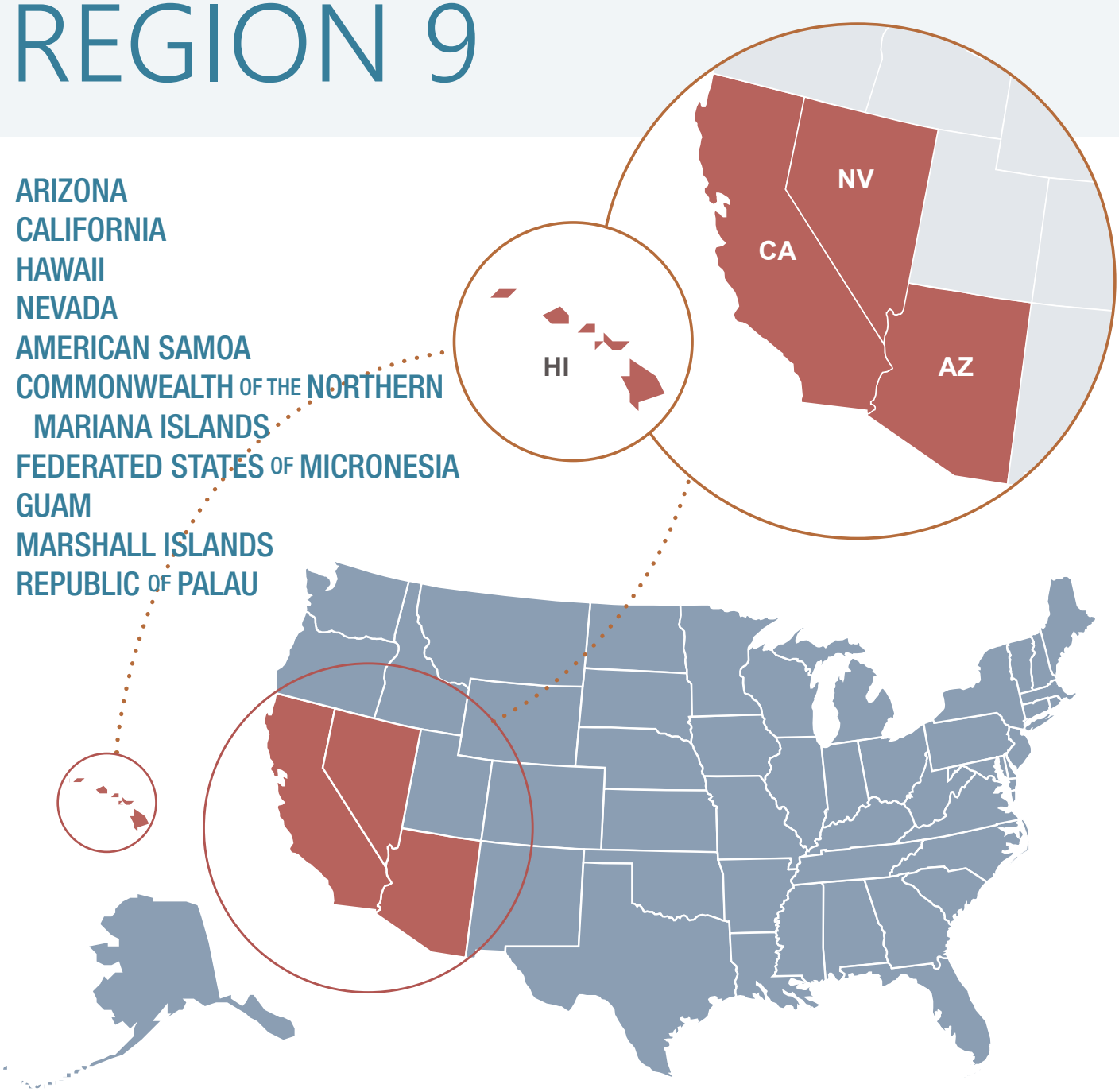
OLDER ADULTS BEHAVIORAL HEALTH PROFILES

REGION 9

ARIZONA
CALIFORNIA
HAWAII
NEVADA
AMERICAN SAMOA
COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS
FEDERATED STATES OF MICRONESIA
GUAM
MARSHALL ISLANDS
REPUBLIC OF PALAU



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, territories, and communities play in addressing the needs of this vital and growing population. Administrators need clear and concise information to plan, implement, and evaluate effective prevention and treatment efforts in their states and territories.

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

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

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

OLDER ADULTS BEHAVIORAL HEALTH PROFILE

Arizona

Arizona

OLDER ADULTS BEHAVIORAL HEALTH PROFILE

September 2016

ARIZONA'S POPULATION

Arizona Population by Age Group

Arizona is home to 6,731,484 people. Of these:

- 2,296,712 (34.1 percent) are over age 50.
- 1,449,556 (21.5 percent) are over age 60.
- 719,112 (10.7 percent) are over age 70.
- 255,774 (3.8 percent) are ages 80 and older.

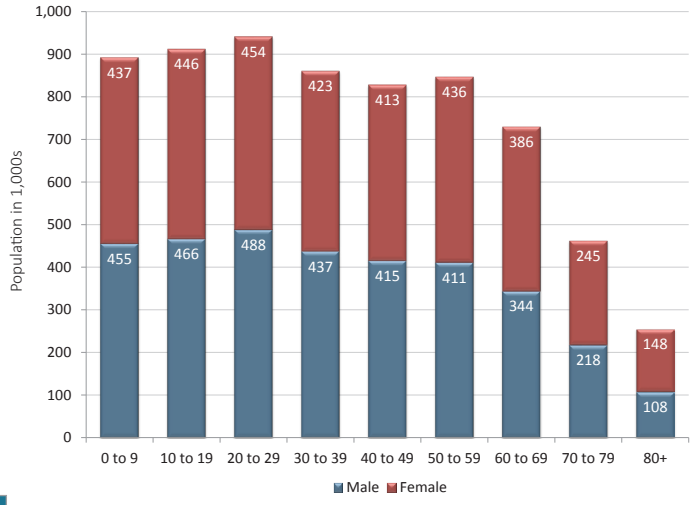
The proportion of women rises fairly steadily in each age group, and women make up 57.7 percent of the 80+ group. The racial/ethnic composition of older Arizonans is as follows:

Race/Ethnicity of Arizonans Ages 50+

White	AI/AN	Black	Asian	NH/PI	Other	Hispanic
89.9%	3.4%	3.1%	2.4%	0.1%	1.0%	16.3%

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.

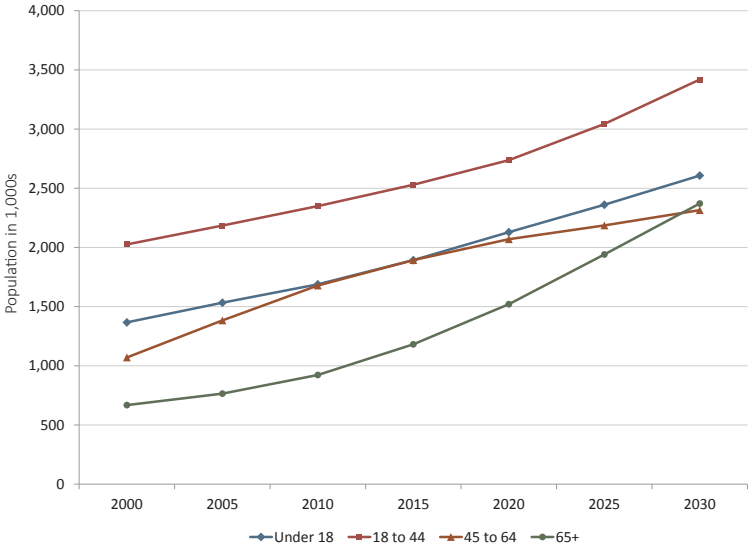
Exhibit 1. Arizona Population by Age Group, 2014



Source: U.S. Census Bureau, 2015

The Number of Older Arizonans Is Growing

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



The proportion of Arizona'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 22.1 percent of Arizona's population will be 65 and older by the year 2030, an increase of 100.7 percent from 2015.

Projected Population in Arizona

Age Group	2015	2025	2030
Under 18	25.2%	24.8%	24.3%
18 to 44	33.7%	31.9%	31.9%
45 to 64	25.2%	22.9%	21.6%
65+	15.8%	20.4%	22.1%

Source: U.S. Census Bureau, 2005

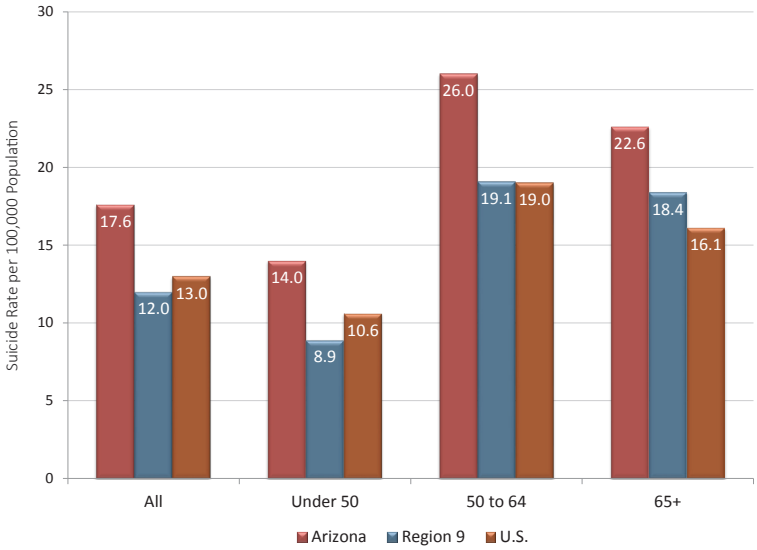
SUICIDE AMONG OLDER ARIZONANS

Arizona Suicide Rate Compared With Regional and National Rates

The suicide rate among Arizonans 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 24.5 per 100,000 people (10.8 for women and 39.8 for men). The rate among those ages 50–64 was higher than both the rate in the region (including California, Hawaii, and Nevada) and the rate in the United States.

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

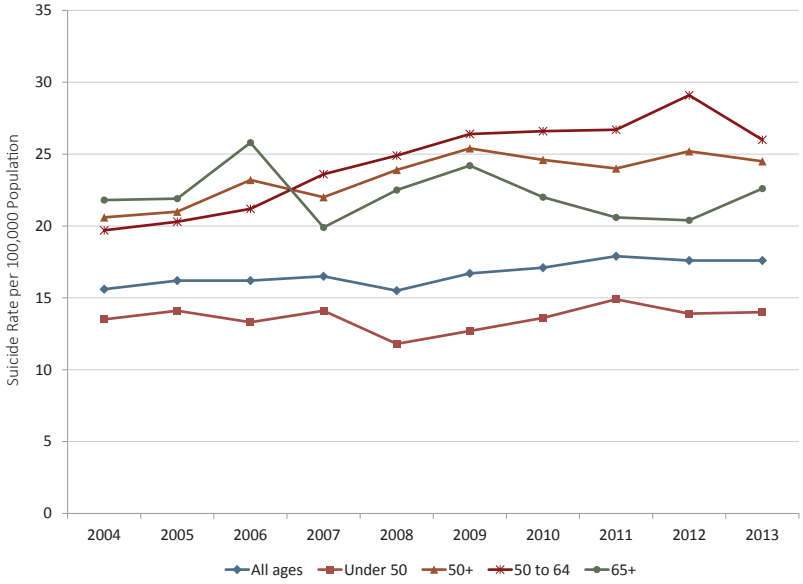
Exhibit 3. Suicide Rates in Arizona, Region 9, and the United States, 2013



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 Arizona

Exhibit 4. Trends in Suicide Rates in Arizona 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 Arizonans ages 50+ fluctuated from a low of 20.6 per 100,000 in 2004 to a high of 25.4 per 100,000 in 2009. From 2004 to 2013, the rate was generally highest among those in the 50–64 age group.

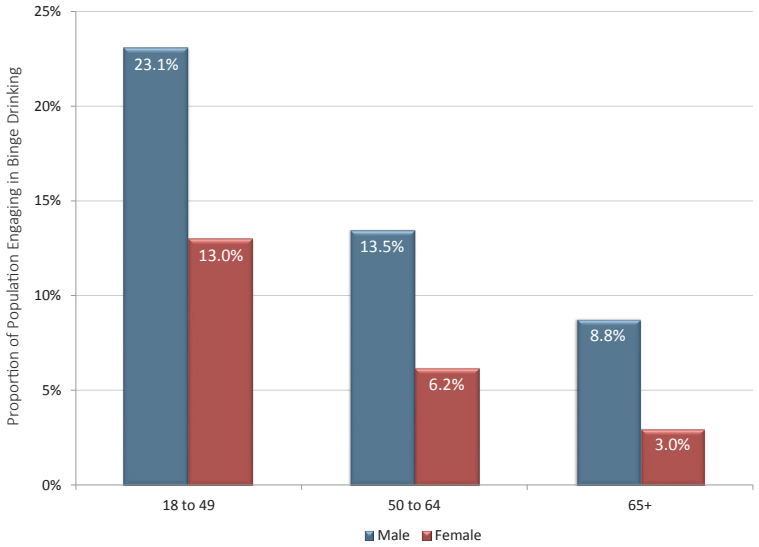
How a state reports suicides can vary from year to year. The number of suicides is generally low, so even a small difference in reported numbers may make the rate fluctuate widely.

SUBSTANCE USE DISORDER AND SUBSTANCE USE DISORDER TREATMENT AMONG OLDER ARIZONANS

30-Day Binge Drinking Among Older Arizonans

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, 13.5 percent of Arizona men ages 50–64 reported binge drinking in the past 30 days, while 8.8 percent of those in the 65+ group reported similar behavior.

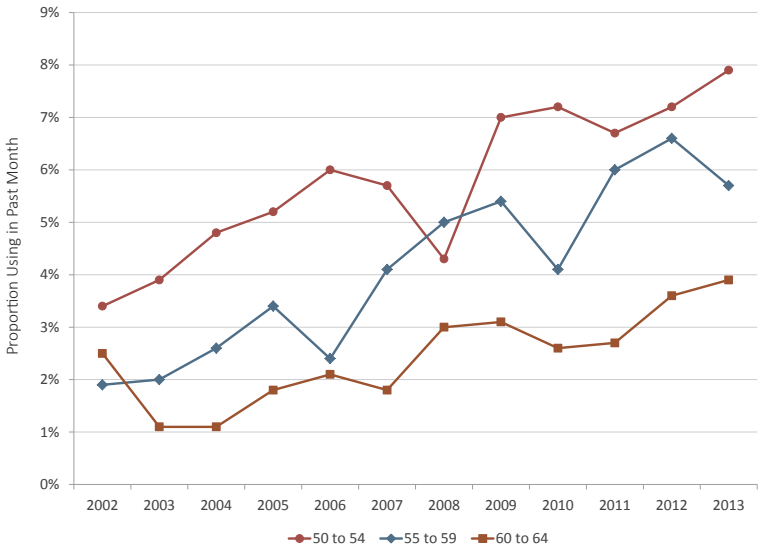
Exhibit 5. Binge Drinking Rates in Arizona by Age Group and Sex, 2013



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 *Arizona 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).

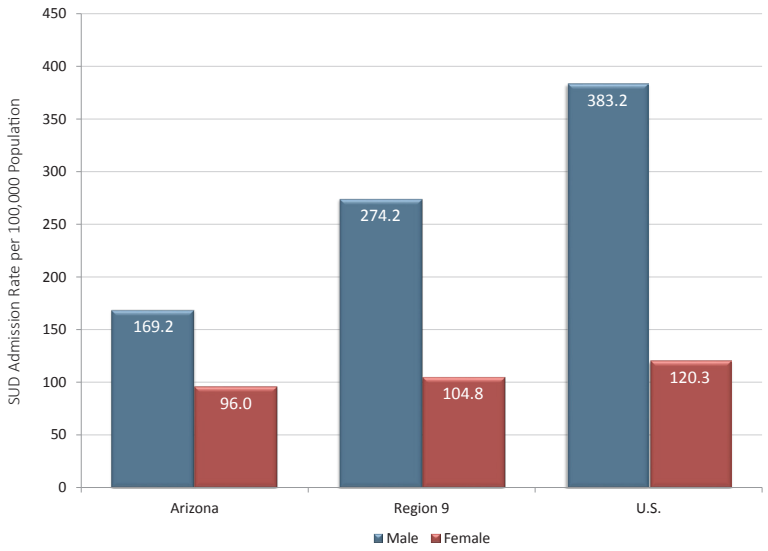
Admissions to Substance Use Disorder Treatment Among Older Arizonans

In 2012, there were 2,997 admissions of Arizonans ages 50 and older to substance use disorder (SUD) treatment in state-funded treatment programs, a rate of 130.5 per 100,000 people ages 50+. This rate was lower than the regional rate and the national average. Men made up 61.1 percent of these admissions. Of all admissions, 84.4 percent were White/Caucasian, 9.3 percent were Black/African American, and 18.8 percent were Hispanic.

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

Self-Referral	Criminal Justice	Other
60.6%	14.3%	25.1%

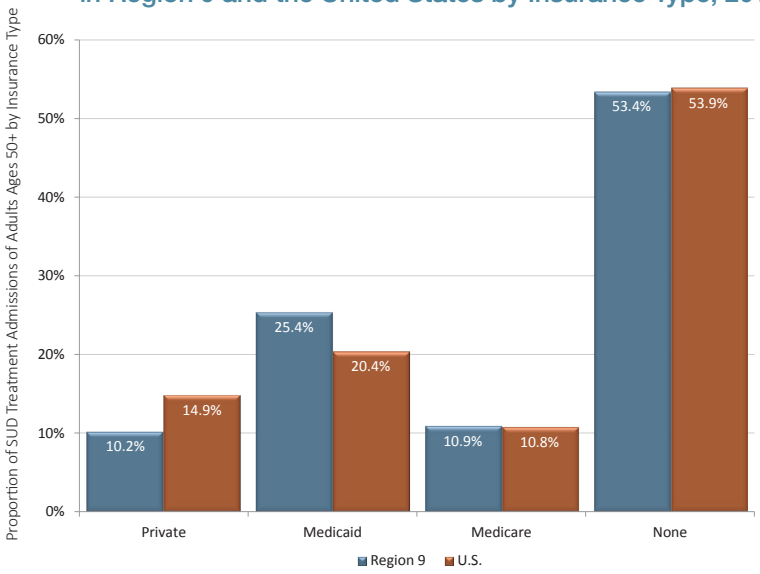
Exhibit 7. SUD Treatment Admissions of Adults Ages 50+ in Arizona, Region 9, and the United States by Sex, 2012



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

SUD Treatment Admissions Among Individuals in Region 9 Ages 50+ by Insurance Type

Exhibit 8. SUD Treatment Admissions of Adults Ages 50+ in Region 9 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 Arizona in 2012. Therefore, the rates for Region 9 are used instead.

In Region 9, 53.4 percent of older adults admitted to SUD treatment were uninsured, 25.4 percent had Medicaid, 10.9 percent had Medicare, and 10.2 percent had private insurance.

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

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

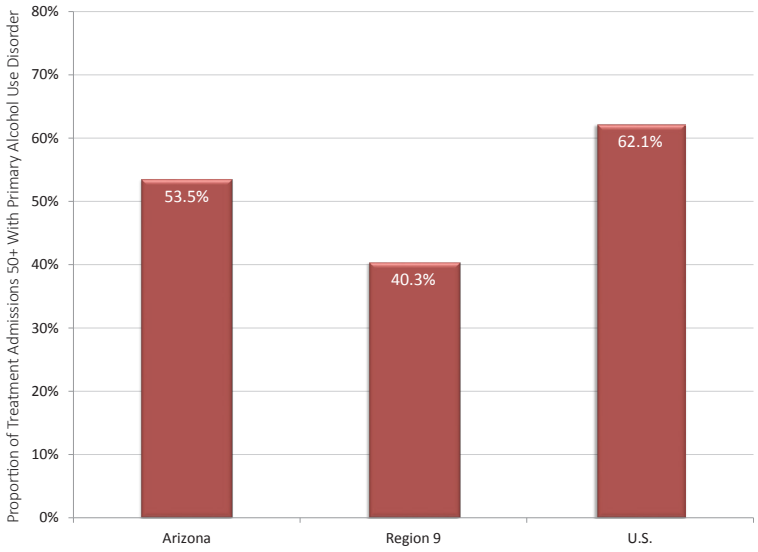
Exhibit 8 and the accompanying text reflect the type of health insurance (if any) clients had at admission; the table above represents primary sources of payment.

[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 Arizonans Ages 50+

Alcohol was the most frequently cited substance used by older Arizonans in publicly financed SUD treatment in 2012. It was mentioned as a substance of use in 53.5 percent of admissions among those ages 50+. This was higher than the regional rate and lower than the national rate.

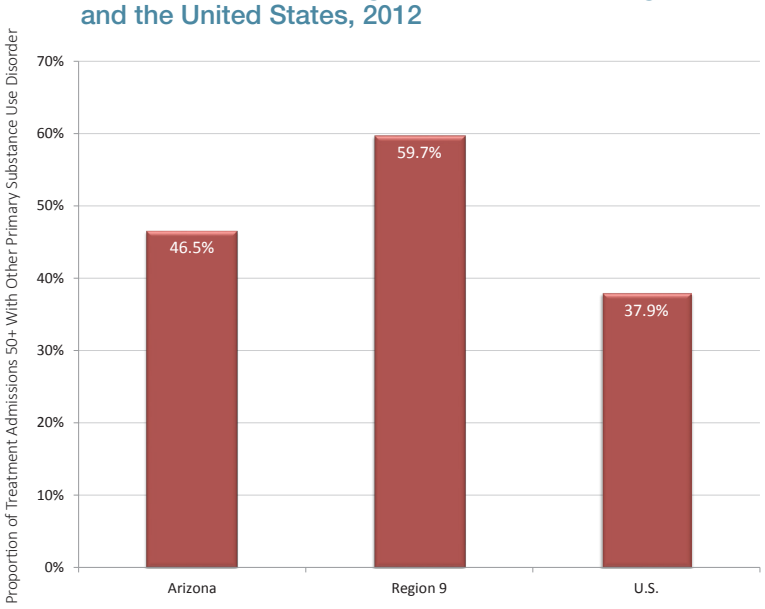
Exhibit 9. Alcohol Use Treatment Admissions of Adults Ages 50+ in Arizona, Region 9, and the United States, 2012



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 Arizona, Region 9, 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 46.5 percent of older adult admissions to publicly funded treatment in Arizona.

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*:

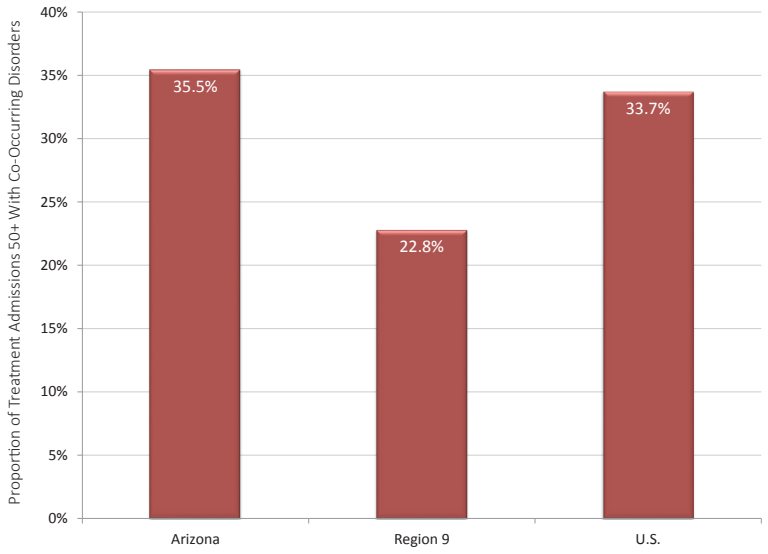
- *In 2004, there were an estimated 115,803 ED visits involving pharmaceutical misuse and abuse by adults aged 50 or older; in 2008, there were 256,097 such visits, representing an increase of 121.1 percent*
- *One fifth (19.7 percent) of ED visits involving pharmaceutical misuse and abuse among older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

Exhibit 11. SUD Treatment Admissions of Adults Ages 50+ With a Co-Occurring Mental Disorder in Arizona, Region 9, 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.

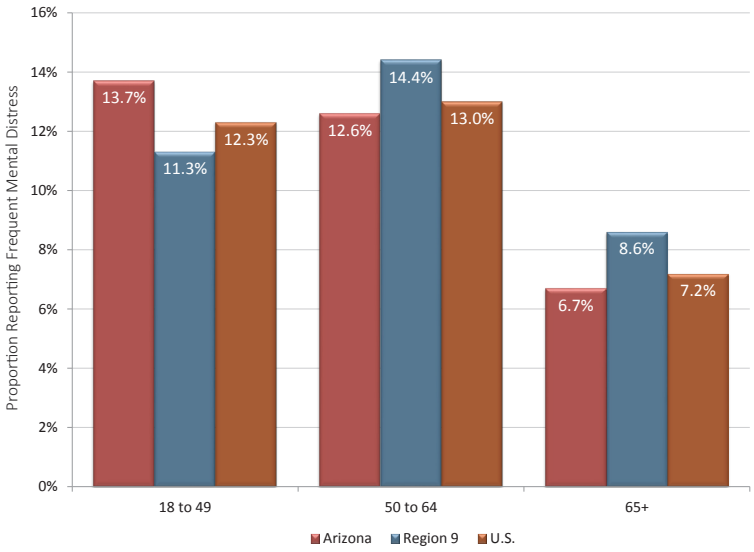
Exhibit 11 shows the proportion of SUD treatment admissions of Arizonans ages 50+ with a co-occurring mental disorder. This rate is higher than the regional rate and the national average. However, state reporting practices are a factor in these results.

MENTAL HEALTH

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

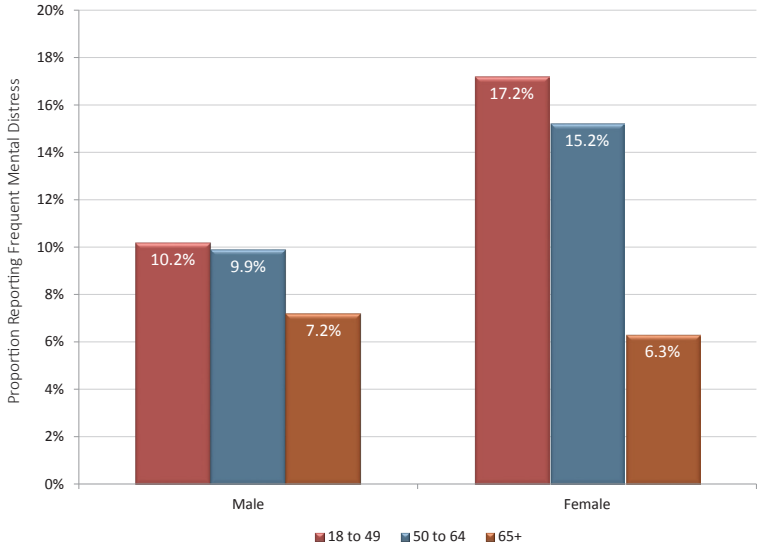
Exhibit 12. Individuals Reporting Frequent Mental Distress in Arizona, Region 9, and the United States, 2013



Source: BRFSS, 2013

Older Arizonans Reporting Frequent Mental Distress by Age Group and Sex

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



Source: BRFSS, 2013

As Exhibit 13 shows, in Arizona, 9.9 percent of men in the 50–64 age group reported FMD (14 days or more per 30-day period) compared with 15.2 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 (7.2 percent compared with 6.3 percent). Hawaii is the only other state in the region where men in the 65+ age group did not report a lower rate of FMD than 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 Arizonans.

Exhibit 14. BRFSS Measures, 2010

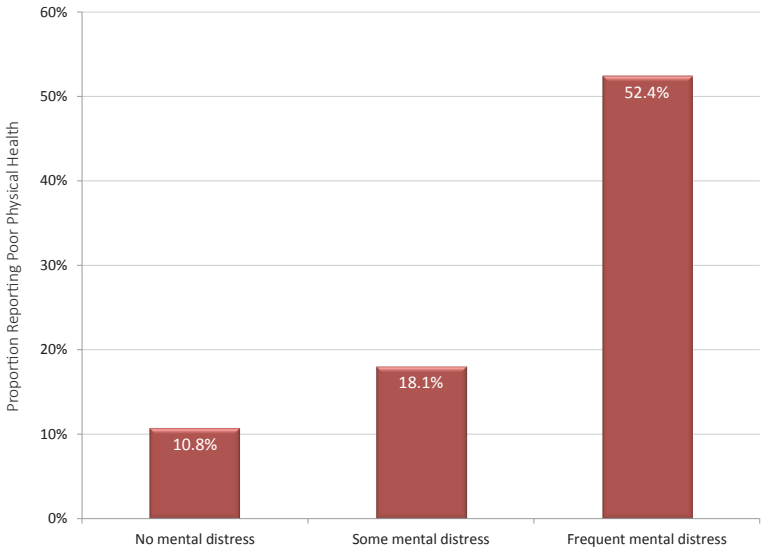
Indicator	Ages 50+	Ages 50–64	Ages 65+
Rarely or never get social or emotional support	10.3%	8.5%	13.3%
Dissatisfied or very dissatisfied	6.5%	8.1%	4.0%

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

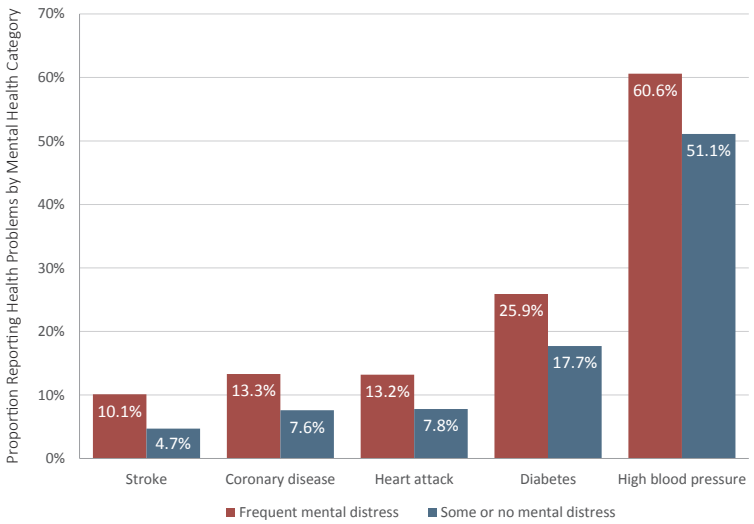


Source: BRFSS, 2013

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 Arizonans Admitted to State Mental Health Services

Approximately 3.4 percent of the people served by the Arizona mental health system were ages 65 and older. This represents more than 5,380 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

California

California

OLDER ADULTS BEHAVIORAL HEALTH PROFILE

September 2016

CALIFORNIA'S POPULATION

California Population by Age Group

California is home to 38,802,500 people. Of these:

- 12,172,699 (31.4 percent) are over age 50.
- 7,058,201 (18.2 percent) are over age 60.
- 3,328,840 (8.6 percent) are over age 70.
- 1,311,686 (3.4 percent) are ages 80 and older.

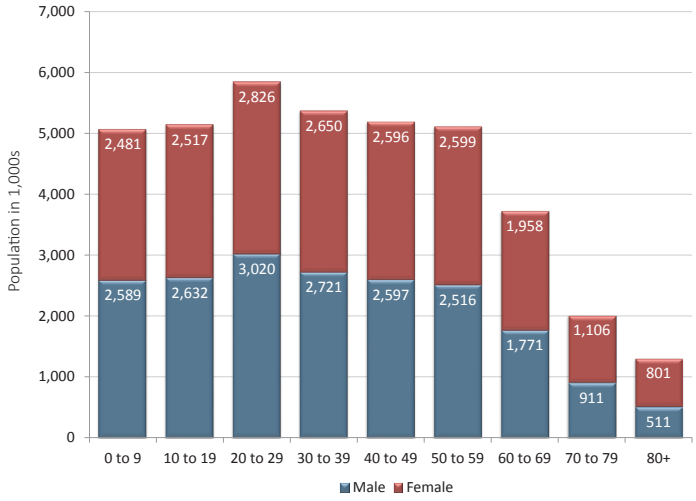
The proportion of women rises fairly steadily in each age group, and women make up 61.1 percent of the 80+ group. The racial/ethnic composition of older Californians is as follows:

Race/Ethnicity of Californians Ages 50+

White	AI/AN	Black	Asian	NH/PI	Other	Hispanic
75.5%	1.2%	6.1%	15.0%	0.4%	1.8%	23.8%

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.

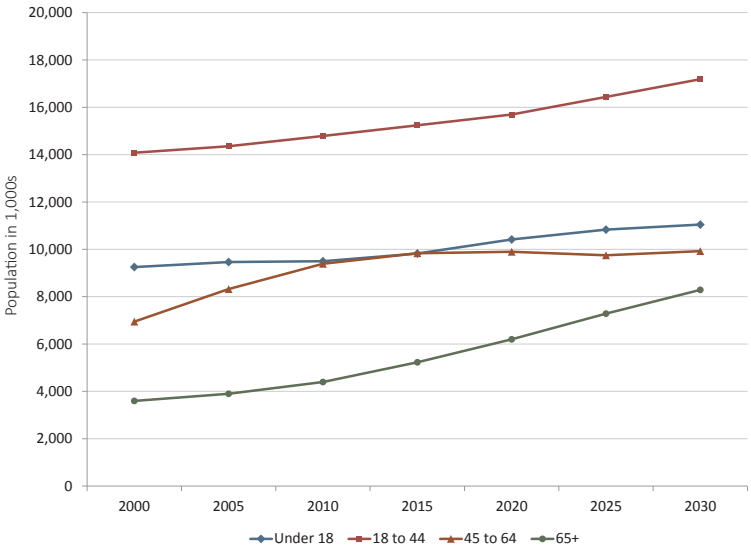
Exhibit 1. California Population by Age Group, 2014



Source: U.S. Census Bureau, 2015

The Number of Older Californians Is Growing

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



The proportion of California'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 17.8 percent of California's population will be 65 and older by the year 2030, an increase of 58.5 percent from 2015.

Projected Population in California

Age Group	2015	2025	2030
Under 18	24.5%	24.4%	23.8%
18 to 44	38.0%	37.1%	37.0%
45 to 64	24.5%	22.0%	21.4%
65+	13.0%	16.4%	17.8%

Source: U.S. Census Bureau, 2005

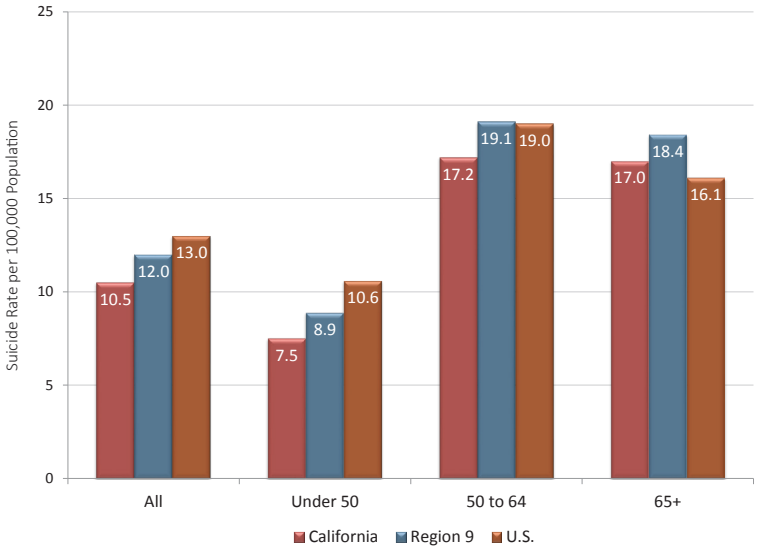
SUICIDE AMONG OLDER CALIFORNIANS

California Suicide Rate Compared With Regional and National Rates

The suicide rate among Californians 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 17.1 per 100,000 people (7.6 for women and 27.9 for men). The rate among those ages 50–64 was lower than both the rate in the region (including Arizona, Hawaii, and Nevada) and the rate in the United States.

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

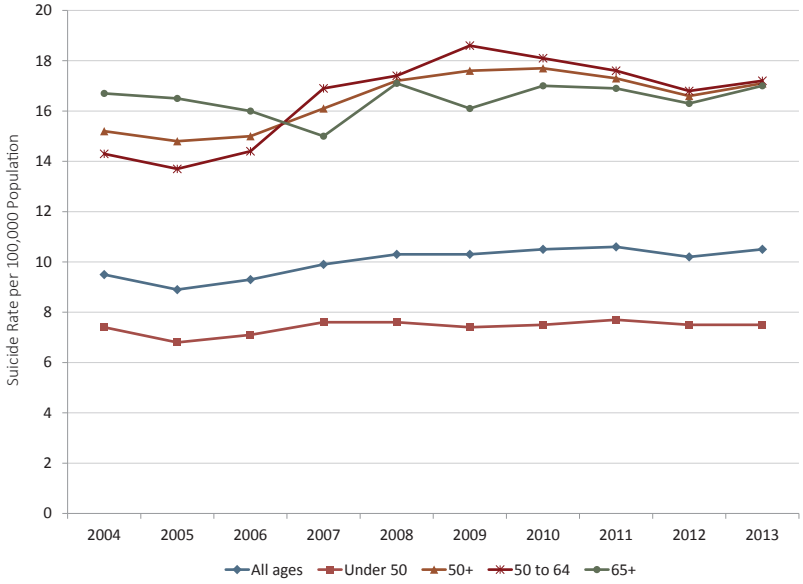
Exhibit 3. Suicide Rates in California, Region 9, and the United States, 2013



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 California

Exhibit 4. Trends in Suicide Rates in California 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 Californians ages 50+ fluctuated from a low of 14.8 per 100,000 in 2005 to a high of 17.7 per 100,000 in 2010. From 2004 to 2013, the rate was generally highest among those in the 50–64 age group.

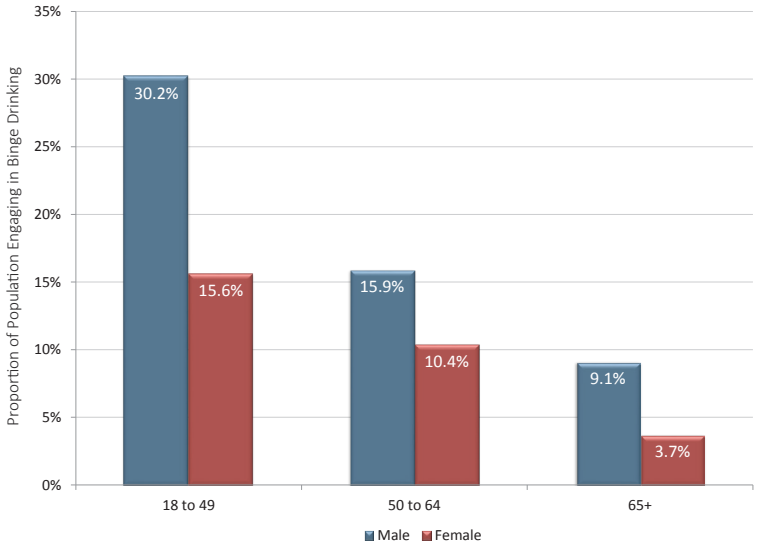
How a state reports suicides can vary from year to year. The number of suicides is generally low, so even a small difference in reported numbers may make the rate fluctuate widely.

SUBSTANCE USE DISORDER AND SUBSTANCE USE DISORDER TREATMENT AMONG OLDER CALIFORNIANS

30-Day Binge Drinking Among Older Californians

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, 15.9 percent of California men ages 50–64 reported binge drinking in the past 30 days, while 9.1 percent of those in the 65+ group reported similar behavior.

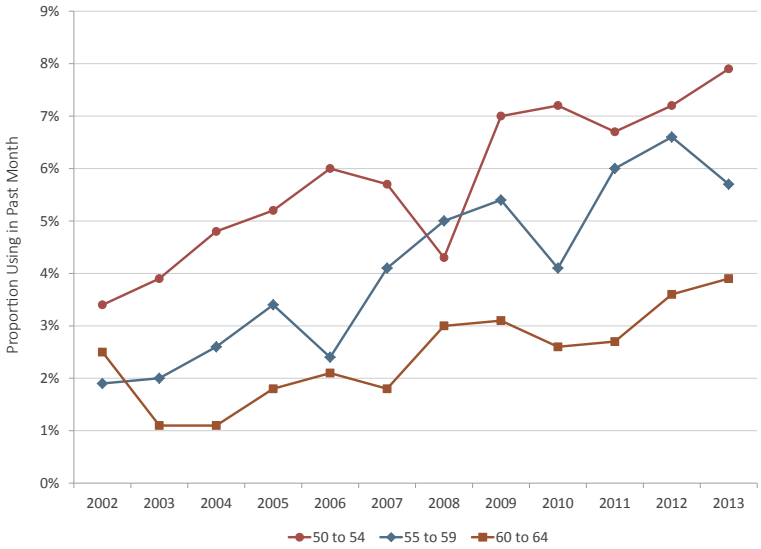
Exhibit 5. Binge Drinking Rates in California by Age Group and Sex, 2013



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 *California 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).

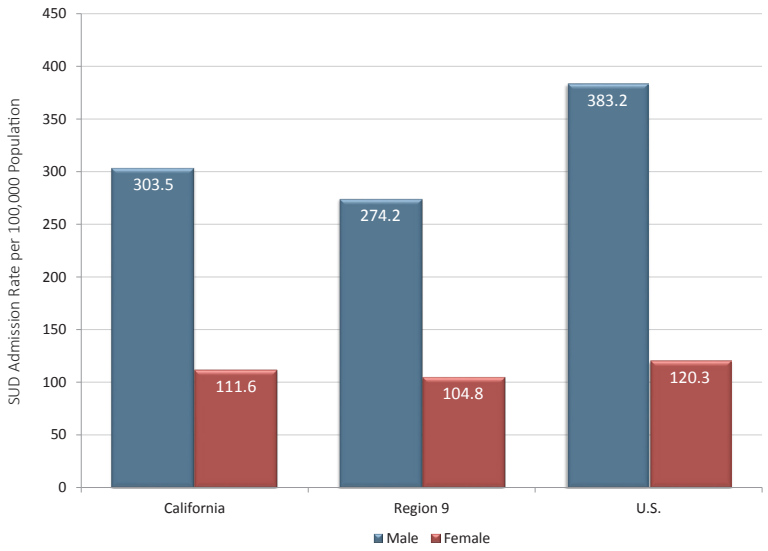
Admissions to Substance Use Disorder Treatment Among Older Californians

In 2012, there were 24,552 admissions of Californians ages 50 and older to substance use disorder (SUD) treatment in state-funded treatment programs, a rate of 201.7 per 100,000 people ages 50+. This rate was higher than the regional rate and lower than the national average. Men made up 70.6 percent of these admissions. Of all admissions, 54.3 percent were White/ Caucasian, 25.6 percent were Black/ African American, and 20.0 percent were Hispanic.

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

Self-Referral	Criminal Justice	Other
56.1%	21.5%	22.4%

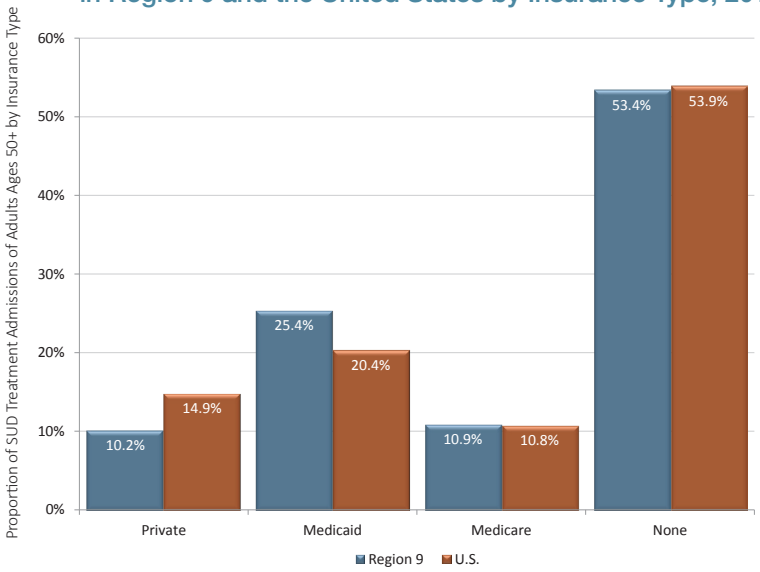
Exhibit 7. SUD Treatment Admissions of Adults Ages 50+ in California, Region 9, and the United States by Sex, 2012



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

SUD Treatment Admissions Among Individuals in Region 9 Ages 50+ by Insurance Type

Exhibit 8. SUD Treatment Admissions of Adults Ages 50+ in Region 9 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 for treatment admission insurance types. These data were not reported by California in 2012. Therefore, the rates for Region 9 are used instead.

In Region 9, 53.4 percent of older adults admitted to SUD treatment were uninsured, 25.4 percent had Medicaid, 10.9 percent had Medicare, and 10.2 percent had private insurance.

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

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

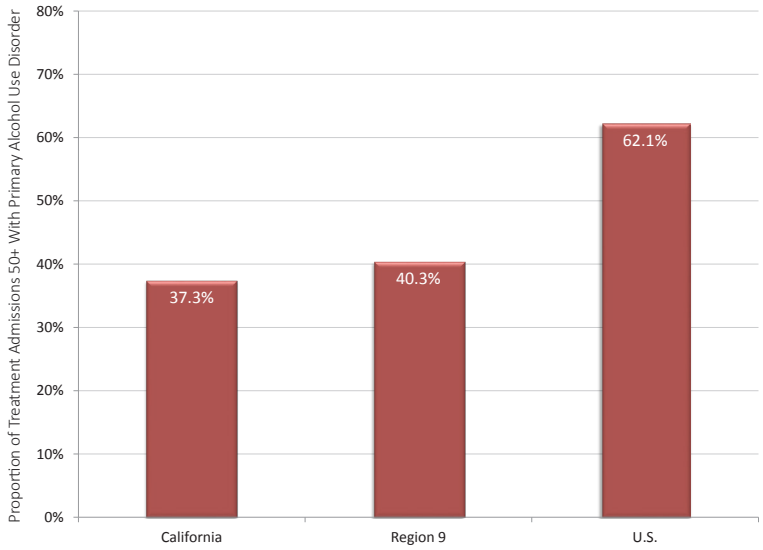
Exhibit 8 and the accompanying text reflect the type of health insurance (if any) clients had at admission; the table above represents primary sources of payment.

[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 Californians Ages 50+

Alcohol was the most frequently cited substance used by older Californians in publicly financed SUD treatment in 2012. It was mentioned as a substance of use in 37.3 percent of admissions among those ages 50+. This was lower than the regional and national rates.

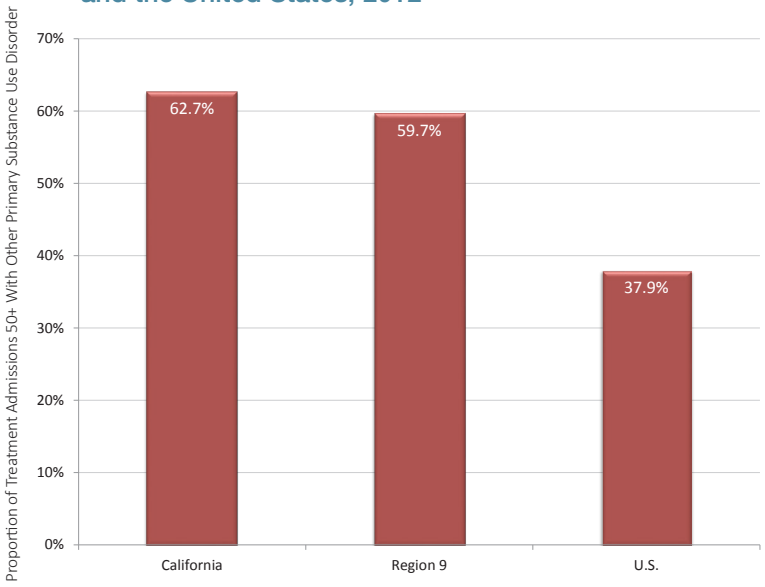
Exhibit 9. Alcohol Use Treatment Admissions of Adults Ages 50+ in California, Region 9, and the United States, 2012



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 California, Region 9, 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 62.7 percent of older adult admissions to publicly funded treatment in California.

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*:

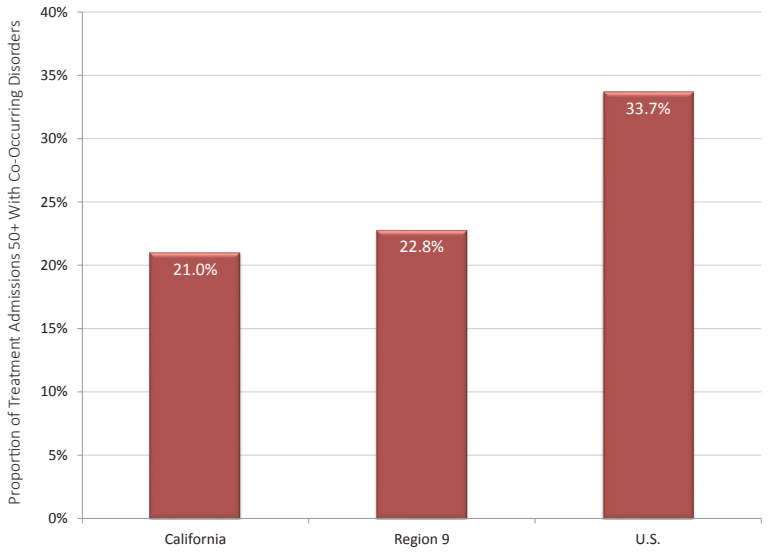
- *In 2004, there were an estimated 115,803 ED visits involving pharmaceutical misuse and abuse by adults aged 50 or older; in 2008, there were 256,097 such visits, representing an increase of 121.1 percent*
- *One fifth (19.7 percent) of ED visits involving pharmaceutical misuse and abuse among older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

Exhibit 11. SUD Treatment Admissions of Adults Ages 50+ With a Co-Occurring Mental Disorder in California, Region 9, 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.

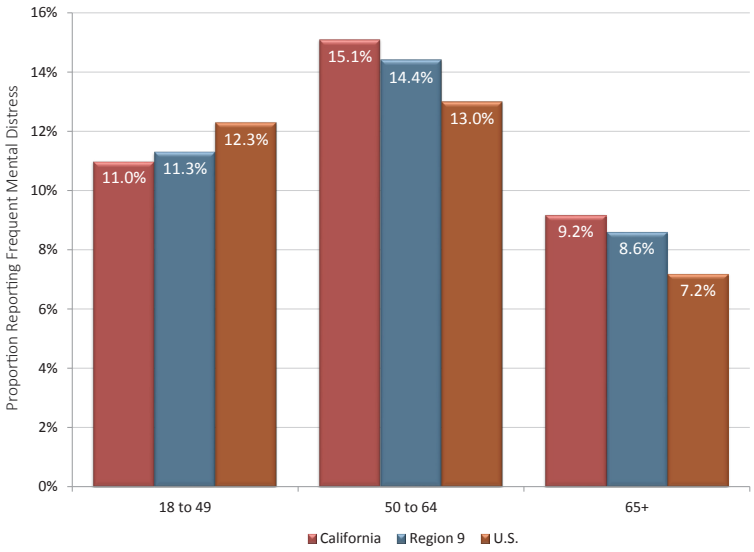
Exhibit 11 shows the proportion of SUD treatment admissions of Californians ages 50+ with a co-occurring mental disorder. This rate is lower than the regional rate and the national average. However, state reporting practices are a factor in these results.

MENTAL HEALTH

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

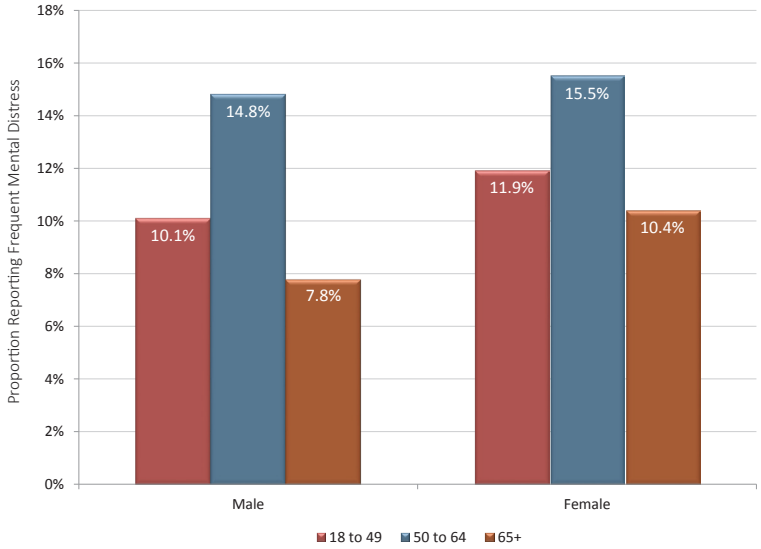
Exhibit 12. Individuals Reporting Frequent Mental Distress in California, Region 9, and the United States, 2013



Source: BRFSS, 2013

Older Californians Reporting Frequent Mental Distress by Age Group and Sex

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



Source: BRFSS, 2013

Older men in California 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, 15.5 percent of women in the 50–64 age group and 10.4 percent in the 65+ age group reported FMD, while 14.8 percent of men in the 50–64 age group and 7.8 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 Californians.

Exhibit 14. BRFSS Measures, 2010

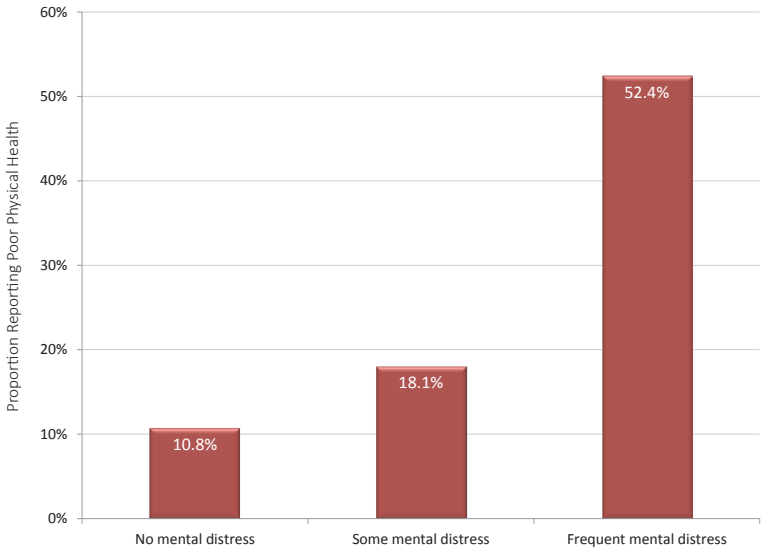
Indicator	Ages 50+	Ages 50–64	Ages 65+
Rarely or never get social or emotional support	12.9%	11.5%	15.0%
Dissatisfied or very dissatisfied	5.6%	6.8%	3.7%

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

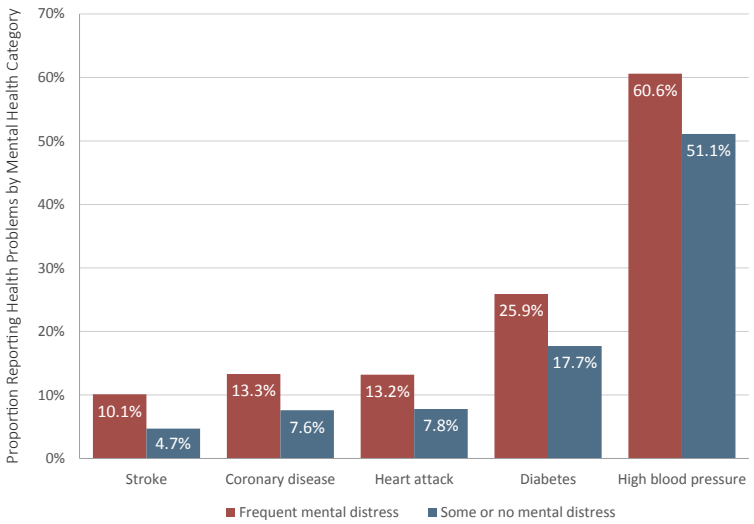


Source: BRFSS, 2013

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 Californians Admitted to State Mental Health Services

Approximately 3.1 percent of the people served by the California mental health system were ages 65 and older. This represents more than 21,720 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

Hawaii

Hawaii

OLDER ADULTS BEHAVIORAL HEALTH PROFILE

September 2016

HAWAII'S POPULATION

Hawaii Population by Age Group

Hawaii is home to 1,419,561 people. Of these:

- 500,115 (35.2 percent) are over age 50.
- 315,230 (22.2 percent) are over age 60.
- 153,548 (10.8 percent) are over age 70.
- 65,873 (4.6 percent) are ages 80 and older.

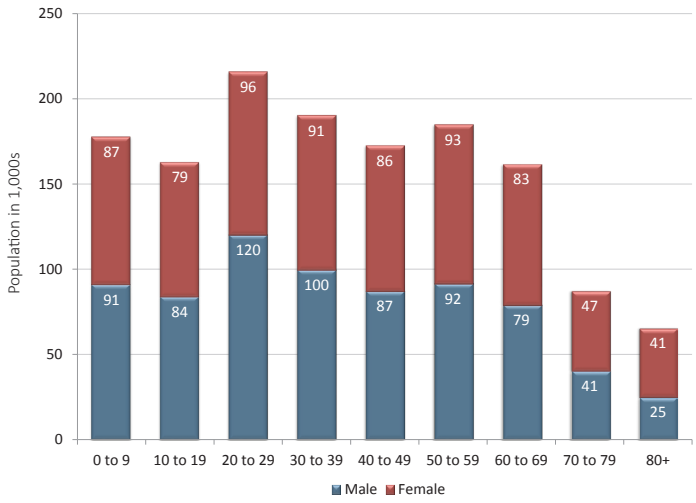
The proportion of women rises fairly steadily in each age group, and women make up 62.1 percent of the 80+ group. The racial/ethnic composition of older Hawaiians is as follows:

Race/Ethnicity of Hawaiians Ages 50+

White	AI/AN	Black	Asian	NH/PI	Other	Hispanic
28.7%	0.3%	1.0%	50.1%	7.3%	12.6%	4.4%

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.

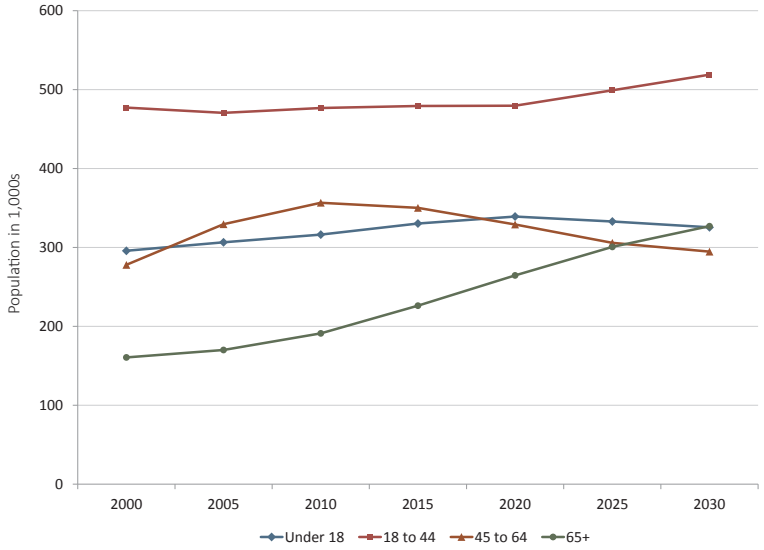
Exhibit 1. Hawaii Population by Age Group, 2014



Source: U.S. Census Bureau, 2015

The Number of Older Hawaiians Is Growing

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



The proportion of Hawaii'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 22.3 percent of Hawaii's population will be 65 and older by the year 2030, an increase of 44.6 percent from 2015.

Projected Population in Hawaii

Age Group	2015	2025	2030
Under 18	23.8%	23.1%	22.2%
18 to 44	34.6%	34.7%	35.4%
45 to 64	25.3%	21.3%	20.1%
65+	16.3%	20.9%	22.3%

Source: U.S. Census Bureau, 2005

SUICIDE AMONG OLDER HAWAIIANS

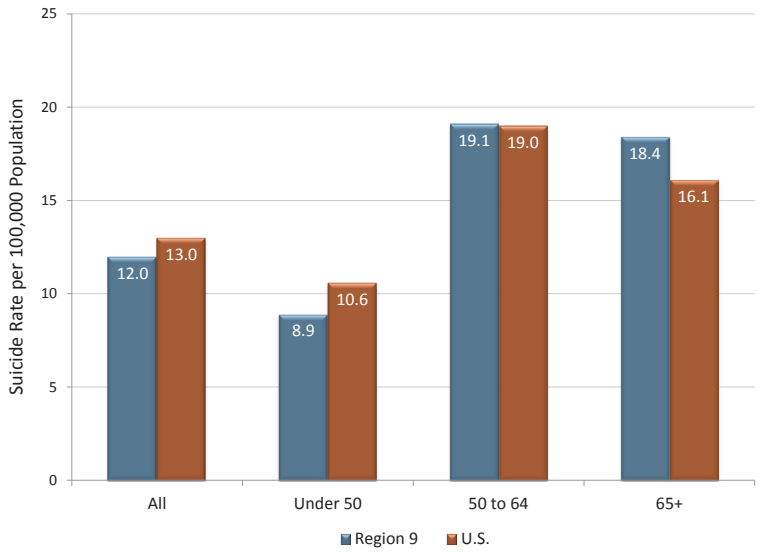
Region 9 Suicide Rates Compared With National Rates

Suicide data for Hawaiians of various ages were unavailable for 2013. Therefore, the rates for Region 9 (including Arizona, California, and Nevada) are used instead.

The suicide rate among individuals ages 50+ in Region 9 was higher than the rate among younger age groups. In 2013, the total suicide rate among all people ages 50+ was 18.8 per 100,000 people (8.3 for women and 30.6 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.

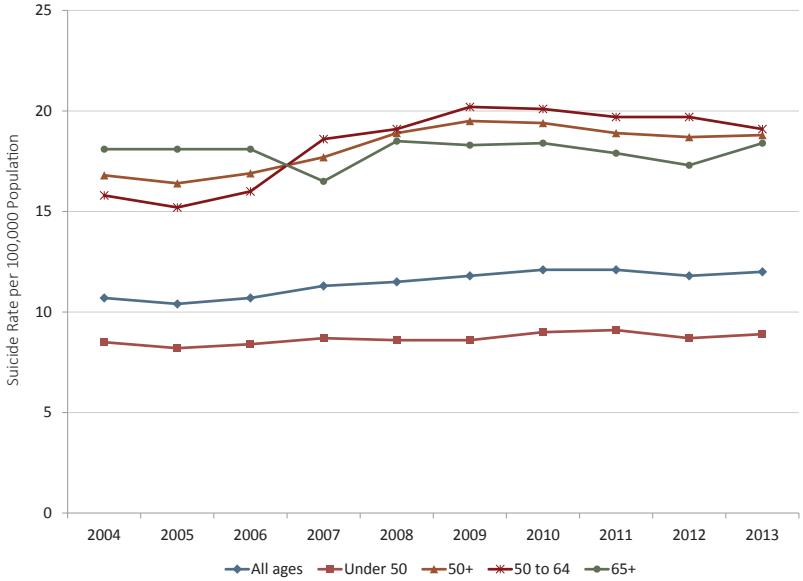
Exhibit 3. Suicide Rates in Region 9 and the United States, 2013



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 9

Exhibit 4. Trends in Suicide Rates in Region 9 by Age Group, 2004–2013



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

Suicide data for Hawaiians of various ages were unavailable. Therefore, the rates for Region 9 are used instead.

The suicide rate among individuals in Region 9 ages 50+ fluctuated from a low of 16.4 per 100,000 in 2005 to a high of 19.5 per 100,000 in 2009. From 2004 to 2013, the rate was generally highest among those in the 50–64 age group.

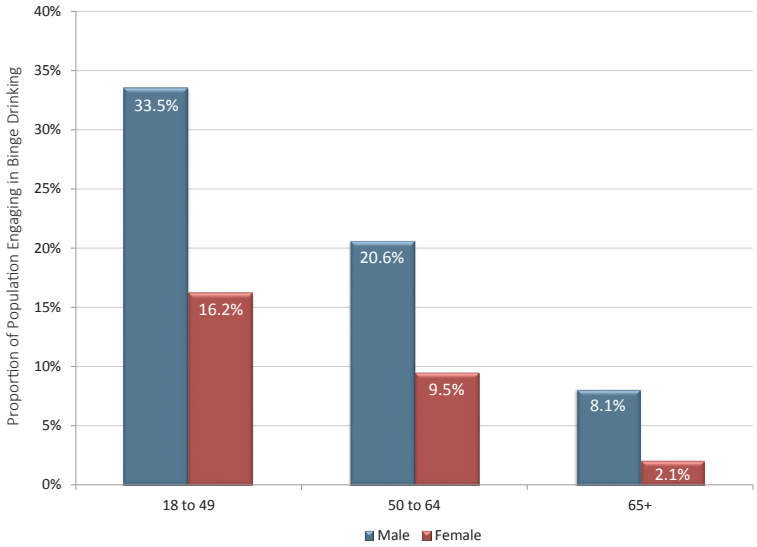
How a state reports suicides can vary from year to year. The number of suicides is generally low, so even a small difference in reported numbers may make the rate fluctuate widely.

SUBSTANCE USE DISORDER AND SUBSTANCE USE DISORDER TREATMENT AMONG OLDER HAWAIIANS

30-Day Binge Drinking Among Older Hawaiians

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, 20.6 percent of Hawaii men ages 50–64 reported binge drinking in the past 30 days, while 8.1 percent of those in the 65+ group reported similar behavior.

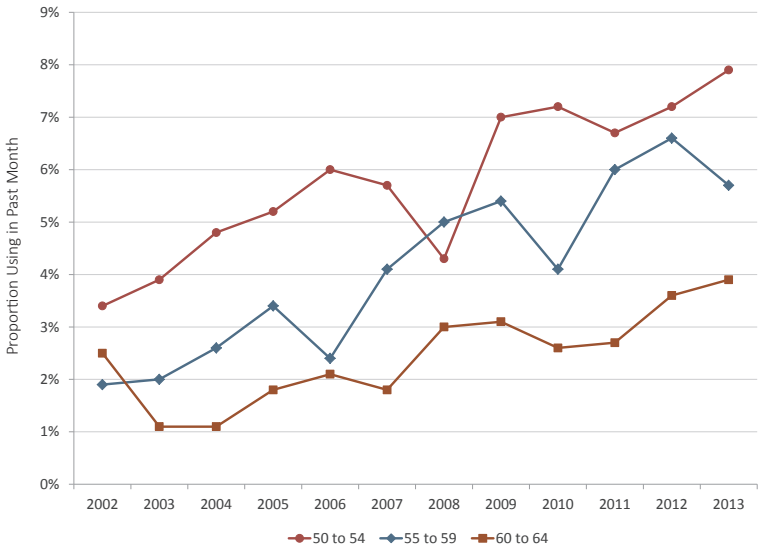
Exhibit 5. Binge Drinking Rates in Hawaii by Age Group and Sex, 2013



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 *Hawaii 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).

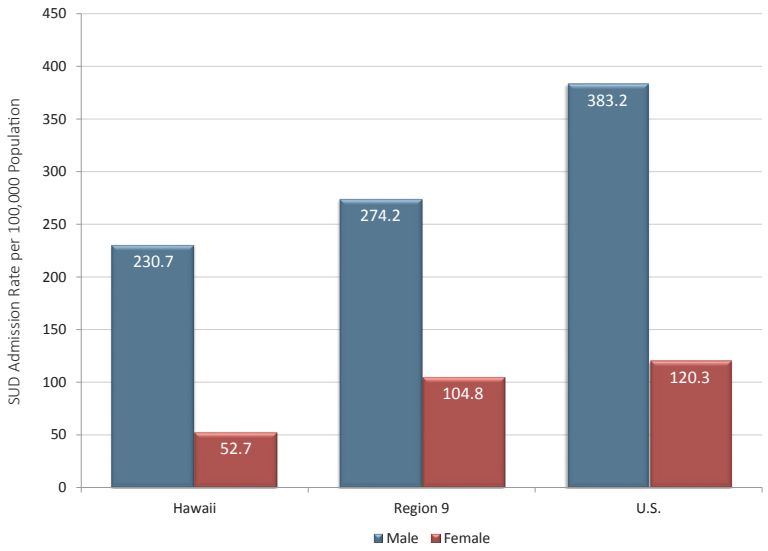
Admissions to Substance Use Disorder Treatment Among Older Hawaiians

In 2012, there were 684 admissions of Hawaiians ages 50 and older to substance use disorder (SUD) treatment in state-funded treatment programs, a rate of 136.8 per 100,000 people ages 50+. This rate was lower than the regional rate and the national average. Men made up 79.7 percent of these admissions. Of all admissions, 51.4 percent were White/Caucasian, 3.2 percent were Black/African American, and 7.0 percent were Hispanic.

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

Self-Referral	Criminal Justice	Other
49.4%	28.5%	22.1%

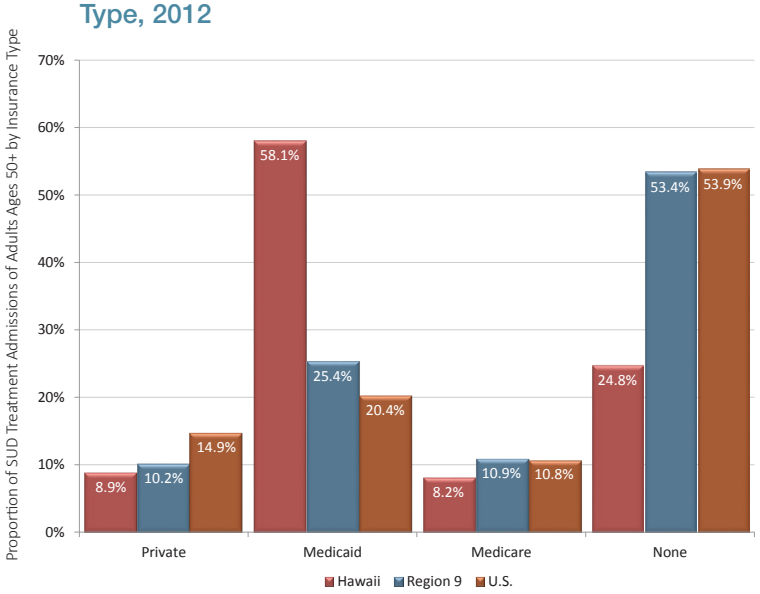
Exhibit 7. SUD Treatment Admissions of Adults Ages 50+ in Hawaii, Region 9, and the United States by Sex, 2012



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

SUD Treatment Admissions Among Hawaiians Ages 50+ by Insurance Type

Exhibit 8. SUD Treatment Admissions of Adults Ages 50+ in Hawaii, Region 9, and the United States by Insurance Type, 2012



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

In Hawaii, 24.8 percent of older adult admissions to SUD treatment were uninsured, 58.1 percent had Medicaid, 8.2 percent had Medicare, and 8.9 percent had private insurance.

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

Self-Pay	Medicaid	Other
9.1%	30.5%	60.4%

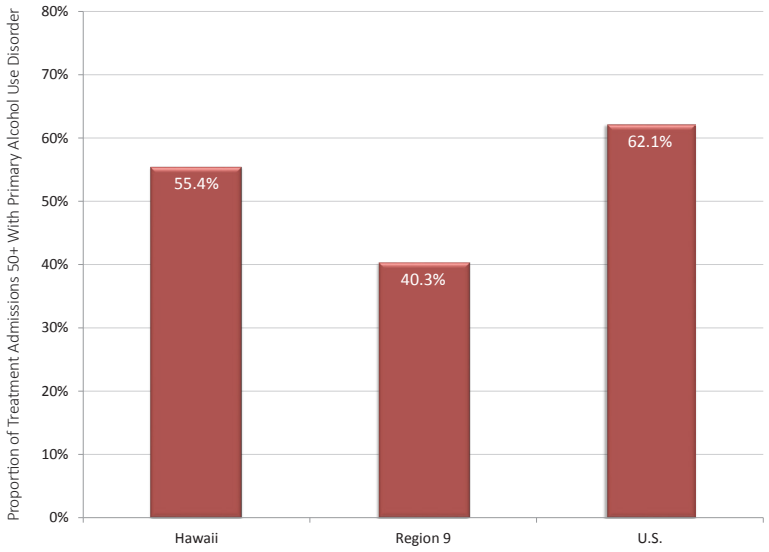
Self-pay data include private insurance.
Exhibit 8 and the accompanying text reflect the type of health insurance (if any) clients had at admission; the table above represents primary sources of payment.

[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 Hawaiians Ages 50+

Alcohol was the most frequently cited substance used by older Hawaiians in publicly financed SUD treatment in 2012. It was mentioned as a substance of use in 55.4 percent of admissions among those ages 50+. This was higher than the regional rate and lower than the national rate.

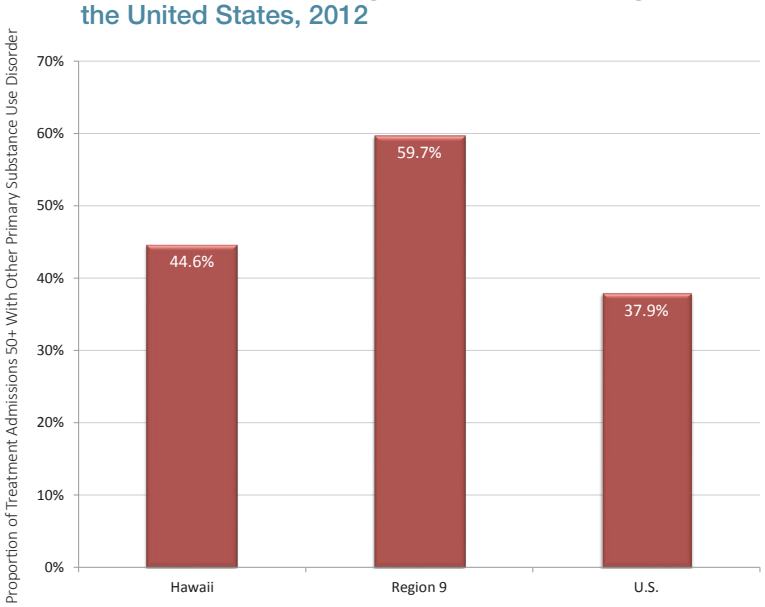
Exhibit 9. Alcohol Use Treatment Admissions of Adults Ages 50+ in Hawaii, Region 9, and the United States, 2012



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 Hawaii, Region 9, 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 44.6 percent of older adult admissions to publicly funded treatment in Hawaii.

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*:

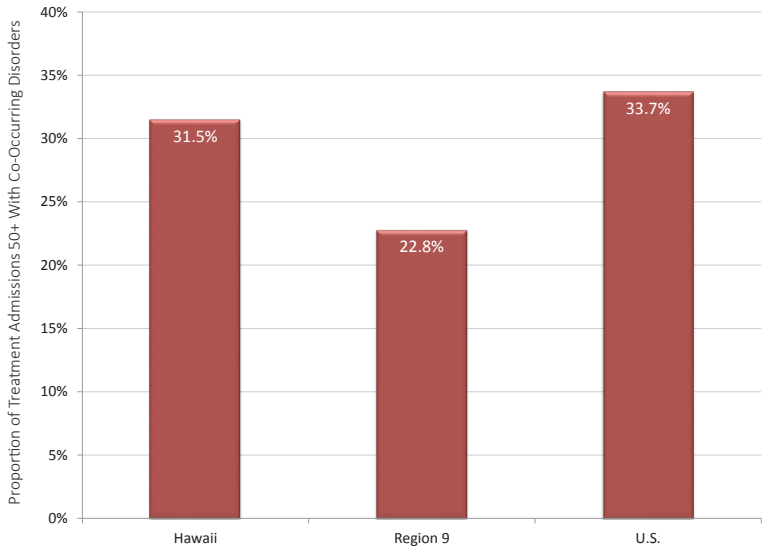
- *In 2004, there were an estimated 115,803 ED visits involving pharmaceutical misuse and abuse by adults aged 50 or older; in 2008, there were 256,097 such visits, representing an increase of 121.1 percent*
- *One fifth (19.7 percent) of ED visits involving pharmaceutical misuse and abuse among older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

Exhibit 11. SUD Treatment Admissions of Adults Ages 50+ With a Co-Occurring Mental Disorder in Hawaii, Region 9, 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.

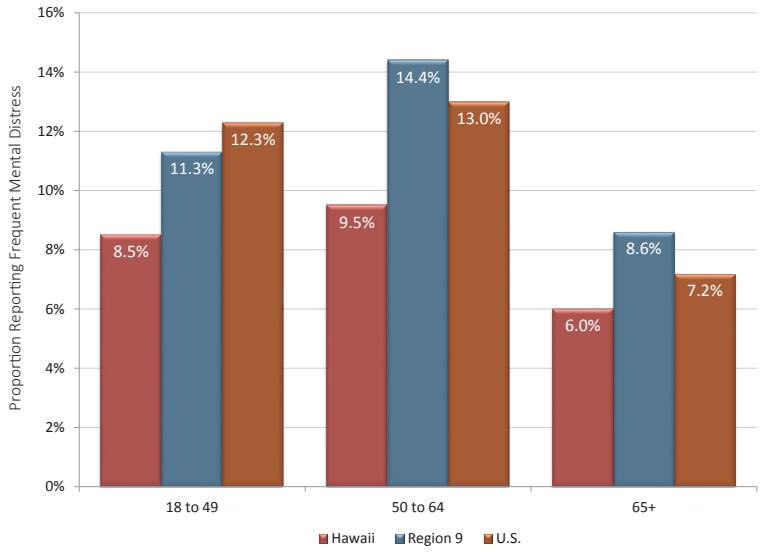
Exhibit 11 shows the proportion of SUD treatment admissions of Hawaiians ages 50+ with a co-occurring mental disorder. This rate is higher than the regional rate and lower than the national average. However, state reporting practices are a factor in these results.

MENTAL HEALTH

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

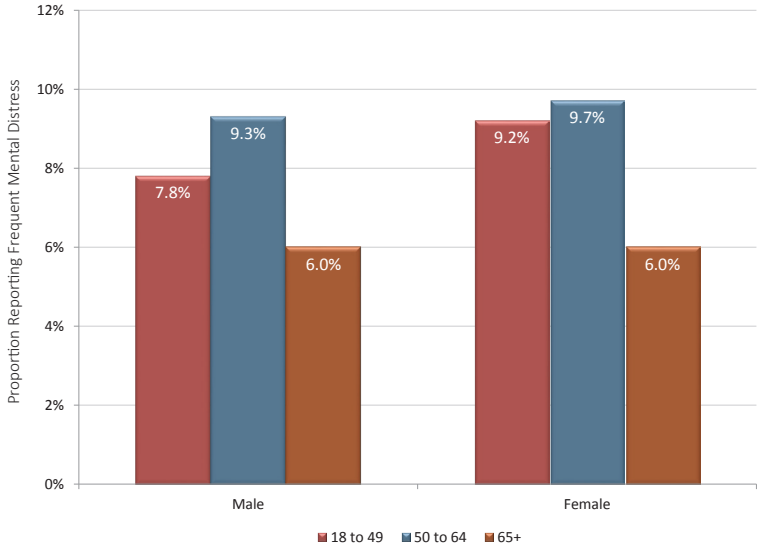
Exhibit 12. Individuals Reporting Frequent Mental Distress in Hawaii, Region 9, and the United States, 2013



Source: BRFSS, 2013

Older Hawaiians Reporting Frequent Mental Distress by Age Group and Sex

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



Source: BRFSS, 2013

As Exhibit 13 shows, in Hawaii, 9.3 percent of men in the 50–64 age group reported FMD (14 days or more per 30-day period) compared with 9.7 percent of women in this age group. Men in the 65+ age group reported the same rate of FMD as women in the same age group (6.0 percent for both). Arizona is the only other state in the region where men in the 65+ age group did not report a lower rate of FMD than 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 Hawaiians.

Exhibit 14. BRFSS Measures, 2010

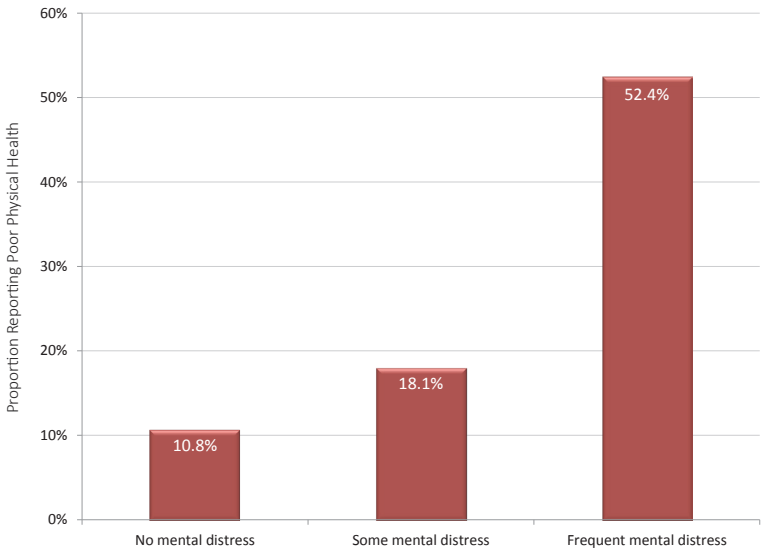
Indicator	Ages 50+	Ages 50–64	Ages 65+
Rarely or never get social or emotional support	16.7%	10.9%	2.4%
Dissatisfied or very dissatisfied	3.3%	3.7%	2.7%

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

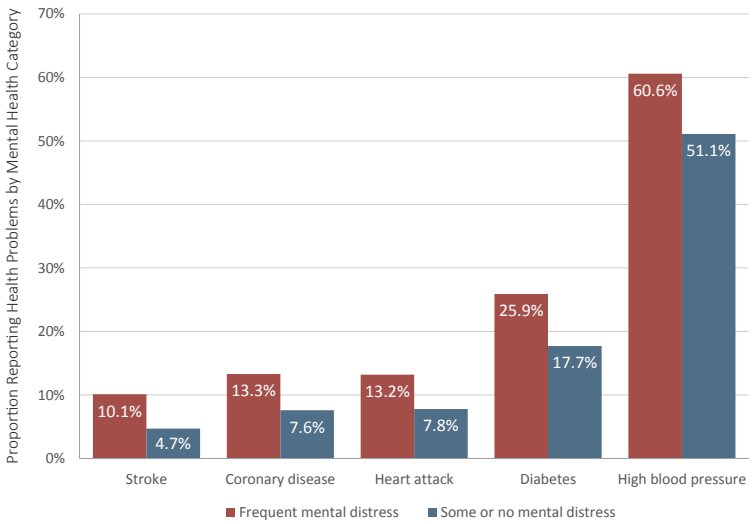


Source: BRFSS, 2013

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 Hawaiians Admitted to State Mental Health Services

Approximately 8.1 percent of the people served by the Hawaii mental health system were ages 65 and older. This represents more than 1,030 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

Nevada

Nevada

OLDER ADULTS BEHAVIORAL HEALTH PROFILE

September 2016

NEVADA'S POPULATION

Nevada Population by Age Group

Nevada is home to 2,839,099 people. Of these:

- 941,249 (33.2 percent) are over age 50.
- 565,626 (19.9 percent) are over age 60.
- 256,379 (9.0 percent) are over age 70.
- 81,448 (2.9 percent) are ages 80 and older.

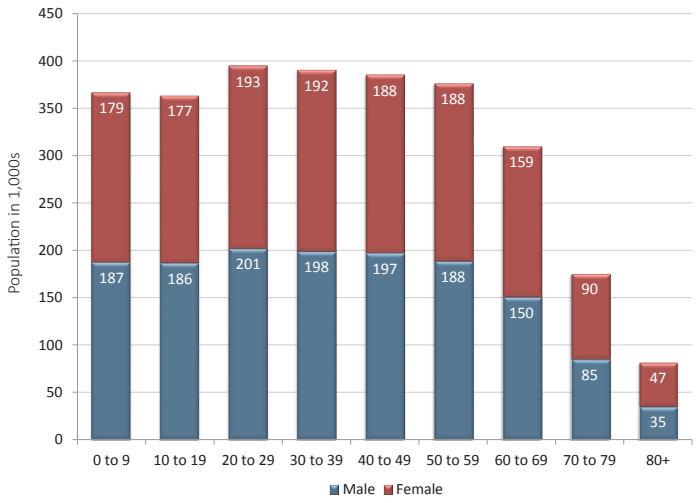
The proportion of women rises fairly steadily in each age group, and women make up 57.5 percent of the 80+ group. The racial/ethnic composition of older Nevadans is as follows:

Race/Ethnicity of Nevadans Ages 50+

White	AI/AN	Black	Asian	NH/PI	Other	Hispanic
80.9%	1.2%	7.2%	8.7%	0.5%	1.5%	14.1%

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.

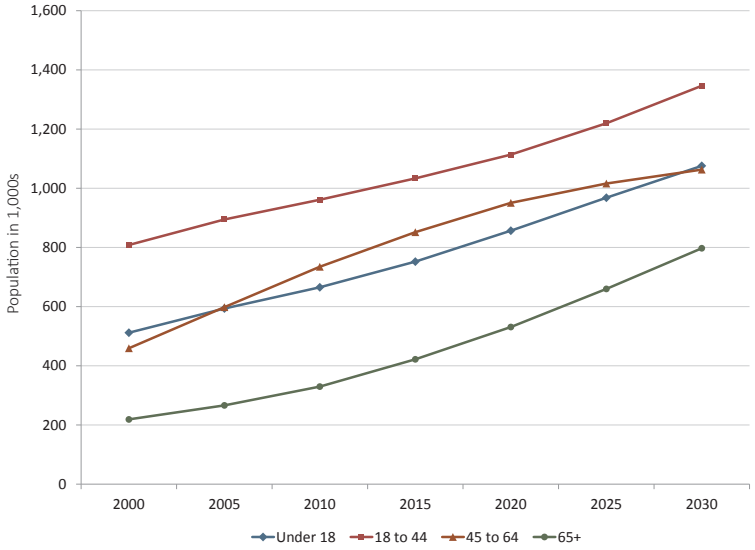
Exhibit 1. Nevada Population by Age Group, 2014



Source: U.S. Census Bureau, 2015

The Number of Older Nevadans Is Growing

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



The proportion of Nevada'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 18.6 percent of Nevada's population will be 65 and older by the year 2030, an increase of 89.0 percent from 2015.

Projected Population in Nevada

Age Group	2015	2025	2030
Under 18	24.6%	25.1%	25.1%
18 to 44	33.8%	31.6%	31.4%
45 to 64	27.8%	26.3%	24.8%
65+	13.8%	17.1%	18.6%

Source: U.S. Census Bureau, 2005

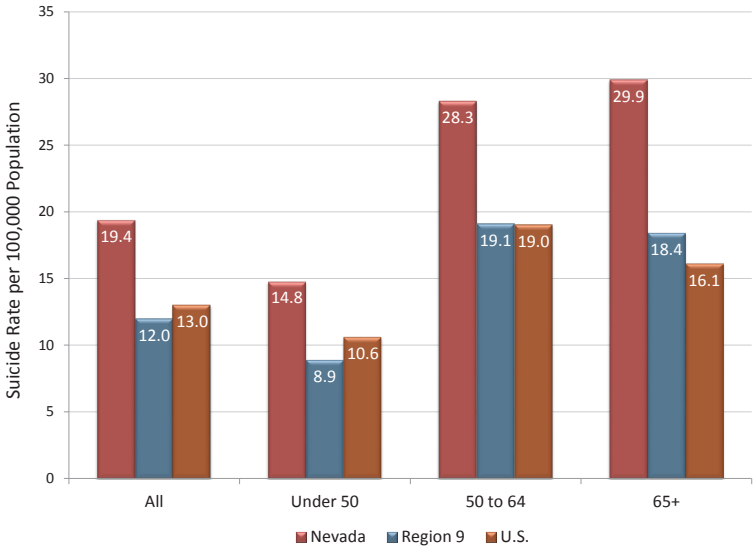
SUICIDE AMONG OLDER NEVADANS

Nevada Suicide Rate Compared With Regional and National Rates

The suicide rate among Nevadans 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 29.0 per 100,000 people (12.2 for women and 46.7 for men). The rate among those ages 50–64 was higher than both the rate in the region (including Arizona, California, and Hawaii) and the rate in the United States.

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

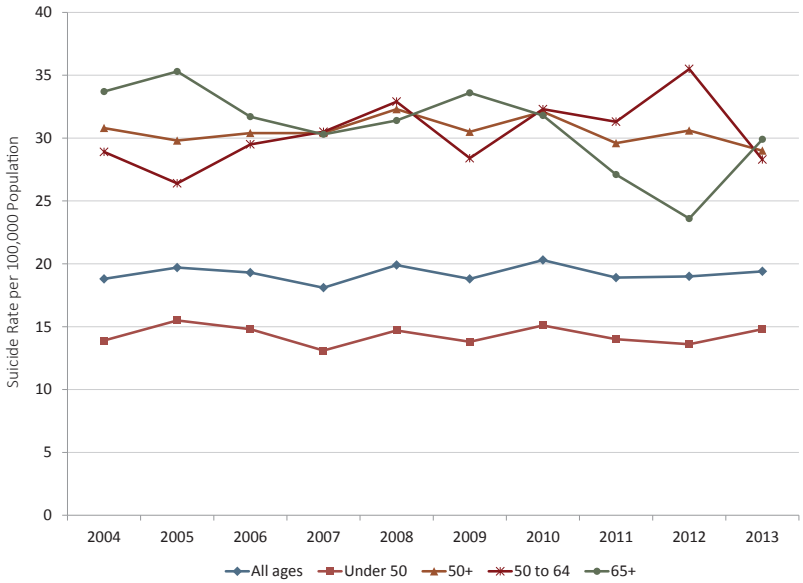
Exhibit 3. Suicide Rates in Nevada, Region 9, and the United States, 2013



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 Nevada

Exhibit 4. Trends in Suicide Rates in Nevada 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 Nevadans ages 50+ fluctuated from a low of 29.0 per 100,000 in 2013 to a high of 32.3 per 100,000 in 2008. From 2004 to 2013, the rate was highest among those in the 50–64 and the 65+ age groups.

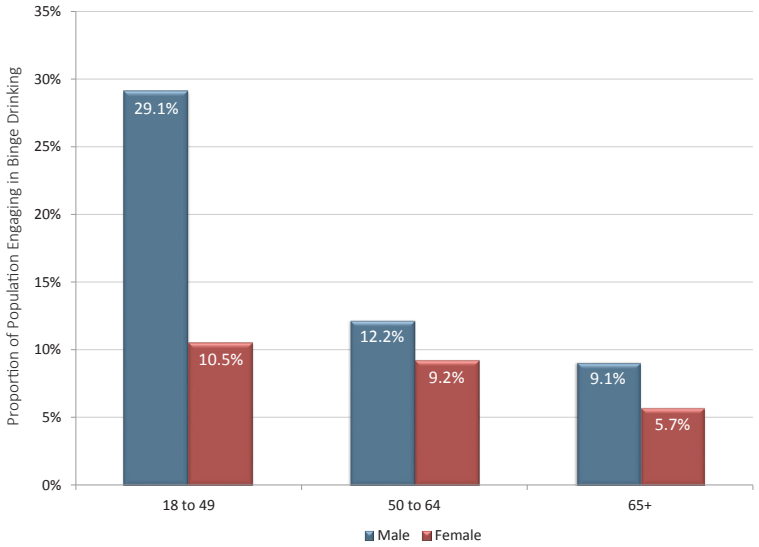
How a state reports suicides can vary from year to year. The number of suicides is generally low, so even a small difference in reported numbers may make the rate fluctuate widely.

SUBSTANCE USE DISORDER AND SUBSTANCE USE DISORDER TREATMENT AMONG OLDER NEVADANS

30-Day Binge Drinking Among Older Nevadans

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, 12.2 percent of Nevada men ages 50–64 reported binge drinking in the past 30 days, while 9.1 percent of those in the 65+ group reported similar behavior.

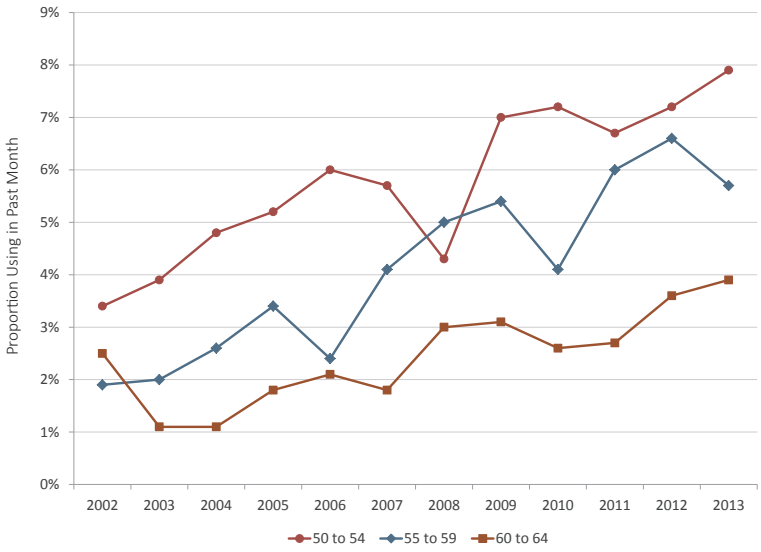
Exhibit 5. Binge Drinking Rates in Nevada by Age Group and Sex, 2013



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 *Nevada 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).

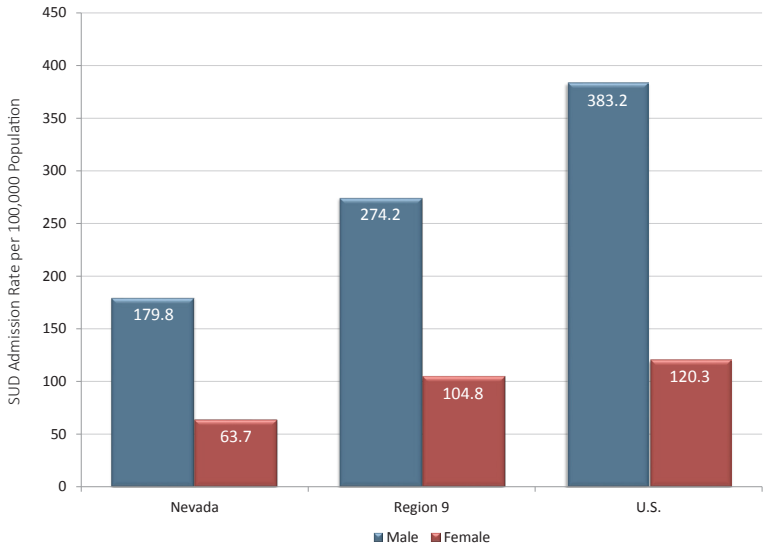
Admissions to Substance Use Disorder Treatment Among Older Nevadans

In 2012, there were 1,131 admissions of Nevadans ages 50 and older to substance use disorder (SUD) treatment in state-funded treatment programs, a rate of 120.2 per 100,000 people ages 50+. This rate was lower than the regional rate and the national average. Men made up 72.8 percent of these admissions. Of all admissions, 71.3 percent were White/Caucasian, 16.2 percent were Black/African American, and 12.6 percent were Hispanic.

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

Self-Referral	Criminal Justice	Other
32.0%	35.1%	32.8%

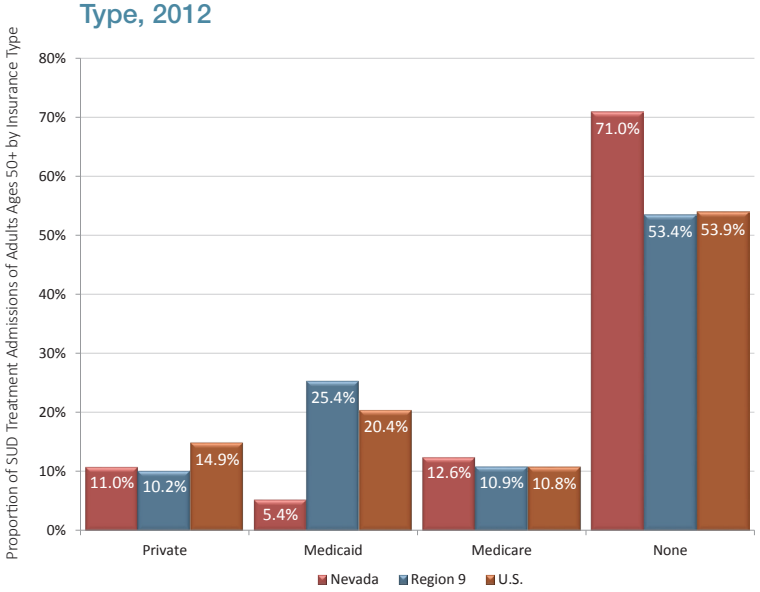
Exhibit 7. SUD Treatment Admissions of Adults Ages 50+ in Nevada, Region 9, and the United States by Sex, 2012



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

SUD Treatment Admissions Among Nevadans Ages 50+ by Insurance Type

Exhibit 8. SUD Treatment Admissions of Adults Ages 50+ in Nevada, Region 9, and the United States by Insurance Type, 2012



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

In Nevada, 71.0 percent of older adult admissions to SUD treatment were uninsured, 5.4 percent had Medicaid, 12.6 percent had Medicare, and 11.0 percent had private insurance.

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

Self-Pay	Medicaid	Other
27.7%	1.2%	71.1%

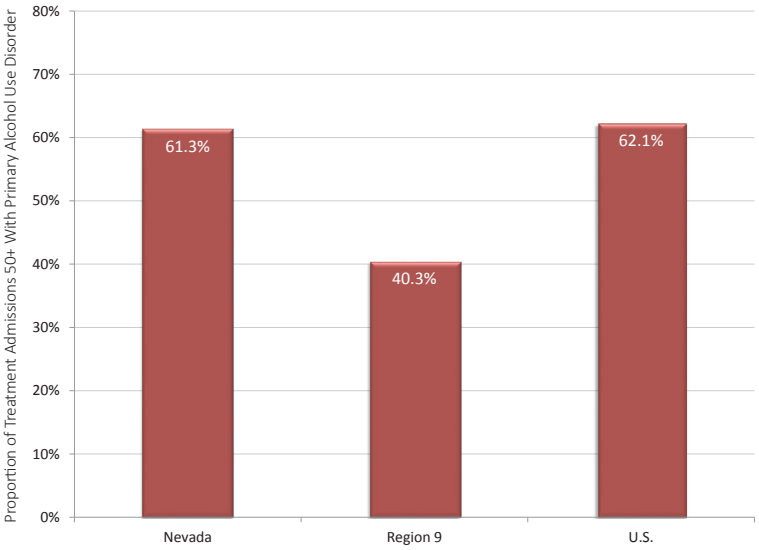
Self-pay data include private insurance.
Exhibit 8 and the accompanying text reflect the type of health insurance (if any) clients had at admission; the table above represents primary sources of payment.

[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 Nevadans Ages 50+

Alcohol was the most frequently cited substance used by older Nevadans in publicly financed SUD treatment in 2012. It was mentioned as a substance of use in 61.3 percent of admissions among those ages 50+. This was higher than the regional rate and lower than the national rate.

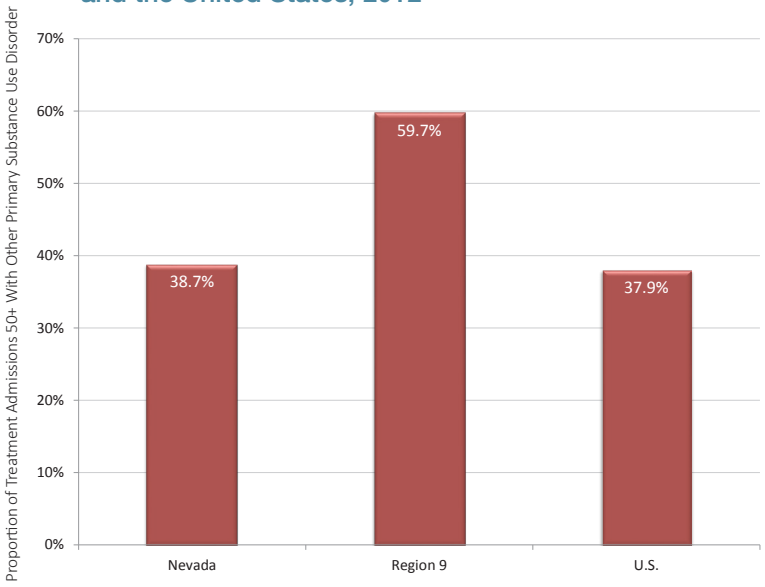
Exhibit 9. Alcohol Use Treatment Admissions of Adults Ages 50+ in Nevada, Region 9, and the United States, 2012



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 Nevada, Region 9, and the United States, 2012



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

Substances other than alcohol were cited as the primary substances of use for 38.7 percent of older adult admissions to publicly funded treatment in Nevada.

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*:

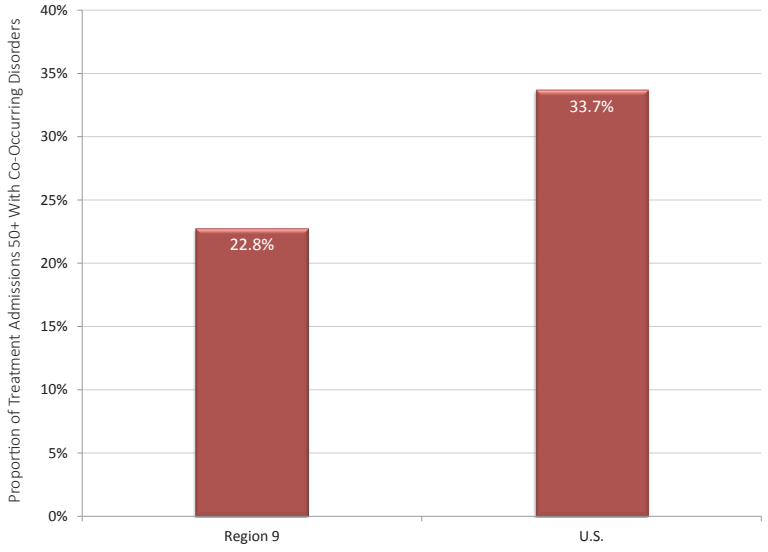
- *In 2004, there were an estimated 115,803 ED visits involving pharmaceutical misuse and abuse by adults aged 50 or older; in 2008, there were 256,097 such visits, representing an increase of 121.1 percent*
- *One fifth (19.7 percent) of ED visits involving pharmaceutical misuse and abuse among older 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 9 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 9 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.

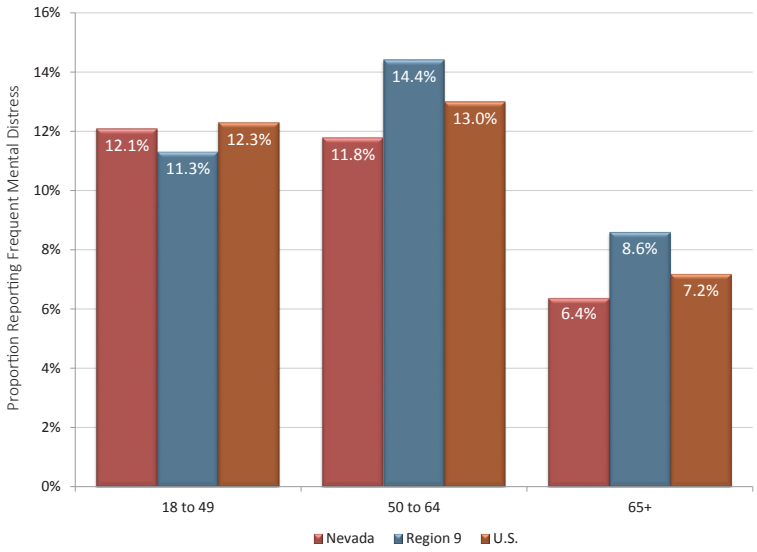
States may choose not to report some of the fields to TEDS, including information on SUD treatment admissions with a co-occurring disorder. These data were not reported by Nevada in 2012. Therefore, Exhibit 11 shows regional and national figures only.

MENTAL HEALTH

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

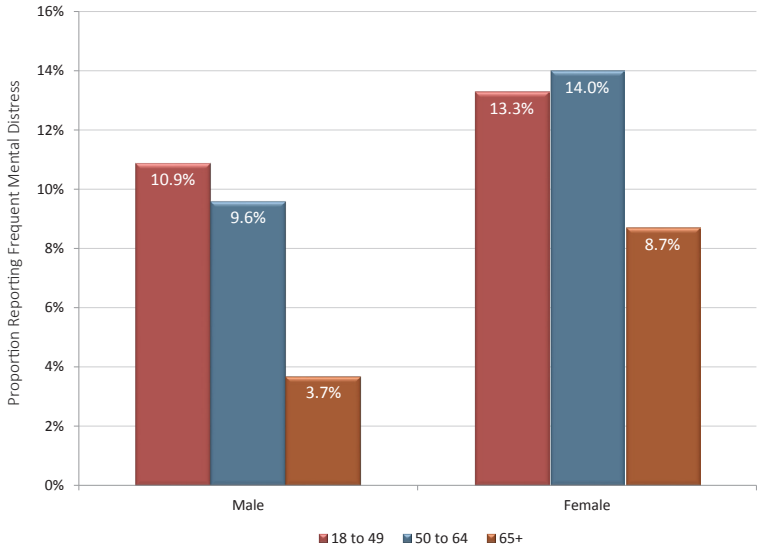
Exhibit 12. Individuals Reporting Frequent Mental Distress in Nevada, Region 9, and the United States, 2013



Source: BRFSS, 2013

Older Nevadans Reporting Frequent Mental Distress by Age Group and Sex

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



Source: BRFSS, 2013

Older men in Nevada were more likely to indulge in binge drinking, but older women were more likely to report that they had FMD (14 days or more per 30-day period). As Exhibit 13 shows, 14.0 percent of women in the 50–64 age group and 8.7 percent in the 65+ age group reported FMD, while 9.6 percent of men in the 50–64 age group and 3.7 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 Nevadans.

Exhibit 14. BRFSS Measures, 2010

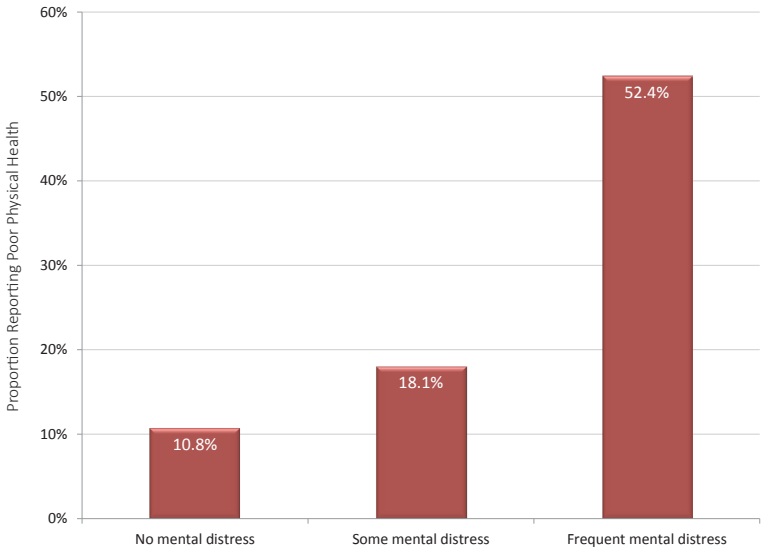
Indicator	Ages 50+	Ages 50–64	Ages 65+
Rarely or never get social or emotional support	9.3%	7.7%	11.6%
Dissatisfied or very dissatisfied	7.4%	9.6%	4.2%

Source: BRFSS, 2010

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

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

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

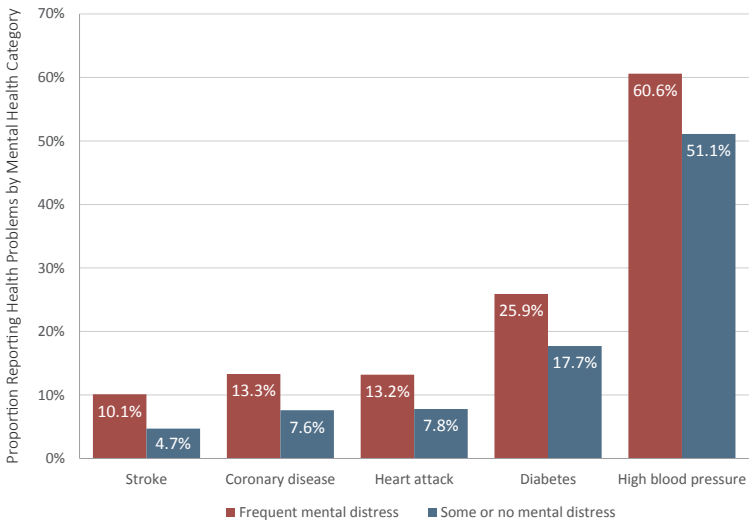


Source: BRFSS, 2013

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

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

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



Source: BRFSS, 2013

Older Nevadans Admitted to State Mental Health Services

Approximately 2.5 percent of the people served by the Nevada mental health system were ages 65 and older. This represents more than 750 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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OLDER ADULTS BEHAVIORAL HEALTH PROFILE

American Samoa

American Samoa

OLDER ADULTS BEHAVIORAL HEALTH PROFILE

September 2016

REGION 9'S POPULATION

Region 9 Population by Age Group

Detailed demographic U.S. Census Bureau data on older American Samoans are unavailable. Therefore, the estimates for Region 9 (which includes Arizona, California, Hawaii, and Nevada) are used instead. Region 9 is home to 49,792,644 people. Of these:

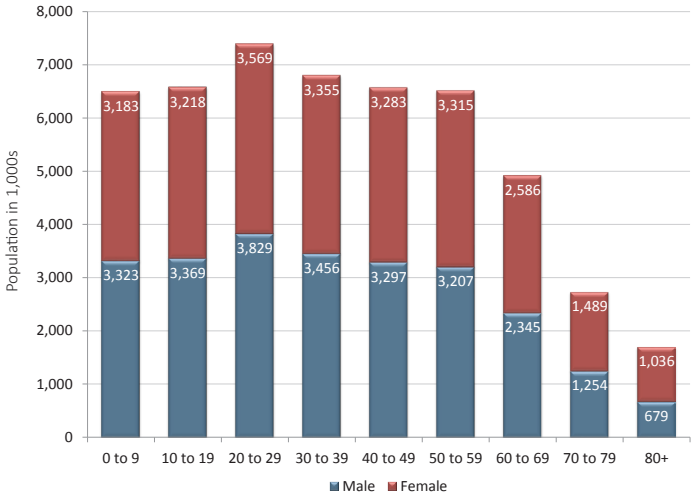
- 15,910,775 (32.0 percent) are over age 50.
- 9,388,613 (18.9 percent) are over age 60.
- 4,457,879 (9.0 percent) are over age 70.
- 1,714,781 (3.4 percent) are ages 80 and older.

Race/Ethnicity of Individuals in Region 9 Ages 50+

White	AI/AN	Black	Asian	NH/PI	Other	Hispanic
76.4%	1.5%	5.6%	13.9%	0.6%	2.0%	21.5%

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

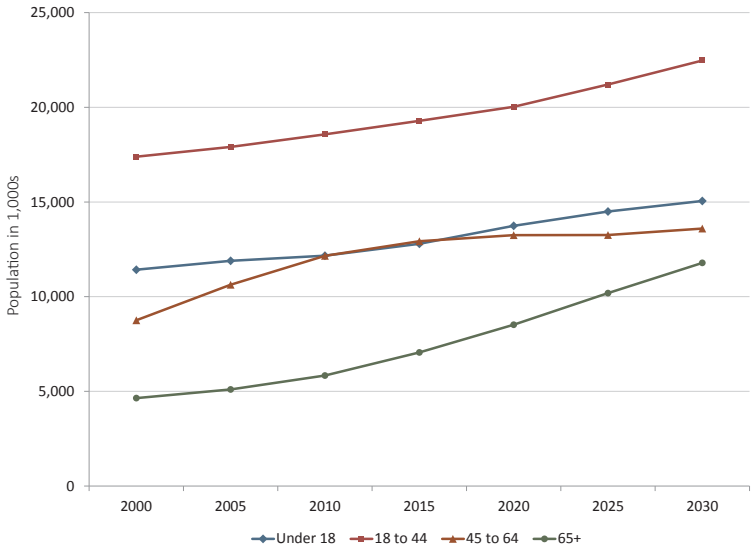
Exhibit 1. Region 9 Population by Age Group, 2014



Source: U.S. Census Bureau, 2015

The Number of Older Adults in Region 9 Is Growing

Exhibit 2. Region 9 Population by Age Group, 2000–2030



Recent population projections for American Samoa are unavailable. Therefore, projections for Region 9 (calculated based on data from Arizona, California, Hawaii, and Nevada) are used instead.

The U.S. Census Bureau estimates that 18.7 percent of Region 9's population will be 65 and older by the year 2030, an increase of 67.0 percent from 2015.

Projected Population in Region 9

Age Group	2015	2025	2030
Under 18	24.6%	24.5%	23.9%
18 to 44	37.0%	35.8%	35.7%
45 to 64	24.8%	22.4%	21.6%
65+	13.6%	17.2%	18.7%

Source: U.S. Census Bureau, 2005

SUICIDE AMONG OLDER ADULTS IN REGION 9

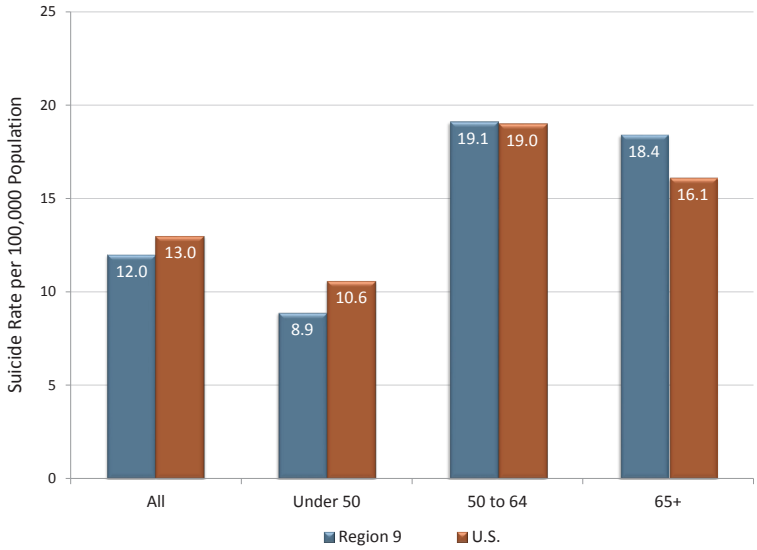
Region 9 Suicide Rates Compared With National Rates

Recent suicide data for American Samoa are not available from the Centers for Disease Control and Prevention (CDC) mortality databases. Therefore, the rates for Region 9 (calculated based on data from Arizona, California, Hawaii, and Nevada) are used instead.

The suicide rate among individuals in Region 9 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 18.8 per 100,000 people (8.3 for women and 30.6 for men). The rate among those ages 50–64 was higher than the rate in the United States.

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

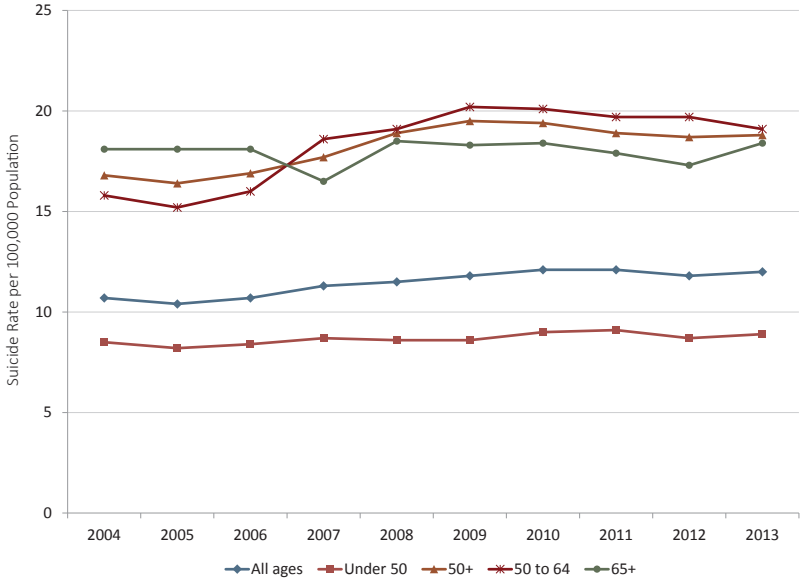
Exhibit 3. Suicide Rates in Region 9 and the United States, 2013



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

Trends in Suicide Rates in Region 9

Exhibit 4. Trends in Suicide Rates in Region 9 by Age Group, 2004–2013



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

Recent suicide data for American Samoa are not available from the CDC mortality databases. Therefore, the rates for Region 9 are used instead.

The suicide rate among individuals in Region 9 ages 50+ fluctuated from a low of 16.4 per 100,000 in 2005 to a high of 19.5 per 100,000 in 2009. From 2004 to 2013, the rate was generally highest among those in the 50–64 age group.

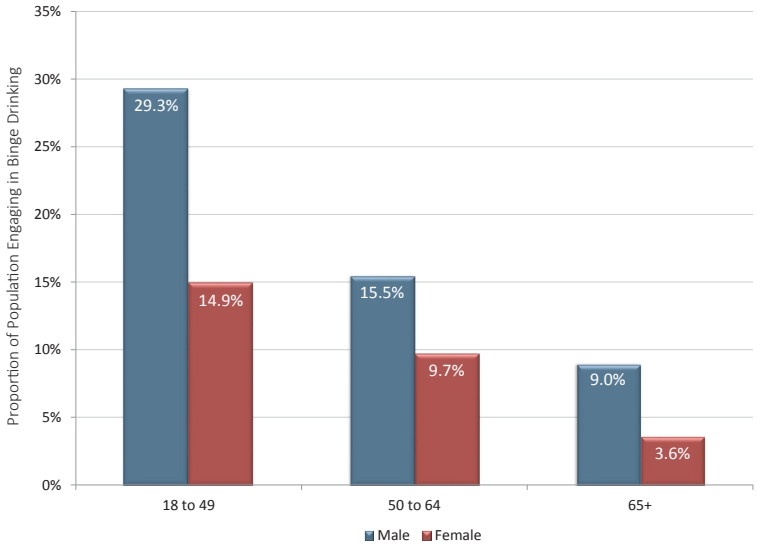
How a state or territory reports suicides can vary from year to year. The number of suicides is generally low, so even a small difference in reported numbers may make the rate fluctuate widely.

SUBSTANCE USE DISORDER AND SUBSTANCE USE DISORDER TREATMENT AMONG OLDER ADULTS IN REGION 9

30-Day Binge Drinking Among Older Adults in Region 9

Binge drinking, defined as five or more drinks for men and four or more drinks for women on a single occasion, can lead to serious health problems. Such problems include neurological damage, cardiovascular disease, liver disease, stroke, and poor control of diabetes. Binge drinkers are more likely to take risks such as driving while intoxicated and to experience falls and other accidents. Older people have a lower tolerance for alcohol. Binge drinking decreases with age and occurs more frequently among men than it does among women. Recent data for American Samoa are unavailable. Therefore, data for Region 9 are used instead. As Exhibit 5 shows, 15.5 percent of Region 9 men ages 50–64 reported binge drinking in the past 30 days, while 9.0 percent of those in the 65+ group reported similar behavior.

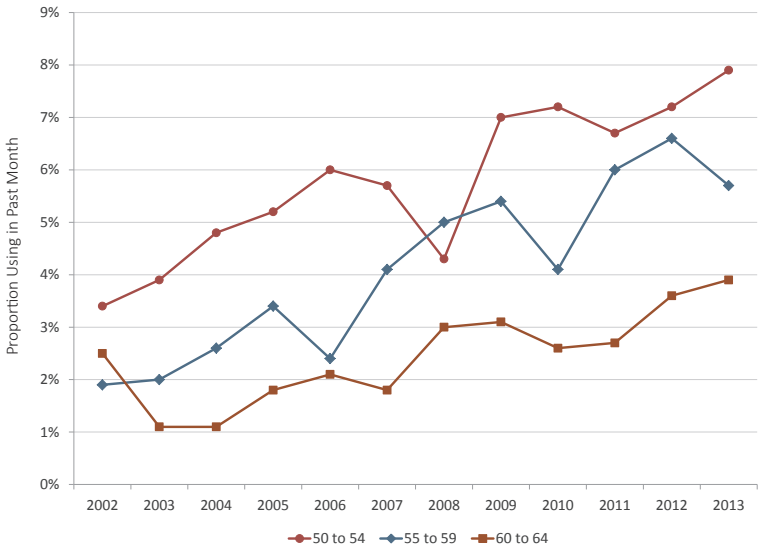
Exhibit 5. Binge Drinking Rates in Region 9 by Age Group and Sex, 2013



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

Illicit Drug Use Among Older Americans

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



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

Nationally, the rate of illicit drug use among older adults ages 50–64 more than doubled from 2002 to 2013. This development partially reflects the entrance into this age group of the baby boom cohort, whose rates of illicit drug use have been higher than those of older cohorts. Although territory-specific data are not available, the *Behavioral Health Barometers* for states in Region 9 are available for download from the Substance Abuse and Mental Health Services Administration (SAMHSA) website (www.samhsa.gov/data/population-data-nsduh/reports?tab=33).

Admissions to Substance Use Disorder Treatment Among Older Adults in Region 9

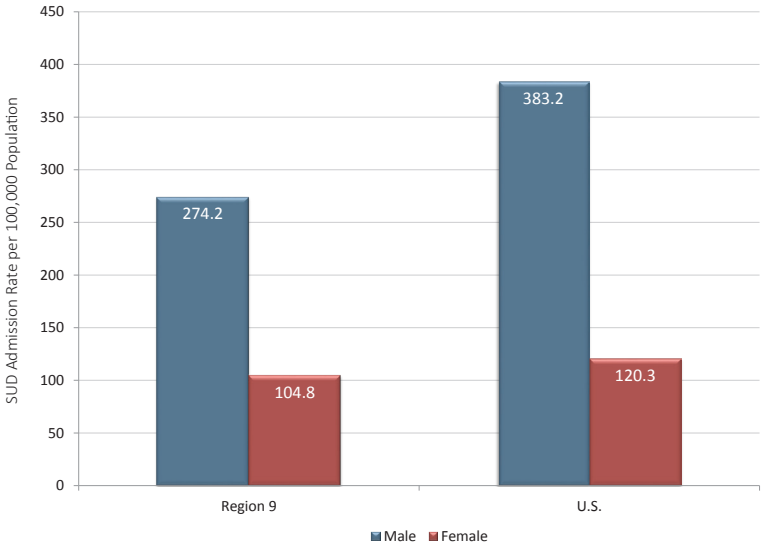
Treatment Episode Data Set (TEDS) data for American Samoa in 2012 are unavailable. Therefore, data for Region 9 are used instead.

In 2012, there were 29,351 admissions of individuals in Region 9 ages 50 and older to substance use disorder (SUD) treatment in state-funded treatment programs, a rate of 184.5 per 100,000 people ages 50+. This rate was lower than the national average. Men made up 69.9 percent of these admissions. Of all admissions, 57.9 percent were White/Caucasian, 23.0 percent were Black/African American, and 19.4 percent were Hispanic.

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

Self-Referral	Criminal Justice	Other
55.4%	21.5%	23.1%

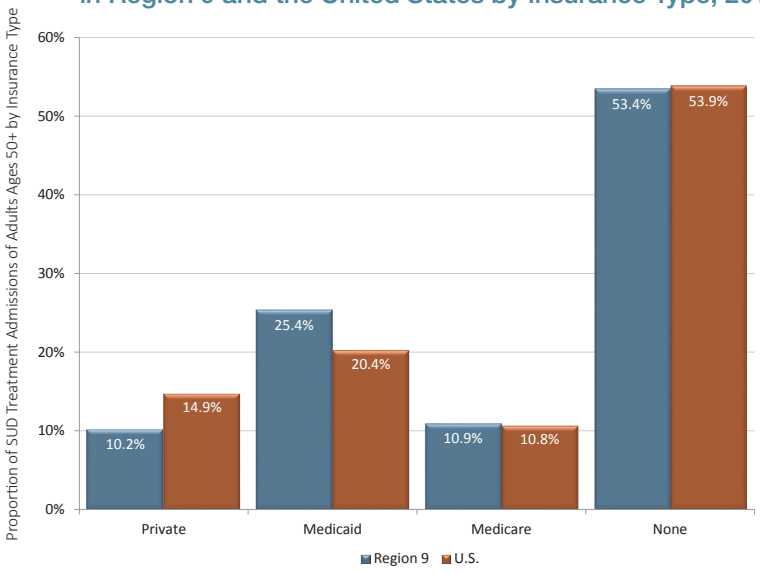
Exhibit 7. SUD Treatment Admissions of Adults Ages 50+ in Region 9 and the United States by Sex, 2012



Source: TEDS, 2012[1]
Data include only those clients reported to SAMHSA.

SUD Treatment Admissions Among Individuals in Region 9 Ages 50+ by Insurance Type

Exhibit 8. SUD Treatment Admissions of Adults Ages 50+ in Region 9 and the United States by Insurance Type, 2012



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

TEDS data for American Samoa in 2012 are unavailable. Therefore, data for Region 9 are used instead.

In Region 9, 53.4 percent of older adult admissions to SUD treatment were uninsured, 25.4 percent had Medicaid, 10.9 percent had Medicare, and 10.2 percent had private insurance.

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

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

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

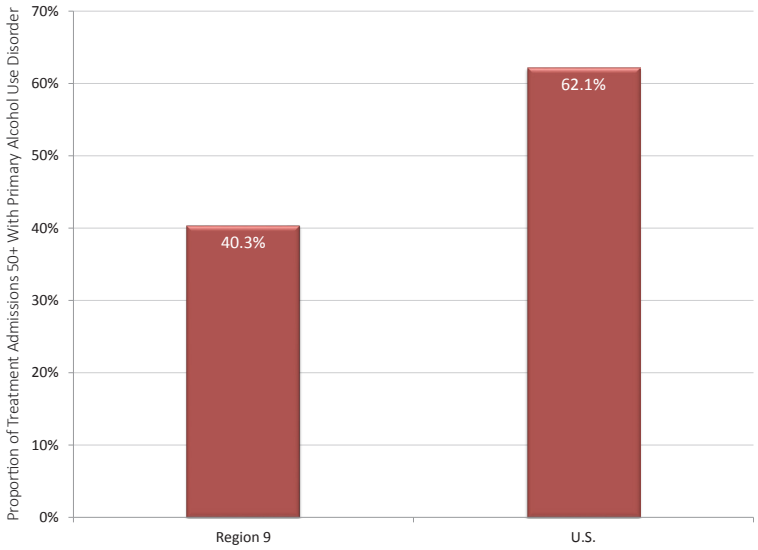
[1] TEDS data are collected by states and territories as a condition of the Substance Abuse Prevention and Treatment Block Grant. Guidelines suggest that states and territories report all clients admitted to publicly financed treatment; however, states and territories are inconsistent in applying the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

Alcohol Use Disorder Treatment Admissions Among Individuals in Region 9 Ages 50+

TEDS data for American Samoa in 2012 are unavailable. Therefore, data for Region 9 are used instead.

Alcohol was the most frequently cited substance used by older individuals in Region 9 in publicly financed SUD treatment in 2012. It was mentioned as a substance of use in 40.3 percent of admissions among those ages 50+. This was lower than the national rate.

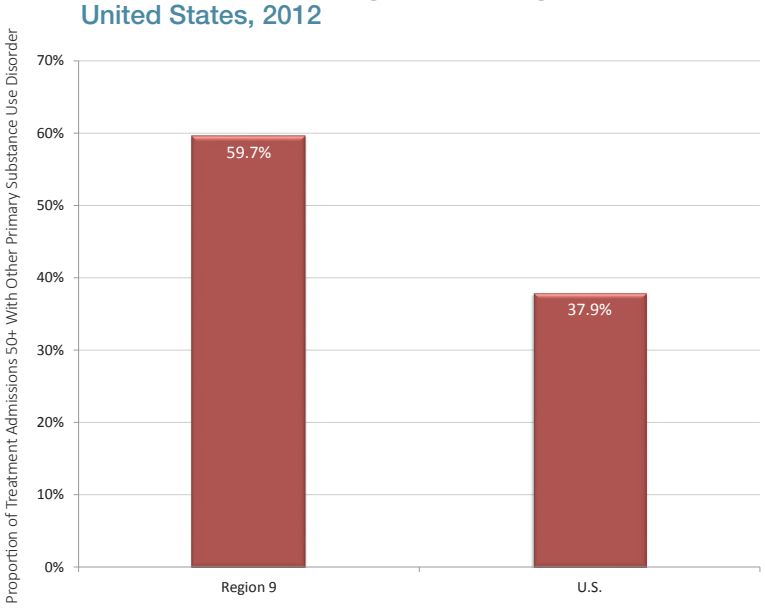
Exhibit 9. Alcohol Use Treatment Admissions of Adults Ages 50+ in Region 9 and the United States, 2012



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 Region 9 and the United States, 2012



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

TEDS data for American Samoa in 2012 are unavailable. Therefore, data for Region 9 are used instead.

Substances other than alcohol were cited as the primary substances of use for 59.7 percent of older adult admissions to publicly funded treatment in Region 9.

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*:

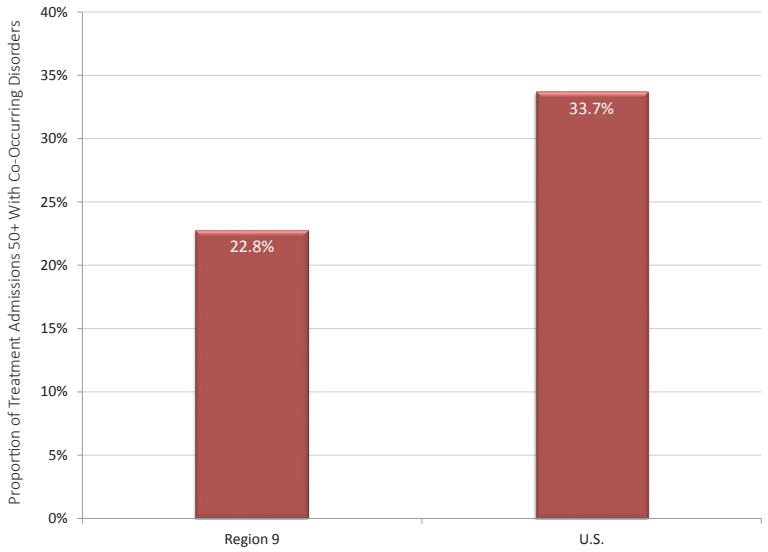
- *In 2004, there were an estimated 115,803 ED visits involving pharmaceutical misuse and abuse by adults aged 50 or older; in 2008, there were 256,097 such visits, representing an increase of 121.1 percent*
- *One fifth (19.7 percent) of ED visits involving pharmaceutical misuse and abuse among older 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 9 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 9 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 American Samoa in 2012 are unavailable. Therefore, Exhibit 11 shows regional and national figures only.

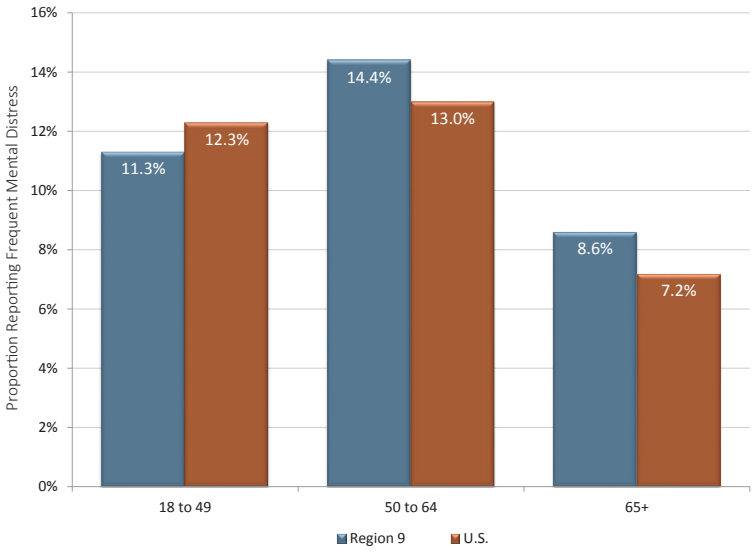
MENTAL HEALTH

Older Adults in Region 9 Reporting Frequent Mental Distress

BRFSS, a household survey conducted in all 50 states and several territories, asks the following question: "Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?" Those individuals reporting 14 or more "Yes" days in response to this question experience frequent mental distress (FMD).

Recent BRFSS data for American Samoa were unavailable. Therefore, data for Region 9 are used instead. Exhibit 12 shows that older adults in Region 9 experience FMD at a rate that is higher than the national rate.

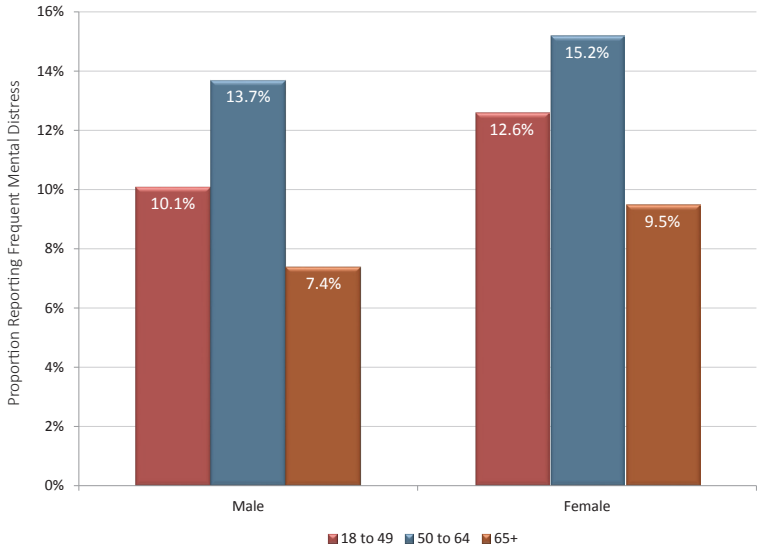
Exhibit 12. Individuals Reporting Frequent Mental Distress in Region 9 and the United States, 2013



Source: BRFSS, 2013

Older Adults in Region 9 Reporting Frequent Mental Distress by Age Group and Sex

Exhibit 13. Individuals in Region 9 Reporting Frequent Mental Distress by Age Group and Sex, 2013



Source: BRFSS, 2013

Older men in Region 9 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, 15.2 percent of women in the 50–64 age group and 9.5 percent in the 65+ age group reported FMD, while 13.7 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 adults in Region 9.

Exhibit 14. BRFSS Measures, 2010

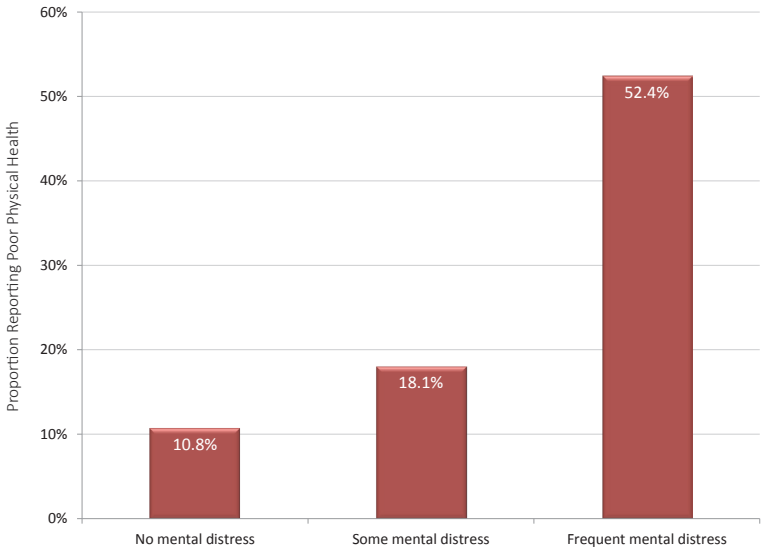
Indicator	Ages 50+	Ages 50–64	Ages 65+
Rarely or never get social or emotional support	12.4%	11.0%	14.9%
Dissatisfied or very dissatisfied	5.8%	7.1%	3.8%

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

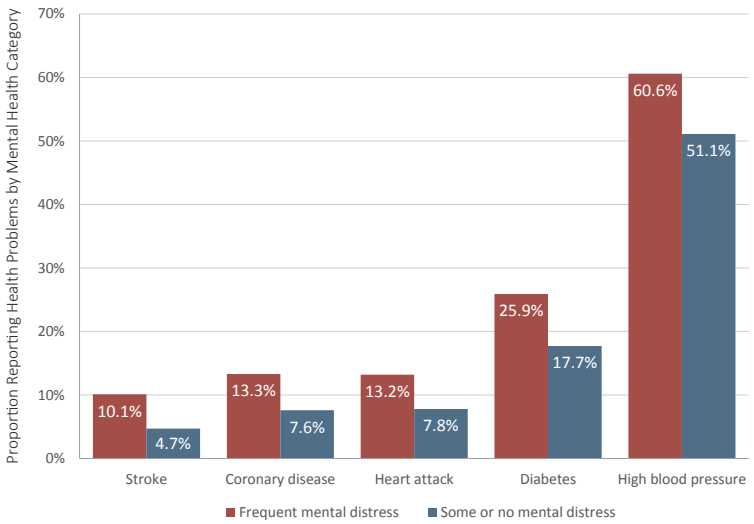


Source: BRFSS, 2013

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 American Samoans Admitted to Territory Mental Health Services

Approximately 5.6 percent of the people served by the American Samoa mental health system were in the 65–74 age group (data were unavailable for ages 75 and over). This represents 4 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

Commonwealth of the Northern Mariana Islands

Commonwealth of the

Northern Mariana Islands

OLDER ADULTS BEHAVIORAL HEALTH PROFILE

September 2016

REGION 9'S POPULATION

Region 9 Population by Age Group

Detailed demographic U.S. Census Bureau data on older Northern Mariana Islanders are unavailable. Therefore, the estimates for Region 9 (which includes Arizona, California, Hawaii, and Nevada) are used instead. Region 9 is home to 49,792,644 people. Of these:

- 15,910,775 (32.0 percent) are over age 50.
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- 4,457,879 (9.0 percent) are over age 70.
- 1,714,781 (3.4 percent) are ages 80 and older.

Race/Ethnicity of Individuals in Region 9 Ages 50+

White	AI/AN	Black	Asian	NH/PI	Other	Hispanic
76.4%	1.5%	5.6%	13.9%	0.6%	2.0%	21.5%

Source: U.S. Census Bureau, 2015
AI/AN stands for American Indian and Alaska Native.
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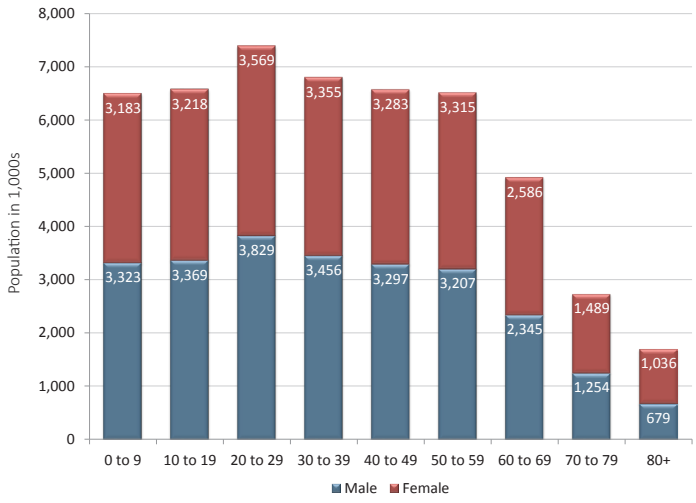
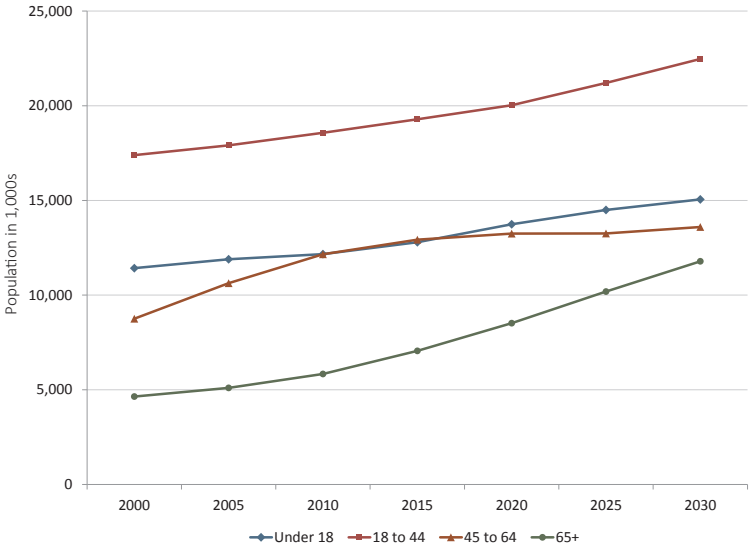


Source: U.S. Census Bureau, 2015

The Number of Older Adults in Region 9 Is Growing

Exhibit 2. Region 9 Population by Age Group, 2000–2030



Recent population projections for the Commonwealth of the Northern Mariana Islands are unavailable. Therefore, projections for Region 9 (calculated based on data from Arizona, California, Hawaii, and Nevada) are used instead.

The U.S. Census Bureau estimates that 18.7 percent of Region 9's population will be 65 and older by the year 2030, an increase of 67.0 percent from 2015.

Projected Population in Region 9

Age Group	2015	2025	2030
Under 18	24.6%	24.5%	23.9%
18 to 44	37.0%	35.8%	35.7%
45 to 64	24.8%	22.4%	21.6%
65+	13.6%	17.2%	18.7%

Source: U.S. Census Bureau, 2005

SUICIDE AMONG OLDER ADULTS IN REGION 9

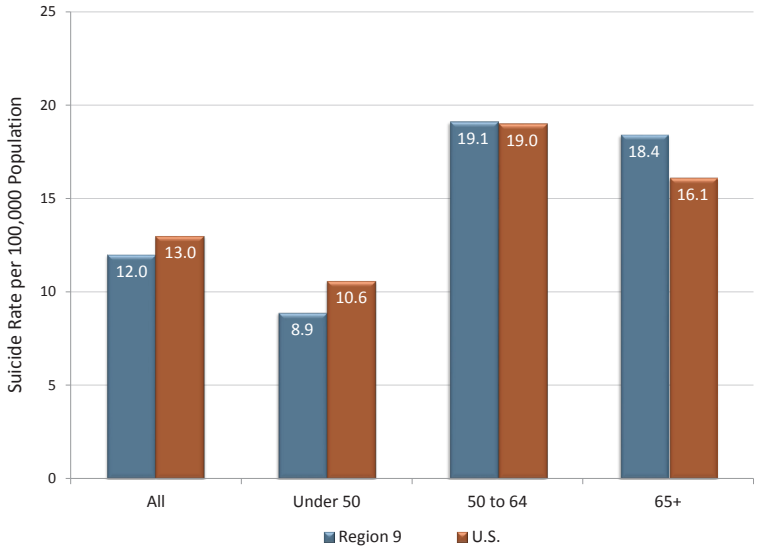
Region 9 Suicide Rates Compared With National Rates

Recent suicide data for the Commonwealth of the Northern Mariana Islands are not available from the Centers for Disease Control and Prevention (CDC) mortality databases. Therefore, the rates for Region 9 (calculated based on data from Arizona, California, Hawaii, and Nevada) are used instead.

The suicide rate among individuals in Region 9 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 18.8 per 100,000 people (8.3 for women and 30.6 for men). The rate among those ages 50–64 was higher than the rate in the United States.

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

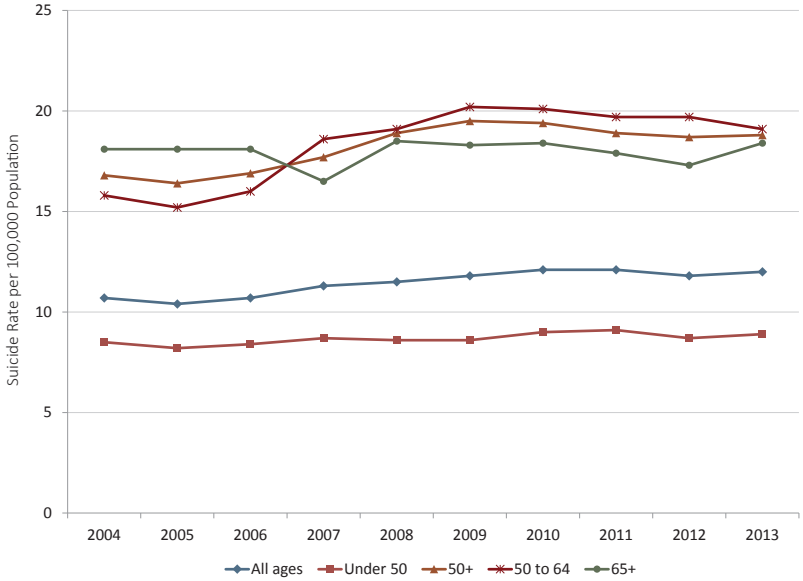
Exhibit 3. Suicide Rates in Region 9 and the United States, 2013



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

Trends in Suicide Rates in Region 9

Exhibit 4. Trends in Suicide Rates in Region 9 by Age Group, 2004–2013



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

Recent suicide data for the Commonwealth of the Northern Mariana Islands are not available from the CDC mortality databases. Therefore, the rates for Region 9 are used instead.

The suicide rate among individuals in Region 9 ages 50+ fluctuated from a low of 16.4 per 100,000 in 2005 to a high of 19.5 per 100,000 in 2009. From 2004 to 2013, the rate was generally highest among those in the 50–64 age group.

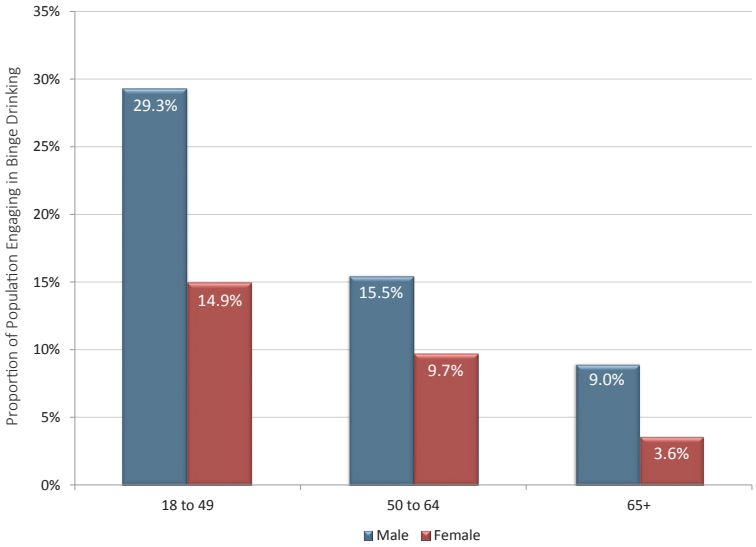
How a state or territory reports suicides can vary from year to year. The number of suicides is generally low, so even a small difference in reported numbers may make the rate fluctuate widely.

SUBSTANCE USE DISORDER AND SUBSTANCE USE DISORDER TREATMENT AMONG OLDER ADULTS IN REGION 9

30-Day Binge Drinking Among Older Adults in Region 9

Binge drinking, defined as five or more drinks for men and four or more drinks for women on a single occasion, can lead to serious health problems. Such problems include neurological damage, cardiovascular disease, liver disease, stroke, and poor control of diabetes. Binge drinkers are more likely to take risks such as driving while intoxicated and to experience falls and other accidents. Older people have a lower tolerance for alcohol. Binge drinking decreases with age and occurs more frequently among men than it does among women. Recent data for the Commonwealth of the Northern Mariana Islands are unavailable. Therefore, data for Region 9 are used instead. As Exhibit 5 shows, 15.5 percent of Region 9 men ages 50–64 reported binge drinking in the past 30 days, while 9.0 percent of those in the 65+ group reported similar behavior.

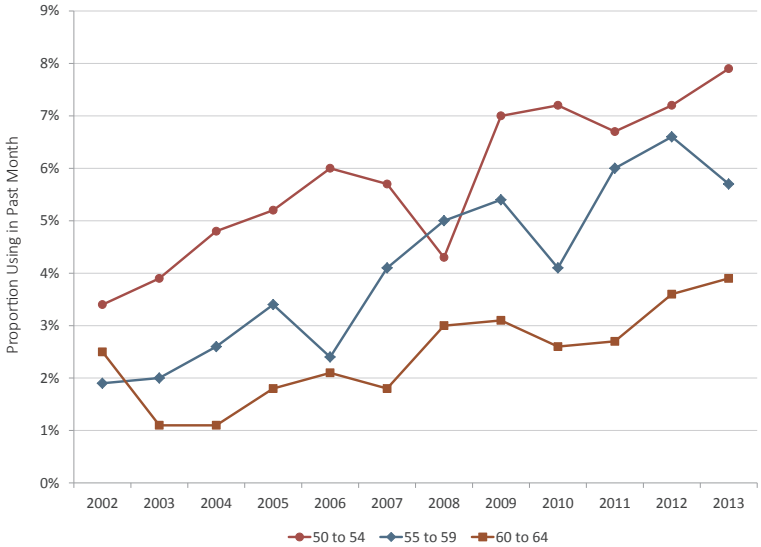
Exhibit 5. Binge Drinking Rates in Region 9 by Age Group and Sex, 2013



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

Illicit Drug Use Among Older Americans

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



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

Nationally, the rate of illicit drug use among older adults ages 50–64 more than doubled from 2002 to 2013. This development partially reflects the entrance into this age group of the baby boom cohort, whose rates of illicit drug use have been higher than those of older cohorts. Although territory-specific data are not available, the *Behavioral Health Barometers* for states in Region 9 are available for download from the Substance Abuse and Mental Health Services Administration (SAMHSA) website (www.samhsa.gov/data/population-data-nsduh/reports?tab=33).

Admissions to Substance Use Disorder Treatment Among Older Adults in Region 9

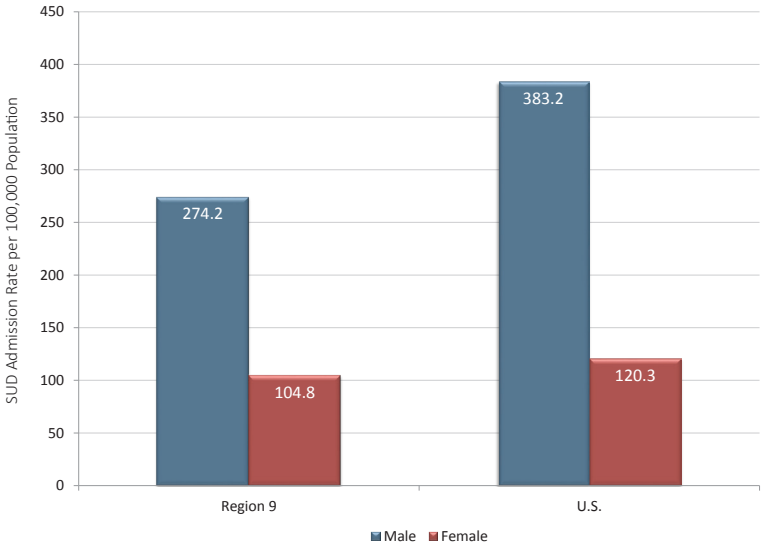
Treatment Episode Data Set (TEDS) data for the Commonwealth of the Northern Mariana Islands in 2012 are unavailable. Therefore, data for Region 9 are used instead.

In 2012, there were 29,351 admissions of individuals in Region 9 ages 50 and older to substance use disorder (SUD) treatment in state-funded treatment programs, a rate of 184.5 per 100,000 people ages 50+. This rate was lower than the national average. Men made up 69.9 percent of these admissions. Of all admissions, 57.9 percent were White/Caucasian, 23.0 percent were Black/African American, and 19.4 percent were Hispanic.

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

Self-Referral	Criminal Justice	Other
55.4%	21.5%	23.1%

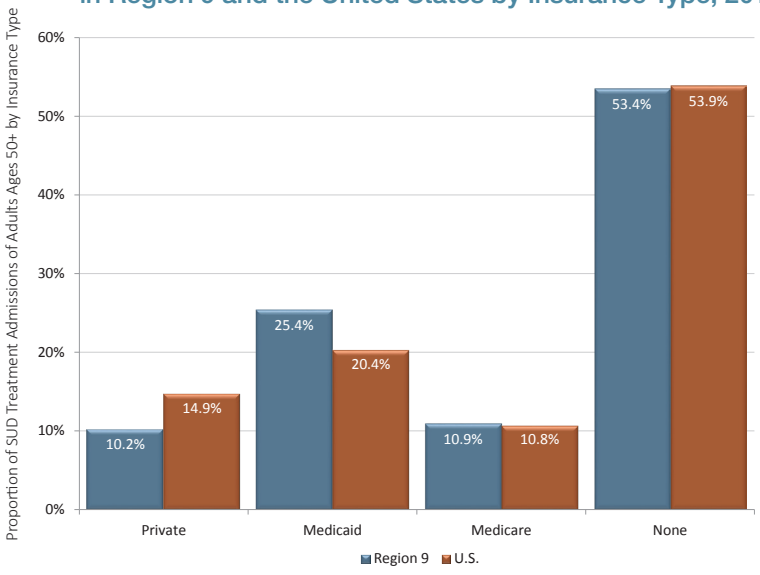
Exhibit 7. SUD Treatment Admissions of Adults Ages 50+ in Region 9 and the United States by Sex, 2012



Source: TEDS, 2012[1]
Data include only those clients reported to SAMHSA.

SUD Treatment Admissions Among Individuals in Region 9 Ages 50+ by Insurance Type

Exhibit 8. SUD Treatment Admissions of Adults Ages 50+ in Region 9 and the United States by Insurance Type, 2012



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

TEDS data for the Commonwealth of the Northern Mariana Islands in 2012 are unavailable. Therefore, data for Region 9 are used instead.

In Region 9, 53.4 percent of older adult admissions to SUD treatment were uninsured, 25.4 percent had Medicaid, 10.9 percent had Medicare, and 10.2 percent had private insurance.

SUD Treatment Admissions Among Northern Mariana Islanders Ages 50+ by Primary Sources of Payment

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

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

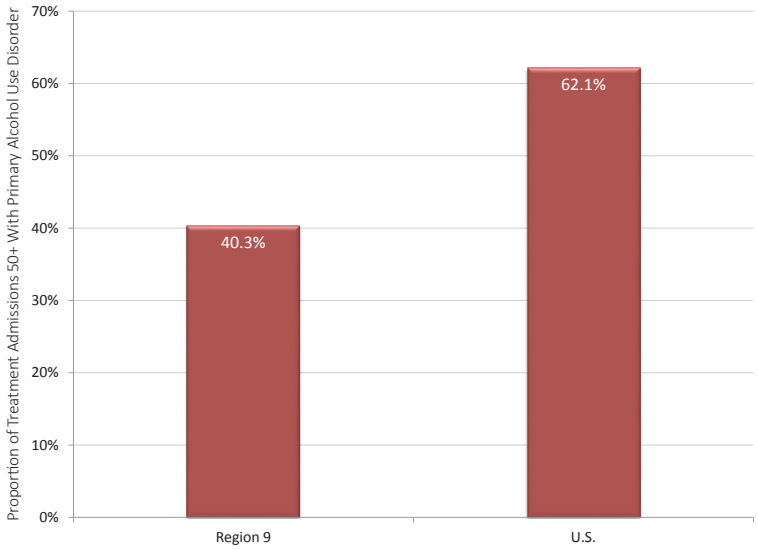
[1] TEDS data are collected by states and territories as a condition of the Substance Abuse Prevention and Treatment Block Grant. Guidelines suggest that states and territories report all clients admitted to publicly financed treatment; however, states and territories are inconsistent in applying the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

Alcohol Use Disorder Treatment Admissions Among Individuals in Region 9 Ages 50+

TEDS data for the Commonwealth of the Northern Mariana Islands in 2012 are unavailable. Therefore, data for Region 9 are used instead.

Alcohol was the most frequently cited substance used by older individuals in Region 9 in publicly financed SUD treatment in 2012. It was mentioned as a substance of use in 40.3 percent of admissions among those ages 50+. This was lower than the national rate.

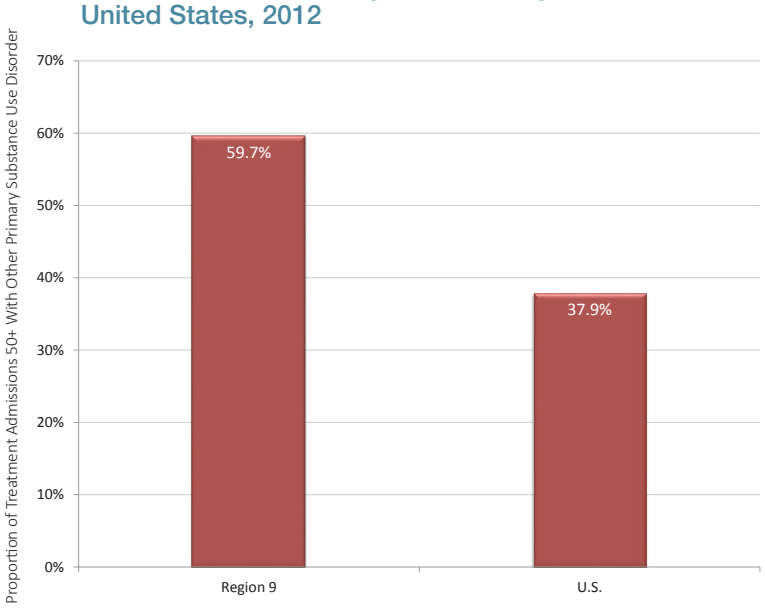
Exhibit 9. Alcohol Use Treatment Admissions of Adults Ages 50+ in Region 9 and the United States, 2012



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 Region 9 and the United States, 2012



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

TEDS data for the Commonwealth of the Northern Mariana Islands in 2012 are unavailable. Therefore, data for Region 9 are used instead.

Substances other than alcohol were cited as the primary substances of use for 59.7 percent of older adult admissions to publicly funded treatment in Region 9.

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*:

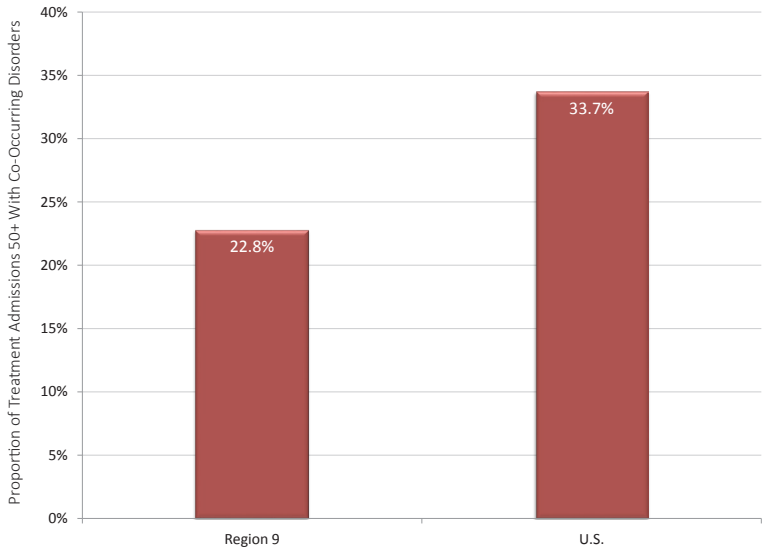
- *In 2004, there were an estimated 115,803 ED visits involving pharmaceutical misuse and abuse by adults aged 50 or older; in 2008, there were 256,097 such visits, representing an increase of 121.1 percent*
- *One fifth (19.7 percent) of ED visits involving pharmaceutical misuse and abuse among older 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 9 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 9 and the United States, 2012



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

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

TEDS data for the Commonwealth of the Northern Mariana Islands in 2012 are unavailable. Therefore, Exhibit 11 shows regional and national figures only.

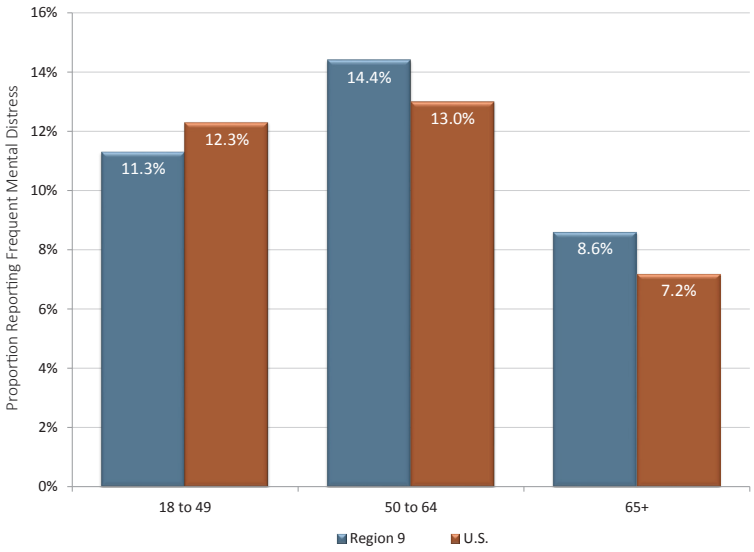
MENTAL HEALTH

Older Adults in Region 9 Reporting Frequent Mental Distress

BRFSS, a household survey conducted in all 50 states and several territories, asks the following question: "Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?" Those individuals reporting 14 or more "Yes" days in response to this question experience frequent mental distress (FMD).

Recent BRFSS data for the Commonwealth of the Northern Mariana Islands were unavailable. Therefore, data for Region 9 are used instead. Exhibit 12 shows that older adults in Region 9 experience FMD at a rate that is higher than the national rate.

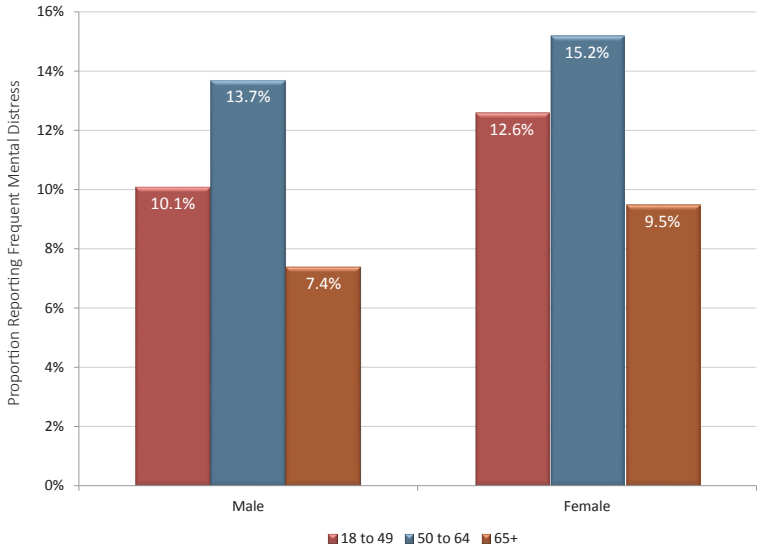
Exhibit 12. Individuals Reporting Frequent Mental Distress in Region 9 and the United States, 2013



Source: BRFSS, 2013

Older Adults in Region 9 Reporting Frequent Mental Distress by Age Group and Sex

Exhibit 13. Individuals in Region 9 Reporting Frequent Mental Distress by Age Group and Sex, 2013



Source: BRFSS, 2013

Older men in Region 9 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, 15.2 percent of women in the 50–64 age group and 9.5 percent in the 65+ age group reported FMD, while 13.7 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 adults in Region 9.

Exhibit 14. BRFSS Measures, 2010

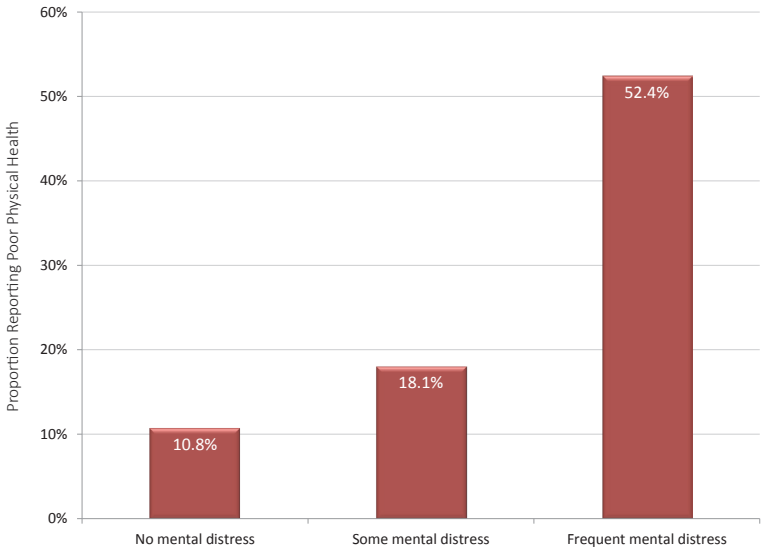
Indicator	Ages 50+	Ages 50–64	Ages 65+
Rarely or never get social or emotional support	12.4%	11.0%	14.9%
Dissatisfied or very dissatisfied	5.8%	7.1%	3.8%

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

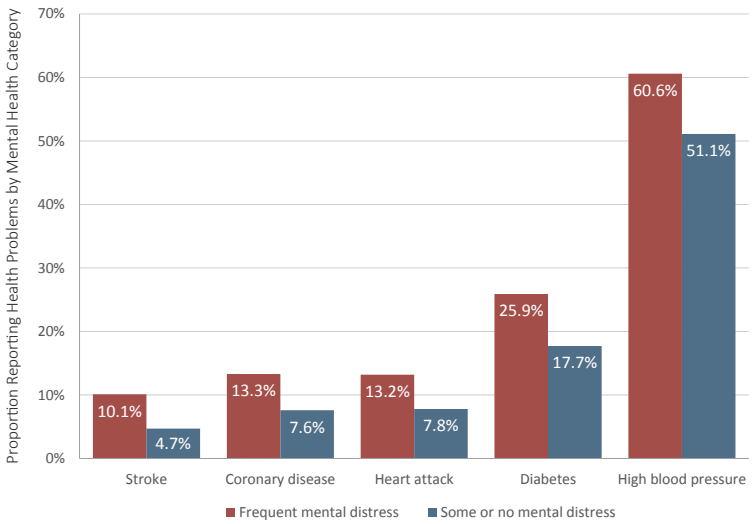


Source: BRFSS, 2013

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 Northern Mariana Islanders Admitted to Territory Mental Health Services

Two people served by the the Commonwealth of the Northern Mariana Islands mental health system were ages 65 and older.

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

DATA SOURCES

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

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

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

NATIONAL SURVEY ON DRUG USE AND HEALTH (https://nsduhweb.rti.org). The NSDUH, managed by SAMHSA, is "an annual nationwide survey involving interviews with approximately 70,000 randomly selected individuals aged 12 and older." NSDUH data are most frequently used by state planners to assess the need for SUD treatment. NSDUH data also include information about mental health conditions.

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

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

OLDER ADULTS BEHAVIORAL HEALTH PROFILE

Federated States of Micronesia

Federated States of Micronesia

OLDER ADULTS BEHAVIORAL HEALTH PROFILE

September 2016

REGION 9'S POPULATION

Region 9 Population by Age Group

Detailed demographic U.S. Census Bureau data on older Micronesians are unavailable. Therefore, the estimates for Region 9 (which includes Arizona, California, Hawaii, and Nevada) are used instead. Region 9 is home to 49,792,644 people. Of these:

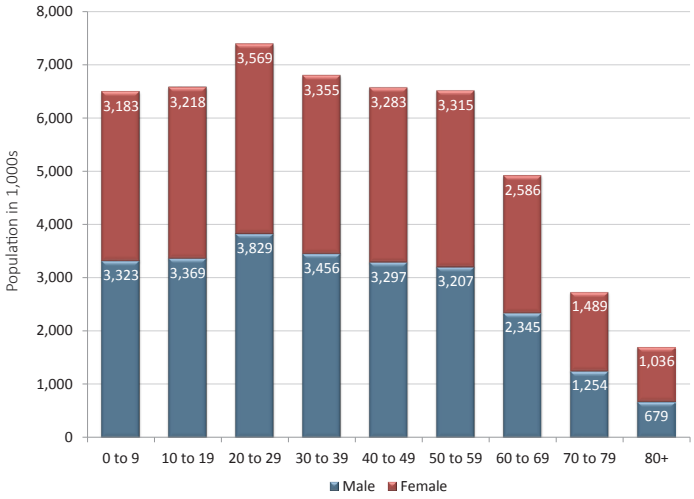
- 15,910,775 (32.0 percent) are over age 50.
- 9,388,613 (18.9 percent) are over age 60.
- 4,457,879 (9.0 percent) are over age 70.
- 1,714,781 (3.4 percent) are ages 80 and older.

Race/Ethnicity of Individuals in Region 9 Ages 50+

White	AI/AN	Black	Asian	NH/PI	Other	Hispanic
76.4%	1.5%	5.6%	13.9%	0.6%	2.0%	21.5%

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

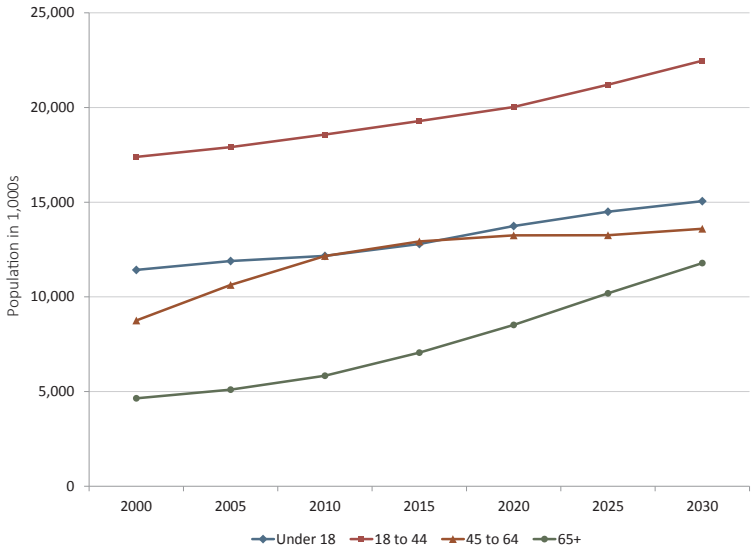
Exhibit 1. Region 9 Population by Age Group, 2014



Source: U.S. Census Bureau, 2015

The Number of Older Adults in Region 9 Is Growing

Exhibit 2. Region 9 Population by Age Group, 2000–2030



Recent population projections for the Federated States of Micronesia are unavailable. Therefore, projections for Region 9 (calculated based on data from Arizona, California, Hawaii, and Nevada) are used instead.

The U.S. Census Bureau estimates that 18.7 percent of Region 9's population will be 65 and older by the year 2030, an increase of 67.0 percent from 2015.

Projected Population in Region 9

Age Group	2015	2025	2030
Under 18	24.6%	24.5%	23.9%
18 to 44	37.0%	35.8%	35.7%
45 to 64	24.8%	22.4%	21.6%
65+	13.6%	17.2%	18.7%

Source: U.S. Census Bureau, 2005

SUICIDE AMONG OLDER ADULTS IN REGION 9

Region 9 Suicide Rates Compared With National Rates

Recent suicide data for the Federated States of Micronesia are not available from the Centers for Disease Control and Prevention (CDC) mortality databases. Therefore, the rates for Region 9 (calculated based on data from Arizona, California, Hawaii, and Nevada) are used instead.

The suicide rate among individuals in Region 9 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 18.8 per 100,000 people (8.3 for women and 30.6 for men). The rate among those ages 50–64 was higher than the rate in the United States.

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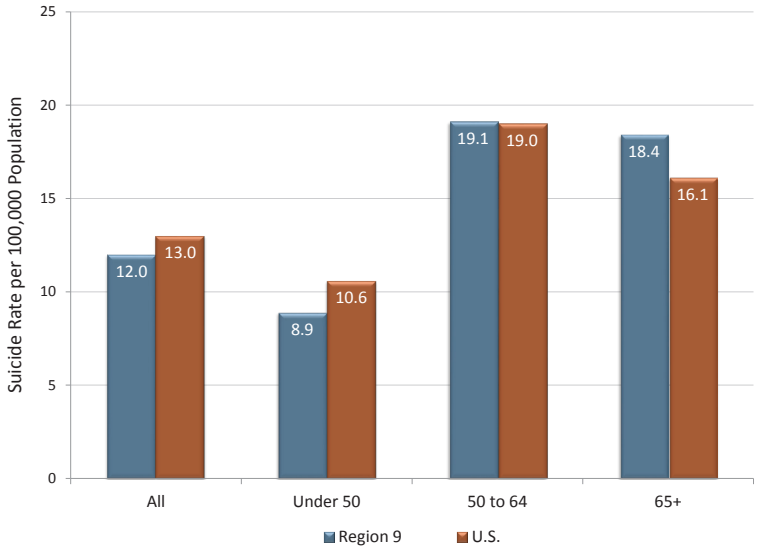

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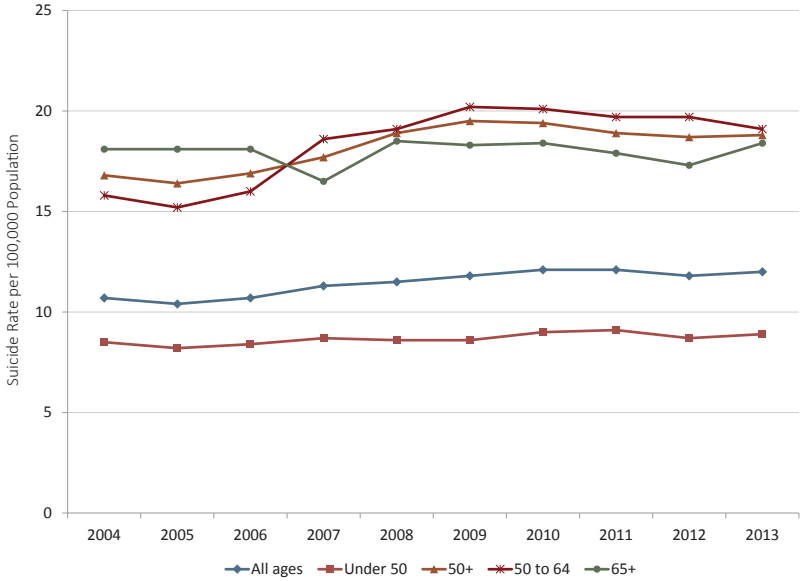

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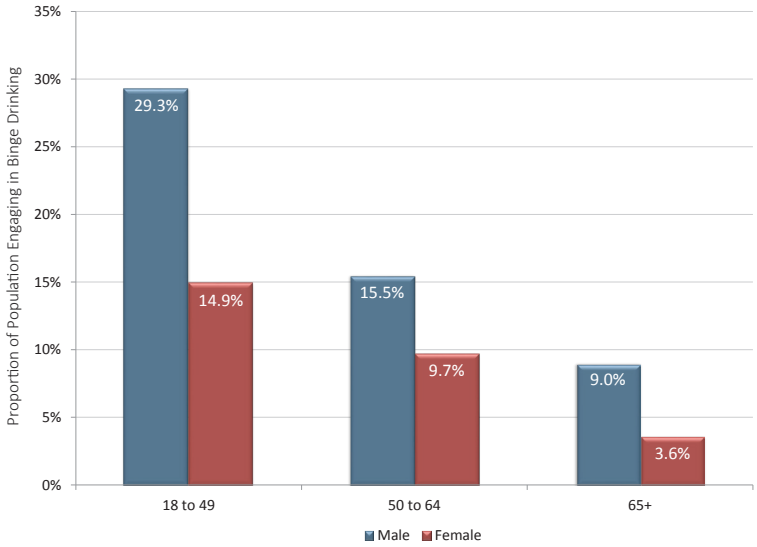

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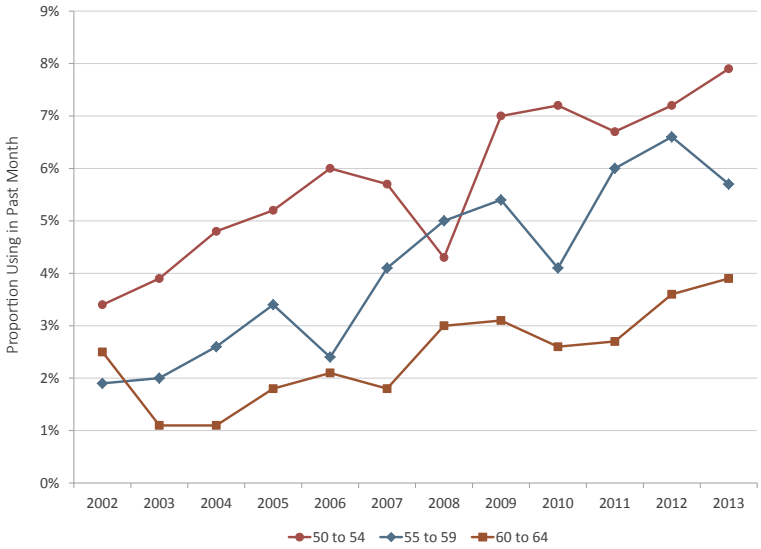

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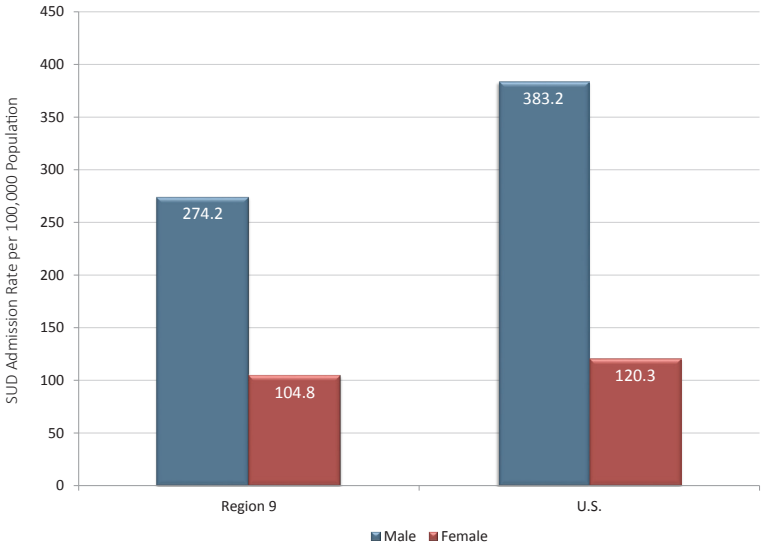
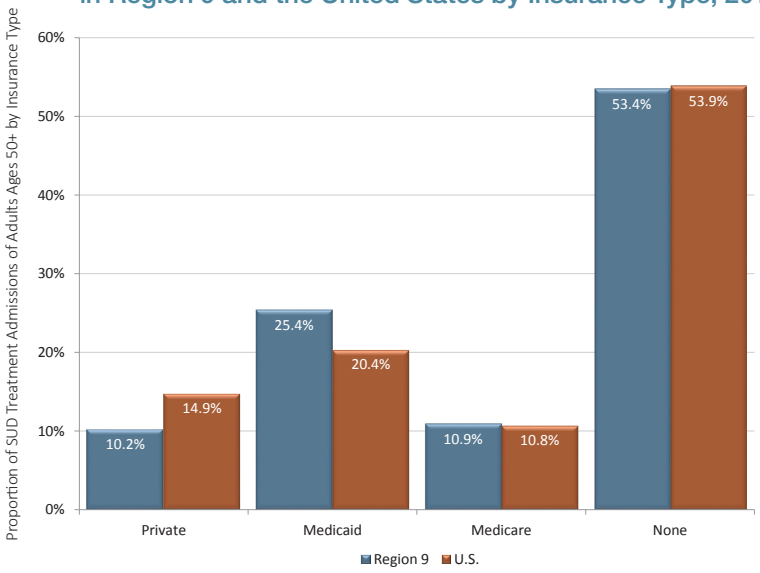


Source: TEDS, 2012[1]
Data include only those clients reported to SAMHSA.

SUD Treatment Admissions Among Individuals in Region 9 Ages 50+ by Insurance Type

Exhibit 8. SUD Treatment Admissions of Adults Ages 50+ in Region 9 and the United States by Insurance Type, 2012



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

TEDS data for the Federated States of Micronesia in 2012 are unavailable. Therefore, data for Region 9 are used instead.

In Region 9, 53.4 percent of older adult admissions to SUD treatment were uninsured, 25.4 percent had Medicaid, 10.9 percent had Medicare, and 10.2 percent had private insurance.

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

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

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

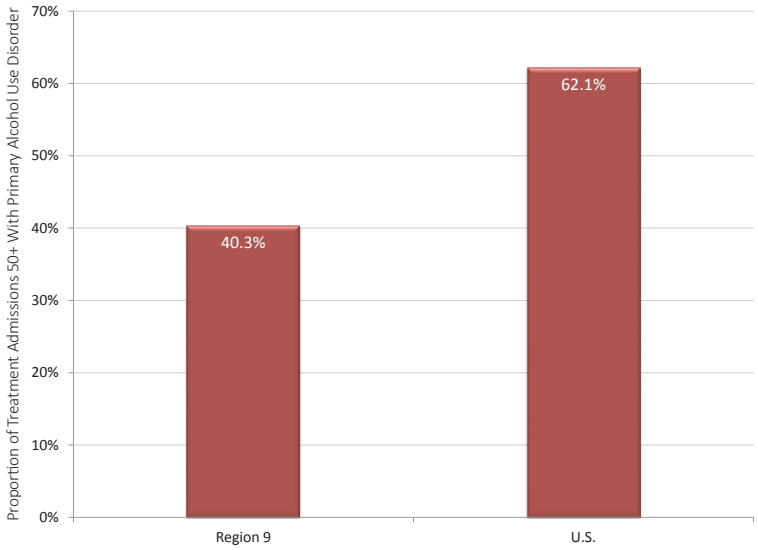
[1] TEDS data are collected by states and territories as a condition of the Substance Abuse Prevention and Treatment Block Grant. Guidelines suggest that states and territories report all clients admitted to publicly financed treatment; however, states and territories are inconsistent in applying the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

Alcohol Use Disorder Treatment Admissions Among Individuals in Region 9 Ages 50+

TEDS data for the Federated States of Micronesia in 2012 are unavailable. Therefore, data for Region 9 are used instead.

Alcohol was the most frequently cited substance used by older individuals in Region 9 in publicly financed SUD treatment in 2012. It was mentioned as a substance of use in 40.3 percent of admissions among those ages 50+. This was lower than the national rate.

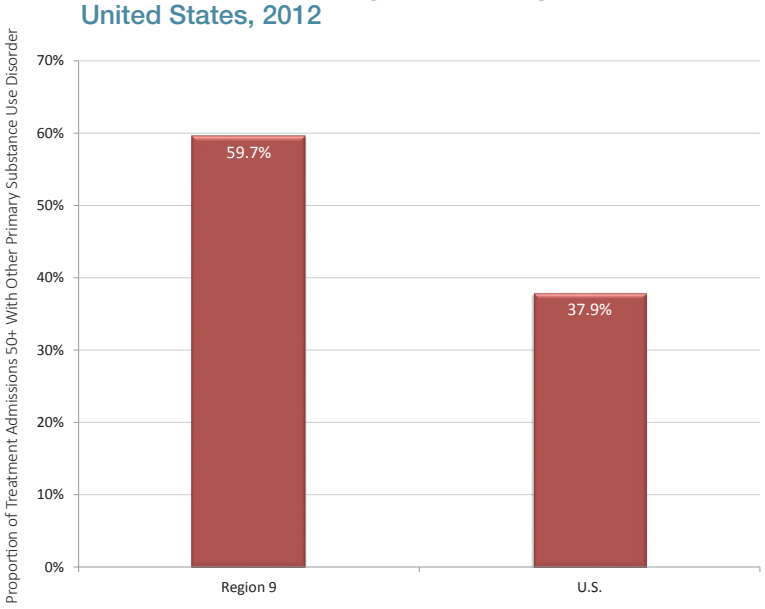
Exhibit 9. Alcohol Use Treatment Admissions of Adults Ages 50+ in Region 9 and the United States, 2012



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 Region 9 and the United States, 2012



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

TEDS data for the Federated States of Micronesia in 2012 are unavailable. Therefore, data for Region 9 are used instead.

Substances other than alcohol were cited as the primary substances of use for 59.7 percent of older adult admissions to publicly funded treatment in Region 9.

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*:

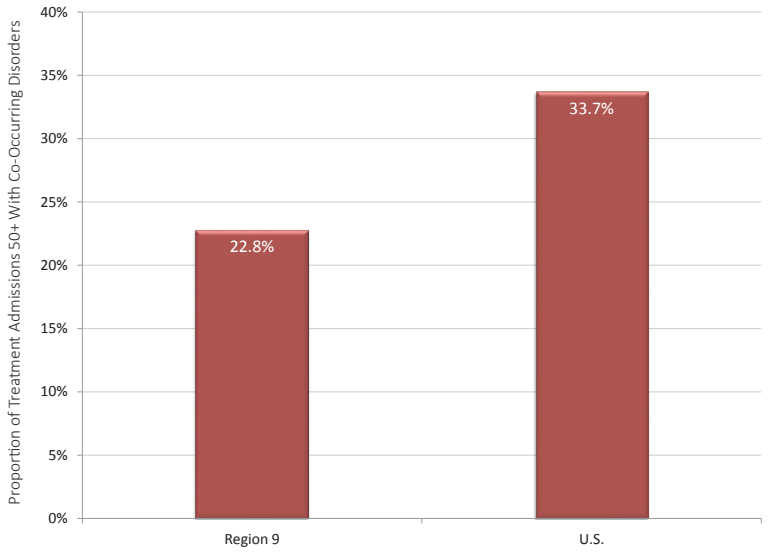
- *In 2004, there were an estimated 115,803 ED visits involving pharmaceutical misuse and abuse by adults aged 50 or older; in 2008, there were 256,097 such visits, representing an increase of 121.1 percent*
- *One fifth (19.7 percent) of ED visits involving pharmaceutical misuse and abuse among older 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 9 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 9 and the United States, 2012



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

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

TEDS data for the Federated States of Micronesia in 2012 are unavailable. Therefore, Exhibit 11 shows regional and national figures only.

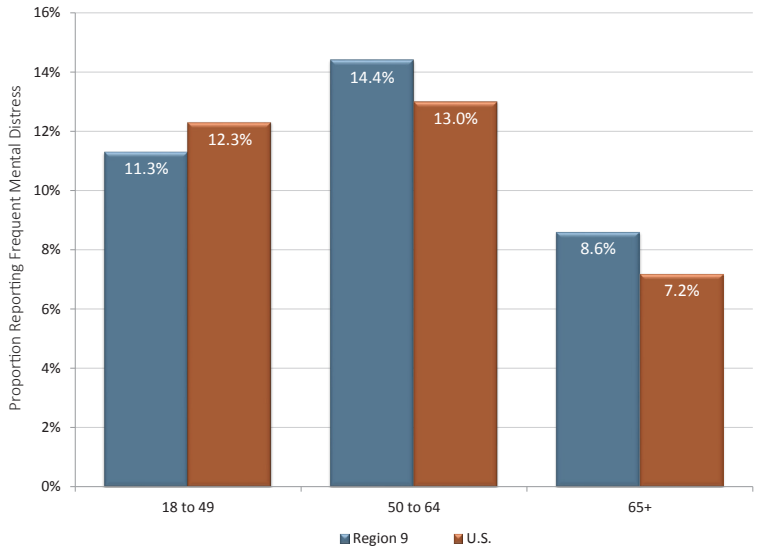
MENTAL HEALTH

Older Adults in Region 9 Reporting Frequent Mental Distress

BRFSS, a household survey conducted in all 50 states and several territories, asks the following question: "Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?" Those individuals reporting 14 or more "Yes" days in response to this question experience frequent mental distress (FMD).

Recent BRFSS data for the Federated States of Micronesia were unavailable. Therefore, data for Region 9 are used instead. Exhibit 12 shows that older adults in Region 9 experience FMD at a rate that is higher than the national rate.

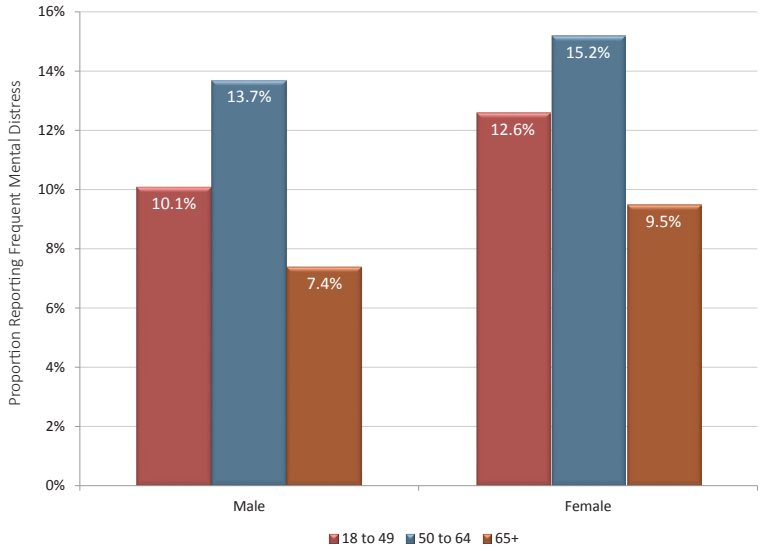
Exhibit 12. Individuals Reporting Frequent Mental Distress in Region 9 and the United States, 2013



Source: BRFSS, 2013

Older Adults in Region 9 Reporting Frequent Mental Distress by Age Group and Sex

Exhibit 13. Individuals in Region 9 Reporting Frequent Mental Distress by Age Group and Sex, 2013



Source: BRFSS, 2013

Older men in Region 9 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, 15.2 percent of women in the 50–64 age group and 9.5 percent in the 65+ age group reported FMD, while 13.7 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 adults in Region 9.

Exhibit 14. BRFSS Measures, 2010

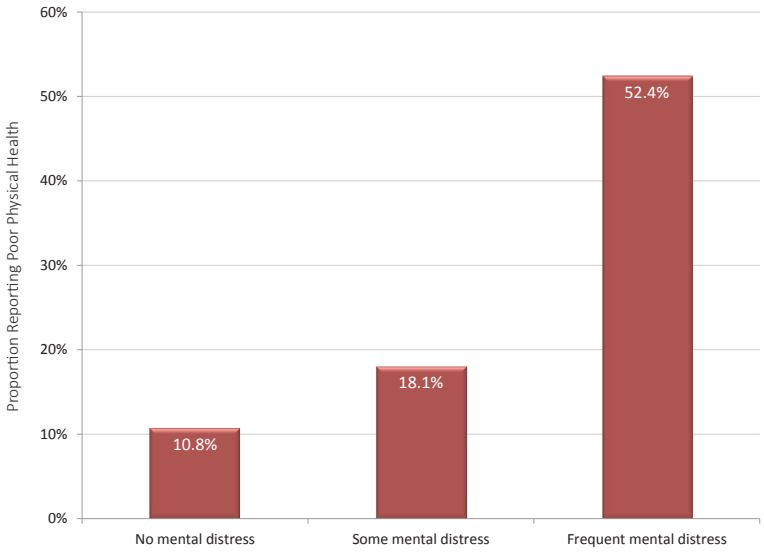
Indicator	Ages 50+	Ages 50–64	Ages 65+
Rarely or never get social or emotional support	12.4%	11.0%	14.9%
Dissatisfied or very dissatisfied	5.8%	7.1%	3.8%

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

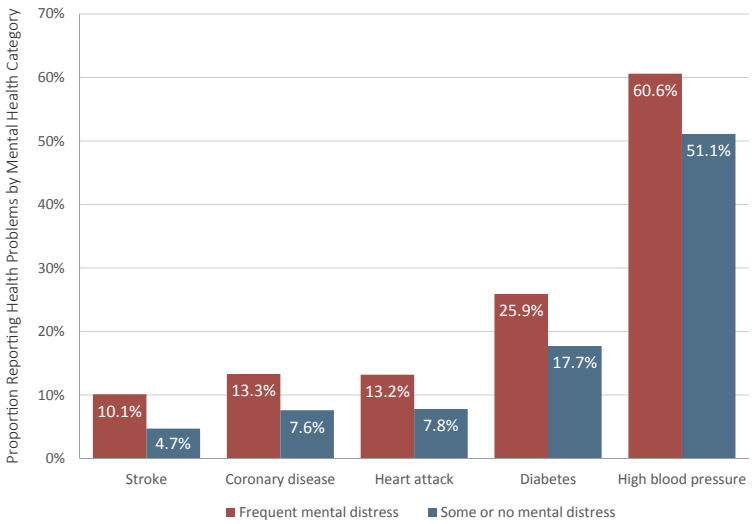


Source: BRFSS, 2013

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 Micronesians Admitted to Territory Mental Health Services

Approximately 3.6 percent of the people served by the Federated States of Micronesia mental health system were ages 65 and older. This represents more than approximately 20 adults.

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

DATA SOURCES

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

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

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

NATIONAL SURVEY ON DRUG USE AND HEALTH (https://nsduhweb.rti.org). The NSDUH, managed by SAMHSA, is "an annual nationwide survey involving interviews with approximately 70,000 randomly selected individuals aged 12 and older." NSDUH data are most frequently used by state planners to assess the need for SUD treatment. NSDUH data also include information about mental health conditions.

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

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

Guam

Guam

OLDER ADULTS BEHAVIORAL HEALTH PROFILE

September 2016

REGION 9'S POPULATION

Region 9 Population by Age Group

Detailed demographic U.S. Census Bureau data on older Guamanians are unavailable. Therefore, the estimates for Region 9 (which includes Arizona, California, Hawaii, and Nevada) are used instead. Region 9 is home to 49,792,644 people. Of these:

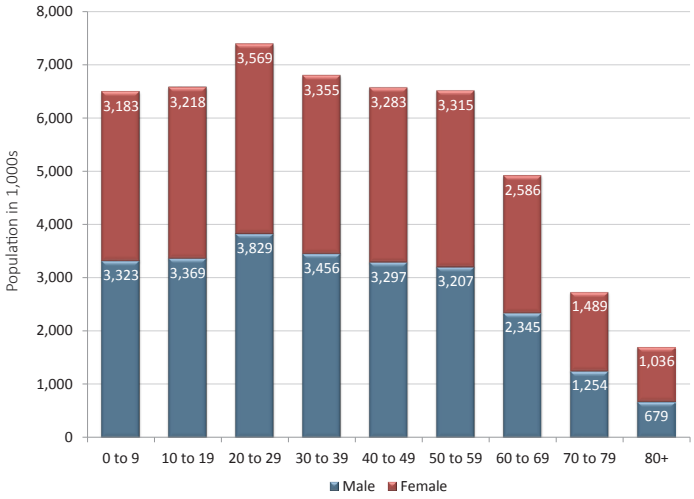
- 15,910,775 (32.0 percent) are over age 50.
- 9,388,613 (18.9 percent) are over age 60.
- 4,457,879 (9.0 percent) are over age 70.
- 1,714,781 (3.4 percent) are ages 80 and older.

Race/Ethnicity of Individuals in Region 9 Ages 50+

White	AI/AN	Black	Asian	NH/PI	Other	Hispanic
76.4%	1.5%	5.6%	13.9%	0.6%	2.0%	21.5%

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

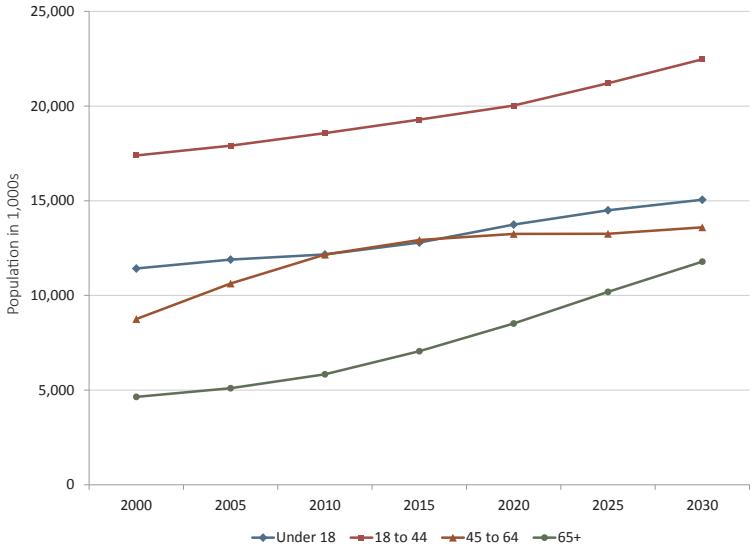
Exhibit 1. Region 9 Population by Age Group, 2014



Source: U.S. Census Bureau, 2015

The Number of Older Adults in Region 9 Is Growing

Exhibit 2. Region 9 Population by Age Group, 2000–2030



Recent population projections for Guam are unavailable. Therefore, projections for Region 9 (calculated based on data from Arizona, California, Hawaii, and Nevada) are used instead.

The U.S. Census Bureau estimates that 18.7 percent of Region 9's population will be 65 and older by the year 2030, an increase of 67.0 percent from 2015.

Projected Population in Region 9

Age Group	2015	2025	2030
Under 18	24.6%	24.5%	23.9%
18 to 44	37.0%	35.8%	35.7%
45 to 64	24.8%	22.4%	21.6%
65+	13.6%	17.2%	18.7%

Source: U.S. Census Bureau, 2005

SUICIDE AMONG OLDER ADULTS IN REGION 9

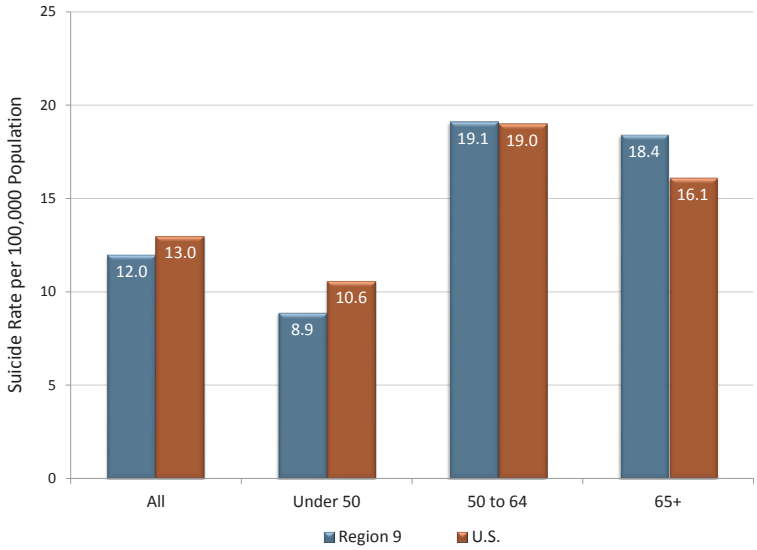
Region 9 Suicide Rates Compared With National Rates

Recent suicide data for Guam are not available from the Centers for Disease Control and Prevention (CDC) mortality databases. Therefore, the rates for Region 9 (calculated based on data from Arizona, California, Hawaii, and Nevada) are used instead.

The suicide rate among individuals in Region 9 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 18.8 per 100,000 people (8.3 for women and 30.6 for men). The rate among those ages 50–64 was higher than the rate in the United States.

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

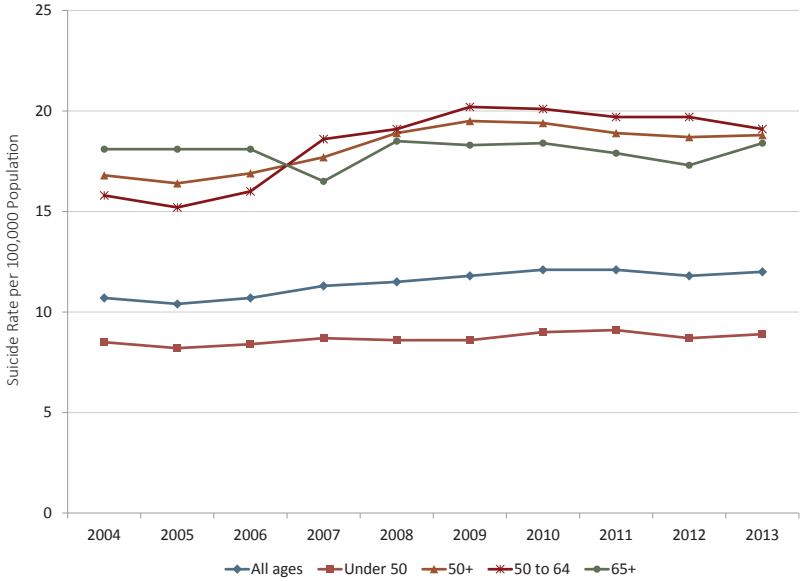
Exhibit 3. Suicide Rates in Region 9 and the United States, 2013



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

Trends in Suicide Rates in Region 9

Exhibit 4. Trends in Suicide Rates in Region 9 by Age Group, 2004–2013



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

Recent suicide data for Guam are not available from the CDC mortality databases. Therefore, the rates for Region 9 are used instead.

The suicide rate among individuals in Region 9 ages 50+ fluctuated from a low of 16.4 per 100,000 in 2005 to a high of 19.5 per 100,000 in 2009. From 2004 to 2013, the rate was generally highest among those in the 50–64 age group.

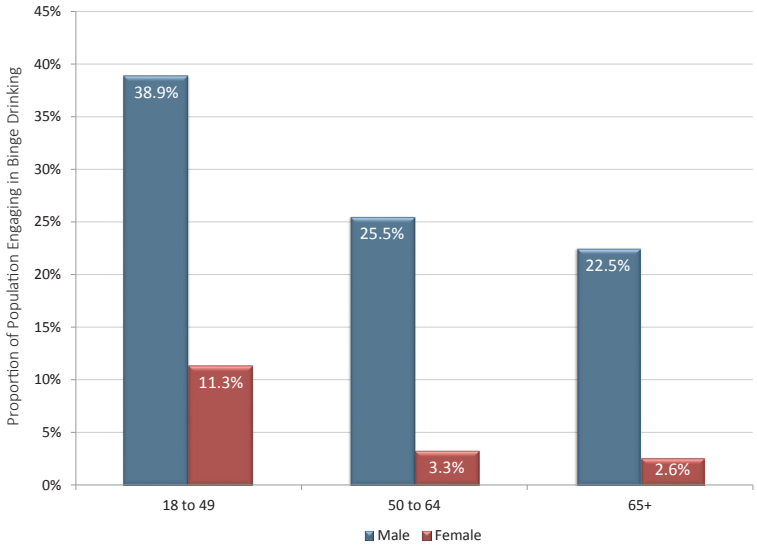
How a state or territory reports suicides can vary from year to year. The number of suicides is generally low, so even a small difference in reported numbers may make the rate fluctuate widely.

SUBSTANCE USE DISORDER AND SUBSTANCE USE DISORDER TREATMENT AMONG OLDER GUAMANIANS

30-Day Binge Drinking Among Guamanians

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, 25.5 percent of Guam men ages 50–64 reported binge drinking in the past 30 days, while 22.5 percent of those in the 65+ group reported similar behavior.

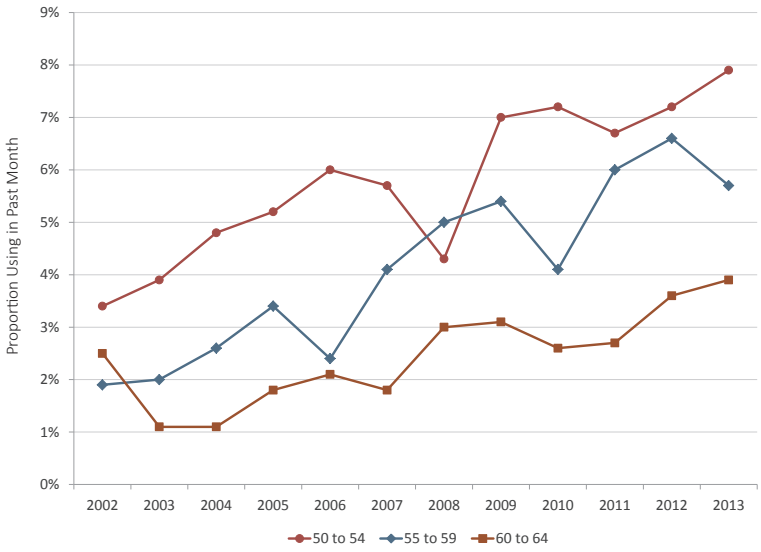
Exhibit 5. Binge Drinking Rates in Guam by Age Group and Sex, 2013



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

Illicit Drug Use Among Older Americans

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



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

Nationally, the rate of illicit drug use among older adults ages 50–64 more than doubled from 2002 to 2013. This development partially reflects the entrance into this age group of the baby boom cohort, whose rates of illicit drug use have been higher than those of older cohorts. Although territory-specific data are not available, the *Behavioral Health Barometers* for states in Region 9 are available for download from the Substance Abuse and Mental Health Services Administration (SAMHSA) website (www.samhsa.gov/data/population-data-nsduh/reports?tab=33).

Admissions to Substance Use Disorder Treatment Among Older Adults in Region 9

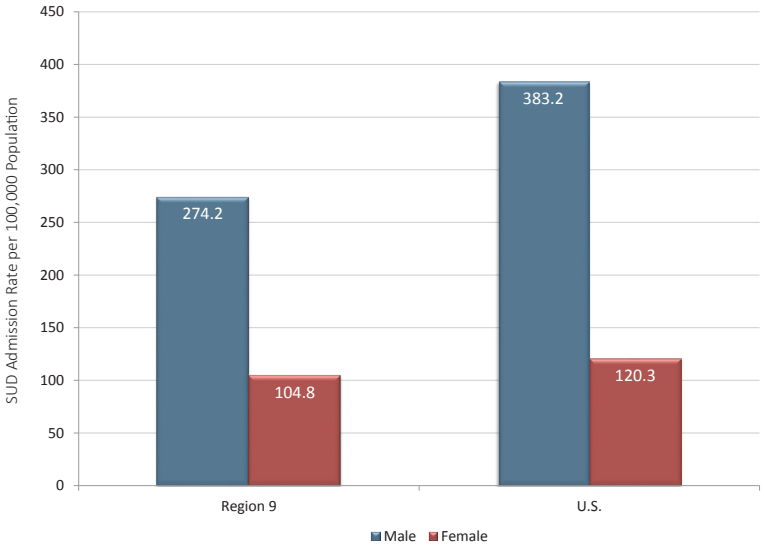
Treatment Episode Data Set (TEDS) data for Guam in 2012 are unavailable. Therefore, data for Region 9 are used instead.

In 2012, there were 29,351 admissions of individuals in Region 9 ages 50 and older to substance use disorder (SUD) treatment in state-funded treatment programs, a rate of 184.5 per 100,000 people ages 50+. This rate was lower than the national average. Men made up 69.9 percent of these admissions. Of all admissions, 57.9 percent were White/Caucasian, 23.0 percent were Black/African American, and 19.4 percent were Hispanic.

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

Self-Referral	Criminal Justice	Other
55.4%	21.5%	23.1%

Exhibit 7. SUD Treatment Admissions of Adults Ages 50+ in Region 9 and the United States by Sex, 2012



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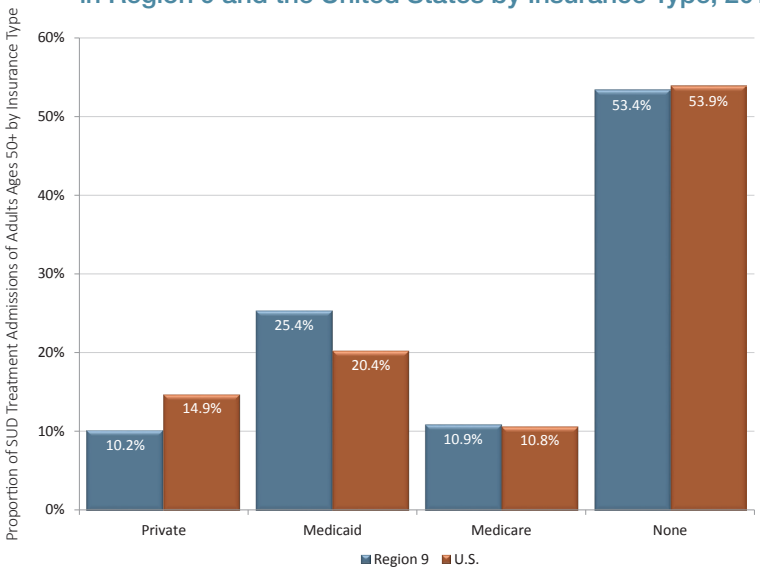

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In Region 9, 53.4 percent of older adult admissions to SUD treatment were uninsured, 25.4 percent had Medicaid, 10.9 percent had Medicare, and 10.2 percent had private insurance.

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

Self-Pay	Medicaid	Other
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Alcohol Use Disorder Treatment Admissions Among Individuals in Region 9 Ages 50+

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Alcohol was the most frequently cited substance used by older individuals in Region 9 in publicly financed SUD treatment in 2012. It was mentioned as a substance of use in 40.3 percent of admissions among those ages 50+. This was lower than the national rate.

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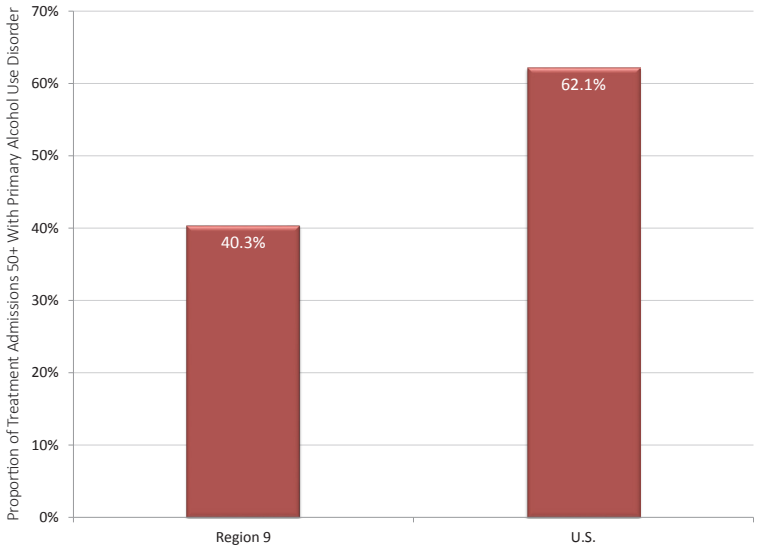

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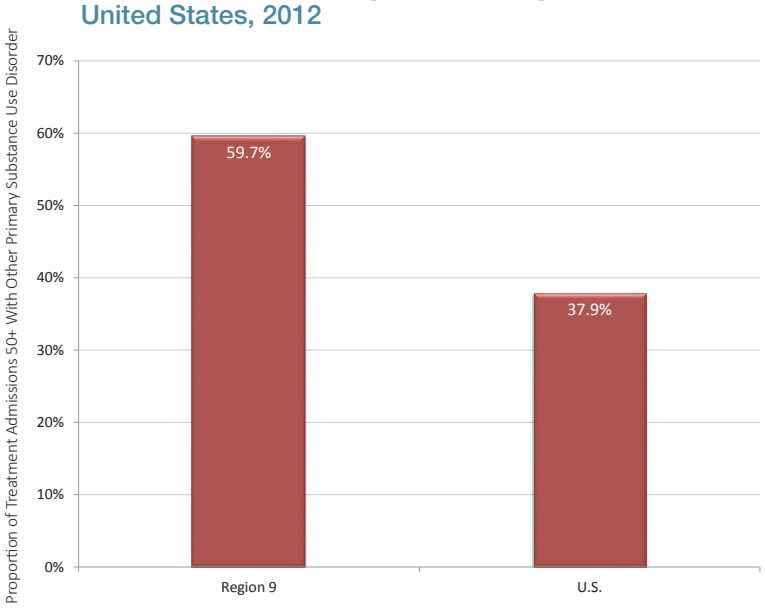

Source: TEDS, 2012
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Substances other than alcohol were cited as the primary substances of use for 59.7 percent of older adult admissions to publicly funded treatment in Region 9.

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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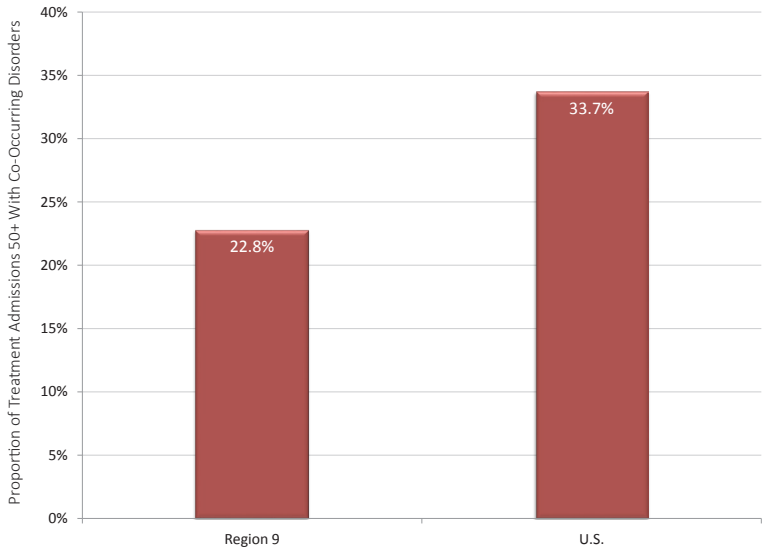

Source: TEDS, 2012
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The national literature shows a strong relationship between substance use and mental disorders. Studies show that 30–80 percent of individuals with a substance use or mental disorder also have a co-occurring disorder.

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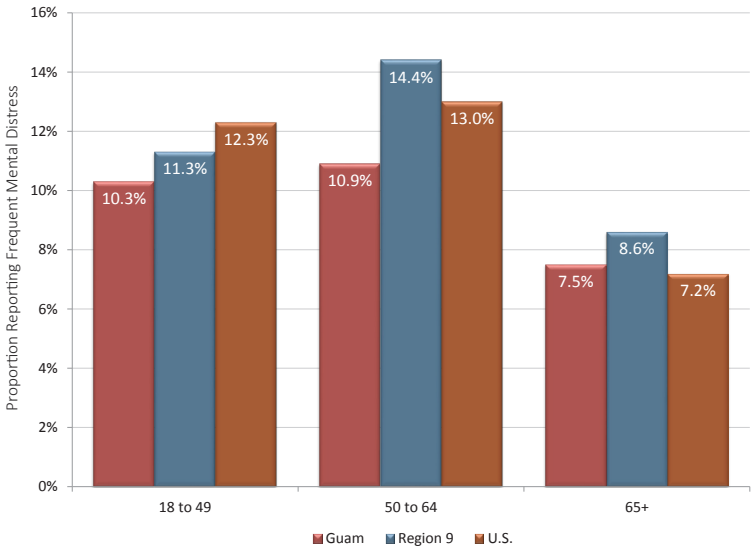
MENTAL HEALTH

Older Guamanians 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 Guamanians 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 lower than the regional rate and higher than the national rate.

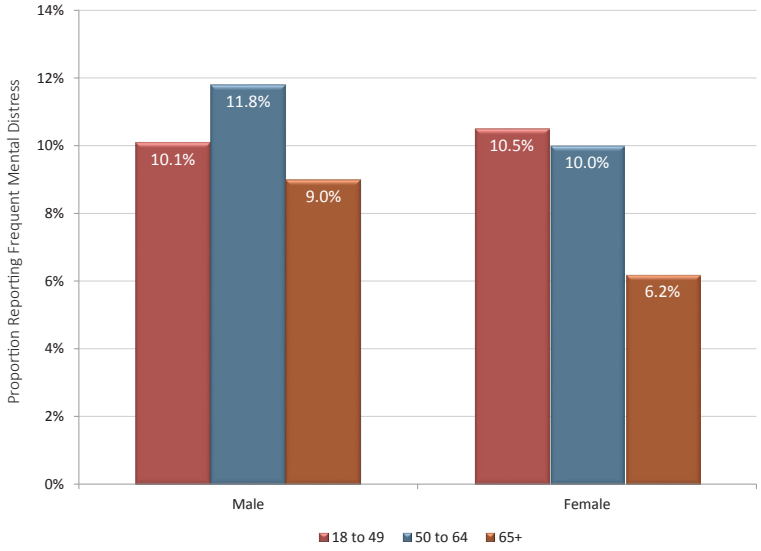
Exhibit 12. Individuals Reporting Frequent Mental Distress in Guam, Region 9, and the United States, 2013



Source: BRFSS, 2013

Older Guamanians Reporting Frequent Mental Distress by Age Group and Sex

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



Source: BRFSS, 2013

As Exhibit 13 shows, in Guam, 10.0 percent of women in the 50–64 age group and 6.2 percent in the 65+ age group reported FMD, while 11.8 percent of men in the 50–64 age group and 9.0 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 Guamanians.

Exhibit 14. BRFSS Measures, 2010

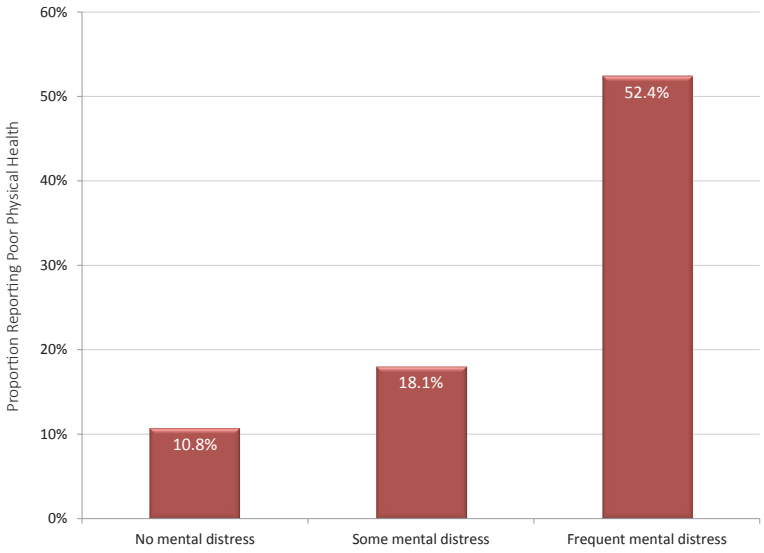
Indicator	Ages 50+	Ages 50–64	Ages 65+
Rarely or never get social or emotional support	27.4%	23.4%	3.5%
Dissatisfied or very dissatisfied	8.8%	9.2%	8.0%

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

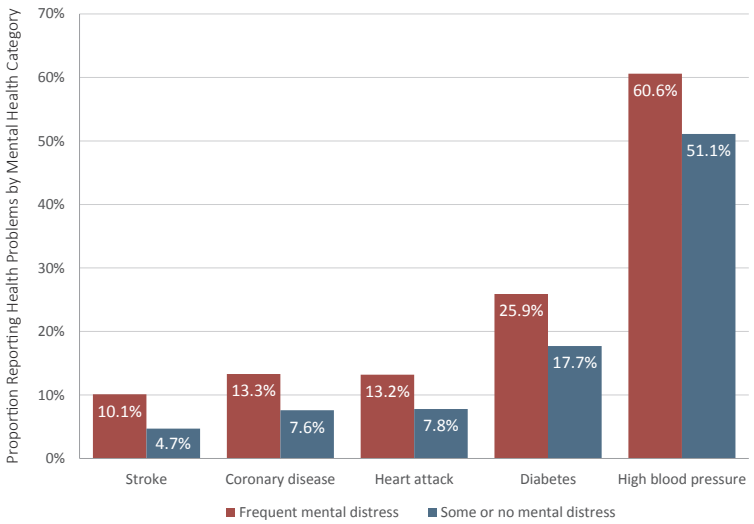


Source: BRFSS, 2013

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 Guamanians Admitted to Territory Mental Health Services

Approximately 8.5 percent of the people served by the Guam mental health system were ages 65 and older. This represents more than 490 adults.

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

DATA SOURCES

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

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

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

NATIONAL SURVEY ON DRUG USE AND HEALTH (https://nsduhweb.rti.org). The NSDUH, managed by SAMHSA, is "an annual nationwide survey involving interviews with approximately 70,000 randomly selected individuals aged 12 and older." NSDUH data are most frequently used by state planners to assess the need for SUD treatment. NSDUH data also include information about mental health conditions.

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

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

OLDER ADULTS BEHAVIORAL HEALTH PROFILE

Marshall Islands

Marshall Islands

OLDER ADULTS BEHAVIORAL HEALTH PROFILE

September 2016

REGION 9'S POPULATION

Region 9 Population by Age Group

Detailed demographic U.S. Census Bureau data on older Marshallese are unavailable. Therefore, the estimates for Region 9 (which includes Arizona, California, Hawaii, and Nevada) are used instead. Region 9 is home to 49,792,644 people. Of these:

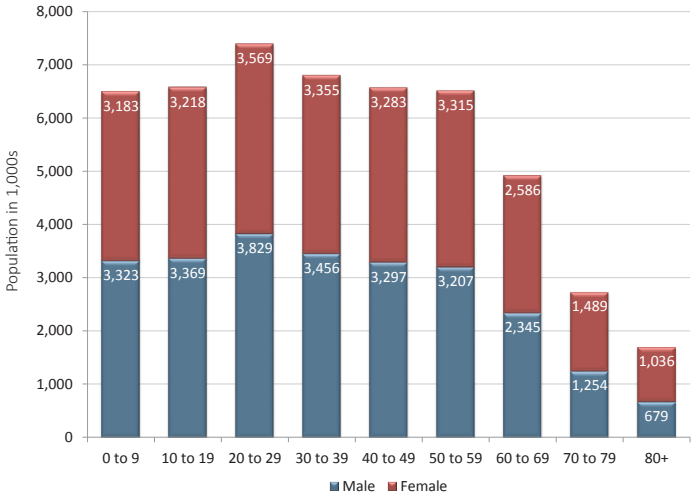
- 15,910,775 (32.0 percent) are over age 50.
- 9,388,613 (18.9 percent) are over age 60.
- 4,457,879 (9.0 percent) are over age 70.
- 1,714,781 (3.4 percent) are ages 80 and older.

Race/Ethnicity of Individuals in Region 9 Ages 50+

White	AI/AN	Black	Asian	NH/PI	Other	Hispanic
76.4%	1.5%	5.6%	13.9%	0.6%	2.0%	21.5%

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

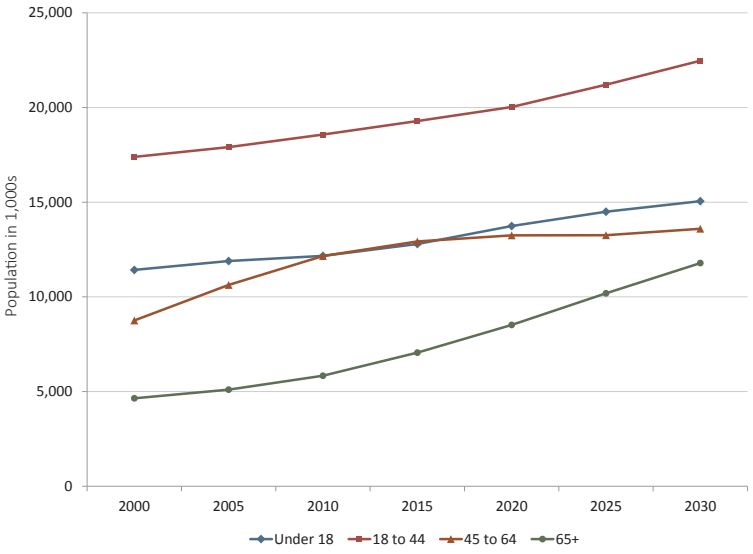
Exhibit 1. Region 9 Population by Age Group, 2014



Source: U.S. Census Bureau, 2015

The Number of Older Adults in Region 9 Is Growing

Exhibit 2. Region 9 Population by Age Group, 2000–2030



Recent population projections for the Marshall Islands are unavailable. Therefore, projections for Region 9 (calculated based on data from Arizona, California, Hawaii, and Nevada) are used instead.

The U.S. Census Bureau estimates that 18.7 percent of Region 9's population will be 65 and older by the year 2030, an increase of 67.0 percent from 2015.

Projected Population in Region 9

Age Group	2015	2025	2030
Under 18	24.6%	24.5%	23.9%
18 to 44	37.0%	35.8%	35.7%
45 to 64	24.8%	22.4%	21.6%
65+	13.6%	17.2%	18.7%

Source: U.S. Census Bureau, 2005

SUICIDE AMONG OLDER ADULTS IN REGION 9

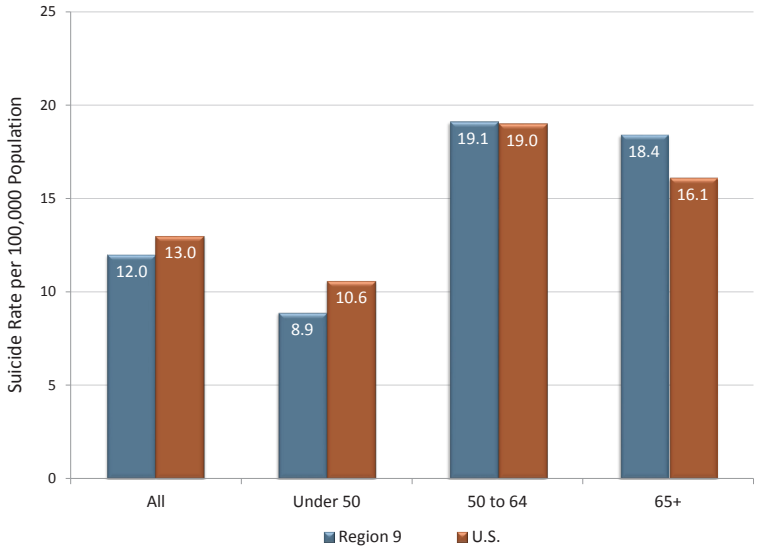
Region 9 Suicide Rates Compared With National Rates

Recent suicide data for the Marshall Islands are not available from the Centers for Disease Control and Prevention (CDC) mortality databases. Therefore, the rates for Region 9 (calculated based on data from Arizona, California, Hawaii, and Nevada) are used instead.

The suicide rate among individuals in Region 9 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 18.8 per 100,000 people (8.3 for women and 30.6 for men). The rate among those ages 50–64 was higher than the rate in the United States.

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

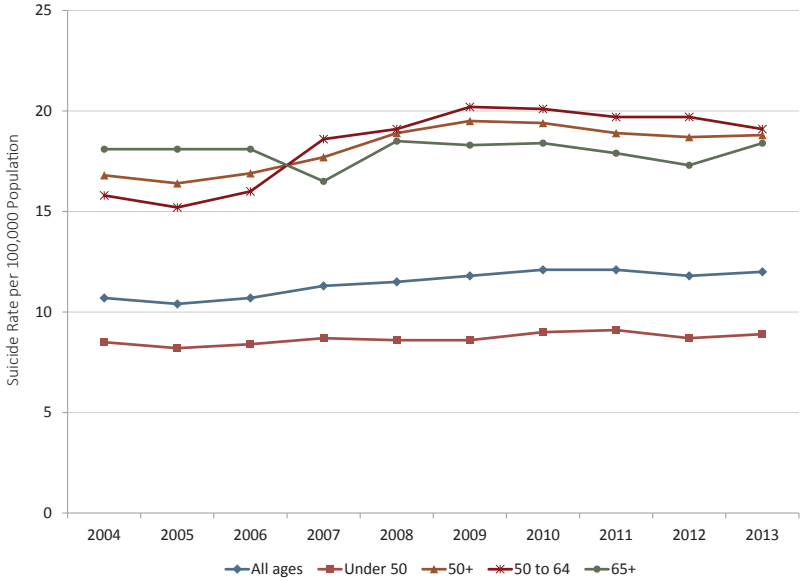
Exhibit 3. Suicide Rates in Region 9 and the United States, 2013



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

Trends in Suicide Rates in Region 9

Exhibit 4. Trends in Suicide Rates in Region 9 by Age Group, 2004–2013



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

Recent suicide data for the Marshall Islands are not available from the CDC mortality databases. Therefore, the rates for Region 9 are used instead.

The suicide rate among individuals in Region 9 ages 50+ fluctuated from a low of 16.4 per 100,000 in 2005 to a high of 19.5 per 100,000 in 2009. From 2004 to 2013, the rate was generally highest among those in the 50–64 age group.

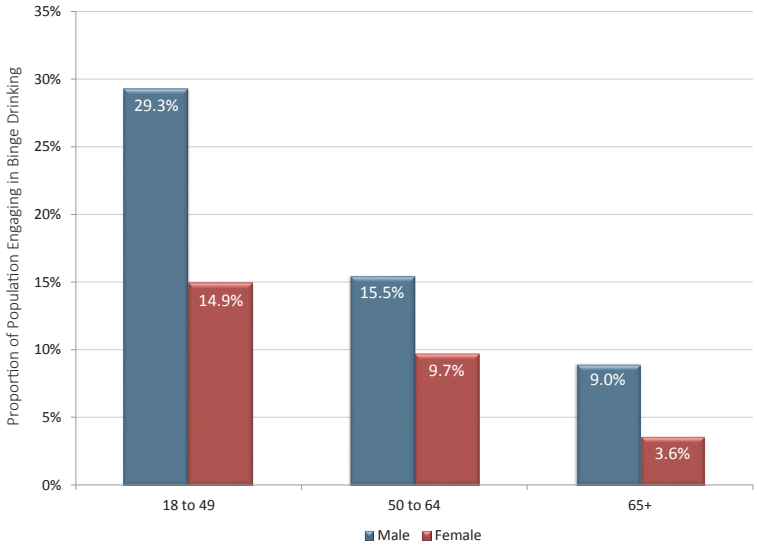
How a state or territory reports suicides can vary from year to year. The number of suicides is generally low, so even a small difference in reported numbers may make the rate fluctuate widely.

SUBSTANCE USE DISORDER AND SUBSTANCE USE DISORDER TREATMENT AMONG OLDER ADULTS IN REGION 9

30-Day Binge Drinking Among Older Adults in Region 9

Binge drinking, defined as five or more drinks for men and four or more drinks for women on a single occasion, can lead to serious health problems. Such problems include neurological damage, cardiovascular disease, liver disease, stroke, and poor control of diabetes. Binge drinkers are more likely to take risks such as driving while intoxicated and to experience falls and other accidents. Older people have a lower tolerance for alcohol. Binge drinking decreases with age and occurs more frequently among men than it does among women. Recent data for the Marshall Islands are unavailable. Therefore, data for Region 9 are used instead. As Exhibit 5 shows, 15.5 percent of Region 9 men ages 50–64 reported binge drinking in the past 30 days, while 9.0 percent of those in the 65+ group reported similar behavior.

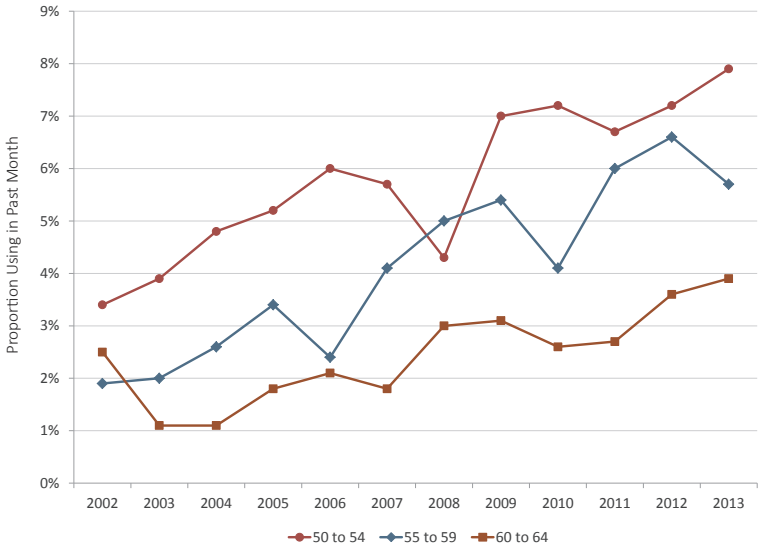
Exhibit 5. Binge Drinking Rates in Region 9 by Age Group and Sex, 2013



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

Illicit Drug Use Among Older Americans

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



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

Nationally, the rate of illicit drug use among older adults ages 50–64 more than doubled from 2002 to 2013. This development partially reflects the entrance into this age group of the baby boom cohort, whose rates of illicit drug use have been higher than those of older cohorts. Although territory-specific data are not available, the *Behavioral Health Barometers* for states in Region 9 are available for download from the Substance Abuse and Mental Health Services Administration (SAMHSA) website (www.samhsa.gov/data/population-data-nsduh/reports?tab=33).

Admissions to Substance Use Disorder Treatment Among Older Adults in Region 9

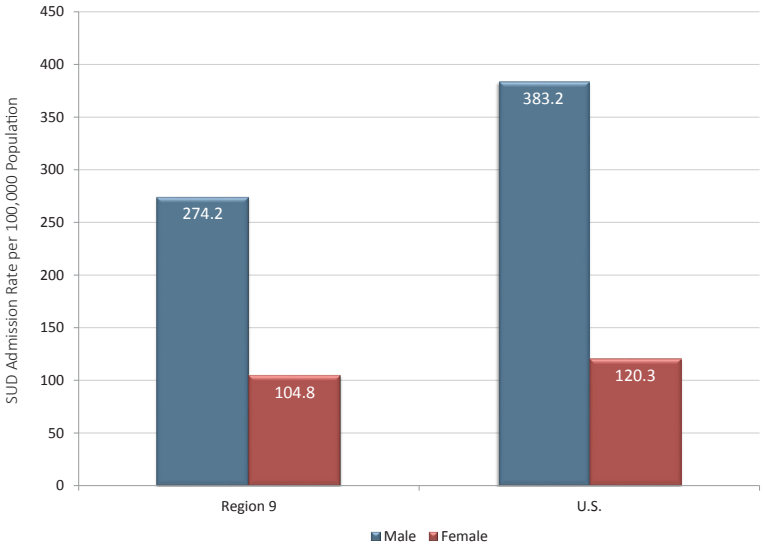
Treatment Episode Data Set (TEDS) data for the Marshall Islands in 2012 are unavailable. Therefore, data for Region 9 are used instead.

In 2012, there were 29,351 admissions of individuals in Region 9 ages 50 and older to substance use disorder (SUD) treatment in state-funded treatment programs, a rate of 184.5 per 100,000 people ages 50+. This rate was lower than the national average. Men made up 69.9 percent of these admissions. Of all admissions, 57.9 percent were White/Caucasian, 23.0 percent were Black/African American, and 19.4 percent were Hispanic.

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

Self-Referral	Criminal Justice	Other
55.4%	21.5%	23.1%

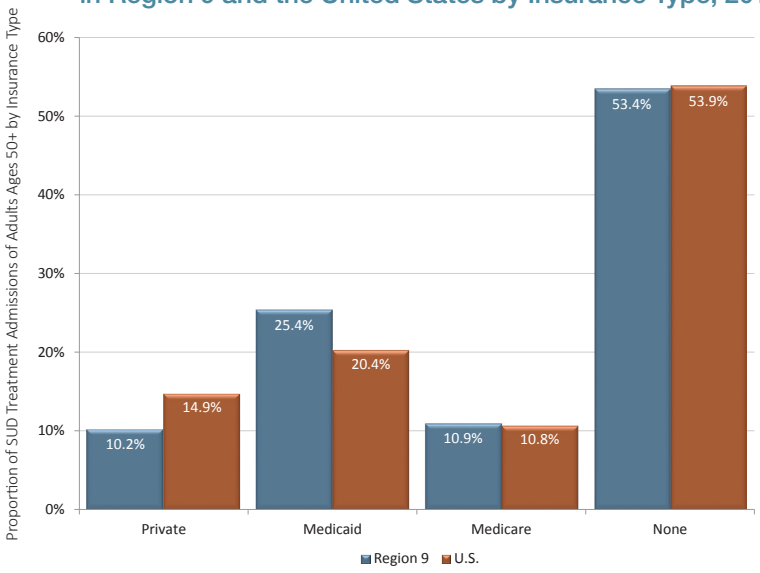
Exhibit 7. SUD Treatment Admissions of Adults Ages 50+ in Region 9 and the United States by Sex, 2012



Source: TEDS, 2012[1]
Data include only those clients reported to SAMHSA.

SUD Treatment Admissions Among Individuals in Region 9 Ages 50+ by Insurance Type

Exhibit 8. SUD Treatment Admissions of Adults Ages 50+ in Region 9 and the United States by Insurance Type, 2012



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

TEDS data for the Marshall Islands in 2012 are unavailable. Therefore, data for Region 9 are used instead.

In Region 9, 53.4 percent of older adult admissions to SUD treatment were uninsured, 25.4 percent had Medicaid, 10.9 percent had Medicare, and 10.2 percent had private insurance.

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

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

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

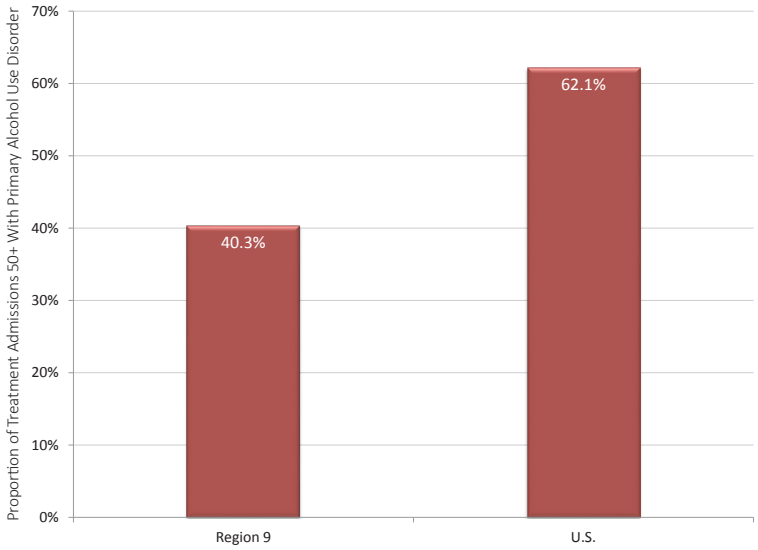
[1] TEDS data are collected by states and territories as a condition of the Substance Abuse Prevention and Treatment Block Grant. Guidelines suggest that states and territories report all clients admitted to publicly financed treatment; however, states and territories are inconsistent in applying the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

Alcohol Use Disorder Treatment Admissions Among Individuals in Region 9 Ages 50+

TEDS data for the Marshall Islands in 2012 are unavailable. Therefore, data for Region 9 are used instead.

Alcohol was the most frequently cited substance used by older individuals in Region 9 in publicly financed SUD treatment in 2012. It was mentioned as a substance of use in 40.3 percent of admissions among those ages 50+. This was lower than the national rate.

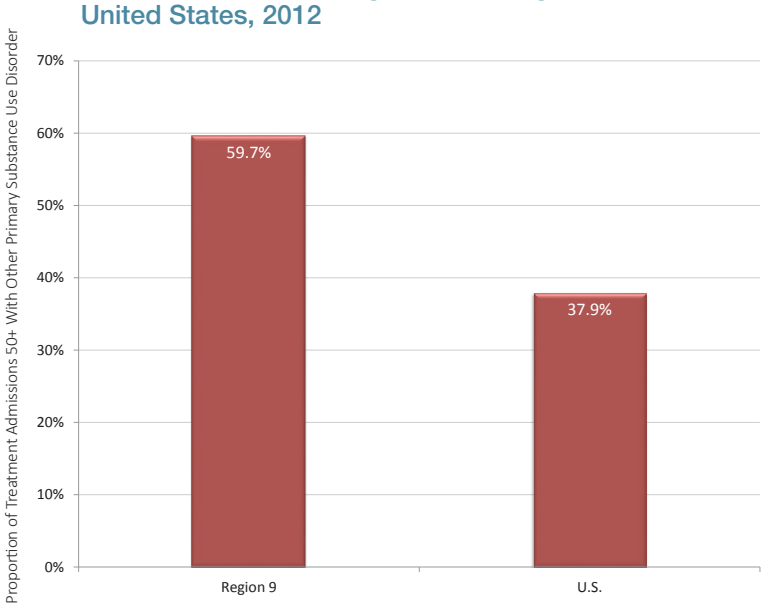
Exhibit 9. Alcohol Use Treatment Admissions of Adults Ages 50+ in Region 9 and the United States, 2012



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 Region 9 and the United States, 2012



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

TEDS data for the Marshall Islands in 2012 are unavailable. Therefore, data for Region 9 are used instead.

Substances other than alcohol were cited as the primary substances of use for 59.7 percent of older adult admissions to publicly funded treatment in Region 9.

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*:

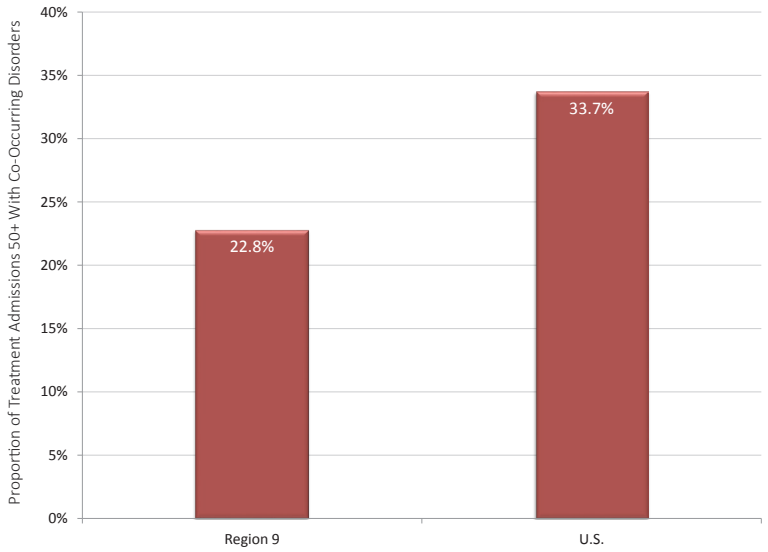
- *In 2004, there were an estimated 115,803 ED visits involving pharmaceutical misuse and abuse by adults aged 50 or older; in 2008, there were 256,097 such visits, representing an increase of 121.1 percent*
- *One fifth (19.7 percent) of ED visits involving pharmaceutical misuse and abuse among older 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 9 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 9 and the United States, 2012



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

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

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

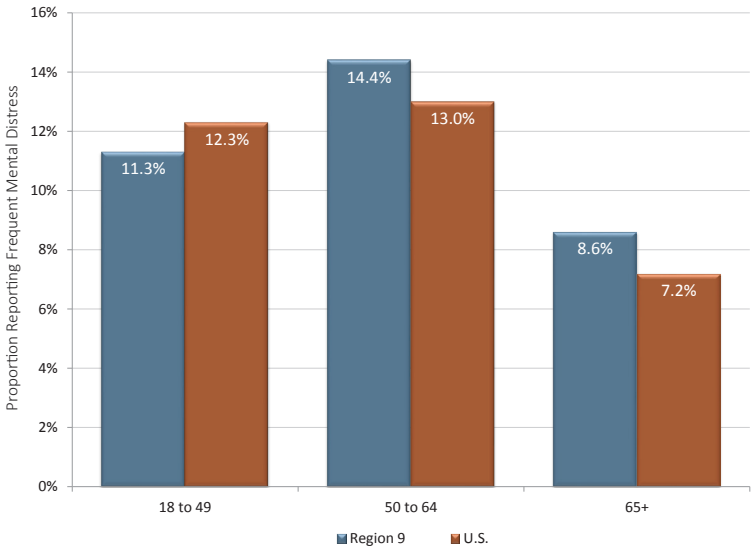
MENTAL HEALTH

Older Adults in Region 9 Reporting Frequent Mental Distress

BRFSS, a household survey conducted in all 50 states and several territories, asks the following question: "Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?" Those individuals reporting 14 or more "Yes" days in response to this question experience frequent mental distress (FMD).

Recent BRFSS data for the Marshall Islands were unavailable. Therefore, data for Region 9 are used instead. Exhibit 12 shows that older adults in Region 9 experience FMD at a rate that is higher than the national rate.

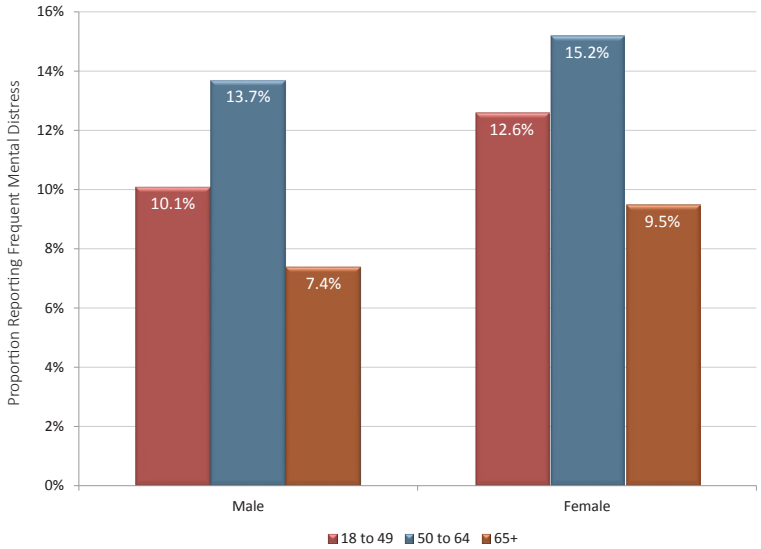
Exhibit 12. Individuals Reporting Frequent Mental Distress in Region 9 and the United States, 2013



Source: BRFSS, 2013

Older Adults in Region 9 Reporting Frequent Mental Distress by Age Group and Sex

Exhibit 13. Individuals in Region 9 Reporting Frequent Mental Distress by Age Group and Sex, 2013



Source: BRFSS, 2013

Older men in Region 9 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, 15.2 percent of women in the 50–64 age group and 9.5 percent in the 65+ age group reported FMD, while 13.7 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 adults in Region 9.

Exhibit 14. BRFSS Measures, 2010

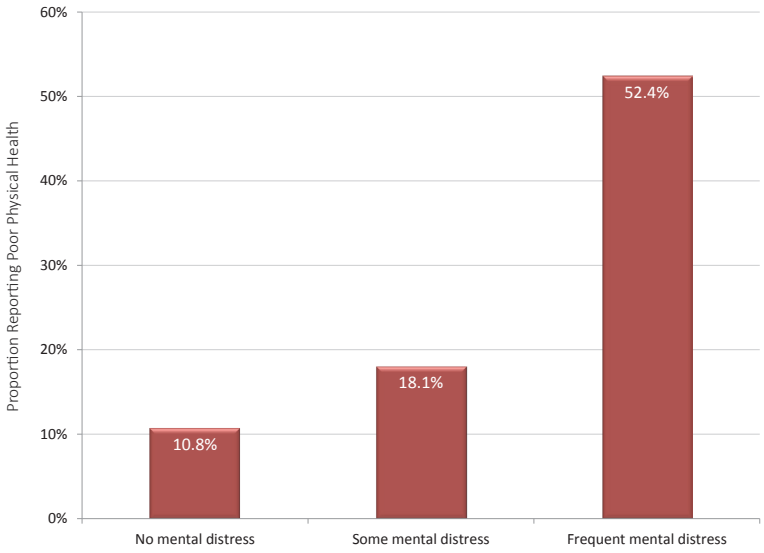
Indicator	Ages 50+	Ages 50–64	Ages 65+
Rarely or never get social or emotional support	12.4%	11.0%	14.9%
Dissatisfied or very dissatisfied	5.8%	7.1%	3.8%

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

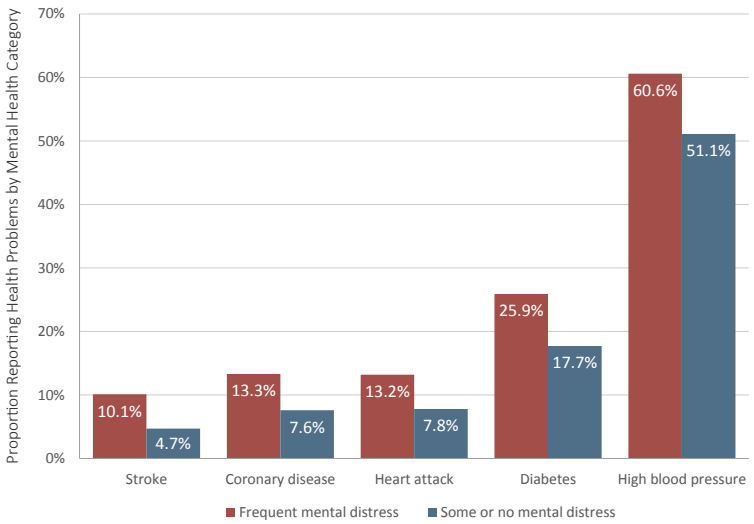


Source: BRFSS, 2013

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 Marshallese Admitted to Territory Mental Health Services

One person served by the Marshall Islands mental health system was in the 65–74 age group (data were unavailable for ages 75 and over).

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."

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OLDER ADULTS BEHAVIORAL HEALTH PROFILE

Republic of Palau

Republic of Palau

OLDER ADULTS BEHAVIORAL HEALTH PROFILE

September 2016

REGION 9'S POPULATION

Region 9 Population by Age Group

Detailed demographic U.S. Census Bureau data on older Palauans are unavailable. Therefore, the estimates for Region 9 (which includes Arizona, California, Hawaii, and Nevada) are used instead. Region 9 is home to 49,792,644 people. Of these:

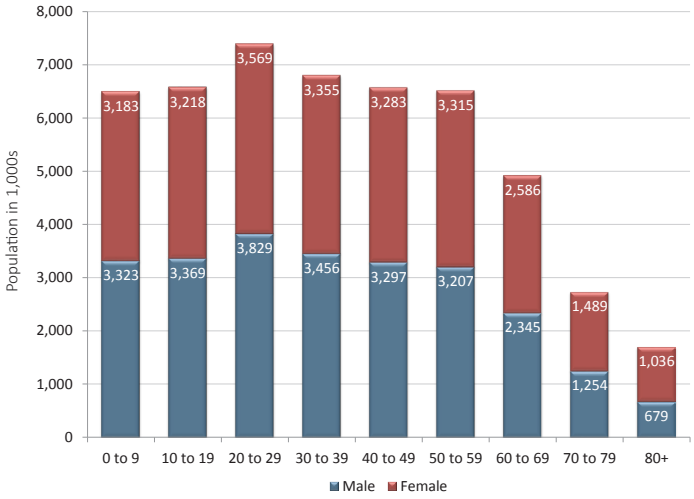
- 15,910,775 (32.0 percent) are over age 50.
- 9,388,613 (18.9 percent) are over age 60.
- 4,457,879 (9.0 percent) are over age 70.
- 1,714,781 (3.4 percent) are ages 80 and older.

Race/Ethnicity of Individuals in Region 9 Ages 50+

White	AI/AN	Black	Asian	NH/PI	Other	Hispanic
76.4%	1.5%	5.6%	13.9%	0.6%	2.0%	21.5%

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

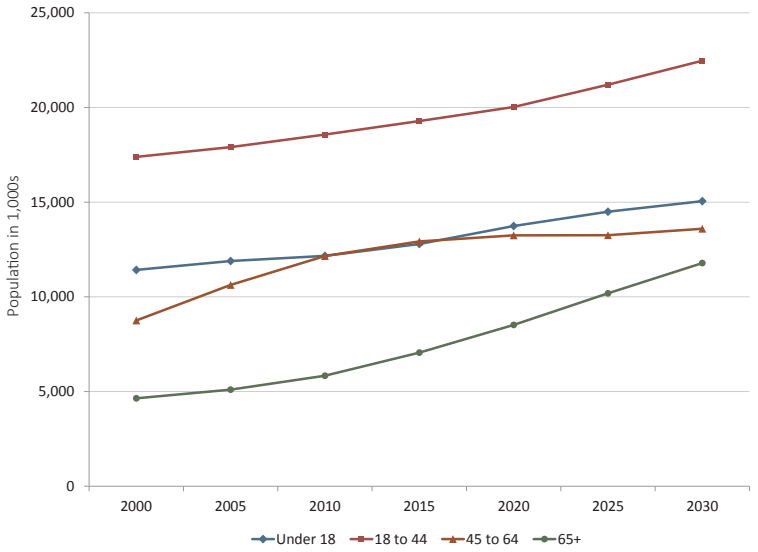
Exhibit 1. Region 9 Population by Age Group, 2014



Source: U.S. Census Bureau, 2015

The Number of Older Adults in Region 9 Is Growing

Exhibit 2. Region 9 Population by Age Group, 2000–2030



Recent population projections for the Republic of Palau are unavailable. Therefore, projections for Region 9 (calculated based on data from Arizona, California, Hawaii, and Nevada) are used instead.

The U.S. Census Bureau estimates that 18.7 percent of Region 9's population will be 65 and older by the year 2030, an increase of 67.0 percent from 2015.

Projected Population in Region 9

Age Group	2015	2025	2030
Under 18	24.6%	24.5%	23.9%
18 to 44	37.0%	35.8%	35.7%
45 to 64	24.8%	22.4%	21.6%
65+	13.6%	17.2%	18.7%

Source: U.S. Census Bureau, 2005

SUICIDE AMONG OLDER ADULTS IN REGION 9

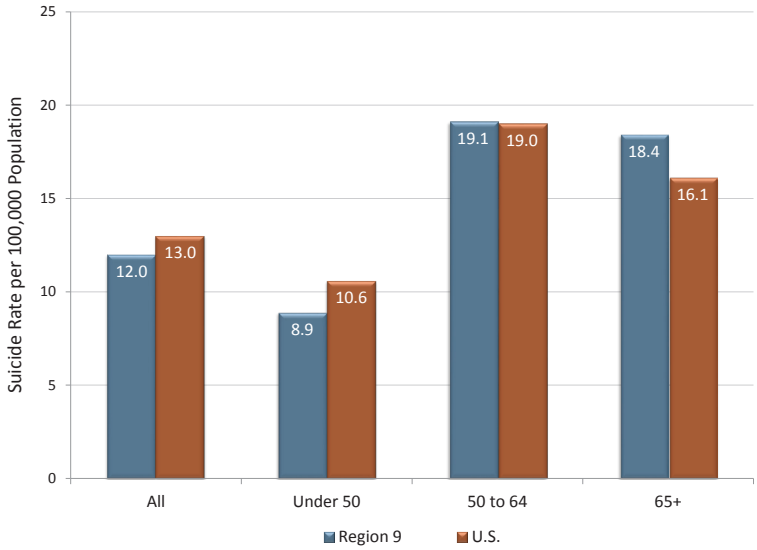
Region 9 Suicide Rates Compared With National Rates

Recent suicide data for the Republic of Palau are not available from the Centers for Disease Control and Prevention (CDC) mortality databases. Therefore, the rates for Region 9 (calculated based on data from Arizona, California, Hawaii, and Nevada) are used instead.

The suicide rate among individuals in Region 9 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 18.8 per 100,000 people (8.3 for women and 30.6 for men). The rate among those ages 50–64 was higher than the rate in the United States.

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

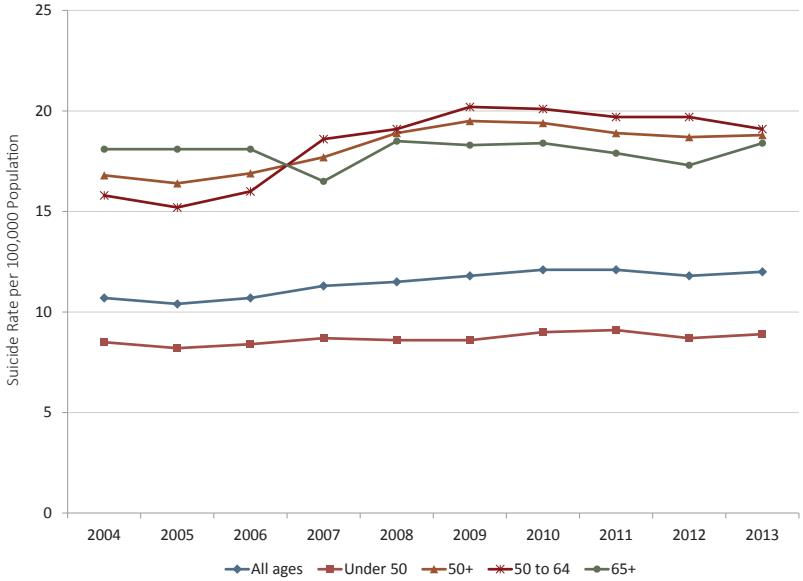
Exhibit 3. Suicide Rates in Region 9 and the United States, 2013



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

Trends in Suicide Rates in Region 9

Exhibit 4. Trends in Suicide Rates in Region 9 by Age Group, 2004–2013



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

Recent suicide data for the Republic of Palau are not available from the CDC mortality databases. Therefore, the rates for Region 9 are used instead.

The suicide rate among individuals in Region 9 ages 50+ fluctuated from a low of 16.4 per 100,000 in 2005 to a high of 19.5 per 100,000 in 2009. From 2004 to 2013, the rate was generally highest among those in the 50–64 age group.

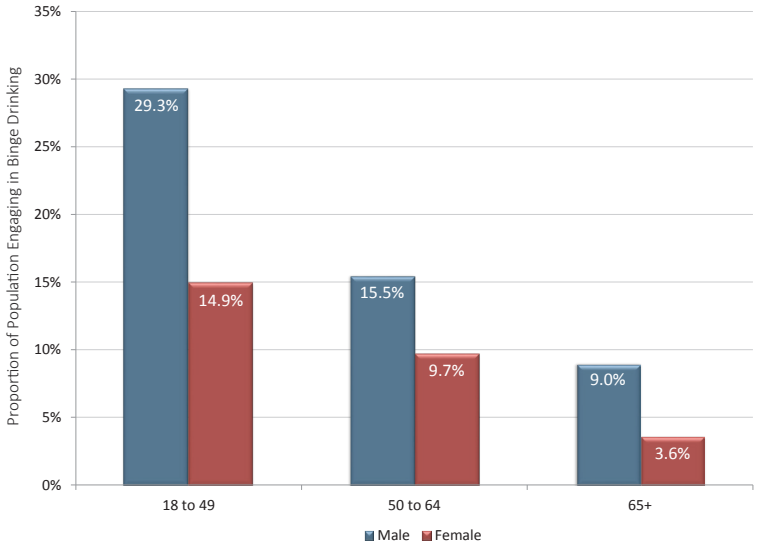
How a state or territory reports suicides can vary from year to year. The number of suicides is generally low, so even a small difference in reported numbers may make the rate fluctuate widely.

SUBSTANCE USE DISORDER AND SUBSTANCE USE DISORDER TREATMENT AMONG OLDER ADULTS IN REGION 9

30-Day Binge Drinking Among Older Adults in Region 9

Binge drinking, defined as five or more drinks for men and four or more drinks for women on a single occasion, can lead to serious health problems. Such problems include neurological damage, cardiovascular disease, liver disease, stroke, and poor control of diabetes. Binge drinkers are more likely to take risks such as driving while intoxicated and to experience falls and other accidents. Older people have a lower tolerance for alcohol. Binge drinking decreases with age and occurs more frequently among men than it does among women. Recent data for the Republic of Palau are unavailable. Therefore, data for Region 9 are used instead. As Exhibit 5 shows, 15.5 percent of Region 9 men ages 50–64 reported binge drinking in the past 30 days, while 9.0 percent of those in the 65+ group reported similar behavior.

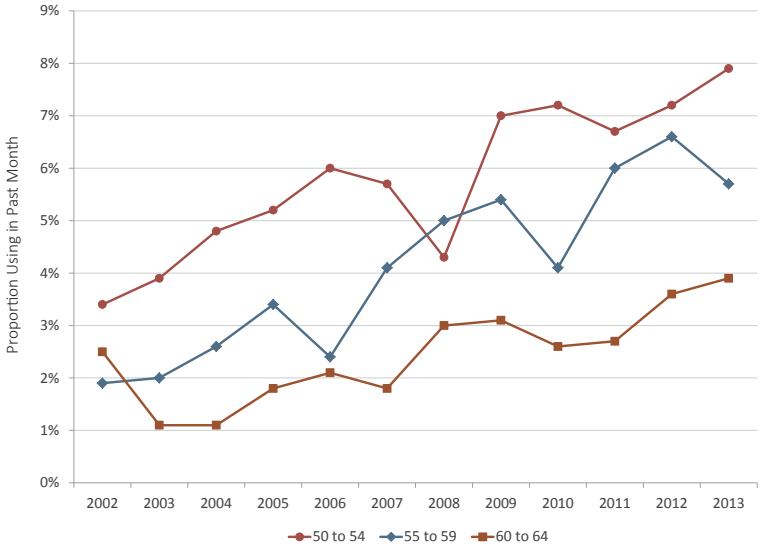
Exhibit 5. Binge Drinking Rates in Region 9 by Age Group and Sex, 2013



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

Illicit Drug Use Among Older Americans

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



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

Nationally, the rate of illicit drug use among older adults ages 50–64 more than doubled from 2002 to 2013. This development partially reflects the entrance into this age group of the baby boom cohort, whose rates of illicit drug use have been higher than those of older cohorts. Although territory-specific data are not available, the *Behavioral Health Barometers* for states in Region 9 are available for download from the Substance Abuse and Mental Health Services Administration (SAMHSA) website (www.samhsa.gov/data/population-data-nsduh/reports?tab=33).

Admissions to Substance Use Disorder Treatment Among Older Adults in Region 9

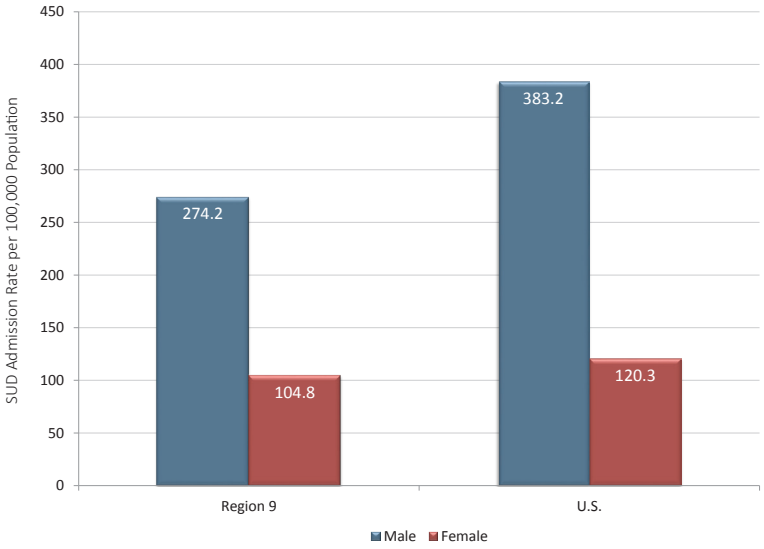
Treatment Episode Data Set (TEDS) data for the Republic of Palau in 2012 are unavailable. Therefore, data for Region 9 are used instead.

In 2012, there were 29,351 admissions of individuals in Region 9 ages 50 and older to substance use disorder (SUD) treatment in state-funded treatment programs, a rate of 184.5 per 100,000 people ages 50+. This rate was lower than the national average. Men made up 69.9 percent of these admissions. Of all admissions, 57.9 percent were White/Caucasian, 23.0 percent were Black/African American, and 19.4 percent were Hispanic.

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

Self-Referral	Criminal Justice	Other
55.4%	21.5%	23.1%

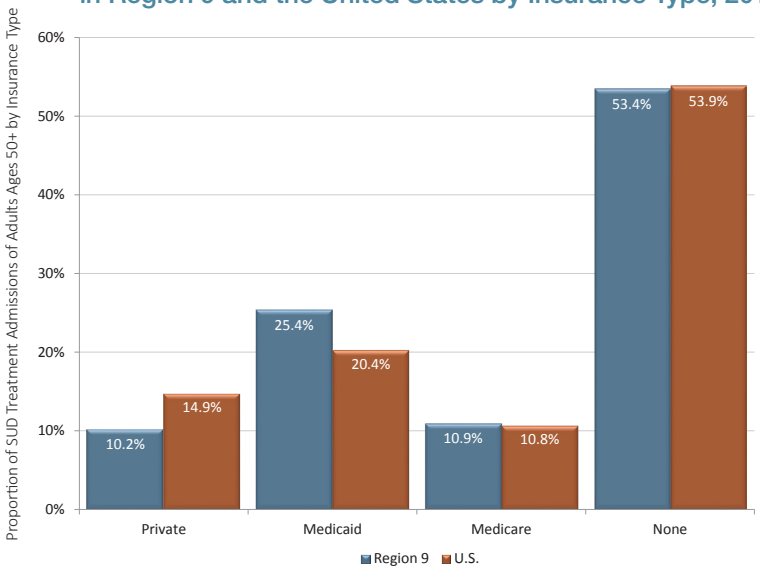
Exhibit 7. SUD Treatment Admissions of Adults Ages 50+ in Region 9 and the United States by Sex, 2012



Source: TEDS, 2012[1]
Data include only those clients reported to SAMHSA.

SUD Treatment Admissions Among Individuals in Region 9 Ages 50+ by Insurance Type

Exhibit 8. SUD Treatment Admissions of Adults Ages 50+ in Region 9 and the United States by Insurance Type, 2012



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

TEDS data for the Republic of Palau in 2012 are unavailable. Therefore, data for Region 9 are used instead.

In Region 9, 53.4 percent of older adult admissions to SUD treatment were uninsured, 25.4 percent had Medicaid, 10.9 percent had Medicare, and 10.2 percent had private insurance.

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

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

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

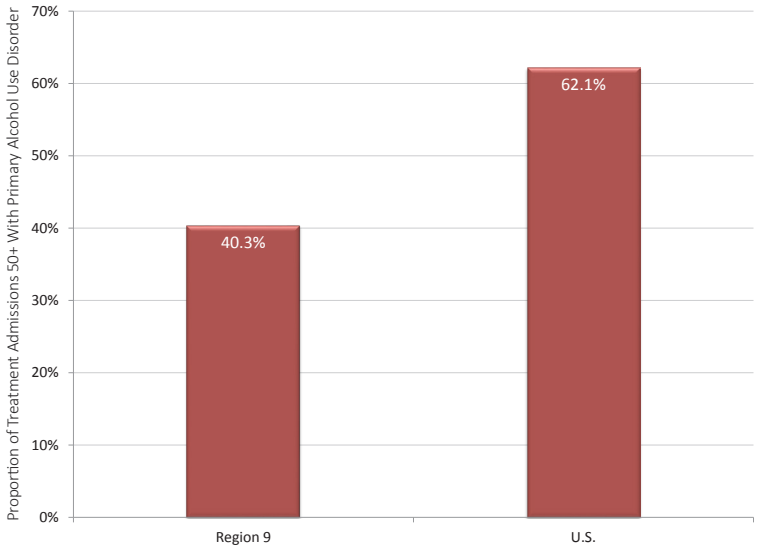
[1] TEDS data are collected by states and territories as a condition of the Substance Abuse Prevention and Treatment Block Grant. Guidelines suggest that states and territories report all clients admitted to publicly financed treatment; however, states and territories are inconsistent in applying the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

Alcohol Use Disorder Treatment Admissions Among Individuals in Region 9 Ages 50+

TEDS data for the Republic of Palau in 2012 are unavailable. Therefore, data for Region 9 are used instead.

Alcohol was the most frequently cited substance used by older individuals in Region 9 in publicly financed SUD treatment in 2012. It was mentioned as a substance of use in 40.3 percent of admissions among those ages 50+. This was lower than the national rate.

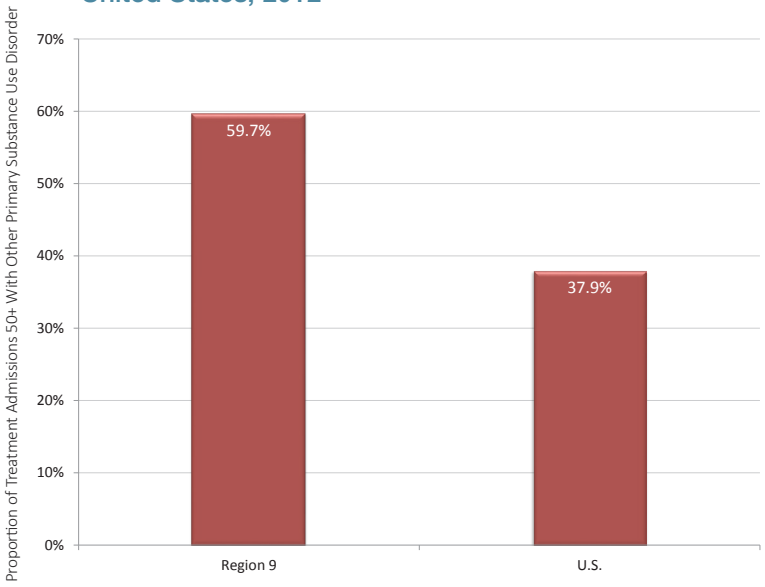
Exhibit 9. Alcohol Use Treatment Admissions of Adults Ages 50+ in Region 9 and the United States, 2012



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 Region 9 and the United States, 2012



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

TEDS data for the Republic of Palau in 2012 are unavailable. Therefore, data for Region 9 are used instead.

Substances other than alcohol were cited as the primary substances of use for 59.7 percent of older adult admissions to publicly funded treatment in Region 9.

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*:

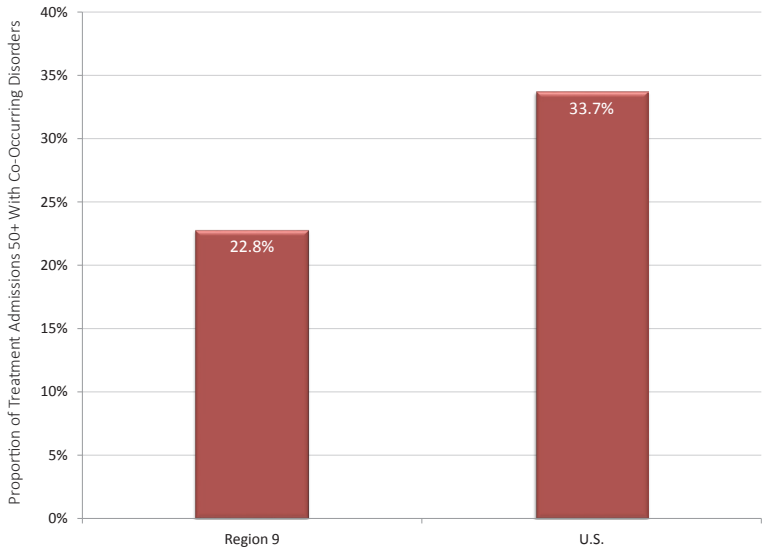
- *In 2004, there were an estimated 115,803 ED visits involving pharmaceutical misuse and abuse by adults aged 50 or older; in 2008, there were 256,097 such visits, representing an increase of 121.1 percent*
- *One fifth (19.7 percent) of ED visits involving pharmaceutical misuse and abuse among older 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 9 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 9 and the United States, 2012



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

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

TEDS data for the Republic of Palau in 2012 are unavailable. Therefore, Exhibit 11 shows regional and national figures only.

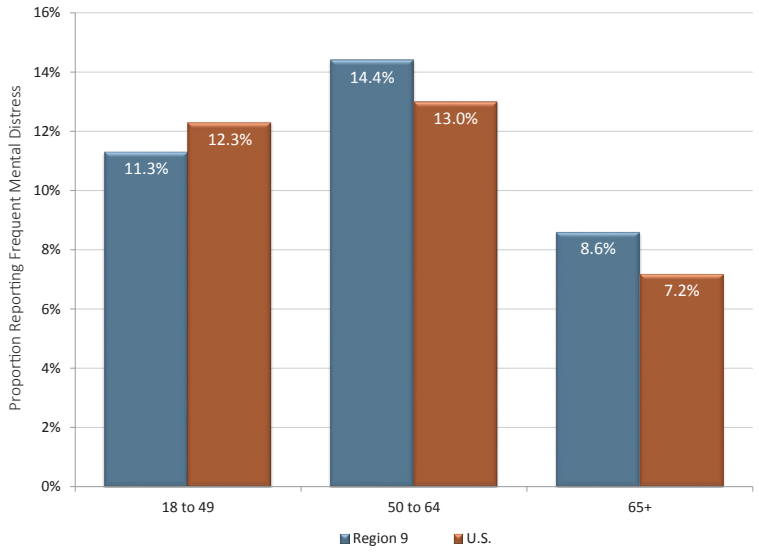
MENTAL HEALTH

Older Adults in Region 9 Reporting Frequent Mental Distress

BRFSS, a household survey conducted in all 50 states and several territories, asks the following question: "Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?" Those individuals reporting 14 or more "Yes" days in response to this question experience frequent mental distress (FMD).

Recent BRFSS data for the Republic of Palau were unavailable. Therefore, data for Region 9 are used instead. Exhibit 12 shows that older adults in Region 9 experience FMD at a rate that is higher than the national rate.

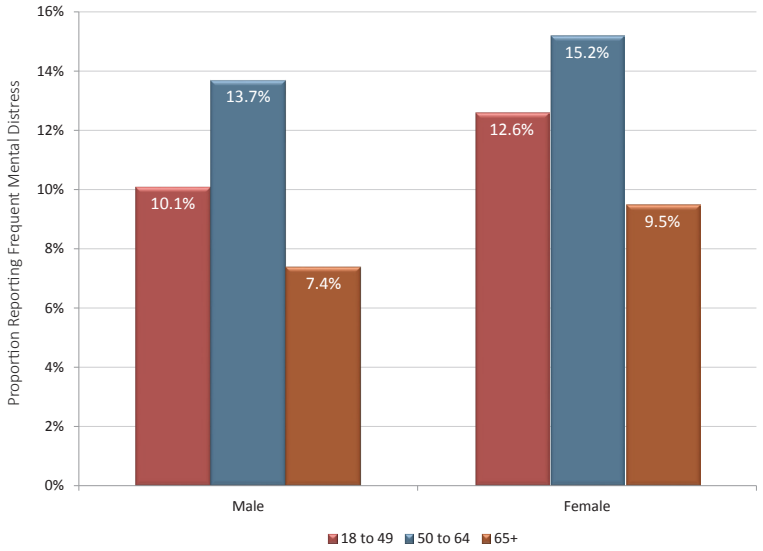
Exhibit 12. Individuals Reporting Frequent Mental Distress in Region 9 and the United States, 2013



Source: BRFSS, 2013

Older Adults in Region 9 Reporting Frequent Mental Distress by Age Group and Sex

Exhibit 13. Individuals in Region 9 Reporting Frequent Mental Distress by Age Group and Sex, 2013



Source: BRFSS, 2013

Older men in Region 9 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, 15.2 percent of women in the 50–64 age group and 9.5 percent in the 65+ age group reported FMD, while 13.7 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 adults in Region 9.

Exhibit 14. BRFSS Measures, 2010

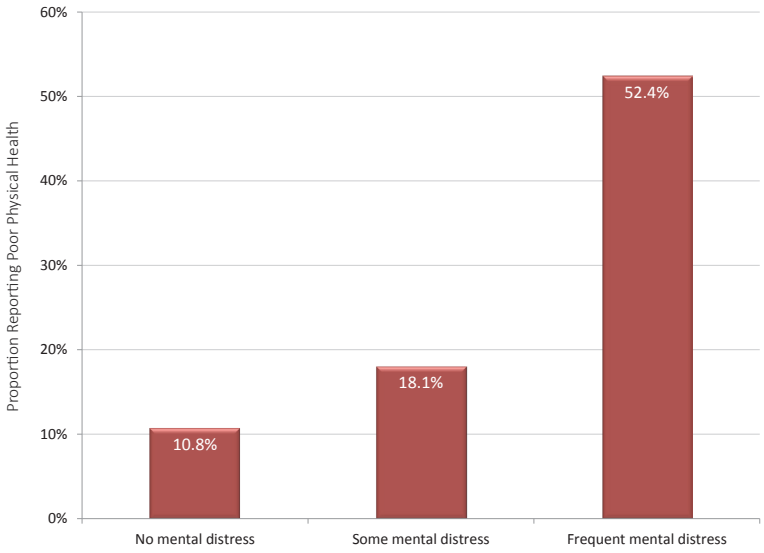
Indicator	Ages 50+	Ages 50–64	Ages 65+
Rarely or never get social or emotional support	12.4%	11.0%	14.9%
Dissatisfied or very dissatisfied	5.8%	7.1%	3.8%

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

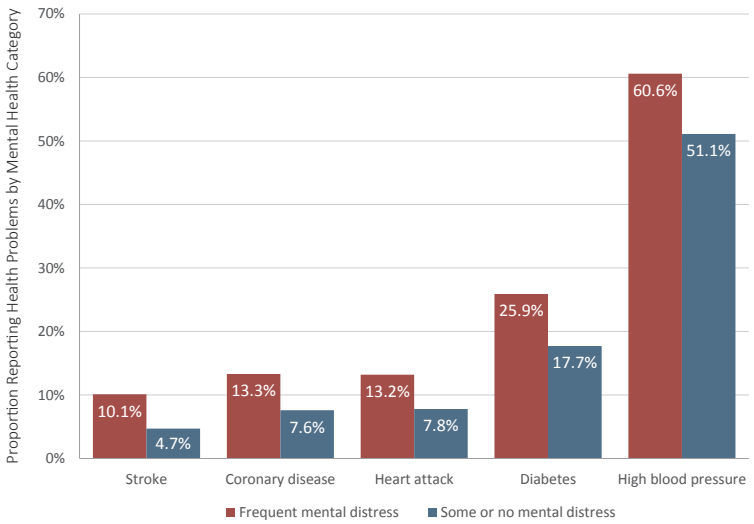


Source: BRFSS, 2013

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 Palauans Admitted to Territory Mental Health Services

Approximately 7.0 percent of the people served by the Republic of Palau mental health system were ages 65 and older. This represents approximately 10 adults.

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

DATA SOURCES

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