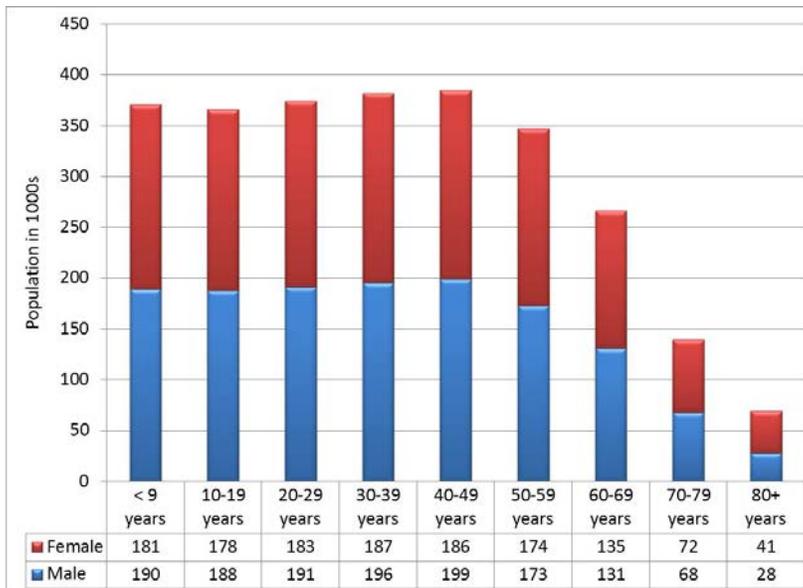


POLICY ACADEMY STATE PROFILE

Nevada's Population

NEVADA POPULATION (IN 1000S) BY AGE GROUP



Source: U.S. Census Bureau, 2010

Nevada is home to more than 2.7 million people. Of these, more than 820,000 (30.5) are over 50; more than 475,000 (17.6) are over 60; about 209,000 (7.7) are over 70; and nearly 70,000 (2.6) are over 80. The proportion of females rises steadily: 59.1 percent of the 80+ population is female. The racial/ethnic composition of Nevadans is as follows:

Race/Ethnicity of Nevadans

Age	White	Black	Am Indian AK Native	Other	White not Hispanic
<55	71.0%	8.4%	1.1%	19.4%	50.0%
55+	82.2%	6.0%	0.9%	10.9%	75.0%

Source: U.S. Census Bureau, 2009 Projections

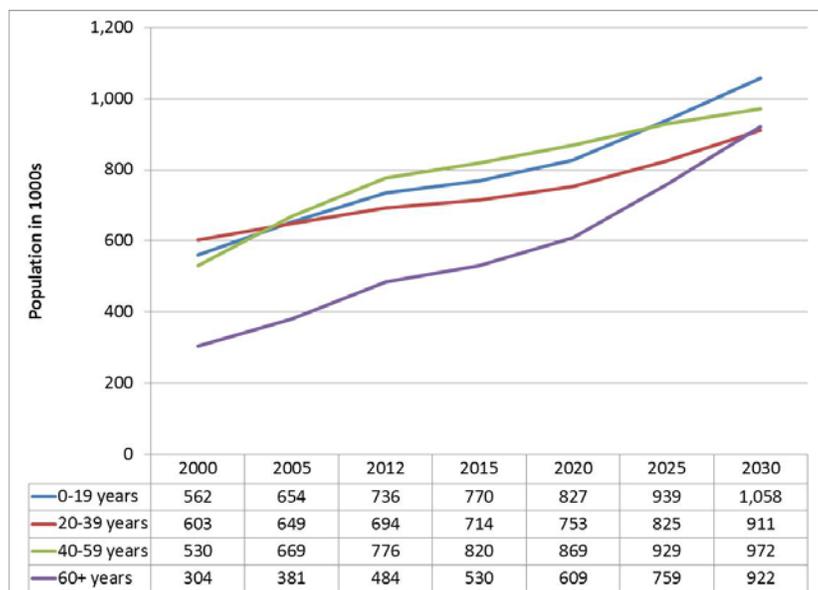
THE NUMBER OF OLDER NEVADANS IS GROWING (POPULATION IN 1000S)

The proportion of Nevada's population that is over 60 is growing more rapidly than other components of the population. The U.S. Census Bureau estimates that about 24 percent of Nevada's population will be over age 60 by the year 2030, an increase of 33 percent from 2012.

Projected Nevada Population

Age Group	2012	2020	2030
0 to 19	27.4%	27.0%	27.4%
20 to 39	25.8%	24.6%	23.6%
40 to 59	28.9%	28.4%	25.2%
60+	18.0%	19.9%	23.9%

Source: U.S. Census Bureau, 2009 Projections

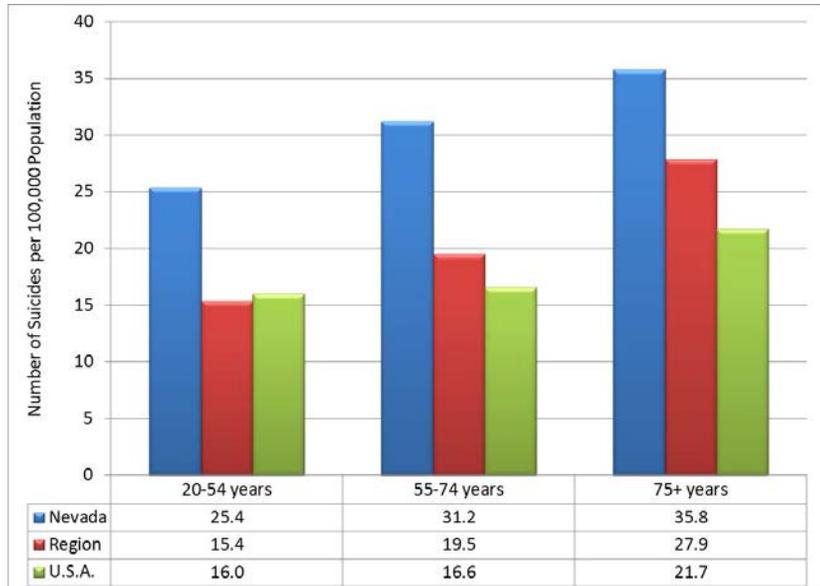


Source: U.S. Census Bureau, 2009 Projections

Suicide Among Older Nevadans

2004-2008 NATIONAL AND REGIONAL SUICIDE RATE PER 100,000 POPULATION

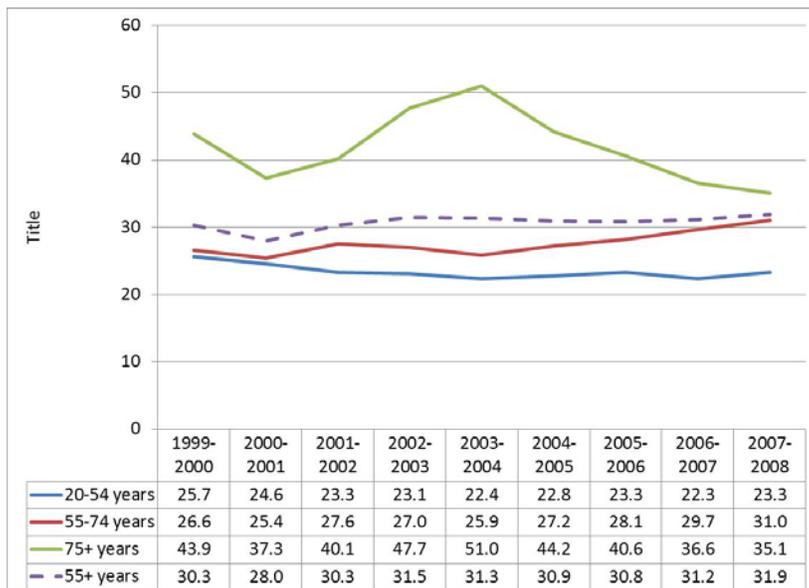
The overall suicide rate among Nevadans age 55 and older, averaged across the five year span of 2004 to 2008, is 32.2 per 100,000 in population. This is higher than the rate in the population under age 55 of 25.4 – primarily due to high rates in the population age 75 and older. These rates appear to be higher than the rates in the Nation and the Western Region (including Alaska, Arizona, California, Hawaii, Idaho, Nevada, Oregon and Washington in addition to Nevada); however, suicide data must be viewed with caution. The rates can fluctuate dramatically with small changes in the number of suicides. In some years, suicide reports were suppressed for some age groups due to small numbers and confidentiality concerns. The numbers here are estimates.



Source: Centers for Disease Control Vital Statistics 2008

Please Note: States vary in their reporting practices surrounding suicide deaths. The apparent rate of suicide is influenced by these reporting practices.

NEVADA SUICIDE TREND



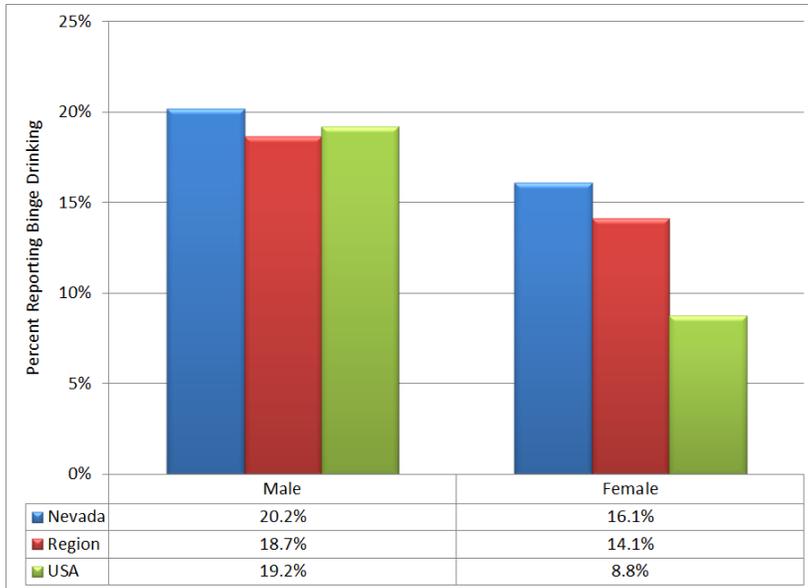
Source: Centers for Disease Control, Vital Statistics 2009

Over the past decade, the two-year moving average rate of suicide among Nevadans age 55 and older – shown with the dashed line- has fluctuated from a high of 31.9 to a low of 28.0 per 100,000. This rate has remained consistently above the rate in younger age groups, and consistently highest in the 75 and older group.

Please Note: States may vary in their reporting practices surrounding suicide deaths from year to year within the same state. The number of suicides is generally low, so even a small difference in reported numbers may make the rate appear to fluctuate widely.

Older Nevadans' Substance Use/Abuse

30-DAY BINGE DRINKING AMONG OLDER NEVADANS BY GENDER



Source: Behavioral Risk Factor Surveillance System 2011

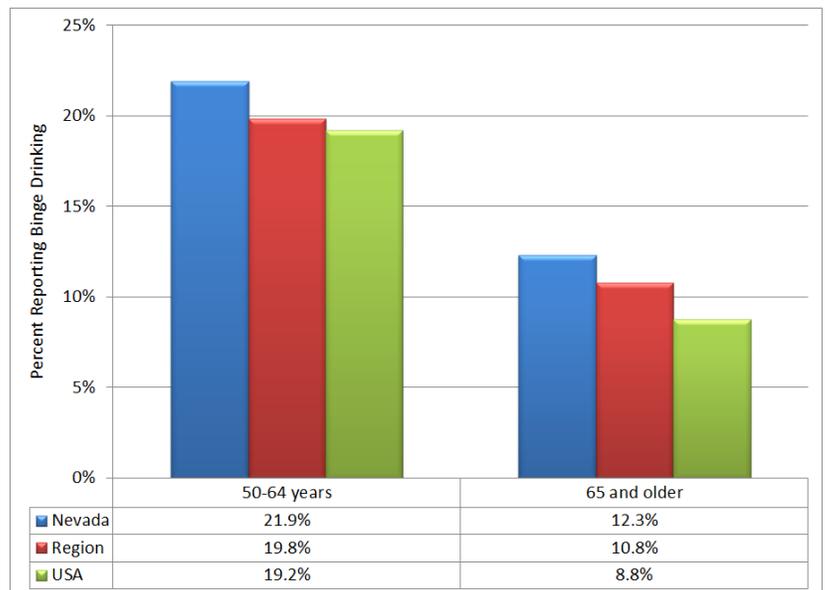
Duke Medicine News (August 17, 2009) notes that binge drinking can cause: “serious problems, such as stroke, cardiovascular disease, liver disease, neurological damage and poor diabetes control.” Binge drinkers are more likely to take risks like driving while intoxicated, and to experience falls and other accidents. Older people have less tolerance for alcohol. Therefore, this table defines a “binge” as 3 or more drinks in one event for women and 4 or more for men. Binge drinking is consistently highest among men. The overall rate of reported binge drinking among Nevadans age 50 and older is 17.1 percent: 20.6 percent of males and 14.6 percent of females. The confidence intervals are less than ± 0.2 and ± 2.0 percent for the regional / national and Nevada estimates respectively.

30-DAY BINGE DRINKING AMONG OLDER NEVADANS BY AGE GROUP

Binge drinking tends to decrease with age. While 21.6 percent of Nevadans age 50-64 reported binge drinking, 10.8 percent of those and 65 and older reported similar behavior. The confidence intervals are less than ± 0.2 and ± 2.0 percent for the regional/national and Nevada estimates respectively. The following table provides a breakdown by age and gender

Reported Binge Drinking among Older Nevadans' by Age and Gender

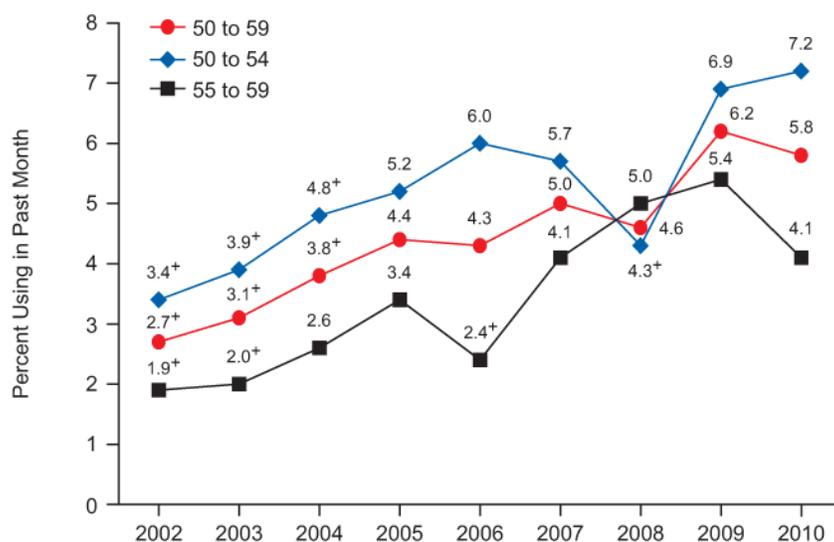
	Male	Female
50-64 years	25.6%	18.7%
65 and older	13.8%	8.6%



Source: Behavioral Risk Factor Surveillance System, 2011

ILLICIT DRUG USE AMONG OLDER AMERICANS

Nationally, illicit drug use has more than doubled among 50-59 year olds since 2002. The rate rose from 3.4 to 7.2 percent among 50-54 year olds and from 1.9 to 4.1 percent among 55-59 year olds. According to the Substance Abuse and Mental Health Services Administration, “These patterns and trends partially reflect the aging into these age groups of members of the baby boom cohort, whose rates of illicit drug use have been higher than those of older cohorts.” Specific data about substance abuse among older Nevadans are not available; however the SAMHSA NSDUH Report (<http://www.oas.samhsa.gov/2k9state/Cover.pdf>), provides general information about substance use in Nevada.



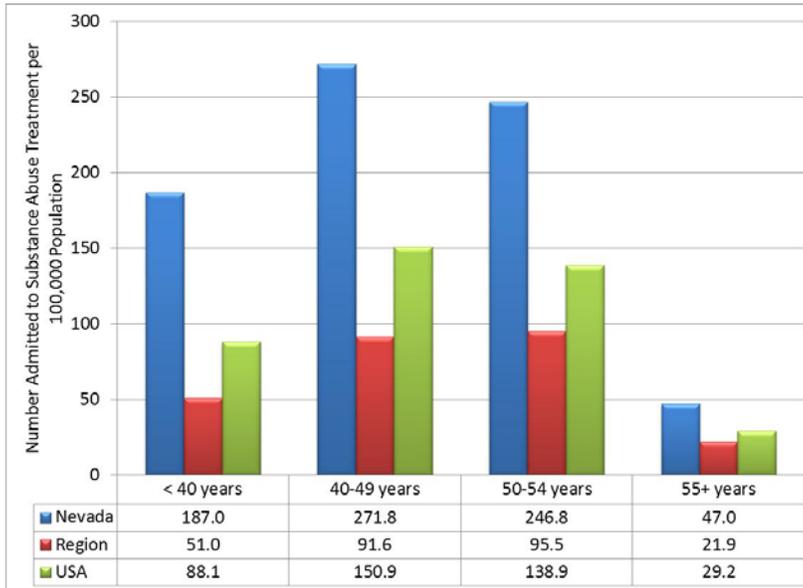
Source: National Survey on Drug Use and Health, 2010
Volume 1. Summary of National Findings

DRUG-RELATED EMERGENCY DEPARTMENT VISITS INVOLVING PHARMACEUTICAL MISUSE AND ABUSE BY OLDER ADULTS

The Substance Abuse and Mental Health Service Administration’s Center for Behavioral Health Statistics and Quality periodically releases reports from the Drug Abuse Warning Network (DAWN). DAWN comprises a nationwide network of hospital emergency rooms (ER) primarily located in large metropolitan areas. DAWN data consist of professional reviews of ER records to determine the likelihood and extent to which alcohol and other drug abuse was involved. The November 25, 2010, DAWN Report showed that (quote):

- In 2004, there were an estimated 115,803 emergency department (ED) visits involving pharmaceutical misuse and abuse by adults aged 50 or older; in 2008, there were 256,097 such visits, representing an increase of 121.1 percent
- One fifth (19.7 percent) of ED visits involving pharmaceutical misuse and abuse among older adults were made by persons aged 70 or older
- Among ED visits made by older adults, pain relievers were the type of pharmaceutical most commonly involved (43.5 percent), followed by drugs used to treat anxiety or insomnia (31.8 percent) and antidepressants (8.6 percent)
- Among patients aged 50 or older who visited the ED for pharmaceutical misuse or abuse, more than half (52.3 percent) were treated and released, and more than one third (37.5 percent) were admitted to the hospital

NEVADANS AGE 50 AND OLDER ADMITTED TO SUBSTANCE ABUSE TREATMENT

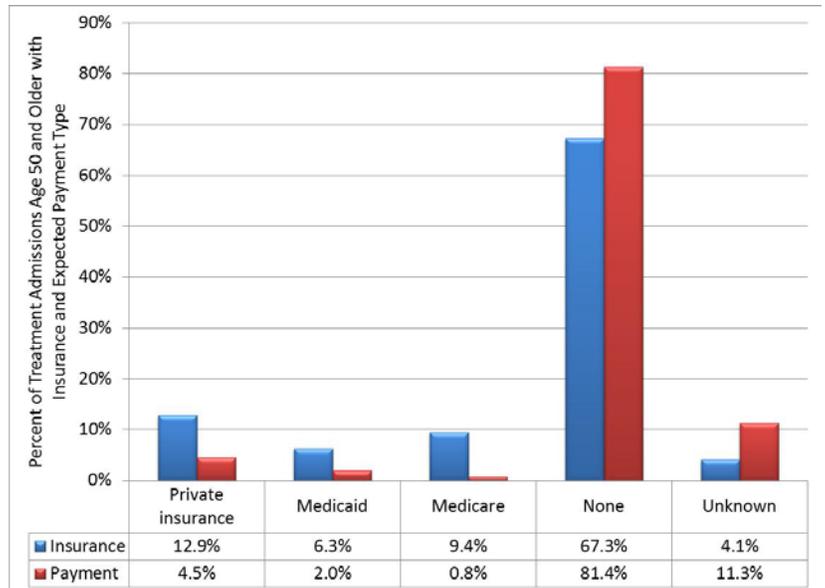


752 Nevadans age 50 or older were admitted to public substance abuse treatment in 2009. This represents a rate of 91.4 admissions per 100,000 in population. This rate appears to be higher than rates in the Nation and the Western Region.

Source; Treatment Episode Data Set, 2009¹
Includes only those clients reported to SAMHSA

TREATMENT ADMISSIONS AMONG AGE 50 AND OLDER BY INSURANCE TYPE

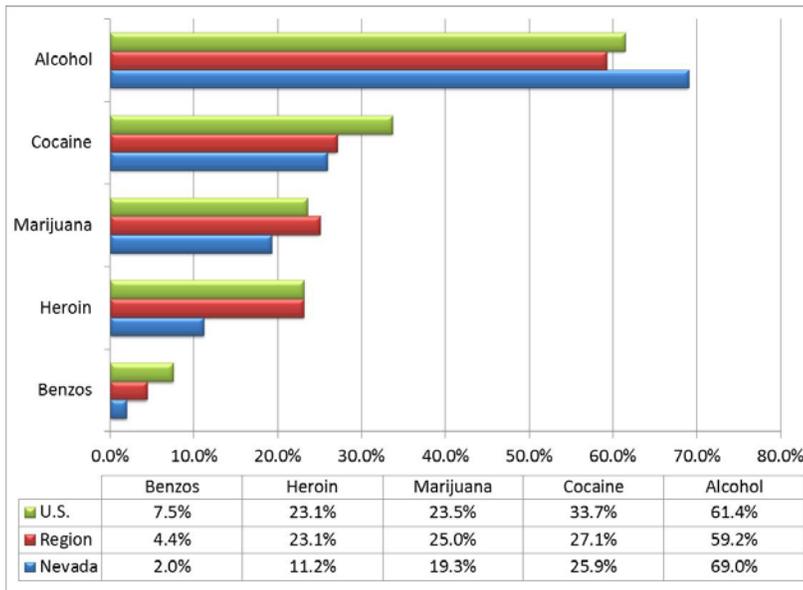
Collectively, about 30 percent of admissions were reported to be covered by Medicaid, Medicare or private insurance. In nearly 70 percent of admissions, the client’s insurance coverage was “None.” In more than 90 percent of admissions, the expected source of payment was “None” or “Unknown.” In these cases, the bills were likely covered by the Block Grant and/or State and other available funding.



Source: Treatment Episode Data Set, 2009
Includes only those clients reported to SAMHSA

¹ TEDS Limitations: TEDS data are collected by states that accept Substance Abuse Prevention and Treatment (SAPT) Block Grant funds. Guidelines suggest that states should report all clients admitted to publicly financed treatment; however, states are inconsistent in applying the guidelines. States also have freedom to structure and implement different quality controls over the data. For example, states may collect different categories of information to answer TEDS questions. Information is then “walked over” to TEDS definitions.

AGE 55+ TREATMENT ADMISSIONS - SUBSTANCES USED

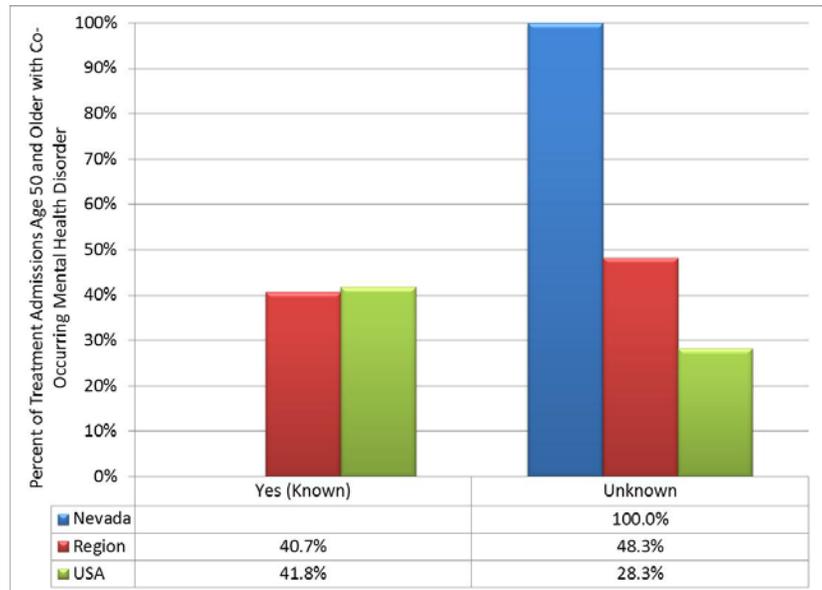


Alcohol was - by far - the most frequent drug used by older Nevadans (age 50 and older) admitted to publicly financed substance abuse treatment in 2009. Alcohol was mentioned as the primary, secondary, tertiary or substance of abuse in nearly 70 percent of these admissions. Alcohol was followed by cocaine at 25.9 percent; marijuana at 19.3 percent, heroin at 11.2 percent and benzodiazepines at 2.0 percent.

Source; Treatment Episode Data Set, 2009²
Includes only those clients reported to SAMHSA

CO-OCCURRING MENTAL HEALTH DISORDER

Research shows a strong relationship between substance use and mental health disorders. Studies show 30-80 percent of people with substance abuse or mental health disorders also have a co-occurring substance abuse/mental health disorder. While the Center for Substance Abuse Treatment (CSAT) recommends that the states should collect information about co-occurring disorders, Nevada did not report these data to the Treatment Episode Data Set (TEDS) in 2009. The graph to the right shows the proportion of people in the Western Region and the Nation who were admitted to substance abuse treatment and also had a mental health diagnosis.



Source: Treatment Episode Data Set, 2009
Includes only those clients reported to SAMHSA

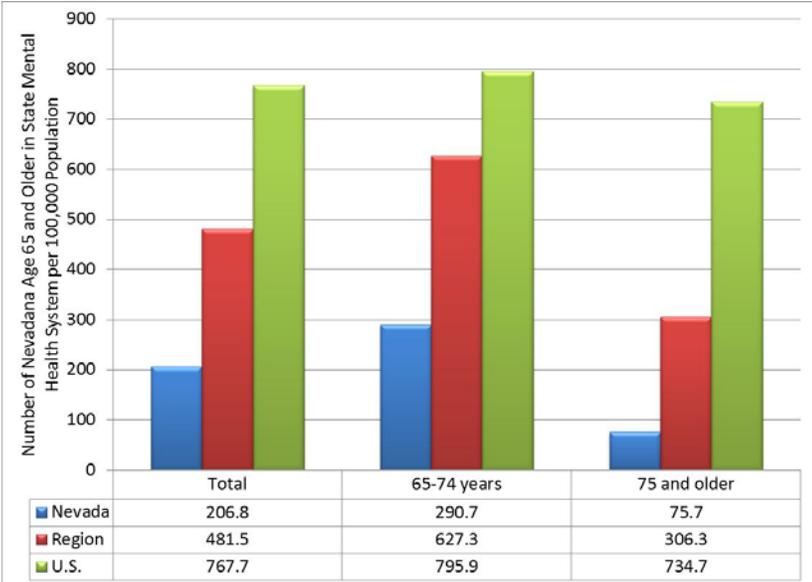
² TEDS Limitations: TEDS data are collected by states that accept Substance Abuse Prevention and Treatment (SAPT) Block Grant funds. Guidelines suggest that states should report all clients admitted to publicly financed treatment; however, states are inconsistent in applying the guidelines. States also have freedom to structure and implement different quality controls over the data. For example, states may collect different categories of information to answer TEDS questions. Information is then “walked over” to TEDS definitions.

Mental Health

OLDER NEVADAS ADMITTED TO STATE MENTAL HEALTH FACILITIES

Just over 2 percent of the people served by the Nevada mental health system were age 65 or older (1.8 percent were age 65 to 74 and 0.3 percent were age 75 or older). This represents a total of approximately 671 people. These and other data about the Nevada mental health system are available at:

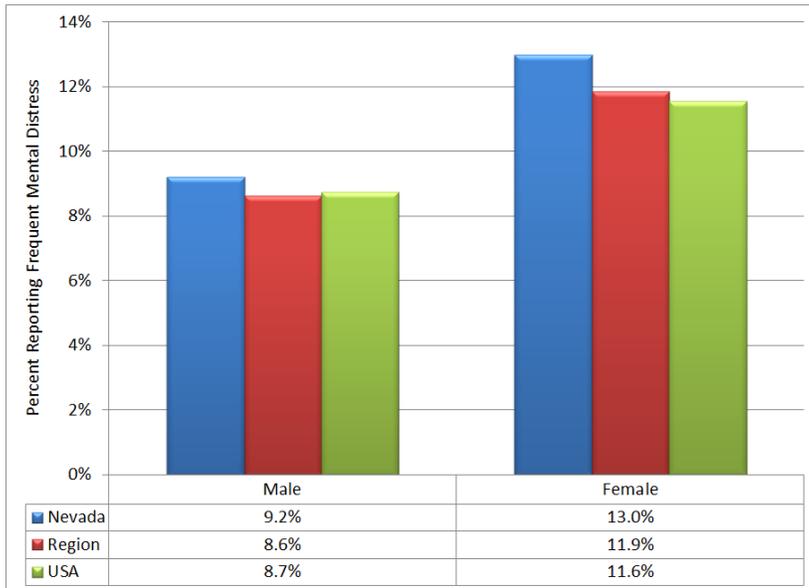
<http://www.samhsa.gov/dataoutcomes/urs/2010/Nevada.pdf>



Source: Center for Mental Health Statistics Uniform Reporting System 2010

Mental Health

OLDER NEVADANS REPORTING FREQUENT MENTAL DISTRESS BY GENDER



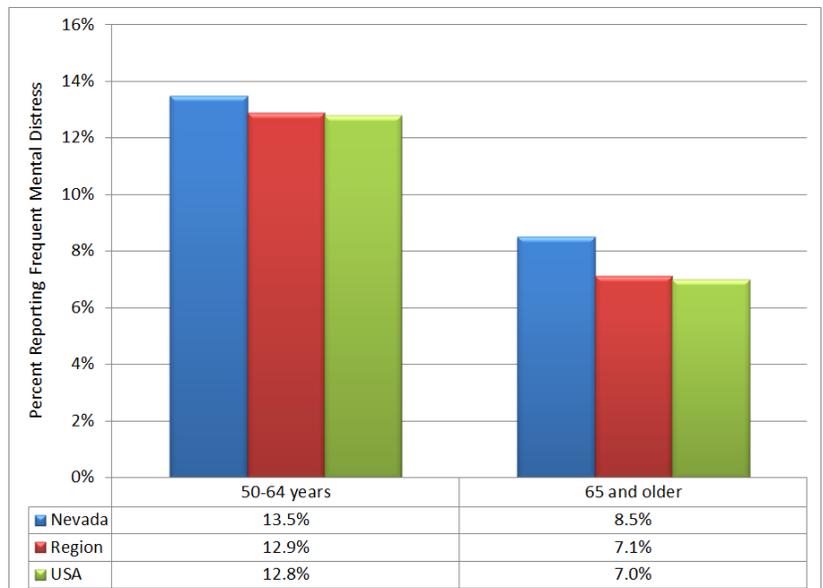
The Behavioral Risk Factor Surveillance System (BRFSS), a household survey conducted in all 50 states and several territories, asks the following question: “Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?” The Centers for Disease Control defines those individuals reporting 14 or more “Yes” days in response to this question as experiencing frequent mental distress (FMD). Overall, 11.3 percent of Nevadans age 50 and older reported FMD: 13.0 percent of females and 9.2 percent of males. Confidence intervals around national / regional estimates are less than ± 0.2 and ± 2.0 percent respectively.

Source: Behavioral Risk Factor Surveillance System, 2011

OLDER NEVADANS REPORTING FREQUENT MENTAL DISTRESS BY AGE GROUP

Nevadans in the 65 and older age group, as in the nation and the Western Region, are less likely to report FMD than Nevadans in the 50-64 age group: 13.5 percent in the 50-64 year age group and 8.5 percent in the 65 and older group. Confidence intervals around national/ regional estimates are less than ± 0.2 and ± 2.0 percent respectively. The following table provides a breakdown by age and gender.

Older Nevadans Reporting Frequent Mental Distress by Age and Gender



Source: Behavioral Risk Factor Surveillance System, 2011

OTHER MEASURES OF MENTAL HEALTH

The Behavioral Health Risk Factor Surveillance System (BRFSS) collected other measures showing risk factors for mental and/or physical illness. These included:

- Social and Emotional Support (2010). The BRFSS asked, “How often do you get the social and emotional support you need?” The responses included: “always,” “usually,” “sometimes,” “rarely” or “never.”
- Life Satisfaction (2010). The BRFSS asked, “In general, how satisfied are you with your life?” The responses included: “Very satisfied,” “Satisfied,” “Dissatisfied” or “Very dissatisfied.”
- Current Depression (2006). In 2006, the BRFSS included a special Anxiety and Depression module which was collected in 38 states and several jurisdictions, including Nevada. The measure presented below was derived from this module.
- Lifetime Diagnosis of Depression (2006). The BRFSS asked, “Has a doctor or other healthcare provider EVER told you that you have a depressive disorder (including depression, major depression, dysthymia, or minor depression)?”
- Lifetime Diagnosis of Anxiety Disorder (2006). The BRFSS asked, “Has a doctor or other healthcare provider EVER told you that you have an anxiety disorder (including acute stress disorder, anxiety, generalized anxiety disorder, obsessive-compulsive disorder, panic attacks, panic disorder, posttraumatic stress disorder, or social anxiety disorder)?”

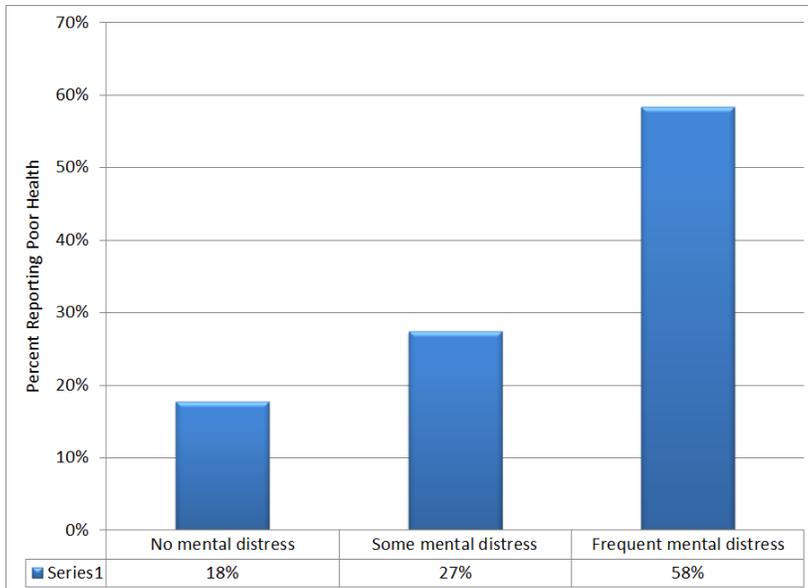
The results of these surveys among older Nevadans are shown below:

BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM, 2010

Indicator	Age Group					
	Age 50+		Age 50–64		Age 65+	
	Data %	Confidence Interval	Data %	Confidence Interval	Data %	Confidence Interval
Core BRFSS Indicators (2010)						
Rarely or never get social or emotional support (revised)	9.3	(8.6-10.0)	7.7	(7.0-8.5)	11.6	(10.5-12.8)
Very dissatisfied or dissatisfied with life (revised)	7.4	(6.8-8.0)	9.6	(8.8-10.5)	4.2	(3.4-4.9)
Anxiety and Depression Optional Module Indicators (2006) ³						
Current Depression	8.6	(6.8-10.7)	9.9	(7.6-12.8)	6.4	(4.2-9.8)
Lifetime Diagnosis of Depression	17.0	(14.7-19.5)	21.5	(18.1-25.2)	10.1	(7.8-13.1)
Lifetime Diagnosis of Anxiety Disorder	12.7	(10.7-14.9)	16.3	(13.4-19.6)	7.2	(5.1-9.9)

³ Data available at <http://apps.nccd.cdc.gov/MAHA/StateDetails.aspx?State=NV>

PEOPLE WITH FREQUENT MENTAL DISTRESS REPORT POOR PHYSICAL HEALTH



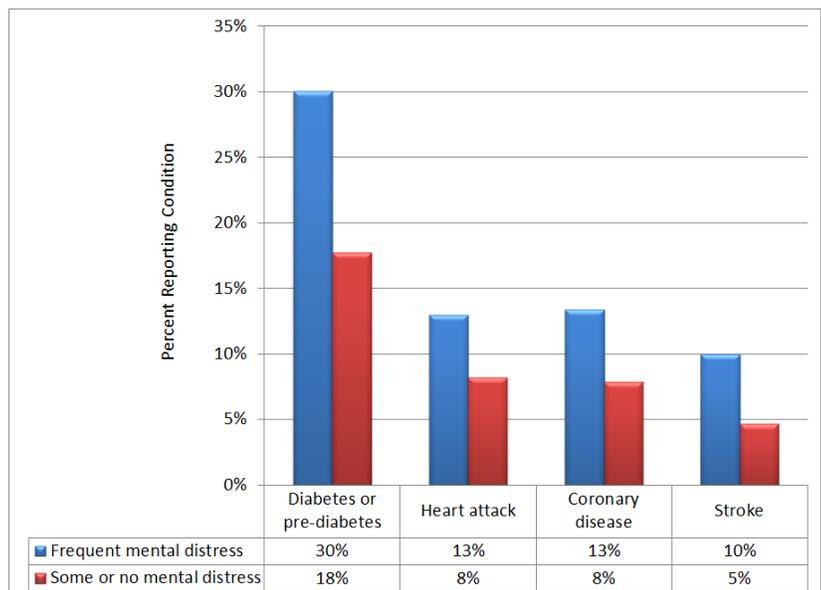
Older Americans who experienced frequent mental distress were more likely to report that their physical health was poor or fair (as opposed to good, very good or excellent). As shown here, while 18 percent of older Americans with no mental distress reported poor or fair physical health, nearly 60 percent – nearly triple the rate – of those with frequent mental distress reported poor/fair health. Older Americans with frequent mental distress were also much more likely to report that they had experienced serious health problems.

These differences are statistically significant.

Source: Behavioral Risk Factor Surveillance System, 2011

RELATIONSHIP BETWEEN MENTAL DISTRESS AND SERIOUS HEALTH PROBLEMS

Older Americans who experience frequent mental distress, such as symptoms of depression or anxiety, are more likely to report that they had chronic health problems. People with frequent mental distress experienced strokes at twice the rate of those with some or no mental distress (10 percent versus 5 percent). They experienced coronary disease, heart attack and diabetes/pre-diabetes at more than 1.5 times the rate of those with some or no mental distress (13 versus 8 percent for coronary disease and heart attack, 30 versus 18 percent for diabetes/pre-diabetes). These differences are statistically significant.



Source: Behavioral Risk Factor Surveillance System, 2011

DATA SOURCES

BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM (<http://www.cdc.gov/brfss/>). Centers for Disease Control and Prevention (CDC). *Behavioral Risk Factor Surveillance System Survey Data*. Atlanta, Georgia: U.S. Department of Health and Human Services, 2010 and 2011. The BRFSS is “the world’s largest, on-going telephone health survey system, tracking health conditions and risk behaviors in the United States yearly since 1984. Currently, data are collected monthly in all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and Guam.” BRFSS data are collected by local jurisdictions and reported to the CDC.

VITAL STATISTICS (<http://www.cdc.gov/nchs/nvss.htm>). Centers for Disease Control and Prevention (CDC), *National Vital Statistics System*, Atlanta, Georgia: U.S. Department of Health and Human Services, 2009. The CDC Web site describes the National Vital Statistics System as “the oldest and most successful example of inter-governmental data sharing in Public Health and the shared relationships, standards, and procedures form the mechanism by which NCHS collects and disseminates the Nation's official vital statistics. These data are provided through contracts between NCHS and vital registration systems operated in the various jurisdictions legally responsible for the registration of vital events – births, deaths, marriages, divorces, and fetal deaths.”

CENTER FOR MENTAL HEALTH SERVICES UNIFORM REPORTING SYSTEM (URS) (<http://www.samhsa.gov/dataoutcomes/urs/>). Center for Mental Health Services (CMHS), *Uniform Reporting System*, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2010. States that receive CMHS Block Grants are required to report aggregate data to the URS. URS reports including information about utilization of mental health services as well as client demographic and outcome information.

NATIONAL SURVEY ON DRUG USE AND HEALTH (NSDUH) (<https://nsduhweb.rti.org/>). United States Department of Health and Human Services. Substance Abuse and Mental Health Services Administration. Center for Behavioral Health Statistics and Quality. National Survey on Drug Use and Health, 2010. ICPSR32722-v1. Ann Arbor, MI: Inter-university Consortium for Political and Social Research [distributor], 2011-12-05. doi:10.3886/ICPSR32722.v1 The NSDUH, managed by SAMHSA, is “ an annual nationwide survey involving interviews with approximately 70,000 randomly selected individuals aged 12 and older.” NSDUH data are most frequently used by State planners to assess the need for substance abuse treatment. NSDUH data also include information about mental health needs.

TREATMENT EPISODE DATA SET (TEDS) (<http://www.icpsr.umich.edu/icpsrweb/SAMHDA/>). United States Department of Health and Human Services. Substance Abuse and Mental Health Services Administration. Office of Applied Studies. Treatment Episode Data Set -- Admissions (TEDS-A), 2009. ICPSR30462-v2. Ann Arbor, MI: Inter-university Consortium for Political and Social Research [distributor], 2012-07-18. doi:10.3886/ICPSR30462.v2 States that participate in the Substance Abuse Prevention and Treatment (SAPT) Block Grant submit individual client data to the TEDS. The TEDS includes both admission and discharge data sets, and some 1.5 million admissions are reported annually. TEDS includes information about utilization of substance abuse treatment services as well as client demographic and outcome information.

U.S. CENSUS BUREAU (<http://www.census.gov/people/>). Two main sources of Census Bureau data were used in this report: (1) Population estimates, and (2) Population projections. Population projections and estimates were created using 2010 Census Data.

This profile was developed by the Substance Abuse and Mental Health Services Administration in partnership with the U.S. Administration on Aging.