



Social and Behavioral Health During COVID-19

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Table of Contents

Executive Summary	1
Introduction	3
Warning Signs: What to Look Out For.....	5
Taking Care of Your Mental Health	6
Social and Behavioral Health Indicators	8
Public Behavior Indicators	8
Figure 1: Percentage of Adults Who Report Always Wearing a Mask in Public	8
Figure 2: Percentage of Adults Who Report They Are Very Likely to Receive the COVID-19 Vaccine	8
Mental Health Indicators	9
Figure 3: Percentage of Adults Reporting Frequent Mental Distress	9
Figure 4: Rate of Disaster Related Mental Health per 10,000 Emergency Department Visits	9
Suicide-related Indicators	10
Figure 5: Rate of Suicide Ideation per 10,000 Emergency Department Visits	10
Figure 6: Rate of Suicide Attempts per 10,000 Emergency Department Visits	10
Figure 7: Number of Deaths by Suicide by Year.....	11
Drug-related Indicators	12
Figure 8: Rate of Drug Overdoses per 10,000 Emergency Department Visits	12
Figure 9: Number of Deaths by Any Drug Overdose by Year	12
Figure 10: Rate of Opioid Overdoses per 10,000 Emergency Department Visits	13
Figure 11: Number of Deaths by Opioid-involved Overdose by Year, Utah 2018-2019	13
Figure 12: Rate of Methamphetamine Use per 10,000 Emergency Department Visits	14
Figure 13: Rate of Alcohol-related Emergency Department Visits per 10,000 Emergency Department Visits	14
Prescription-related Indicators	15
Figure 14: Number of Prescription Days Supplied	15
Figure 15: Number of Prescriptions Filled	15
Figure 16: Number of Opioid Prescriptions Filled	16
Figure 17: Number of Anti Anxiety Prescriptions Filled	16
Figure 18: Number of Anti Hypertensive Prescriptions Filled	17
Figure 19: Number of Antidepressant Depression Prescriptions Filled	17
Service Utilization.....	18
Figure 20: Number of New Intakes at Local Mental Health Authorities	18
Figure 21: Number of New intakes at Local Substance Abuse Authorities	18
Table 1: Outcome Questionnaire Assessments by Youth and Adult Outcomes	19
Figure 22: The Number of Crisis Line and Warm Line Calls, SafeUT, and Total Crisis Volume	20
Figure 23: Syringe Service New Participants	21
Figure 24: Syringe Service Total Encounters	21
Considerations of Families	22
Children and Adolescents	22
Child Abuse and Neglect.....	24
Domestic Violence.....	25
Appendix A. Data Description and Limitations	27
References.....	29

Key Findings

- Reports of suicide ideation and attempt remained stable throughout the pre-COVID-19 period and during the COVID-19 interventions period.
- The number of suicide deaths did not increase in the first 39 weeks of 2020; the number of suicide deaths in Utah is consistent with the previous three years.
- The number of drug overdoses reported to emergency departments remained stable through the first 50 weeks of 2020.
- Fatal drug overdoses remained stable throughout the first 39 weeks of 2020, were consistent with drug overdose death counts in 2019, and were lower than drug overdose death deaths in 2018.
- The number of alcohol-related emergency department visits was stable in the first 50 weeks of 2020.
- There was a modest decrease in the number of prescription medications filled in the first 50 weeks of 2020.
- Calls to the Suicide Prevention CrisisLine increased throughout the first 10 months of 2020, but this growth is similar to increases in previous years.
- Syringe service utilization increased in the first eight months of 2020 (compared to 2019), but this increase is likely due to expansion of services across the state.

Key Takeaways

- The typical response to multiple stressors and crises is resilience and recovery; most people live through and effectively manage crises, serious mental illness, and extremely difficult circumstances.
- Receiving care in a timely manner is critical for people experiencing increased emotional, mental, or substance use related concerns.
- Providers have the ability to meet with patients virtually and facilities are taking abundant and effective precautions to prevent the spread of COVID-19—it is safe to seek professional help.

**Seek help for yourself or for someone you care about:
800-273-TALK or find more resources at
coronavirus.utah.gov/mental-health/#Mental-Health-Resources**

The evolution of the COVID-19 pandemic has dominated the headlines and increased public concern over the past several months. In this time, there has also been growing worry that the impacts of both the pandemic and public health disease mitigation strategies, including stay-at-home orders and social distancing, would have negative impacts on behavioral health outcomes in Utah. There is evidence that the stress of the uncertainty of the current situation, financially, physically and mentally has taken its toll on the mental health of many Utahns. This is evidenced in the increased calls to local crisis hotlines and the levels of distress exhibited by callers. However there is currently no evidence that directly links public health measures to increased levels of mental distress among Utahns.

Utah has a wealth of timely data to monitor social and behavioral health indicators. Fortunately, Utah has not seen increases in mental health indicators including suicide ideation, attempts, or deaths. In addition, drug related indicators have not increased during the COVID-19 pandemic compared with previous years. This includes overall drug overdoses and deaths that include opioids, methamphetamines, or alcohol. As the pandemic continues to unfold, it will be necessary for public health to continue monitoring these indicators closely. Routine monitoring allows professionals the ability to restructure resources to meet the needs of vulnerable populations and be responsive to Utah communities.

It is imperative that individuals continue to take care of their own mental health. It is critical for people experiencing increased emotional, mental, or substance use related concerns to receive care in a timely manner. Providers have the ability to meet with patients virtually and health care facilities are taking abundant and effective precautions to prevent the spread of COVID-19. It is safe to seek professional help. It is also important for local communities to be responsive to the needs of its members in promoting connectedness and resiliency. Communities can also ensure their citizens are aware of important financial, emotional, and other relevant resources.

Utah and its people are incredibly strong and the typical response of both individuals and our communities in times of crisis have been resilience and recovery. In addition, most people who experience crises, serious mental illness, and extremely difficult situations survive and move forward to thrive. There is also strength in reaching out for help and offering help when it is needed. As Utahns, we pride ourselves on caring about our neighbors and always being willing to lend a helping hand.

This publication provides an overview of social and behavioral health during the COVID-19 pandemic in Utah. The goal is to highlight data related to mental health and substance use in Utah prior to COVID-19 interventions and the weeks following, in addition to concurrent unprecedented events (Figure 1). Utah is fortunate to have a robust system of timely data to monitor social and behavioral health indicators. Routine monitoring of these indicators allows professionals the ability to restructure resources to meet the needs of Utahns in order to prevent further negative impacts.

This report is being released at a time of great hope and great uncertainty: COVID-19 vaccines are being distributed, yet new infections, hospitalizations, and deaths as a result of COVID-19 are all increasing. Research from past pandemics, such as Ebola and H1N1 is limited in what it can tell us about our current circumstances.

Stay-at-home (SAH) orders and social distancing, while necessary to limit the spread of COVID-19, were thought to possibly lead to increased anxiety, depression, and loneliness (loneliness is defined as a subjective feeling of being alone in the presence or absence of social interactions). However, one study found increased hand washing and mask wearing “were associated with fewer severe psychiatric symptoms” in the workplace. Indeed, taking precautions against COVID-19 not only allowed individuals to return to work, but provided peace of mind that they were safe doing so.¹

At the same time, Utahns dealt with a significant earthquake, a devastating season of wildfires, hurricane force winds, and civil unrest. These events further complicated a challenging and uncertain time. A timeline of events can be found in Figure 1 and additional detail can be found on the [Utah COVID-19 Response StoryMap](#). It has been predicted that individuals with lower socio-economic status would be subjected to higher levels of distress due to the added effect of financial insecurity. Studies conducted in the US, UK, Germany, and China during the first few months of the pandemic have confirmed these predictions, including patterns of mental distress observed from previous pandemics. The patterns of increased anxiety, financial insecurity, depression, and loneliness was observed across all age groups and genders.² Further, individual quarantines resulted in post traumatic stress disorder, anxiety, and depression across all age groups.³ These negative outcomes increased as the duration of SAH or quarantine increased, and also increased as the length of the pandemic became increasingly unknown.⁴

Previous research gives good reason to be concerned about those with lower socio-economic status. Only one quarter of Americans had a job that could be performed at home, according to one estimate. This led to increased job insecurity and heightened feelings of anxiety, stress, and increased blood pressure. Many struggled with the anxiety and stress of losing their job versus risking exposure by continuing to work. Even if an individual was able to find another job, likely of lesser quality, the negative effects remained.⁵ One in four Americans do not have access to the internet or a device that supports video conferencing. This was thought to be a hindrance to seeking professional help for feelings resulting from the pandemic for those who were already suffering with mental health issues and for those needing help due to new issues surrounding the current pandemic. Lack of connectivity to the web also impaired individuals’ ability to connect to social media, support groups, and online religious gatherings, in addition to seeking care through telemedicine.⁶

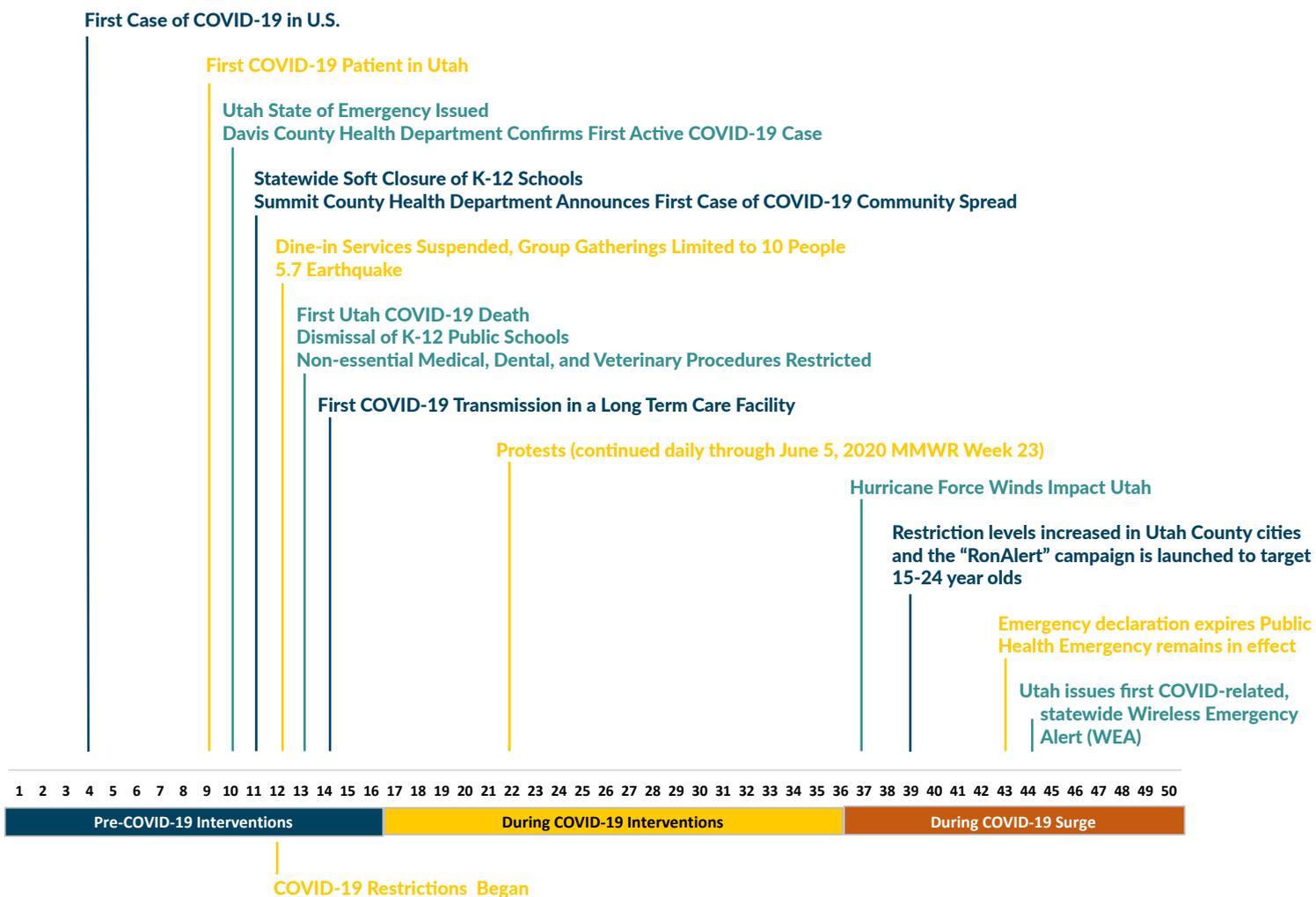
In summary, the pandemic has impacted Utahns in significant ways, yet preliminary data in this report shows Utahns are resilient. Importantly, as the pandemic continues, we must continue to take care of our mental health. It is natural for people to experience different and strong emotions during and after this pandemic. Understanding the social and behavioral health needs of Utahns during the COVID-19 pandemic will mitigate negative impacts and allow us to identify gaps in approaches, needed resources, and considerations for vulnerable populations.

MMWR Weeks

The Morbidity and Mortality Weekly Report (MMWR) week is the week of the epidemiologic year for which the National Notifiable Diseases Surveillance System (NNDSS) disease report is assigned by the reporting local or state health department for the purposes of MMWR disease incidence reporting and publishing. Much of the data in this report is by MMWR week. For the purposes of this report, we have identified MMWR Weeks 1-11 as pre-COVID-19 interventions period, prior to Utah specific closures and directives. MMWR Weeks 12 to 36 are defined as the period when specific closures and directives were issued, potentially impacting Utahns social and behavioral health. MMWR weeks 37 to 50 are defined as the period when Utah saw several surges in cases, hospitalizations, and deaths leading to increased interventions.

- MMWR Weeks 1-12: Pre-COVID-19 Interventions (December 29, 2019–March 21, 2020)
- MMWR Weeks 12-36: During COVID-19 Interventions (March 22, 2020–September 5, 2020)
- MMWR Weeks 37-50: During COVID-19 Surge (September 6, 2020–December 12, 2020)

Timeline of Events



The long term consequences of the pandemic on mental health, suicide, and substance abuse will take time to understand. This report does not fully represent the breadth of the impact on Utahns: many have faced financial insecurity, job loss, housing instability, challenges related to school, troubles connecting with family and friends, and elevated health concerns related to the virus, among others.

Here are some signs to look watch for:

- Feelings of hopelessness
- Social isolation
- Barriers to accessing effective behavioral healthcare
- Substance abuse
- Physical illness (due to not accessing healthcare services)
- Access to lethal means (i.e.; more time at home with unrestricted access to unsecured firearms and/or prescription medications)
- Increases in domestic violence and child maltreatment incidents
- Loss (relationship, social, work, financial, freedom due to restrictions)

We are not powerless to the difficult circumstances around us. Know the warning signs of deteriorating mental health and suicide:

- Talking about suicide or death
- Increased substance use, including alcohol and drugs
- Withdrawing or isolating from friends and family
- Unexpected and unexplained changes in sleep, appetite, mood, or daily activities
- Giving away prized possessions
- Seeking lethal means (firearms, medication), or searching for suicide methods online
- Frequent irritability and anger
- Onset of depression or anxiety, or changes related to known mental health disorders

Despite these difficult times, however, **THERE IS HOPE**. We all have opportunities to **TAKE ACTION** to prevent suicide during this time. Below are action steps individuals and communities can take to promote connection and resiliency in our homes, our communities, and in our state.

As news about COVID-19 dominates the headlines and public concern continues, taking care of your mental health is as important as looking after your physical health. Additional tips on how to manage stress and anxiety can be found in Appendix A. Taking Care of Your Mental Health.

Individual

- Maintain a sense of hope and positive thinking.
- Read something uplifting.
- Socially connect with friends and loved ones via phone, email, text messaging, or through “face to face” platforms such as Skype or FaceTime.
- Acknowledge your feelings and talk to a friend or loved one about them.
- Be discerning in your exposure to news media and find your balance in being informed and stepping away.
- Get some physical activity daily.
- Take a break and go outside.
- Spend time in person in groups of fewer than 10 people while maintaining good physical distancing (6 feet apart) and/or wearing masks.
- Ask for support, including professional support if needed.
- Continue any behavioral healthcare or treatment for a substance use disorder or mental health disorder that was in place before the pandemic. This can include telemental health.
- Seek or continue medical treatment for new or existing physical ailments as needed. This may include telehealth appointments.
- During high stress times, store firearms off site at a friend or loved one’s home until the crisis is resolved.
- Safely store firearms in a gun safe or lockbox in which youth don’t have access.
- Safely store prescription medications so they are not accessible to youth and discard leftover medications.
- Take care of yourself, then take care of others (Airplane Rules: Put your own oxygen mask on before helping others).
- Take time to talk to children about COVID-19.
- Ask for support, including professional support if needed. Asking for help is a sign of strength; none of us can do this alone.

Relationship

- Socially connect with friends and loved ones via phone, email, text messaging, or through “face to face” platforms such as Skype or FaceTime.
- Spend time in person in groups of fewer than 10 people while maintaining good physical distancing (6 feet apart) and/or wearing masks.
- Check on others whom you haven't heard from in a few days, especially those living alone.
- Educate yourself on suicide warning signs so you can recognize when someone you know is struggling and needs help.
- Learn about the mental health and crisis resources in your area.
- Connect family and loved ones with these resources in your community as needed.
- Safely reach out to others and support people around you.
- Take time to talk to children about COVID-19.

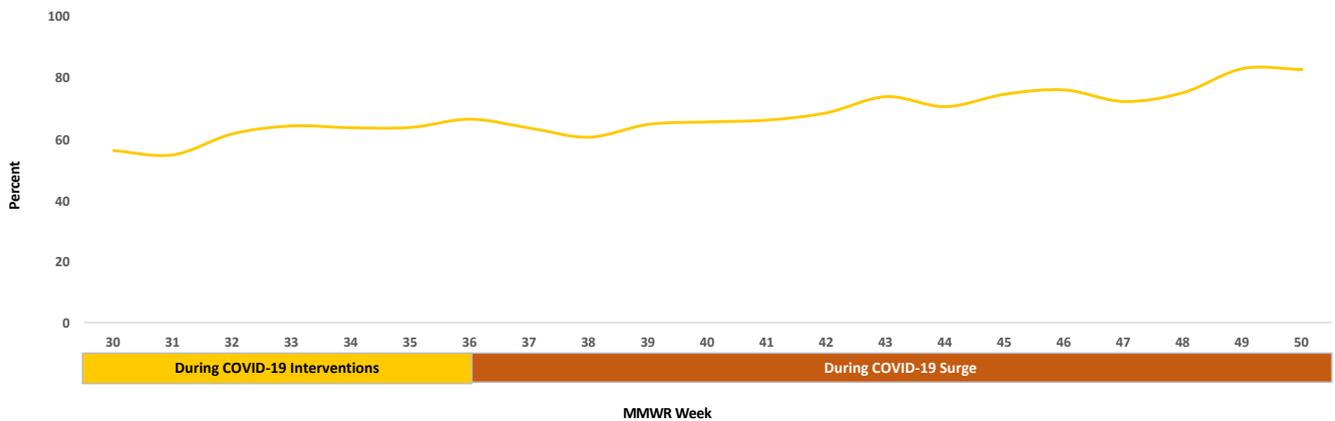
Community/Society

- Promote social connectedness in the community while providing guidance for physical distancing and mask wearing.
- Provide virtual QPR gatekeeper training in the community.
- Educate the community about:
 - Mental health and crisis resources that are still available during the pandemic including increased access to telemental health.
 - Safe storage for firearms and prescription medications.
 - Available domestic violence and child abuse resources.
 - Available mental health and other resources related to the COVID-19 pandemic.

Public Behavior Indicators

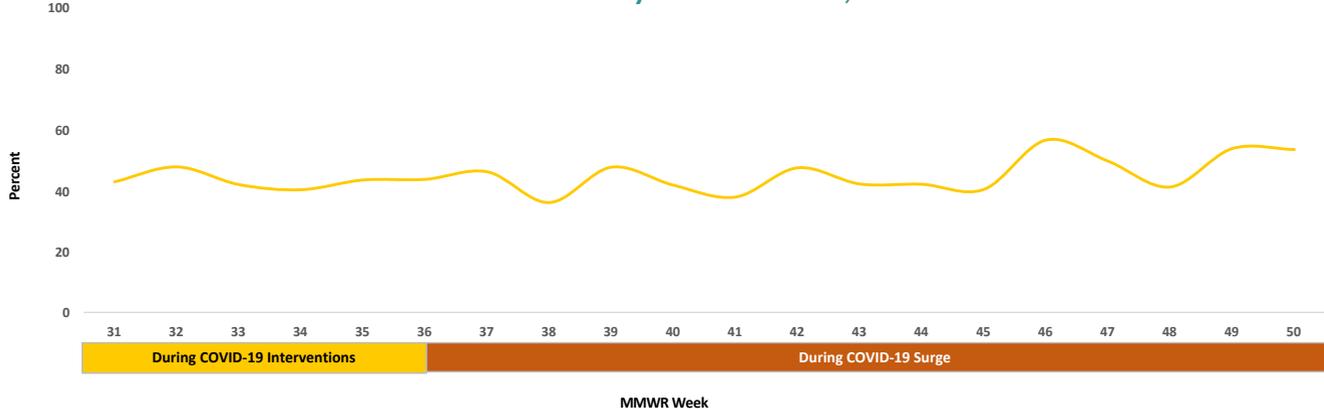
The overall trend of the percentage of Utah adults reporting they always wear a mask in public remained stable from MMWR Week 30 when data was first collected through MMWR Week 50. There was no notable difference during the COVID-19 Interventions period trend (MMWR Weeks 30-36), and during the COVID-19 Surge trend (MMWR Weeks 37-50) (**Figure 1**). See Behavioral Risk Factor Surveillance System Data Description and Limitations in Appendix A. Data Description and Limitations.

Figure 1: Percentage of Adults Who Report Always Wearing a Mask in Public by MMWR Week, Utah 2020



The overall trend of the percentage of Utah adults reporting they are very likely to receive the COVID-19 vaccine remained stable from MMWR Week 31 when data was first collected through MMWR Week 50. There was no notable difference during the COVID-19 Interventions period trend (MMWR Weeks 31-36), and during the COVID-19 Surge trend (MMWR Weeks 37-50) (**Figure 2**). See Behavioral Risk Factor Surveillance System Data Description and Limitations in Appendix A. Data Description and Limitations (**Figure 2**).

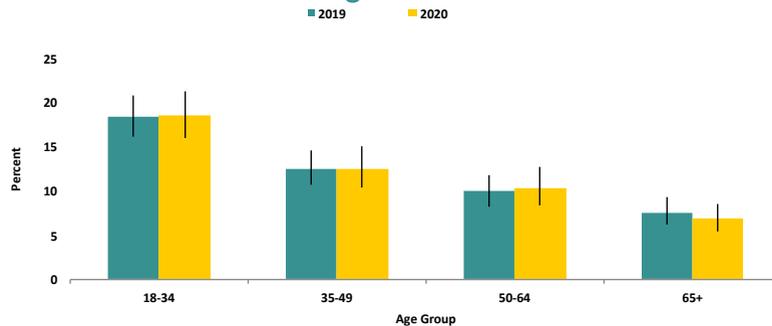
Figure 2: Percentage of Adults Who Report They Are Very Likely to Receive the COVID-19 Vaccine by MMWR Week, Utah 2020



Mental Health Indicators

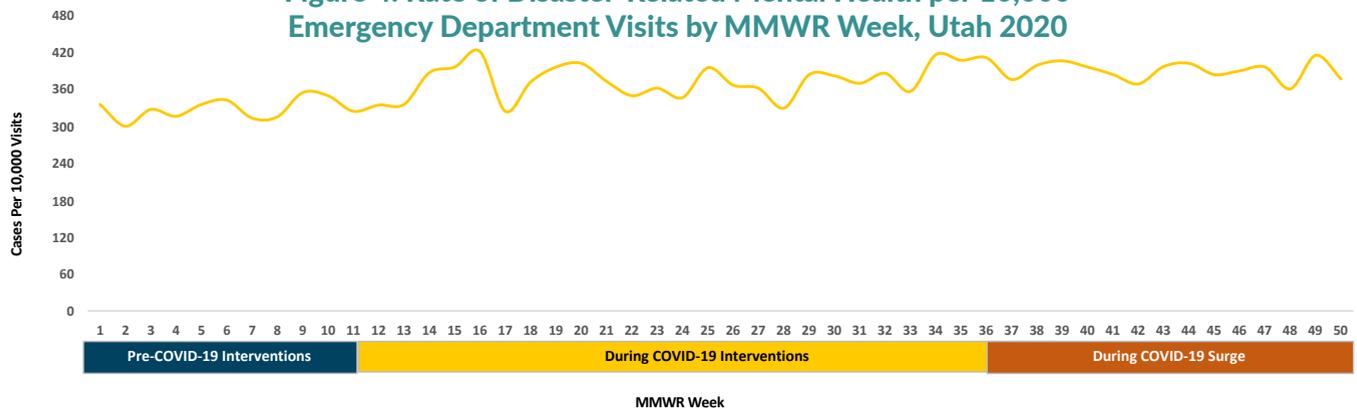
There were no differences in the rate of Utah adults reporting frequent mental distress from March through August of 2019 compared with 2020 (13.5% and 13.4% respectively). Utah adults ages 18-34 were more likely to report frequent mental distress compared with other age groups. Overall females were significantly more likely to report frequent mental distress compared with males, particularly those between the ages of 18-34 years and 50-64 years (**Figure 3**). In 2020, 10.4% of adults did not believe they could seek help without judgment or discrimination for mental health problems. Frequent mental distress is defined as reporting 14 or more of the past 30 days with poor mental health. See Behavioral Risk Factor Surveillance System Data Description and Limitations in Appendix A. Data Description and Limitations.

Figure 3: Percentage of Adults Reporting Frequent Mental Distress by Age Group, Utah Mar-Aug 2019 and 2020



Emergency department visit patterns differ during the two designated periods of this report. After Utah’s “Stay Safe, Stay Home Directive” issued in MMWR Week 13, fewer individuals accessed Utah’s emergency departments. The reasons for decreased access include, but are not limited to delaying care, utilizing primary or urgent care, and reductions in injuries or illness attributable to changing activity patterns during the pandemic (such as lower risks for occupational and motor vehicle injuries or other infectious diseases). See Syndromic Surveillance Data Description and Limitations in Appendix A. Data Description and Limitations. The overall trend of disaster-related mental health per 10,000 emergency department visits remained stable from MMWR Weeks 1 through 50. There was no notable difference in the pre-COVID-19 Interventions period trend (MMWR Weeks 1-11), during the COVID-19 Interventions period trend (MMWR Weeks 12-36), and during the COVID-19 Surge trend (MMWR Weeks 37-50) (**Figure 4**).

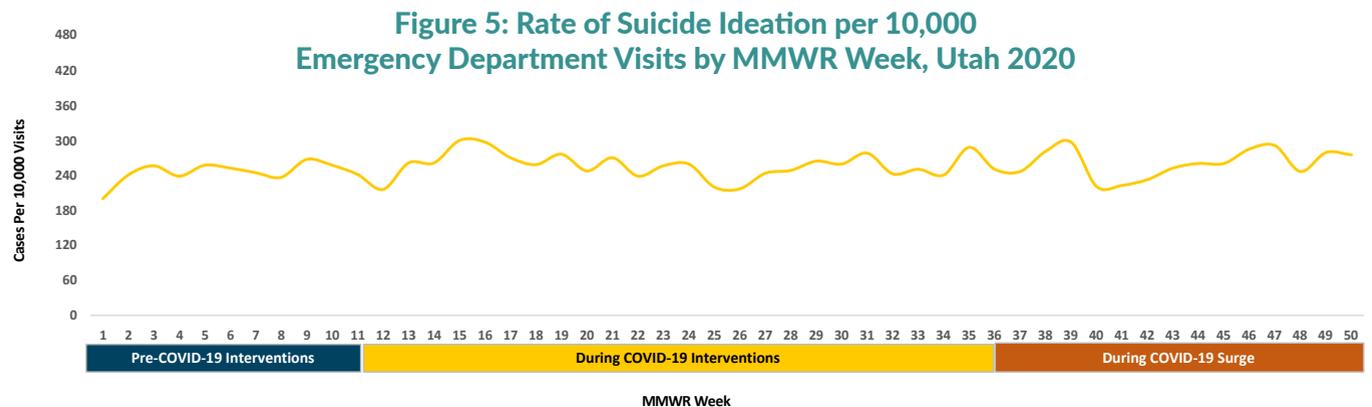
Figure 4: Rate of Disaster-Related Mental Health per 10,000 Emergency Department Visits by MMWR Week, Utah 2020



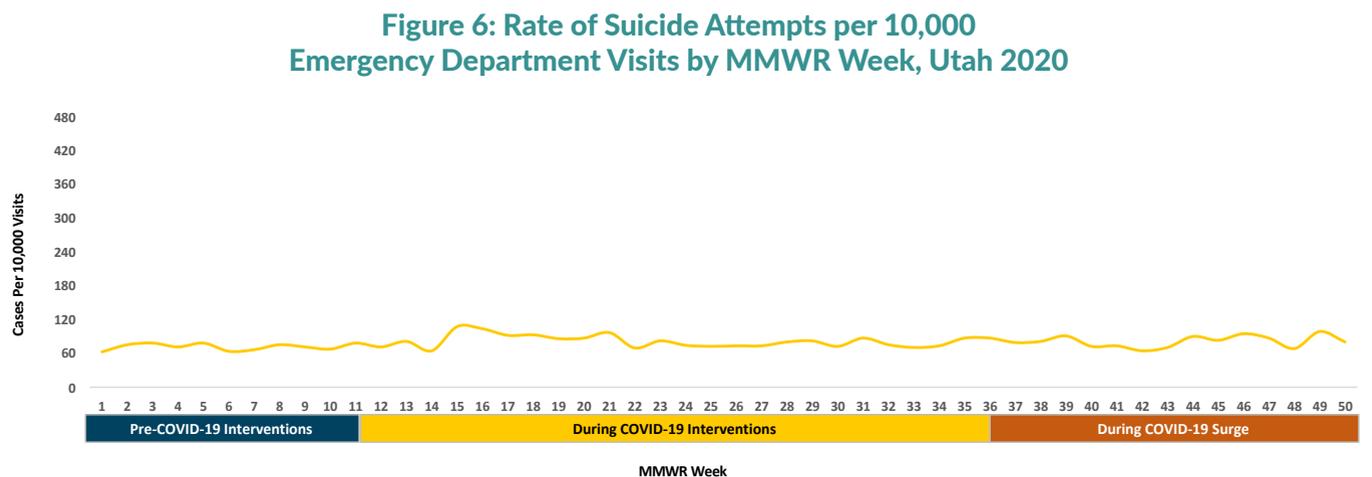
Suicide-related Indicators

Emergency department visit patterns differ during the two designated periods of this report. After Utah's "Stay Safe, Stay Home Directive" issued in MMWR Week 13, fewer individuals accessed Utah's emergency departments. The reasons for decreased access include, but are not limited to, delaying care, utilizing primary or urgent care, and reductions in injuries or illness attributable to changing activity patterns during the pandemic (such as lower risks for occupational and motor vehicle injuries or other infectious diseases). See Syndromic Surveillance Data Description and Limitations in Appendix A. Data Description and Limitations.

The overall trend of suicide ideation per 10,000 emergency department visits remained stable from MMWR Weeks 1 through 50. The rate decreased in the trend in the pre-COVID-19 interventions period (MMWR Weeks 1-11). The rate increased early in the COVID-19 interventions period (MMWR Weeks 12-36), but this rate decreased to pre-COVID-19 levels soon after, and remained stable throughout the COVID-19 surge period trend (MMWR Weeks 37-50) (**Figure 5**).



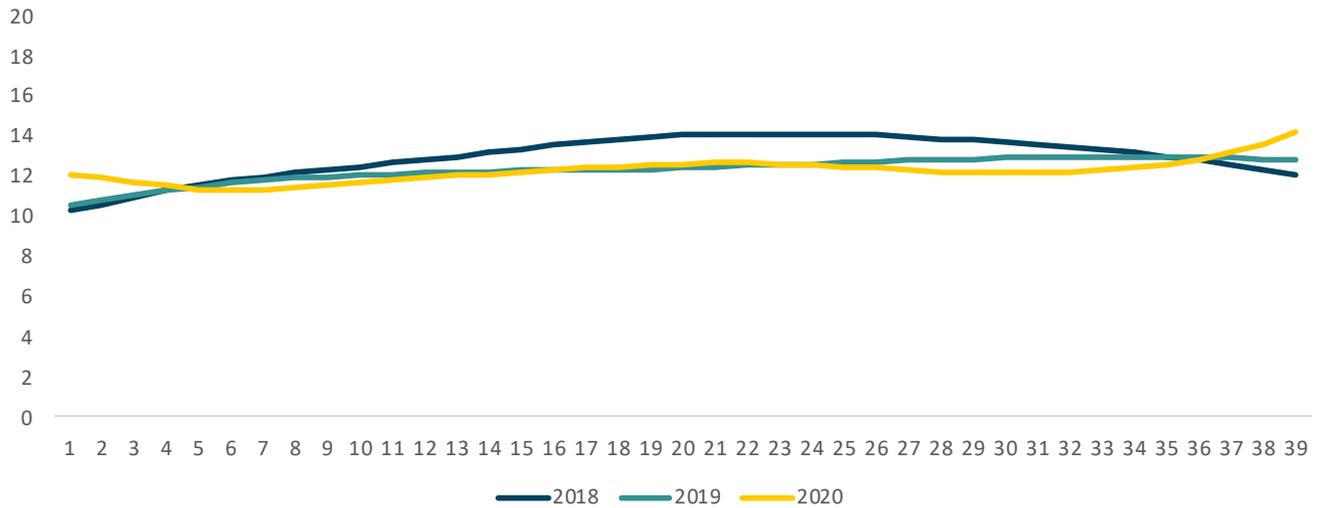
The overall trend of suicide attempts per 10,000 emergency department visits remained stable from MMWR Weeks 1 through 50. There was no notable difference in the pre-COVID-19 Interventions period trend (MMWR Weeks 1-11), during the COVID-19 Interventions period trend (MMWR Weeks 12-36), and during the COVID-19 Surge trend (MMWR Weeks 37-50) (**Figure 6**).



Suicide-related Indicators

The overall trend of deaths by suicide remained stable from MMWR Weeks 1 through 26 and since 2018. In 2020, there was not an observed difference in the pre-COVID-19 Interventions period trend (MMWR Weeks 1-11) compared with COVID-19 Interventions period trend (MMWR Weeks 12-26) (**Figure 7**). See Medical Examiner Database Data Description and Limitations in Appendix A: Data Description and Limitations.

Figure 7: Number of Deaths by Suicide by Year and MMWR Week, Utah 2018-2020



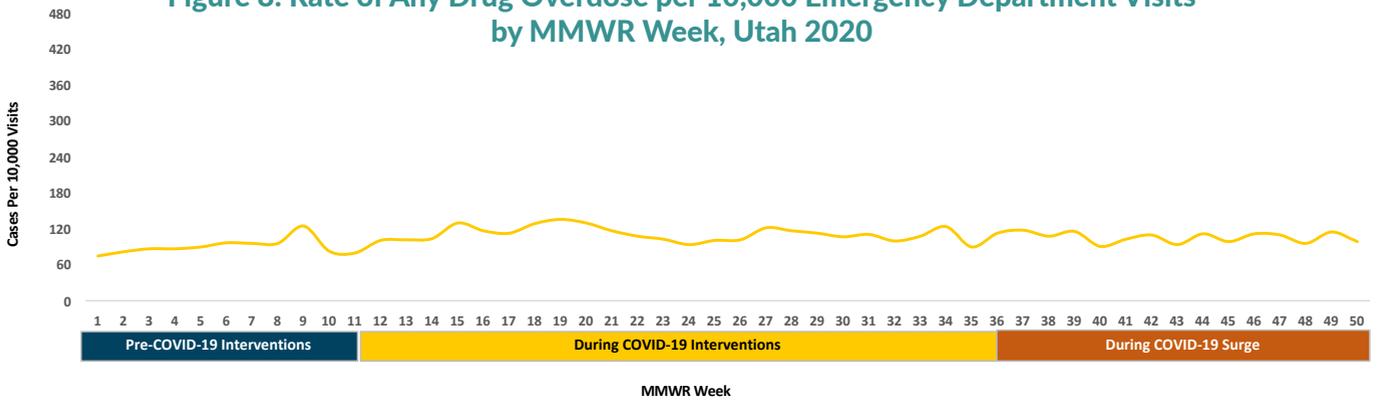
Data Notes: These data are abstracted from the Utah Medical Examiner Database and are occurrence data. Counts and derivations of 2019 and 2020 data are preliminary. Trend lines for each year were derived using LOWESS (Locally Weighted Scatterplot Smoothing) using a bandwidth coefficient of 0.8.

Drug-related Indicators

Emergency department visit patterns differ during the two designated periods of this report. After Utah’s “Stay Safe, Stay Home Directive” issued in MMWR Week 13, fewer individuals accessed Utah’s emergency departments. The reasons for decreased access include, but are not limited to, delaying care, utilizing primary or urgent care, and reductions in injuries or illness attributable to changing activity patterns during the pandemic (such as lower risks for occupational and motor vehicle injuries or other infectious diseases). See Syndromic Surveillance Data Description and Limitations in Appendix A. Data Description and Limitations.

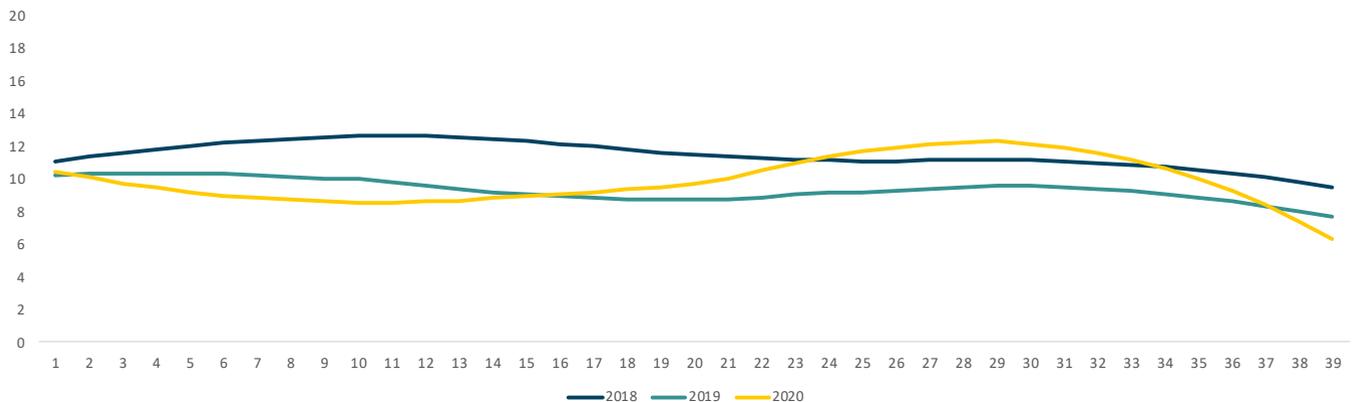
The overall trend of drug overdoses per 10,000 emergency department visits remained stable from MMWR Weeks 1 through 50. There was no notable difference in the pre-COVID-19 Interventions period trend (MMWR Weeks 1-11), during the COVID-19 Interventions period trend (MMWR Weeks 12-36), and during the COVID-19 Surge trend (MMWR Weeks 37-50) (**Figure 8**).

Figure 8: Rate of Any Drug Overdose per 10,000 Emergency Department Visits by MMWR Week, Utah 2020



The overall trend of deaths by drug overdose remained stable in weeks 1 through 39 of 2020. Drug overdose deaths remained low in the pre-COVID-interventions period (MMWR weeks 1-11), reflecting a continuous decline in drug overdose deaths starting in 2018. In the COVID intervention period (MMWR weeks 12-36), there was a modest increase in the number of drug overdose deaths, but this trend decreased in the COVID-19 surge period (MMWR weeks 37-39) (**Figure 9**). See Medical Examiner Database Data Description and Limitations in Appendix A. Data Description and Limitations.

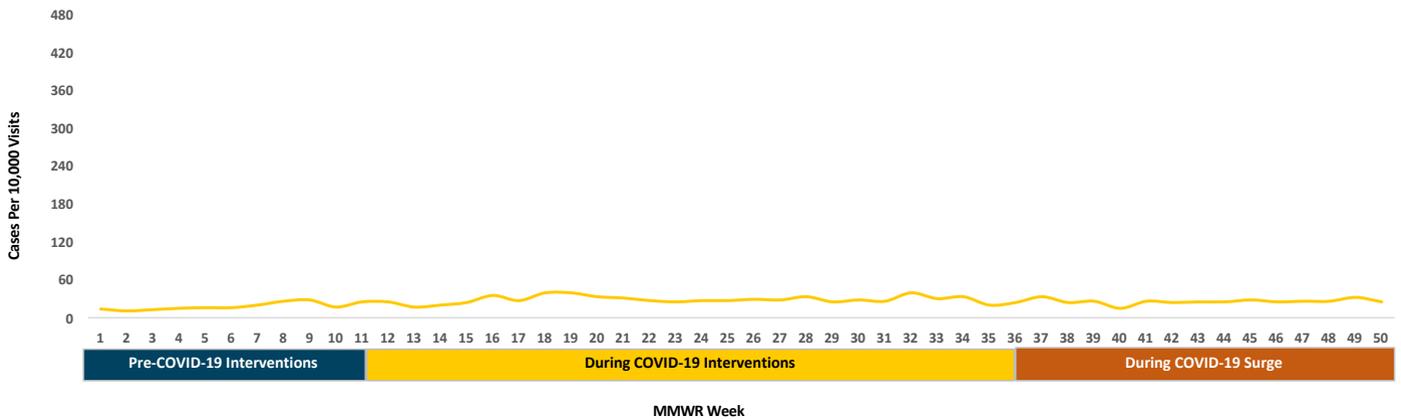
Figure 9: Number of Deaths by Any Drug Overdose by Year, Utah 2018-2020



Drug-related Indicators

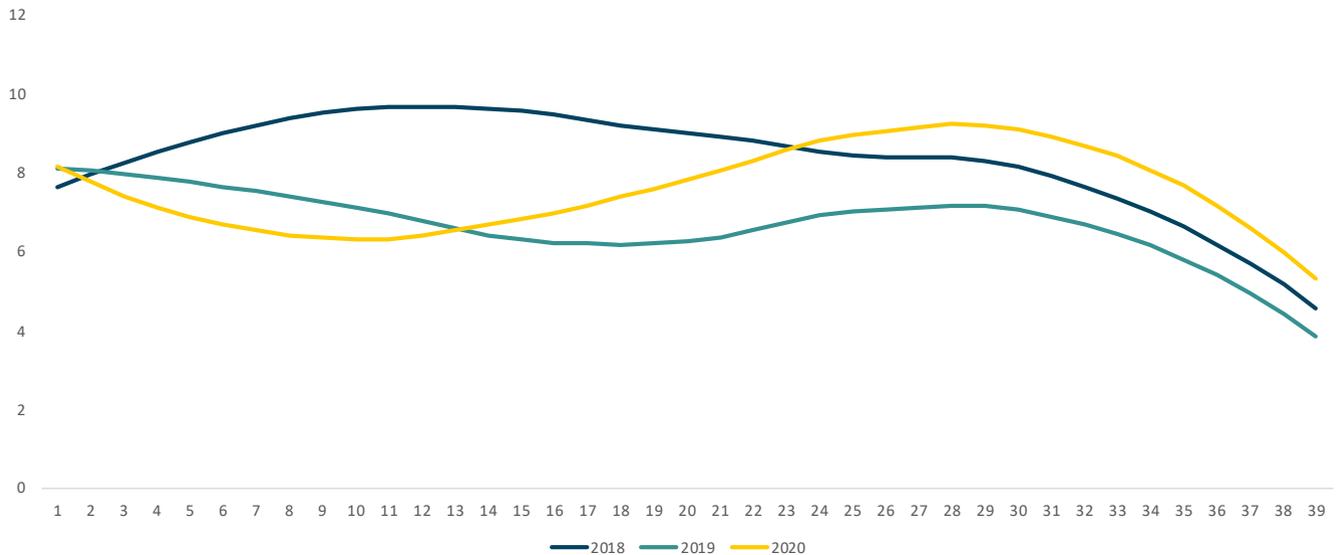
The overall trend of opioid overdoses per 10,000 emergency department visits remained stable from MMWR Weeks 1 through 50. There was no notable difference in the pre-COVID-19 Interventions period trend (MMWR Weeks 1-11), during the COVID-19 Interventions period trend (MMWR Weeks 12-36), and during the COVID-19 Surge trend (MMWR Weeks 37-50) (Figure 10).

Figure 10: Rate of Opioid Overdoses per 10,000 Emergency Department Visits by MMWR Week, Utah 2020



The overall trend of fatal overdoses involving an opioid remained stable in weeks 1 through 39 of 2020. Overdose deaths involving an opioid remained low in the pre-COVID-interventions period (MMWR weeks 1-11), reflecting a continuous decline in overdose deaths starting in 2018. An increase was observed in the COVID intervention period (MMWR weeks 12-36), but this trend decreased in the COVID-19 surge period (MMWR weeks 37-39) (Figure 11).

Figure 11: Number of Deaths by Opioid-involved Overdose by Year, Utah 2018-2020

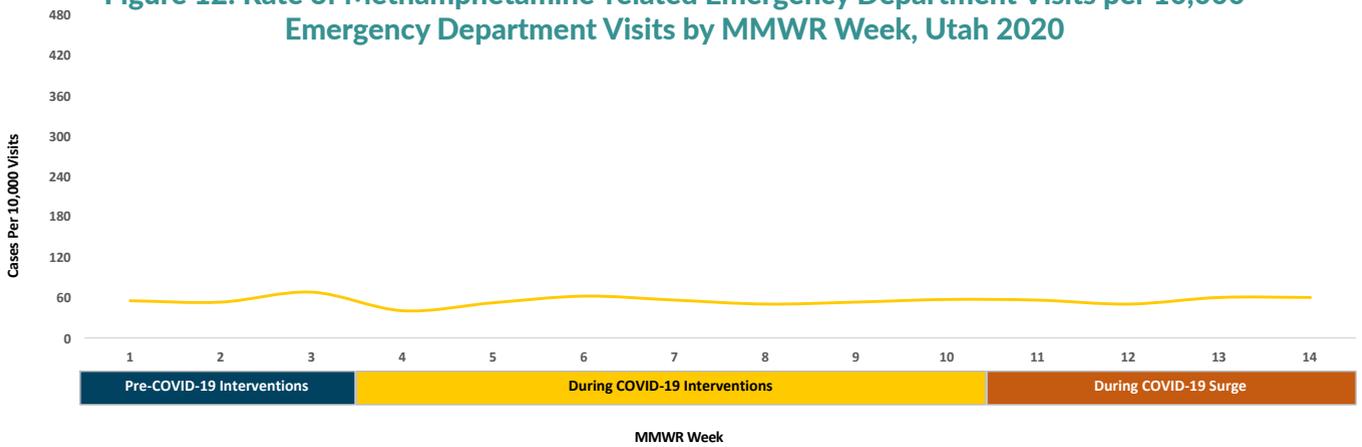


Drug-related Indicators

Emergency department visit patterns differ during the two designated periods of this report. After Utah’s “Stay Safe, Stay Home Directive” issued in MMWR Week 13, fewer individuals accessed Utah’s emergency departments. The reasons for decreased access include, but are not limited to, delaying care, utilizing primary or urgent care, and reductions in injuries or illness attributable to changing activity patterns during the pandemic (such as lower risks for occupational and motor vehicle injuries or other infectious diseases).

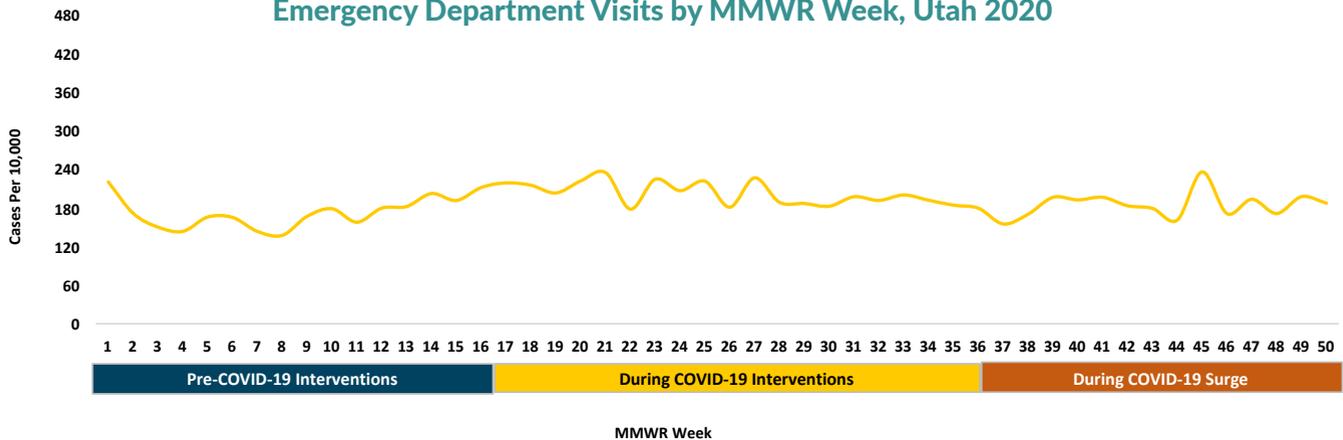
The overall trend of methamphetamine-related emergency department visits per 10,000 emergency department visits remained stable from MMWR Weeks 1 through 50. There was no notable difference in the pre-COVID-19 Interventions period trend (MMWR Weeks 1-11), during the COVID-19 Interventions period trend (MMWR Weeks 12-36), and during the COVID-19 Surge trend (MMWR Weeks 37-50) (Figure 12).

Figure 12: Rate of Methamphetamine-related Emergency Department Visits per 10,000 Emergency Department Visits by MMWR Week, Utah 2020



The overall trend of alcohol-related emergency department visits per 10,000 emergency department visits remained stable from MMWR Weeks 1 through 50. There was a decrease in the trend in the pre-COVID-19 Interventions period (MMWR Weeks 1-11) compared with the COVID-19 Interventions period (MMWR Weeks 12-36) and during the COVID-19 Surge period (MMWR Weeks 37-50) (Figure 13).

Figure 13: Rate of Alcohol-related Emergency Department Visits per 10,000 Emergency Department Visits by MMWR Week, Utah 2020

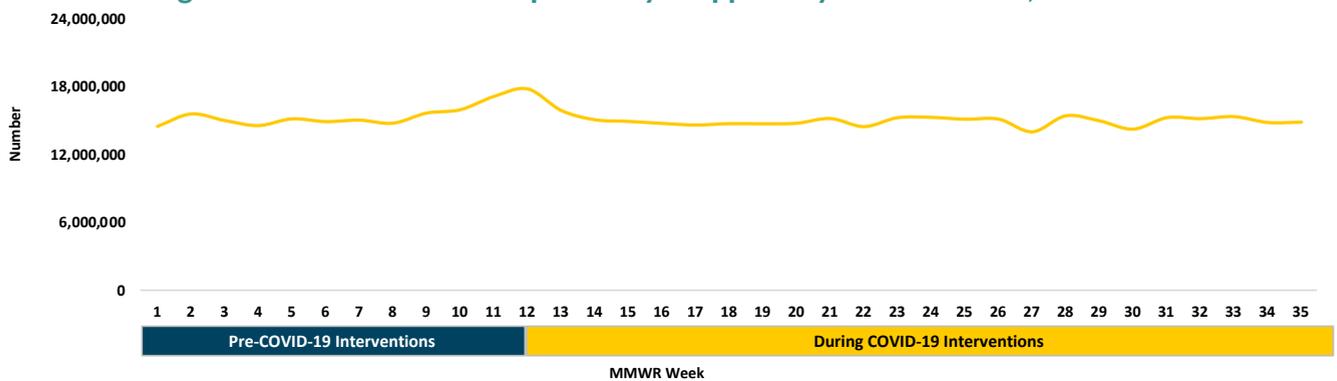


Prescription-related Indicators

The overall trend of prescription days supplied decreased from MMWR Weeks 1 through 35. There was an increase in the trend in the pre-COVID-19 Interventions period (MMWR Weeks 1-11) compared to the COVID-19 Interventions period (MMWR Weeks 12-35) (**Figure 14**).

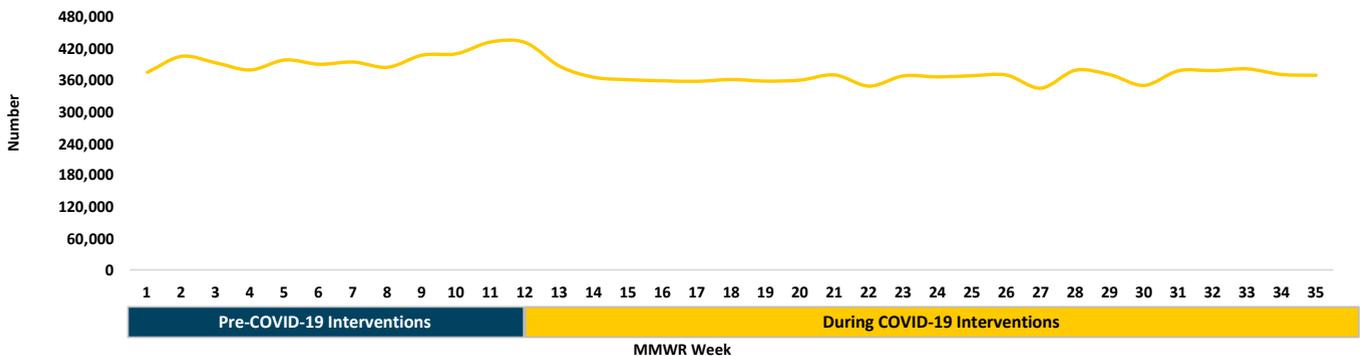
The increase during the pre-COVID-19 Interventions period spanned many different types of medications as shown in **Figures 16-19**. Part of this increase could be due to some restrictions being lifted for the number of days for the number of days supplied allowed by several insurance companies.

Figure 14: Number of Prescription Days Supplied by MMWR Week, Utah 2020



The overall trend of prescriptions filled decreased from MMWR Weeks 1 through 35. There was an increase in the trend in the pre-COVID-19 Interventions period (MMWR Weeks 1-11) compared with the COVID-19 Interventions period (MMWR Weeks 12-35) (**Figure 15**).

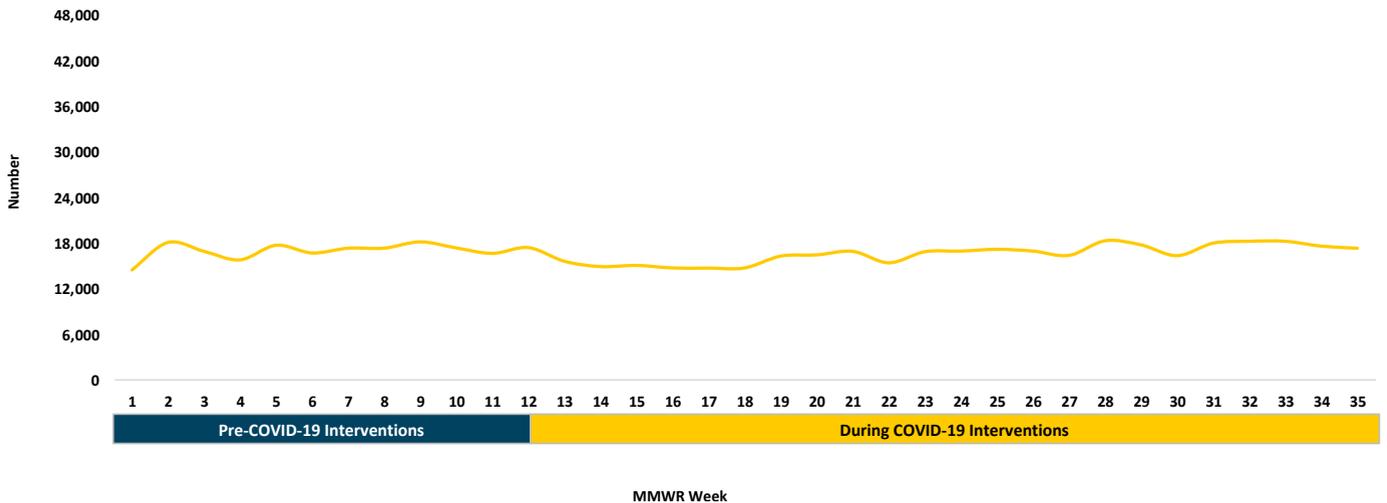
Figure 15: Number of Prescriptions Filled by MMWR Week, Utah 2020



Prescription-related Indicators

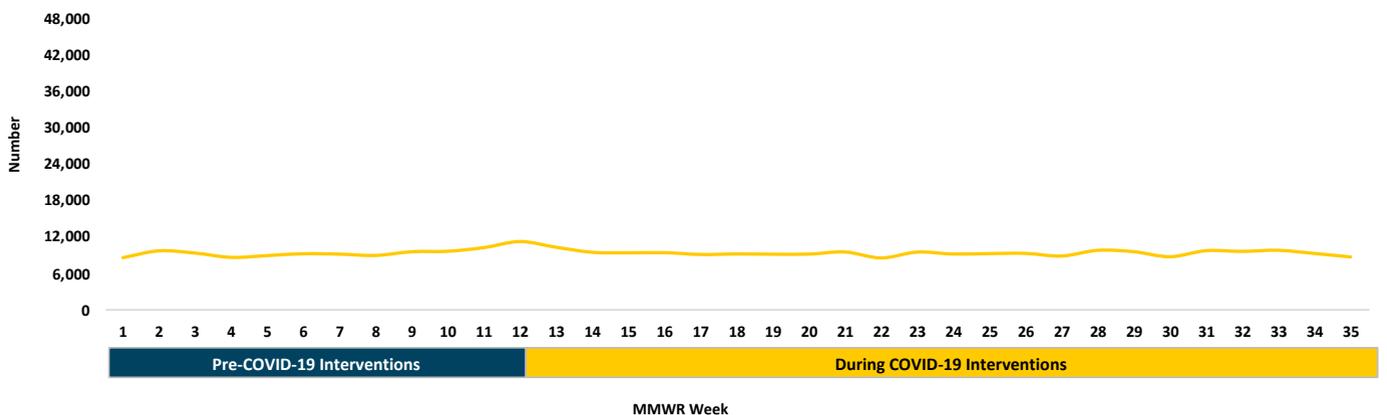
The overall trend of opioid prescriptions filled increased from MMWR Weeks 1 through 35. There was an increase in the trend in the pre-COVID-19 Interventions period (MMWR Weeks 1-11) and an increase in the trend during the COVID-19 Interventions period (MMWR Weeks 12-35) (Figure 16).

Figure 16: Number of Opioid Prescriptions Filled by MMWR Week, Utah 2020



The overall trend of anti-anxiety prescriptions filled remained stable from MMWR Weeks 1 through 35. There was an increase in the trend in the pre-COVID-19 Interventions period (MMWR Weeks 1-11) compared with the COVID-19 Interventions period (MMWR Weeks 12-35) (Figure 17).

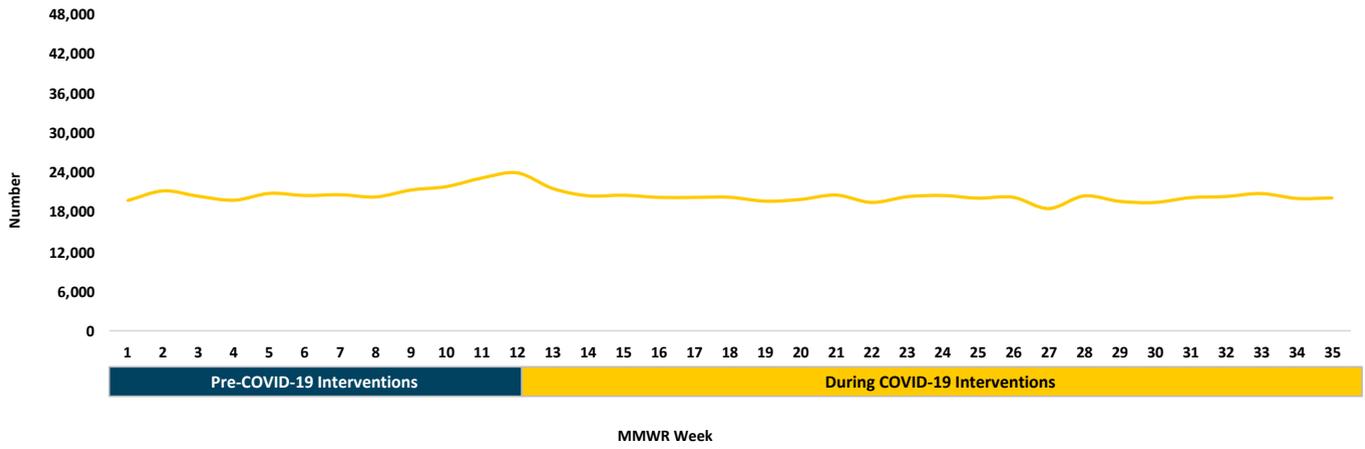
Figure 17: Number of Anti-Anxiety Prescriptions Filled by MMWR Week, Utah 2020



Prescription-related Indicators

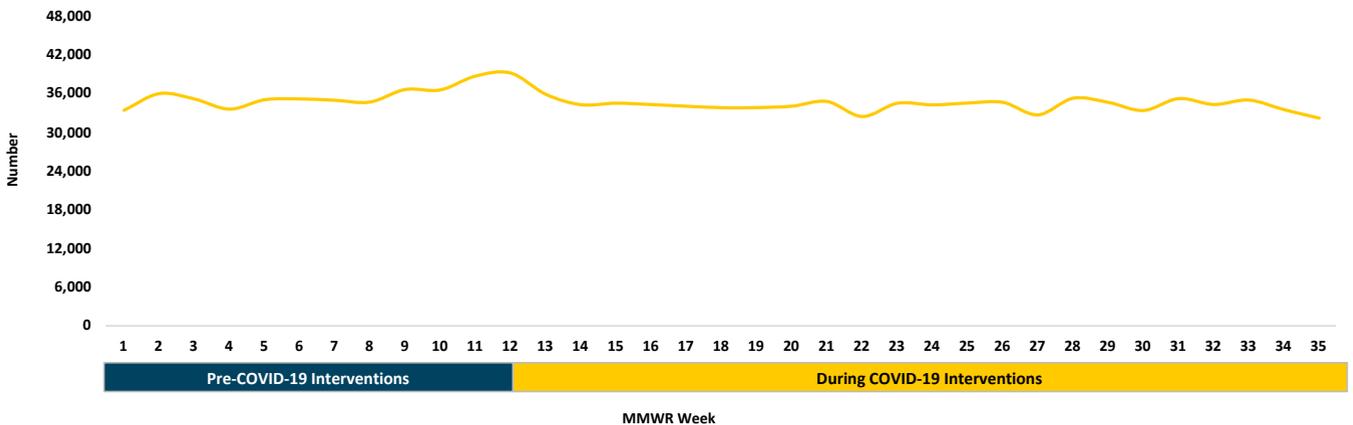
The overall trend of anti-hypertensive prescriptions filled decreased from MMWR Weeks 1 through 35. There was an increase in the trend in the pre-COVID-19 Interventions period (MMWR Weeks 1-11) compared with a decrease during the COVID-19 Interventions period (MMWR Weeks 12-35) (**Figure 18**).

Figure 18: Number of Anti-Hypertensive Prescriptions Filled by MMWR Week, Utah 2020



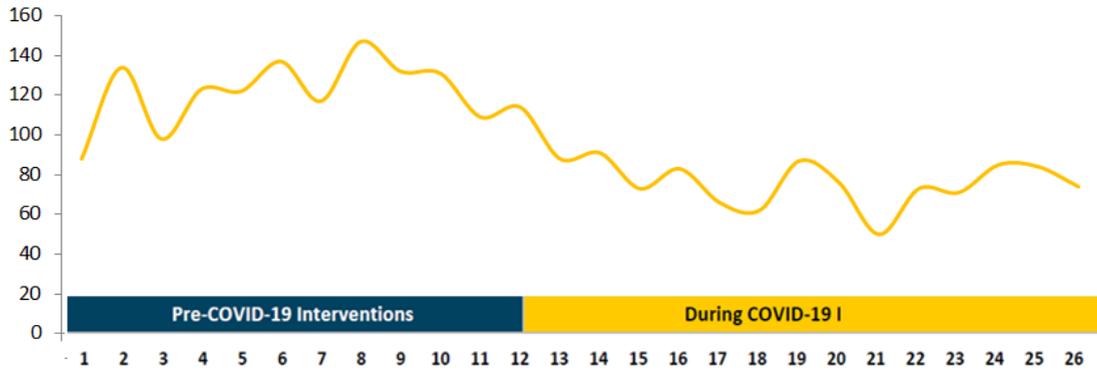
The overall trend of antidepressant prescriptions filled decreased from MMWR Weeks 1 through 35. There was an increase in the trend in the pre-COVID-19 Interventions period (MMWR Weeks 1-11) compared with a decrease during the COVID-19 Interventions period (MMWR Weeks 12-35) (**Figure 19**).

Figure 19: Number of Antidepressant Prescriptions Filled by MMWR Week, Utah 2020



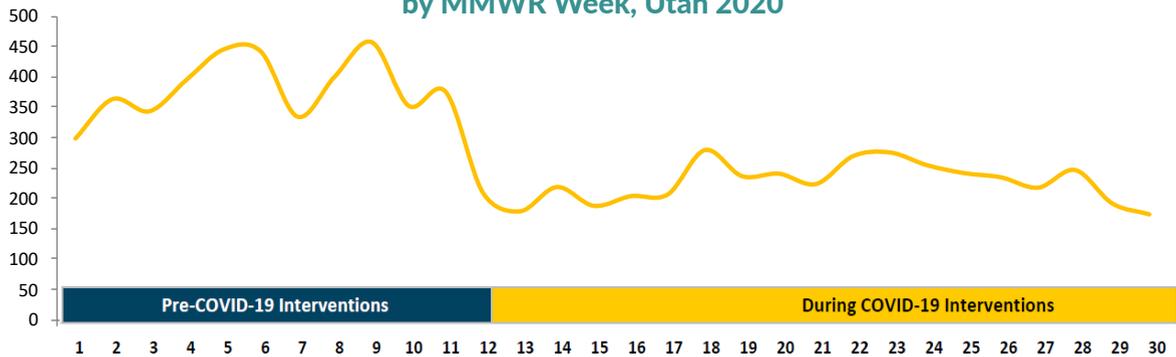
The number of first contacts to public mental health treatment services from March through July of 2019 compared with the same time period in 2020, decreased by 33.4% (Figure 20).

Figure 20: Number of new intakes at Local Mental Health Authorities by MMWR Week, Utah 2020



For those seeking services for substance use disorders, first contacts decreased by 44.3% (Figure 21).

Figure 21: Number of New Intakes at Local Substance Abuse Authorities by MMWR Week, Utah 2020



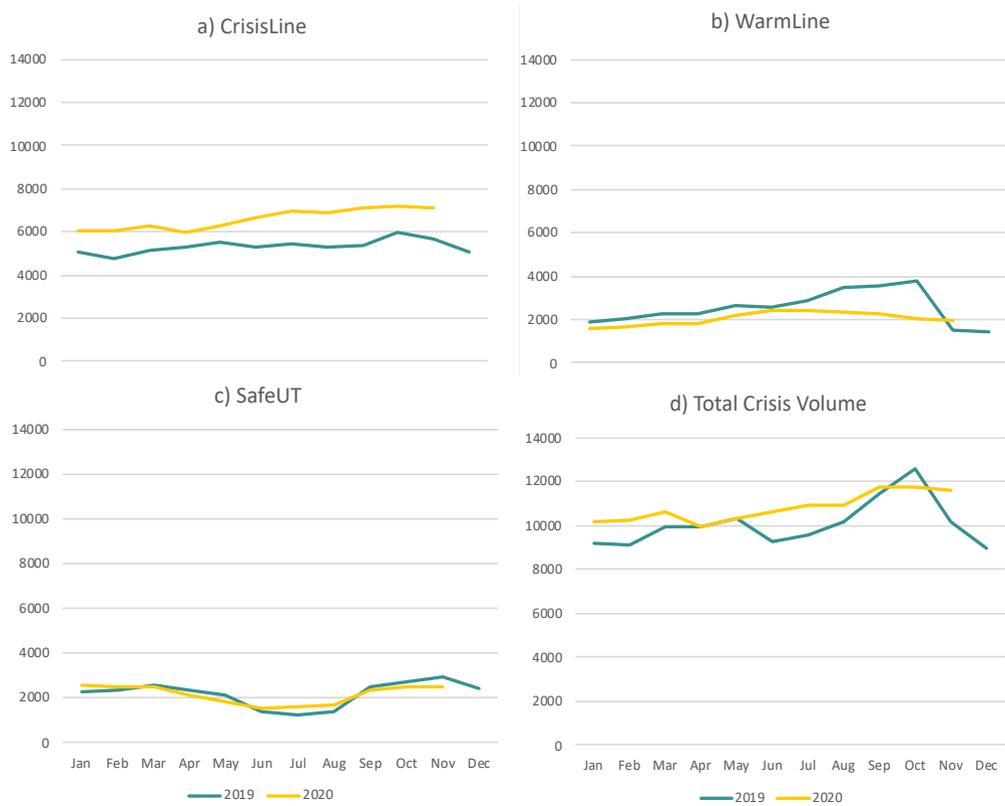
In Utah, local mental health authorities use an Outcome Questionnaire (OQ) Assessments to determine if, the client had recovered (attained a score below the clinical cut off), improved (demonstrated a significantly lower score than at baseline), deteriorated (demonstrated a significantly higher score than at baseline) or not shown reliable change. This data suggests that interventions/treatment during the COVID-19 time period remained as effective as the previous year even in the face of a sudden shift to primarily telemental health.

Table 1: Outcome Questionnaire Assessments by Youth and Adult Outcomes, March 2019-July 2019 and March 2020-July 2020

	3/1 through 7/31	2019	2020
Youth outcomes	Number of "most recent" scores with valid statuses within the timeframe	4,888	2,083
	Percent Deteriorated	12.7%	13.4%
	Percent Improved	16.5%	16.8%
	Percent No reliable change	42.0%	39.7%
	Percent Recovered	28.8%	30.0%
Adult outcomes	Number of "most recent" scores with valid statuses within the timeframe	6,193	2,557
	Deteriorated	15.6%	13.8%
	Improved	16.6%	17.1%
	No reliable change	45.1%	44.2%
	Recovered	22.8%	24.9%

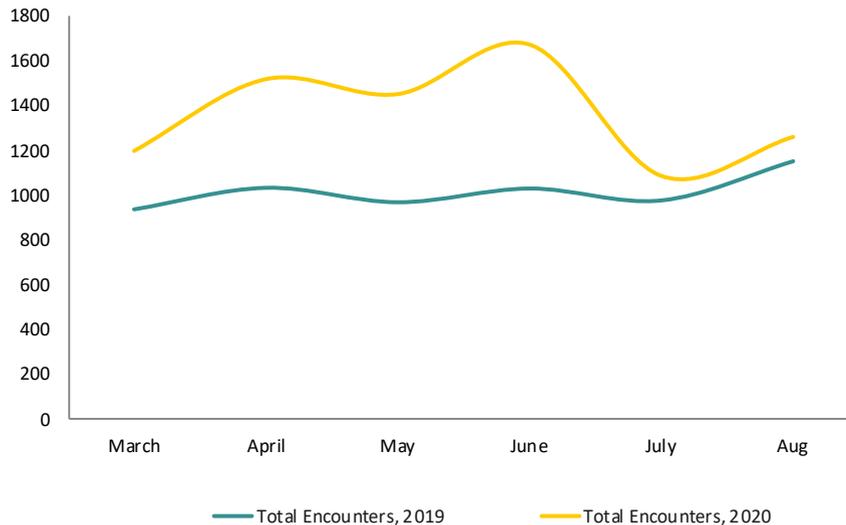
Data from the Utah Crisis Line has seen continuous increases in crisis call volume over the past several years including noticeable increases during the COVID-19 pandemic. The daily call volumes continue to increase with an average of 202 calls per day in March 2020 to an average of 230 per day in October 2020. During COVID-19, individuals calling are presenting with more severe distress. There was a 13.6% increase in call volume to the crisis line in May 2020 compared with May 2019. The crisis line has been tracking the percentage of calls that mention COVID-19 as a stressor; in March and April, 38% of callers discussed COVID-19. That portion of callers decreased to 23% in June and July and to 6% in October.

Figure 22: The Number of Crisis Line and Warm Line Calls, SafeUT, and Total Crisis Volume



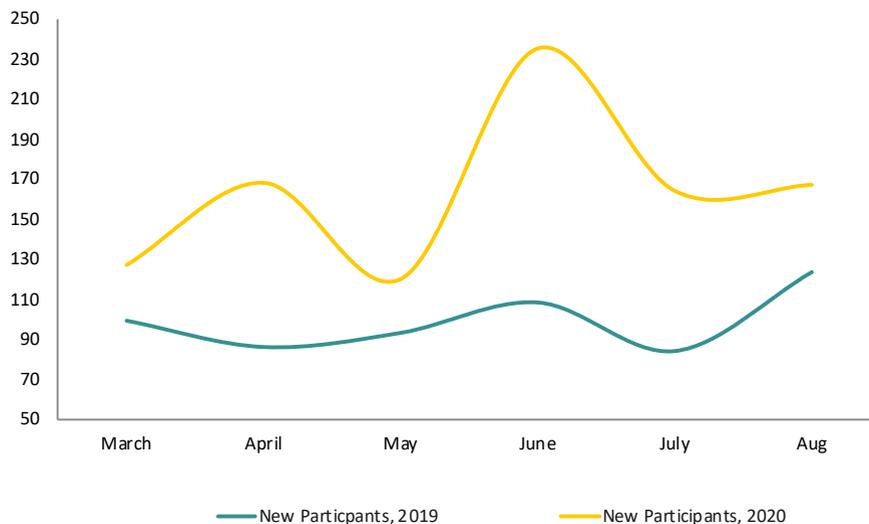
Syringe service metrics are calculated to determine the reach of program services. Compared with 2019, most metrics increased in 2020. The overall increase is likely due to the expansion of syringe services across the state. We believe this consistent growth from last year also demonstrates syringe services are an essential service that continues to be utilized during the COVID-19 pandemic (**Figure 21**).

Figure 23: Syringe Service New Participants, Mar-Aug 2019 and Mar-Aug 2020



In March to August of 2020, syringe service providers enrolled 981 new participants to the program. That is an increase of 388 from 593 new participants for the same six-month span in 2019. Another measure of syringe service utility is the number of total encounters or visits from all of the syringe service provider sites in each month. From March to August in 2020, SSPs conducted 8,193 visits up from 6,099 visits in 2019. On average, that is ~1,361 visits each month in 2020, compared with ~1,017 visits each month in 2019. Data from syringe service metrics displays that people who use drugs continue to utilize the syringe service program to exchange syringes, but also to receive support services in the time of pandemic (**Figure 22**).

Figure 24: Syringe Service Total Encounters, Mar-Aug 2019 and Mar-Aug 2020



Children and Adolescents

Children and adolescents may have different mental health needs related to the current COVID-19 outbreak. This is especially important with the uncertainty surrounding everyday activities like schooling and the need to socialize. As families are impacted, it is important to understand how to effectively listen and communicate with children and adolescents about what they are experiencing.

Be open, honest, and age appropriate

It is important to be able to discuss issues such as coronavirus (COVID-19) with your children in an open and honest way. Your children have already heard and seen information about things that are happening. Try to limit what they see and hear (limit yourself as well) and have them check with you to help them understand myth from fact. When having conversations, it is necessary to find out what they know and what questions they may have.

When speaking to children, be developmentally appropriate. Answer honestly and clearly and make sure your children know you are available to have ongoing conversations. When addressing mental health and stress, use language that makes sense for them and avoid making things too complex. Be open to any questions or thoughts your children may have. Let children and adolescents lead the conversations if they want to. The work of children is play (which can be different for all children). Play with your children and look for themes of fear or danger where you can be reassuring, comforting, supportive and shift to positive outcomes.

Mental Health and Stress in Children and Youth

Mental health and stress can express themselves in many ways for children. Often, children convey how they are feeling through their behaviors. Younger children may express fear and worry by withdrawing or becoming clingy with a parent or caregiver. They may have stomach aches or changes in sleeping habits. For older children, they may argue with others, disengage from family and friends or engage in other behaviors that are not typical for them. More signs include:

BEHAVIORAL	PHYSICAL	EMOTIONAL	THINKING
Clingy	Headaches or other pain	Feeling anxious	Feeling confused
Increase in irritability or worrying	Changes in appetite or eating habits	Feeling angry	Trouble remembering
Acting out behaviors	Easily startled	Feeling sad or depressed	Difficulty concentrating
Having trouble relaxing or sleeping	Stomachaches	Not caring about anything	Difficulty with decision making

As parents and caregivers, you can help children by:

- Paying attention, being a good listener, and acknowledging worries
- Allowing them to ask questions
- Limiting their news exposure
- Encouraging positive coping activities
- Practicing controlled breathing with them
- Trying progressive muscle relaxation with them
- Setting a timer for worries
- Using a journal or feelings tracker with them
- Helping them focus on what we can change and practicing letting go of what we can't
- Helping them write or draw a story/picture about defeating their worries
- Modeling and highlighting the importance of self-care
- Keeping routines and schedules, including creating school, homework, and social time
- Scheduling and having positive family time
- Remaining calm and reassuring

When children and adolescents are experiencing these issues, remember that it is normal, especially in time of uncertainty. Children and adolescents should be allowed to feel and have these experiences, while also having access to the support they need from parents, teachers, healthcare providers, and other trusted adults. If these issues persist, resources are available for children and adolescents of all ages across the state and through virtual means like telehealth. For more information about these resources, see the Resources section.

Child Abuse and Neglect

Child abuse and neglect are a serious public health problem. Early adversity and childhood trauma can have long-term impacts on mental and physical health and wellbeing over the lifespan. While it is difficult to interpret state child abuse and neglect data this early in the pandemic, we do know the risk factors for child abuse and neglect are prevalent (social isolation, parental and family stress, substance use, financial stress, etc.). Utah Division of Child and Family Services (DCFS) data during the pandemic show an overall decrease in referrals, however this decrease in referrals appears to be connected with the cessation of in-person learning across the state. Between April and June (Q4 FY2020) DCFS saw a significant drop in school referrals.

During this time of uncertainty where significant stress, depression, and anxiety impact families, it is important to recognize the risk for child maltreatment increases substantially. It is therefore important to focus on those risk factors that lead to abuse and neglect. Parents must realize it is normal to feel concern about the immediate future and how it may impact their family. It is also important to recognize the stressors that impact parents also influence children and their behavior.

Children may be more likely to act out or withdraw which can create even more stress for parents which can, in turn, increase risk for abuse. Due to these many unprecedented challenges, parents should be encouraged to reach out for help when needed. Services such as rental assistance, food banks, SNAP programs, and unemployment can help relieve some of the financial stressors associated with parenting and supporting family during the pandemic. These stressors, if left unattended, can lead to adverse outcomes for children. Other programs such as Family Support Centers and crisis nurseries can provide needed respite for parents who feel overwhelmed. Please reach out to a friend, family member, mental health provider, pediatrician, family physician, or a clergy member for advice and support.

All parents need support, but the traditional sources of support are diminished with COVID-19. In such an atmosphere vulnerable parents may feel cut off and further alienated, isolated, alone, and children living in these environments remain at risk, or are at even greater risk. Check on your friends, neighbors, and co-workers who have children. Offer to help. A kind word of understanding or a simple smile can go a long way in helping struggling parents cope. It is extremely important for all of us to act as engaged bystanders. Show compassion and empathy to a struggling parent. Offer help or a kind word when it is appropriate. By improving mental and emotional support for parents, we improve long-term outcomes for children.

Domestic Violence

Since mid-March, the COVID-19 pandemic has forced the majority of Utahns to distance themselves from their normal social and familial interactions in order to help limit the spread of the disease. There are restrictions in our schools, workplaces, and places of recreation, as we are asked to “Stay Home, Stay Safe.” However, for thousands of Utahns, home is not a safe place.

Approximately 425,000 Utahns have experienced domestic violence,⁷ and experts fear the COVID-19 pandemic and the isolation necessary to combat it could drive those numbers even higher. Seeking help and getting out of abusive situations already poses many challenges for survivors. Now, with increased isolation, the amount of control held by abusers could put individuals at increased risk for domestic violence.

We know that isolation can be a significant risk factor for domestic violence. Other risk factors for violence have also increased during the COVID-19 pandemic, including: unemployment, stress, anxiety, and substance misuse.

Recent media stories in Utah seem to indicate that in some areas of the state, domestic violence calls have significantly increased since the “Stay Home, Stay Safe” restrictions were implemented in Utah. While there isn’t information available on an increased volume of calls on a statewide level, the data coming from local law enforcement and victim service agencies seem to indicate an escalation of family violence.

Many people who experience violence survive it but suffer from long-term physical, mental, and emotional health problems ([CDC](#)). Social distancing has impacted protective factors that tend to minimize violence such as social support, financial stability, and access to health and mental health care. Additionally, social distancing measures can force an abuser and victim to occupy space more often, increasing abuse and the mental health impacts that result from abuse. At the same time, victims may be unable to access help and resources due to social distancing or fear of COVID-19; further increasing pressure, stress, anxiety, and depression they may experience. Mental health and safety can also be impacted in the following ways due to COVID-19:

- Abusers further isolating and controlling victims of violence. ([CDC](#))
- Abusers may share misinformation about the pandemic to control or frighten victims or prevent them from seeking medical treatment. ([CDC](#))
- Travel restrictions may impact a victim’s escape or safety plan. ([CDC](#))

This unique climate and increasing violence could put victims of domestic violence at higher risk for a variety of adverse health and safety issues, including mental health impacts.

Individuals have varied barriers to seeking and accepting support. These barriers can be personal or they can be external influences. Intimate partner violence and family violence carry social stigma and can be a source of embarrassment for anyone involved. This can prevent victims and secondary survivors, as well as abusers, from seeking support and resources. Victims can also have concerns beyond the violence itself related to

security and safety. Many survivors of interpersonal violence (IPV) fear intervention itself can cause more harm. Concerns related to financial hardship issues (housing, expenses, children's needs and safety, employment, and feelings of connection and attachment to the abuser impact a survivor's desire and participation in seeking or accepting support. Additionally, these issues can be exacerbated and impact support seeking related to an abuser leaving or being incarcerated. Although seeking support can provide a stop to the violence it can be very disruptive to other aspects of family life and the life of the survivor. It is common for victims to believe abuse will stop soon or get worse if they seek support services. They also fear their family will be separated or children may be removed or taken from them if they report.

COVID-19 increases the stress of friends, family, or even acquaintances of those experiencing or believed to be experiencing abuse. You may not be able to visit or check-in on survivors in person. This can add to an already stressful situation. It is important for those who are worried to remember that even though you can't make decisions for someone else, you can still encourage and support those you care about. Let them know you are thinking about their wellbeing. Remind them you are always happy to support them with safety plans and to practice self-care while they are in their home.

**Fewer than 15% of individuals who seek help actually receive help.
Isolation may decrease an individual's ability to seek help.⁷**

It is critical for people experiencing increased emotional, mental, or substance use related concerns to receive care in a timely manner. It is dangerous to delay health care. Hospitals and clinics are taking abundant and effective precautions to prevent the spread of COVID-19; it is safe to go to your doctor, urgent care, primary care provider, pharmacist, and therapist. **Nearly every mental health care provider has the ability to meet with patients virtually.** Behavioral health services are open for care and those experiencing mental health or substance use concerns can get help by contacting your insurance provider or visiting <https://dsamh.utah.gov/contact/location-map>.

Behavioral Risk Factor Surveillance System (BRFSS)

Description: The BRFSS is the nation's premier system of health-related telephone surveys that collect state data about U.S. residents regarding their health-related risk behaviors, chronic health conditions, and use of preventive services. BRFSS collects data in all 50 states as well as the District of Columbia and three U.S. territories. BRFSS completes more than 400,000 adult interviews each year, making it the largest continuously conducted health survey system in the world.

Limitations: The BRFSS relies on information reported directly by the respondent, so it may be subject to a number of sources of possible error. How questions are worded may elicit responses in a certain way and can result in what is called "measurement error." Similarly, the ability to accurately recall details varies by person and how much time has passed since the event they are trying to recall, which leads to "response error." It is also possible the people who choose to participate are different than those who do not.

Syndromic Surveillance

Description: Syndromic surveillance provides public health officials with a timely system for detecting, understanding, and monitoring health events. By tracking symptoms of patients in emergency departments (ED)—before a diagnosis is confirmed—public health can detect unusual levels of illness to determine whether a response is warranted. Syndromic data can serve as an early warning system for public health concerns such as flu outbreaks and have been used in responses for opioid overdoses, vaping-associated lung disease, Zika virus infection, and natural disasters.

Limitations: Hospitals reporting change over time as facilities are added, diagnostic categories rely on the use of specific codes which might be missing or used inconsistently across hospitals and providers, and the number of persons who did not visit the ED but received treatment elsewhere is not captured.

All Payer's Claim Database (APCD)

Description: Utah's APCD contains data from health insurance carriers, Medicaid, and third party administrators. These data consist of medical, pharmacy, and dental claims as well as insurance enrollment and health care provider data. During processing these files are cleaned, standardized, and enhanced with analytics software that produces data on risk and burden of illness.

Limitations: This data is pulled from the raw monthly submissions, so although pharmacy claim adjustments are rare this data will not take these adjustments into account. Additionally, while the two years contain the same payer mix the number of individuals enrolled in certain plans may fluctuate year to year or as persons gain or lose employment. This may also be impacted by continued roll out of the Medicaid expansion. Finally the trends in the graphs below may not be predictive of future pharmaceutical use. The impact of the COVID-19 pandemic is ever changing.

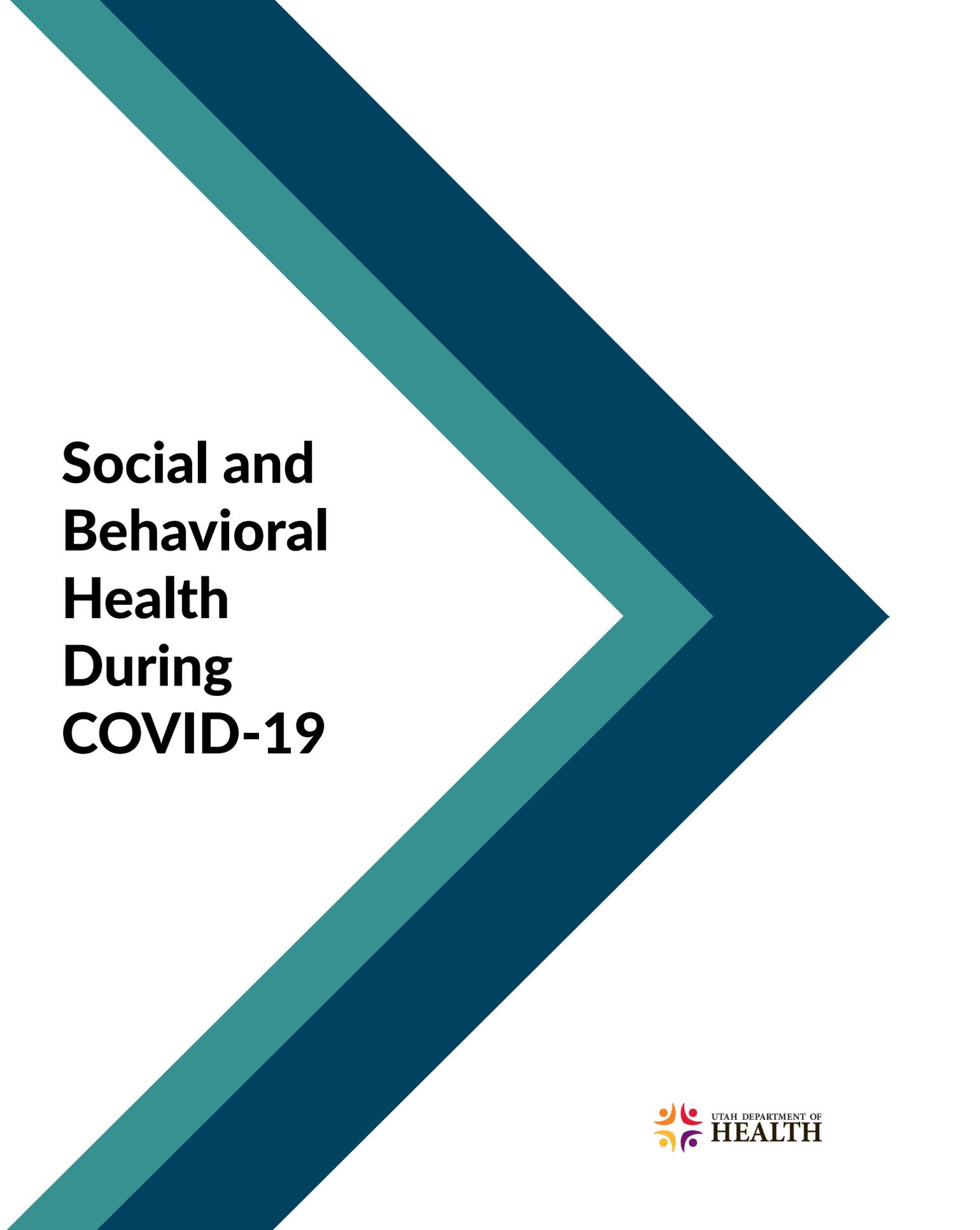
Utah Medical Examiner Database

Description: These data are abstracted from the Utah Medical Examiner Database and are occurrence data. Counts and derivations of 2019 and 2020 data are preliminary. Trend lines for each year were derived using LOWESS (Locally Weighted Scatterplot Smoothing) using a bandwidth coefficient of 0.8.

Drug poisoning (overdose) deaths involving any drug were defined as having an International Classification of Diseases, 10th Revision (ICD-10) underlying-cause-of-death code of X40–X44 (unintentional) or Y10–Y14 (undetermined intent). The following ICD-10 multiple-cause-of-death codes were included for opioid-related overdoses: opium (T40.0); heroin (T40.1); natural and semi-synthetic opioids (T40.2); methadone (T40.3); synthetic opioids other than methadone (T40.4); and other and unspecified narcotics (T40.6).

Limitations: Readers should use caution when interpreting these data as final. It is possible that current pending deaths will be certified as a drug overdose in the future and the manner of death in currently registered cases may be amended as additional information about the death becomes available, ultimately increasing 2020 overdose numbers.

1. Wanqiu Tan, Fengyi Hao, Roger S. McIntyre, Li Jiang, Xiaojiang Jiang, Ling Zhang, Xinling Zhao, Yiran Zou, Yirong Hu, Xi Luo, Zhisong Zhang, Andre Lai, Roger Ho, Bach Tran, Cyrus Ho, Wilson Tam, Is returning to work during the COVID-19 pandemic stressful? A study on immediate mental health status and psychoneuroimmunity prevention measures of Chinese workforce, *Brain, Behavior, and Immunity*, Volume 87, 2020, Pages 84-92, ISSN 0889-1591, <https://doi.org/10.1016/j.bbi.2020.04.055>. (<http://www.sciencedirect.com/science/article/pii/S0889159120306036>)
2. Tull et al. (<https://doi.org/10.1016/j.psychres.2020.113098>)
3. Brooks et al (*Lancet* doi: 10.1016/S0140-6736(20)30460-8)
4. Gan et al (*Psychological Medicine* doi:10.1017/S0033291720003116)
5. Baker et. al (doi:10.2105/AJPH.2020.305738)
6. Benda and Ancker (doi:10.2105/AJPH.2020.305784)
7. Office of Public Health Assessment. Utah Behavioral Risk Factor Surveillance System (BRFSS).



Social and Behavioral Health During COVID-19