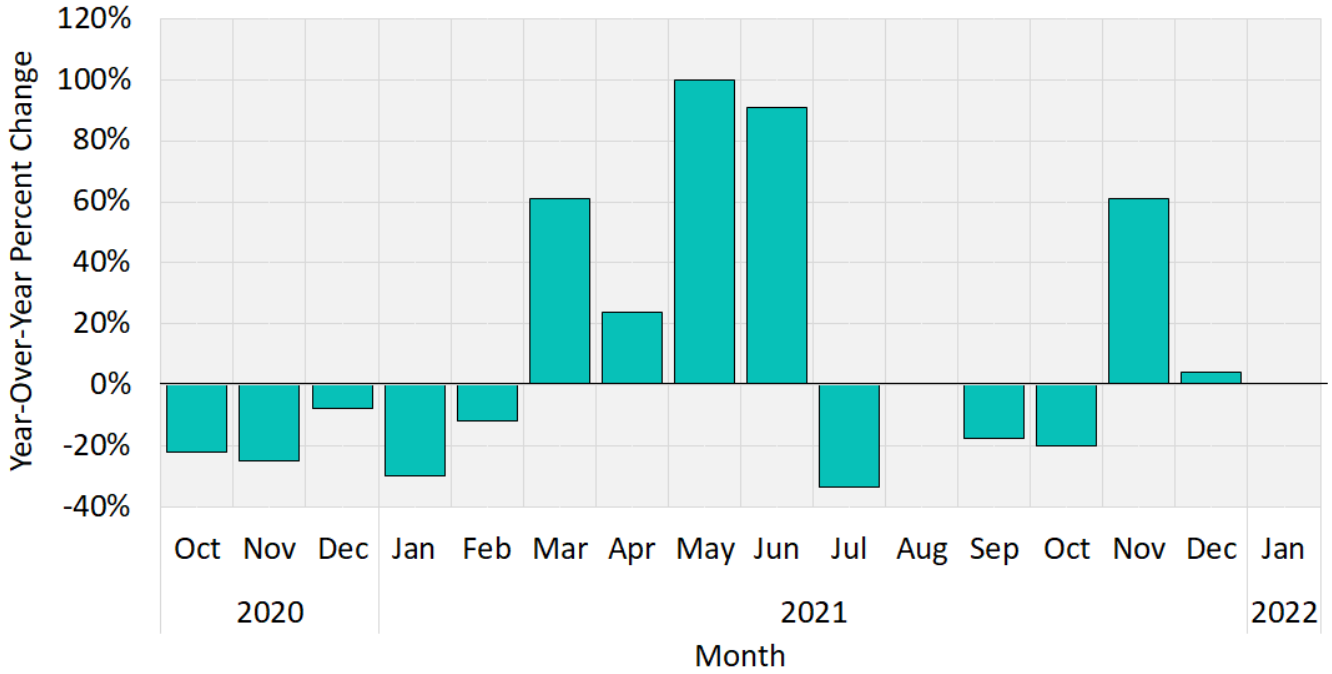
Court Reporting

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

Mental Illness (Minor) Filings

Monthly filings from the AOC show the initiation of a court case by formal submission for mental illness (minor) cases. Most recently, there was no year-over-year[13] percent change in January 2022 for monthly mental illness (minor) case filings (+4%), compared to the previous year (Graph 12).

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



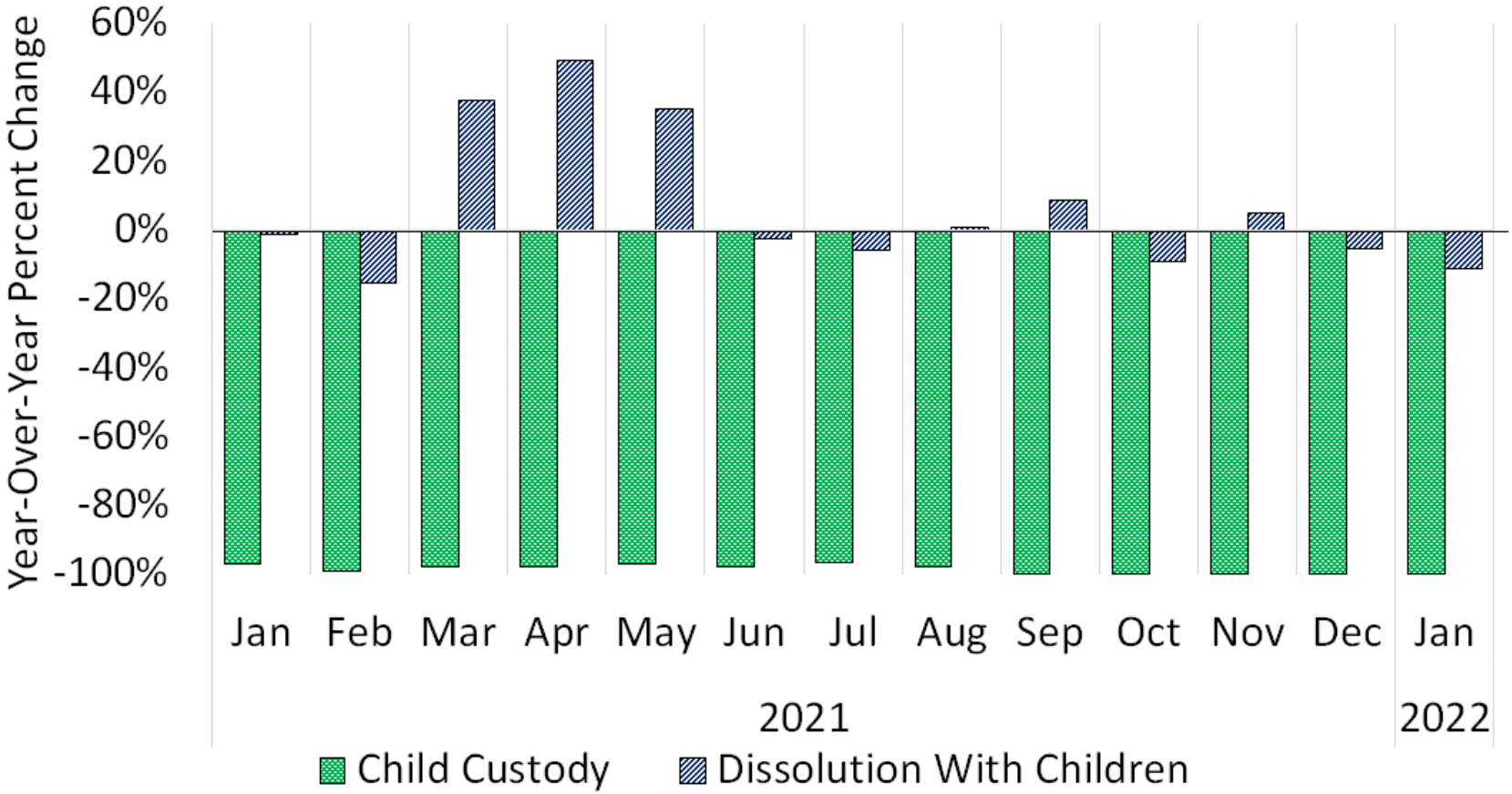
Note: Each unique mental illness case number is reported as a single filing, no matter how many subsequent petitions are filed during the life of a case. A case reopened for subsequent adjudication after the initial judgment is not considered a new filing unless there is a new case number. Mental illness (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.

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

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. In January 2022, there was a year-over-year percent decrease in for monthly child custody case filings (-100%) and in dissolution with children (-11%) (Graph 13).

Graph 13: Percent change of child custody and marriage dissolution with children filings, by month (Source: AOC)

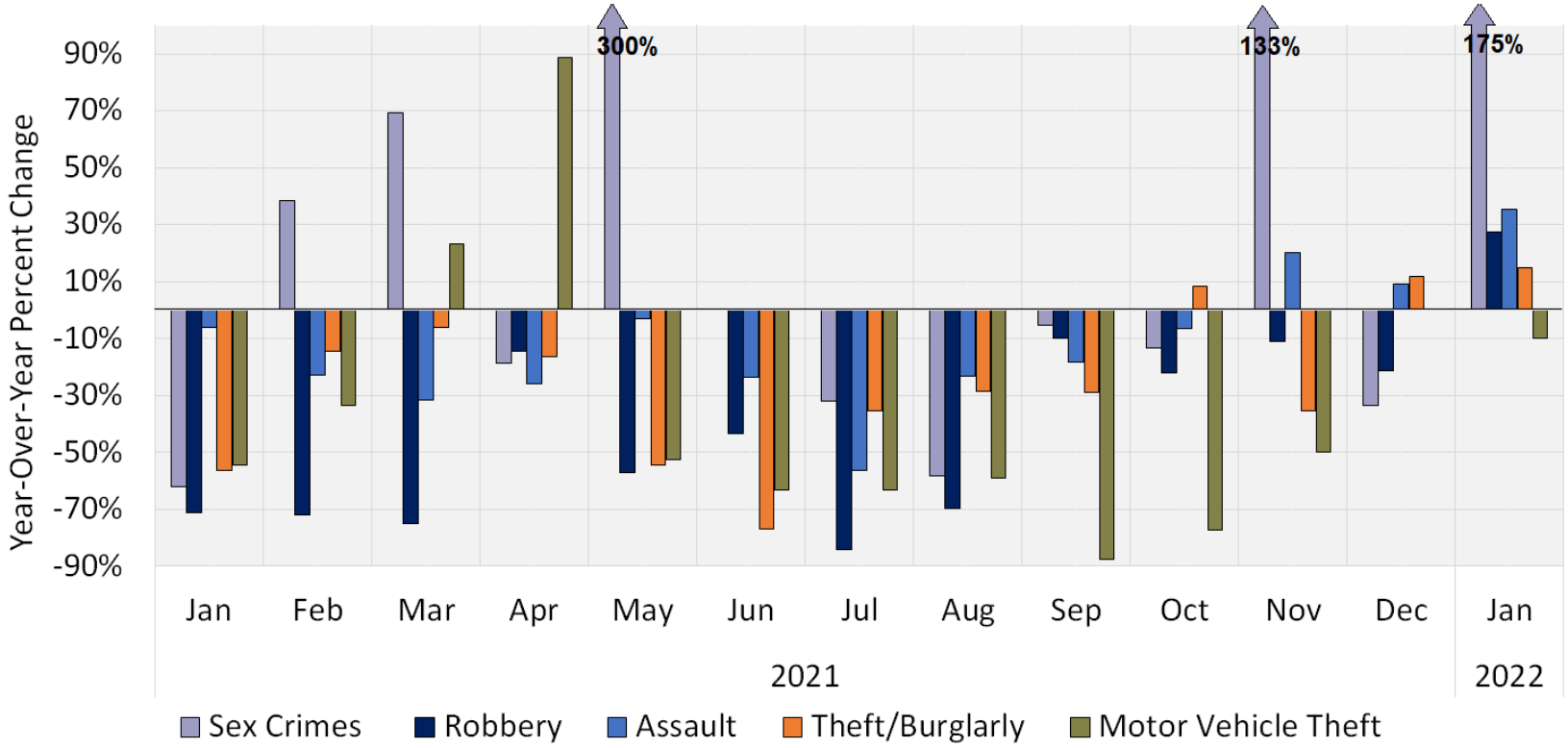


Note: Monthly filings from the AOC show the initiation of a court case by formal submission for child custody (i.e., dispute involving immediate charge and control of a child) and dissolution with children of the marriage (i.e., termination of a marriage other than by annulment, with dependent children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

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. Most recently, there were year-over-year percent changes in January 2022 for monthly juvenile offender filings with a 175% increase in sex crimes, a 27% increase in robberies, a 35% increase in assaults, a 15% increase in thefts/burglaries, and a 10% decrease in motor vehicle thefts (Graph 14).

Graph 14: Percent change of juvenile offender filings, by charge and month (Source: AOC)

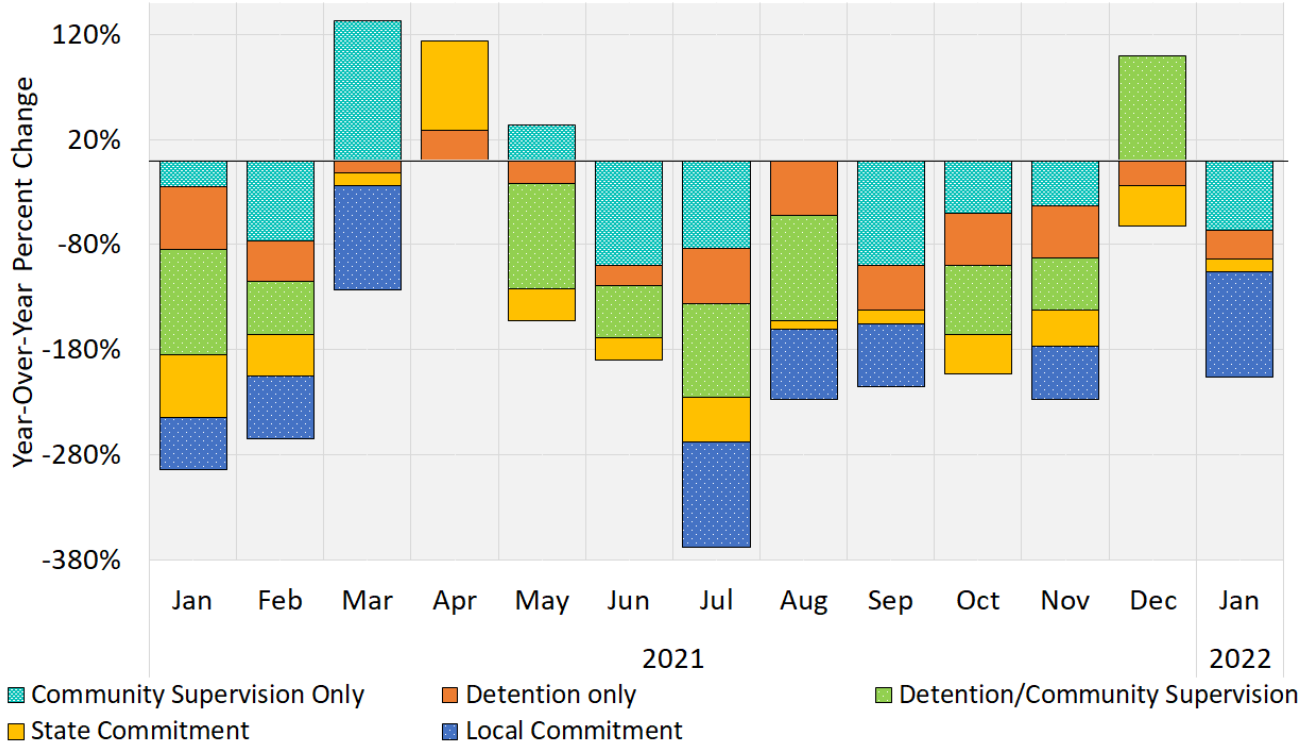


Note: **Sex crimes** involve sexual exploitation of a minor, incest, rape, statutory rape, or indecent liberties. **Robbery** involves theft of property by the use of force, violence, or fear of injury to a person or their property. **Assault** involves assault or intent to cause another person physical 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. Most recently, there were year-over-year percent decreases in January 2022 for state commitment (-12%), detention only (-28%), local commitment (-100%), and community supervision only (-67%); no changes were found in detention/community supervision (Graph 15).

Graph 15: 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.

Acknowledgements

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