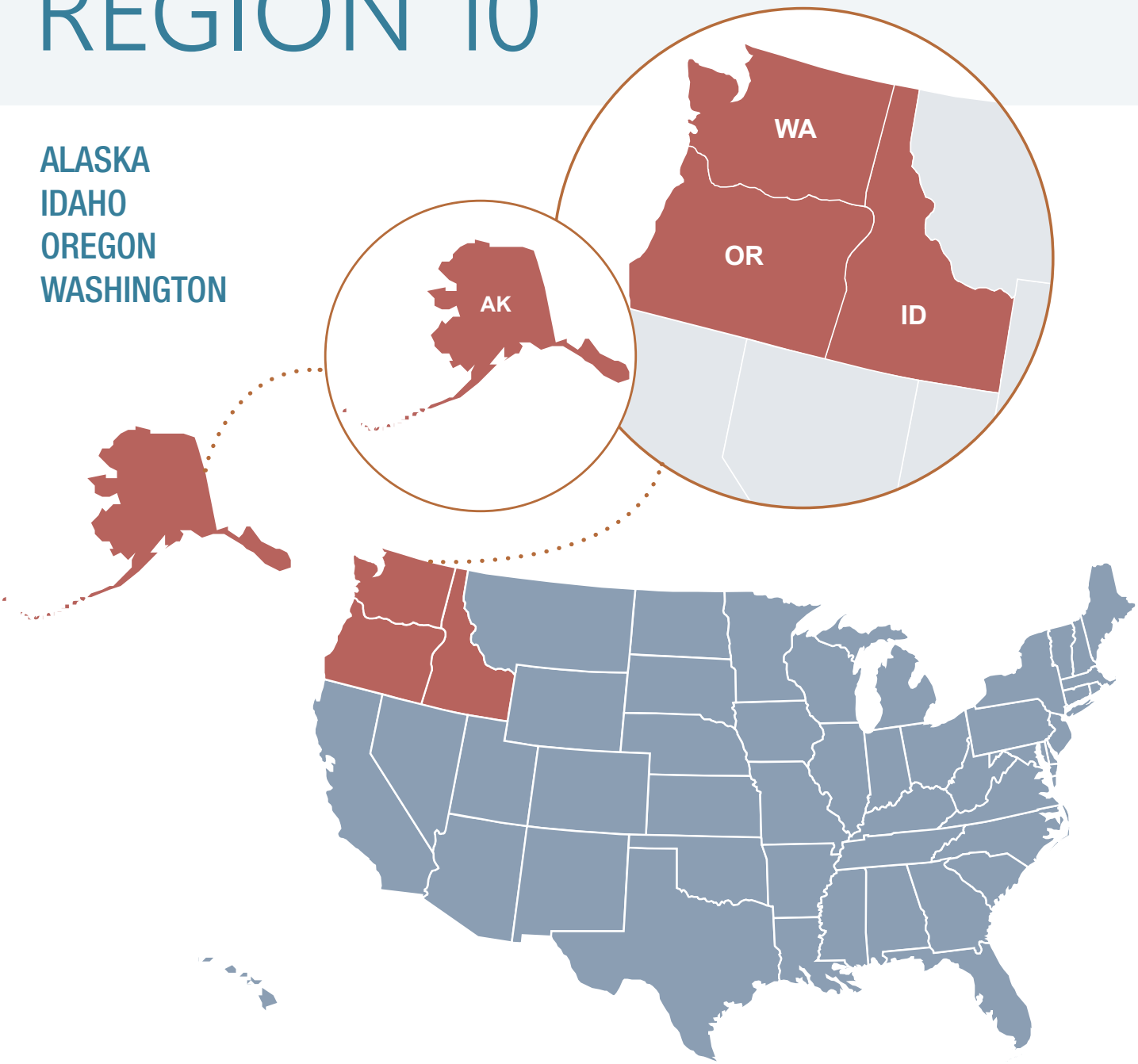
OLDER ADULTS BEHAVIORAL HEALTH PROFILES

REGION 10

ALASKA
IDAHO
OREGON
WASHINGTON



A Behavioral Health Resource

SAMHSA's State Technical Assistance Contract

September 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

Alaska

Alaska

OLDER ADULTS BEHAVIORAL HEALTH PROFILE

September 2016

ALASKA'S POPULATION

Alaska Population by Age Group

Alaska is home to 736,732 people.
Of these:

- 214,814 (29.2 percent) are over age 50.
- 111,461 (15.1 percent) are over age 60.
- 40,398 (5.5 percent) are over age 70.
- 12,492 (1.7 percent) are ages 80 and older.

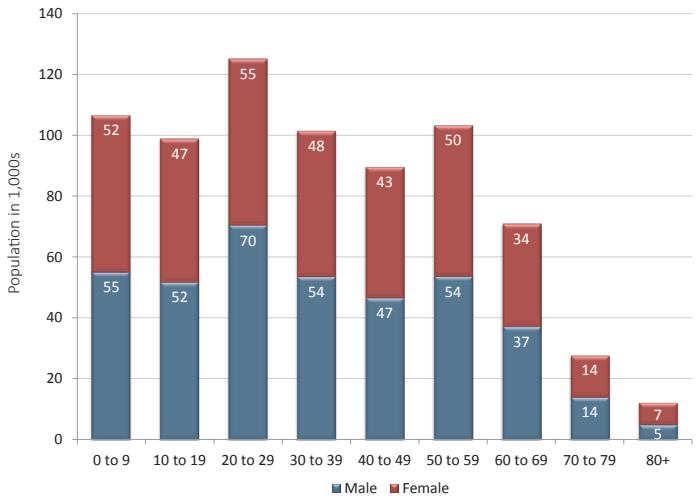
The proportion of women rises fairly steadily in each age group, and women make up 59.3 percent of the 80+ group. The racial/ethnic composition of older Alaskans is as follows:

Race/Ethnicity of Alaskans Ages 50+

White	AI/AN	Black	Asian	NH/PI	Other	Hispanic
75.8%	12.1%	2.8%	5.9%	0.6%	2.8%	3.4%

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.

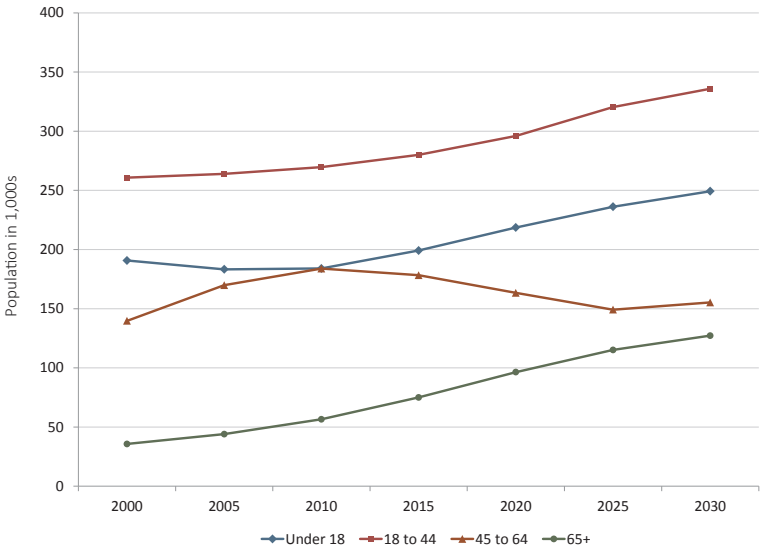
Exhibit 1. Alaska Population by Age Group, 2014



Source: U.S. Census Bureau, 2015

The Number of Older Alaskans Is Growing

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



The proportion of Alaska'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 14.7 percent of Alaska's population will be 65 and older by the year 2030, an increase of 69.6 percent from 2015.

Projected Population in Alaska

Age Group	2015	2025	2030
Under 18	27.2%	28.8%	28.7%
18 to 44	38.2%	39.0%	38.7%
45 to 64	24.3%	18.2%	17.9%
65+	10.2%	14.0%	14.7%

Source: U.S. Census Bureau, 2005

SUICIDE AMONG OLDER ADULTS IN REGION 10

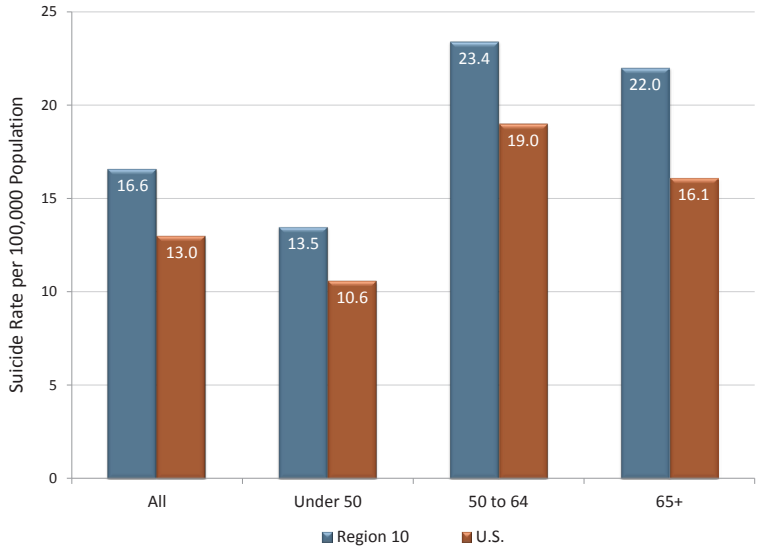
Region 10 Suicide Rate Compared With National Rates

Suicide data for Alaskans of various ages were unavailable for 2013. Therefore, the rates for Region 10 (including Idaho, Oregon, and Washington) are used instead.

The suicide rate among individuals ages 50+ in Region 10 was higher than the rate among younger age groups. In 2013, the total suicide rate among all people ages 50+ was 22.8 per 100,000 people (10.7 for women and 36.2 for men). The rate among those ages 50–64 was higher than the rate in the United States.

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

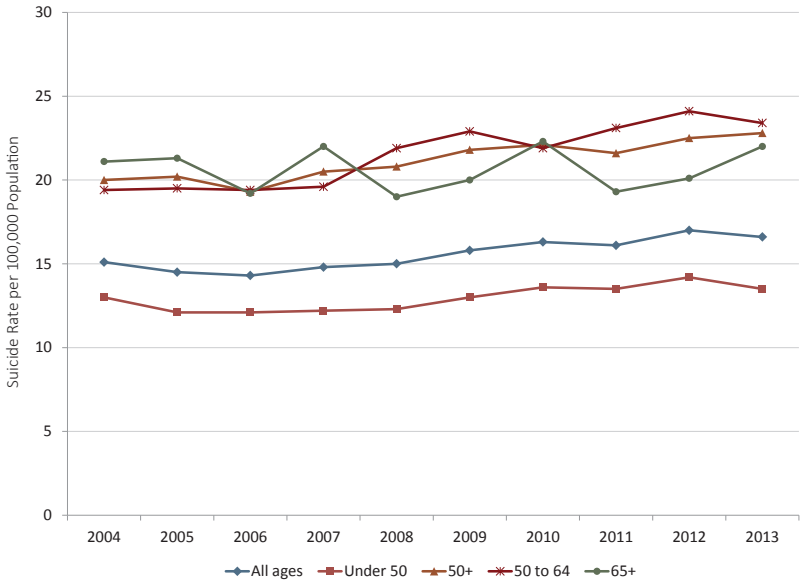
Exhibit 3. Suicide Rates in Region 10 and the United States, 2013



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 10

Exhibit 4. Trends in Suicide Rates in Region 10 by Age Group, 2004–2013



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

Suicide data for Alaskans of various ages were unavailable. Therefore, the rates for Region 10 are used instead.

The suicide rate among individuals in Region 10 ages 50+ fluctuated from a low of 19.3 per 100,000 in 2006 to a high of 22.8 per 100,000 in 2013. From 2004 to 2013, the rate was generally highest among those in the 50–64 age group.

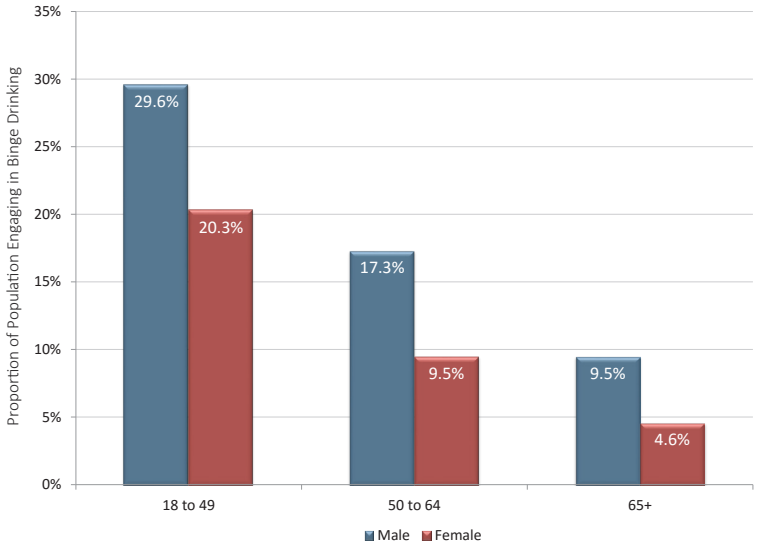
How a state reports suicides can vary from year to year. The number of suicides is generally low, so even a small difference in reported numbers may make the rate fluctuate widely.

SUBSTANCE USE DISORDER AND SUBSTANCE USE DISORDER TREATMENT AMONG OLDER ALASKANS

30-Day Binge Drinking Among Older Alaskans

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, 17.3 percent of Alaska men ages 50–64 reported binge drinking in the past 30 days, while 9.5 percent of those in the 65+ group reported similar behavior.

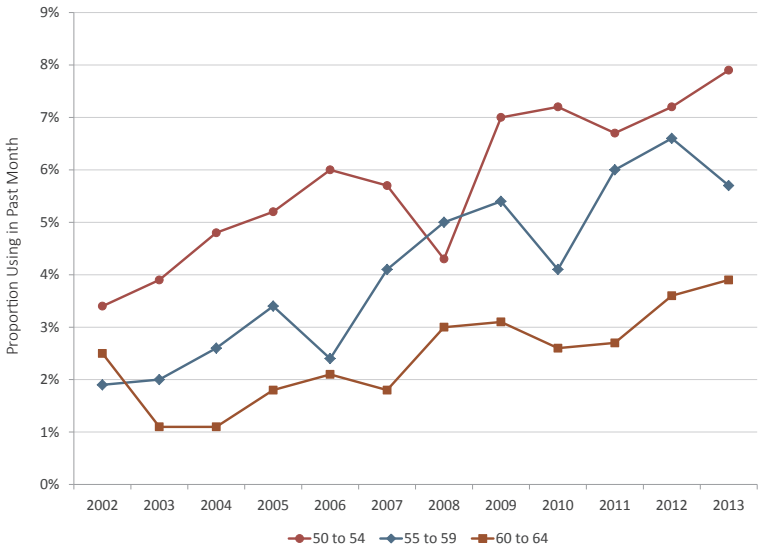
Exhibit 5. Binge Drinking Rates in Alaska by Age Group and Sex, 2013



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 *Alaska 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).

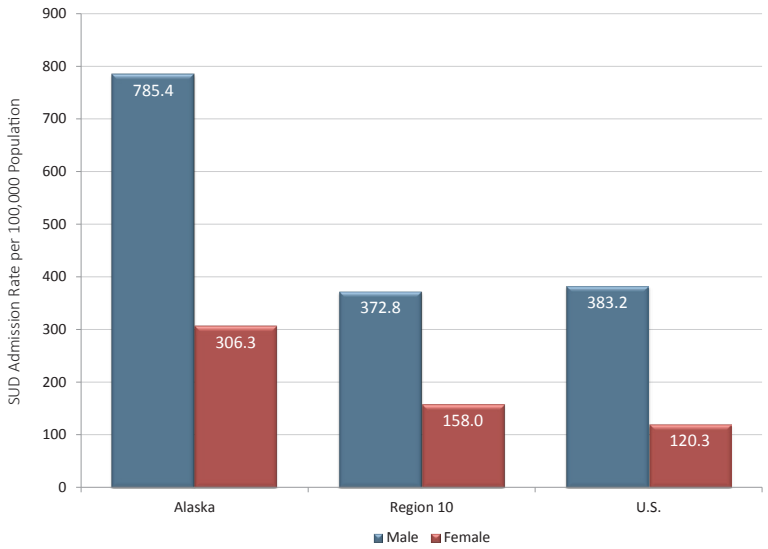
Admissions to Substance Use Disorder Treatment Among Older Alaskans

In 2012, there were 1,185 admissions of Alaskans ages 50 and older to substance use disorder (SUD) treatment in state-funded treatment programs, a rate of 551.6 per 100,000 people ages 50+. This rate was higher than the regional rate and the national average. Men made up 72.9 percent of these admissions. Of all admissions, 33.1 percent were White/Caucasian, 2.0 percent were Black/African American, and 1.2 percent were Hispanic.

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

Self-Referral	Criminal Justice	Other
42.0%	17.0%	41.1%

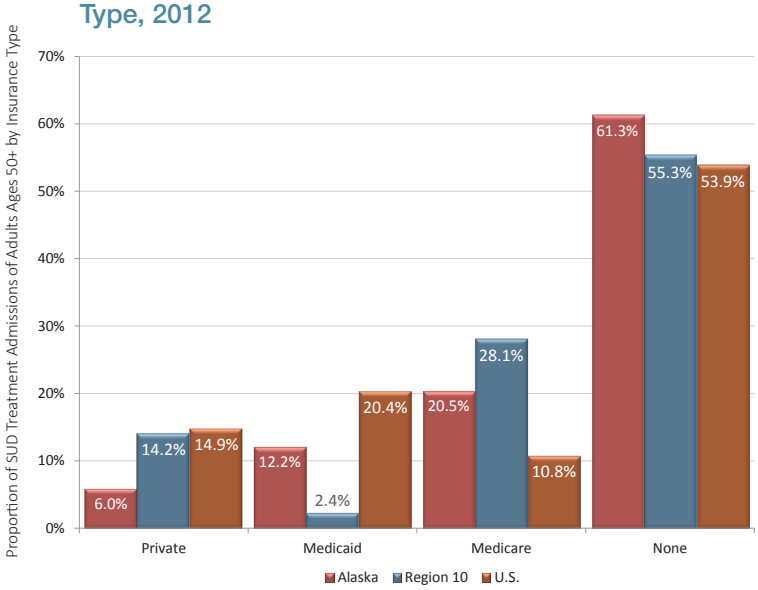
Exhibit 7. SUD Treatment Admissions of Adults Ages 50+ in Alaska, Region 10, and the United States by Sex, 2012



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

SUD Treatment Admissions Among Alaskans Ages 50+ by Insurance Type

Exhibit 8. SUD Treatment Admissions of Adults Ages 50+ in Alaska, Region 10, and the United States by Insurance Type, 2012



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

In Alaska, 61.3 percent of older adult admissions to SUD treatment were uninsured, 12.2 percent had Medicaid, 20.5 percent had Medicare, and 6.0 percent had private insurance.

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

Self-Pay	Medicaid	Other
67.6%	14.2%	18.2%

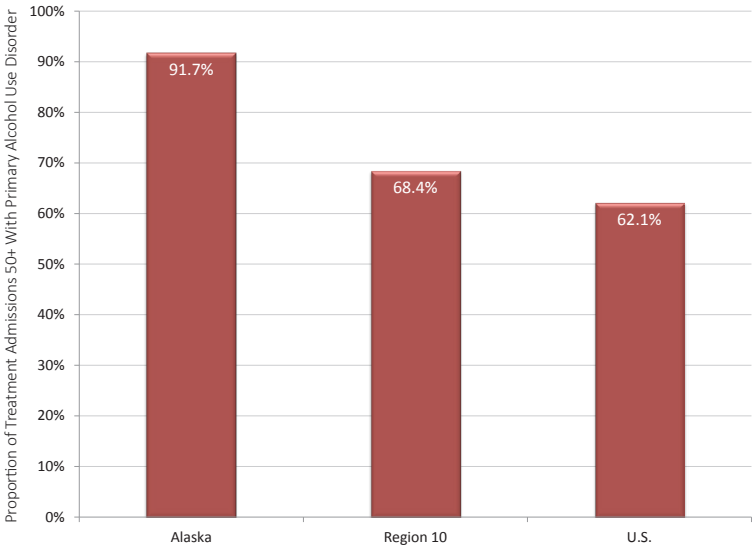
Self-pay data include private insurance.
Exhibit 8 and the accompanying text reflect the type of health insurance (if any) clients had at admission; the table above represents primary sources of payment.

[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 Alaskans Ages 50+

Alcohol was the most frequently cited substance used by older Alaskans in publicly financed SUD treatment in 2012. It was mentioned as a substance of use in 91.7 percent of admissions among those ages 50+. This was higher than the regional and national rates.

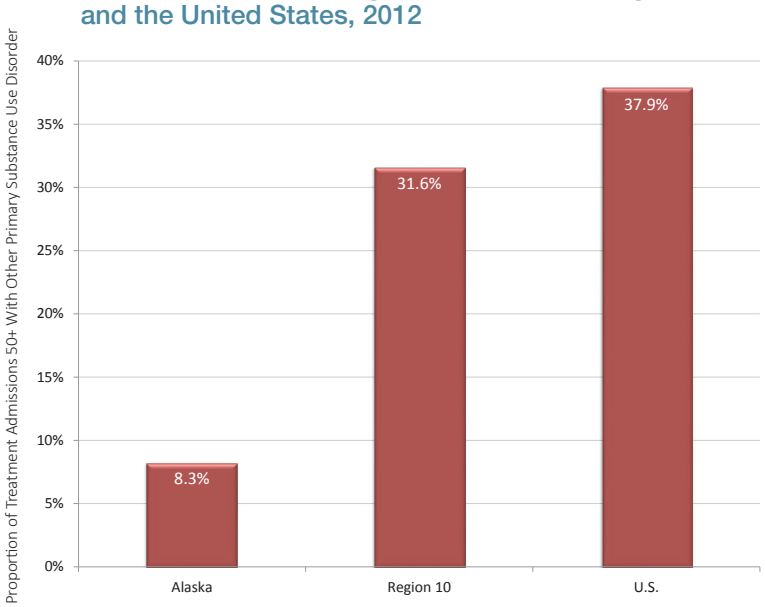
Exhibit 9. Alcohol Use Treatment Admissions of Adults Ages 50+ in Alaska, Region 10, and the United States, 2012



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 Alaska, Region 10, 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 8.3 percent of older adult admissions to publicly funded treatment in Alaska.

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*:

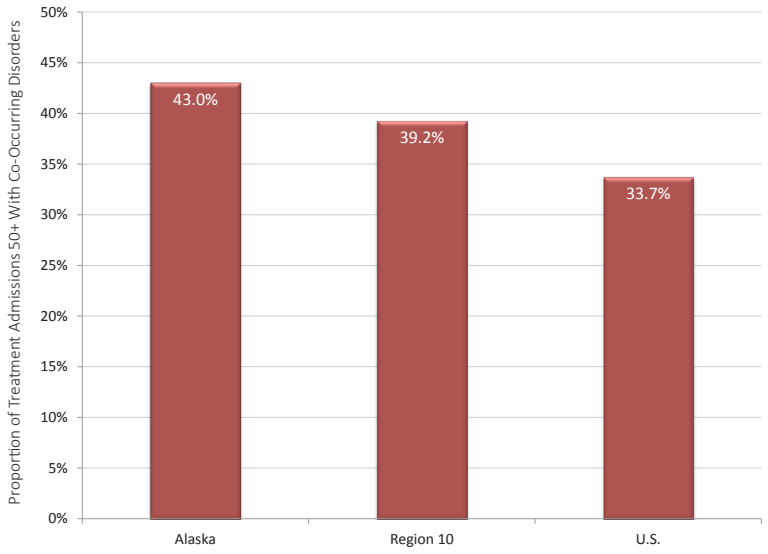
- *In 2004, there were an estimated 115,803 ED visits involving pharmaceutical misuse and abuse by adults aged 50 or older; in 2008, there were 256,097 such visits, representing an increase of 121.1 percent*
- *One fifth (19.7 percent) of ED visits involving pharmaceutical misuse and abuse among older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

Exhibit 11. SUD Treatment Admissions of Adults Ages 50+ With a Co-Occurring Mental Disorder in Alaska, Region 10, 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.

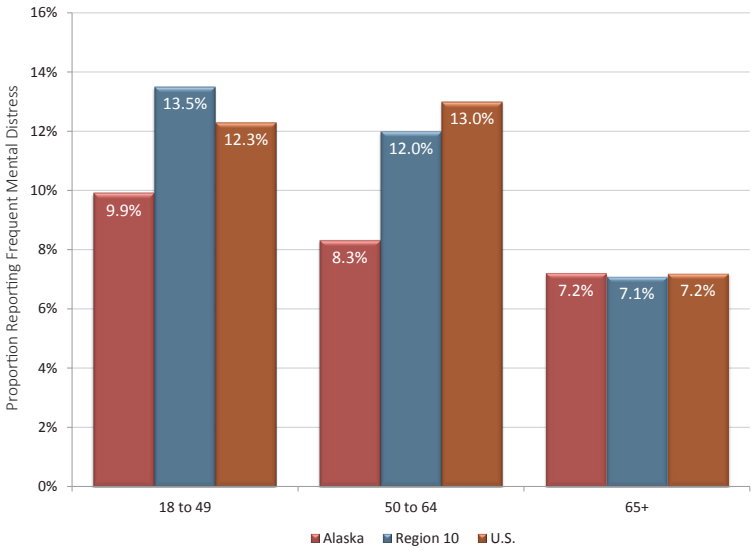
Exhibit 11 shows the proportion of SUD treatment admissions of Alaskans ages 50+ with a co-occurring mental disorder. This rate is higher than the regional rate and the national average. However, state reporting practices are a factor in these results.

MENTAL HEALTH

Older Alaskans 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 Alaskans in the 50–64 age group experience FMD at a rate that is lower than the regional and national rates, while those in the 65+ age group experience it at a rate that is roughly similar to the regional and national rates.

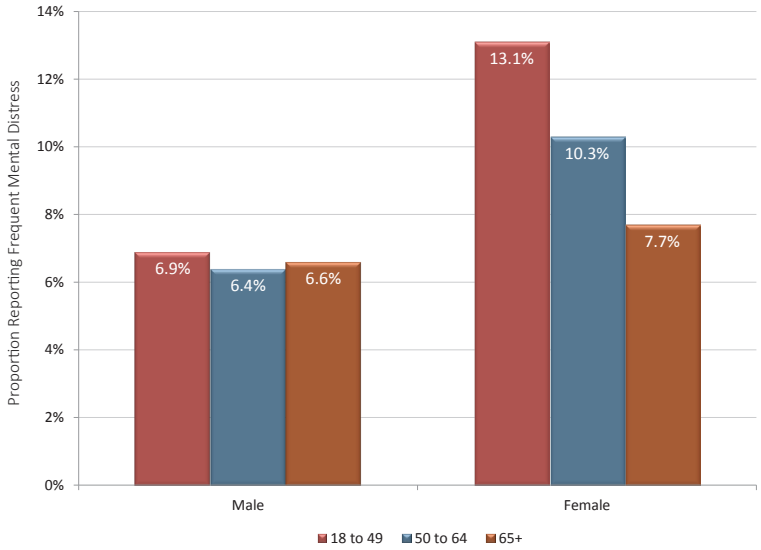
Exhibit 12. Individuals Reporting Frequent Mental Distress in Alaska, Region 10, and the United States, 2013



Source: BRFSS, 2013

Older Alaskans Reporting Frequent Mental Distress by Age Group and Sex

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



Source: BRFSS, 2013

Older men in Alaska 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, 10.3 percent of women in the 50–64 age group and 7.7 percent in the 65+ age group reported FMD, while 6.4 percent of men in the 50–64 age group and 6.6 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 Alaskans.

Exhibit 14. BRFSS Measures, 2010

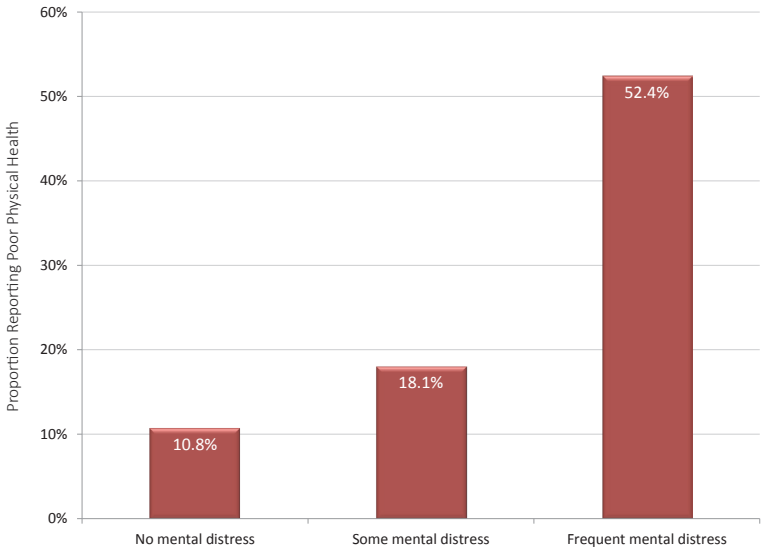
Indicator	Ages 50+	Ages 50–64	Ages 65+
Rarely or never get social or emotional support	9.6%	8.0%	13.4%
Dissatisfied or very dissatisfied	4.9%	5.0%	4.7%

Source: BRFSS, 2010

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

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

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

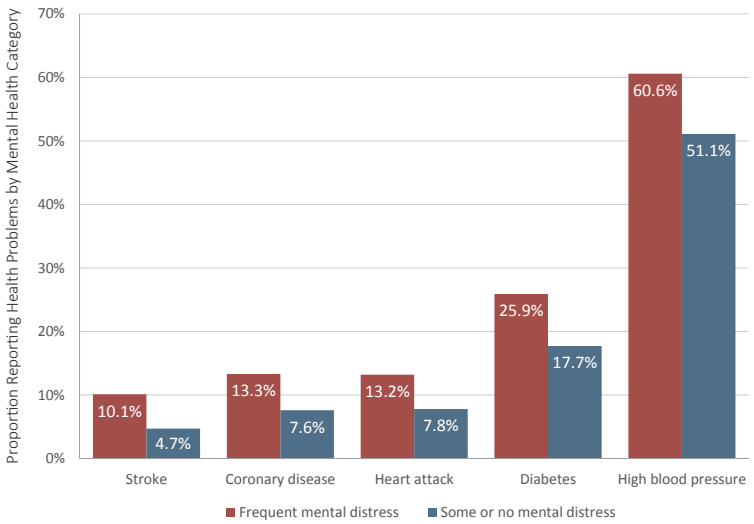


Source: BRFSS, 2013

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

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

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



Source: BRFSS, 2013

Older Alaskans Admitted to State Mental Health Services

Approximately 2.9 percent of the people served by the Alaska mental health system were ages 65 and older. This represents more than 650 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

Idaho

Idaho

OLDER ADULTS BEHAVIORAL HEALTH PROFILE

September 2016

IDAHO'S POPULATION

Idaho Population by Age Group

Idaho is home to 1,634,464 people. Of these:

- 537,540 (32.9 percent) are over age 50.
- 328,788 (20.1 percent) are over age 60.
- 153,364 (9.4 percent) are over age 70.
- 54,697 (3.3 percent) are ages 80 and older.

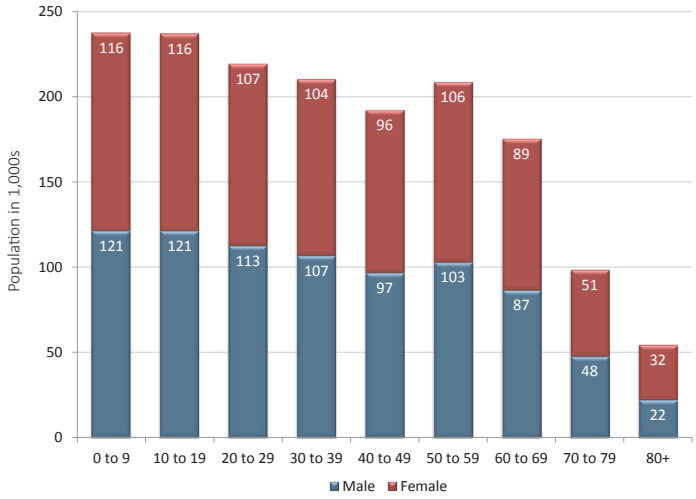
The proportion of women rises fairly steadily in each age group, and women make up 59.1 percent of the 80+ group. The racial/ethnic composition of older Idahoans is as follows:

Race/Ethnicity of Idahoans Ages 50+

White	AI/AN	Black	Asian	NH/PI	Other	Hispanic
96.2%	1.2%	0.4%	1.1%	0.1%	1.0%	5.1%

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.

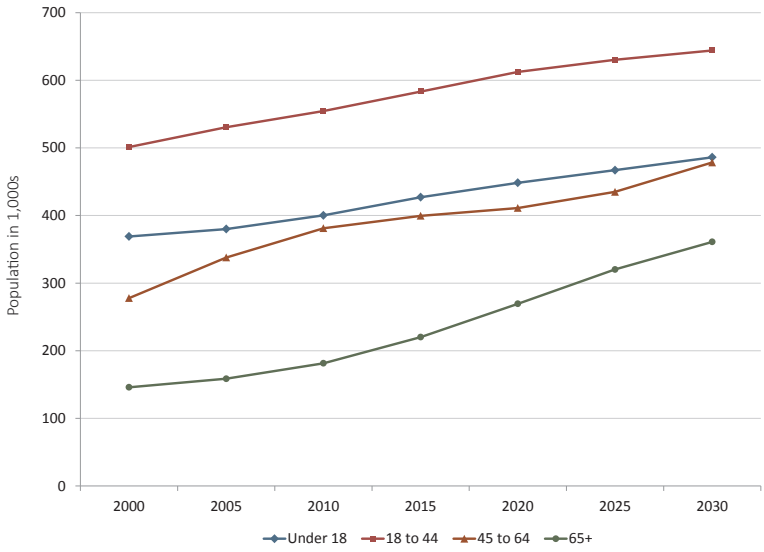
Exhibit 1. Idaho Population by Age Group, 2014



Source: U.S. Census Bureau, 2015

The Number of Older Idahoans Is Growing

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



The proportion of Idaho'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 18.3 percent of Idaho's population will be 65 and older by the year 2030, an increase of 64.0 percent from 2015.

Projected Population in Idaho

Age Group	2015	2025	2030
Under 18	26.2%	25.2%	24.7%
18 to 44	35.8%	34.0%	32.7%
45 to 64	24.5%	23.5%	24.3%
65+	13.5%	17.3%	18.3%

Source: U.S. Census Bureau, 2005

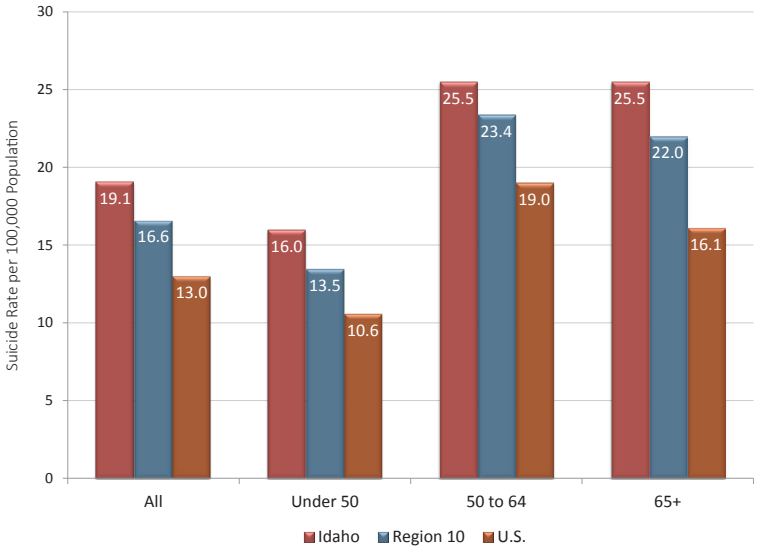
SUICIDE AMONG OLDER IDAHOANS

Idaho Suicide Rate Compared With Regional and National Rates

The suicide rate among Idahoans 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 25.5 per 100,000 people (9.2 for women and 43.0 for men). The rate among those ages 50–64 was higher than both the rate in the region (including Alaska, Oregon, and Washington) and the rate in the United States.

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

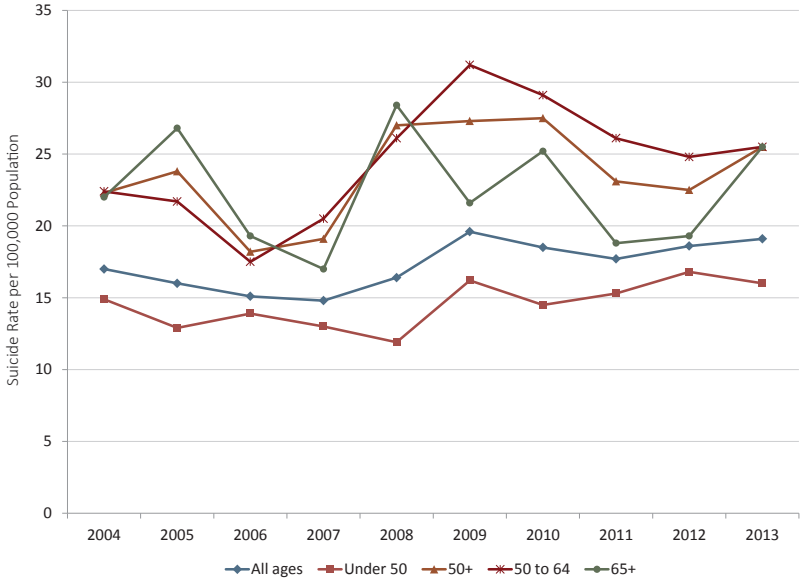
Exhibit 3. Suicide Rates in Idaho, Region 10, and the United States, 2013



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 Idaho

Exhibit 4. Trends in Suicide Rates in Idaho 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 Idahoans ages 50+ fluctuated from a low of 18.2 per 100,000 in 2006 to a high of 27.5 per 100,000 in 2010. From 2004 to 2013, the rate was generally highest among those in the 50–64 age group.

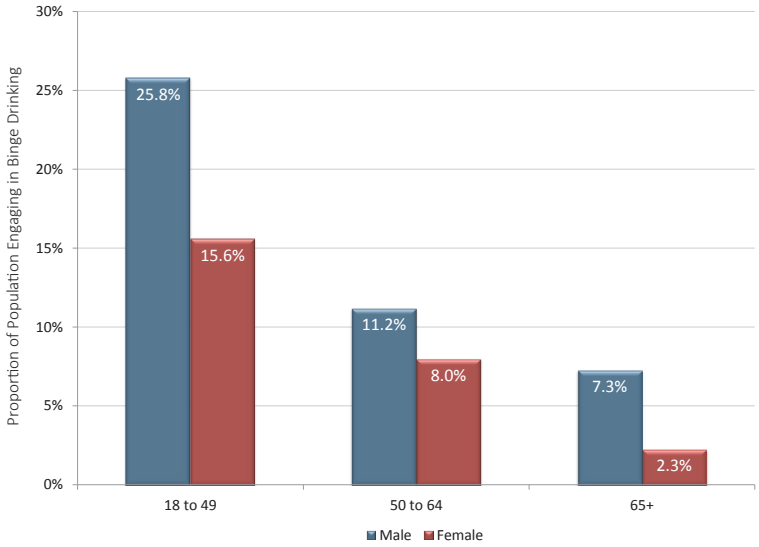
How a state reports suicides can vary from year to year. The number of suicides is generally low, so even a small difference in reported numbers may make the rate fluctuate widely.

SUBSTANCE USE DISORDER AND SUBSTANCE USE DISORDER TREATMENT AMONG OLDER IDAHOANS

30-Day Binge Drinking Among Older Idahoans

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, 11.2 percent of Idaho men ages 50–64 reported binge drinking in the past 30 days, while 7.3 percent of those in the 65+ group reported similar behavior.

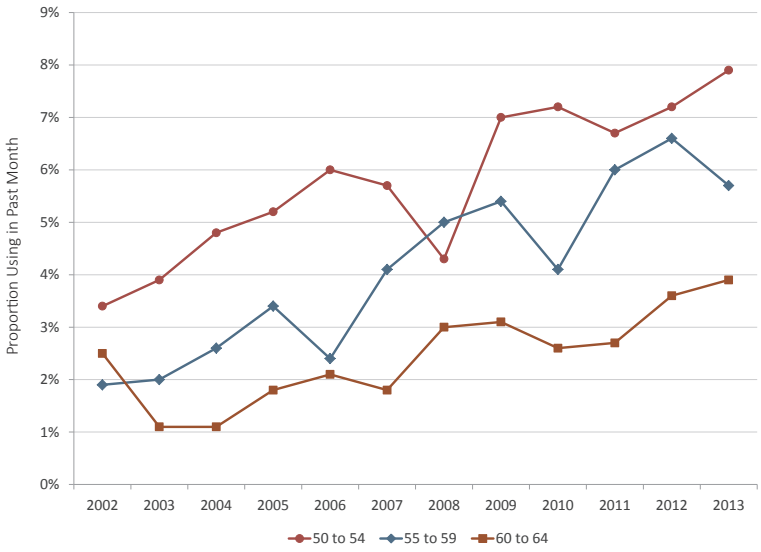
Exhibit 5. Binge Drinking Rates in Idaho by Age Group and Sex, 2013



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 *Idaho 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).

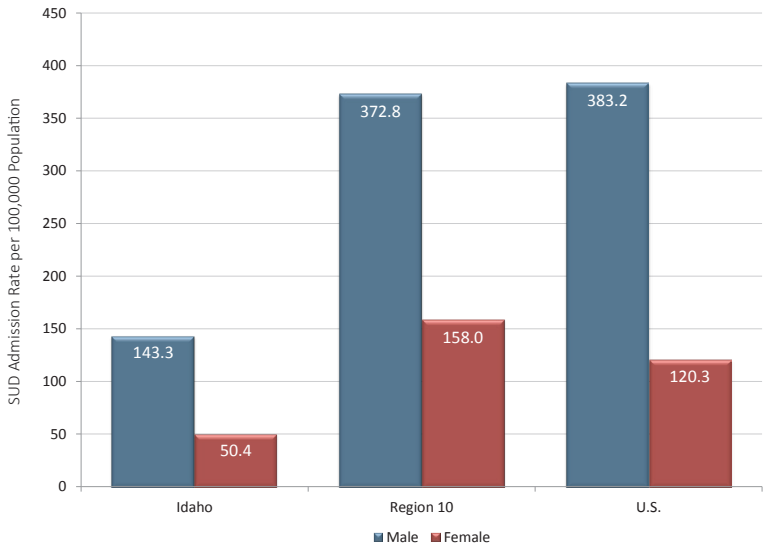
Admissions to Substance Use Disorder Treatment Among Older Idahoans

In 2012, there were 512 admissions of Idahoans ages 50 and older to substance use disorder (SUD) treatment in state-funded treatment programs, a rate of 95.2 per 100,000 people ages 50+. This rate was lower than both the regional rate and the national average. Men made up 72.7 percent of these admissions. Of all admissions, 90.2 percent were White/ Caucasian, 1.0 percent were Black/ African American, and 6.7 percent were Hispanic.

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

Self-Referral	Criminal Justice	Other
6.4%	74.6%	18.9%

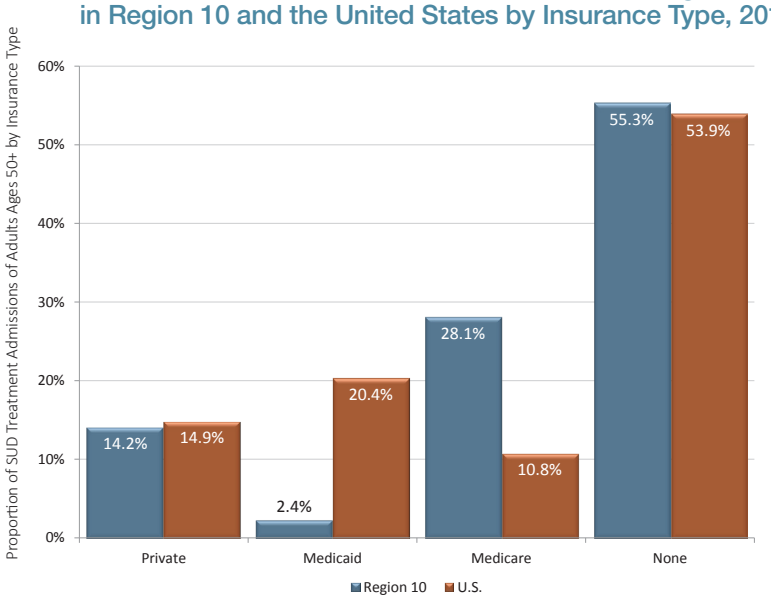
Exhibit 7. SUD Treatment Admissions of Adults Ages 50+ in Idaho, Region 10, and the United States by Sex, 2012



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

SUD Treatment Admissions Among Individuals in Region 10 Ages 50+ by Insurance Type

Exhibit 8. SUD Treatment Admissions of Adults Ages 50+ in Region 10 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 Idaho in 2012. Therefore, the rates for Region 10 are used instead.

In Region 10, 55.3 percent of older adult admissions to SUD treatment were uninsured, 2.4 percent had Medicaid, 28.1 percent had Medicare, and 14.2 percent had private insurance.

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

Self-Pay	Medicaid	Other
1.4%	0.2%	98.4%

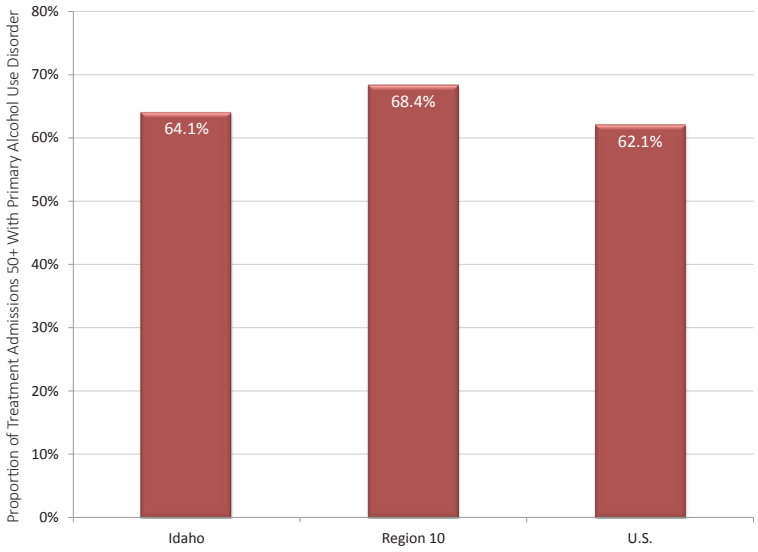
Self-pay data include private insurance.
Exhibit 8 and the accompanying text reflect the type of health insurance (if any) clients had at admission; the table above represents primary sources of payment.

[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 Idahoans Ages 50+

Alcohol was the most frequently cited substance used by older Idahoans in publicly financed SUD treatment in 2012. It was mentioned as a substance of use in 64.1 percent of admissions among those ages 50+. This was lower than the regional rate and higher than the national rate.

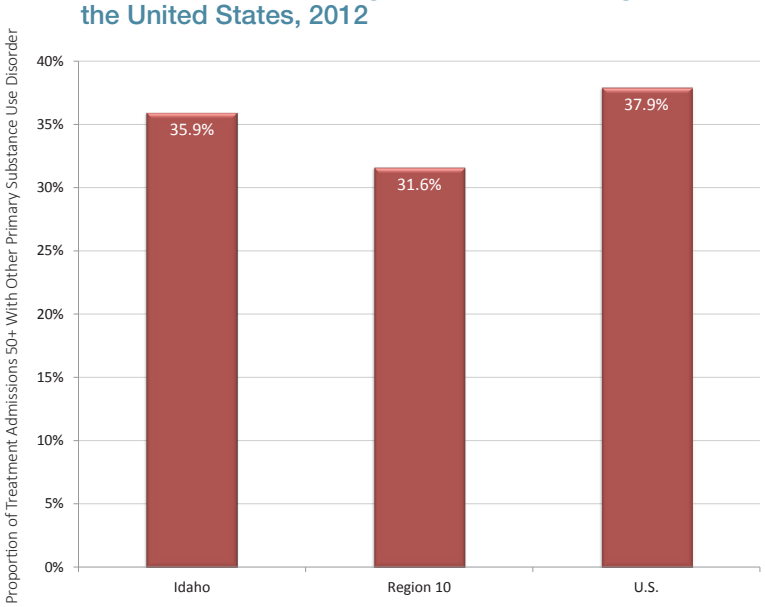
Exhibit 9. Alcohol Use Treatment Admissions of Adults Ages 50+ in Idaho, Region 10, and the United States, 2012



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 Idaho, Region 10, 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 35.9 percent of older adult admissions to publicly funded treatment in Idaho.

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*:

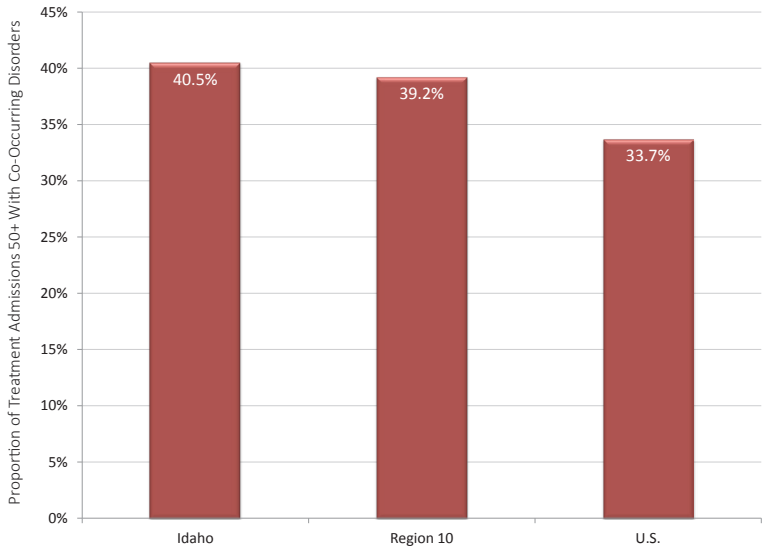
- *In 2004, there were an estimated 115,803 ED visits involving pharmaceutical misuse and abuse by adults aged 50 or older; in 2008, there were 256,097 such visits, representing an increase of 121.1 percent*
- *One fifth (19.7 percent) of ED visits involving pharmaceutical misuse and abuse among older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

Exhibit 11. SUD Treatment Admissions of Adults Ages 50+ With a Co-Occurring Mental Disorder in Idaho, Region 10, 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.

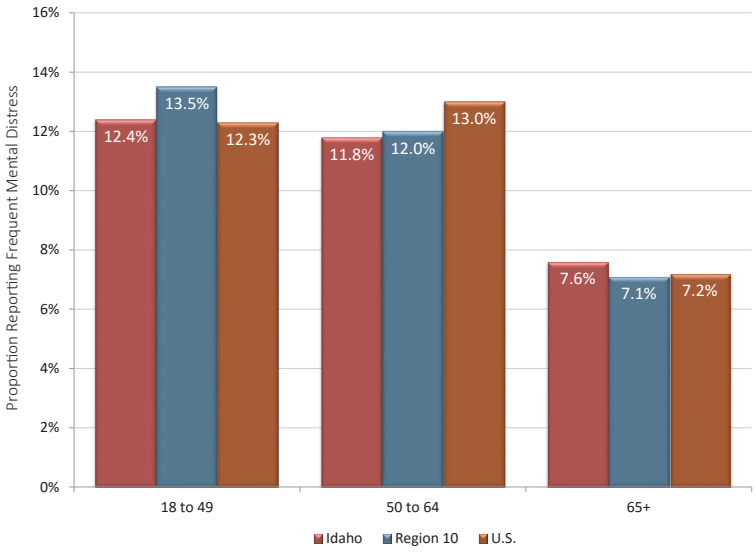
Exhibit 11 shows the proportion of SUD treatment admissions of Idahoans ages 50+ with a co-occurring mental disorder. This rate is higher than the regional rate and the national average. However, state reporting practices are a factor in these results.

MENTAL HEALTH

Older Idahoans 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 Idahoans in the 50–64 age group experience FMD at a rate that is lower than the regional and national rates, while those in the 65+ age group experience it at a rate that is higher than the regional and national rates.

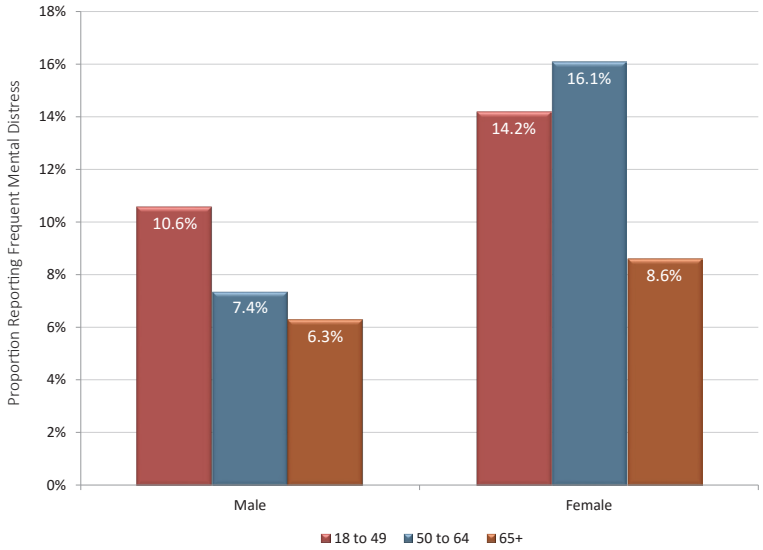
Exhibit 12. Individuals Reporting Frequent Mental Distress in Idaho, Region 10, and the United States, 2013



Source: BRFSS, 2013

Older Idahoans Reporting Frequent Mental Distress by Age Group and Sex

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



Source: BRFSS, 2013

Older men in Idaho 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, 16.1 percent of women in the 50–64 age group and 8.6 percent in the 65+ age group reported FMD, while 7.4 percent of men in the 50–64 age group and 6.3 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 Idahoans.

Exhibit 14. BRFSS Measures, 2010

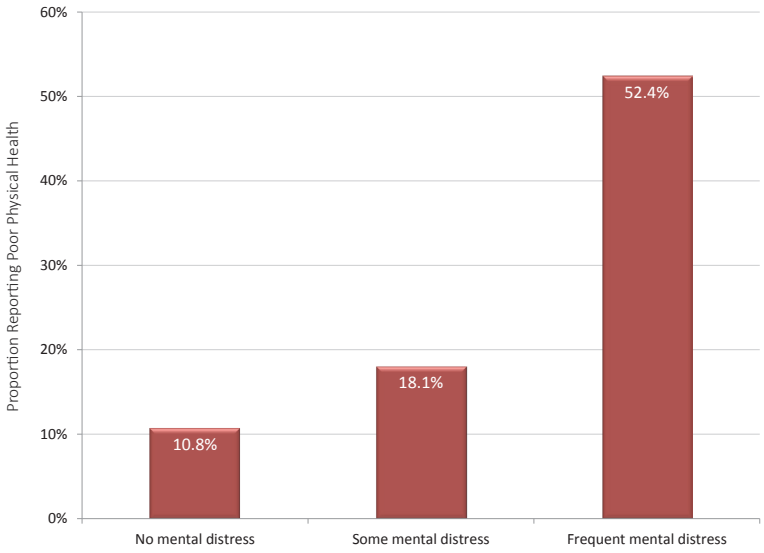
Indicator	Ages 50+	Ages 50–64	Ages 65+
Rarely or never get social or emotional support	7.2%	5.2%	10.2%
Dissatisfied or very dissatisfied	4.5%	5.4%	3.1%

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

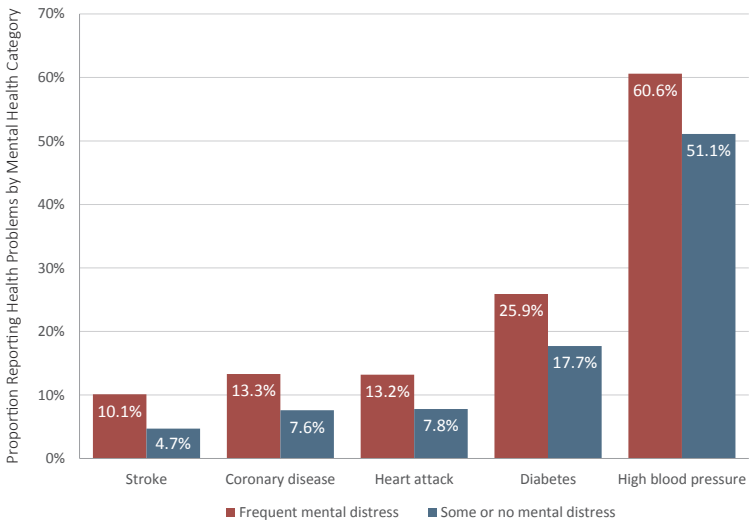


Source: BRFSS, 2013

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 Idahoans Admitted to State Mental Health Services

Approximately 2.9 percent of the people served by the Idaho mental health system were ages 65 and older. This represents more than 400 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

Oregon

Oregon

OLDER ADULTS BEHAVIORAL HEALTH PROFILE

September 2016

OREGON'S POPULATION

Oregon Population by Age Group

Oregon is home to 3,970,239 people. Of these:

- 1,440,764 (36.3 percent) are over age 50.
- 899,941 (22.7 percent) are over age 60.
- 413,683 (10.4 percent) are over age 70.
- 156,467 (3.9 percent) are ages 80 and older.

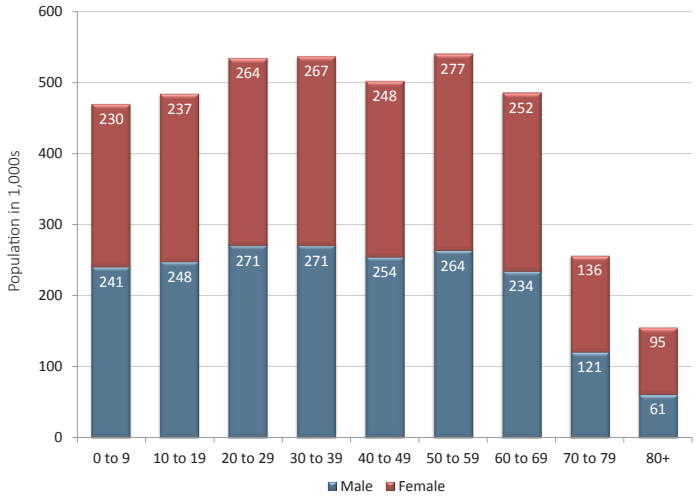
The proportion of women rises fairly steadily in each age group, and women make up 60.8 percent of the 80+ group. The racial/ethnic composition of older Oregonians is as follows:

Race/Ethnicity of Oregonians Ages 50+

White	AI/AN	Black	Asian	NH/PI	Other	Hispanic
92.6%	1.2%	1.3%	3.1%	0.2%	1.5%	4.6%

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

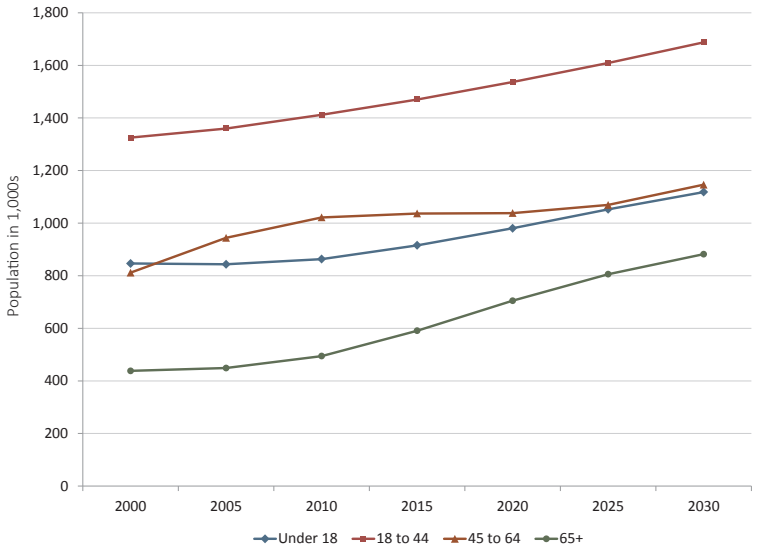
Exhibit 1. Oregon Population by Age Group, 2014



Source: U.S. Census Bureau, 2015

The Number of Older Oregonians Is Growing

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



The proportion of Oregon'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 18.2 percent of Oregon's population will be 65 and older by the year 2030, an increase of 49.3 percent from 2015.

Projected Population in Oregon

Age Group	2015	2025	2030
Under 18	22.8%	23.2%	23.1%
18 to 44	36.6%	35.5%	34.9%
45 to 64	25.8%	23.6%	23.7%
65+	14.7%	17.8%	18.2%

Source: U.S. Census Bureau, 2005

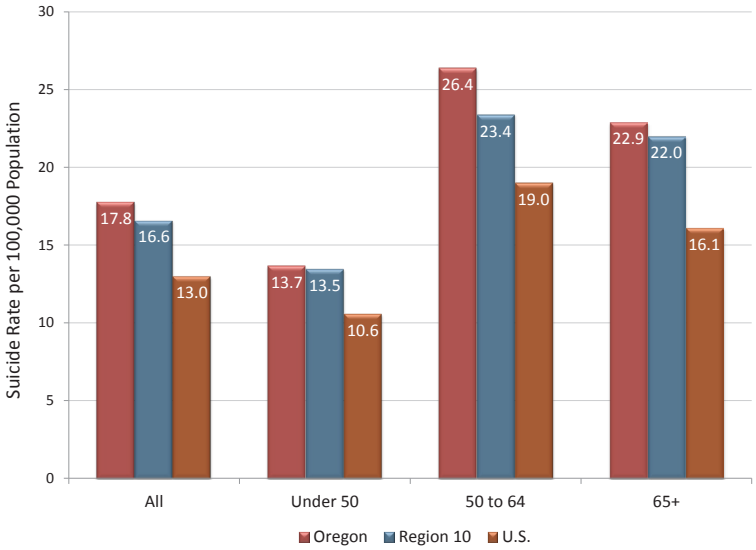
SUICIDE AMONG OLDER OREGONIANS

Oregon Suicide Rate Compared With Regional and National Rates

The suicide rate among Oregonians 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 24.9 per 100,000 people (11.5 for women and 39.9 for men). The rate among those ages 50–64 was higher than both the rate in the region (including Alaska, Idaho, and Washington) and the rate in the United States.

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

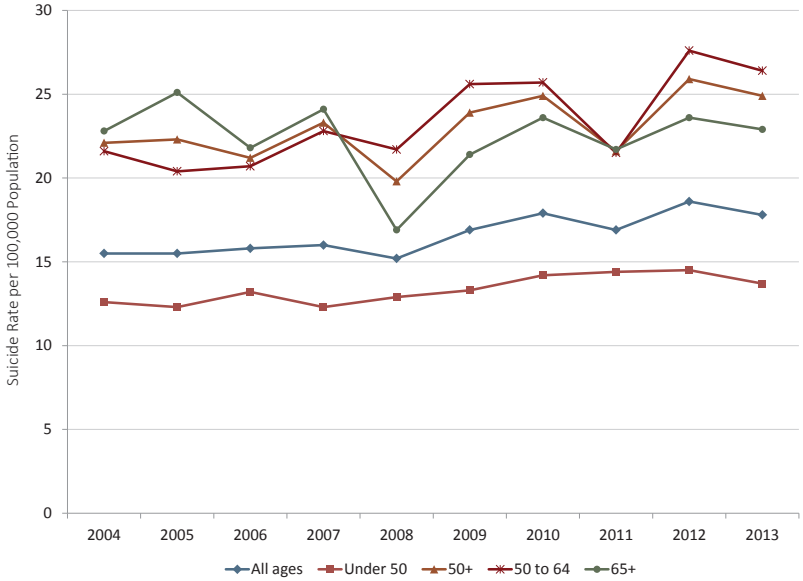
Exhibit 3. Suicide Rates in Oregon, Region 10, and the United States, 2013



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 Oregon

Exhibit 4. Trends in Suicide Rates in Oregon 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 Oregonians ages 50+ fluctuated from a low of 19.8 per 100,000 in 2008 to a high of 25.9 per 100,000 in 2012. From 2004 to 2013, the rate was generally highest among those in the 50–64 and 65+ age groups.

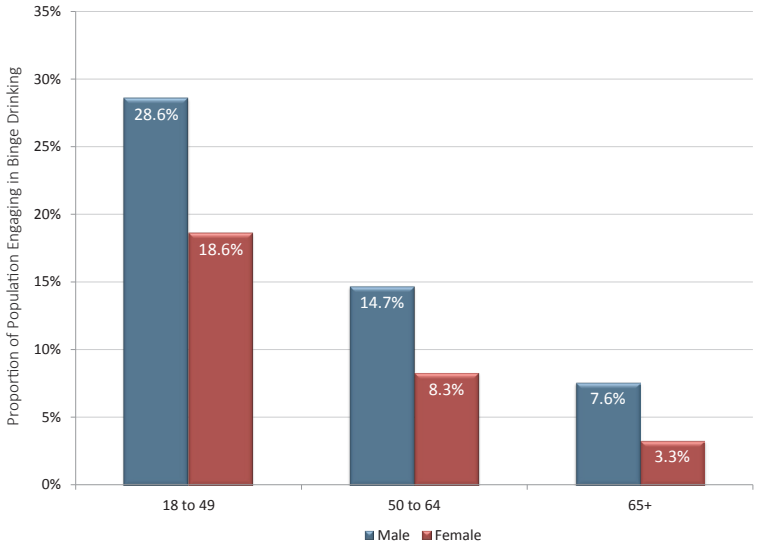
How a state reports suicides can vary from year to year. The number of suicides is generally low, so even a small difference in reported numbers may make the rate fluctuate widely.

SUBSTANCE USE DISORDER AND SUBSTANCE USE DISORDER TREATMENT AMONG OLDER OREGONIANS

30-Day Binge Drinking Among Older Oregonians

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, 14.7 percent of Oregon men ages 50–64 reported binge drinking in the past 30 days, while 7.6 percent of those in the 65+ group reported similar behavior.

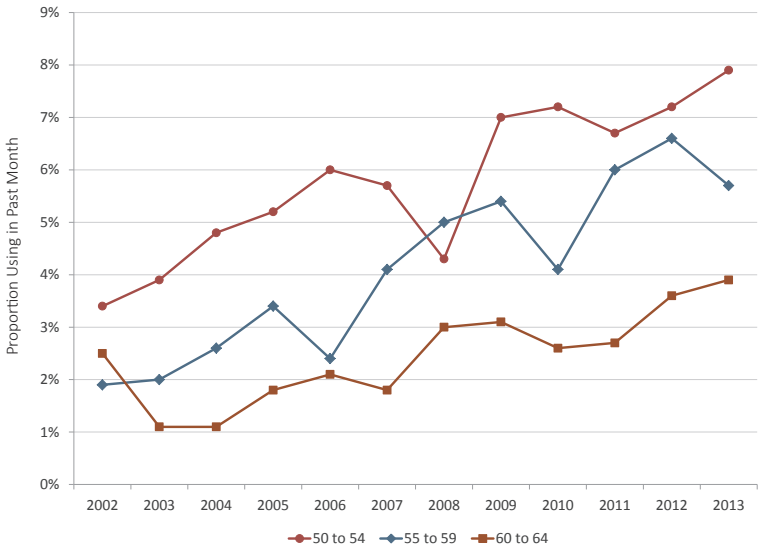
Exhibit 5. Binge Drinking Rates in Oregon by Age Group and Sex, 2013



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 *Oregon 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).

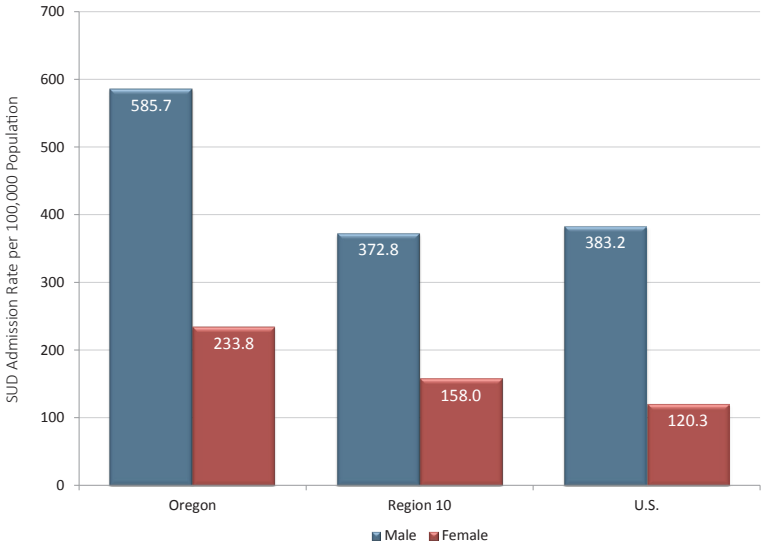
Admissions to Substance Use Disorder Treatment Among Older Oregonians

In 2012, there were 5,762 admissions of Oregonians ages 50 and older to substance use disorder (SUD) treatment in state-funded treatment programs, a rate of 399.9 per 100,000 people ages 50+. This rate was higher than the regional rate and the national average. Men made up 69.1 percent of these admissions. Of all admissions, 87.9 percent were White/Caucasian, 5.8 percent were Black/African American, and 4.2 percent were Hispanic.

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

Self-Referral	Criminal Justice	Other
33.0%	59.0%	8.1%

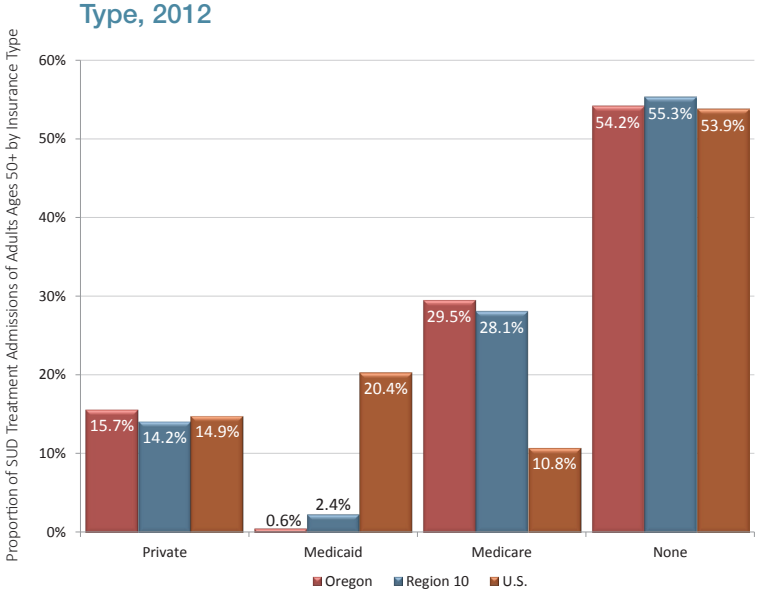
Exhibit 7. SUD Treatment Admissions of Adults Ages 50+ in Oregon, Region 10, and the United States by Sex, 2012



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

SUD Treatment Admissions Among Oregonians Ages 50+ by Insurance Type

Exhibit 8. SUD Treatment Admissions of Adults Ages 50+ in Oregon, Region 10, and the United States by Insurance Type, 2012



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

In Oregon, 54.2 percent of older adult admissions to SUD treatment were uninsured, 0.6 percent had Medicaid, 29.5 percent had Medicare, and 15.7 percent had private insurance.

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

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

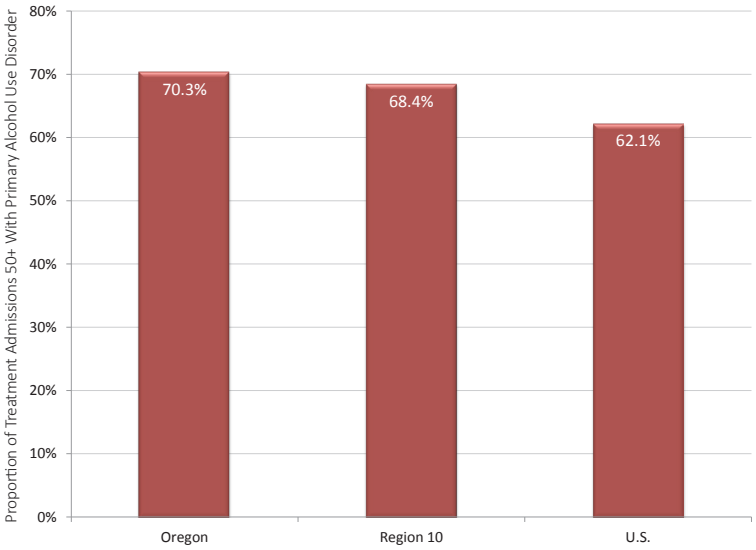
Exhibit 8 and the accompanying text reflect the type of health insurance (if any) clients had at admission; the table above represents primary sources of payment.

[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 Oregonians Ages 50+

Alcohol was the most frequently cited substance used by older Oregonians in publicly financed SUD treatment in 2012. It was mentioned as a substance of use in 70.3 percent of admissions among those ages 50+. This was higher than the regional and national rates.

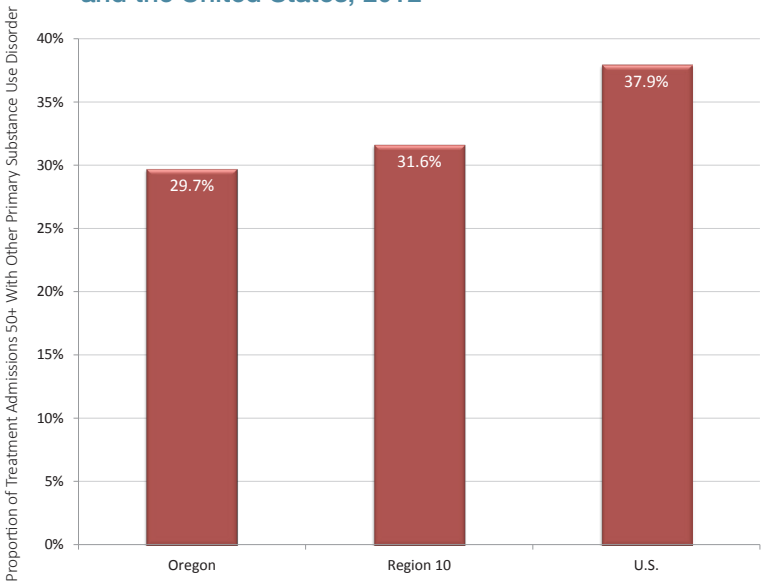
Exhibit 9. Alcohol Use Treatment Admissions of Adults Ages 50+ in Oregon, Region 10, and the United States, 2012



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 Oregon, Region 10, 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 29.7 percent of older adult admissions to publicly funded treatment in Oregon.

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*:

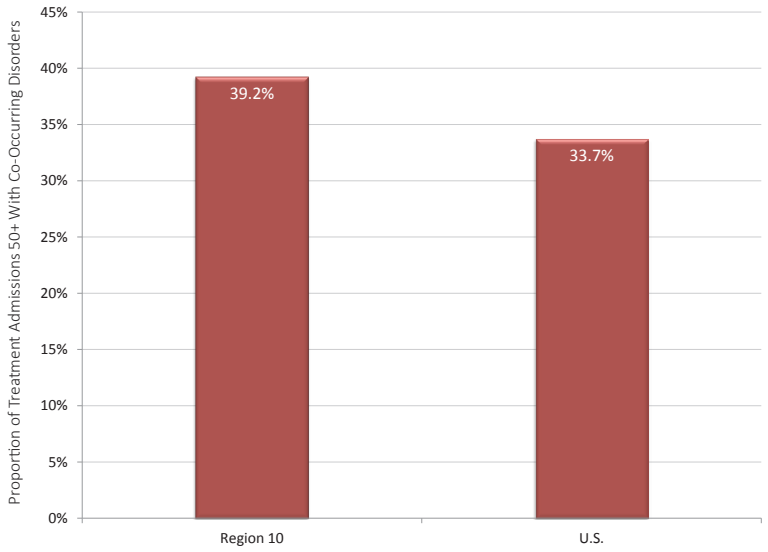
- *In 2004, there were an estimated 115,803 ED visits involving pharmaceutical misuse and abuse by adults aged 50 or older; in 2008, there were 256,097 such visits, representing an increase of 121.1 percent*
- *One fifth (19.7 percent) of ED visits involving pharmaceutical misuse and abuse among older 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 10 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 10 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.

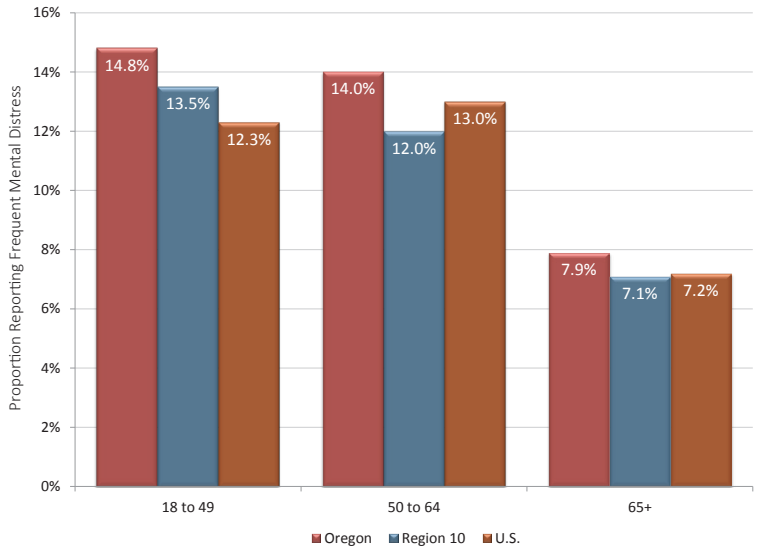
States may choose not to report some of the fields to TEDS, including information on SUD treatment admissions with a co-occurring disorder. These data were not reported by Oregon in 2012. Therefore, Exhibit 11 shows regional and national figures only.

MENTAL HEALTH

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

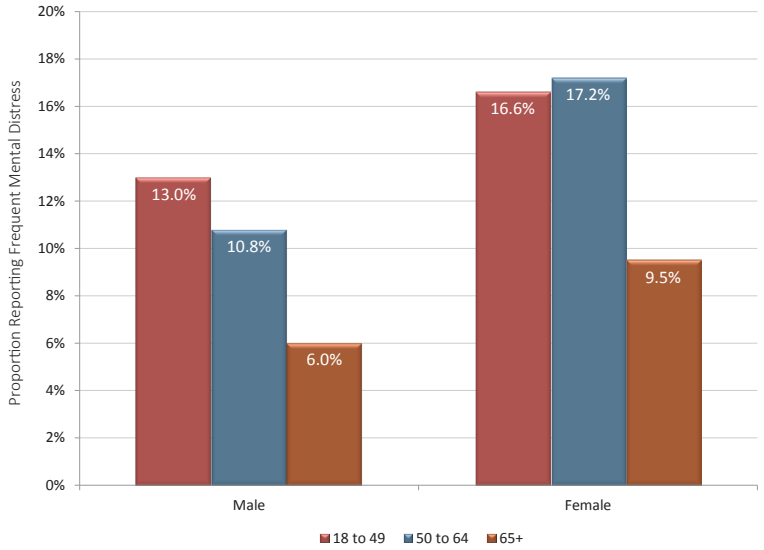
Exhibit 12. Individuals Reporting Frequent Mental Distress in Oregon, Region 10, and the United States, 2013



Source: BRFSS, 2013

Older Oregonians Reporting Frequent Mental Distress by Age Group and Sex

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



Source: BRFSS, 2013

Older men in Oregon 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, 17.2 percent of women in the 50–64 age group and 9.5 percent in the 65+ age group reported FMD, while 10.8 percent of men in the 50–64 age group and 6.0 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 Oregonians.

Exhibit 14. BRFSS Measures, 2010

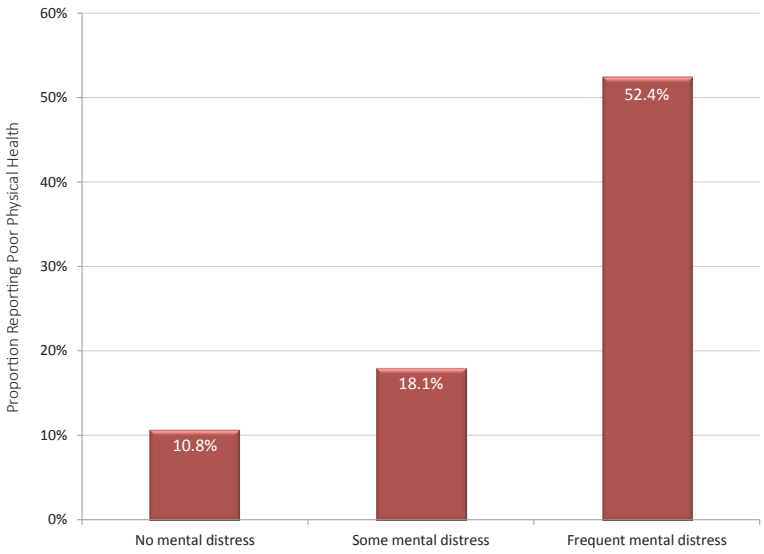
Indicator	Ages 50+	Ages 50–64	Ages 65+
Rarely or never get social or emotional support	6.5%	6.3%	6.8%
Dissatisfied or very dissatisfied	5.6%	6.7%	4.0%

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

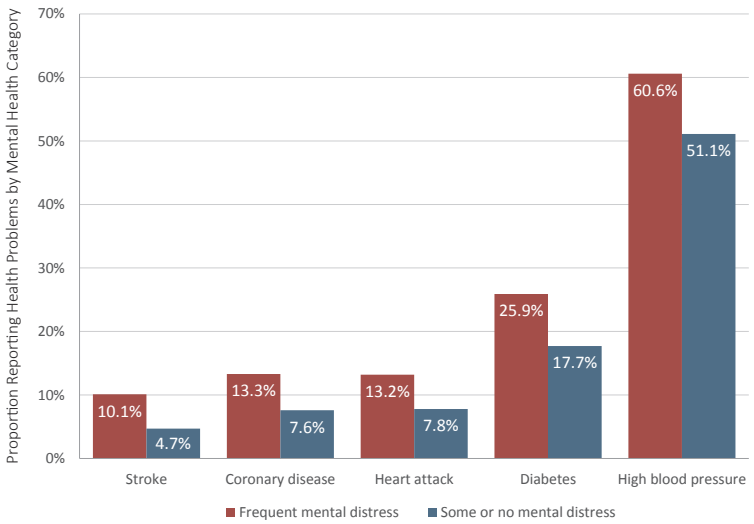


Source: BRFSS, 2013

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 Oregonians Admitted to State Mental Health Services

Approximately 4.2 percent of the people served by the Oregon mental health system were ages 65 and older. This represents more than 5,080 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

Washington

Washington

OLDER ADULTS BEHAVIORAL HEALTH PROFILE

September 2016

WASHINGTON'S POPULATION

Washington Population by Age Group

Washington is home to 7,061,530 people. Of these:

- 2,396,923 (33.9 percent) are over age 50.
- 1,422,309 (20.1 percent) are over age 60.
- 642,968 (9.1 percent) are over age 70.
- 242,195 (3.4 percent) are ages 80 and older.

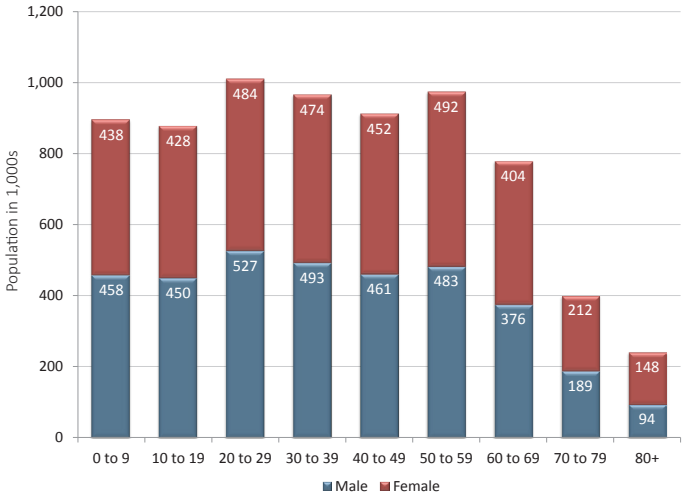
The proportion of women rises fairly steadily in each age group, and women make up 61.1 percent of the 80+ group. The racial/ethnic composition of older Washingtonians is as follows:

Race/Ethnicity of Washingtonians Ages 50+

White	AI/AN	Black	Asian	NH/PI	Other	Hispanic
87.2%	1.3%	2.8%	6.7%	0.4%	1.6%	4.6%

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

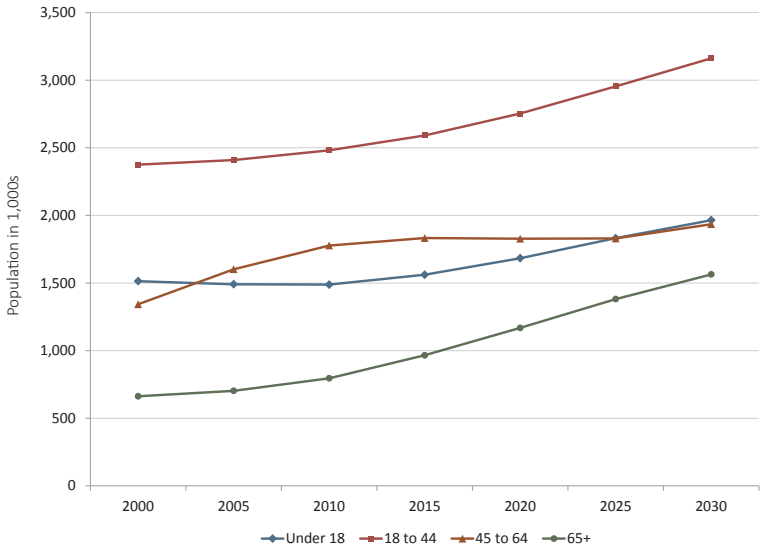
Exhibit 1. Washington Population by Age Group, 2014



Source: U.S. Census Bureau, 2015

The Number of Older Washingtonians Is Growing

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



The proportion of Washington'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 18.1 percent of Washington's population will be 65 and older by the year 2030, an increase of 62.0 percent from 2015.

Projected Population in Washington

Age Group	2015	2025	2030
Under 18	22.5%	22.9%	22.8%
18 to 44	37.3%	36.9%	36.7%
45 to 64	26.4%	22.9%	22.4%
65+	13.9%	17.3%	18.1%

Source: U.S. Census Bureau, 2005

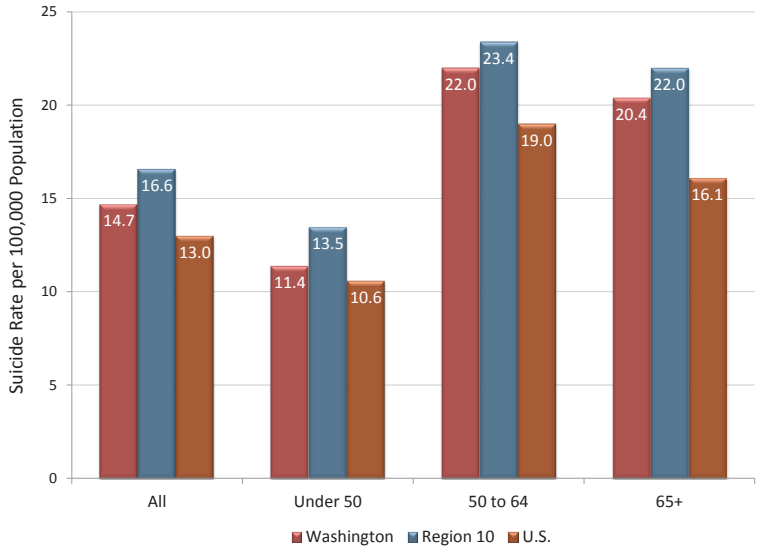
SUICIDE AMONG OLDER WASHINGTONIANS

Washington Suicide Rate Compared With Regional and National Rates

The suicide rate among Washingtonians 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 21.3 per 100,000 people (10.5 for women and 33.3 for men). The rate among those ages 50–64 was lower than the rate in the region (including Alaska, Idaho, and Oregon) and higher than the rate in the United States.

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

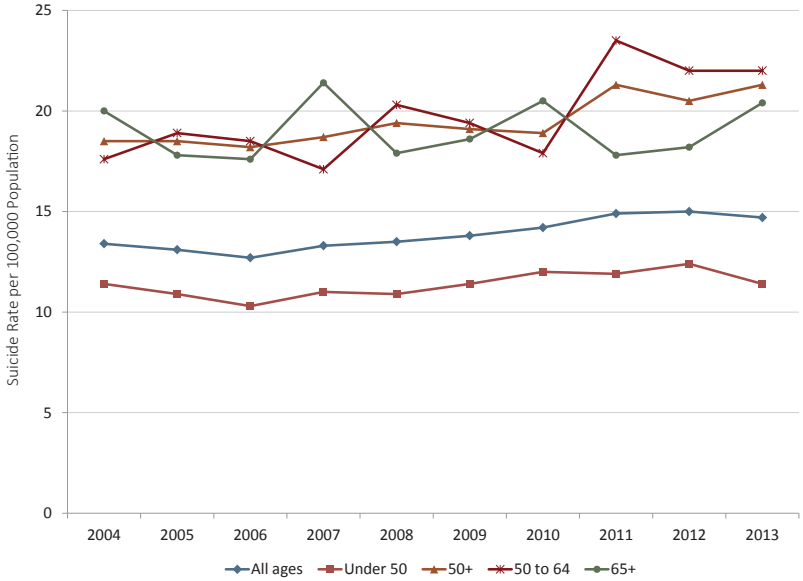
Exhibit 3. Suicide Rates in Washington, Region 10, and the United States, 2013



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 Washington

Exhibit 4. Trends in Suicide Rates in Washington 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 Washingtonians ages 50+ fluctuated from a low of 18.2 per 100,000 in 2006 to a high of 21.3 per 100,000 in 2011 and 2013. From 2004 to 2013, the rate was generally highest among those in the 50–64 age group.

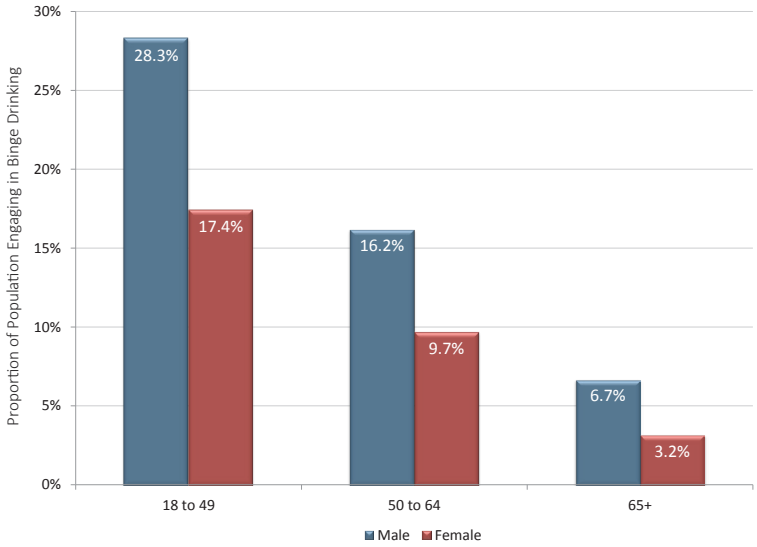
How a state reports suicides can vary from year to year. The number of suicides is generally low, so even a small difference in reported numbers may make the rate fluctuate widely.

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, 16.2 percent of Washington men ages 50–64 reported binge drinking in the past 30 days, while 6.7 percent of those in the 65+ group reported similar behavior.

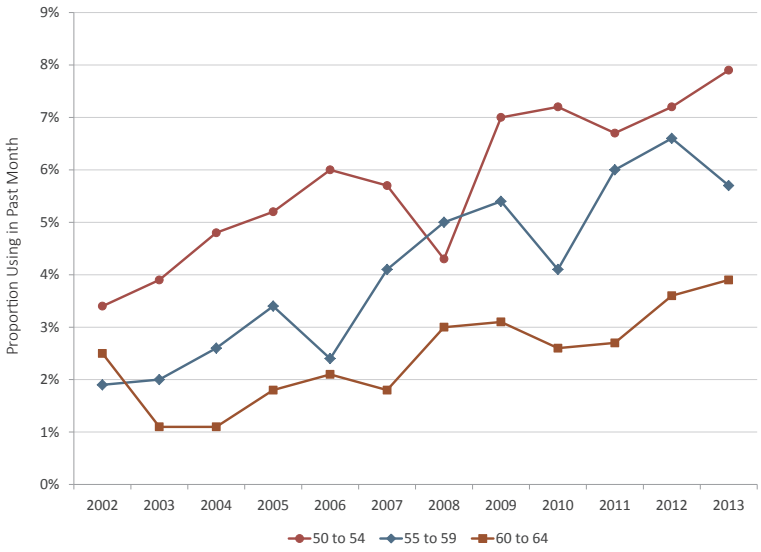
Exhibit 5. Binge Drinking Rates in Washington by Age Group and Sex, 2013



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 *Washington 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).

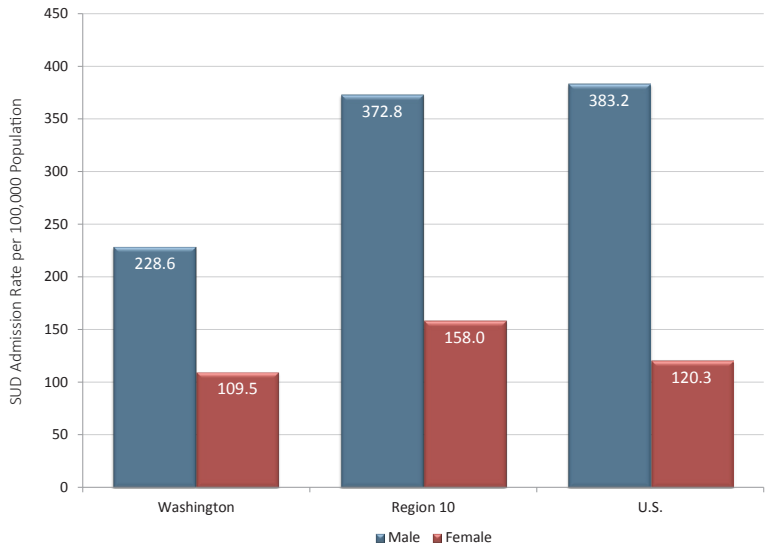
Admissions to Substance Use Disorder Treatment Among Older Washingtonians

In 2012, there were 3,983 admissions of Washingtonians ages 50 and older to substance use disorder (SUD) treatment in state-funded treatment programs, a rate of 166.2 per 100,000 people ages 50+. This rate was lower than the regional rate and the national average. Men made up 65.5 percent of these admissions. Of all admissions, 70.1 percent were White/ Caucasian, 12.5 percent were Black/ African American, and 5.9 percent were Hispanic.

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

Self-Referral	Criminal Justice	Other
18.0%	39.5%	42.5%

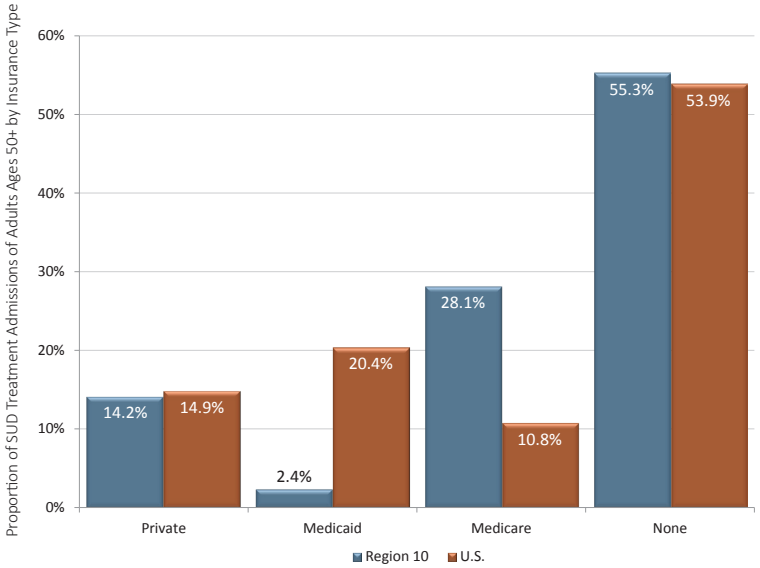
Exhibit 7. SUD Treatment Admissions of Adults Ages 50+ in Washington, Region 10, and the United States by Sex, 2012



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

SUD Treatment Admissions Among Individuals in Region 10 Ages 50+ by Insurance Type

Exhibit 8. SUD Treatment Admissions of Adults Ages 50+ in Region 10 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 Washington in 2012. Therefore, the rates for Region 10 are used instead.

In Region 10, 55.3 percent of older adult admissions to SUD treatment were uninsured, 2.4 percent had Medicaid, 28.1 percent had Medicare, and 14.2 percent had private insurance.

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

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

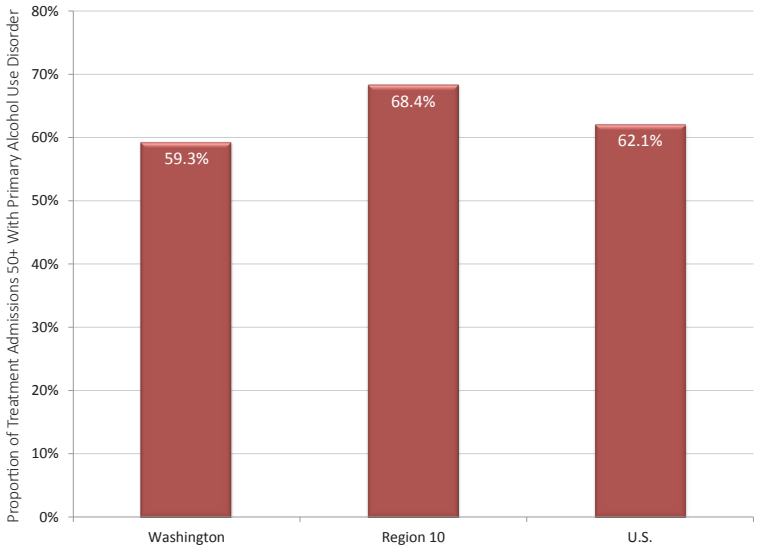
Exhibit 8 and the accompanying text reflect the type of health insurance (if any) clients had at admission; the table above represents primary sources of payment.

[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 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 59.3 percent of admissions among those ages 50+. This was lower than the regional and national rates.

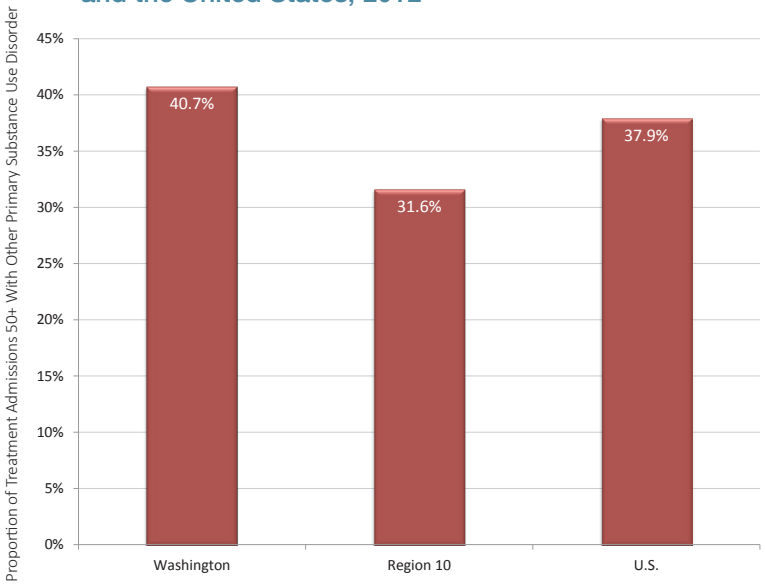
Exhibit 9. Alcohol Use Treatment Admissions of Adults Ages 50+ in Washington, Region 10, and the United States, 2012



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 Washington, Region 10, 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 40.7 percent of older adult admissions to publicly funded treatment in Washington.

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

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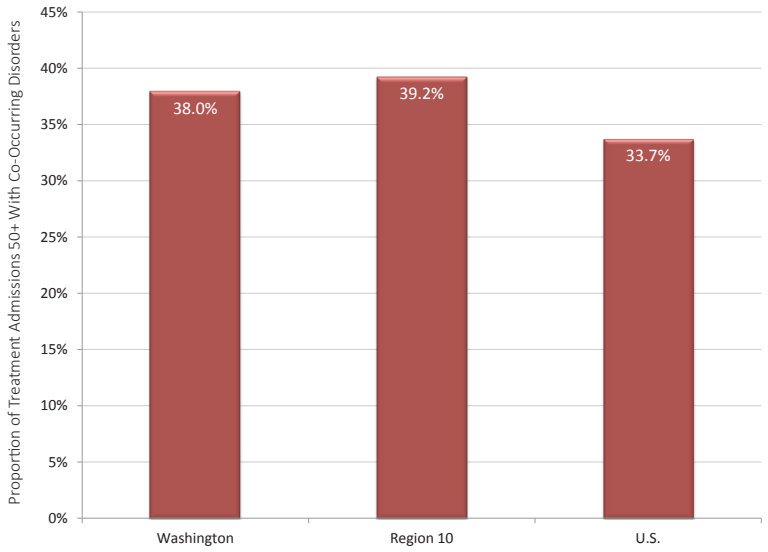


Source: TEDS, 2012
Data include only those clients reported to SAMHSA.

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.

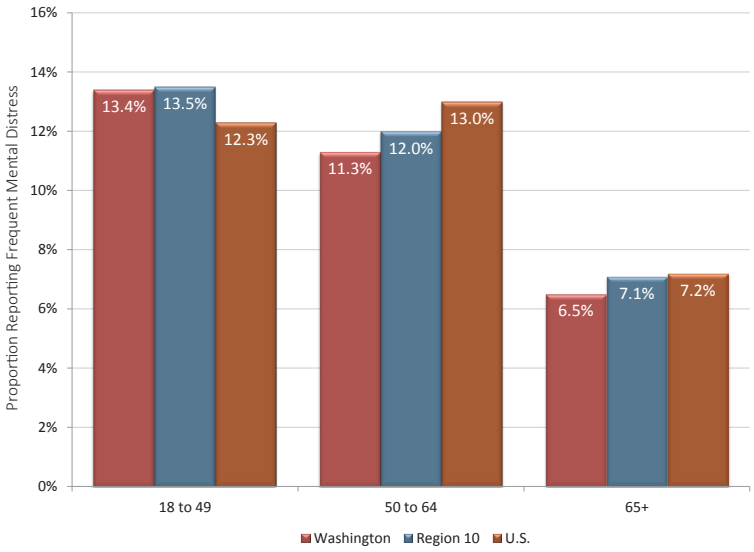
Exhibit 11 shows the proportion of SUD treatment admissions of Washingtonians ages 50+ with a co-occurring mental disorder. This rate is lower than the regional rate and higher than the national average. However, state reporting practices are a factor in these results.

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 lower than the regional and national rates.

Exhibit 12. Individuals Reporting Frequent Mental Distress in Washington, Region 10, and the United States, 2013



Source: BRFSS, 2013

Older Washingtonians Reporting Frequent Mental Distress by Age Group and Sex

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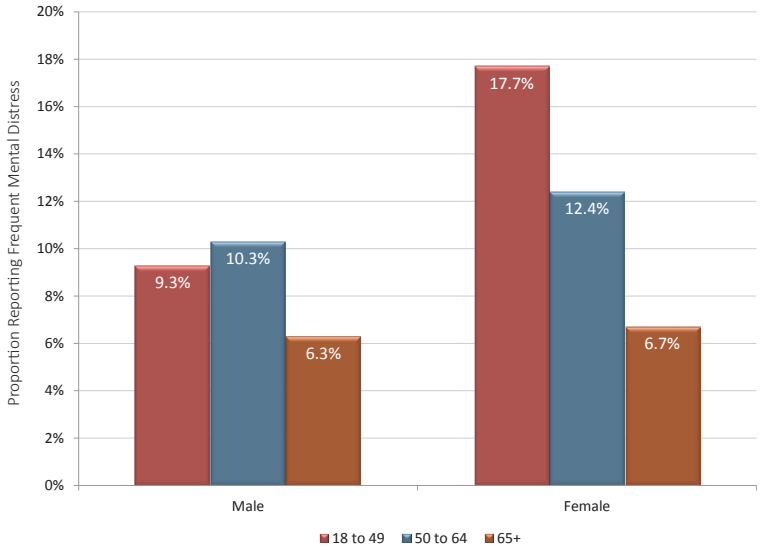

Source: BRFSS, 2013

Older men in Washington 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, 12.4 percent of women in the 50–64 age group and 6.7 percent in the 65+ age group reported FMD, while 10.3 percent of men in the 50–64 age group and 6.3 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.
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Exhibit 14. BRFSS Measures, 2010

Indicator	Ages 50+	Ages 50–64	Ages 65+
Rarely or never get social or emotional support	6.1%	5.2%	7.7%
Dissatisfied or very dissatisfied	4.8%	6.0%	3.0%

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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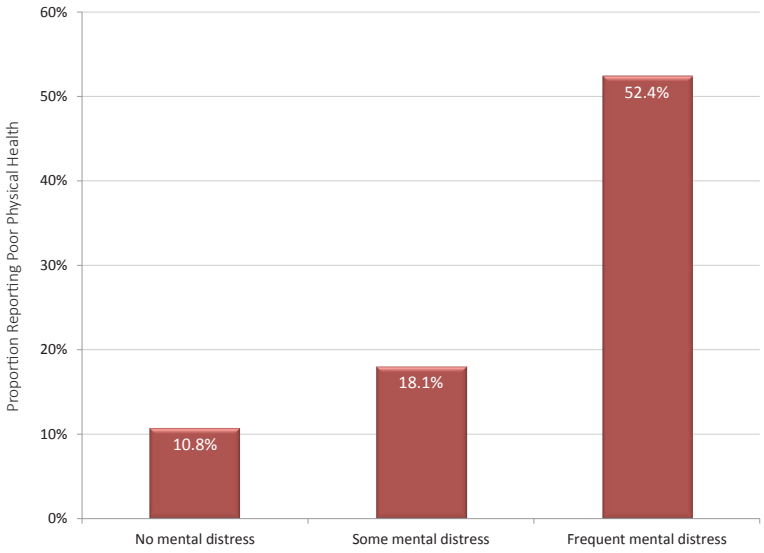
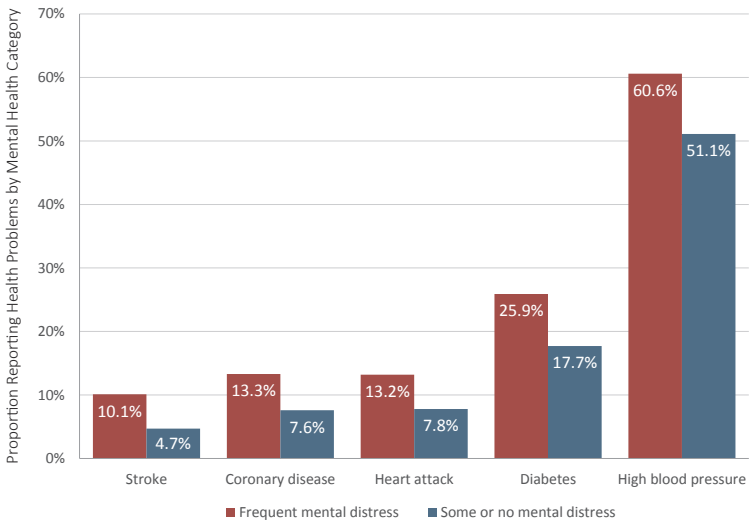


Source: BRFSS, 2013

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 Washingtonians Admitted to State Mental Health Services

Approximately 5.9 percent of the people served by the Washington mental health system were ages 65 and older. This represents more than 8,960 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.