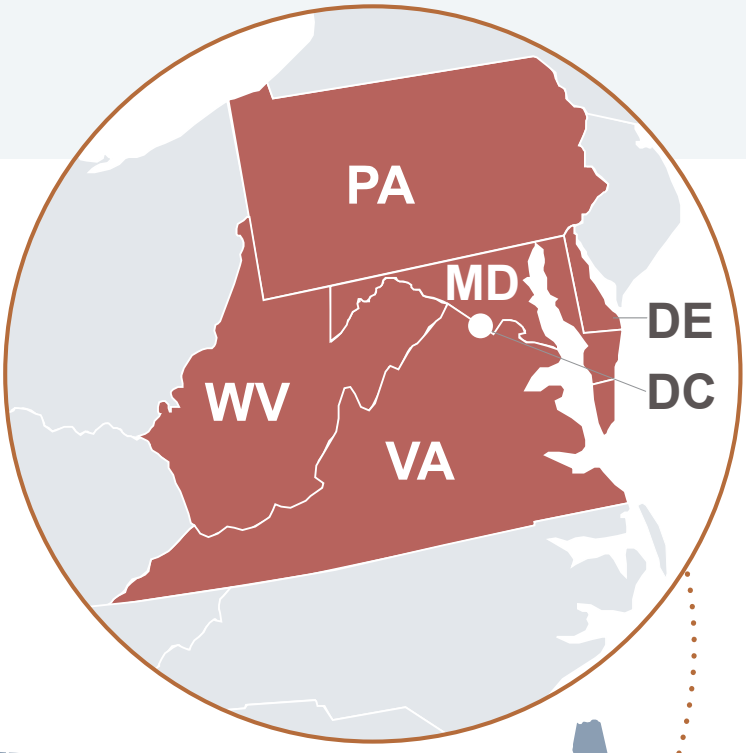
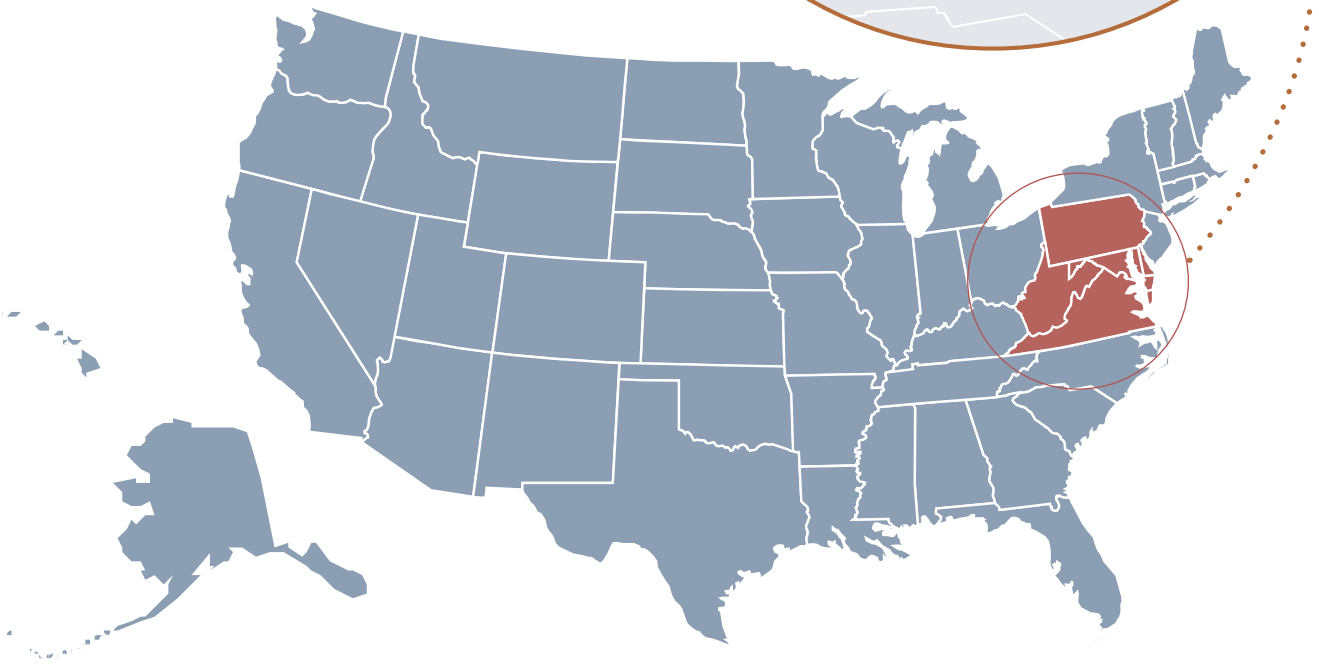
OLDER ADULTS BEHAVIORAL HEALTH PROFILES

REGION 3

DELAWARE
DISTRICT OF COLUMBIA
MARYLAND
PENNSYLVANIA
VIRGINIA
WEST VIRGINIA





A Behavioral Health Resource

SAMHSA's State Technical Assistance Contract

August 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 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.

The Older Adults Behavioral Health Profiles help states 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 trends with those in the region and the nation. State 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

Delaware

Delaware

OLDER ADULTS BEHAVIORAL HEALTH PROFILE

August 2016

DELAWARE'S POPULATION

Delaware Population by Age Group

Delaware is home to 935,614 people. Of these:

- 345,838 (37.0 percent) are over age 50.
- 212,184 (22.7 percent) are over age 60.
- 101,557 (10.9 percent) are over age 70.
- 36,606 (3.9 percent) are ages 80 and older.

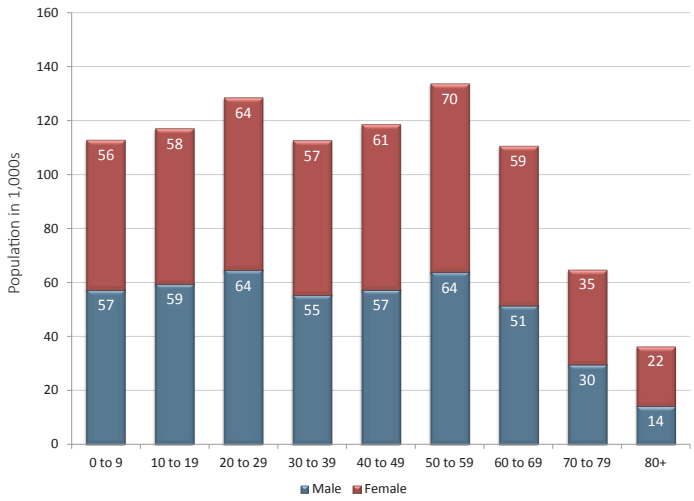
The proportion of women rises fairly steadily in each age group, and women make up 60.9 percent of the 80+ group. The racial/ethnic composition of older Delawareans is as follows:

Race/Ethnicity of Delawareans Ages 50+

White	AI/AN	Black	Asian	NH/PI	Other	Hispanic
79.1%	0.5%	17.1%	2.5%	0.0%	0.8%	3.3%

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.

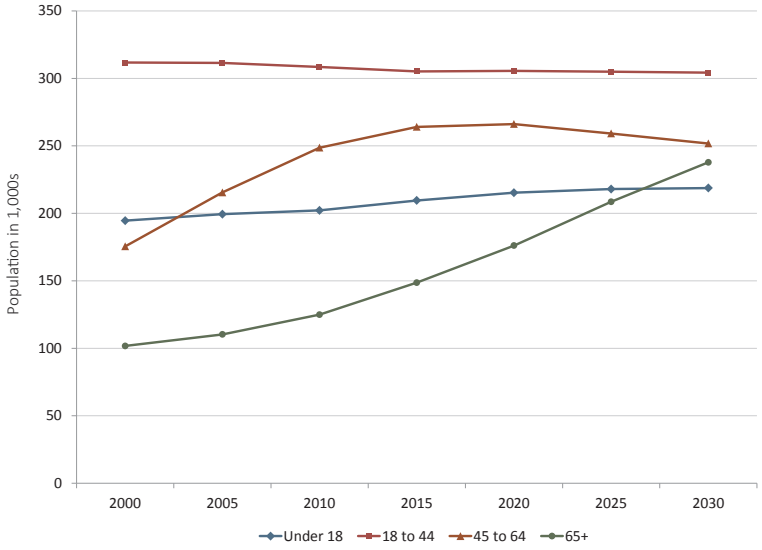
Exhibit 1. Delaware Population by Age Group, 2014



Source: U.S. Census Bureau, 2015

The Number of Older Delawareans Is Growing

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



The proportion of Delaware'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 23.5 percent of Delaware's population will be 65 and older by the year 2030, an increase of 60.0 percent from 2015.

Projected Population in Delaware

Age Group	2015	2025	2030
Under 18	22.6%	22.0%	21.6%
18 to 44	32.9%	30.8%	30.0%
45 to 64	28.5%	26.2%	24.9%
65+	16.0%	21.1%	23.5%

Source: U.S. Census Bureau, 2005

SUICIDE AMONG OLDER ADULTS IN REGION 3

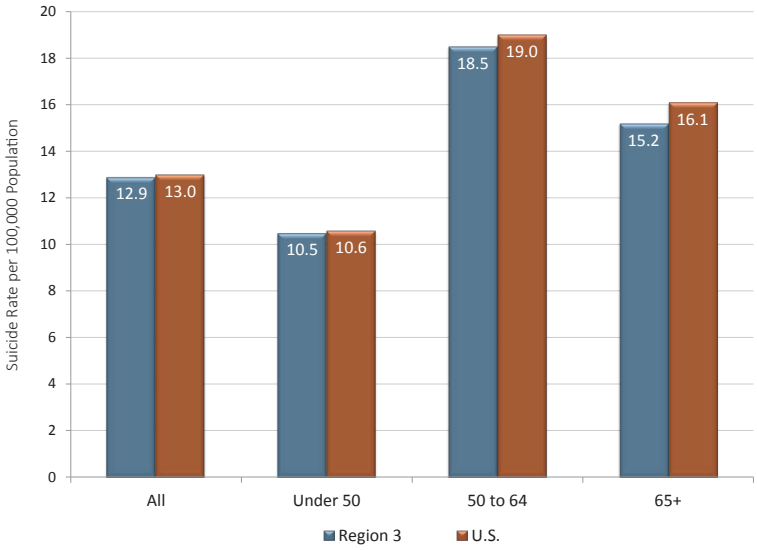
Region 3 Suicide Rates Compared With National Rates

Suicide data for Delawareans of various ages were unavailable for 2013. Therefore, the rates for Region 3 (including the District of Columbia, Maryland, Pennsylvania, Virginia, and West Virginia) are used instead.

The suicide rate among individuals ages 50+ in Region 3 was higher than the rate among younger age groups. In 2013, the total suicide rate among all people ages 50+ was 17.1 per 100,000 people (6.2 for women and 29.9 for men). The rate among those ages 50–64 was lower than the rate in the United States.

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

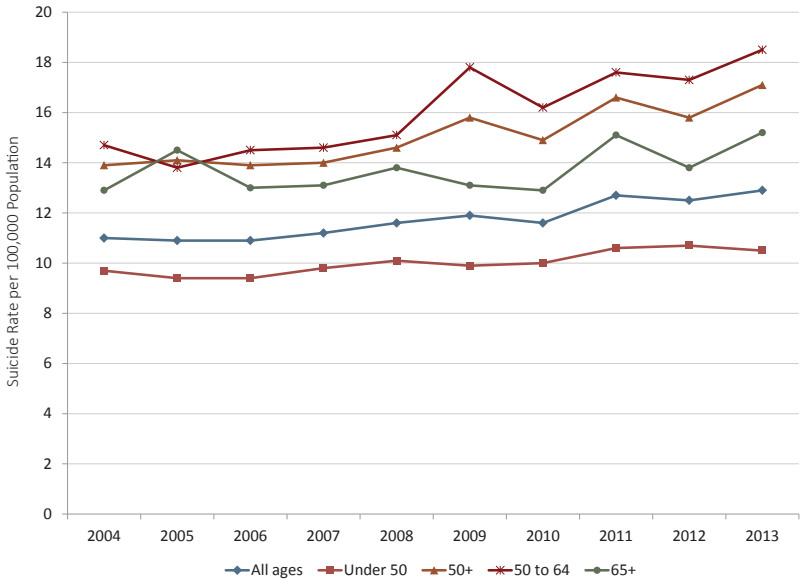
Exhibit 3. Suicide Rates in Region 3 and the United States, 2013



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 Region 3

Exhibit 4. Trends in Suicide Rates in Region 3 by Age Group, 2004–2013



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

Suicide data for Delawareans of various ages were unavailable. Therefore, the rates for Region 3 are used instead.

The suicide rate among individuals in Region 3 ages 50+ fluctuated from a low of 13.9 per 100,000 in 2004 and 2006 to a high of 17.1 per 100,000 in 2013. From 2004 to 2013, the rate was generally highest among those in the 50–64 age group.

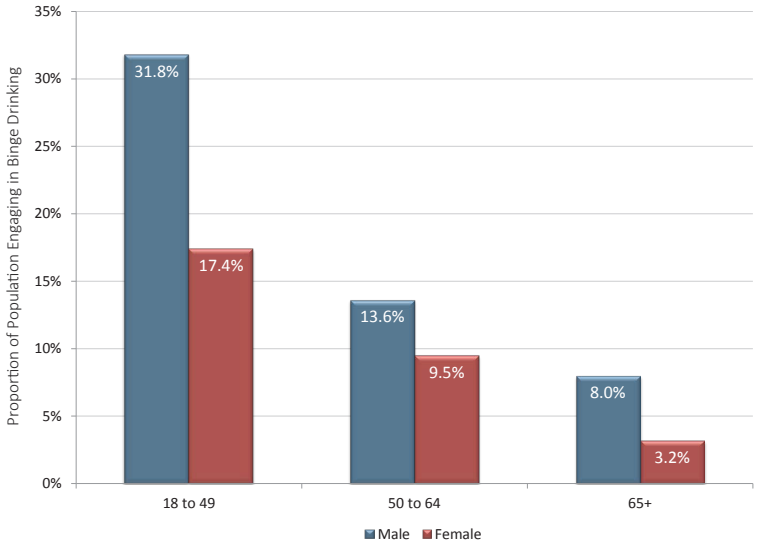
How a state reports suicides can vary from year to year. The number of suicides is generally low, so even a small difference in reported numbers may make the rate fluctuate widely.

SUBSTANCE USE DISORDER AND SUBSTANCE USE DISORDER TREATMENT AMONG OLDER DELAWAREANS

30-Day Binge Drinking Among Older Delawareans

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, 13.6 percent of Delaware men ages 50–64 reported binge drinking in the past 30 days, while 8.0 percent of those in the 65+ group reported similar behavior.

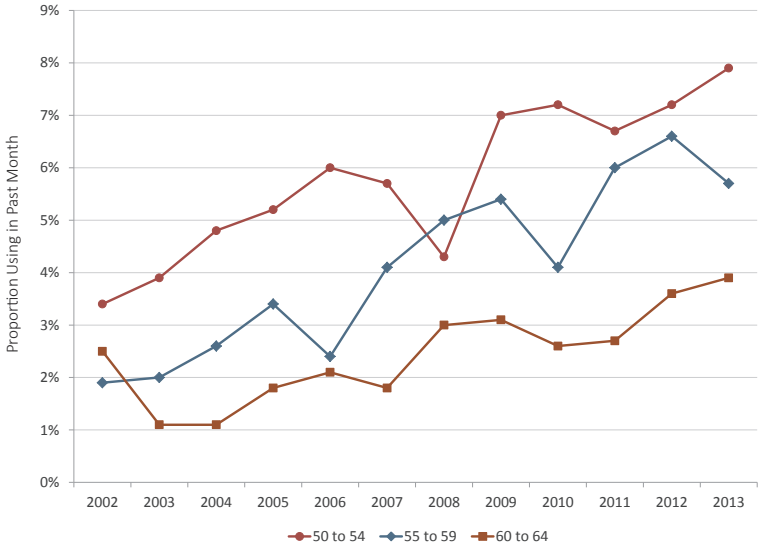
Exhibit 5. Binge Drinking Rates in Delaware by Age Group and Sex, 2013



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 *Delaware 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).

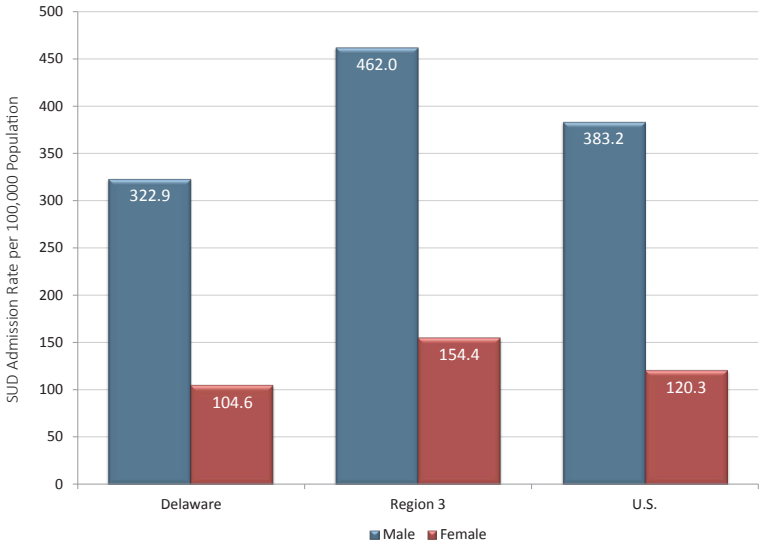
Admissions to Substance Use Disorder Treatment Among Older Delawareans

In 2012, there were 709 admissions of Delawareans ages 50 and older to substance use disorder (SUD) treatment in state-funded treatment programs, a rate of 205.0 per 100,000 people ages 50+. This rate was lower than the regional rate and the national average. Men made up 72.5 percent of these admissions. Of all admissions, 62.0 percent were White/Caucasian, 36.0 percent were Black/African American, and 2.7 percent were Hispanic.

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

Self-Referral	Criminal Justice	Other
69.6%	19.0%	11.4%

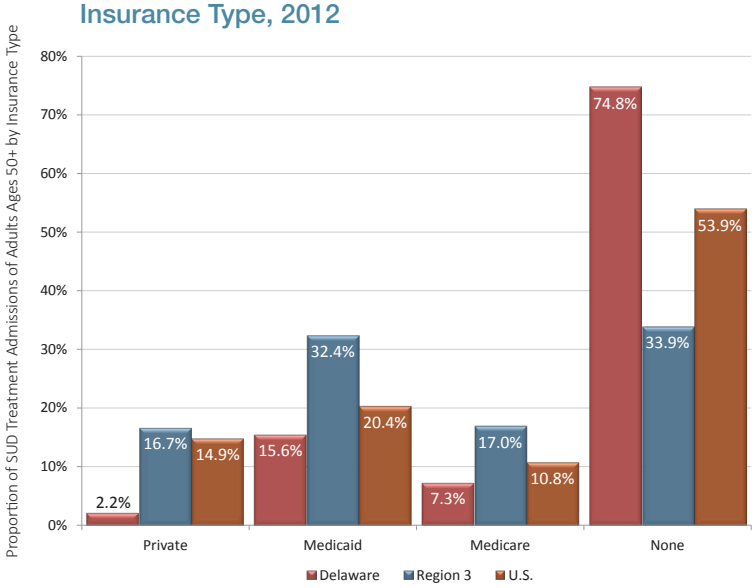
Exhibit 7. SUD Treatment Admissions of Adults Ages 50+ in Delaware, Region 3, and the United States by Sex, 2012



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

SUD Treatment Admissions Among Delawareans Ages 50+ by Insurance Type

Exhibit 8. SUD Treatment Admissions of Adults Ages 50+ in Delaware, Region 3, and the United States by Insurance Type, 2012



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

In Delaware, 74.8 percent of older adult admissions to SUD treatment were uninsured, 15.6 percent had Medicaid, 7.3 percent had Medicare, and 2.2 percent had private insurance.

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

Self-Pay	Medicaid	Other
1.5%	8.2%	90.3%

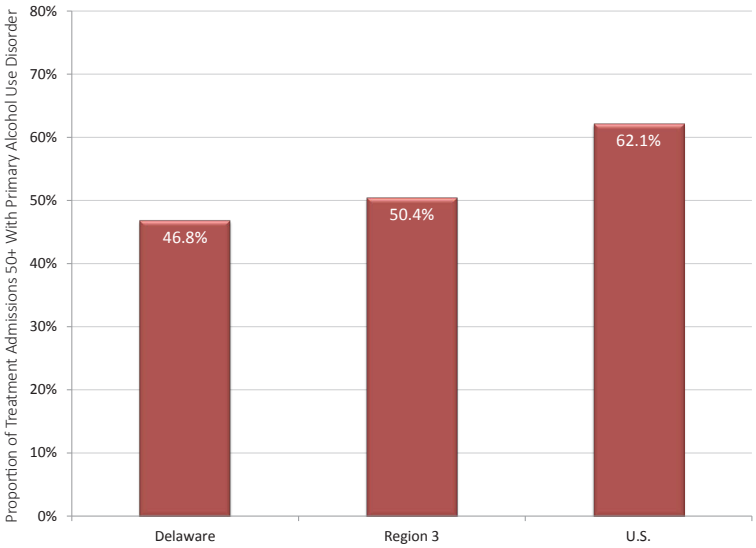
Self-pay data include private insurance.
Exhibit 8 and the accompanying text reflect the type of health insurance (if any) clients had at admission; the table above represents primary sources of payment.

[1] TEDS data are collected by states 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 Delawareans Ages 50+

Alcohol was the most frequently cited substance used by older Delawareans in publicly financed SUD treatment in 2012. It was mentioned as a substance of use in 46.8 percent of admissions among those ages 50+. This was lower than the regional and national rates.

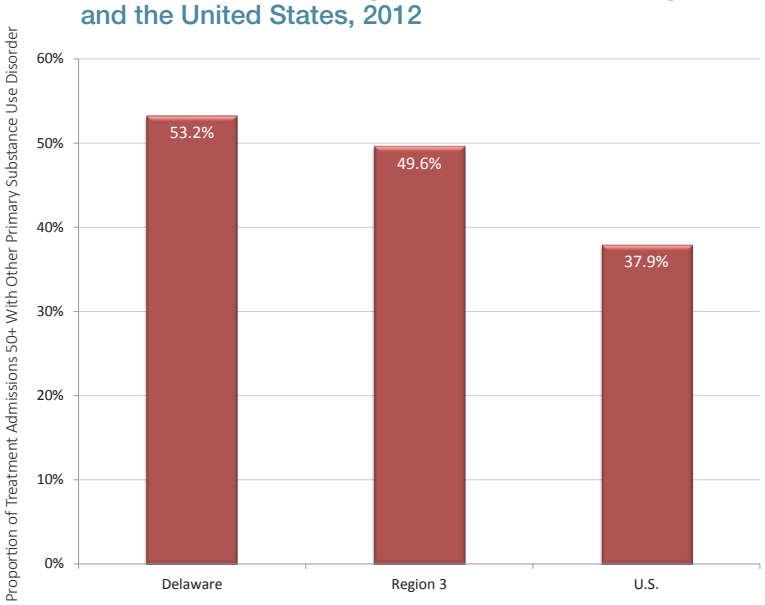
Exhibit 9. Alcohol Use Treatment Admissions of Adults Ages 50+ in Delaware, Region 3, and the United States, 2012



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 Delaware, Region 3, 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 53.2 percent of older adult admissions to publicly funded treatment in Delaware.

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*:

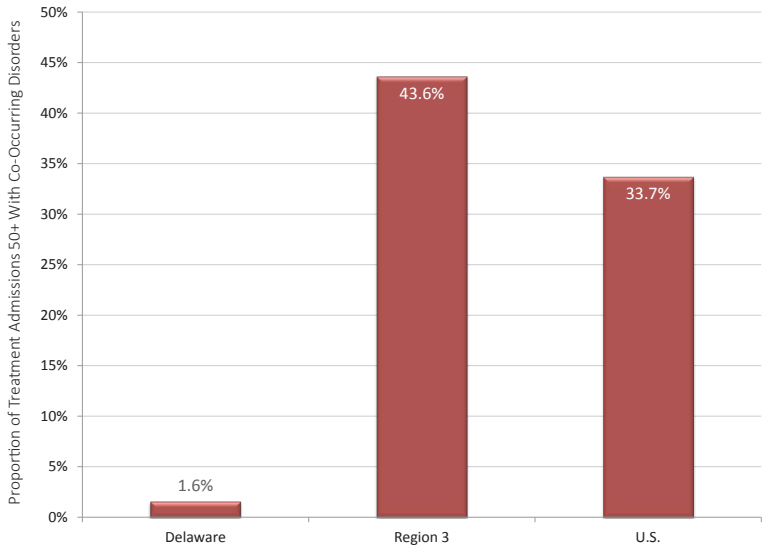
- *In 2004, there were an estimated 115,803 ED visits involving pharmaceutical misuse and abuse by adults aged 50 or older; in 2008, there were 256,097 such visits, representing an increase of 121.1 percent*
- *One fifth (19.7 percent) of ED visits involving pharmaceutical misuse and abuse among older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

Exhibit 11. SUD Treatment Admissions of Adults Ages 50+ With a Co-Occurring Mental Disorder in Delaware, Region 3, 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.

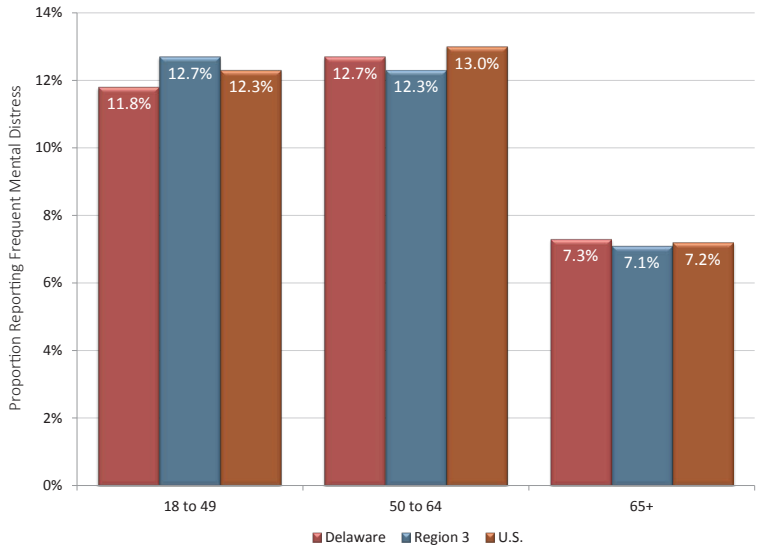
Exhibit 11 shows the proportion of SUD treatment admissions of Delawareans ages 50+ with a co-occurring mental disorder. This rate is lower than the regional rate and the national average. However, state reporting practices are a factor in these results.

MENTAL HEALTH

Older Delawareans 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 Delawareans experience FMD at a rate that is higher than the regional rate and roughly similar to the national rate.

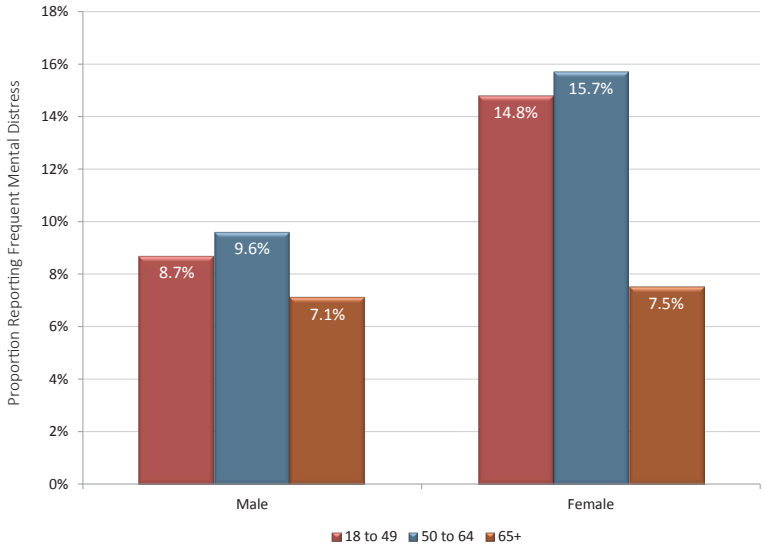
Exhibit 12. Individuals Reporting Frequent Mental Distress in Delaware, Region 3, and the United States, 2013



Source: BRFSS, 2013

Older Delawareans Reporting Frequent Mental Distress by Age Group and Sex

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



Source: BRFSS, 2013

Older men in Delaware 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, 15.7 percent of women in the 50–64 age group and 7.5 percent in the 65+ age group reported FMD, while 9.6 percent of men in the 50–64 age group and 7.1 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 Delawareans.

Exhibit 14. BRFSS Measures, 2010

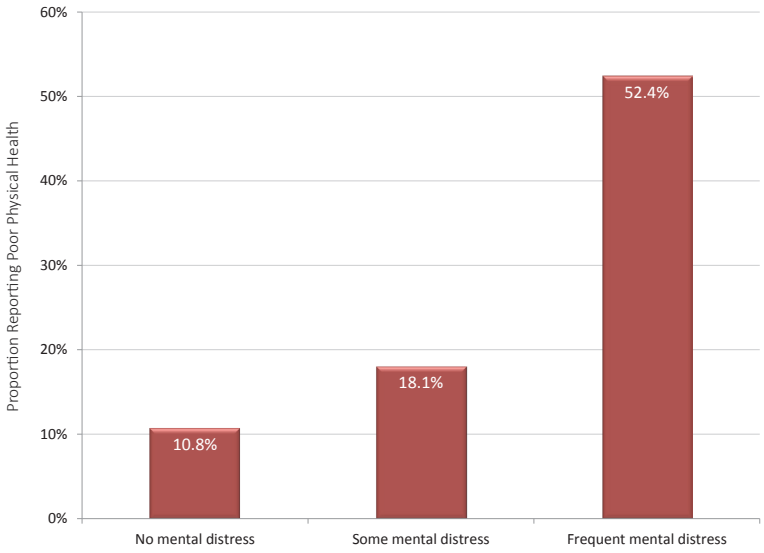
Indicator	Ages 50+	Ages 50–64	Ages 65+
Rarely or never get social or emotional support	6.5%	5.0%	8.5%
Dissatisfied or very dissatisfied	4.9%	5.8%	3.8%

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

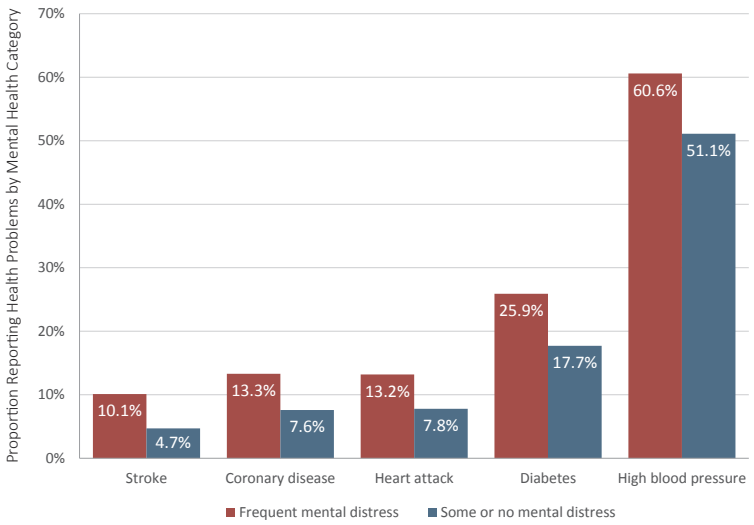


Source: BRFSS, 2013

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 Delawareans Admitted to State Mental Health Services

Approximately 5.5 percent of the people served by the Delaware mental health system were ages 65 and older. This represents more than 540 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

District of Columbia

District of Columbia

OLDER ADULTS BEHAVIORAL HEALTH PROFILE

August 2016

DISTRICT OF COLUMBIA'S POPULATION

District of Columbia Population by Age Group

The District of Columbia is home to 658,893 people. Of these:

- 182,731 (27.7 percent) are over age 50.
- 107,117 (16.3 percent) are over age 60.
- 49,522 (7.5 percent) are over age 70.
- 20,190 (3.1 percent) are ages 80 and older.

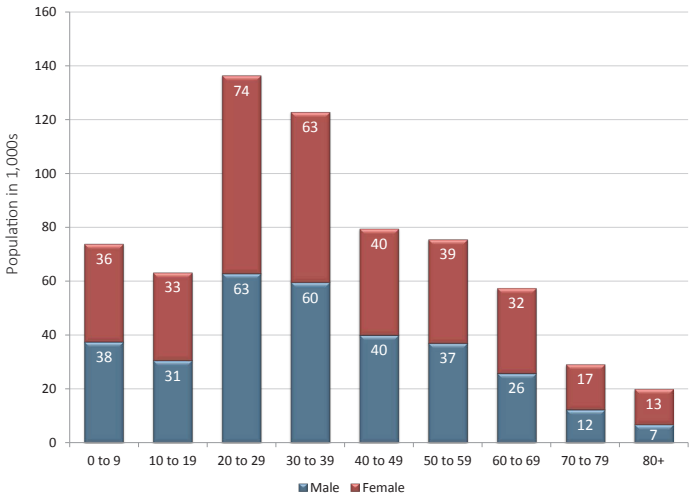
The proportion of women rises fairly steadily in each age group, and women make up 66.2 percent of the 80+ group. The racial/ethnic composition of older Washingtonians is as follows:

Race/Ethnicity of Washingtonians Ages 50+

White	AI/AN	Black	Asian	NH/PI	Other	Hispanic
35.2%	0.5%	60.4%	2.4%	0.1%	1.4%	6.4%

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.

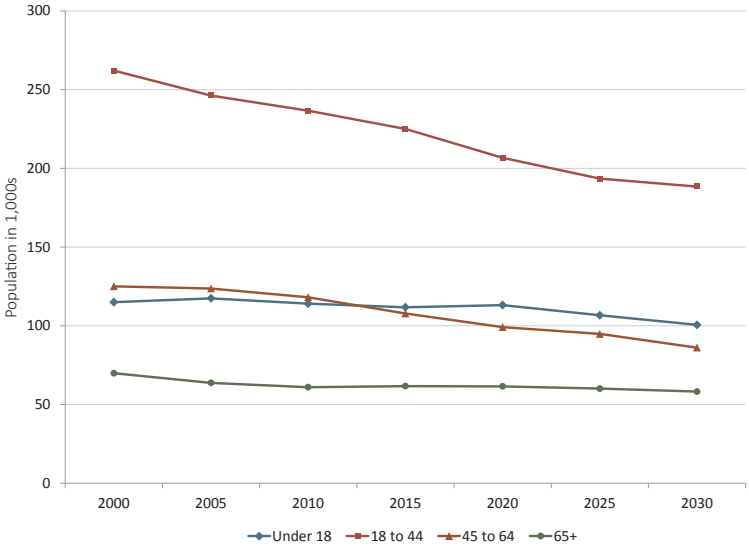
Exhibit 1. District of Columbia Population by Age Group, 2014



Source: U.S. Census Bureau, 2015

The Proportion of Older Washingtonians Is Growing

Exhibit 2. The District of Columbia Population by Age Group, 2000–2030



The proportion of the District of Columbia'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 13.4 percent of the District of Columbia's population will be 65 and older by the year 2030. However, the total number of individuals 65 and older is expected to decrease by 5.6 percent by 2030.

Projected Population in the District of Columbia

Age Group	2015	2025	2030
Under 18	22.1%	23.4%	23.2%
18 to 44	44.4%	42.5%	43.5%
45 to 64	21.3%	20.8%	19.9%
65+	12.2%	13.2%	13.4%

Source: U.S. Census Bureau, 2005

SUICIDE AMONG OLDER ADULTS IN REGION 3

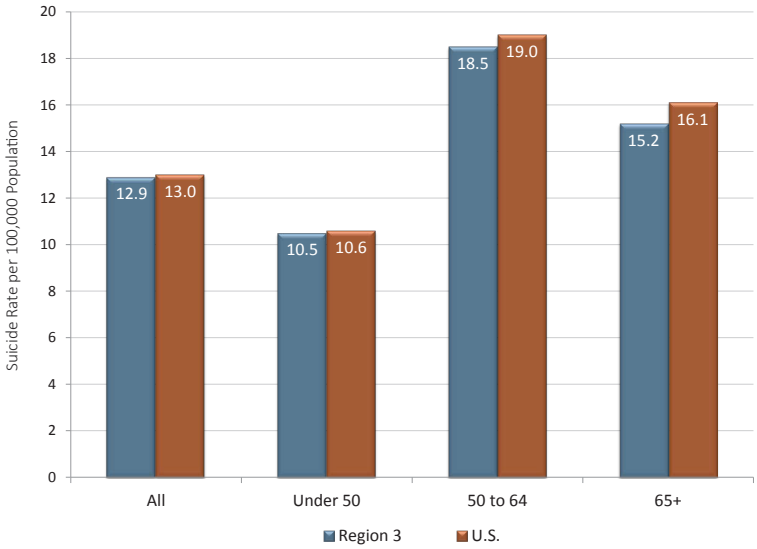
Region 3 Suicide Rates Compared With National Rates

Suicide data for Washingtonians of various age groups were unavailable. Therefore, the rates for Region 3 (including Delaware, Maryland, Pennsylvania, Virginia, and West Virginia) are used instead.

The suicide rate among individuals ages 50+ in Region 3 was higher than the rate among younger age groups. In 2013, the total suicide rate among all people ages 50+ was 17.1 per 100,000 people (6.2 for women and 29.9 for men). The rate among those ages 50–64 was lower than the rate in the United States.

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

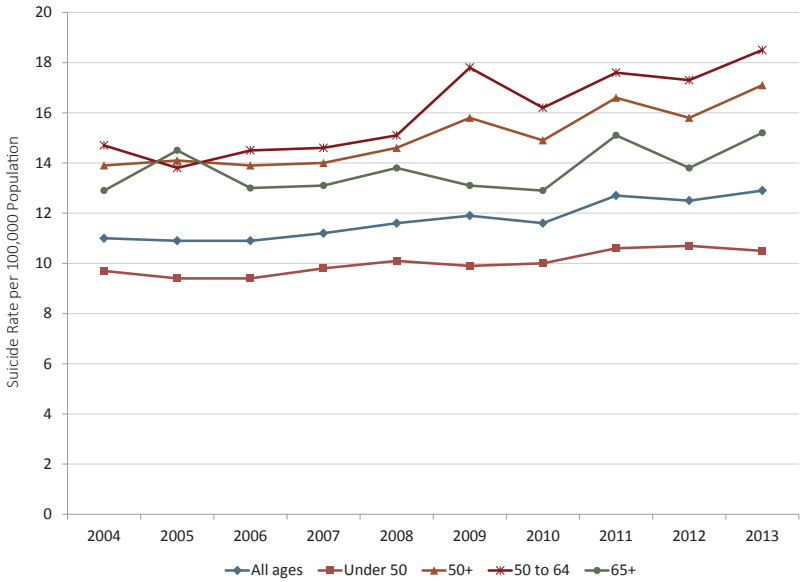
Exhibit 3. Suicide Rates in Region 3 and the United States, 2013



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 Region 3

Exhibit 4. Trends in Suicide Rates in Region 3 by Age Group, 2004–2013



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

Suicide data for Washingtonians of various ages were unavailable. Therefore, the rates for Region 3 are used instead.

The suicide rate among individuals in Region 3 ages 50+ fluctuated from a low of 13.9 per 100,000 in 2004 and 2006 to a high of 17.1 per 100,000 in 2013. From 2004 to 2013, the rate was generally highest among those in the 50–64 age group.

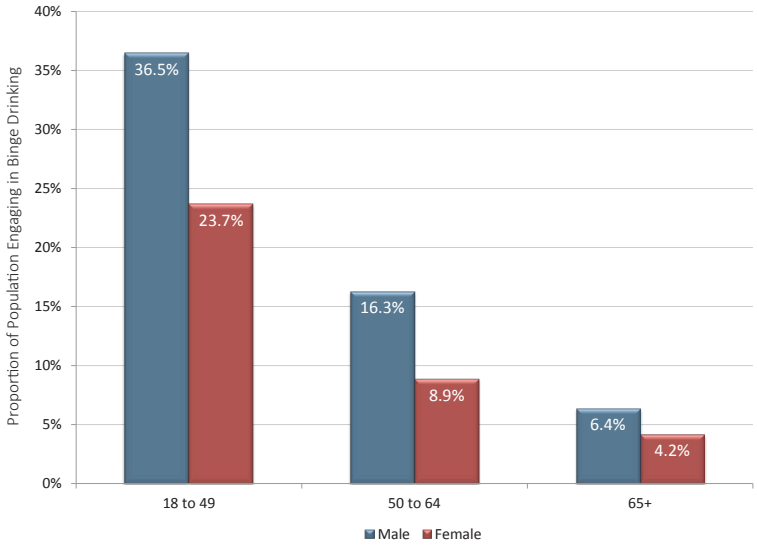
How a state reports suicides can vary from year to year. The number of suicides is generally low, so even a small difference in reported numbers may make the rate fluctuate widely.

SUBSTANCE USE DISORDER AND SUBSTANCE USE DISORDER TREATMENT AMONG OLDER WASHINGTONIANS

30-Day Binge Drinking Among Older Washingtonians

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 the District of Columbia men ages 50–64 reported binge drinking in the past 30 days, while 6.4 percent of those in the 65+ group reported similar behavior.

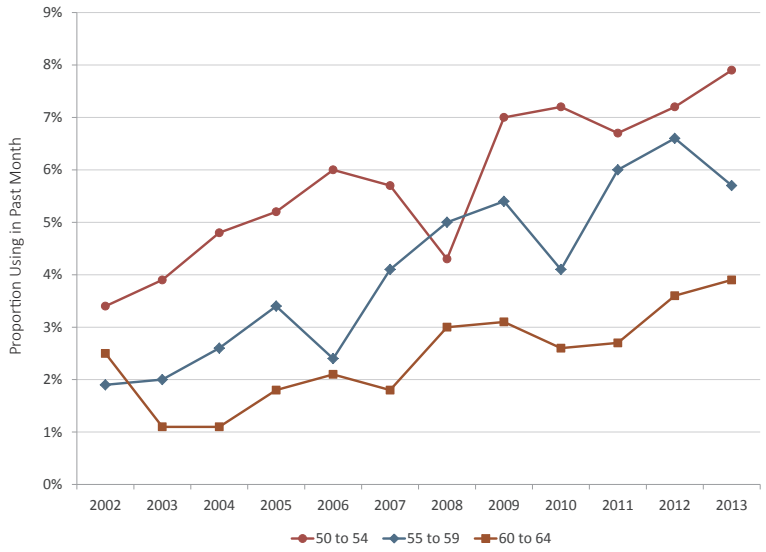
Exhibit 5. Binge Drinking Rates in the District of Columbia by Age Group and Sex, 2013



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 *District of Columbia 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).

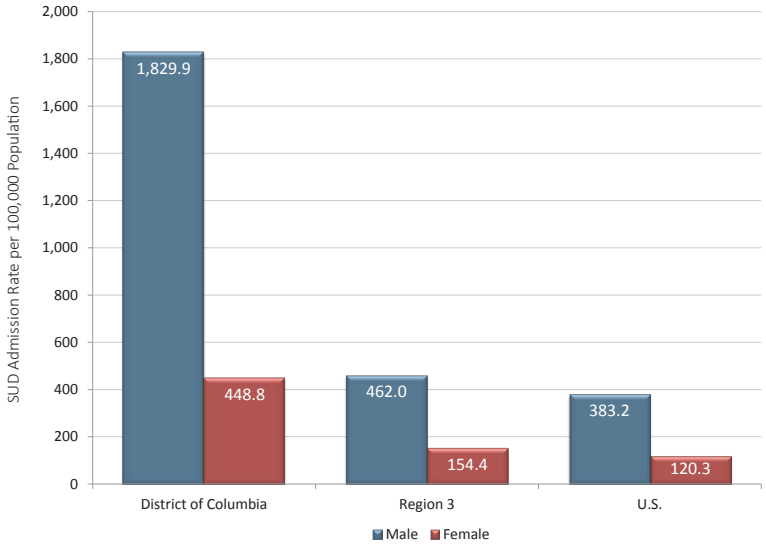
Admissions to Substance Use Disorder Treatment Among Older Washingtonians

In 2012, there were 1,953 admissions of Washingtonians ages 50 and older to substance use disorder (SUD) treatment in state-funded treatment programs, a rate of 1,068.8 per 100,000 people ages 50+. This rate was higher than the regional rate and the national average. Men made up 76.9 percent of these admissions. Of all admissions, 2.2 percent were White/Caucasian, 95.6 percent were Black/African American, and 3.5 percent were Hispanic.

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

Self-Referral	Criminal Justice	Other
24.2%	10.7%	65.0%

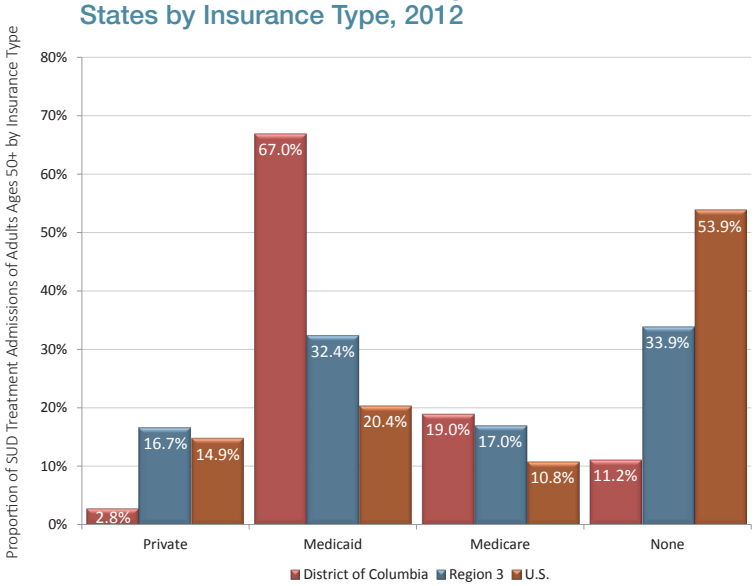
Exhibit 7. SUD Treatment Admissions of Adults Ages 50+ in the District of Columbia, Region 3, and the United States by Sex, 2012



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

SUD Treatment Admissions Among Washingtonians Ages 50+ by Insurance Type

Exhibit 8. SUD Treatment Admissions of Adults Ages 50+ in the District of Columbia, Region 3, and the United States by Insurance Type, 2012



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

In the District of Columbia, 11.2 percent of older adult admissions to SUD treatment were uninsured, 67.0 percent had Medicaid, 19.0 percent had Medicare, and 2.8 percent had private insurance.

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

Self-Pay	Medicaid	Other
2.0%	20.1%	77.9%

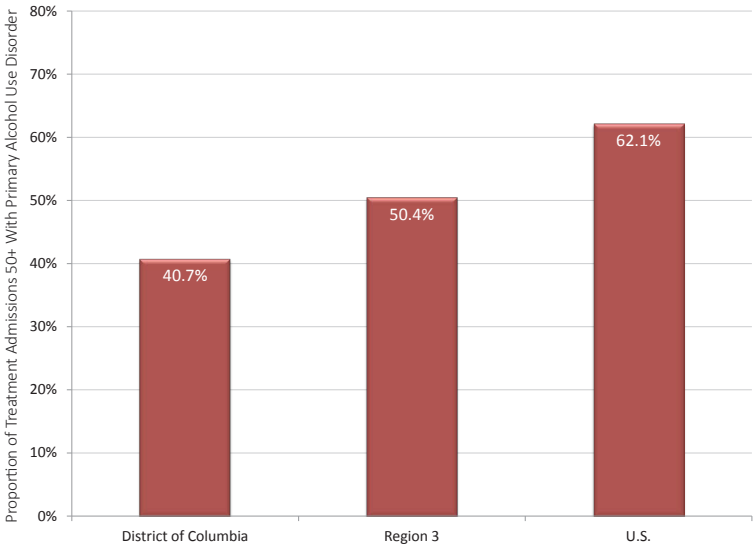
Self-pay data include private insurance.
Exhibit 8 and the accompanying text reflect the type of health insurance (if any) clients had at admission; the table above represents primary sources of payment.

[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 Washingtonians Ages 50+

Alcohol was the most frequently cited substance used by older Washingtonians in publicly financed SUD treatment in 2012. It was mentioned as a substance of use in 40.7 percent of admissions among those ages 50+. This was lower than the regional and national rates.

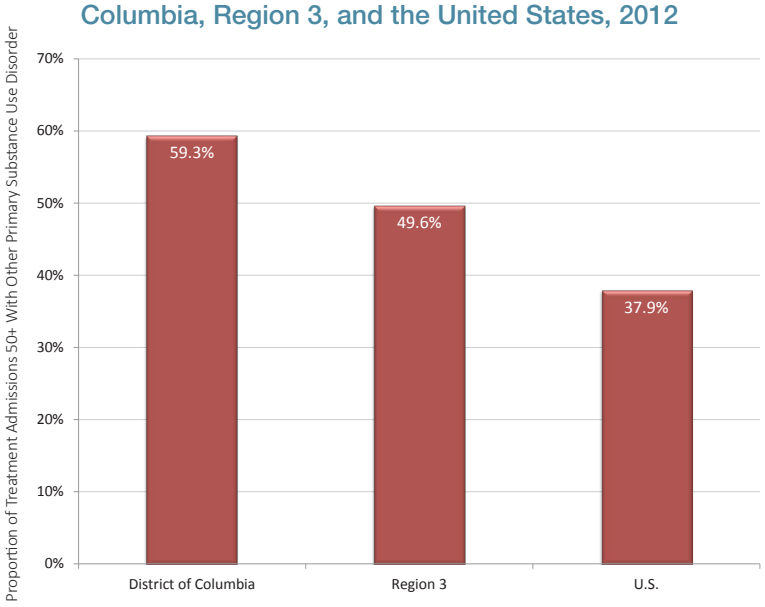
Exhibit 9. Alcohol Use Treatment Admissions of Adults Ages 50+ in the District of Columbia, Region 3, and the United States, 2012



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 the District of Columbia, Region 3, 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 59.3 percent of older adult admissions to publicly funded treatment in the District of Columbia.

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*:

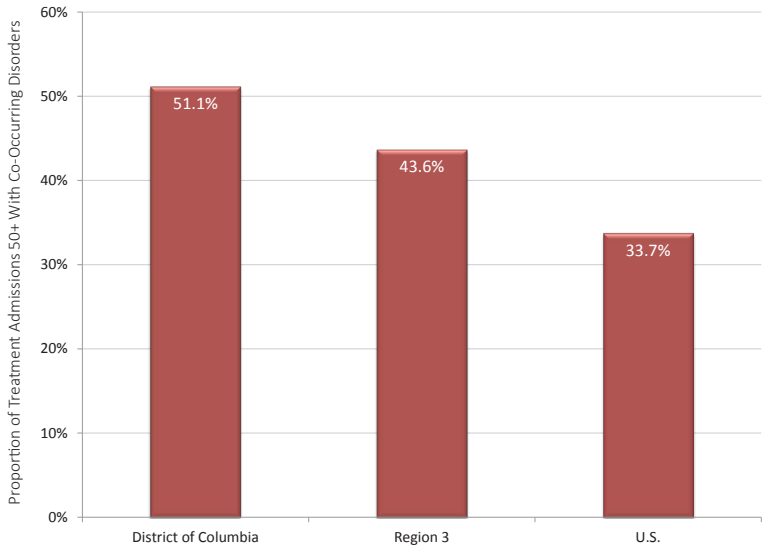
- *In 2004, there were an estimated 115,803 ED visits involving pharmaceutical misuse and abuse by adults aged 50 or older; in 2008, there were 256,097 such visits, representing an increase of 121.1 percent*
- *One fifth (19.7 percent) of ED visits involving pharmaceutical misuse and abuse among older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

Exhibit 11. SUD Treatment Admissions of Adults Ages 50+ With a Co-Occurring Mental Disorder in the District of Columbia, Region 3, 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.

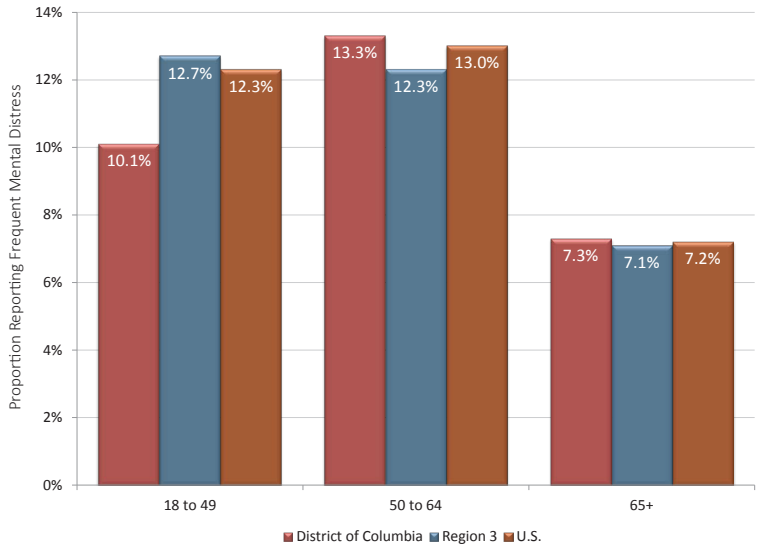
Exhibit 11 shows the proportion of SUD treatment admissions of Washingtonians ages 50+ with a co-occurring mental disorder. This rate is higher than the regional rate and the national average. However, state reporting practices are a factor in these results.

MENTAL HEALTH

Older Washingtonians 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 Washingtonians experience FMD at a rate that is higher than the regional rate and roughly similar to the national rate.

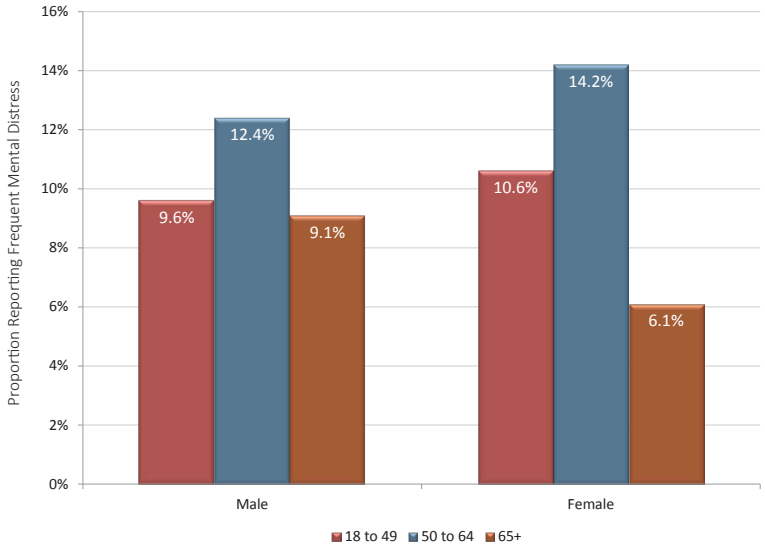
Exhibit 12. Individuals Reporting Frequent Mental Distress in the District of Columbia, Region 3, and the United States, 2013



Source: BRFSS, 2013

Older Washingtonians Reporting Frequent Mental Distress by Age Group and Sex

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



Source: BRFSS, 2013

As Exhibit 13 shows, in the District of Columbia, 12.4 percent of men in the 50–64 age group reported FMD (14 days or more per 30-day period) compared with 14.2 percent of women in this age group. Men in the 65+ age group reported a higher rate of FMD than women in the same age group (9.1 percent compared with 6.1 percent). Virginia is the only state in the region where men in the 65+ age group reported a higher rate of FMD than did women in this age group.

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 Washingtonians.

Exhibit 14. BRFSS Measures, 2010

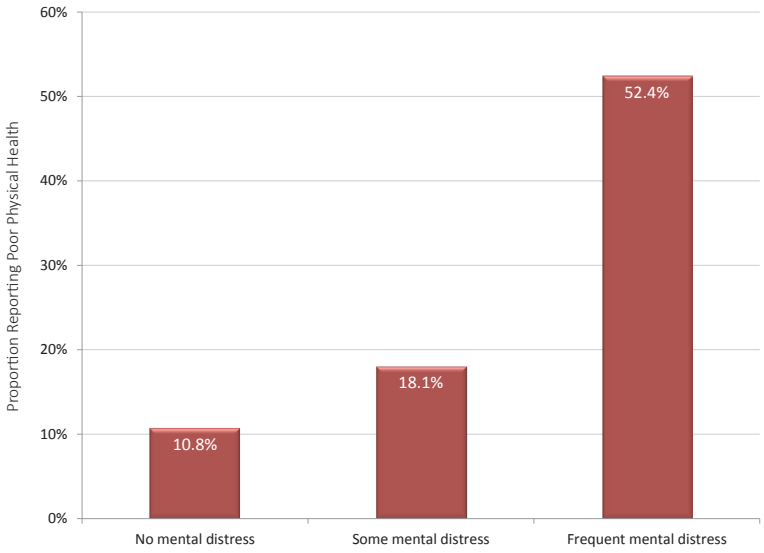
Indicator	Ages 50+	Ages 50–64	Ages 65+
Rarely or never get social or emotional support	10.8%	8.4%	15.2%
Dissatisfied or very dissatisfied	5.3%	6.5%	3.1%

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

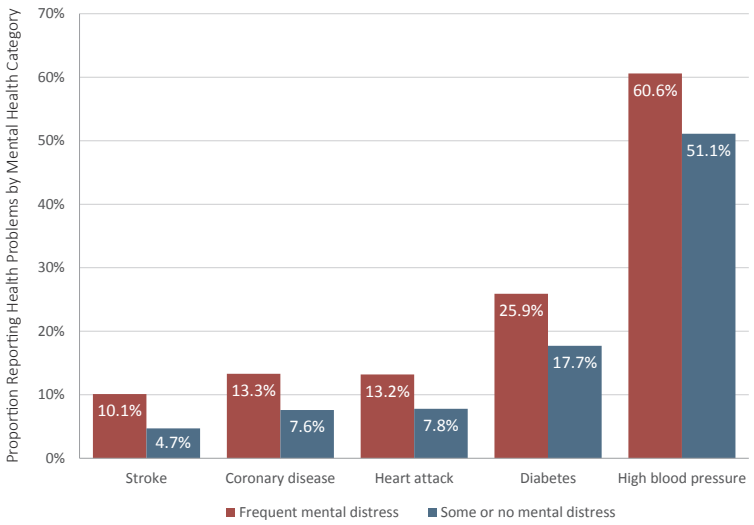


Source: BRFSS, 2013

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 Washingtonians Admitted to State Mental Health Services

Approximately 3.8 percent of the people served by the the District of Columbia mental health system were ages 65 and older. This represents more than 900 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

Maryland

Maryland

OLDER ADULTS BEHAVIORAL HEALTH PROFILE

August 2016

MARYLAND'S POPULATION

Maryland Population by Age Group

Maryland is home to 5,976,407 people. Of these:

- 2,043,018 (34.2 percent) are over age 50.
- 1,168,949 (19.6 percent) are over age 60.
- 541,496 (9.1 percent) are over age 70.
- 209,762 (3.5 percent) are ages 80 and older.

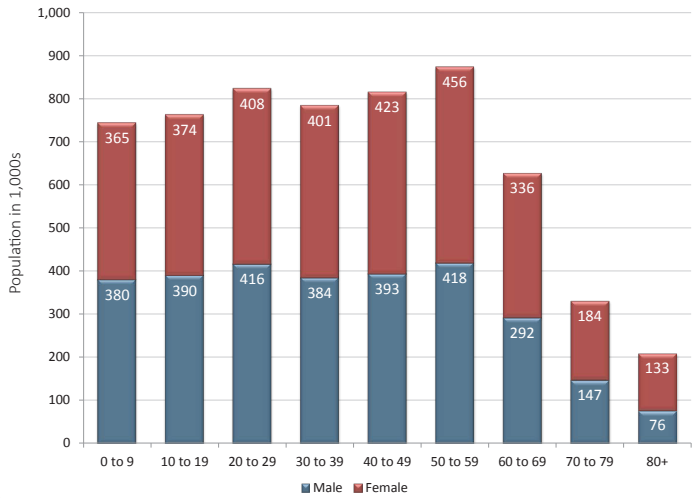
The proportion of women rises fairly steadily in each age group, and women make up 63.6 percent of the 80+ group. The racial/ethnic composition of older Marylanders is as follows:

Race/Ethnicity of Marylanders Ages 50+

White	AI/AN	Black	Asian	NH/PI	Other	Hispanic
66.9%	0.4%	26.4%	5.3%	0.1%	1.0%	4.2%

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.

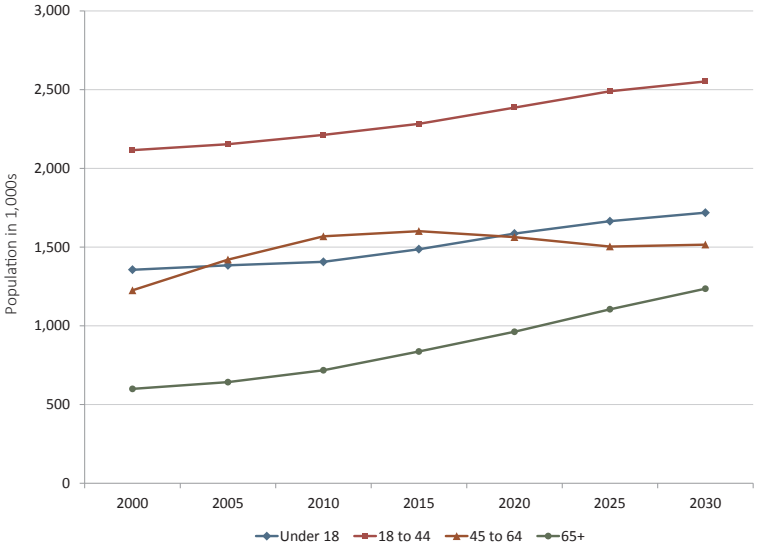
Exhibit 1. Maryland Population by Age Group, 2014



Source: U.S. Census Bureau, 2015

The Number of Older Marylanders Is Growing

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



The proportion of Maryland'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 17.6 percent of Maryland's population will be 65 and older by the year 2030, an increase of 47.6 percent from 2015.

Projected Population in Maryland

Age Group	2015	2025	2030
Under 18	23.9%	24.6%	24.5%
18 to 44	36.8%	36.8%	36.3%
45 to 64	25.8%	22.2%	21.6%
65+	13.5%	16.3%	17.6%

Source: U.S. Census Bureau, 2005

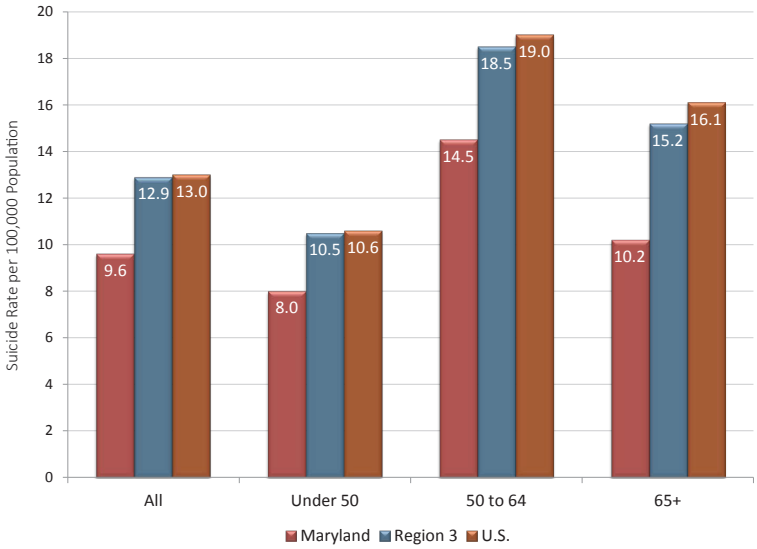
SUICIDE AMONG OLDER MARYLANDERS

Maryland Suicide Rate Compared With Regional and National Rates

The suicide rate among Marylanders 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 12.8 per 100,000 people (4.8 for women and 22.3 for men). The rate among those ages 50–64 was lower than both the rate in the region (including Delaware, the District of Columbia, Pennsylvania, Virginia, and West Virginia) and the rate in the United States.

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

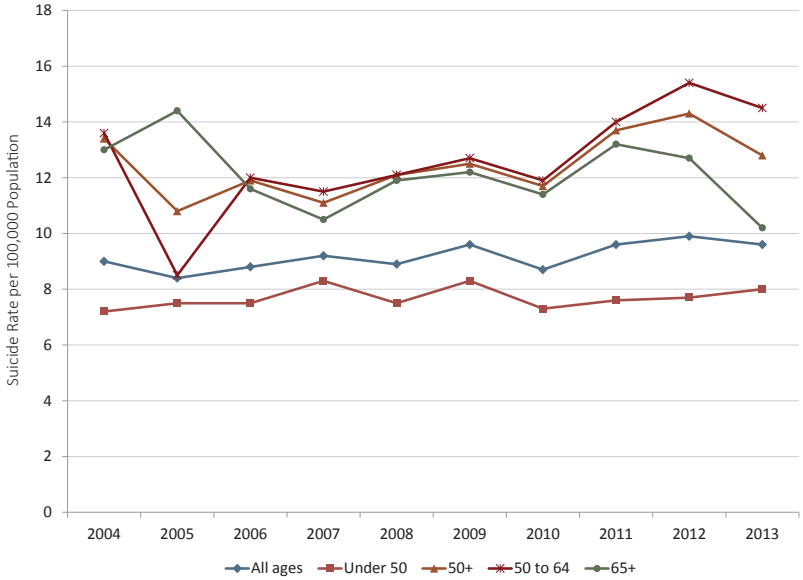
Exhibit 3. Suicide Rates in Maryland, Region 3, and the United States, 2013



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 Maryland

Exhibit 4. Trends in Suicide Rates in Maryland 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 Marylanders ages 50+ fluctuated from a low of 10.8 per 100,000 in 2005 to a high of 14.3 per 100,000 in 2012. From 2004 to 2013, the rate was generally highest among those in the 50–64 age group.

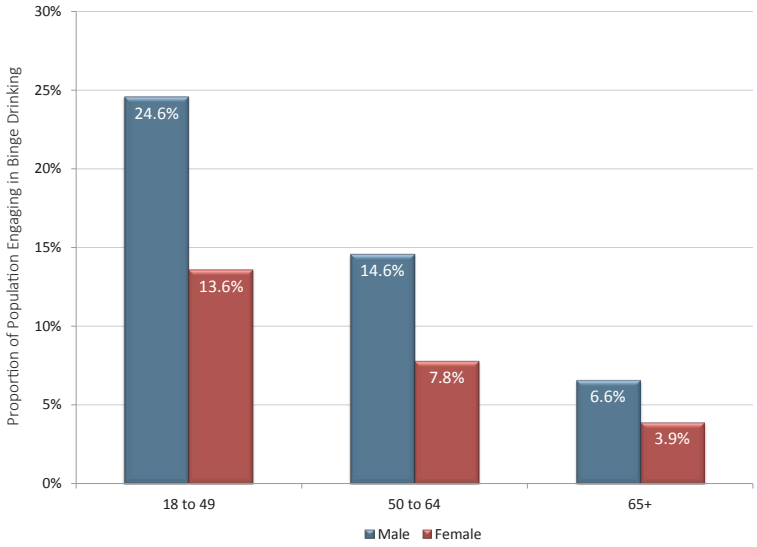
How a state reports suicides can vary from year to year. The number of suicides is generally low, so even a small difference in reported numbers may make the rate fluctuate widely.

SUBSTANCE USE DISORDER AND SUBSTANCE USE DISORDER TREATMENT AMONG OLDER MARYLANDERS

30-Day Binge Drinking Among Older Marylanders

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, 14.6 percent of Maryland men ages 50–64 reported binge drinking in the past 30 days, while 6.6 percent of those in the 65+ group reported similar behavior.

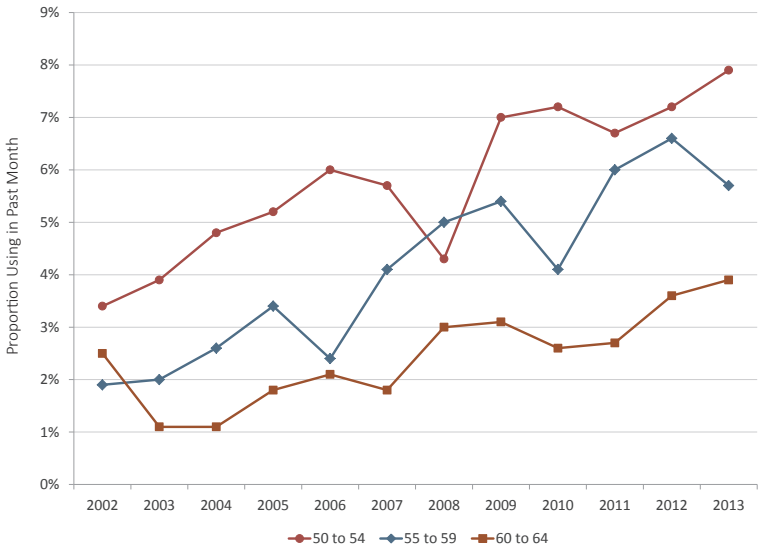
Exhibit 5. Binge Drinking Rates in Maryland by Age Group and Sex, 2013



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 *Maryland 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).

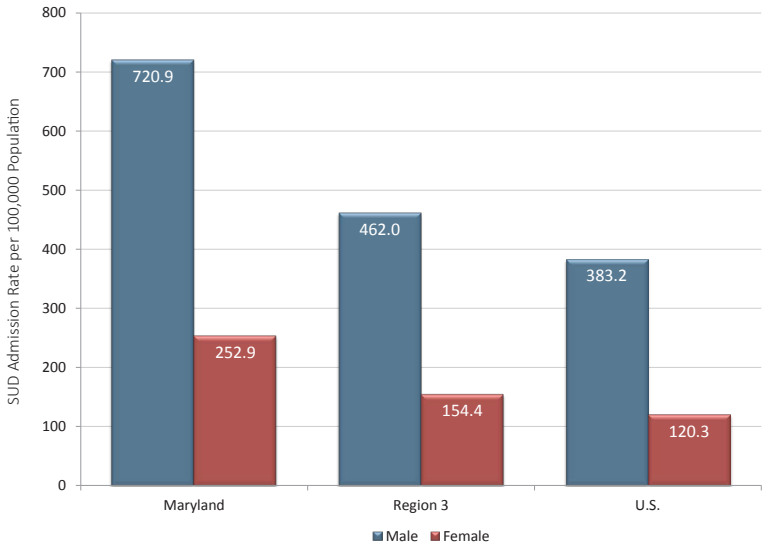
Admissions to Substance Use Disorder Treatment Among Older Marylanders

In 2012, there were 9,536 admissions of Marylanders ages 50 and older to substance use disorder (SUD) treatment in state-funded treatment programs, a rate of 466.8 per 100,000 people ages 50+. This rate was higher than the regional rate and the national average. Men made up 70.6 percent of these admissions. Of all admissions, 43.9 percent were White/Caucasian, 54.1 percent were Black/African American, and 2.7 percent were Hispanic.

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

Self-Referral	Criminal Justice	Other
39.5%	25.7%	34.7%

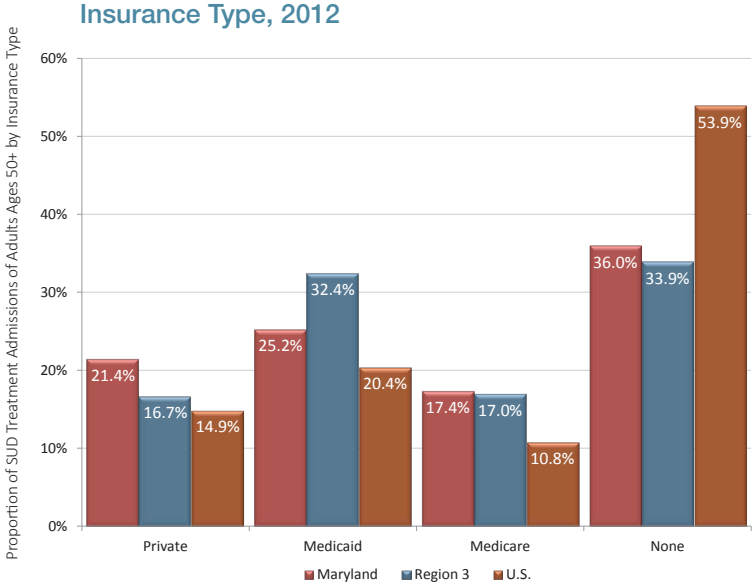
Exhibit 7. SUD Treatment Admissions of Adults Ages 50+ in Maryland, Region 3, and the United States by Sex, 2012



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

SUD Treatment Admissions Among Marylanders Ages 50+ by Insurance Type

Exhibit 8. SUD Treatment Admissions of Adults Ages 50+ in Maryland, Region 3, and the United States by Insurance Type, 2012



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

In Maryland, 36.0 percent of older adult admissions to SUD treatment were uninsured, 25.2 percent had Medicaid, 17.4 percent had Medicare, and 21.4 percent had private insurance.

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

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

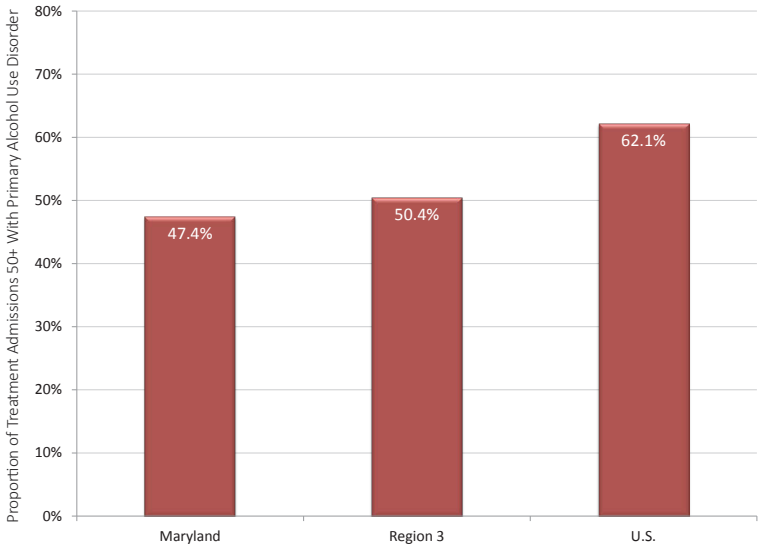
Exhibit 8 and the accompanying text reflect the type of health insurance (if any) clients had at admission; the table above represents primary sources of payment.

[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 Marylanders Ages 50+

Alcohol was the most frequently cited substance used by older Marylanders in publicly financed SUD treatment in 2012. It was mentioned as a substance of use in 47.4 percent of admissions among those ages 50+. This was lower than the regional and national rates.

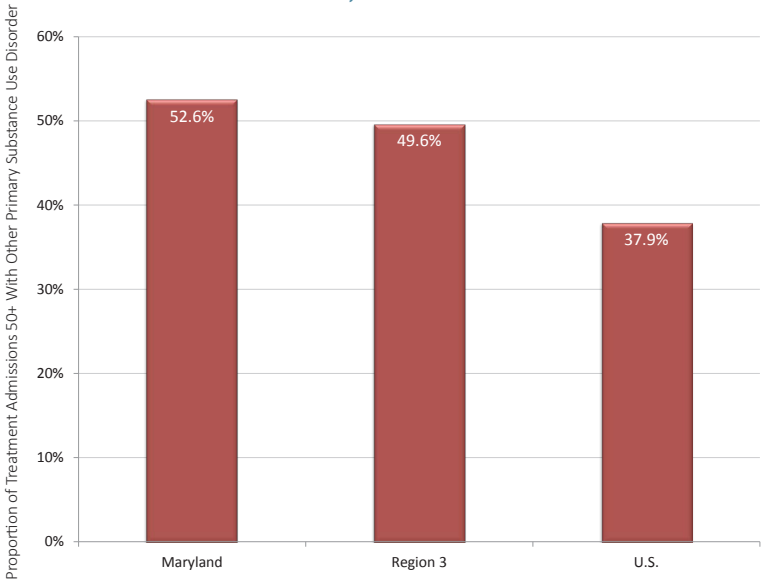
Exhibit 9. Alcohol Use Treatment Admissions of Adults Ages 50+ in Maryland, Region 3, and the United States, 2012



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 Maryland, Region 3, 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 52.6 percent of older adult admissions to publicly funded treatment in Maryland.

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*:

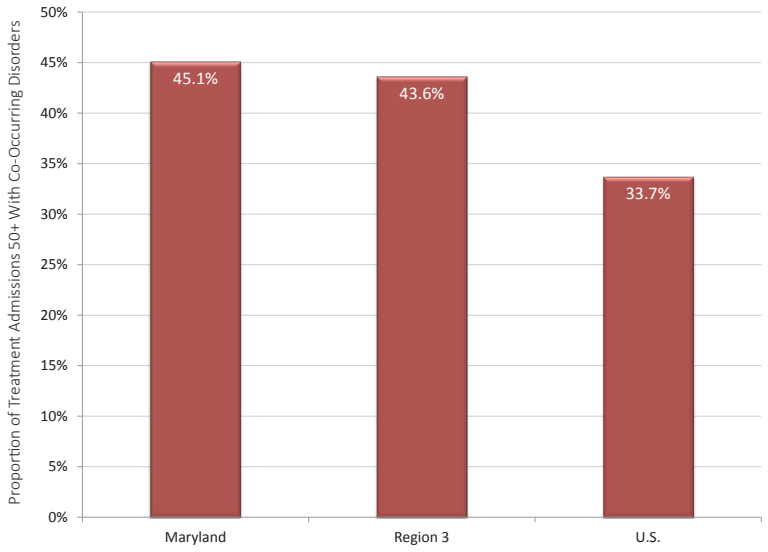
- *In 2004, there were an estimated 115,803 ED visits involving pharmaceutical misuse and abuse by adults aged 50 or older; in 2008, there were 256,097 such visits, representing an increase of 121.1 percent*
- *One fifth (19.7 percent) of ED visits involving pharmaceutical misuse and abuse among older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

Exhibit 11. SUD Treatment Admissions of Adults Ages 50+ With a Co-Occurring Mental Disorder in Maryland, Region 3, 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.

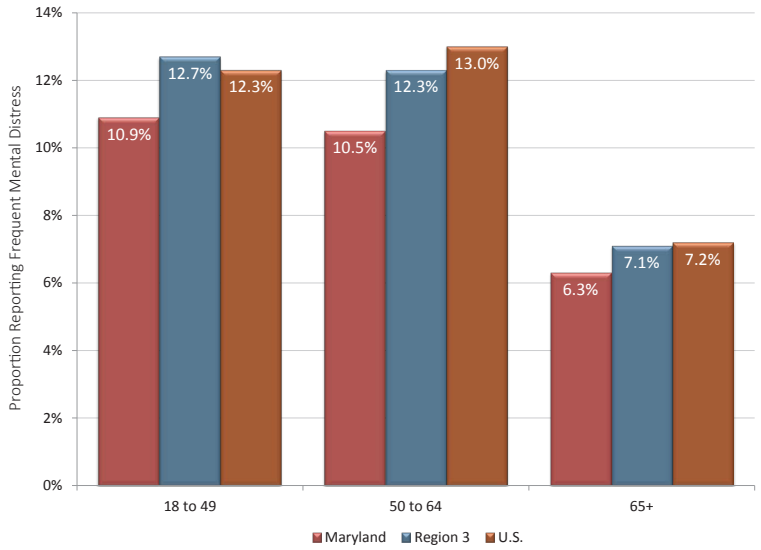
Exhibit 11 shows the proportion of SUD treatment admissions of Marylanders ages 50+ with a co-occurring mental disorder. This rate is higher than the regional rate and the national average. However, state reporting practices are a factor in these results.

MENTAL HEALTH

Older Marylanders 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 Marylanders experience FMD at a rate that is lower than the regional and national rates.

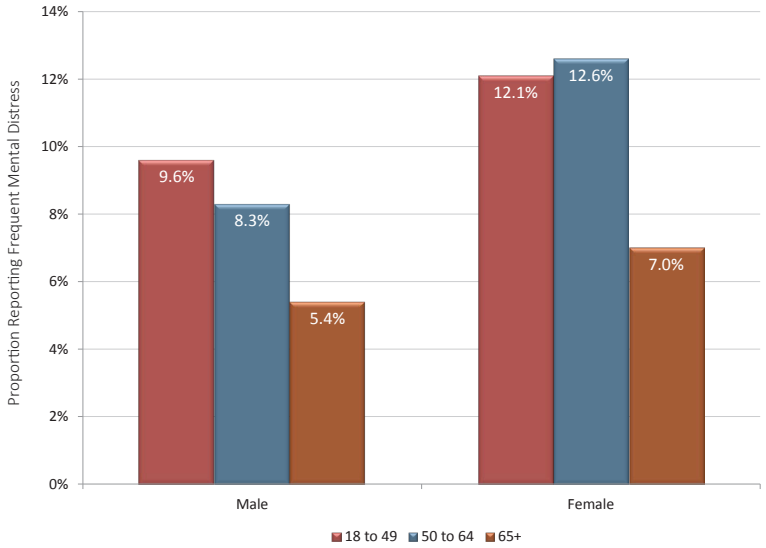
Exhibit 12. Individuals Reporting Frequent Mental Distress in Maryland, Region 3, and the United States, 2013



Source: BRFSS, 2013

Older Marylanders Reporting Frequent Mental Distress by Age Group and Sex

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



Source: BRFSS, 2013

Older men in Maryland 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, 12.6 percent of women in the 50–64 age group and 7.0 percent in the 65+ age group reported FMD, while 8.3 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 Marylanders.

Exhibit 14. BRFSS Measures, 2010

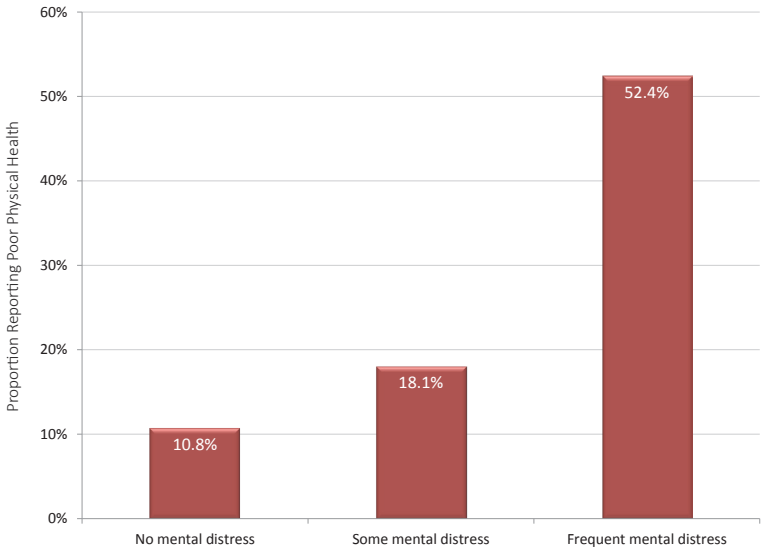
Indicator	Ages 50+	Ages 50–64	Ages 65+
Rarely or never get social or emotional support	8.1%	7.1%	9.6%
Dissatisfied or very dissatisfied	5.0%	5.2%	4.8%

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

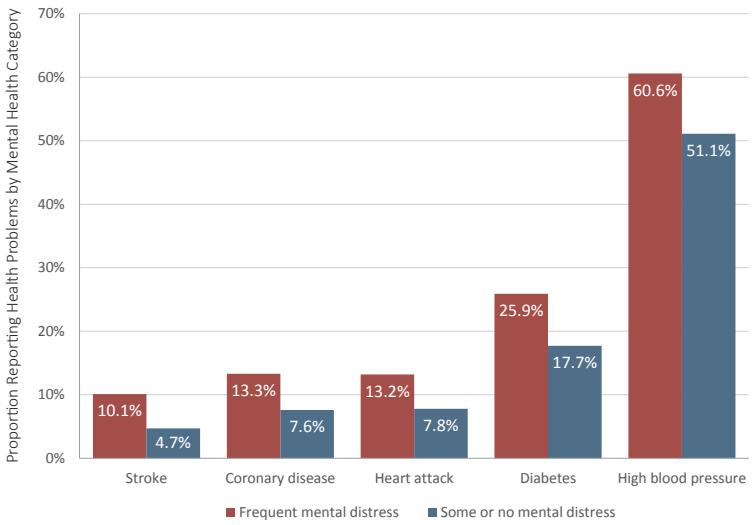


Source: BRFSS, 2013

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 Marylanders Admitted to State Mental Health Services

Approximately 1.1 percent of the people served by the Maryland mental health system were ages 65 and older. This represents more than 1,850 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

Pennsylvania

Pennsylvania

OLDER ADULTS BEHAVIORAL HEALTH PROFILE

August 2016

PENNSYLVANIA'S POPULATION

Pennsylvania Population by Age Group

Pennsylvania is home to 12,787,209 people. Of these:

- 4,851,157 (37.9 percent) are over age 50.
- 2,953,705 (23.1 percent) are over age 60.
- 1,470,225 (11.5 percent) are over age 70.
- 618,011 (4.8 percent) are ages 80 and older.

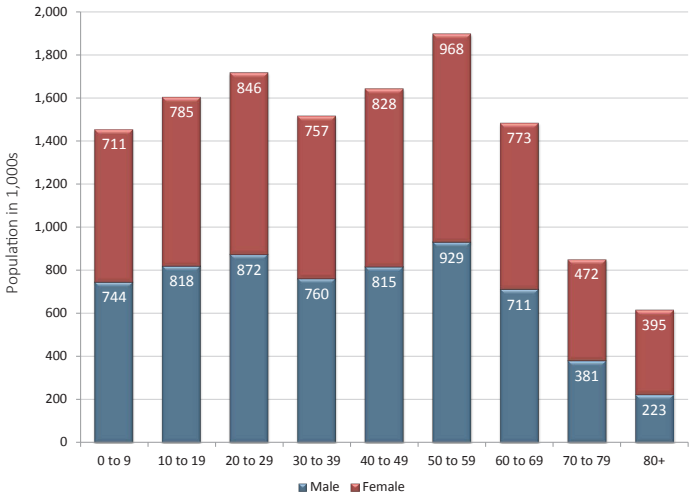
The proportion of women rises fairly steadily in each age group, and women make up 63.9 percent of the 80+ group. The racial/ethnic composition of older Pennsylvanians is as follows:

Race/Ethnicity of Pennsylvanians Ages 50+

White	AI/AN	Black	Asian	NH/PI	Other	Hispanic
88.8%	0.2%	8.4%	2.0%	0.0%	0.6%	2.8%

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.

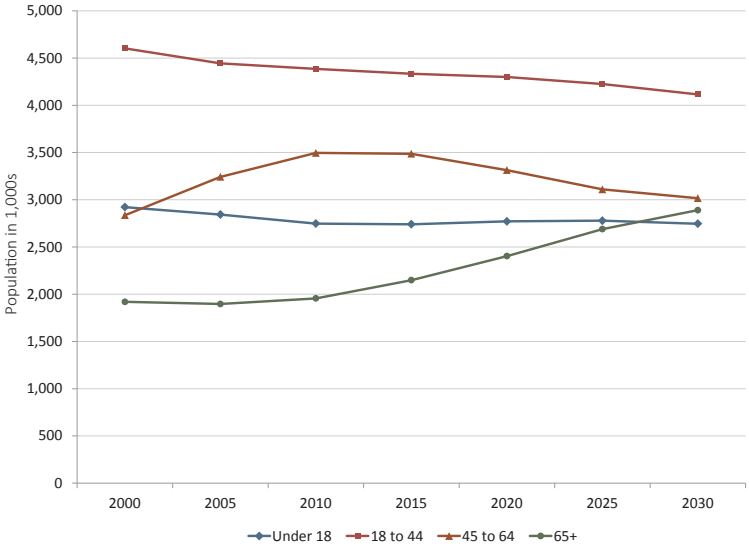
Exhibit 1. Pennsylvania Population by Age Group, 2014



Source: U.S. Census Bureau, 2015

The Number of Older Pennsylvanians Is Growing

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



The proportion of Pennsylvania'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 22.6 percent of Pennsylvania's population will be 65 and older by the year 2030, an increase of 34.5 percent from 2015.

Projected Population in Pennsylvania

Age Group	2015	2025	2030
Under 18	21.6%	21.7%	21.5%
18 to 44	34.1%	33.0%	32.2%
45 to 64	27.4%	24.3%	23.6%
65+	16.9%	21.0%	22.6%

Source: U.S. Census Bureau, 2005

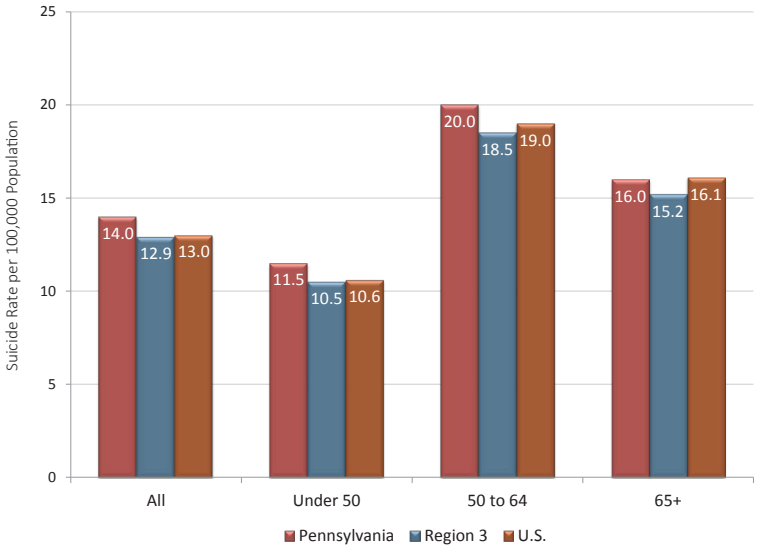
SUICIDE AMONG OLDER PENNSYLVANIANS

Pennsylvania Suicide Rate Compared With Regional and National Rates

The suicide rate among Pennsylvanians 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 18.2 per 100,000 people (6.7 for women and 31.7 for men). The rate among those ages 50–64 was higher than both the rate in the region (including Delaware, the District of Columbia, Maryland, Virginia, and West Virginia) and the rate in the United States.

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

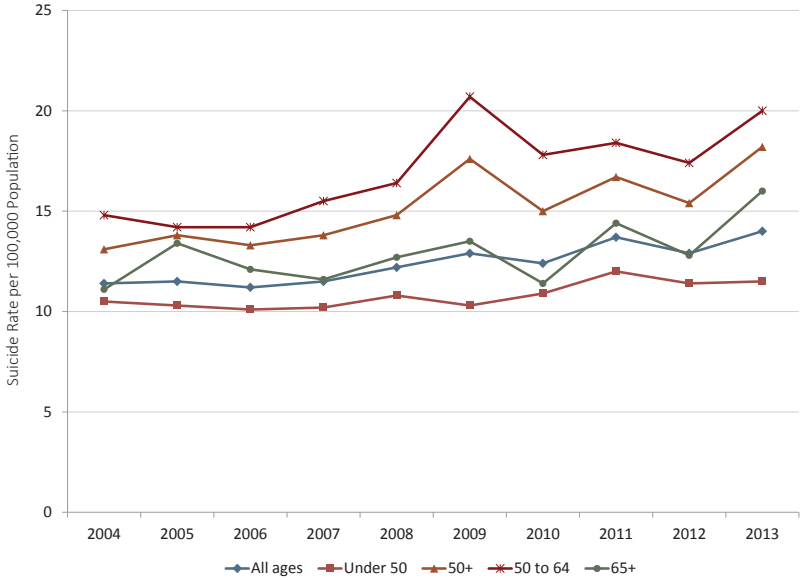
Exhibit 3. Suicide Rates in Pennsylvania, Region 3, and the United States, 2013



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 Pennsylvania

Exhibit 4. Trends in Suicide Rates in Pennsylvania 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 Pennsylvanians ages 50+ fluctuated from a low of 13.1 per 100,000 in 2004 to a high of 18.2 per 100,000 in 2013. From 2004 to 2013, the rate was highest among those in the 50–64 age group.

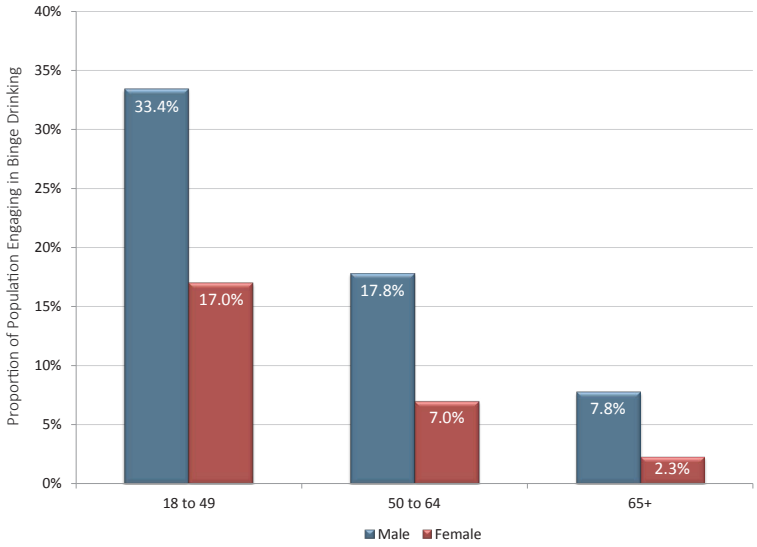
How a state reports suicides can vary from year to year. The number of suicides is generally low, so even a small difference in reported numbers may make the rate fluctuate widely.

SUBSTANCE USE DISORDER AND SUBSTANCE USE DISORDER TREATMENT AMONG OLDER PENNSYLVANIANS

30-Day Binge Drinking Among Older Pennsylvanians

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, 17.8 percent of Pennsylvania men ages 50–64 reported binge drinking in the past 30 days, while 7.8 percent of those in the 65+ group reported similar behavior.

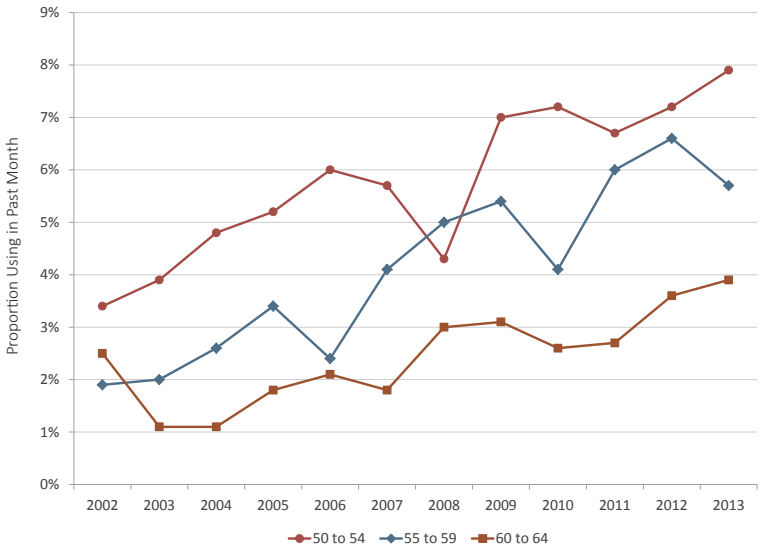
Exhibit 5. Binge Drinking Rates in Pennsylvania by Age Group and Sex, 2013



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 *Pennsylvania 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 Adults in Region 3

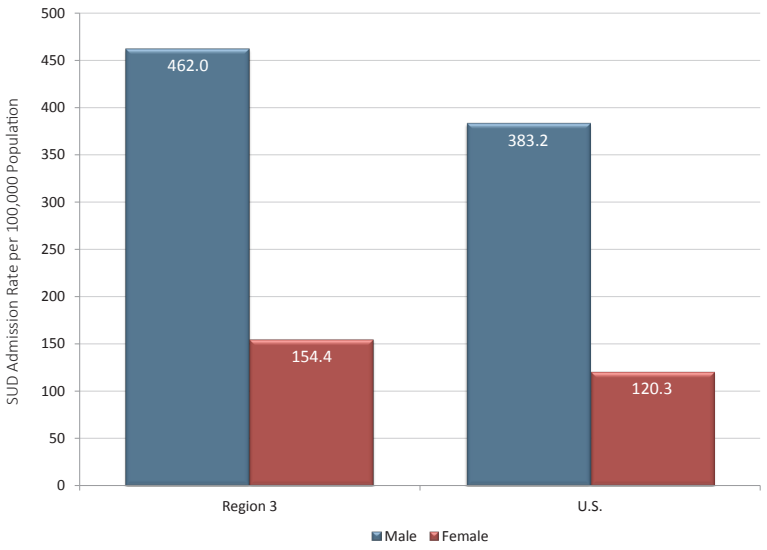
Treatment Episode Data Set (TEDS) data for Pennsylvania in 2012 are unavailable. Therefore, data for Region 3 are used instead.

In 2012, there were 15,911 admissions of individuals in Region 3 ages 50 and older to substance use disorder (SUD) treatment in state-funded treatment programs, a rate of 296.3 per 100,000 people ages 50+. This rate was higher than the national average. Men made up 71.9 percent of these admissions. Of all admissions, 42.5 percent were White/Caucasian, 54.7 percent were Black/African American, and 3.0 percent were Hispanic.

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

Self-Referral	Criminal Justice	Other
38.9%	25.9%	35.3%

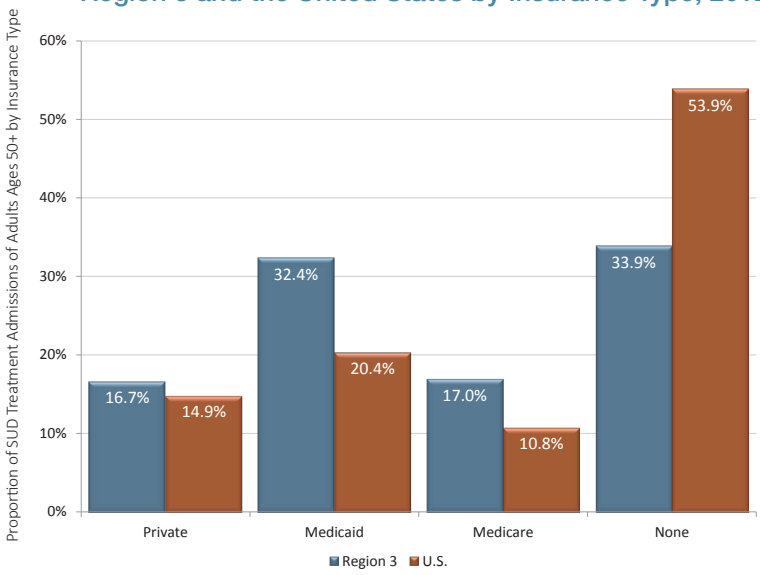
Exhibit 7. SUD Treatment Admissions of Adults Ages 50+ in Region 3 and the United States by Sex, 2012



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

SUD Treatment Admissions Among Individuals in Region 3 Ages 50+ by Insurance Type

Exhibit 8. SUD Treatment Admissions of Adults Ages 50+ in Region 3 and the United States by Insurance Type, 2012



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

TEDS data for Pennsylvania in 2012 are unavailable. Therefore, data for Region 3 are used instead.

In Region 3, 33.9 percent of older adult admissions to SUD treatment were uninsured, 32.4 percent had Medicaid, 17.0 percent had Medicare, and 16.7 percent had private insurance.

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

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.

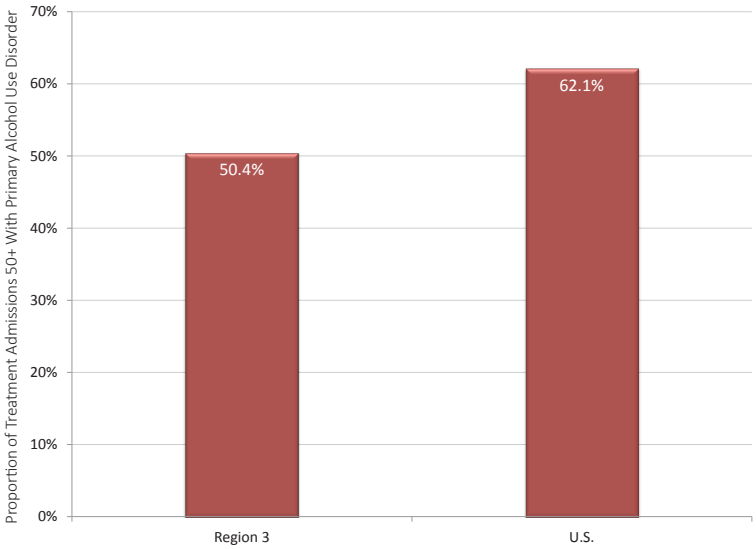
[1] TEDS data are collected by states as a condition of the Substance Abuse Prevention and Treatment Block Grant. Guidelines suggest that states report all clients admitted to publicly financed treatment; however, states are inconsistent in applying the guidelines. States may structure and implement 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 Individuals in Region 3 Ages 50+

TEDS data for Pennsylvania in 2012 are unavailable. Therefore, data for Region 3 are used instead.

Alcohol was the most frequently cited substance used by older individuals in Region 3 in publicly financed SUD treatment in 2012. It was mentioned as a substance of use in 50.4 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 3 and the United States, 2012



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

SUD Treatment Admissions for Non-Alcohol Substance Use in Region 3

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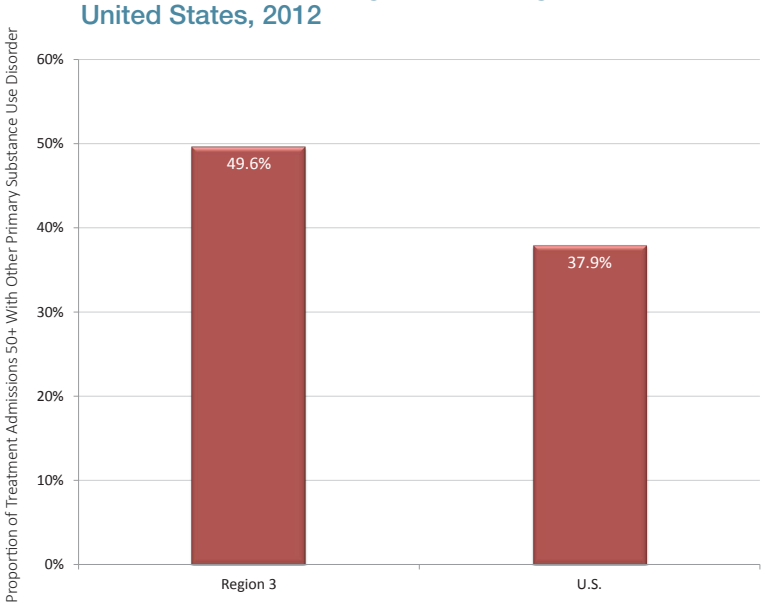

Source: TEDS, 2012
Data include only those clients reported to SAMHSA.

TEDS data for Pennsylvania in 2012 are unavailable. Therefore, data for Region 3 are used instead.

Substances other than alcohol were cited as the primary substances of use for 49.6 percent of older adult admissions to publicly funded treatment in Region 3.

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*:

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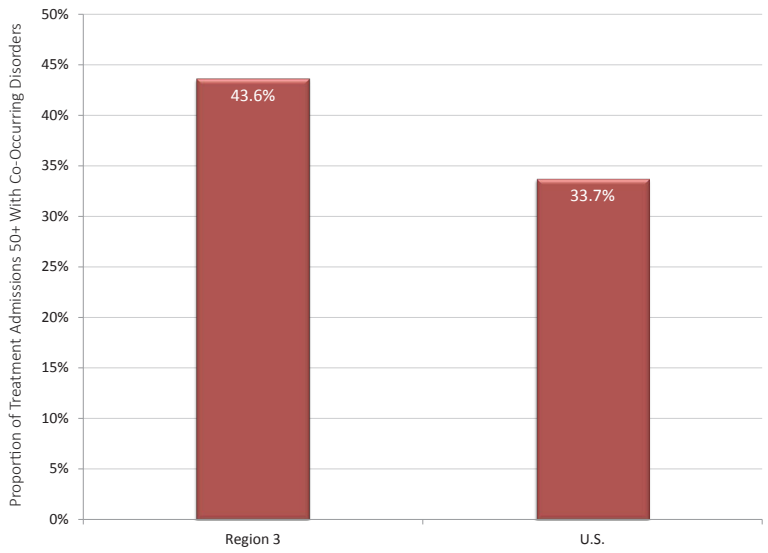
CO-OCCURRING SUBSTANCE USE AND MENTAL DISORDERS

Older Adults in Region 3 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 3 and the United States, 2012



Source: TEDS, 2012
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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.

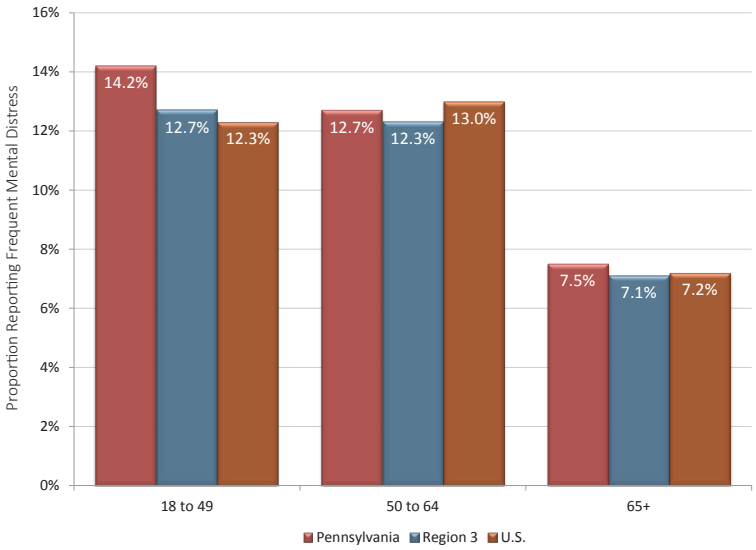
TEDS data for Pennsylvania in 2012 are unavailable. Therefore, Exhibit 11 shows regional and national figures only.

MENTAL HEALTH

Older Pennsylvanians 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 Pennsylvanians experience FMD at a rate that is higher than the regional rate and roughly similar to the national rate.

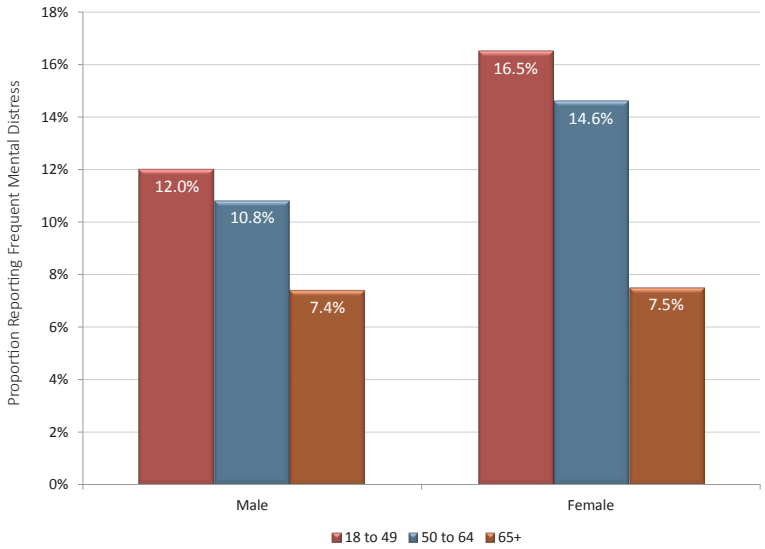
Exhibit 12. Individuals Reporting Frequent Mental Distress in Pennsylvania, Region 3, and the United States, 2013



Source: BRFSS, 2013

Older Pennsylvanians Reporting Frequent Mental Distress by Age Group and Sex

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



Source: BRFSS, 2013

Older men in Pennsylvania 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, 14.6 percent of women in the 50–64 age group and 7.5 percent in the 65+ age group reported FMD, while 10.8 percent of men in the 50–64 age group and 7.4 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 Pennsylvanians.

Exhibit 14. BRFSS Measures, 2010

Indicator	Ages 50+	Ages 50–64	Ages 65+
Rarely or never get social or emotional support	9.6%	7.4%	12.4%
Dissatisfied or very dissatisfied	5.0%	6.1%	3.6%

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.

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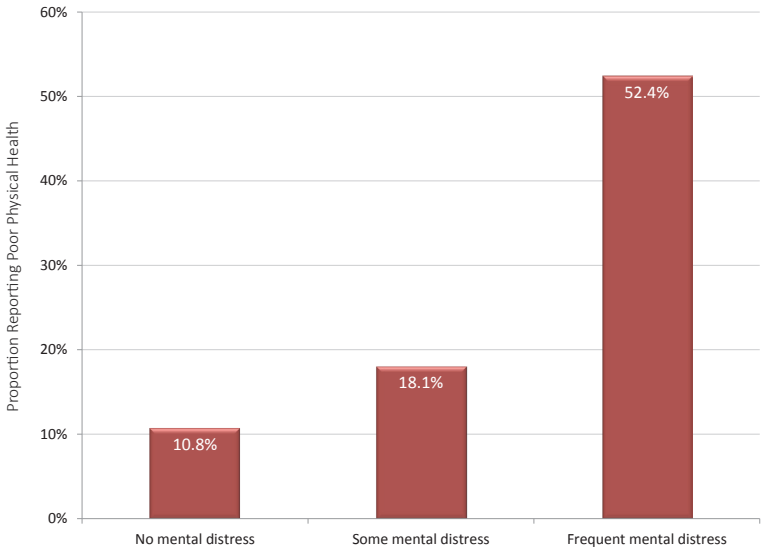
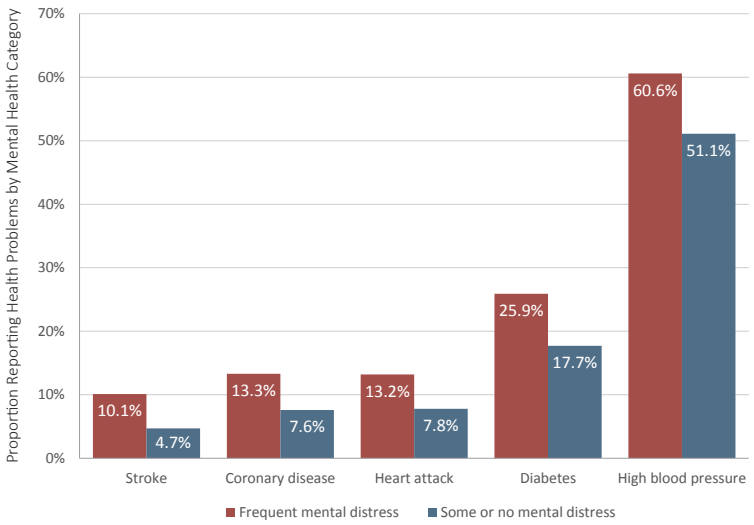


Source: BRFSS, 2013

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 Pennsylvanians Admitted to State Mental Health Services

Approximately 3.7 percent of the people served by the Pennsylvania mental health system were ages 65 and older. This represents more than 22,820 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.

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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

Virginia

Virginia

OLDER ADULTS BEHAVIORAL HEALTH PROFILE

August 2016

VIRGINIA'S POPULATION

Virginia Population by Age Group

Virginia is home to 8,326,289 people. Of these:

- 2,796,109 (33.6 percent) are over age 50.
- 1,623,093 (19.5 percent) are over age 60.
- 750,055 (9.0 percent) are over age 70.
- 274,188 (3.3 percent) are ages 80 and older.

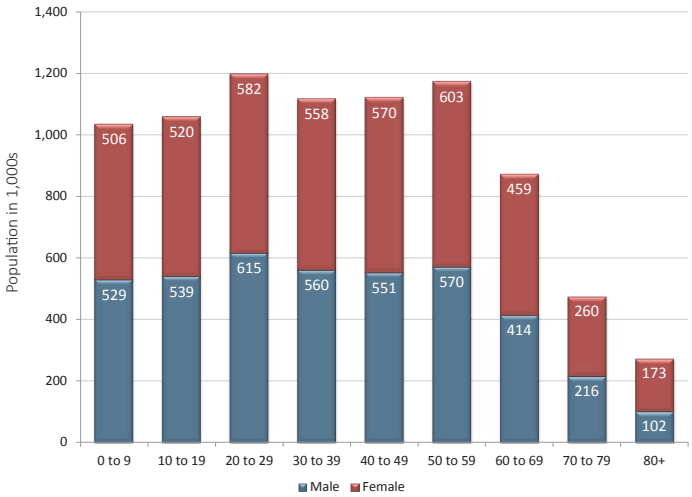
The proportion of women rises fairly steadily in each age group, and women make up 62.9 percent of the 80+ group. The racial/ethnic composition of older Virginians is as follows:

Race/Ethnicity of Virginians Ages 50+

White	AI/AN	Black	Asian	NH/PI	Other	Hispanic
76.3%	0.4%	17.4%	4.8%	0.1%	1.0%	3.9%

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.

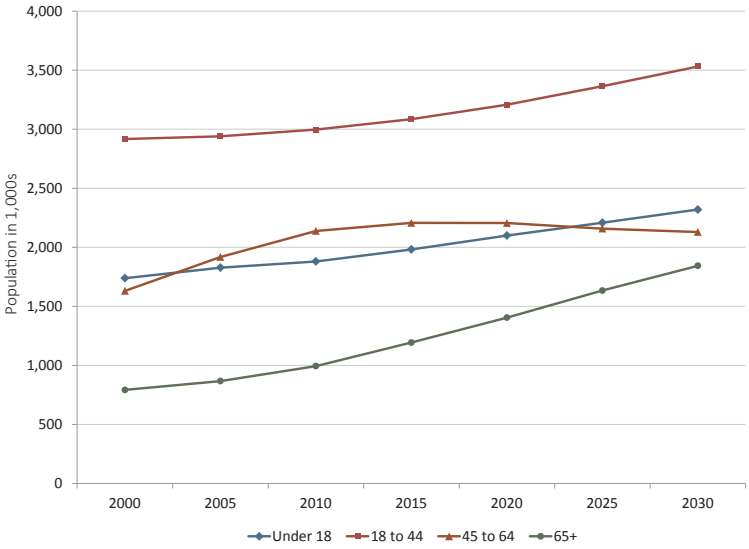
Exhibit 1. Virginia Population by Age Group, 2014



Source: U.S. Census Bureau, 2015

The Number of Older Virginians Is Growing

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



The proportion of Virginia'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 18.8 percent of Virginia's population will be 65 and older by the year 2030, an increase of 54.5 percent from 2015.

Projected Population in Virginia

Age Group	2015	2025	2030
Under 18	23.4%	23.6%	23.6%
18 to 44	36.4%	35.9%	35.9%
45 to 64	26.1%	23.0%	21.7%
65+	14.1%	17.4%	18.8%

Source: U.S. Census Bureau, 2005

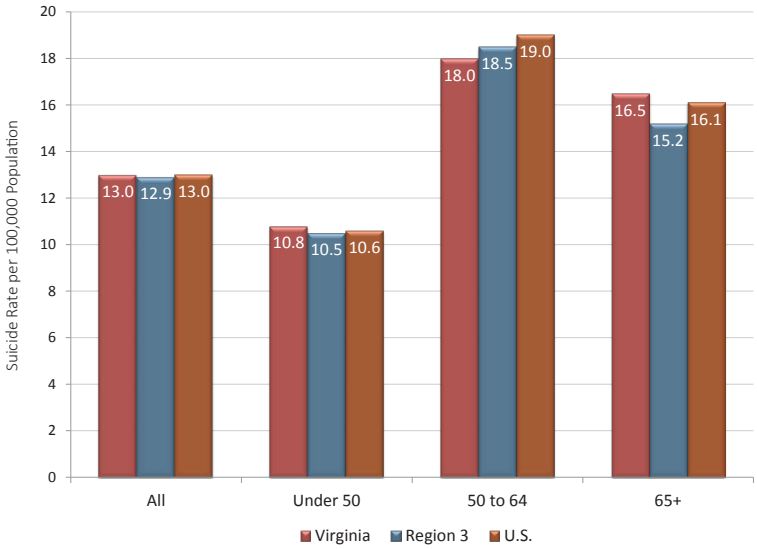
SUICIDE AMONG OLDER VIRGINIANS

Virginia Suicide Rate Compared With Regional and National Rates

The suicide rate among Virginians 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 17.4 per 100,000 people (6.6 for women and 29.8 for men). The rate among those ages 50–64 was lower than both the rate in the region (including Delaware, the District of Columbia, Maryland, Pennsylvania, and West Virginia) and the rate in the United States.

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

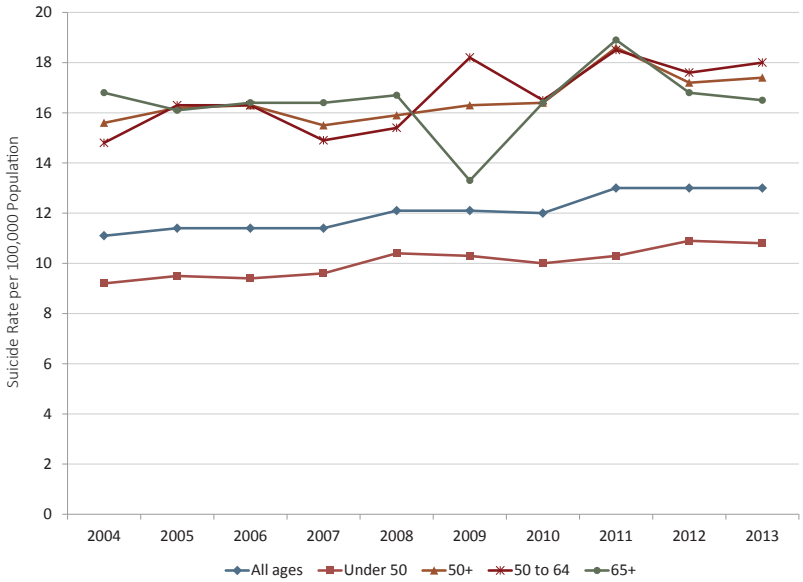
Exhibit 3. Suicide Rates in Virginia, Region 3, and the United States, 2013



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 Virginia

Exhibit 4. Trends in Suicide Rates in Virginia 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 Virginians ages 50+ fluctuated from a low of 15.5 per 100,000 in 2007 to a high of 18.6 per 100,000 in 2011. From 2004 to 2013, the rate was highest among those in the 50–64 and 65+ age groups.

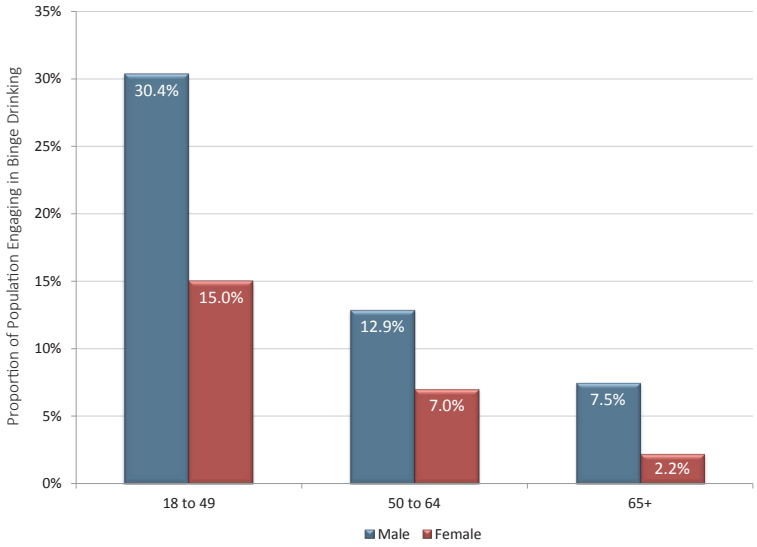
How a state reports suicides can vary from year to year. The number of suicides is generally low, so even a small difference in reported numbers may make the rate fluctuate widely.

SUBSTANCE USE DISORDER AND SUBSTANCE USE DISORDER TREATMENT AMONG OLDER VIRGINIANS

30-Day Binge Drinking Among Older Virginians

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, 12.9 percent of Virginia men ages 50–64 reported binge drinking in the past 30 days, while 7.5 percent of those in the 65+ group reported similar behavior.

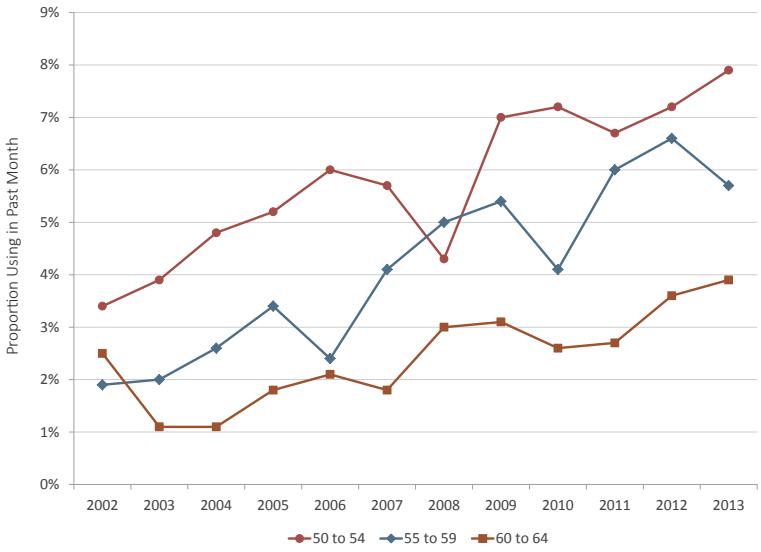
Exhibit 5. Binge Drinking Rates in Virginia by Age Group and Sex, 2013



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 *Virginia 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).

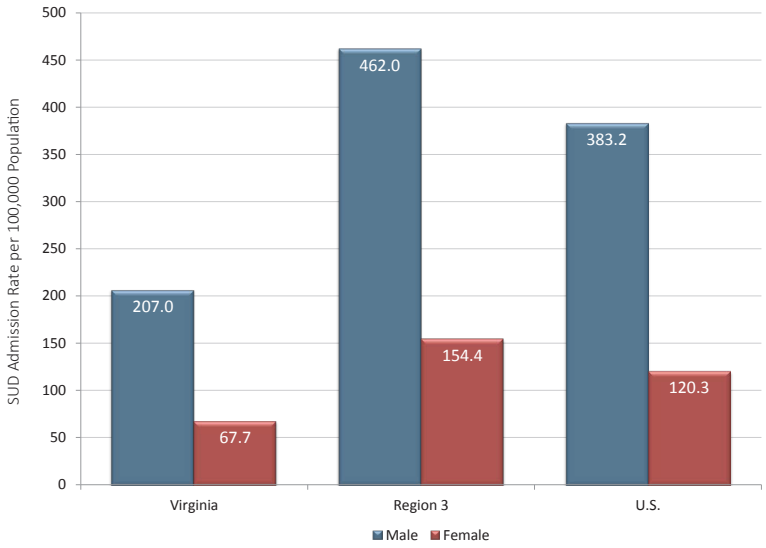
Admissions to Substance Use Disorder Treatment Among Older Virginians

In 2012, there were 3,713 admissions of Virginians ages 50 and older to substance use disorder (SUD) treatment in state-funded treatment programs, a rate of 132.8 per 100,000 people ages 50+. This rate was lower than the regional rate and the national average. Men made up 72.7 percent of these admissions. Of all admissions, 56.5 percent were White/Caucasian, 38.2 percent were Black/African American, and 3.4 percent were Hispanic.

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

Self-Referral	Criminal Justice	Other
39.4%	36.4%	24.1%

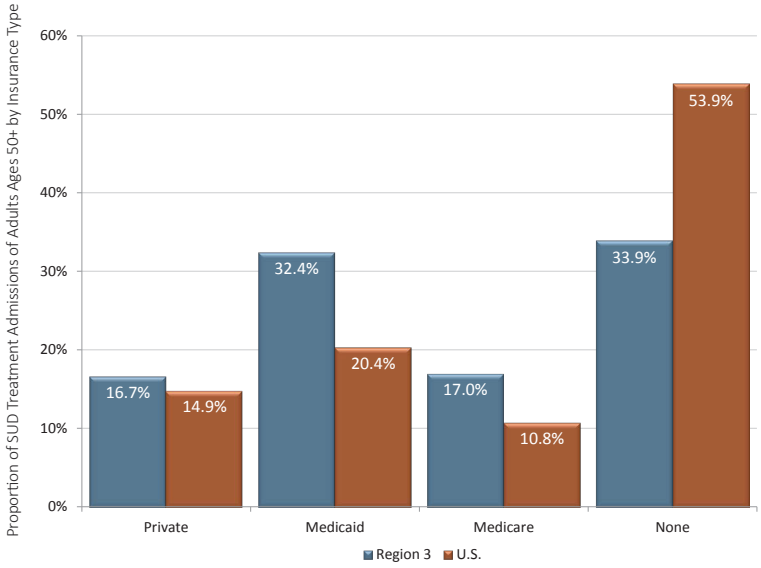
Exhibit 7. SUD Treatment Admissions of Adults Ages 50+ in Virginia, Region 3, and the United States by Sex, 2012



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

SUD Treatment Admissions Among Individuals in Region 3 Ages 50+ by Insurance Type

Exhibit 8. SUD Treatment Admissions of Adults Ages 50+ in Region 3 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 Virginia in 2012. Therefore, the rates for Region 3 are used instead.

In Region 3, 33.9 percent of older adult admissions to SUD treatment were uninsured, 32.4 percent had Medicaid, 17.0 percent had Medicare, and 16.7 percent had private insurance.

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

Data not available	Data not available	Data not available

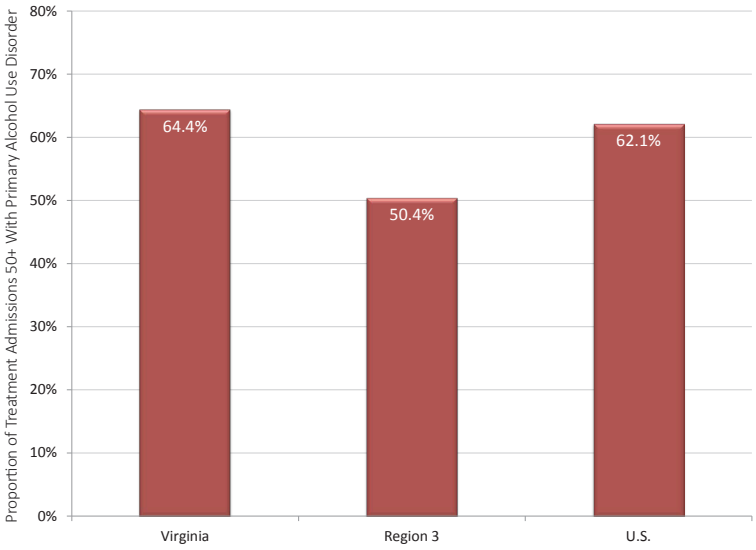
Exhibit 8 and the accompanying text reflect the type of health insurance (if any) clients had at admission; the table above represents primary sources of payment.

[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 Virginians Ages 50+

Alcohol was the most frequently cited substance used by older Virginians in publicly financed SUD treatment in 2012. It was mentioned as a substance of use in 64.4 percent of admissions among those ages 50+. This was higher than the regional and national rates.

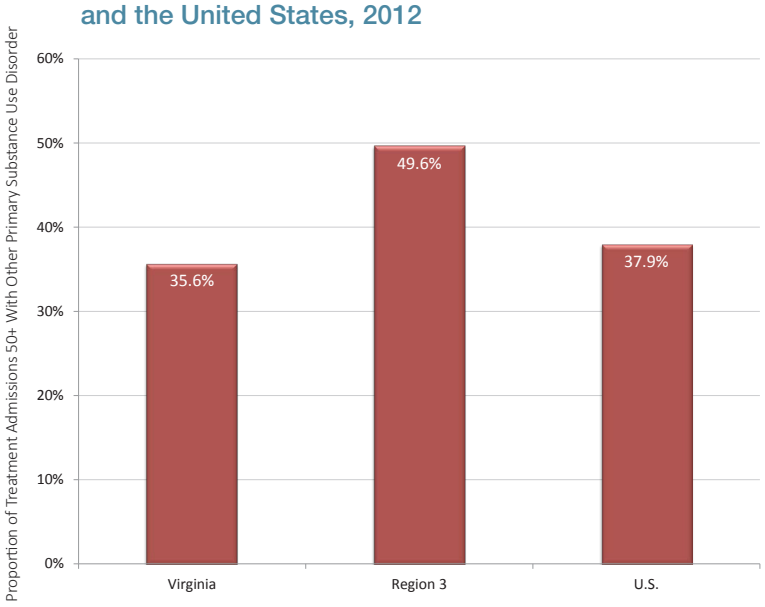
Exhibit 9. Alcohol Use Treatment Admissions of Adults Ages 50+ in Virginia, Region 3, and the United States, 2012



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 Virginia, Region 3, 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 35.6 percent of older adult admissions to publicly funded treatment in Virginia.

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*:

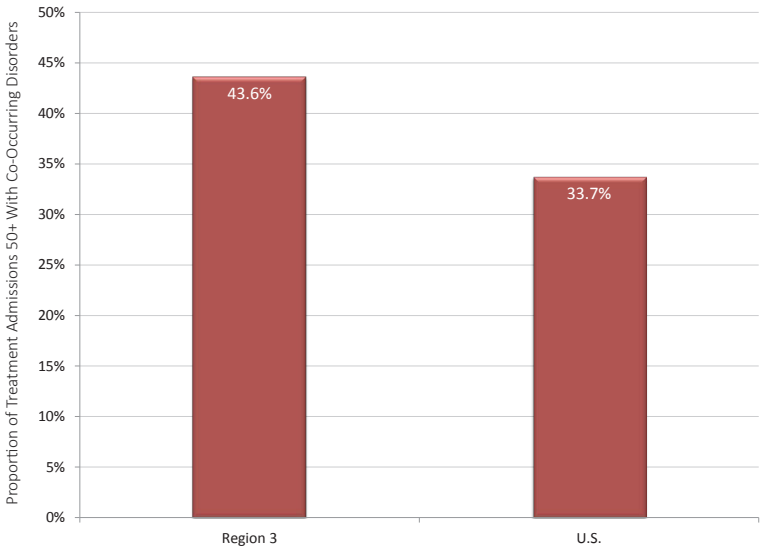
- *In 2004, there were an estimated 115,803 ED visits involving pharmaceutical misuse and abuse by adults aged 50 or older; in 2008, there were 256,097 such visits, representing an increase of 121.1 percent*
- *One fifth (19.7 percent) of ED visits involving pharmaceutical misuse and abuse among older 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 3 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 3 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.

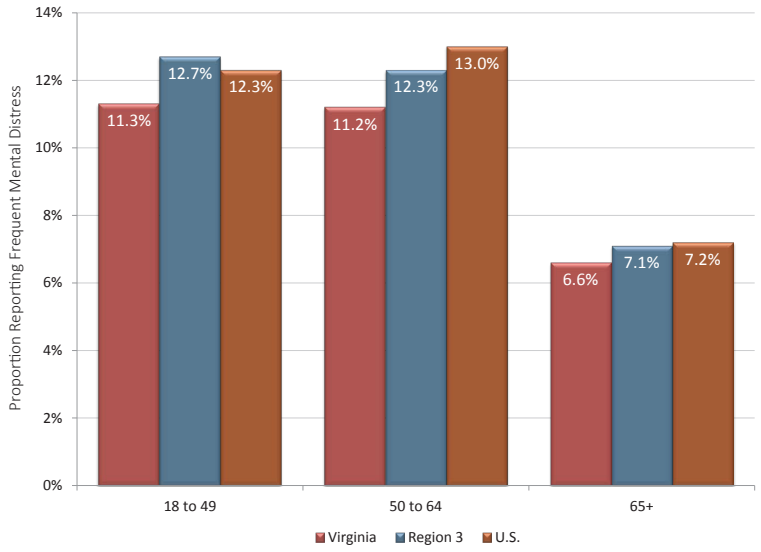
States may choose not to report some of the fields to TEDS, including information on SUD treatment admissions with a co-occurring disorder. These data were not reported by Virginia in 2012. Therefore, Exhibit 11 shows regional and national figures only.

MENTAL HEALTH

Older Virginians 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 Virginians experience FMD at a rate that is lower than the regional and national rates.

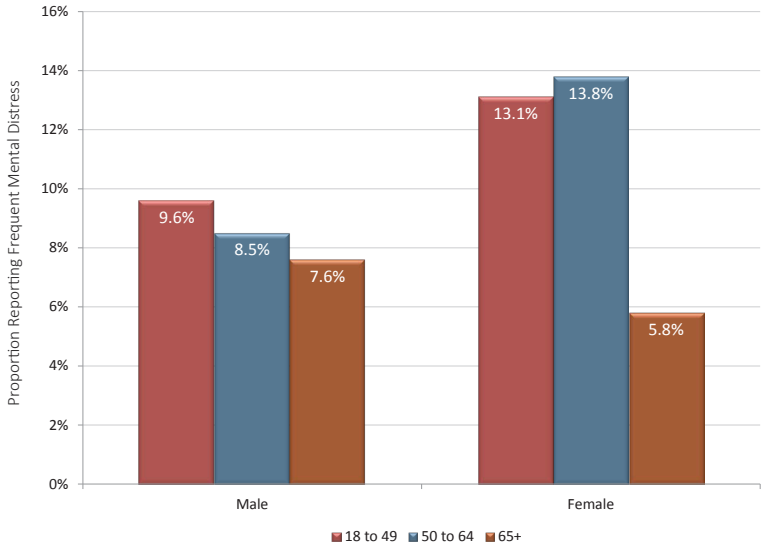
Exhibit 12. Individuals Reporting Frequent Mental Distress in Virginia, Region 3, and the United States, 2013



Source: BRFSS, 2013

Older Virginians Reporting Frequent Mental Distress by Age Group and Sex

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



Source: BRFSS, 2013

As Exhibit 13 shows, in Virginia, 8.5 percent of men in the 50–64 age group reported FMD (14 days or more per 30-day period) compared with 13.8 percent of women in this age group. Men in the 65+ age group reported a higher rate of FMD than women in the same age group (7.6 percent compared with 5.8 percent). The District of Columbia is the only other state-level jurisdiction in the region where men in the 65+ age group reported a higher rate of FMD than did women in this age group.

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 Virginians.

Exhibit 14. BRFSS Measures, 2010

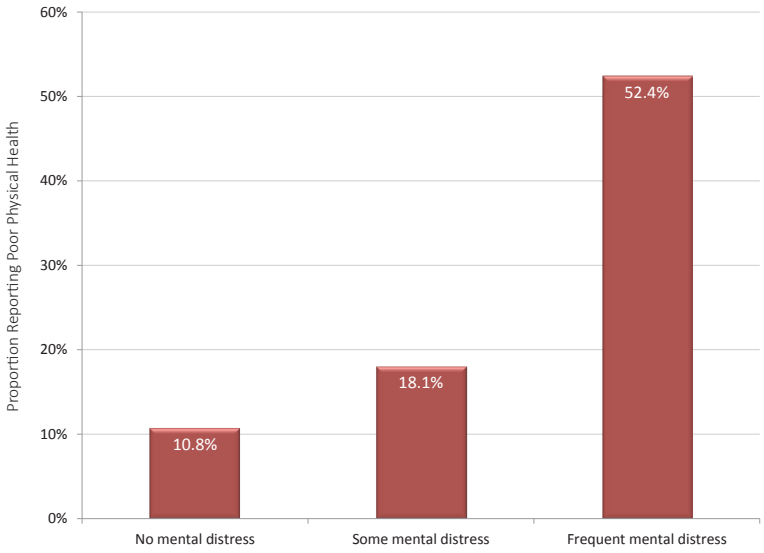
Indicator	Ages 50+	Ages 50–64	Ages 65+
Rarely or never get social or emotional support	8.8%	7.7%	10.4%
Dissatisfied or very dissatisfied	4.4%	5.1%	3.3%

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.

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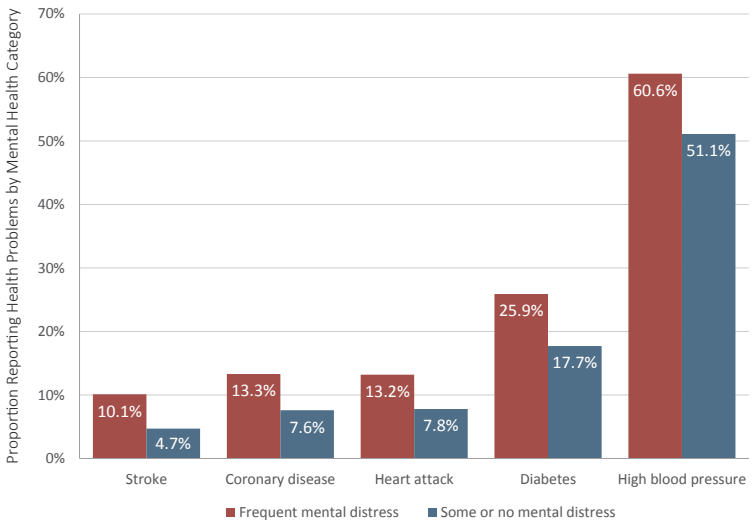

Source: BRFSS, 2013

Older Virginians Admitted to State Mental Health Services

Approximately 4.7 percent of the people served by the Virginia mental health system were ages 65 and older. This represents more than 5,310 adults.

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

DATA SOURCES

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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

West Virginia

West Virginia

OLDER ADULTS BEHAVIORAL HEALTH PROFILE

August 2016

WEST VIRGINIA'S POPULATION

West Virginia Population by Age Group

West Virginia is home to 1,850,326 people. Of these:

- 731,224 (39.5 percent) are over age 50.
- 460,005 (24.9 percent) are over age 60.
- 217,284 (11.7 percent) are over age 70.
- 78,952 (4.3 percent) are ages 80 and older.

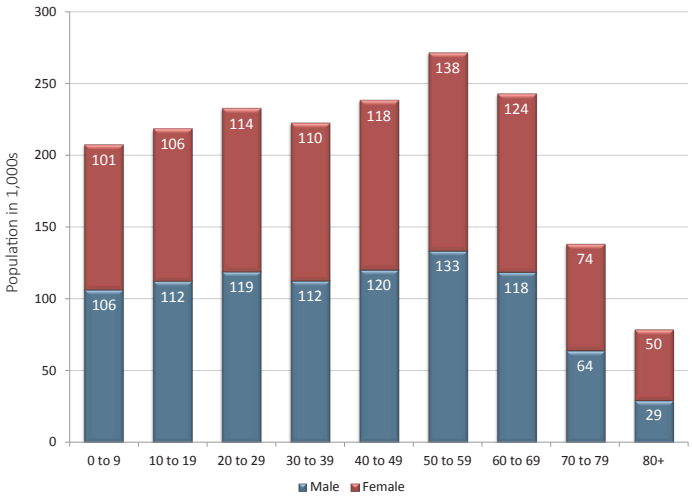
The proportion of women rises fairly steadily in each age group, and women make up 62.8 percent of the 80+ group. The racial/ethnic composition of older West Virginians is as follows:

Race/Ethnicity of West Virginians Ages 50+

White	AI/AN	Black	Asian	NH/PI	Other	Hispanic
95.7%	0.2%	2.8%	0.5%	0.0%	0.7%	0.7%

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.

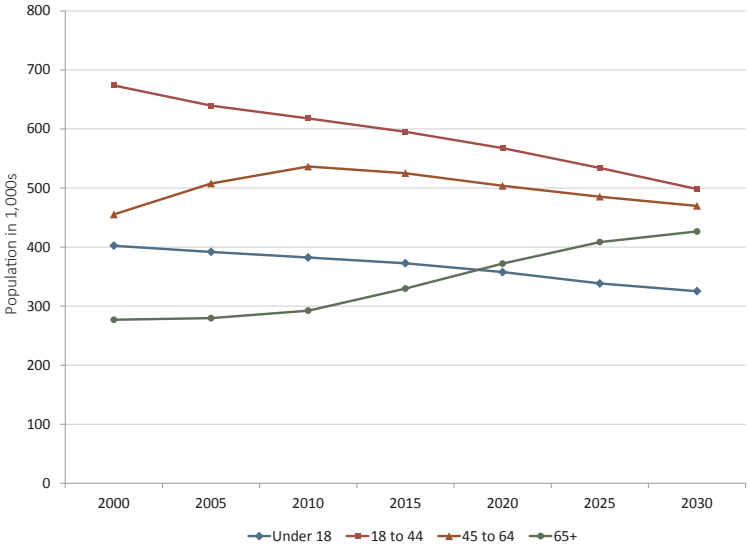
Exhibit 1. West Virginia Population by Age Group, 2014



Source: U.S. Census Bureau, 2015

The Number of Older West Virginians Is Growing

Exhibit 2. West Virginia Population by Age Group, 2000–2030



The proportion of West Virginia'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 24.8 percent of West Virginia's population will be 65 and older by the year 2030, an increase of 29.3 percent from 2015.

Projected Population in West Virginia

Age Group	2015	2025	2030
Under 18	20.4%	19.2%	18.9%
18 to 44	32.7%	30.2%	29.0%
45 to 64	28.8%	27.5%	27.3%
65+	18.1%	23.1%	24.8%

Source: U.S. Census Bureau, 2005

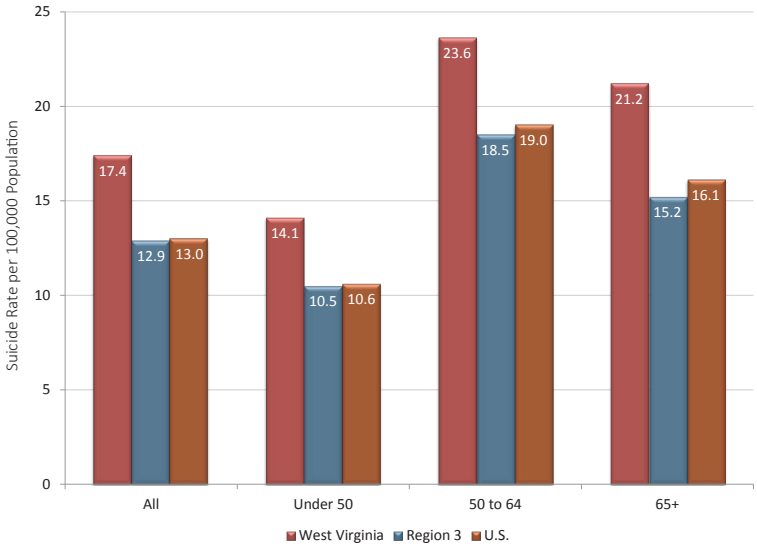
SUICIDE AMONG OLDER WEST VIRGINIANS

West Virginia Suicide Rate Compared With Regional and National Rates

The suicide rate among West Virginians 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 22.6 per 100,000 people (unreliable data for women and 42.3 for men). The rate among those ages 50–64 was higher than both the rate in the region (including Delaware, the District of Columbia, Maryland, Pennsylvania, and Virginia) and the rate in the United States.

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

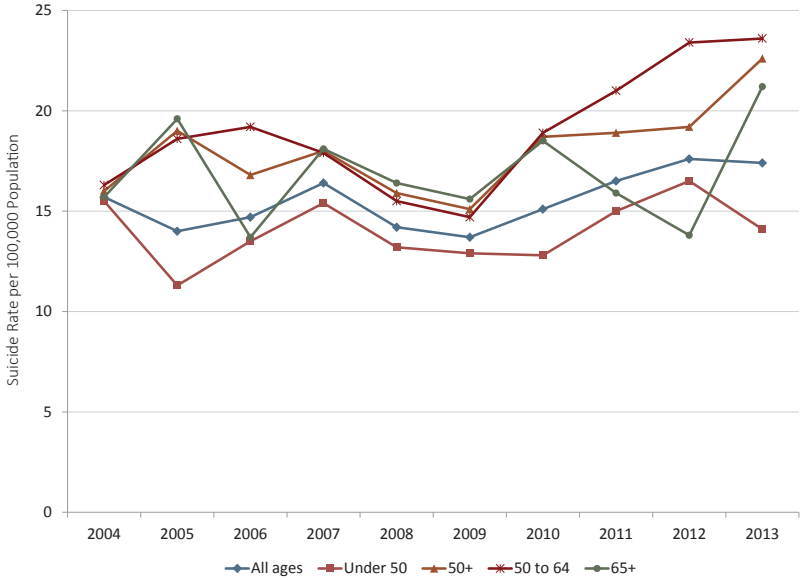
Exhibit 3. Suicide Rates in West Virginia, Region 3, and the United States, 2013



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 West Virginia

Exhibit 4. Trends in Suicide Rates in West Virginia 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 West Virginians ages 50+ fluctuated from a low of 15.1 per 100,000 in 2009 to a high of 22.6 per 100,000 in 2013. From 2004 to 2013, the rate was generally highest among those in the 50–64 age group.

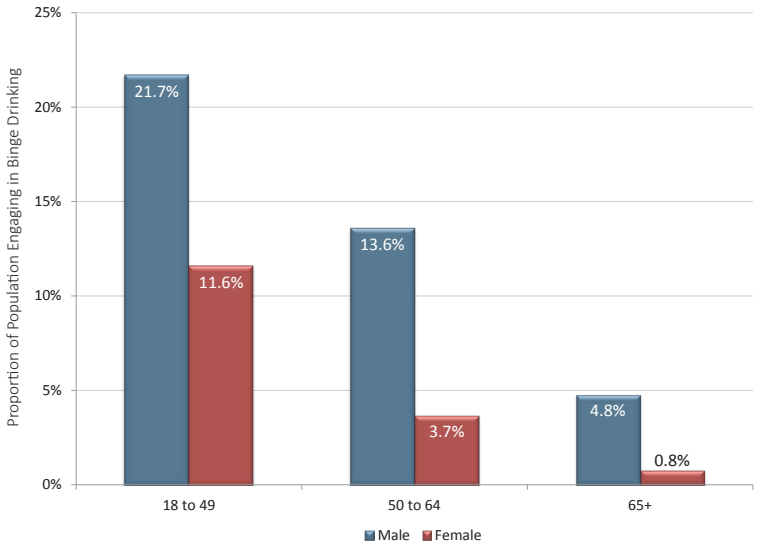
How a state reports suicides can vary from year to year. The number of suicides is generally low, so even a small difference in reported numbers may make the rate fluctuate widely.

SUBSTANCE USE DISORDER AND SUBSTANCE USE DISORDER TREATMENT AMONG OLDER WEST VIRGINIANS

30-Day Binge Drinking Among Older West Virginians

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, 13.6 percent of West Virginia men ages 50–64 reported binge drinking in the past 30 days, while 4.8 percent of those in the 65+ group reported similar behavior.

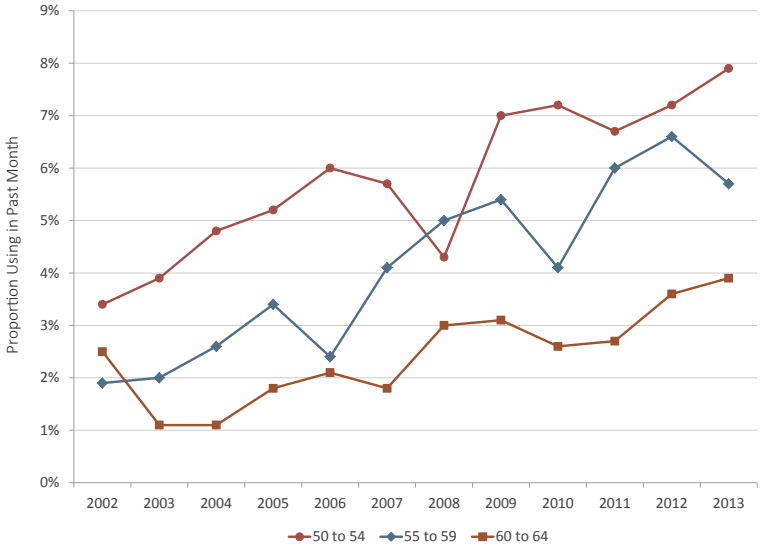
Exhibit 5. Binge Drinking Rates in West Virginia by Age Group and Sex, 2013



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 *West Virginia 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 Adults in Region 3

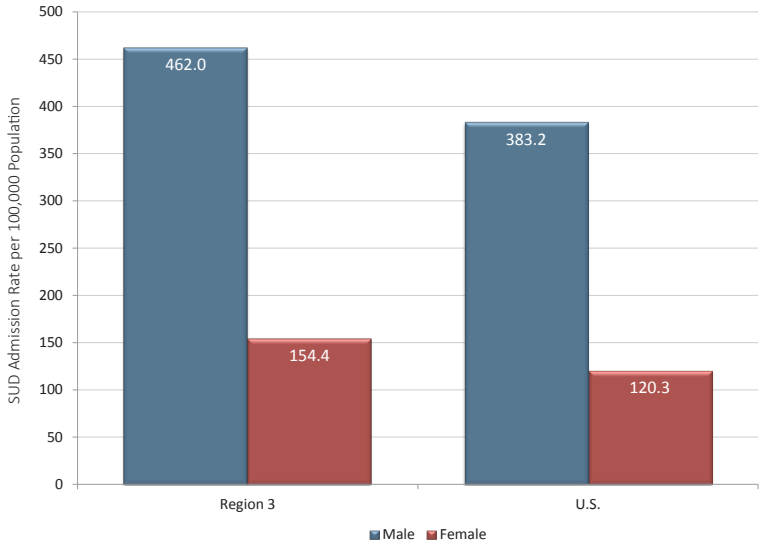
Treatment Episode Data Set (TEDS) data for West Virginia in 2012 are unavailable. Therefore, the rates for Region 3 are used instead.

In 2012, there were 15,911 admissions of individuals in Region 3 ages 50 and older to substance use disorder (SUD) treatment in state-funded treatment programs, a rate of 296.3 per 100,000 people ages 50+. This rate was higher than the national average. Men made up 71.9 percent of these admissions. Of all admissions, 42.5 percent were White/Caucasian, 54.7 percent were Black/African American, and 3.0 percent were Hispanic.

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

Self-Referral	Criminal Justice	Other
38.9%	25.9%	35.3%

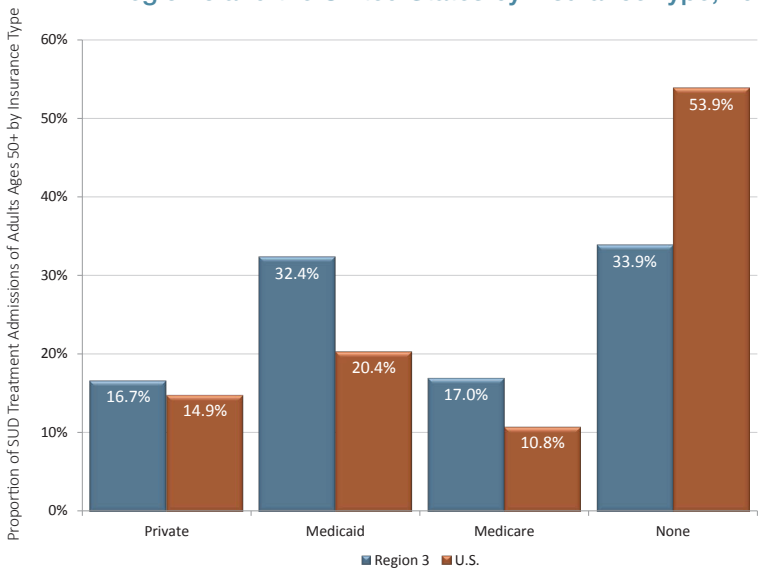
Exhibit 7. SUD Treatment Admissions of Adults Ages 50+ in Region 3 and the United States by Sex, 2012



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

SUD Treatment Admissions Among Individuals in Region 3 Ages 50+ by Insurance Type

Exhibit 8. SUD Treatment Admissions of Adults Ages 50+ in Region 3 and the United States by Insurance Type, 2012



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

TEDS data for West Virginia in 2012 are unavailable. Therefore, data for Region 3 are used instead.

In Region 3, 33.9 percent of older adult admissions to SUD treatment were uninsured, 32.4 percent had Medicaid, 17.0 percent had Medicare, and 16.7 percent had private insurance.

SUD Treatment Admissions Among West Virginians 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.

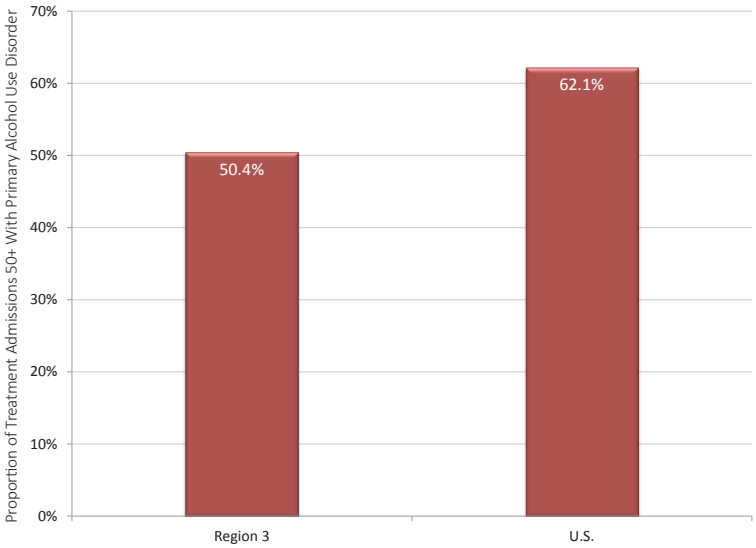
[1] TEDS data are collected by states as a condition of the Substance Abuse Prevention and Treatment Block Grant. Guidelines suggest that states report all clients admitted to publicly financed treatment; however, states are inconsistent in applying the guidelines. States may structure and implement 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 Individuals in Region 3 Ages 50+

TEDS data for West Virginia in 2012 are unavailable. Therefore, data for Region 3 are used instead.

Alcohol was the most frequently cited substance used by older individuals in Region 3 in publicly financed SUD treatment in 2012. It was mentioned as a substance of use in 50.4 percent of admissions among those ages 50+. This was lower than the national rate.

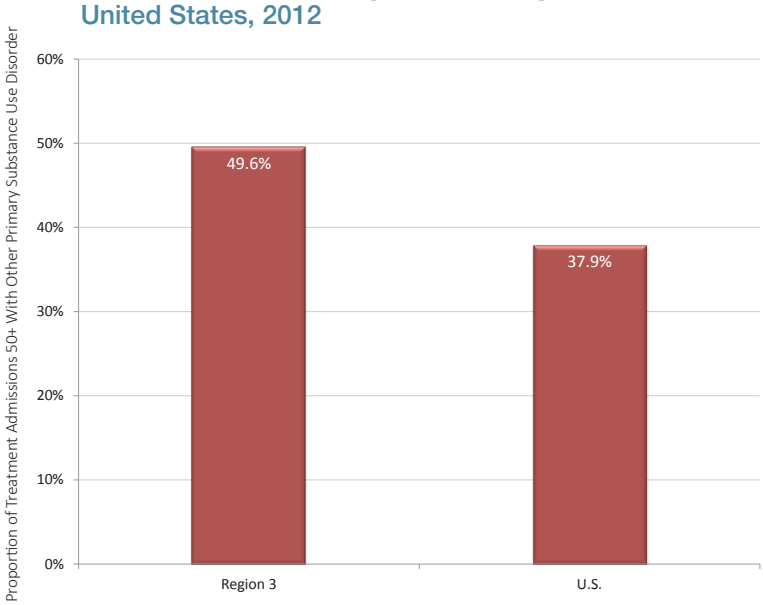
Exhibit 9. Alcohol Use Treatment Admissions of Adults Ages 50+ in Region 3 and the United States, 2012



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

SUD Treatment Admissions for Non-Alcohol Substance Use in Region 3

Exhibit 10. Non-Alcohol Substance Use Treatment Admissions of Adults Ages 50+ in Region 3 and the United States, 2012



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

TEDS data for West Virginia in 2012 are unavailable. Therefore, data for Region 3 are used instead.

Substances other than alcohol were cited as the primary substances of use for 49.6 percent of older adult admissions to publicly funded treatment in Region 3.

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*:

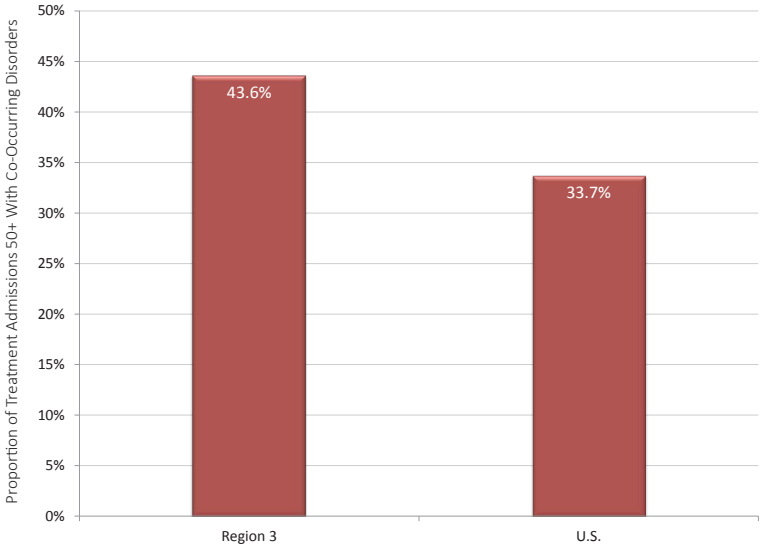
- *In 2004, there were an estimated 115,803 ED visits involving pharmaceutical misuse and abuse by adults aged 50 or older; in 2008, there were 256,097 such visits, representing an increase of 121.1 percent*
- *One fifth (19.7 percent) of ED visits involving pharmaceutical misuse and abuse among older 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 3 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 3 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.

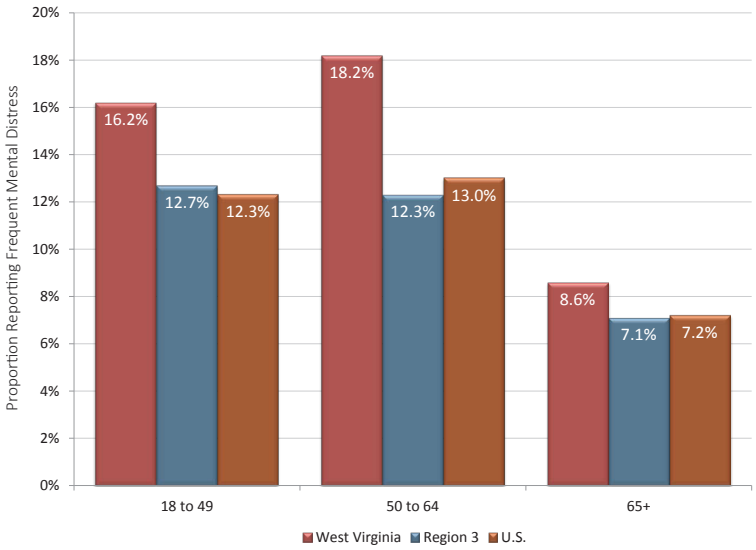
TEDS data for West Virginia in 2012 are unavailable. Therefore, Exhibit 11 shows regional and national figures only.

MENTAL HEALTH

Older West Virginians 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 West Virginians experience FMD at a rate that is higher than the regional and national rates.

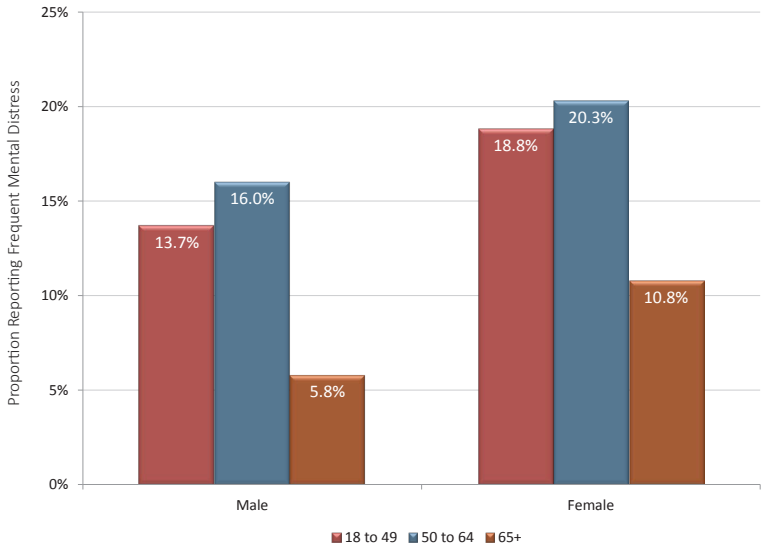
Exhibit 12. Individuals Reporting Frequent Mental Distress in West Virginia, Region 3, and the United States, 2013



Source: BRFSS, 2013

Older West Virginians Reporting Frequent Mental Distress by Age Group and Sex

Exhibit 13. West Virginians Reporting Frequent Mental Distress by Age Group and Sex, 2013



Source: BRFSS, 2013

Older men in West Virginia 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, 20.3 percent of women in the 50–64 age group and 10.8 percent in the 65+ age group reported FMD, while 16.0 percent of men in the 50–64 age group and 5.8 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 West Virginians.

Exhibit 14. BRFSS Measures, 2010

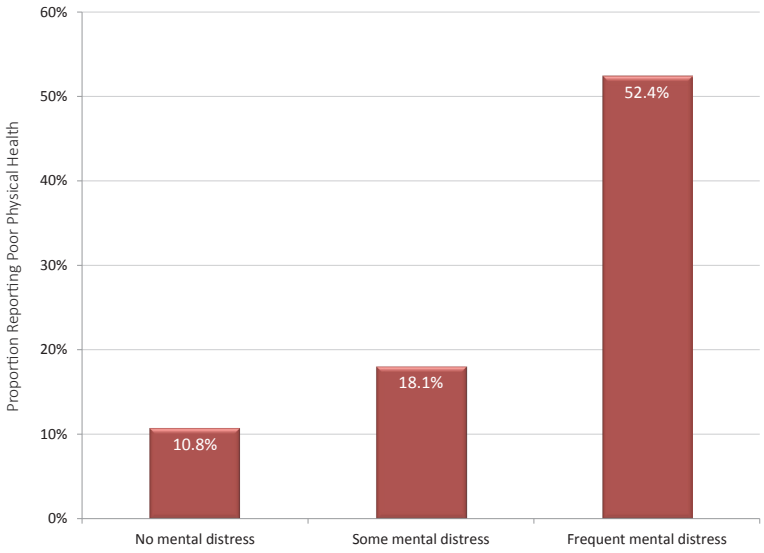
Indicator	Ages 50+	Ages 50–64	Ages 65+
Rarely or never get social or emotional support	7.1%	8.1%	5.9%
Dissatisfied or very dissatisfied	6.6%	8.4%	4.4%

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

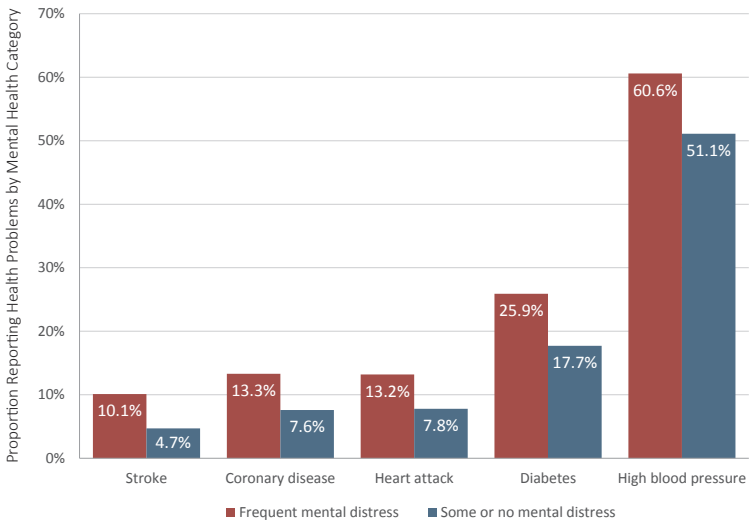


Source: BRFSS, 2013

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 West Virginians Admitted to State Mental Health Services

Approximately 3.8 percent of the people served by the West Virginia mental health system were ages 65 and older. This represents more than 2,200 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.