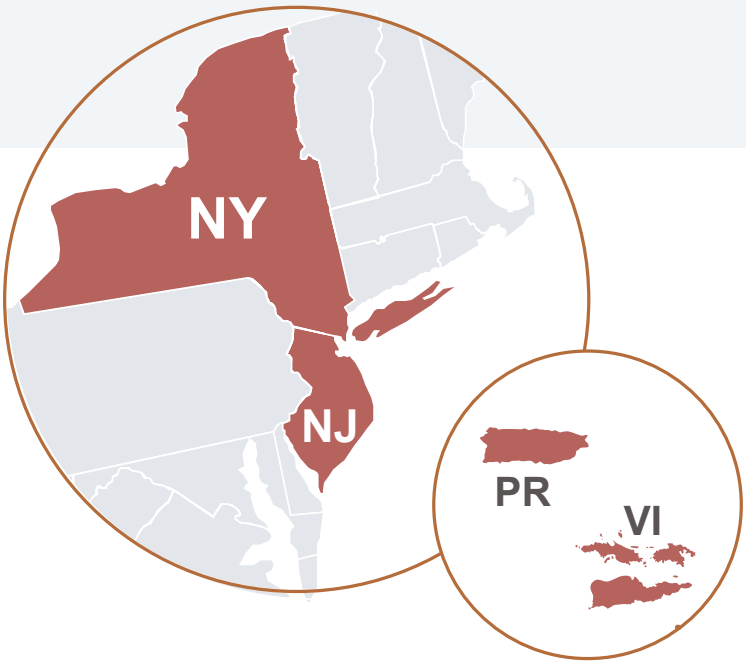
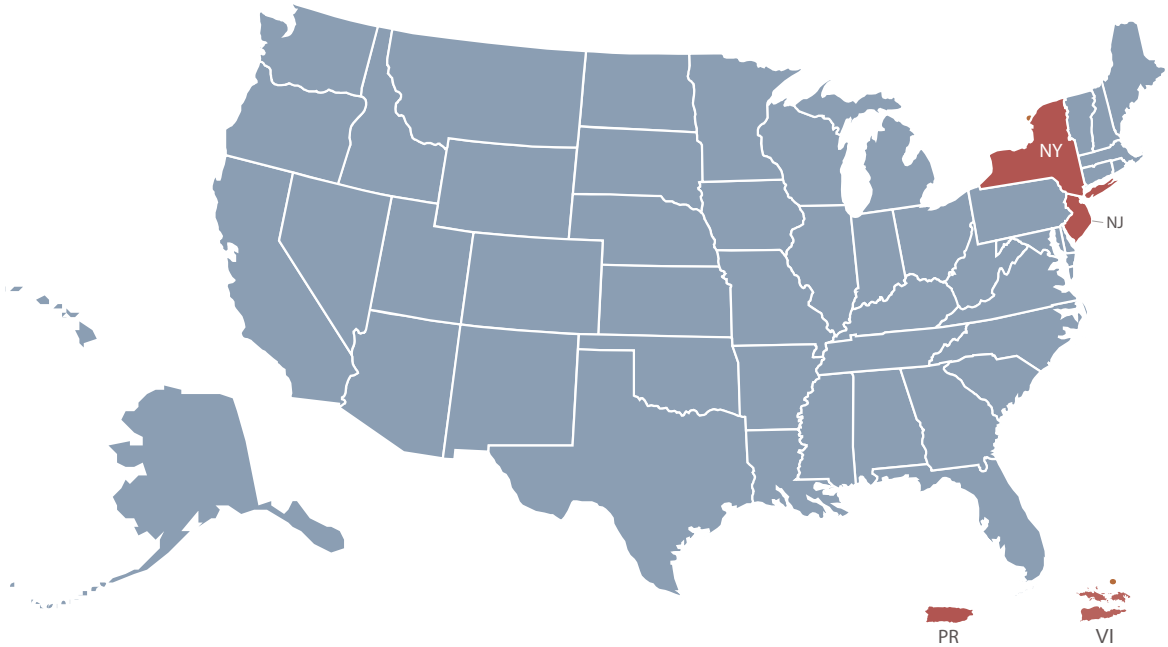
OLDER ADULTS BEHAVIORAL HEALTH PROFILES

REGION 2



NEW JERSEY
NEW YORK
PUERTO RICO
U.S. VIRGIN ISLANDS



A Behavioral Health Resource

SAMHSA's State Technical Assistance Contract

April 2016

OLDER ADULTS BEHAVIORAL HEALTH PROFILES

OVERVIEW

The Substance Abuse and Mental Health Services Administration recognizes the importance of behavioral health for older adults and the key role states, territories, and communities play in addressing the needs of this vital and growing population. Administrators need clear and concise information to plan, implement, and evaluate effective prevention and treatment efforts in their states and territories.

The Older Adults Behavioral Health Profiles help states, territories, and communities identify focus areas for behavioral health plans, select population-level goals, and coordinate and target services to address priority issues. The profiles compare state and territory trends with those in the region and the nation. State, territory, and community administrators, planners, and providers can use the information in these profiles and their own data, knowledge, and experience to establish and implement policies that improve the health and future of our valued older citizens.

Disclaimer: Data were current at the time this document was prepared.

Developed under the Substance Abuse and Mental Health Services Administration's State Technical Assistance Task Order. Reference #HHSS283201200002I/Task Order No. HHSS28342002T.

OLDER ADULTS BEHAVIORAL HEALTH PROFILE

New Jersey

New Jersey

OLDER ADULTS BEHAVIORAL HEALTH PROFILE

April 2016

NEW JERSEY'S POPULATION

New Jersey Population by Age Group

New Jersey is home to 8,938,175 people. Of these:

- 3,157,445 (35.3 percent) are over age 50.
- 1,830,792 (20.5 percent) are over age 60.
- 891,368 (10.0 percent) are over age 70.
- 365,686 (4.1 percent) are ages 80 and older.

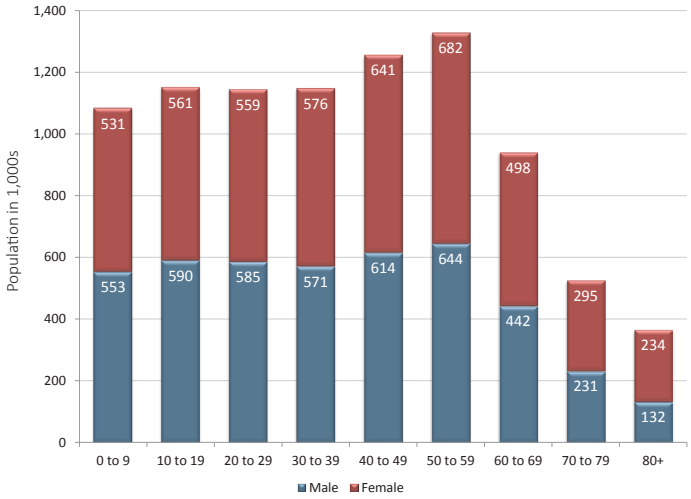
The proportion of women rises fairly steadily in each age group, and women make up 64.0 percent of the 80+ group. The racial/ethnic composition of older New Jerseyans is as follows:

Race/Ethnicity of New Jerseyans Ages 50+

White	AI/AN	Black	Asian	NH/PI	Other	Hispanic
79.5%	0.4%	11.9%	7.3%	0.1%	0.9%	11.6%

Source: U.S. Census Bureau, 2015
AI/AN stands for American Indian and Alaska Native.
NH/PI stands for Native Hawaiian and Other Pacific Islander.

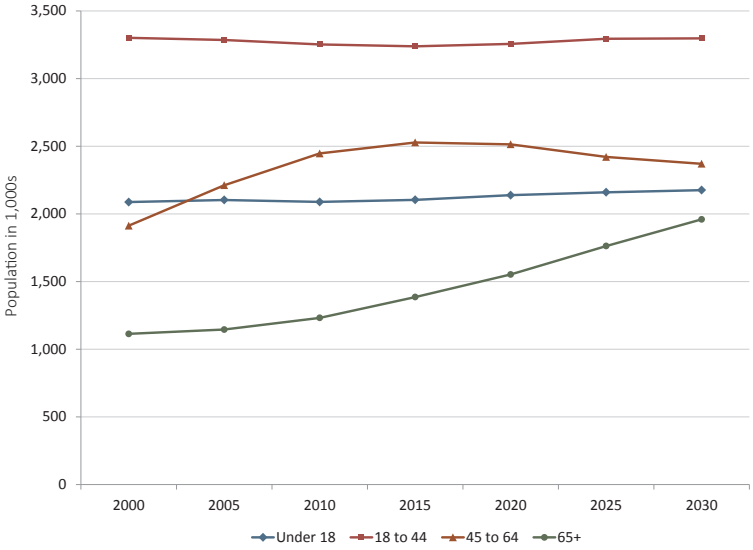
Exhibit 1. New Jersey Population by Age Group, 2014



Source: U.S. Census Bureau, 2015

The Number of Older New Jerseyans Is Growing

Exhibit 2. New Jersey Population by Age Group, 2000–2030



The proportion of New Jersey's population that is 65 and older is growing while the proportion that is younger than 65 is shrinking. The U.S. Census Bureau estimates that 20.0 percent of New Jersey's population will be 65 and older by the year 2030, an increase of 41.5 percent from 2015.

Projected Population in New Jersey

Age Group	2015	2025	2030
Under 18	22.7%	22.4%	22.2%
18 to 44	35.0%	34.2%	33.6%
45 to 64	27.3%	25.1%	24.2%
65+	15.0%	18.3%	20.0%

Source: U.S. Census Bureau, 2005

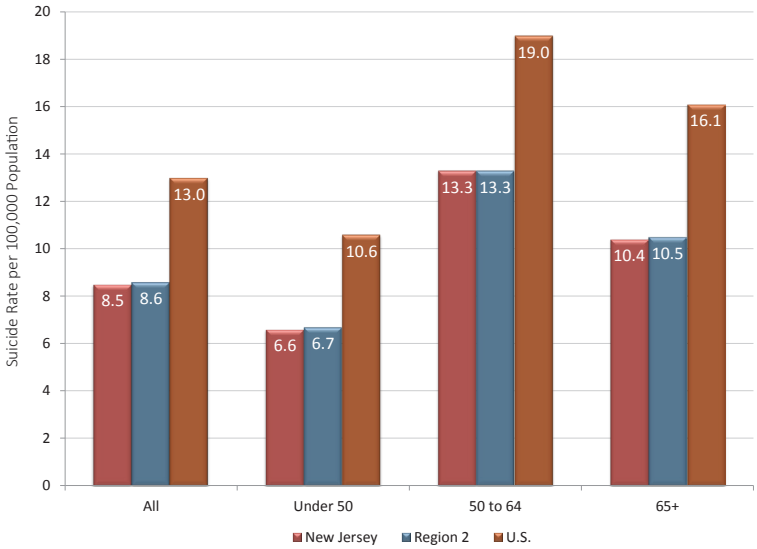
SUICIDE AMONG OLDER NEW JERSEYANS

New Jersey Suicide Rate Compared With Regional and National Rates

The suicide rate among New Jerseyans ages 50 and older is higher than the rate among younger age groups. In 2013, the total suicide rate among all people ages 50+ was 12.1 per 100,000 people (4.9 for women and 20.6 for men). The rate among those ages 50–64 was equal to the rate in the region (calculated based on data from New Jersey and New York) and lower than the rate in the United States.

States vary in their reporting of suicides. The suicide rate is influenced by these reporting practices.

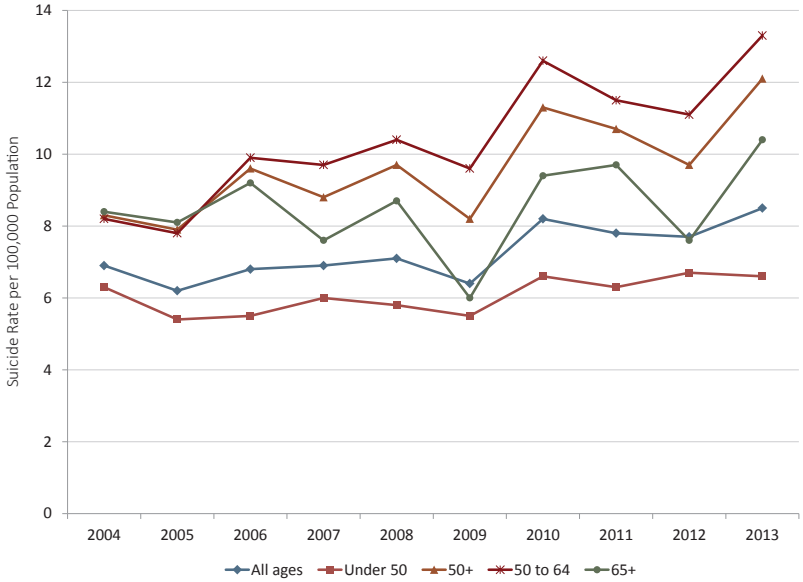
Exhibit 3. Suicide Rates in New Jersey, Region 2, and the United States, 2013



Source: Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Underlying Cause of Death 1999-2013 on CDC WONDER Online Database, released 2015

Trends in Suicide Rates in New Jersey

Exhibit 4. Trends in Suicide Rates in New Jersey by Age Group, 2004–2013



Source: CDC, NCHS, Underlying Cause of Death 1999-2013 on CDC WONDER Online Database, released 2015

The suicide rate among New Jerseyans ages 50+ fluctuated from a low of 7.9 per 100,000 in 2005 to a high of 12.1 per 100,000 in 2013. From 2004 to 2013, the rate was generally highest among those in the 50–64 age group.

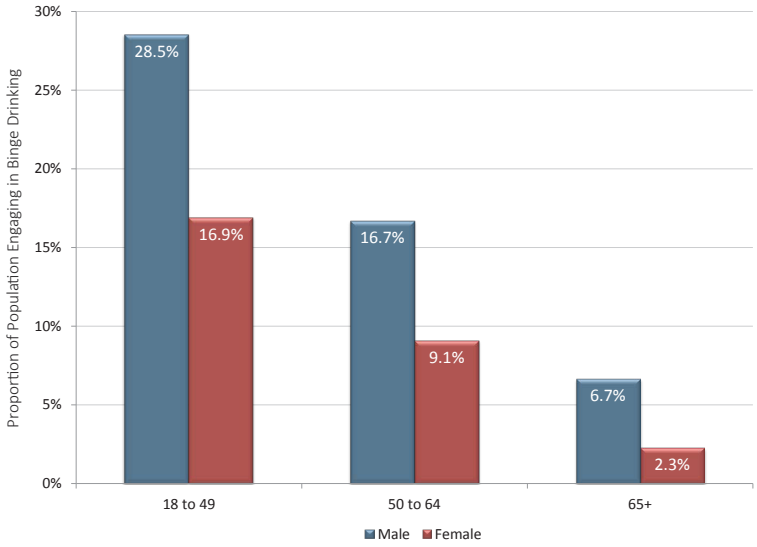
How a state reports suicides can vary from year to year. The number of suicides is generally low, so even a small difference in reported numbers may make the rate fluctuate widely.

SUBSTANCE USE DISORDER AND SUBSTANCE USE DISORDER TREATMENT AMONG OLDER NEW JERSEYANS

30-Day Binge Drinking Among Older New Jerseyans

Binge drinking, defined as five or more drinks for men and four or more drinks for women on a single occasion, can lead to serious health problems. Such problems include neurological damage, cardiovascular disease, liver disease, stroke, and poor control of diabetes. Binge drinkers are more likely to take risks such as driving while intoxicated and to experience falls and other accidents. Older people have a lower tolerance for alcohol. Binge drinking decreases with age and occurs more frequently among men than it does among women. As Exhibit 5 shows, 16.7 percent of New Jersey men ages 50–64 reported binge drinking in the past 30 days, while 6.7 percent of those in the 65+ group reported similar behavior.

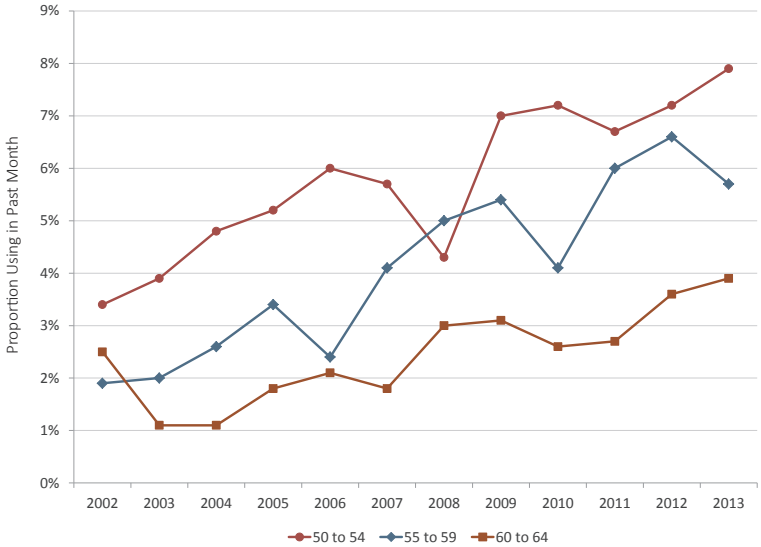
Exhibit 5. Binge Drinking Rates in New Jersey by Age Group and Sex, 2013



Source: Behavioral Risk Factor Surveillance System (BRFSS), 2013

Illicit Drug Use Among Older Americans

Exhibit 6. Illicit Drug Use Among Older Americans, 2002–2013



Source: National Survey on Drug Use and Health (NSDUH), 2013
Illicit drug use includes illegal drugs and prescription drugs used nonmedically. SAMHSA provides a list of drugs included in its survey in the NSDUH methodological summary.

Nationally, the rate of illicit drug use among older adults ages 50–64 more than doubled from 2002 to 2013. This development partially reflects the entrance into this age group of the baby boom cohort, whose rates of illicit drug use have been higher than those of older cohorts. Although state-specific data are not available, the *New Jersey Behavioral Health Barometer* is available for download from the Substance Abuse and Mental Health Services Administration (SAMHSA) website (www.samhsa.gov/data/population-data-nsduh/reports?tab=33).

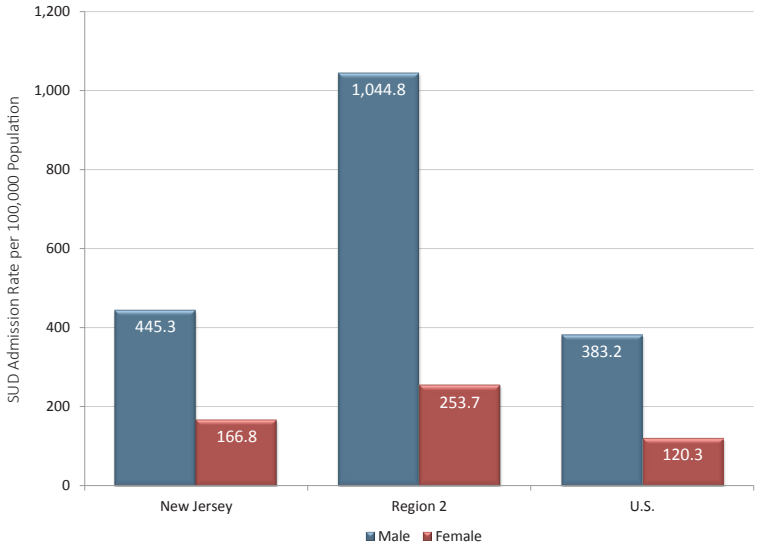
Admissions to Substance Use Disorder Treatment Among Older New Jerseyans

In 2012, there were 9,303 admissions of New Jerseyans ages 50 and older to substance use disorder (SUD) treatment in state-funded treatment programs, a rate of 294.6 per 100,000 people ages 50+. This rate was lower than the regional rate and higher than the national average. Men made up 69.4 percent of these admissions. Of all admissions, 65.9 percent were White/ Caucasian, 32.6 percent were Black/ African American, and 9.8 percent were Hispanic.

The principal sources of referral to treatment among those ages 50 and older were:

Self-Referral	Criminal Justice	Other
45.1%	29.1%	25.7%

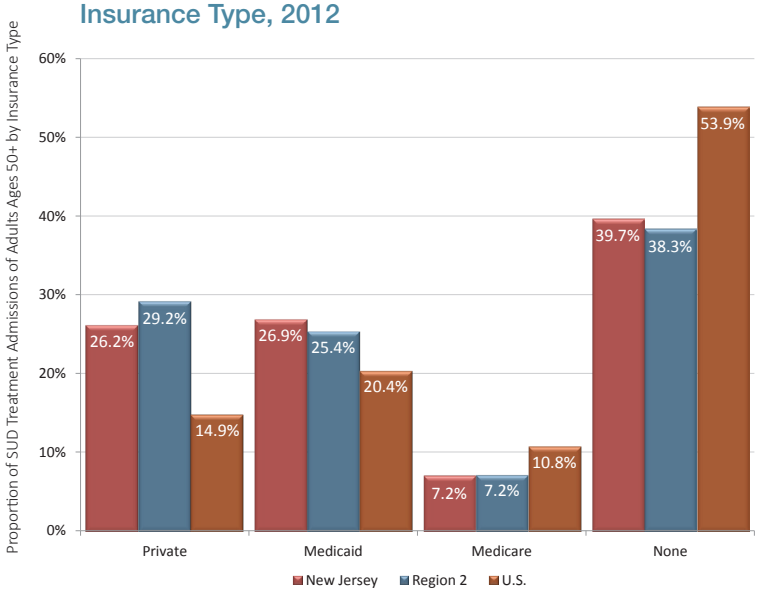
Exhibit 7. SUD Treatment Admissions of Adults Ages 50+ in New Jersey, Region 2, and the United States by Sex, 2012



Source: Treatment Episode Data Set (TEDS), 2012[1]
Data include only those clients reported to SAMHSA.

SUD Treatment Admissions Among New Jerseyans Ages 50+ by Insurance Type

Exhibit 8. SUD Treatment Admissions of Adults Ages 50+ in New Jersey, Region 2, and the United States by Insurance Type, 2012



Source: TEDS, 2012
Data include only those clients reported to SAMHSA.

In New Jersey, 39.7 percent of older adult admissions to SUD treatment were uninsured, 26.9 percent had Medicaid, 7.2 percent had Medicare, and 26.2 percent had private insurance.

SUD Treatment Admissions Among New Jerseyans Ages 50+ by Primary Sources of Payment

Self-Pay	Medicaid	Other
33.8%	9.6%	56.6%

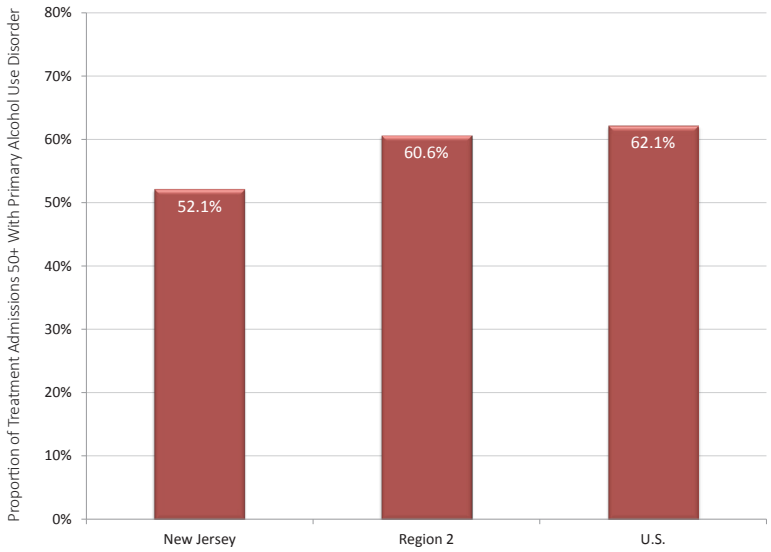
Self-pay data include private insurance.
Exhibit 8 and the accompanying text reflect the type of health insurance (if any) clients had at admission; the table above represents primary sources of payment.

[1] TEDS data are collected by states as a condition of the Substance Abuse Prevention and Treatment Block Grant. Guidelines suggest that states report all clients admitted to publicly financed treatment; however, states are inconsistent in applying the guidelines. States may 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.

Alcohol Use Disorder Treatment Admissions Among New Jerseyans Ages 50+

Alcohol was the most frequently cited substance used by older New Jerseyans in publicly financed SUD treatment in 2012. It was mentioned as a substance of use in 52.1 percent of admissions among those ages 50+. This was lower than the regional and national rates.

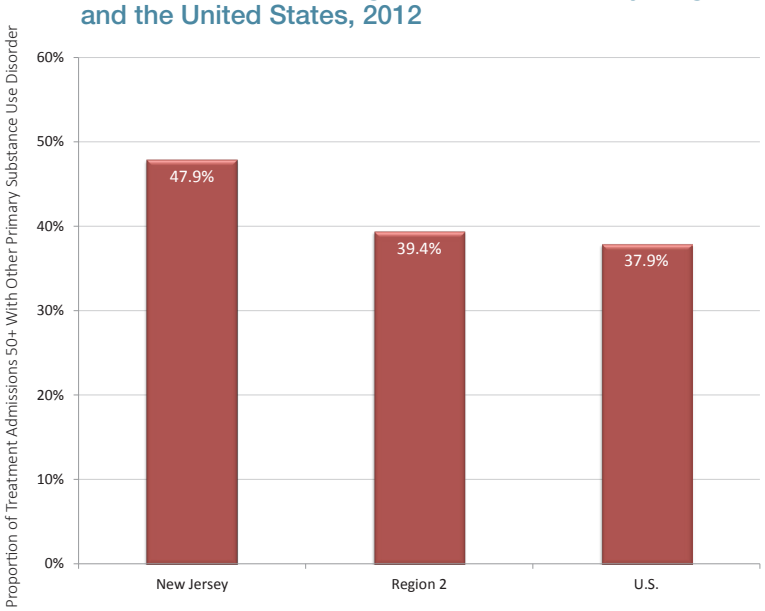
Exhibit 9. Alcohol Use Treatment Admissions of Adults Ages 50+ in New Jersey, Region 2, and the United States, 2012



Source: TEDS, 2012
Data include only those clients reported to SAMHSA.

SUD Treatment Admissions for Non-Alcohol Substance Use

Exhibit 10. Non-Alcohol Substance Use Treatment Admissions of Adults Ages 50+ in New Jersey, Region 2, and the United States, 2012



Source: TEDS, 2012
Data include only those clients reported to SAMHSA.

Substances other than alcohol were cited as the primary substances of use for 47.9 percent of older adult admissions to publicly funded treatment in New Jersey.

Drug-Related Emergency Department Visits Involving Pharmaceutical Misuse and Abuse by Older Adults

SAMHSA periodically releases reports from the Drug Abuse Warning Network (DAWN). DAWN, discontinued in 2011, consisted of a nationwide network of hospital emergency departments (EDs) primarily located in large metropolitan areas. DAWN data consist of professional reviews of ED records to determine the extent to which alcohol and other substance abuse was involved in ED visits. According to the November 25, 2010, *DAWN Report*:

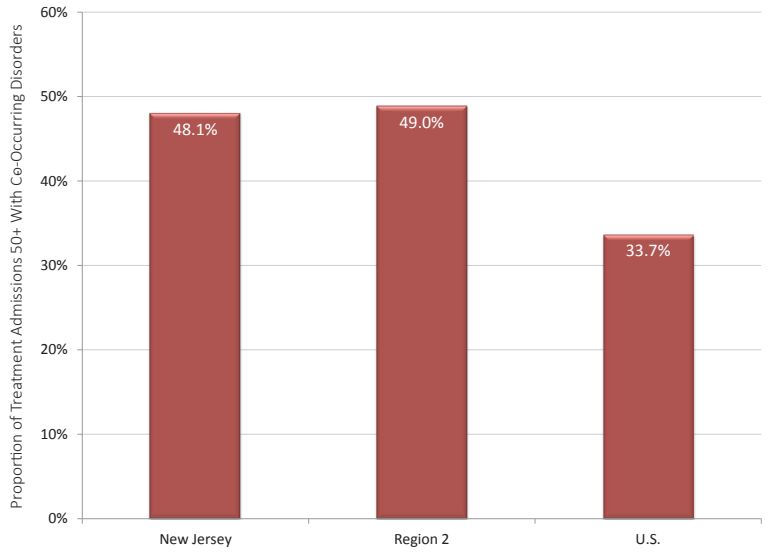
- *In 2004, there were an estimated 115,803 ED visits involving pharmaceutical misuse and abuse by adults aged 50 or older; in 2008, there were 256,097 such visits, representing an increase of 121.1 percent*
- *One fifth (19.7 percent) of ED visits involving pharmaceutical misuse and abuse among older 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*

Bulleted text in italics above is taken from SAMHSA's Center for Behavioral Health Statistics and Quality. (2010, November 25). ***The DAWN Report: Drug-related emergency department visits involving pharmaceutical misuse and abuse by older adults.*** Rockville, MD: SAMHSA.

CO-OCCURRING SUBSTANCE USE AND MENTAL DISORDERS

Older New Jerseyans in SUD Treatment With Co-Occurring Mental Disorders

Exhibit 11. SUD Treatment Admissions of Adults Ages 50+ With a Co-Occurring Mental Disorder in New Jersey, Region 2, and the United States, 2012



Source: TEDS, 2012
Data include only those clients reported to SAMHSA.

The national literature shows a strong relationship between substance use and mental disorders. Studies show that 30–80 percent of individuals with a substance use or mental disorder also have a co-occurring disorder.

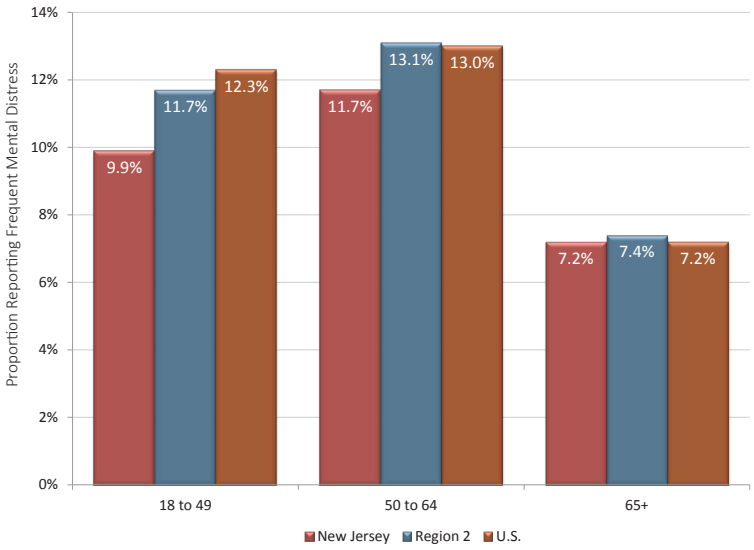
Exhibit 11 shows the proportion of SUD treatment admissions of New Jerseyans ages 50+ with a co-occurring mental disorder. This rate is lower than the regional rate and higher than the national average. However, state reporting practices are a factor in these results.

MENTAL HEALTH

Older New Jerseyans Reporting Frequent Mental Distress

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?" Those individuals reporting 14 or more "Yes" days in response to this question experience frequent mental distress (FMD). Exhibit 12 shows that New Jerseyans in the 50–64 age group experience FMD at a rate that is lower than the regional and national rates, while those in the 65+ age group experience it at a rate that is roughly similar to the regional and national rates.

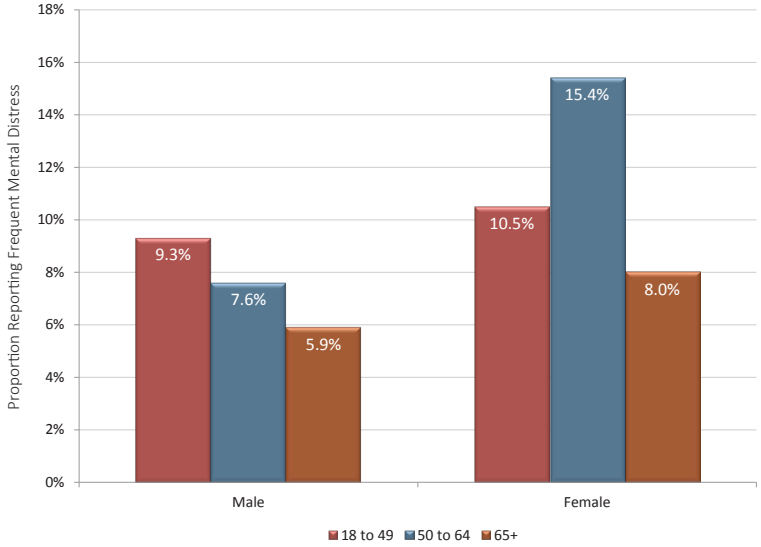
Exhibit 12. Individuals Reporting Frequent Mental Distress in New Jersey, Region 2, and the United States, 2013



Source: BRFSS, 2013

Older New Jerseyans Reporting Frequent Mental Distress by Age Group and Sex

Exhibit 13. New Jerseyans Reporting Frequent Mental Distress by Age Group and Sex, 2013



Source: BRFSS, 2013

Older men in New Jersey were more likely to indulge in binge drinking, but older women were more likely to report that they had FMD (14 days or more per 30-day period). As Exhibit 13 shows, 15.4 percent of women in the 50–64 age group and 8.0 percent in the 65+ age group reported FMD, while 7.6 percent of men in the 50–64 age group and 5.9 percent in the 65+ age group reported FMD.

Other Measures of Mental Health

BRFSS collected other measures showing risk factors for mental and/or physical illness. These included:

- Social and Emotional Support (2010). BRFSS asked, "How often do you get the social and emotional support you need?" The possible responses were always, usually, sometimes, rarely, or never.
- Life Satisfaction (2010). BRFSS asked, "In general, how satisfied are you with your life?" The possible responses were very satisfied, satisfied, dissatisfied, or very dissatisfied.

Exhibit 14 presents the results of these surveys among older New Jerseyans.

Exhibit 14. BRFSS Measures, 2010

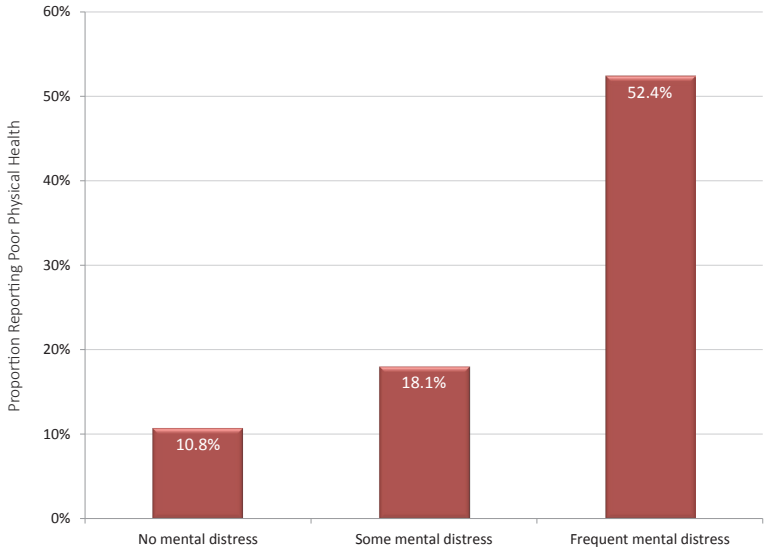
Indicator	Ages 50+	Ages 50–64	Ages 65+
Rarely or never get social or emotional support	10.0%	9.7%	10.3%
Dissatisfied or very dissatisfied	5.1%	5.4%	4.7%

Source: BRFSS, 2010

Individuals With Frequent Mental Distress Report High Rates of Poor Physical Health

Older Americans who experienced FMD were more likely to report that their physical health was poor (14 days or more in the past 30-day period when physical health was "not good"). As shown in Exhibit 15, although nearly 11 percent of older Americans with no mental distress reported poor physical health, more than 50 percent of those with FMD reported poor physical health.

Exhibit 15. Individuals Ages 50+ in the United States Reporting Poor Physical Health by Level of Mental Distress, 2013

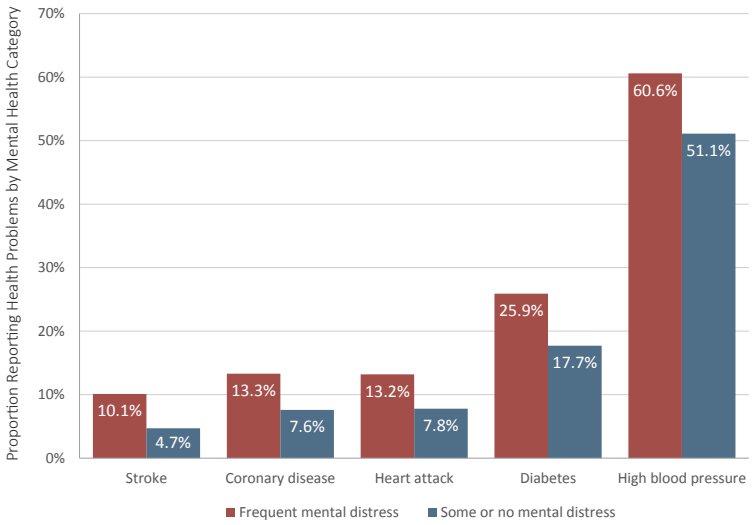


Source: BRFSS, 2013

Relationship Among Mental Distress, Diabetes, Stroke, Heart Attack, High Blood Pressure, and Coronary Disease

Older Americans who experience FMD are more likely to report that they have health problems. People with FMD were more than twice as likely to report having a stroke than those with some or no mental distress. They experienced coronary disease and heart attack at more than 1.6 times, diabetes at more than 1.4 times, and high blood pressure at nearly 1.2 times the rate of those with some or no mental distress.

Exhibit 16. Individuals Ages 50+ in the United States With Mental Distress and Serious Health Problems, 2013



Source: BRFSS, 2013

Older New Jerseyans Admitted to State Mental Health Services

Approximately 15.1 percent of the people served by the New Jersey mental health system were ages 65 and older. This represents more than 52,270 adults.

Source: Center for Mental Health Services (CMHS) Uniform Reporting System (URS) Output Tables, 2014

DATA SOURCES

BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM (www.cdc.gov/brfss). BRFSS, managed by CDC, is the largest ongoing telephone health survey system in the world, tracking health conditions and risk behaviors in the United States annually since 1984. Data are collected on a monthly basis in all 50 states, the District of Columbia, and participating territories. BRFSS data are collected by local jurisdictions and reported to CDC.

CENTERS FOR DISEASE CONTROL AND PREVENTION, NATIONAL CENTER FOR HEALTH STATISTICS, UNDERLYING CAUSE OF DEATH 1999-2013 ON CDC WONDER ONLINE DATABASE, RELEASED 2015 (http://wonder.cdc.gov/ucd-icd10.html). The WONDER online database "contains mortality and population counts for all U.S. counties. Data are based on death certificates for U.S. residents. Each death certificate identifies a single underlying cause of death and demographic data. The number of deaths, crude death rates or age-adjusted death rates, and 95% confidence intervals and standard errors for death rates can be obtained by place of residence (total U.S., region, state and county), age group (single-year-of age, 5-year age groups, 10-year age groups and infant age groups), race, Hispanic ethnicity, gender, year, cause-of-death (4-digit ICD-10 code or group of codes), injury intent and injury mechanism, drug/alcohol induced causes and urbanization categories. Data are also available for place of death, month and week day of death, and whether an autopsy was performed."

CENTER FOR MENTAL HEALTH SERVICES UNIFORM REPORTING SYSTEM (www.samhsa.gov/data/us_map). States that receive CMHS Block Grants are required to report aggregate data to URS. URS reports include information about utilization of mental health services and client demographic and outcome information.

NATIONAL SURVEY ON DRUG USE AND HEALTH (https://nsduhweb.rti.org). 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 SUD treatment. NSDUH data also include information about mental health conditions.

TREATMENT EPISODE DATA SET (www.samhsa.gov/data/client-level-data-teds/reports?tab=19). States that receive Substance Abuse Prevention and Treatment Block Grant funds submit individual client data to TEDS. TEDS includes both admission and discharge data sets, and some 1.5 million admissions are reported annually. TEDS includes information about utilization of SUD treatment services and client demographic and outcome information. TEDS is an admission-based system, and TEDS admissions do not represent individuals. Thus, an individual admitted to treatment twice within a calendar year would be counted as two admissions.

U.S. CENSUS BUREAU (www.census.gov/people). Two main sources of Census Bureau data were used in this report: (1) population estimates and (2) population projections.

OLDER ADULTS BEHAVIORAL HEALTH PROFILE

New York

New York

OLDER ADULTS BEHAVIORAL HEALTH PROFILE

April 2016

NEW YORK'S POPULATION

New York Population by Age Group

New York is home to 19,746,227 people. Of these:

- 6,836,587 (34.6 percent) are over age 50.
- 4,045,153 (20.5 percent) are over age 60.
- 1,965,192 (10.0 percent) are over age 70.
- 802,640 (4.1 percent) are ages 80 and older.

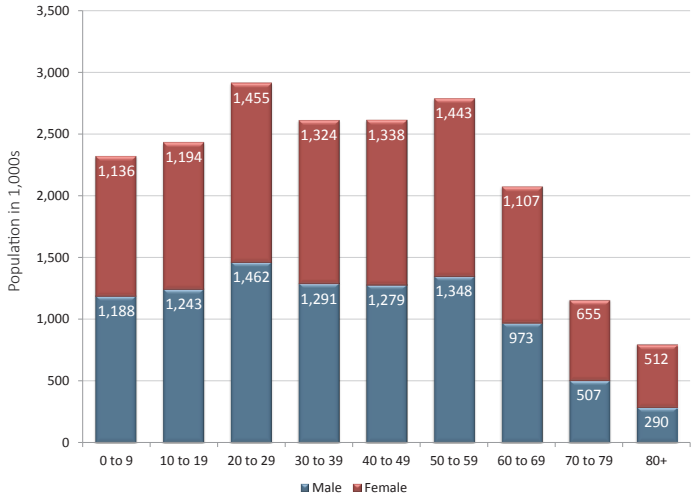
The proportion of women rises fairly steadily in each age group, and women make up 63.8 percent of the 80+ group. The racial/ethnic composition of older New Yorkers is as follows:

Race/Ethnicity of New Yorkers Ages 50+

White	AI/AN	Black	Asian	NH/PI	Other	Hispanic
76.0%	0.6%	15.1%	7.1%	0.1%	1.1%	12.3%

Source: U.S. Census Bureau, 2015
AI/AN stands for American Indian and Alaska Native.
NH/PI stands for Native Hawaiian and Other Pacific Islander.

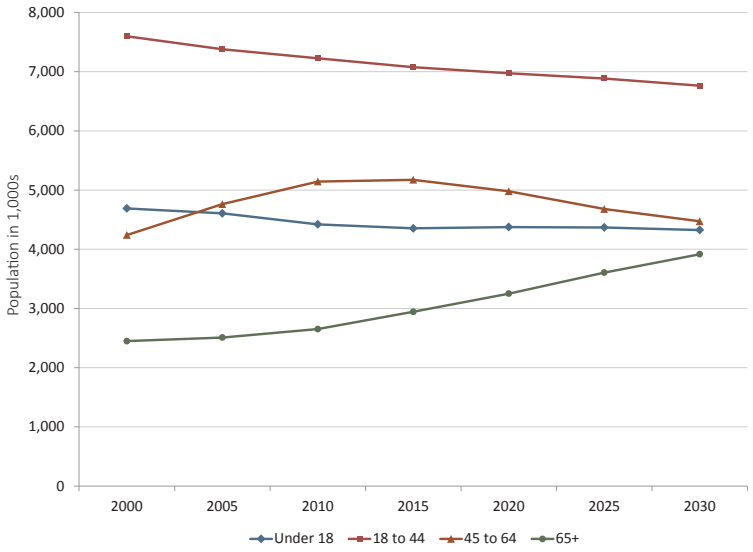
Exhibit 1. New York Population by Age Group, 2014



Source: U.S. Census Bureau, 2015

The Number of Older New Yorkers Is Growing

Exhibit 2. New York Population by Age Group, 2000–2030



The proportion of New York's population that is 65 and older is growing while the proportion that is younger than 65 is shrinking. The U.S. Census Bureau estimates that 20.1 percent of New York's population will be 65 and older by the year 2030, an increase of 33.1 percent from 2015.

Projected Population in New York

Age Group	2015	2025	2030
Under 18	22.3%	22.4%	22.2%
18 to 44	36.2%	35.2%	34.7%
45 to 64	26.5%	24.0%	23.0%
65+	15.1%	18.5%	20.1%

Source: U.S. Census Bureau, 2005

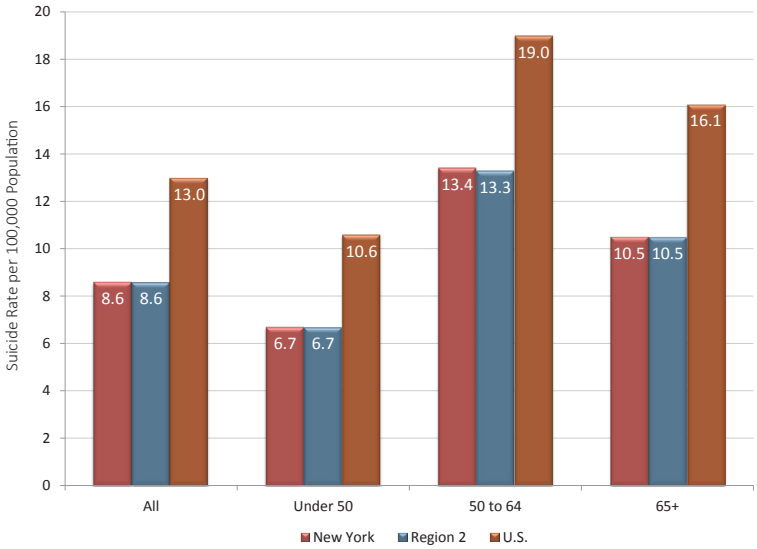
SUICIDE AMONG OLDER NEW YORKERS

New York Suicide Rate Compared With Regional and National Rates

The suicide rate among New Yorkers ages 50 and older is higher than the rate among younger age groups. In 2013, the total suicide rate among all people ages 50+ was 12.2 per 100,000 people (5.5 for women and 20.1 for men). The rate among those ages 50–64 was higher than the rate in the region (calculated based on data from New Jersey and New York) and lower than the rate in the United States.

States vary in their reporting of suicides. The suicide rate is influenced by these reporting practices.

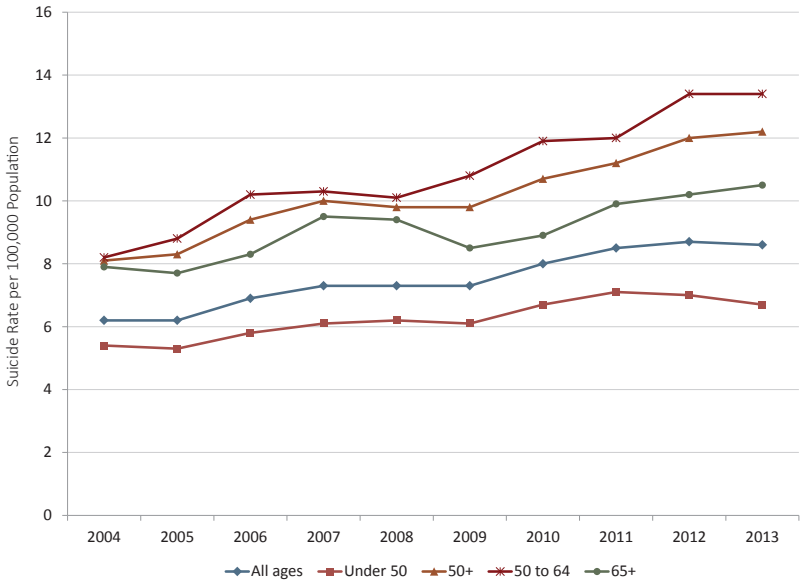
Exhibit 3. Suicide Rates in New York, Region 2, and the United States, 2013



Source: Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Underlying Cause of Death 1999-2013 on CDC WONDER Online Database, released 2015

Trends in Suicide Rates in New York

Exhibit 4. Trends in Suicide Rates in New York by Age Group, 2004–2013



Source: CDC, NCHS, Underlying Cause of Death 1999-2013 on CDC WONDER Online Database, released 2015

The suicide rate among New Yorkers ages 50+ fluctuated from a low of 8.1 per 100,000 in 2004 to a high of 12.2 per 100,000 in 2013. From 2004 to 2013, the rate was highest among those in the 50–64 age group.

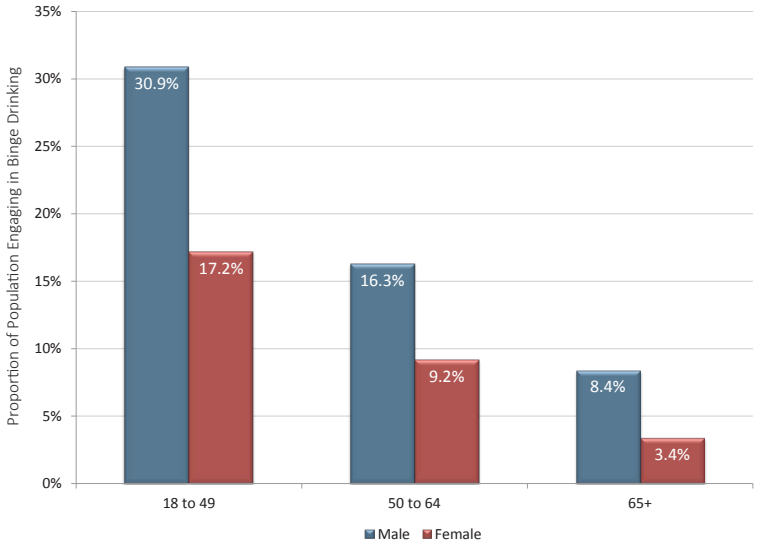
How a state reports suicides can vary from year to year. The number of suicides is generally low, so even a small difference in reported numbers may make the rate fluctuate widely.

SUBSTANCE USE DISORDER AND SUBSTANCE USE DISORDER TREATMENT AMONG OLDER NEW YORKERS

30-Day Binge Drinking Among Older New Yorkers

Binge drinking, defined as five or more drinks for men and four or more drinks for women on a single occasion, can lead to serious health problems. Such problems include neurological damage, cardiovascular disease, liver disease, stroke, and poor control of diabetes. Binge drinkers are more likely to take risks such as driving while intoxicated and to experience falls and other accidents. Older people have a lower tolerance for alcohol. Binge drinking decreases with age and occurs more frequently among men than it does among women. As Exhibit 5 shows, 16.3 percent of New York men ages 50–64 reported binge drinking in the past 30 days, while 8.4 percent of those in the 65+ group reported similar behavior.

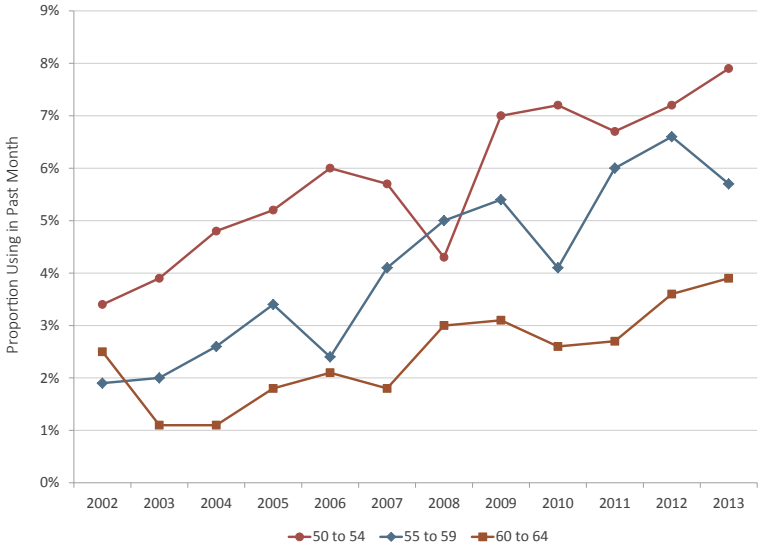
Exhibit 5. Binge Drinking Rates in New York by Age Group and Sex, 2013



Source: Behavioral Risk Factor Surveillance System (BRFSS), 2013

Illicit Drug Use Among Older Americans

Exhibit 6. Illicit Drug Use Among Older Americans, 2002–2013



Source: National Survey on Drug Use and Health (NSDUH), 2013
Illicit drug use includes illegal drugs and prescription drugs used nonmedically. SAMHSA provides a list of drugs included in its survey in the NSDUH methodological summary.

Nationally, the rate of illicit drug use among older adults ages 50–64 more than doubled from 2002 to 2013. This development partially reflects the entrance into this age group of the baby boom cohort, whose rates of illicit drug use have been higher than those of older cohorts. Although state-specific data are not available, the *New York Behavioral Health Barometer* is available for download from the Substance Abuse and Mental Health Services Administration (SAMHSA) website (www.samhsa.gov/data/population-data-nsduh/reports?tab=33).

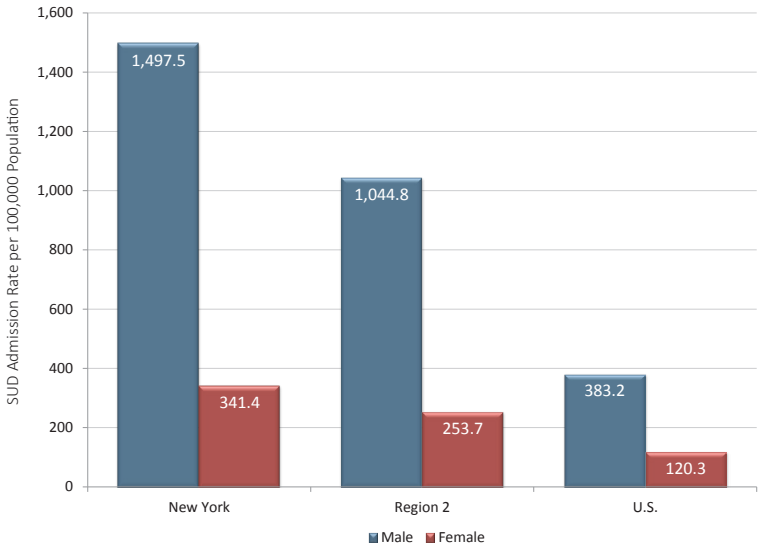
Admissions to Substance Use Disorder Treatment Among Older New Yorkers

In 2012, there were 59,393 admissions of New Yorkers ages 50 and older to substance use disorder (SUD) treatment in state-funded treatment programs, a rate of 868.8 per 100,000 people ages 50+. This rate was higher than the regional rate and the national average. Men made up 78.6 percent of these admissions. Of all admissions, 39.8 percent were White/Caucasian, 41.5 percent were Black/African American, and 18.4 percent were Hispanic.

The principal sources of referral to treatment among those ages 50 and older were:

Self-Referral	Criminal Justice	Other
48.7%	10.9%	40.4%

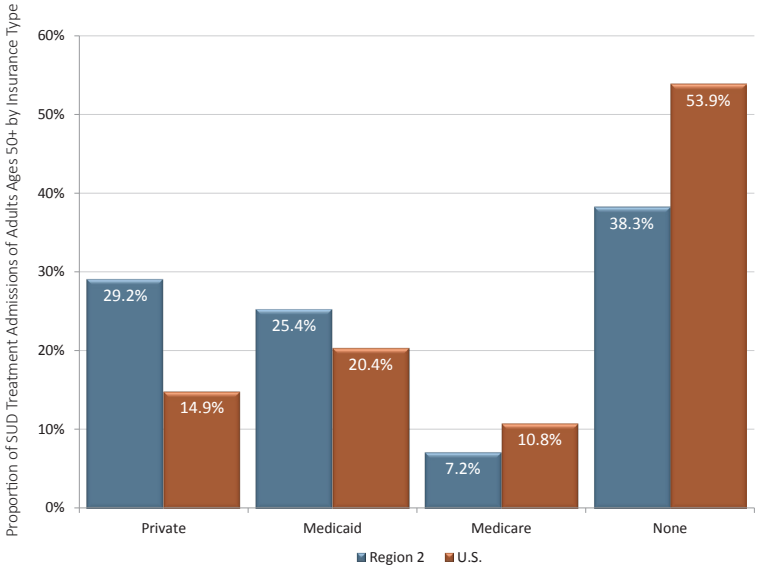
Exhibit 7. SUD Treatment Admissions of Adults Ages 50+ in New York, Region 2, and the United States by Sex, 2012



Source: Treatment Episode Data Set (TEDS), 2012[1]
Data include only those clients reported to SAMHSA.

SUD Treatment Admissions Among Individuals in Region 2 Ages 50+ by Insurance Type

Exhibit 8. SUD Treatment Admissions of Adults Ages 50+ in Region 2 and the United States by Insurance Type, 2012



Source: TEDS, 2012
Data include only those clients reported to SAMHSA.

States may choose not to report some of the fields to TEDS, including information on treatment admission insurance types. These data were not reported by New York in 2012. Therefore, the rates for Region 2 are used instead.

In Region 2, 38.3 percent of older adult admissions to SUD treatment were uninsured, 25.4 percent had Medicaid, 7.2 percent had Medicare, and 29.2 percent had private insurance.

SUD Treatment Admissions Among New Yorkers Ages 50+ by Primary Sources of Payment

Self-Pay	Medicaid	Other
Data not available	Data not available	Data not available

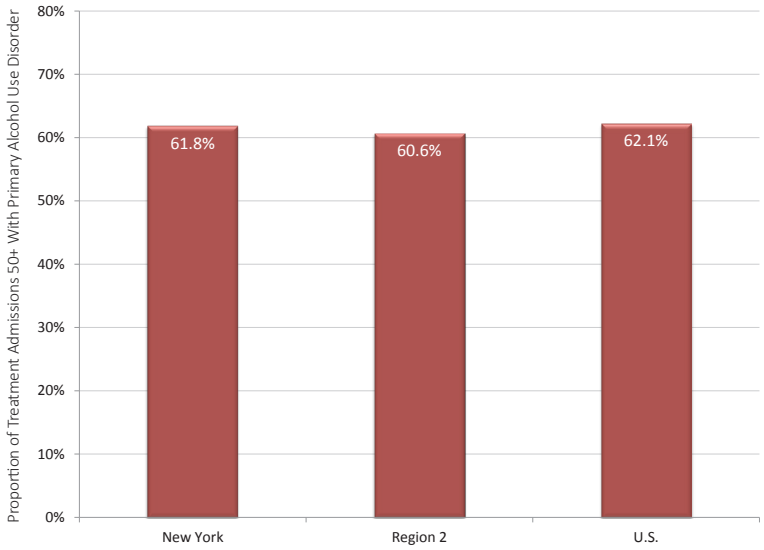
Exhibit 8 and the accompanying text reflect the type of health insurance (if any) clients had at admission; the table above represents primary sources of payment.

[1] TEDS data are collected by states as a condition of the Substance Abuse Prevention and Treatment Block Grant. Guidelines suggest that states report all clients admitted to publicly financed treatment; however, states are inconsistent in applying the guidelines. States may 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.

Alcohol Use Disorder Treatment Admissions Among New Yorkers Ages 50+

Alcohol was the most frequently cited substance used by older New Yorkers in publicly financed SUD treatment in 2012. It was mentioned as a substance of use in 61.8 percent of admissions among those ages 50+. This was higher than the regional rate and lower than the national rate.

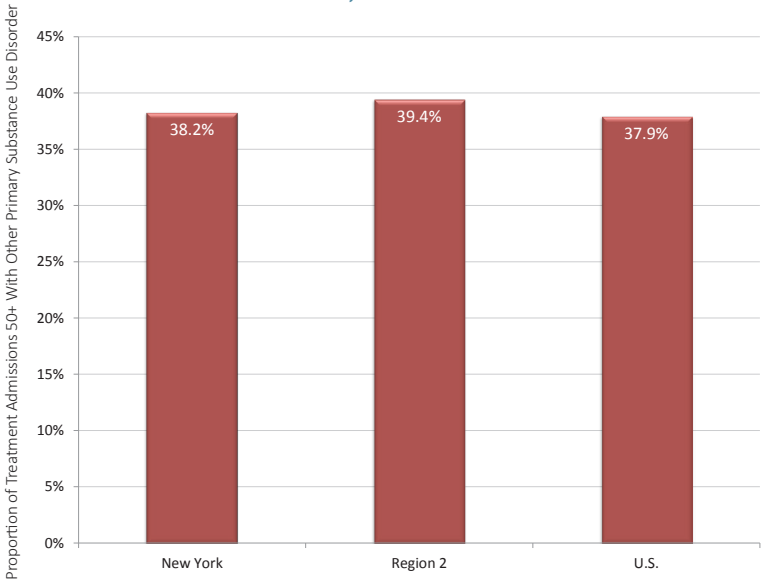
Exhibit 9. Alcohol Use Treatment Admissions of Adults Ages 50+ in New York, Region 2, and the United States, 2012



Source: TEDS, 2012
Data include only those clients reported to SAMHSA.

SUD Treatment Admissions for Non-Alcohol Substance Use

Exhibit 10. Non-Alcohol Substance Use Treatment Admissions of Adults Ages 50+ in New York, Region 2, and the United States, 2012



Source: TEDS, 2012
Data include only those clients reported to SAMHSA.

Substances other than alcohol were cited as the primary substances of use for 38.2 percent of older adult admissions to publicly funded treatment in New York.

Drug-Related Emergency Department Visits Involving Pharmaceutical Misuse and Abuse by Older Adults

SAMHSA periodically releases reports from the Drug Abuse Warning Network (DAWN). DAWN, discontinued in 2011, consisted of a nationwide network of hospital emergency departments (EDs) primarily located in large metropolitan areas. DAWN data consist of professional reviews of ED records to determine the extent to which alcohol and other substance abuse was involved in ED visits. According to the November 25, 2010, *DAWN Report*:

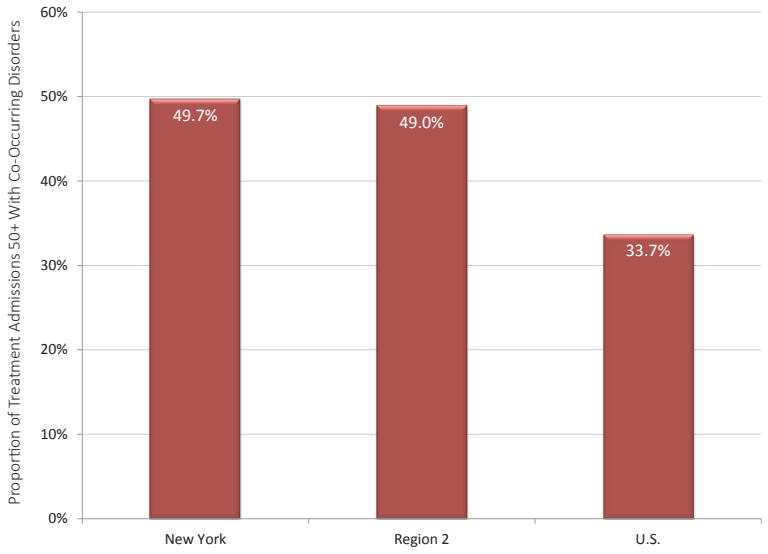
- *In 2004, there were an estimated 115,803 ED visits involving pharmaceutical misuse and abuse by adults aged 50 or older; in 2008, there were 256,097 such visits, representing an increase of 121.1 percent*
- *One fifth (19.7 percent) of ED visits involving pharmaceutical misuse and abuse among older 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*

Bulleted text in italics above is taken from SAMHSA's Center for Behavioral Health Statistics and Quality. (2010, November 25). ***The DAWN Report: Drug-related emergency department visits involving pharmaceutical misuse and abuse by older adults.*** Rockville, MD: SAMHSA.

CO-OCCURRING SUBSTANCE USE AND MENTAL DISORDERS

Older New Yorkers in SUD Treatment With Co-Occurring Mental Disorders

Exhibit 11. SUD Treatment Admissions of Adults Ages 50+ With a Co-Occurring Mental Disorder in New York, Region 2, and the United States, 2012



Source: TEDS, 2012
Data include only those clients reported to SAMHSA.

The national literature shows a strong relationship between substance use and mental disorders. Studies show that 30–80 percent of individuals with a substance use or mental disorder also have a co-occurring disorder.

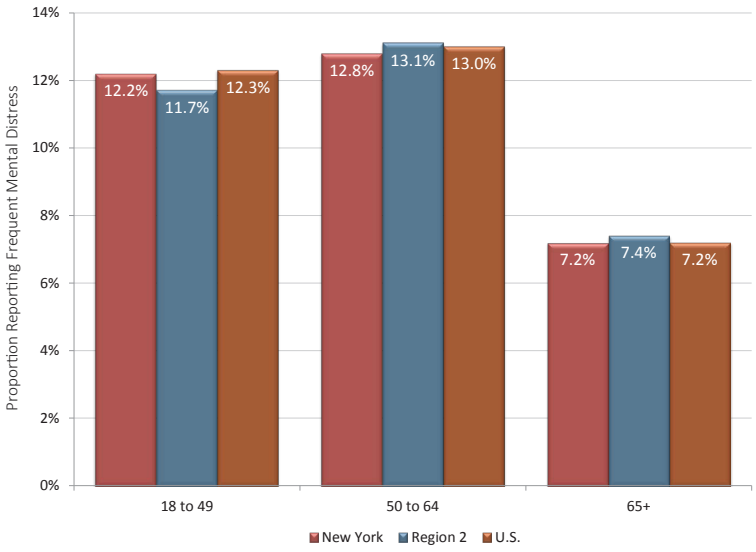
Exhibit 11 shows the proportion of SUD treatment admissions of New Yorkers ages 50+ with a co-occurring mental disorder. This rate is higher than the regional rate and the national average. However, state reporting practices are a factor in these results.

MENTAL HEALTH

Older New Yorkers Reporting Frequent Mental Distress

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?" Those individuals reporting 14 or more "Yes" days in response to this question experience frequent mental distress (FMD). Exhibit 12 shows that older New Yorkers experience FMD at a rate that is roughly similar to the regional and national rates.

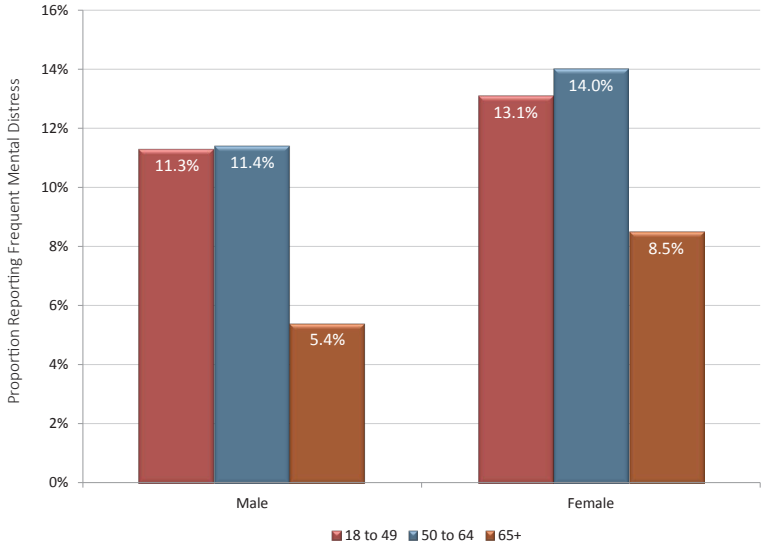
Exhibit 12. Individuals Reporting Frequent Mental Distress in New York, Region 2, and the United States, 2013



Source: BRFSS, 2013

Older New Yorkers Reporting Frequent Mental Distress by Age Group and Sex

Exhibit 13. New Yorkers Reporting Frequent Mental Distress by Age Group and Sex, 2013



Source: BRFSS, 2013

Older men in New York were more likely to indulge in binge drinking, but older women were more likely to report that they had FMD (14 days or more per 30-day period). As Exhibit 13 shows, 14.0 percent of women in the 50–64 age group and 8.5 percent in the 65+ age group reported FMD, while 11.4 percent of men in the 50–64 age group and 5.4 percent in the 65+ age group reported FMD.

Other Measures of Mental Health

BRFSS collected other measures showing risk factors for mental and/or physical illness. These included:

- Social and Emotional Support (2010). BRFSS asked, "How often do you get the social and emotional support you need?" The possible responses were always, usually, sometimes, rarely, or never.
- Life Satisfaction (2010). BRFSS asked, "In general, how satisfied are you with your life?" The possible responses were very satisfied, satisfied, dissatisfied, or very dissatisfied.

Exhibit 14 presents the results of these surveys among older New Yorkers.

Exhibit 14. BRFSS Measures, 2010

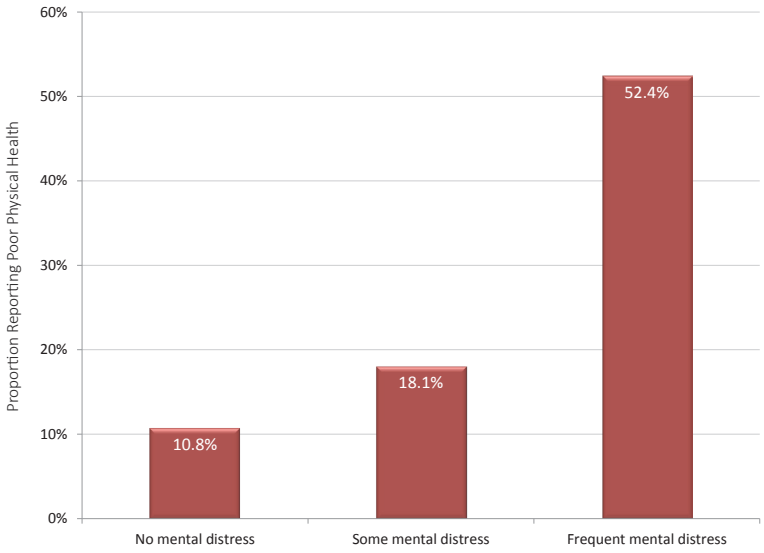
Indicator	Ages 50+	Ages 50–64	Ages 65+
Rarely or never get social or emotional support	11.5%	9.7%	13.9%
Dissatisfied or very dissatisfied	6.1%	7.5%	4.1%

Source: BRFSS, 2010

Individuals With Frequent Mental Distress Report High Rates of Poor Physical Health

Older Americans who experienced FMD were more likely to report that their physical health was poor (14 days or more in the past 30-day period when physical health was "not good"). As shown in Exhibit 15, although nearly 11 percent of older Americans with no mental distress reported poor physical health, more than 50 percent of those with FMD reported poor physical health.

Exhibit 15. Individuals Ages 50+ in the United States Reporting Poor Physical Health by Level of Mental Distress, 2013

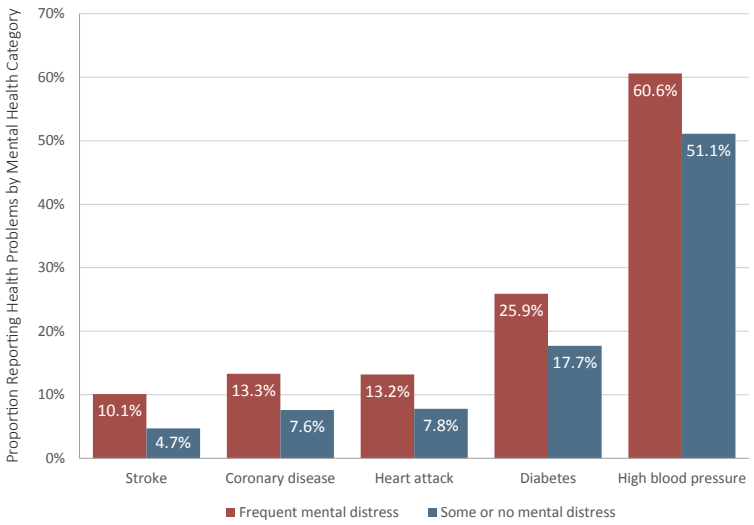


Source: BRFSS, 2013

Relationship Among Mental Distress, Diabetes, Stroke, Heart Attack, High Blood Pressure, and Coronary Disease

Older Americans who experience FMD are more likely to report that they have health problems. People with FMD were more than twice as likely to report having a stroke than those with some or no mental distress. They experienced coronary disease and heart attack at more than 1.6 times, diabetes at more than 1.4 times, and high blood pressure at nearly 1.2 times the rate of those with some or no mental distress.

Exhibit 16. Individuals Ages 50+ in the United States With Mental Distress and Serious Health Problems, 2013



Source: BRFSS, 2013

Older New Yorkers Admitted to State Mental Health Services

Approximately 7.1 percent of the people served by the New York mental health system were ages 65 and older. This represents more than 51,660 adults.

Source: Center for Mental Health Services (CMHS) Uniform Reporting System (URS) Output Tables, 2014

DATA SOURCES

BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM (www.cdc.gov/brfss). BRFSS, managed by CDC, is the largest ongoing telephone health survey system in the world, tracking health conditions and risk behaviors in the United States annually since 1984. Data are collected on a monthly basis in all 50 states, the District of Columbia, and participating territories. BRFSS data are collected by local jurisdictions and reported to CDC.

CENTERS FOR DISEASE CONTROL AND PREVENTION, NATIONAL CENTER FOR HEALTH STATISTICS, UNDERLYING CAUSE OF DEATH 1999-2013 ON CDC WONDER ONLINE DATABASE, RELEASED 2015 (http://wonder.cdc.gov/ucd-icd10.html). The WONDER online database "contains mortality and population counts for all U.S. counties. Data are based on death certificates for U.S. residents. Each death certificate identifies a single underlying cause of death and demographic data. The number of deaths, crude death rates or age-adjusted death rates, and 95% confidence intervals and standard errors for death rates can be obtained by place of residence (total U.S., region, state and county), age group (single-year-of age, 5-year age groups, 10-year age groups and infant age groups), race, Hispanic ethnicity, gender, year, cause-of-death (4-digit ICD-10 code or group of codes), injury intent and injury mechanism, drug/alcohol induced causes and urbanization categories. Data are also available for place of death, month and week day of death, and whether an autopsy was performed."

CENTER FOR MENTAL HEALTH SERVICES UNIFORM REPORTING SYSTEM (www.samhsa.gov/data/us_map). States that receive CMHS Block Grants are required to report aggregate data to URS. URS reports include information about utilization of mental health services and client demographic and outcome information.

NATIONAL SURVEY ON DRUG USE AND HEALTH (https://nsduhweb.rti.org). 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 SUD treatment. NSDUH data also include information about mental health conditions.

TREATMENT EPISODE DATA SET (www.samhsa.gov/data/client-level-data-teds/reports?tab=19). States that receive Substance Abuse Prevention and Treatment Block Grant funds submit individual client data to TEDS. TEDS includes both admission and discharge data sets, and some 1.5 million admissions are reported annually. TEDS includes information about utilization of SUD treatment services and client demographic and outcome information. TEDS is an admission-based system, and TEDS admissions do not represent individuals. Thus, an individual admitted to treatment twice within a calendar year would be counted as two admissions.

U.S. CENSUS BUREAU (www.census.gov/people). Two main sources of Census Bureau data were used in this report: (1) population estimates and (2) population projections.

OLDER ADULTS BEHAVIORAL HEALTH PROFILE

Puerto Rico

Puerto Rico

OLDER ADULTS BEHAVIORAL HEALTH PROFILE

April 2016

PUERTO RICO'S POPULATION

Puerto Rico Population by Age Group

Puerto Rico is home to 3,548,397 people. Of these:

- 1,282,082 (36.1 percent) are over age 50.
- 831,148 (23.4 percent) are over age 60.
- 420,852 (11.9 percent) are over age 70.
- 146,963 (4.1 percent) are ages 80 and older.

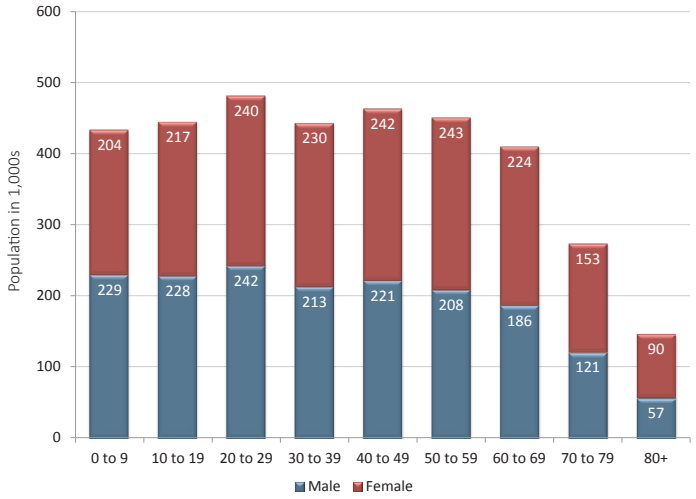
The proportion of women rises fairly steadily in each age group, and women make up 61.3 percent of the 80+ group. The racial/ethnic composition of older Puerto Ricans is as follows:

Race/Ethnicity of Puerto Ricans Ages 50+

White	AI/AN	Black	Asian	NH/PI	Other	Hispanic
73.1%	0.3%	9.2%	0.1%	0.0%	17.3%	99.0%

Source: U.S. Census Bureau, 2015
AI/AN stands for American Indian and Alaska Native.
NH/PI stands for Native Hawaiian and Other Pacific Islander.

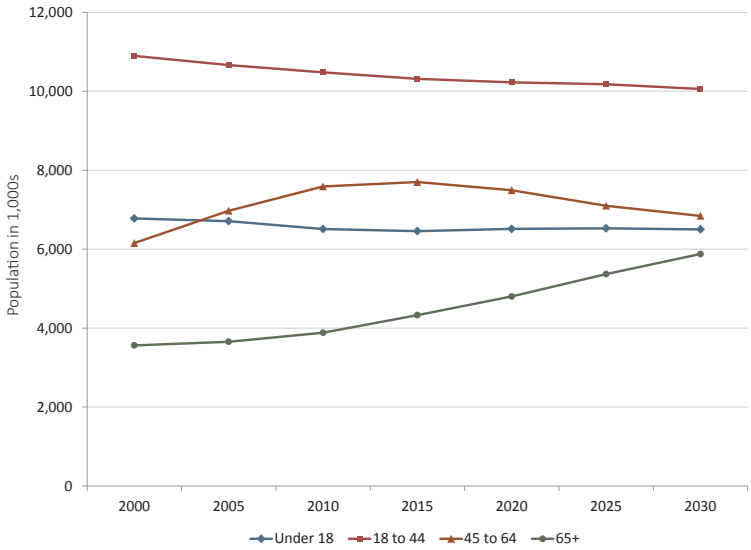
Exhibit 1. Puerto Rico Population by Age Group, 2014



Source: U.S. Census Bureau, 2015

The Number of Older Adults in Region 2 Is Growing

Exhibit 2. Region 2 Population by Age Group, 2000–2030



Recent population projections for Puerto Rico are unavailable. Therefore, projections for Region 2 (calculated based on data from New Jersey and New York) are used instead.

The U.S. Census Bureau estimates that 20.1 percent of Region 2's population will be 65 and older by the year 2030, an increase of 35.8 percent from 2015.

Projected Population in Region 2

Age Group	2015	2025	2030
Under 18	22.4%	22.4%	22.2%
18 to 44	35.8%	34.9%	34.4%
45 to 64	26.7%	24.3%	23.4%
65+	15.0%	18.4%	20.1%

Source: U.S. Census Bureau, 2005

SUICIDE AMONG OLDER ADULTS IN REGION 2

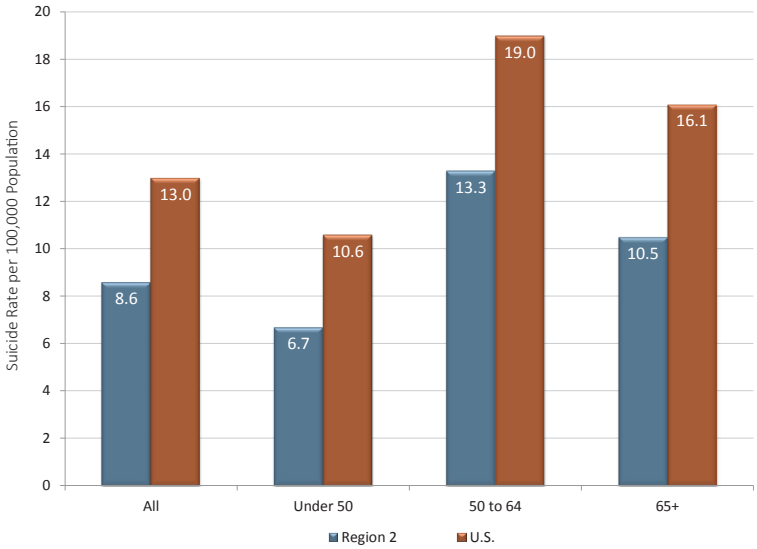
Region 2 Suicide Rates Compared With National Rates

Recent suicide data for Puerto Rico are not available from the Centers for Disease Control and Prevention (CDC) mortality databases. Therefore, the rates for Region 2 (calculated based on data from New Jersey and New York) are used instead.

The suicide rate among individuals in Region 2 ages 50 and older is higher than the rate among younger age groups. In 2013, the total suicide rate among all people ages 50+ was 12.1 per 100,000 people (5.3 for women and 20.3 for men). The rate among those ages 50–64 was lower than the rate in the United States.

States and territories vary in their reporting of suicides. The suicide rate is influenced by these reporting practices.

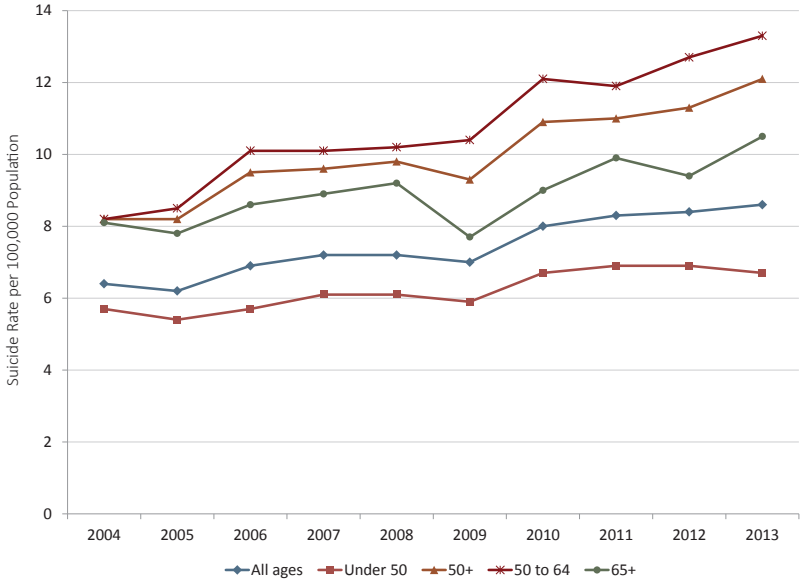
Exhibit 3. Suicide Rates in Region 2 and the United States, 2013



Source: CDC, National Center for Health Statistics (NCHS), Underlying Cause of Death 1999-2013 on CDC WONDER Online Database, released 2015

Trends in Suicide Rates in Region 2

Exhibit 4. Trends in Suicide Rates in Region 2 by Age Group, 2004–2013



Source: CDC, NCHS, Underlying Cause of Death 1999-2013 on CDC WONDER Online Database, released 2015

Recent suicide data for Puerto Rico are not available from the CDC mortality databases. Therefore, the rates for Region 2 are used instead.

The suicide rate among individuals in Region 2 ages 50+ fluctuated from a low of 8.2 per 100,000 in 2004 to a high of 12.1 per 100,000 in 2013. From 2004 to 2013, the rate was generally highest among those in the 50–64 age group.

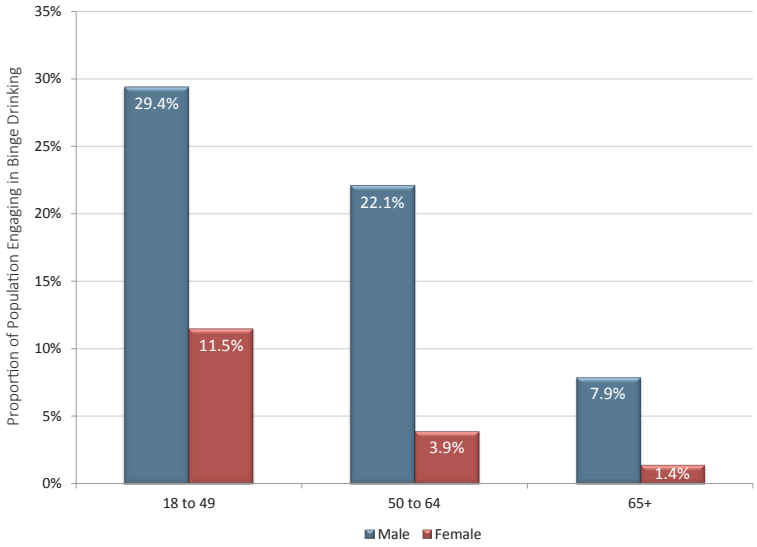
How a state or territory reports suicides can vary from year to year. The number of suicides is generally low, so even a small difference in reported numbers may make the rate fluctuate widely.

SUBSTANCE USE DISORDER AND SUBSTANCE USE DISORDER TREATMENT AMONG OLDER PUERTO RICANS

30-Day Binge Drinking Among Older Puerto Ricans

Binge drinking, defined as five or more drinks for men and four or more drinks for women on a single occasion, can lead to serious health problems. Such problems include neurological damage, cardiovascular disease, liver disease, stroke, and poor control of diabetes. Binge drinkers are more likely to take risks such as driving while intoxicated and to experience falls and other accidents. Older people have a lower tolerance for alcohol. Binge drinking decreases with age and occurs more frequently among men than it does among women. As Exhibit 5 shows, 22.1 percent of Puerto Rico men ages 50–64 reported binge drinking in the past 30 days, while 7.9 percent of those in the 65+ group reported similar behavior.

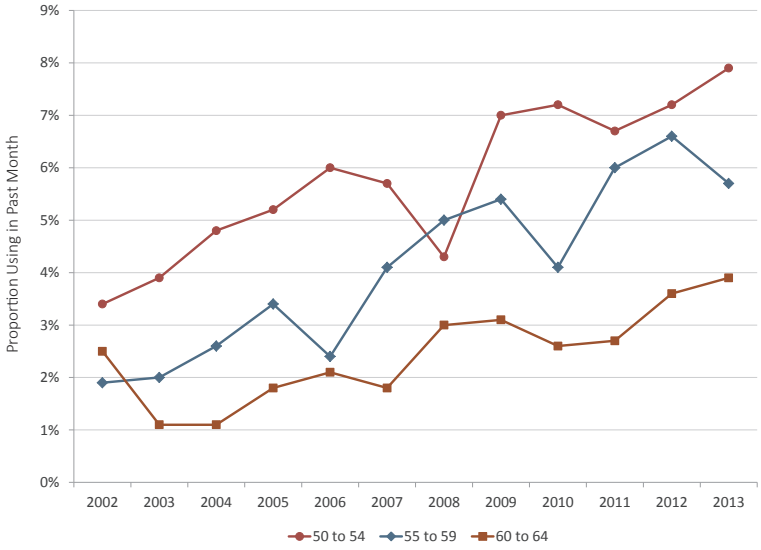
Exhibit 5. Binge Drinking Rates in Puerto Rico by Age Group and Sex, 2013



Source: Behavioral Risk Factor Surveillance System (BRFSS), 2013

Illicit Drug Use Among Older Americans

Exhibit 6. Illicit Drug Use Among Older Americans, 2002–2013



Source: National Survey on Drug Use and Health (NSDUH), 2013
Illicit drug use includes illegal drugs and prescription drugs used nonmedically. SAMHSA provides a list of drugs included in its survey in the NSDUH methodological summary.

Nationally, the rate of illicit drug use among older adults ages 50–64 more than doubled from 2002 to 2013. This development partially reflects the entrance into this age group of the baby boom cohort, whose rates of illicit drug use have been higher than those of older cohorts. Although territory-specific data are not available, the *Behavioral Health Barometers* for states in Region 2 are available for download from the Substance Abuse and Mental Health Services Administration (SAMHSA) website (www.samhsa.gov/data/population-data-nsduh/reports?tab=33).

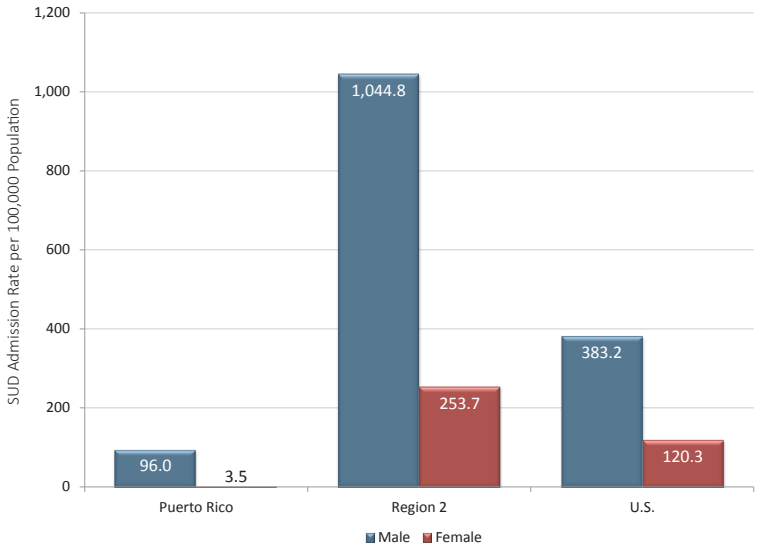
Admissions to Substance Use Disorder Treatment Among Older Puerto Ricans

In 2012, there were 574 admissions of Puerto Ricans ages 50 and older to substance use disorder (SUD) treatment in territory-funded treatment programs, a rate of 44.8 per 100,000 people ages 50+. This rate was lower than the regional rate and the national average. Men made up 95.6 percent of these admissions. Of all admissions, 1.9 percent were White/Caucasian, and 99.8 percent were Hispanic. There were no reported Black/African American admissions.

The principal sources of referral to treatment among those ages 50 and older were:

Self-Referral	Criminal Justice	Other
19.1%	72.9%	7.9%

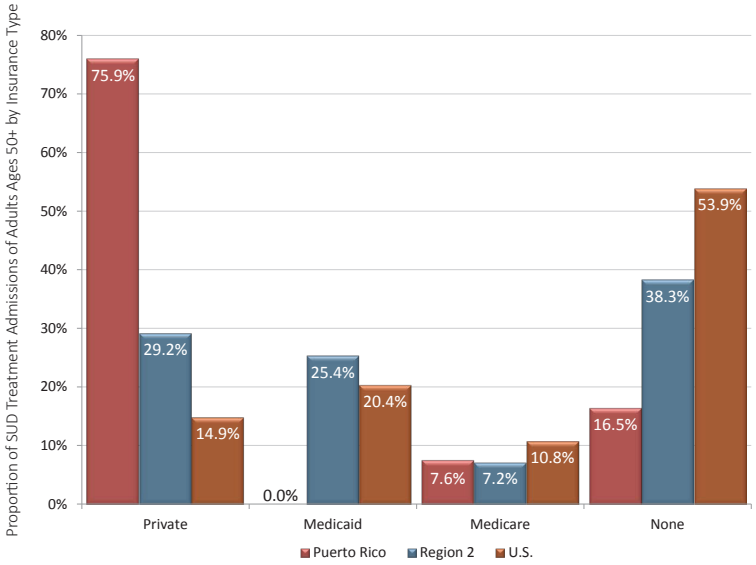
Exhibit 7. SUD Treatment Admissions of Adults Ages 50+ in Puerto Rico, Region 2, and the United States by Sex, 2012



Source: Treatment Episode Data Set (TEDS), 2012[1]
Data include only those clients reported to SAMHSA.

SUD Treatment Admissions Among Puerto Ricans Ages 50+ by Insurance Type

Exhibit 8. SUD Treatment Admissions of Adults Ages 50+ in Puerto Rico, Region 2, and the United States by Insurance Type, 2012



Source: TEDS, 2012
Data include only those clients reported to SAMHSA.

In Puerto Rico, 16.5 percent of older adult admissions to SUD treatment were uninsured, 7.6 percent had Medicare, and 75.9 percent private insurance. There were no reported Medicaid admissions.

SUD Treatment Admissions Among Puerto Ricans Ages 50+ by Primary Sources of Payment

Self-Pay	Medicaid	Other
65.1%	0.5%	34.3%

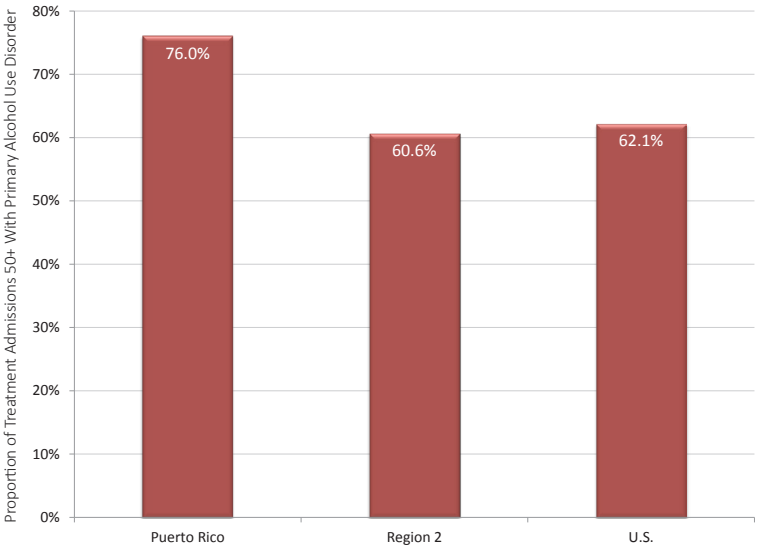
Self-pay data include private insurance.
Exhibit 8 and the accompanying text reflect the type of health insurance (if any) clients had at admission; the table above represents primary sources of payment.

[1] TEDS data are collected by states and territories as a condition of the Substance Abuse Prevention and Treatment Block Grant. Guidelines suggest that states and territories report all clients admitted to publicly financed treatment; however, states and territories are inconsistent in applying the guidelines. States and territories may structure and implement different quality controls over the data. For example, states and territories may collect different categories of information to answer TEDS questions. Information is then "walked over" to TEDS definitions.

Alcohol Use Disorder Treatment Admissions Among Puerto Ricans Ages 50+

Alcohol was the most frequently cited substance used by older Puerto Ricans in publicly financed SUD treatment in 2012. It was mentioned as a substance of use in 76.0 percent of admissions among those ages 50+. This was higher than the regional and national rates.

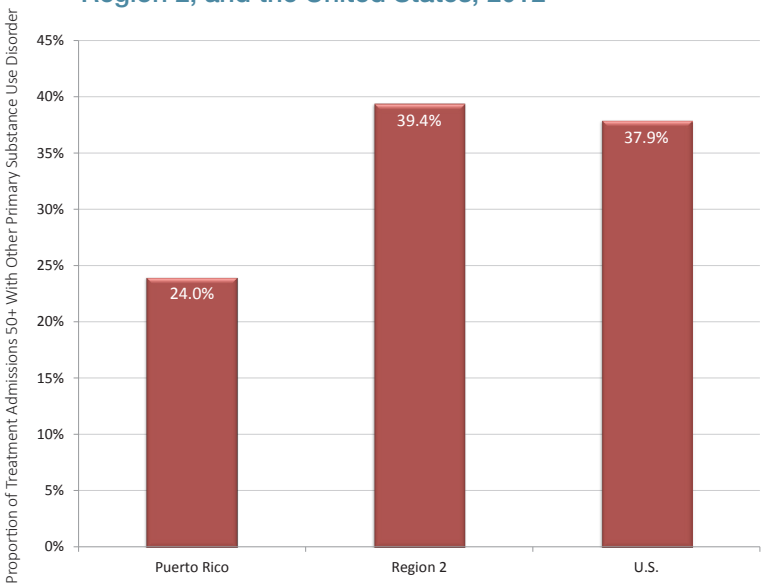
Exhibit 9. Alcohol Use Treatment Admissions of Adults Ages 50+ in Puerto Rico, Region 2, and the United States, 2012



Source: TEDS, 2012
Data include only those clients reported to SAMHSA.

SUD Treatment Admissions for Non-Alcohol Substance Use

Exhibit 10. Non-Alcohol Substance Use Treatment Admissions of Adults Ages 50+ in Puerto Rico, Region 2, and the United States, 2012



Source: TEDS, 2012
Data include only those clients reported to SAMHSA.

Substances other than alcohol were cited as the primary substances of use for 24.0 percent of older adult admissions to publicly funded treatment in Puerto Rico.

Drug-Related Emergency Department Visits Involving Pharmaceutical Misuse and Abuse by Older Adults

SAMHSA periodically releases reports from the Drug Abuse Warning Network (DAWN). DAWN, discontinued in 2011, consisted of a nationwide network of hospital emergency departments (EDs) primarily located in large metropolitan areas. DAWN data consist of professional reviews of ED records to determine the extent to which alcohol and other substance abuse was involved in ED visits. According to the November 25, 2010, *DAWN Report*:

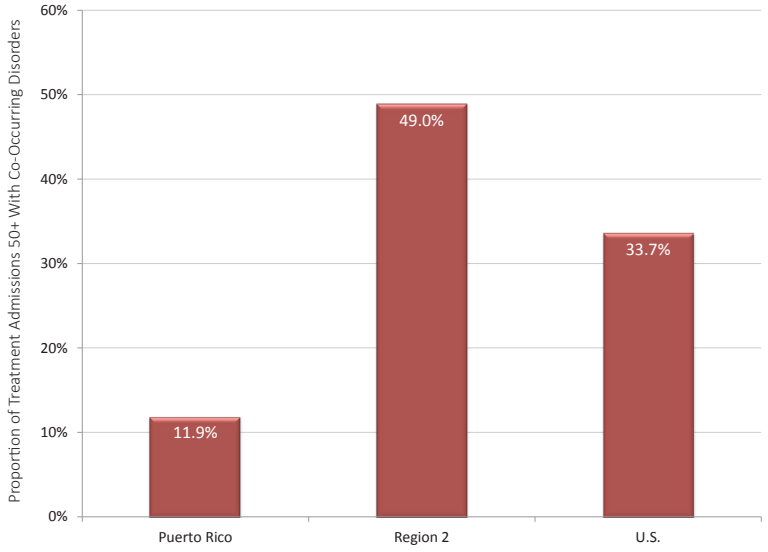
- *In 2004, there were an estimated 115,803 ED visits involving pharmaceutical misuse and abuse by adults aged 50 or older; in 2008, there were 256,097 such visits, representing an increase of 121.1 percent*
- *One fifth (19.7 percent) of ED visits involving pharmaceutical misuse and abuse among older 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*

Bulleted text in italics above is taken from SAMHSA's Center for Behavioral Health Statistics and Quality. (2010, November 25). ***The DAWN Report: Drug-related emergency department visits involving pharmaceutical misuse and abuse by older adults.*** Rockville, MD: SAMHSA.

CO-OCCURRING SUBSTANCE USE AND MENTAL DISORDERS

Older Puerto Ricans in SUD Treatment With Co-Occurring Mental Disorders

Exhibit 11. SUD Treatment Admissions of Adults Ages 50+ With a Co-Occurring Mental Disorder in Puerto Rico, Region 2, and the United States, 2012



Source: TEDS, 2012
Data include only those clients reported to SAMHSA.

The national literature shows a strong relationship between substance use and mental disorders. Studies show that 30–80 percent of individuals with a substance use or mental disorder also have a co-occurring disorder.

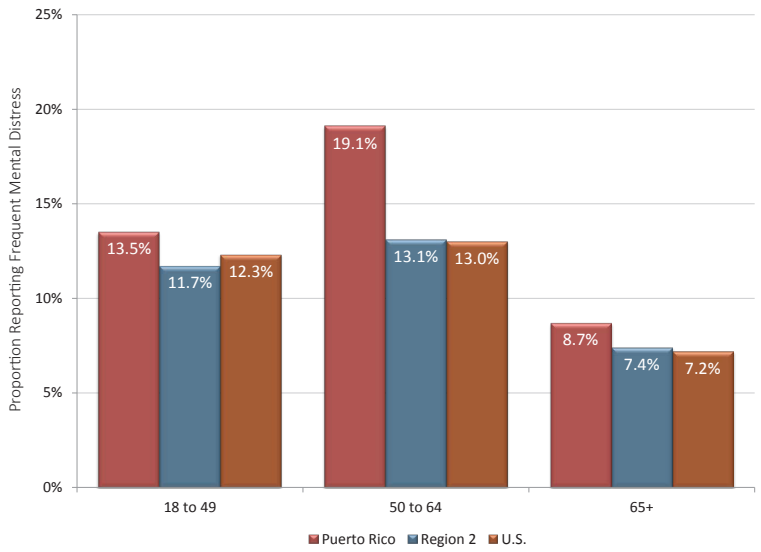
Exhibit 11 shows the proportion of SUD treatment admissions of Puerto Ricans ages 50+ with a co-occurring mental disorder. This rate is lower than the regional rate and the national average. However, state and territory reporting practices are a factor in these results.

MENTAL HEALTH

Older Puerto Ricans Reporting Frequent Mental Distress

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?" Those individuals reporting 14 or more "Yes" days in response to this question experience frequent mental distress (FMD). Exhibit 12 shows that older Puerto Ricans experience FMD at a rate that is higher than the regional and national rates.

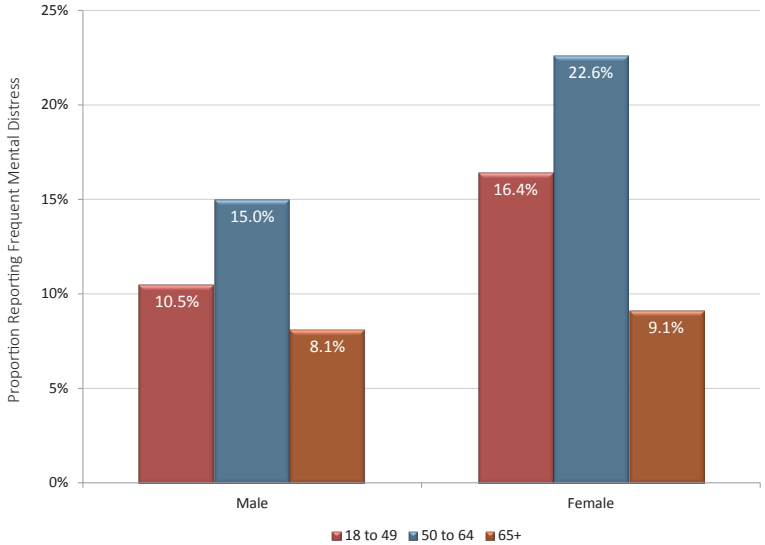
Exhibit 12. Individuals Reporting Frequent Mental Distress in Puerto Rico, Region 2, and the United States, 2013



Source: BRFSS, 2013

Older Puerto Ricans Reporting Frequent Mental Distress by Age Group and Sex

Exhibit 13. Puerto Ricans Reporting Frequent Mental Distress by Age Group and Sex, 2013



Source: BRFSS, 2013

Older men in Puerto Rico were more likely to indulge in binge drinking, but older women were more likely to report that they had FMD (14 days or more per 30-day period). As Exhibit 13 shows, 22.6 percent of women in the 50–64 age group and 9.1 percent in the 65+ age group reported FMD, while 15.0 percent of men in the 50–64 age group and 8.1 percent in the 65+ age group reported FMD.

Other Measures of Mental Health

BRFSS collected other measures showing risk factors for mental and/or physical illness. These included:

- Social and Emotional Support (2010). BRFSS asked, "How often do you get the social and emotional support you need?" The possible responses were always, usually, sometimes, rarely, or never.
- Life Satisfaction (2010). BRFSS asked, "In general, how satisfied are you with your life?" The possible responses were very satisfied, satisfied, dissatisfied, or very dissatisfied.

Exhibit 14 presents the results of these surveys among older Puerto Ricans.

Exhibit 14. BRFSS Measures, 2010

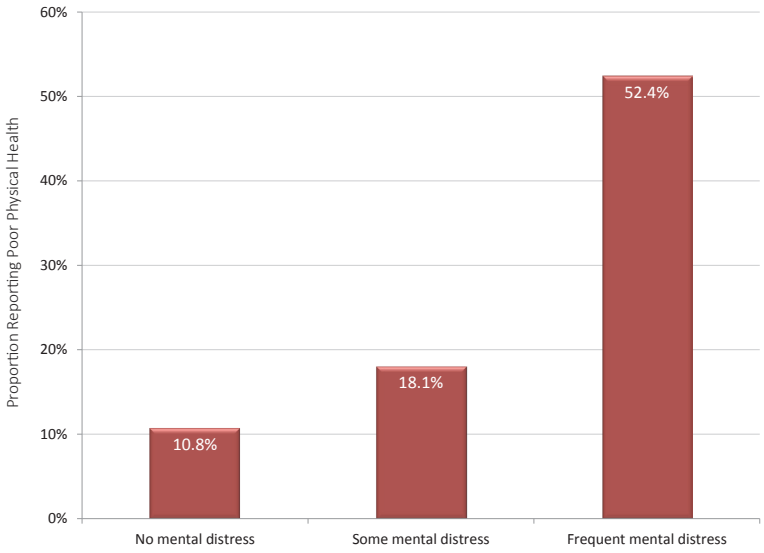
Indicator	Ages 50+	Ages 50–64	Ages 65+
Rarely or never get social or emotional support	9.4%	9.4%	9.5%
Dissatisfied or very dissatisfied	3.4%	4.3%	2.2%

Source: BRFSS, 2010

Individuals With Frequent Mental Distress Report High Rates of Poor Physical Health

Older Americans who experienced FMD were more likely to report that their physical health was poor (14 days or more in the past 30-day period when physical health was "not good"). As shown in Exhibit 15, although nearly 11 percent of older Americans with no mental distress reported poor physical health, more than 50 percent of those with FMD reported poor physical health.

Exhibit 15. Individuals Ages 50+ in the United States Reporting Poor Physical Health by Level of Mental Distress, 2013

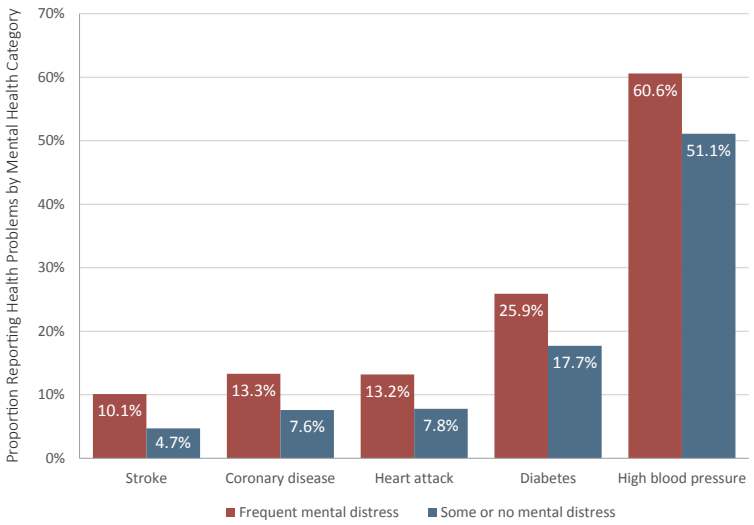


Source: BRFSS, 2013

Relationship Among Mental Distress, Diabetes, Stroke, Heart Attack, High Blood Pressure, and Coronary Disease

Older Americans who experience FMD are more likely to report that they have health problems. People with FMD were more than twice as likely to report having a stroke than those with some or no mental distress. They experienced coronary disease and heart attack at more than 1.6 times, diabetes at more than 1.4 times, and high blood pressure at nearly 1.2 times the rate of those with some or no mental distress.

Exhibit 16. Individuals Ages 50+ in the United States With Mental Distress and Serious Health Problems, 2013



Source: BRFSS, 2013

Older Puerto Ricans Admitted to Territory Mental Health Services

Approximately 4.9 percent of the people served by the Puerto Rico mental health system were ages 65 and older. This represents more than 760 adults.

Source: Center for Mental Health Services (CMHS) Uniform Reporting System (URS) Output Tables, 2014

DATA SOURCES

BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM (www.cdc.gov/brfss). BRFSS, managed by CDC, is the largest ongoing telephone health survey system in the world, tracking health conditions and risk behaviors in the United States annually since 1984. Data are collected on a monthly basis in all 50 states, the District of Columbia, and participating territories. BRFSS data are collected by local jurisdictions and reported to CDC.

CENTERS FOR DISEASE CONTROL AND PREVENTION, NATIONAL CENTER FOR HEALTH STATISTICS, UNDERLYING CAUSE OF DEATH 1999-2013 ON CDC WONDER ONLINE DATABASE, RELEASED 2015 (http://wonder.cdc.gov/ucd-icd10.html). The WONDER online database "contains mortality and population counts for all U.S. counties. Data are based on death certificates for U.S. residents. Each death certificate identifies a single underlying cause of death and demographic data. The number of deaths, crude death rates or age-adjusted death rates, and 95% confidence intervals and standard errors for death rates can be obtained by place of residence (total U.S., region, state and county), age group (single-year-of age, 5-year age groups, 10-year age groups and infant age groups), race, Hispanic ethnicity, gender, year, cause-of-death (4-digit ICD-10 code or group of codes), injury intent and injury mechanism, drug/alcohol induced causes and urbanization categories. Data are also available for place of death, month and week day of death, and whether an autopsy was performed."

CENTER FOR MENTAL HEALTH SERVICES UNIFORM REPORTING SYSTEM (www.samhsa.gov/data/us_map). States and territories that receive CMHS Block Grants are required to report aggregate data to URS. URS reports include information about utilization of mental health services and client demographic and outcome information.

NATIONAL SURVEY ON DRUG USE AND HEALTH (https://nsduhweb.rti.org). 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 SUD treatment. NSDUH data also include information about mental health conditions.

TREATMENT EPISODE DATA SET (www.samhsa.gov/data/client-level-data-teds/reports?tab=19). States and territories that receive Substance Abuse Prevention and Treatment Block Grant funds submit individual client data to TEDS. TEDS includes both admission and discharge data sets, and some 1.5 million admissions are reported annually. TEDS includes information about utilization of SUD treatment services and client demographic and outcome information. TEDS is an admission-based system, and TEDS admissions do not represent individuals. Thus, an individual admitted to treatment twice within a calendar year would be counted as two admissions.

U.S. CENSUS BUREAU (www.census.gov/people). Two main sources of Census Bureau data were used in this report: (1) population estimates and (2) population projections.

OLDER ADULTS BEHAVIORAL HEALTH PROFILE

U.S. Virgin Islands

U.S. Virgin Islands

OLDER ADULTS BEHAVIORAL HEALTH PROFILE

April 2016

REGION 2'S POPULATION

Region 2 Population by Age Group

Detailed demographic U.S. Census Bureau data on older U.S. Virgin Islanders are unavailable. Therefore, the estimates for Region 2 (which includes New Jersey, New York, and Puerto Rico) are used instead. Region 2 is home to 32,232,799 people. Of these:

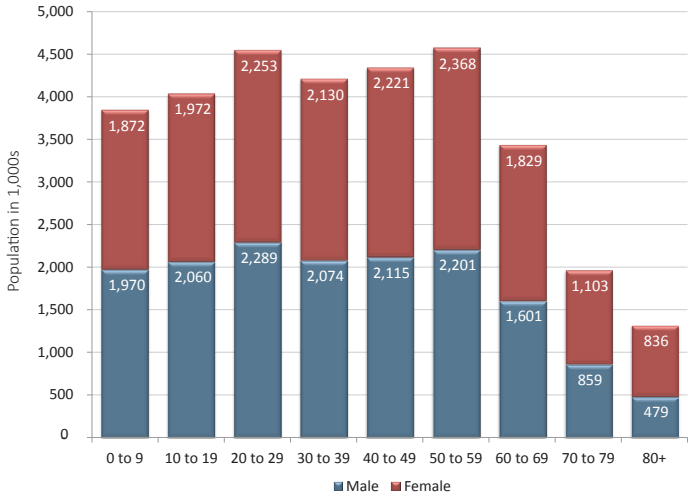
- 11,276,114 (35.0 percent) are over age 50.
- 6,707,093 (20.8 percent) are over age 60.
- 3,277,412 (10.2 percent) are over age 70.
- 1,315,289 (4.1 percent) are ages 80 and older.

Race/Ethnicity of Individuals in Region 2 Ages 50+

White	AI/AN	Black	Asian	NH/PI	Other	Hispanic
76.6%	0.5%	13.5%	6.4%	0.1%	2.9%	22.0%

Source: U.S. Census Bureau, 2015
AI/AN stands for American Indian and Alaska Native.
NH/PI stands for Native Hawaiian and Other Pacific Islander.

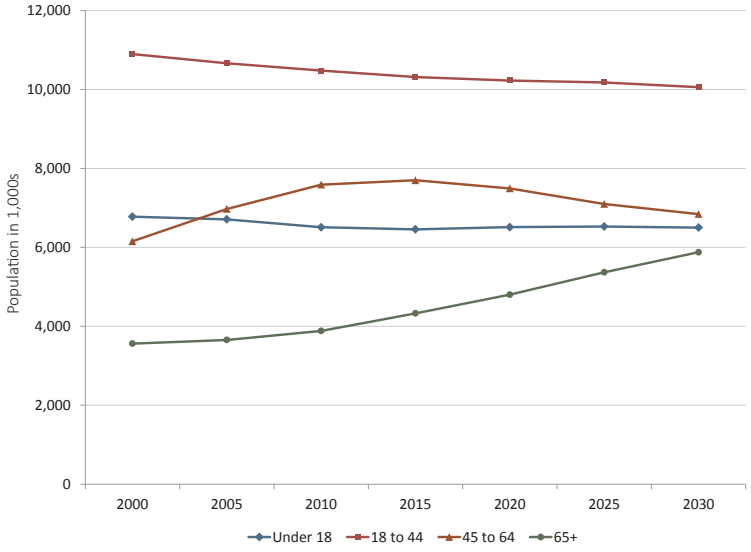
Exhibit 1. Region 2 Population by Age Group, 2014



Source: U.S. Census Bureau, 2015

The Number of Older Adults in Region 2 Is Growing

Exhibit 2. Region 2 Population by Age Group, 2000–2030



Recent population projections for the U.S. Virgin Islands are unavailable. Therefore, projections for Region 2 (calculated based on data from New Jersey and New York) are used instead.

The U.S. Census Bureau estimates that 20.1 percent of Region 2's population will be 65 and older by the year 2030, an increase of 35.8 percent from 2015.

Projected Population in Region 2

Age Group	2015	2025	2030
Under 18	22.4%	22.4%	22.2%
18 to 44	35.8%	34.9%	34.4%
45 to 64	26.7%	24.3%	23.4%
65+	15.0%	18.4%	20.1%

Source: U.S. Census Bureau, 2005

SUICIDE AMONG OLDER ADULTS IN REGION 2

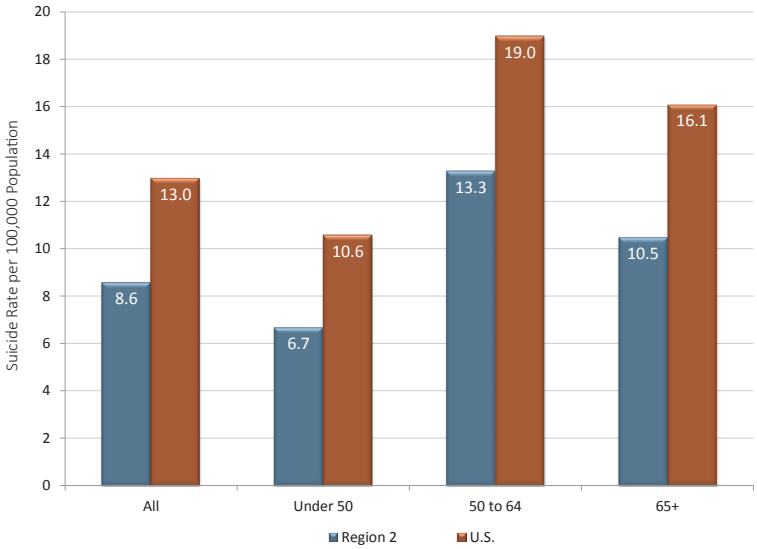
Region 2 Suicide Rates Compared With National Rates

Recent suicide data for the U.S. Virgin Islands are not available from the Centers for Disease Control and Prevention (CDC) mortality databases. Therefore, the rates for Region 2 (calculated based on data from New Jersey and New York) are used instead.

The suicide rate among individuals in Region 2 ages 50 and older is higher than the rate among younger age groups. In 2013, the total suicide rate among all people ages 50+ was 12.1 per 100,000 people (5.3 for women and 20.3 for men). The rate among those ages 50–64 was lower than the rate in the United States.

States and territories vary in their reporting of suicides. The suicide rate is influenced by these reporting practices.

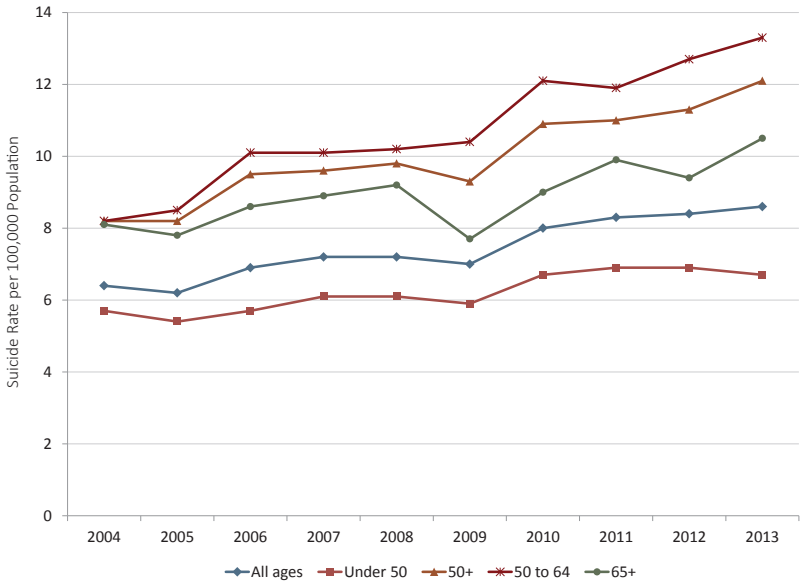
Exhibit 3. Suicide Rates in Region 2 and the United States, 2013



Source: CDC, National Center for Health Statistics (NCHS), Underlying Cause of Death 1999-2013 on CDC WONDER Online Database, released 2015

Trends in Suicide Rates in Region 2

Exhibit 4. Trends in Suicide Rates in Region 2 by Age Group, 2004–2013



Source: CDC, NCHS, Underlying Cause of Death 1999-2013 on CDC WONDER Online Database, released 2015

Recent suicide data for the U.S. Virgin Islands are not available from the CDC mortality databases. Therefore, the rates for Region 2 are used instead.

The suicide rate among individuals in Region 2 ages 50+ fluctuated from a low of 8.2 per 100,000 in 2004 to a high of 12.1 per 100,000 in 2013. From 2004 to 2013, the rate was generally highest among those in the 50–64 age group.

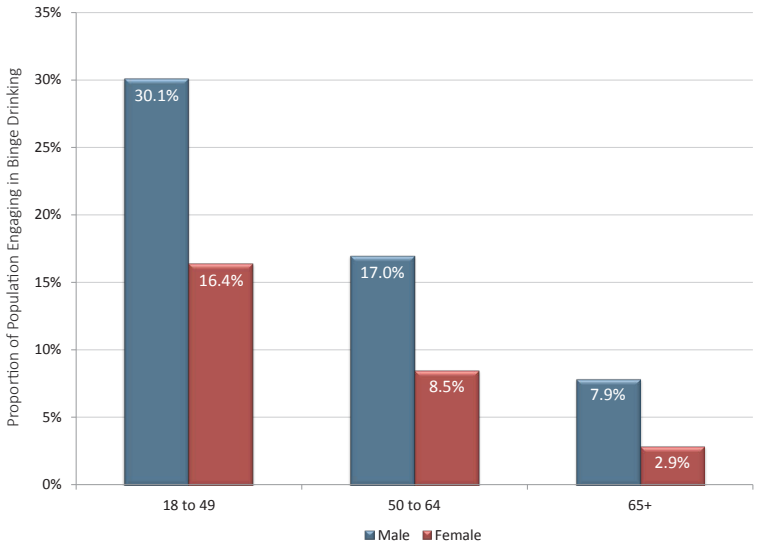
How a state or territory reports suicides can vary from year to year. The number of suicides is generally low, so even a small difference in reported numbers may make the rate fluctuate widely.

SUBSTANCE USE DISORDER AND SUBSTANCE USE DISORDER TREATMENT AMONG OLDER ADULTS IN REGION 2

30-Day Binge Drinking Among Older Adults in Region 2

Binge drinking, defined as five or more drinks for men and four or more drinks for women on a single occasion, can lead to serious health problems. Such problems include neurological damage, cardiovascular disease, liver disease, stroke, and poor control of diabetes. Binge drinkers are more likely to take risks such as driving while intoxicated and to experience falls and other accidents. Older people have a lower tolerance for alcohol. Binge drinking decreases with age and occurs more frequently among men than it does among women. Recent data for the U.S. Virgin Islands are unavailable. Therefore, data for Region 2 are used instead. As Exhibit 5 shows, 17.0 percent of Region 2 men ages 50–64 reported binge drinking in the past 30 days, while 7.9 percent of those in the 65+ group reported similar behavior.

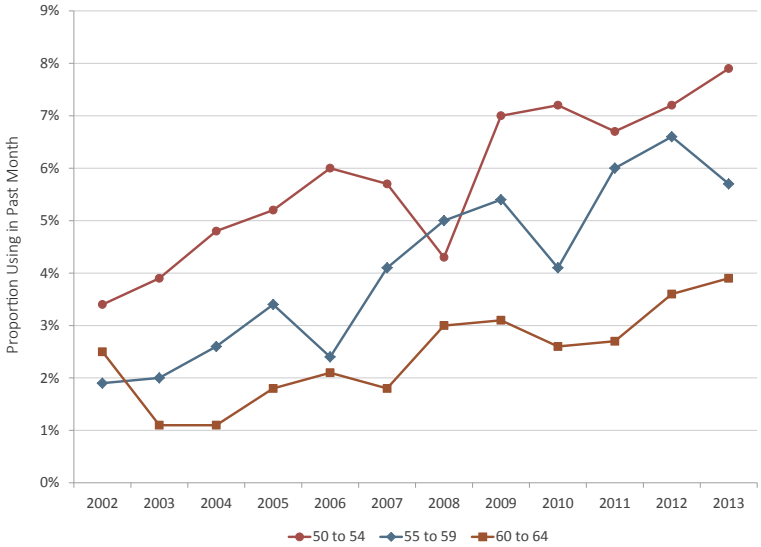
Exhibit 5. Binge Drinking Rates in Region 2 by Age Group and Sex, 2013



Source: Behavioral Risk Factor Surveillance System (BRFSS), 2013

Illicit Drug Use Among Older Americans

Exhibit 6. Illicit Drug Use Among Older Americans, 2002–2013



Source: National Survey on Drug Use and Health (NSDUH), 2013
Illicit drug use includes illegal drugs and prescription drugs used nonmedically. SAMHSA provides a list of drugs included in its survey in the NSDUH methodological summary.

Nationally, the rate of illicit drug use among older adults ages 50–64 more than doubled from 2002 to 2013. This development partially reflects the entrance into this age group of the baby boom cohort, whose rates of illicit drug use have been higher than those of older cohorts. Although territory-specific data are not available, *the Behavioral Health Barometers* for states in Region 2 are available for download from the Substance Abuse and Mental Health Services Administration (SAMHSA) website (www.samhsa.gov/data/population-data-nsduh/reports?tab=33).

Admissions to Substance Use Disorder Treatment Among Older Adults in Region 2

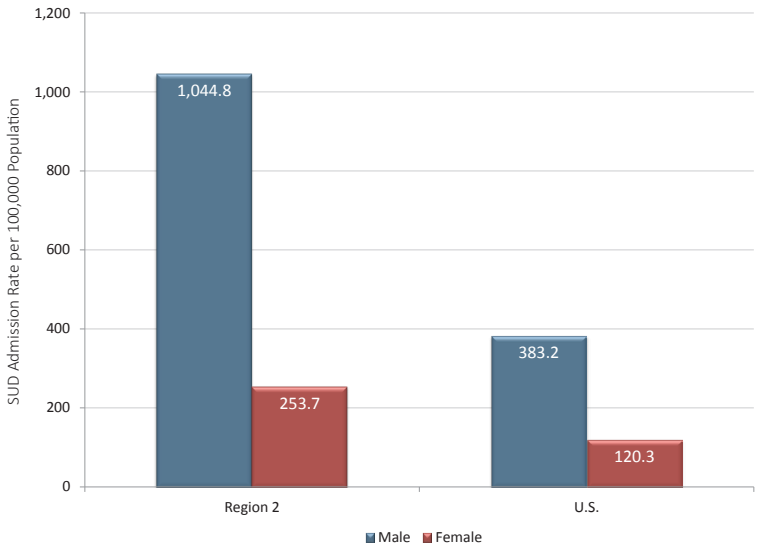
Treatment Episode Data Set (TEDS) data for the U.S. Virgin Islands in 2012 are unavailable. Therefore, data for Region 2 are used instead.

In 2012, there were 69,269 admissions of individuals in Region 2 ages 50 and older to substance use disorder (SUD) treatment in state- and territory-funded treatment programs. Of all admissions, 43.0 percent were White/Caucasian, 40.0 percent were Black/African American, and 17.9 percent were Hispanic.

The principal sources of referral to treatment among those ages 50 and older were:

Self-Referral	Criminal Justice	Other
47.8%	13.7%	38.4%

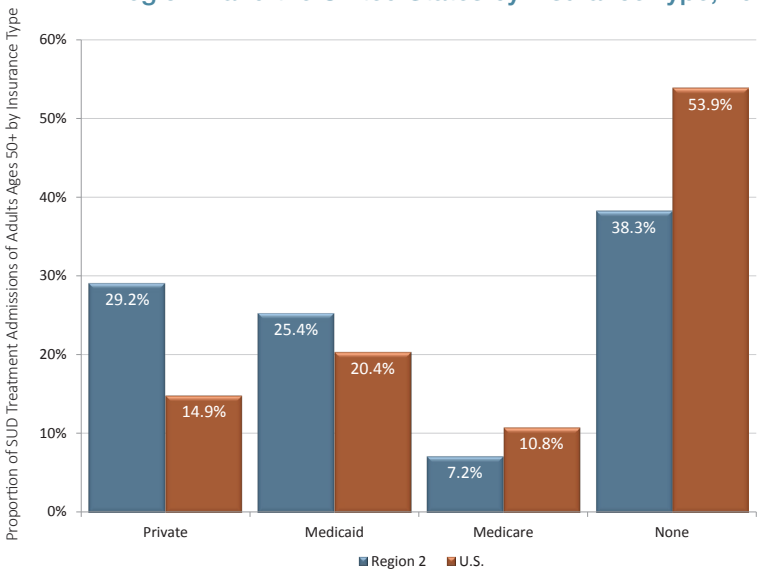
Exhibit 7. SUD Treatment Admissions of Adults Ages 50+ in Region 2 and the United States by Sex, 2012



Source: Treatment Episode Data Set (TEDS), 2012[1]
Data include only those clients reported to SAMHSA.

SUD Treatment Admissions Among Individuals in Region 2 Ages 50+ by Insurance Type

Exhibit 8. SUD Treatment Admissions of Adults Ages 50+ in Region 2 and the United States by Insurance Type, 2012



Source: TEDS, 2012
Data include only those clients reported to SAMHSA.

TEDS data for the U.S. Virgin Islands in 2012 are unavailable. Therefore, data for Region 2 are used instead.

In Region 2, 38.3 percent of older adult admissions to SUD treatment were uninsured, 25.4 percent had Medicaid, 7.2 percent had Medicare, and 29.2 percent had private insurance.

SUD Treatment Admissions Among U.S. Virgin Islanders Ages 50+ by Primary Sources of Payment

Self-Pay	Medicaid	Other
Data not available	Data not available	Data not available

Exhibit 8 and the accompanying text reflect the type of health insurance (if any) clients had at admission; the table above represents primary sources of payment.

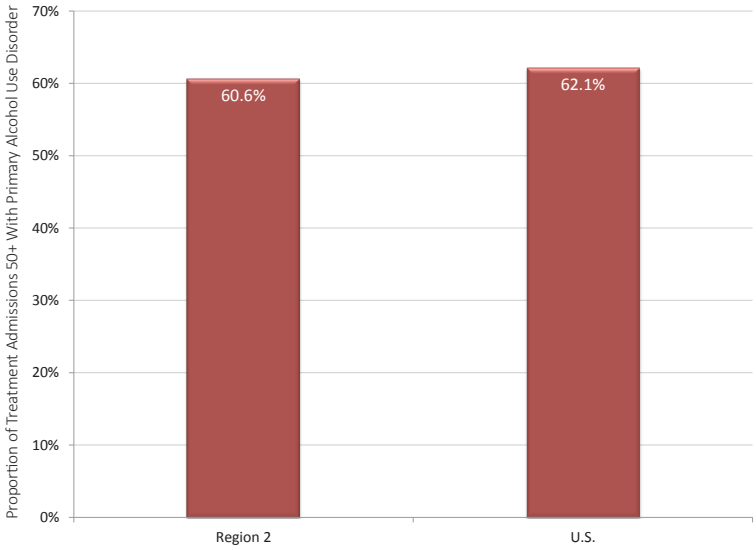
[1] TEDS data are collected by states and territories as a condition of the Substance Abuse Prevention and Treatment Block Grant. Guidelines suggest that states and territories report all clients admitted to publicly financed treatment; however, states and territories are inconsistent in applying the guidelines. States and territories may structure and implement different quality controls over the data. For example, states and territories may collect different categories of information to answer TEDS questions. Information is then "walked over" to TEDS definitions.

Alcohol Use Disorder Treatment Admissions Among Individuals in Region 2 Ages 50+

TEDS data for the U.S. Virgin Islands in 2012 are unavailable. Therefore, data for Region 2 are used instead.

Alcohol was the most frequently cited substance used by older individuals in Region 2 in publicly financed SUD treatment in 2012. It was mentioned as a substance of use in 60.6 percent of admissions among those ages 50+. This was lower than the national rate.

Exhibit 9. Alcohol Use Treatment Admissions of Adults Ages 50+ in Region 2 and the United States, 2012



Source: TEDS, 2012
Data include only those clients reported to SAMHSA.

SUD Treatment Admissions for Non-Alcohol Substance Use

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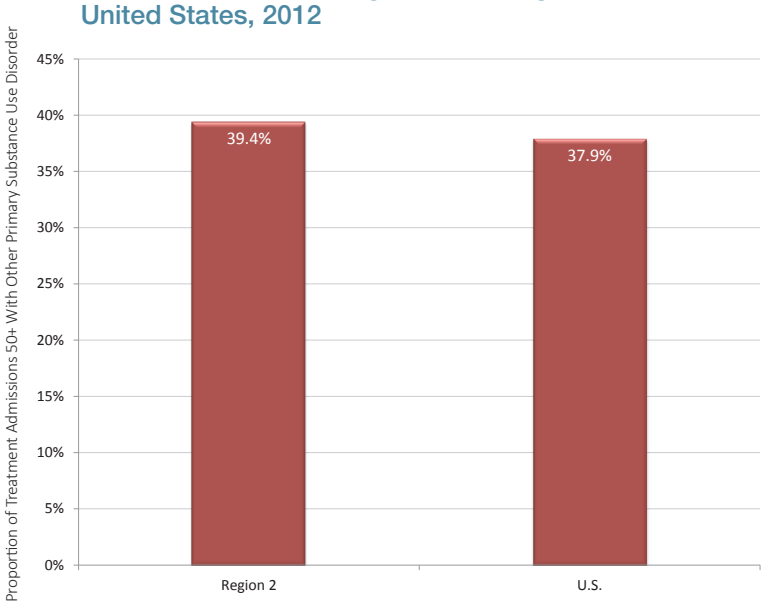


Source: TEDS, 2012
Data include only those clients reported to SAMHSA.

TEDS data for the U.S. Virgin Islands in 2012 are unavailable. Therefore, data for Region 2 are used instead.

Substances other than alcohol were cited as the primary substances of use for 39.4 percent of older adult admissions to publicly funded treatment in Region 2.

Drug-Related Emergency Department Visits Involving Pharmaceutical Misuse and Abuse by Older Adults

SAMHSA periodically releases reports from the Drug Abuse Warning Network (DAWN). DAWN, discontinued in 2011, consisted of a nationwide network of hospital emergency departments (EDs) primarily located in large metropolitan areas. DAWN data consist of professional reviews of ED records to determine the extent to which alcohol and other substance abuse was involved in ED visits. According to the November 25, 2010, *DAWN Report*:

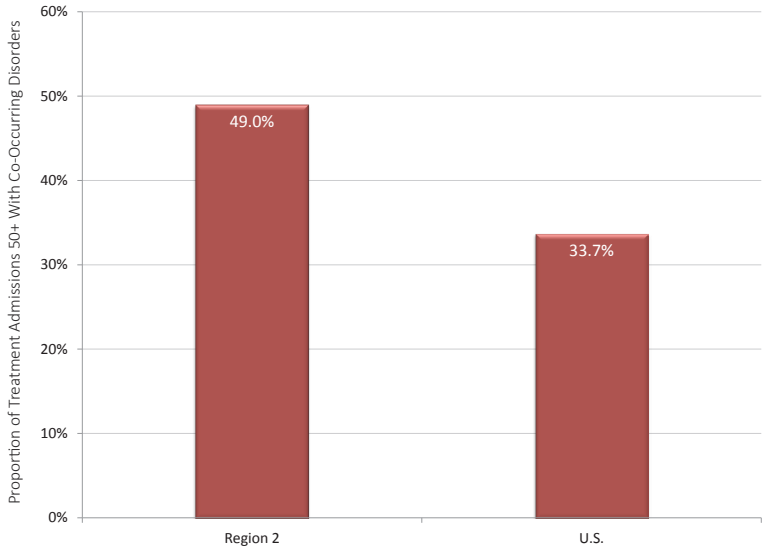
- *In 2004, there were an estimated 115,803 ED visits involving pharmaceutical misuse and abuse by adults aged 50 or older; in 2008, there were 256,097 such visits, representing an increase of 121.1 percent*
- *One fifth (19.7 percent) of ED visits involving pharmaceutical misuse and abuse among older 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*

Bulleted text in italics above is taken from SAMHSA's Center for Behavioral Health Statistics and Quality. (2010, November 25). ***The DAWN Report: Drug-related emergency department visits involving pharmaceutical misuse and abuse by older adults.*** Rockville, MD: SAMHSA.

CO-OCCURRING SUBSTANCE USE AND MENTAL DISORDERS

Older Adults in Region 2 in SUD Treatment With Co-Occurring Mental Disorders

Exhibit 11. SUD Treatment Admissions of Adults Ages 50+ With a Co-Occurring Mental Disorder in Region 2 and the United States, 2012



Source: TEDS, 2012
Data include only those clients reported to SAMHSA.

The national literature shows a strong relationship between substance use and mental disorders. Studies show that 30–80 percent of individuals with a substance use or mental disorder also have a co-occurring disorder.

TEDS data for the U.S. Virgin Islands in 2012 are unavailable. Therefore, Exhibit 11 shows regional and national figures only.

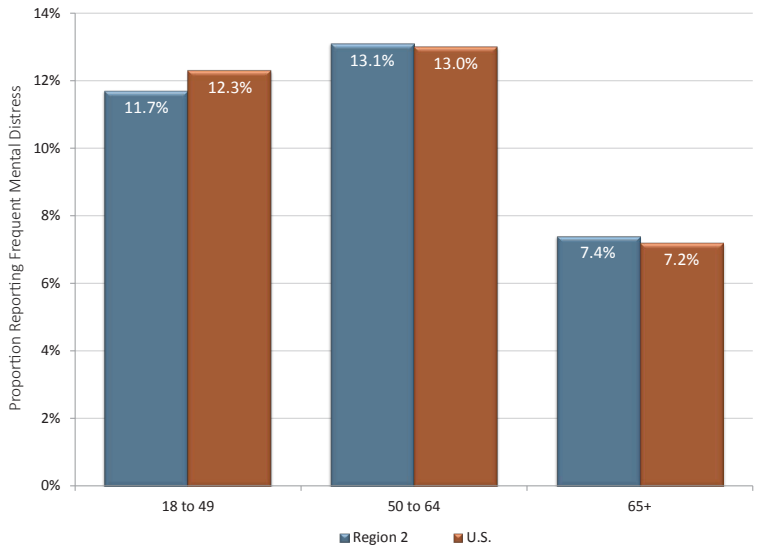
MENTAL HEALTH

Older Adults in Region 2 Reporting Frequent Mental Distress

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?" Those individuals reporting 14 or more "Yes" days in response to this question experience frequent mental distress (FMD).

Recent BRFSS data for the U.S. Virgin Islands were unavailable. Therefore, data for Region 2 are used instead. Exhibit 12 shows that older adults in Region 2 experience FMD at a rate that is roughly similar to the national rate.

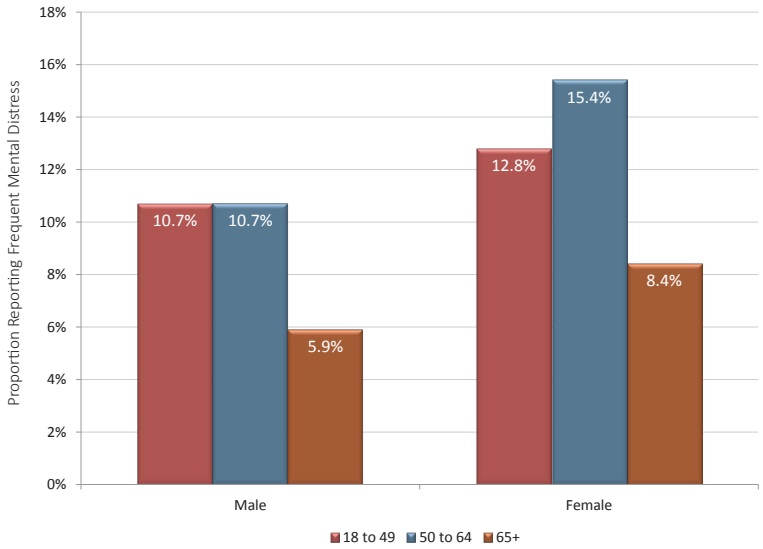
Exhibit 12. Individuals Reporting Frequent Mental Distress in Region 2 and the United States, 2013



Source: BRFSS, 2013

Older Adults in Region 2 Reporting Frequent Mental Distress by Age Group and Sex

Exhibit 13. Individuals in Region 2 Reporting Frequent Mental Distress by Age Group and Sex, 2013



Source: BRFSS, 2013

Older men in Region 2 were more likely to indulge in binge drinking, but older women were more likely to report that they had FMD (14 days or more per 30-day period). As Exhibit 13 shows, 15.4 percent of women in the 50–64 age group and 8.4 percent in the 65+ age group reported FMD, while 10.7 percent of men in the 50–64 age group and 5.9 percent in the 65+ age group reported FMD.

Other Measures of Mental Health

BRFSS collected other measures showing risk factors for mental and/or physical illness. These included:

- Social and Emotional Support (2010). BRFSS asked, "How often do you get the social and emotional support you need?" The possible responses were always, usually, sometimes, rarely, or never.
- Life Satisfaction (2010). BRFSS asked, "In general, how satisfied are you with your life?" The possible responses were very satisfied, satisfied, dissatisfied, or very dissatisfied.

Exhibit 14 presents the results of these surveys among older U.S. Virgin Islanders.

Exhibit 14. BRFSS Measures, 2010

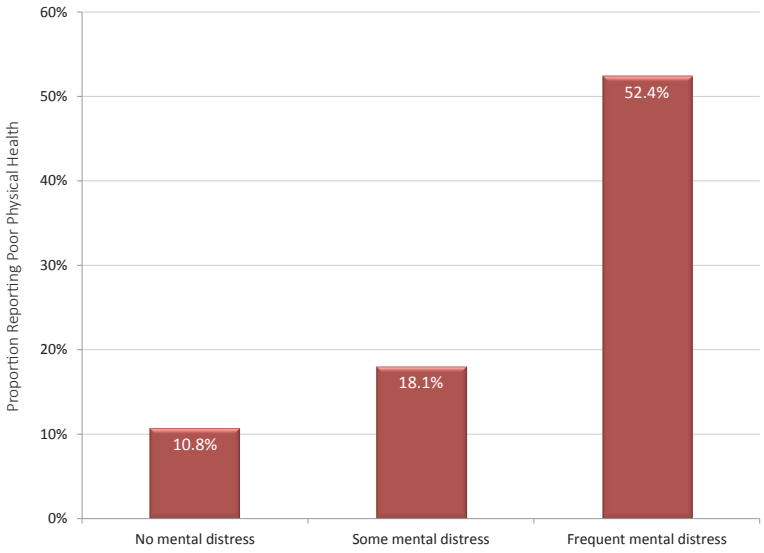
Indicator	Ages 50+	Ages 50–64	Ages 65+
Rarely or never get social or emotional support	14.6%	13.5%	16.9%
Dissatisfied or very dissatisfied	4.8%	5.5%	3.3%

Source: BRFSS, 2010

Individuals With Frequent Mental Distress Report High Rates of Poor Physical Health

Older Americans who experienced FMD were more likely to report that their physical health was poor (14 days or more in the past 30-day period when physical health was "not good"). As shown in Exhibit 15, although nearly 11 percent of older Americans with no mental distress reported poor physical health, more than 50 percent of those with FMD reported poor physical health.

Exhibit 15. Individuals Ages 50+ in the United States Reporting Poor Physical Health by Level of Mental Distress, 2013

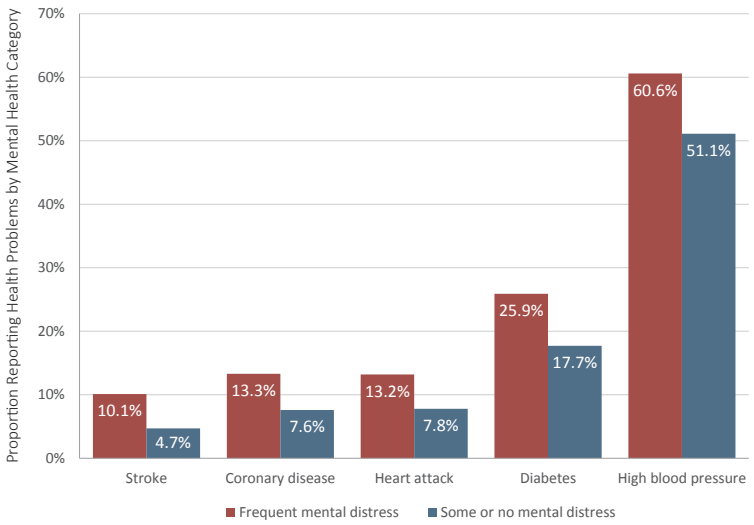


Source: BRFSS, 2013

Relationship Among Mental Distress, Diabetes, Stroke, Heart Attack, High Blood Pressure, and Coronary Disease

Older Americans who experience FMD are more likely to report that they have health problems. People with FMD were more than twice as likely to report having a stroke than those with some or no mental distress. They experienced coronary disease and heart attack at more than 1.6 times, diabetes at more than 1.4 times, and high blood pressure at nearly 1.2 times the rate of those with some or no mental distress.

Exhibit 16. Individuals Ages 50+ in the United States With Mental Distress and Serious Health Problems, 2013



Source: BRFSS, 2013

Older U.S. Virgin Islanders Admitted to Territory Mental Health Services

Approximately 8.1 percent of the people served by the U.S. Virgin Islands mental health system were ages 65 and older. This represents more than 40 adults.

Source: Center for Mental Health Services (CMHS) Uniform Reporting System (URS) Output Tables, 2013

DATA SOURCES

BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM (www.cdc.gov/brfss). BRFSS, managed by CDC, is the largest ongoing telephone health survey system in the world, tracking health conditions and risk behaviors in the United States annually since 1984. Data are collected on a monthly basis in all 50 states, the District of Columbia, and participating territories. BRFSS data are collected by local jurisdictions and reported to CDC.

CENTERS FOR DISEASE CONTROL AND PREVENTION, NATIONAL CENTER FOR HEALTH STATISTICS, UNDERLYING CAUSE OF DEATH 1999-2013 ON CDC WONDER ONLINE DATABASE, RELEASED 2015 (http://wonder.cdc.gov/ucd-icd10.html). The WONDER online database "contains mortality and population counts for all U.S. counties. Data are based on death certificates for U.S. residents. Each death certificate identifies a single underlying cause of death and demographic data. The number of deaths, crude death rates or age-adjusted death rates, and 95% confidence intervals and standard errors for death rates can be obtained by place of residence (total U.S., region, state and county), age group (single-year-of age, 5-year age groups, 10-year age groups and infant age groups), race, Hispanic ethnicity, gender, year, cause-of-death (4-digit ICD-10 code or group of codes), injury intent and injury mechanism, drug/alcohol induced causes and urbanization categories. Data are also available for place of death, month and week day of death, and whether an autopsy was performed."

CENTER FOR MENTAL HEALTH SERVICES UNIFORM REPORTING SYSTEM (www.samhsa.gov/data/us_map). States and territories that receive CMHS Block Grants are required to report aggregate data to URS. URS reports include information about utilization of mental health services and client demographic and outcome information.

NATIONAL SURVEY ON DRUG USE AND HEALTH (https://nsduhweb.rti.org). 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 SUD treatment. NSDUH data also include information about mental health conditions.

TREATMENT EPISODE DATA SET (www.samhsa.gov/data/client-level-data-teds/reports?tab=19). States and territories that receive Substance Abuse Prevention and Treatment Block Grant funds submit individual client data to TEDS. TEDS includes both admission and discharge data sets, and some 1.5 million admissions are reported annually. TEDS includes information about utilization of SUD treatment services and client demographic and outcome information. TEDS is an admission-based system, and TEDS admissions do not represent individuals. Thus, an individual admitted to treatment twice within a calendar year would be counted as two admissions.

U.S. CENSUS BUREAU (www.census.gov/people). Two main sources of Census Bureau data were used in this report: (1) population estimates and (2) population projections.