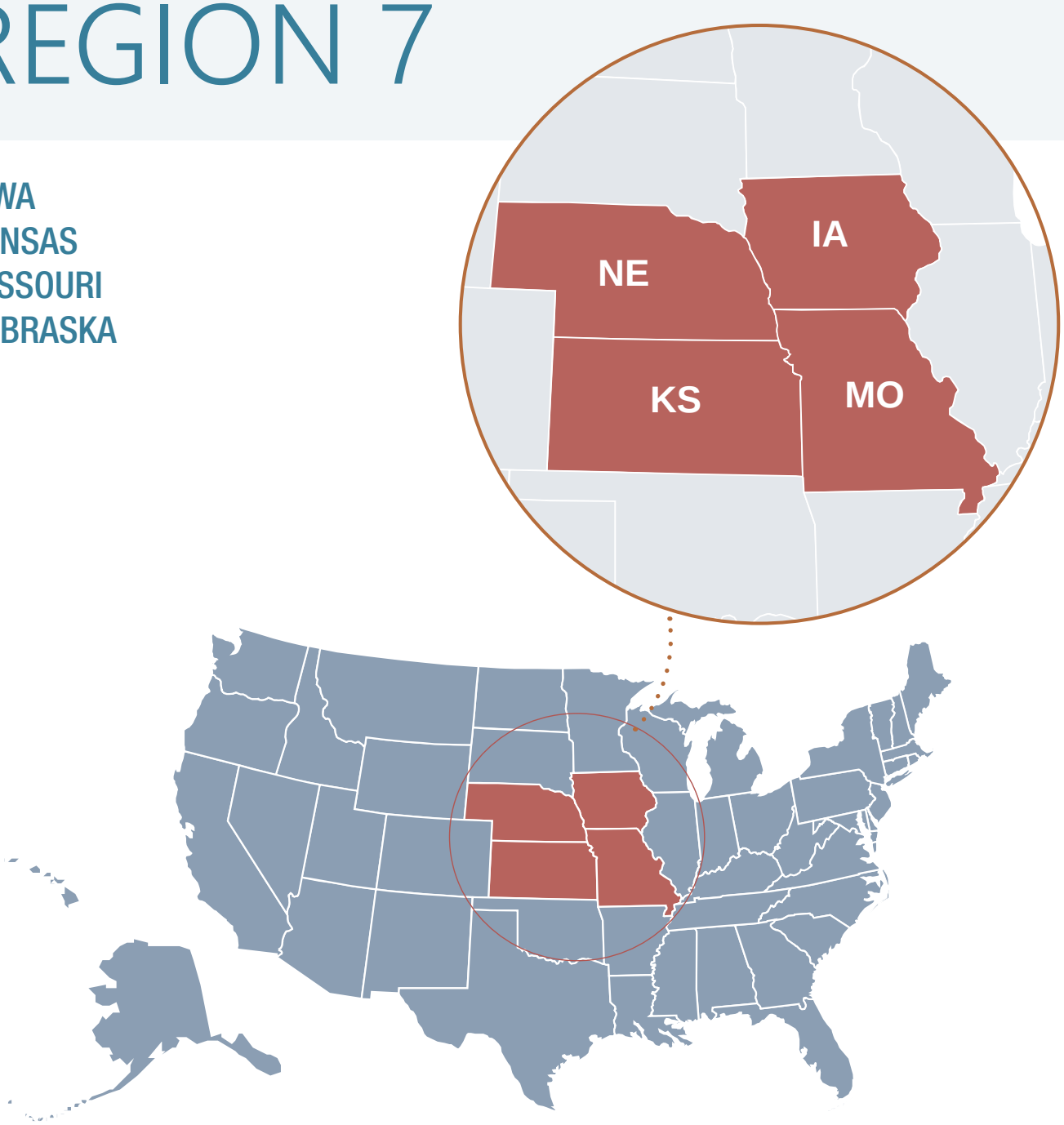
OLDER ADULTS BEHAVIORAL HEALTH PROFILES

REGION 7

IOWA
KANSAS
MISSOURI
NEBRASKA



A Behavioral Health Resource

SAMHSA's State Technical Assistance Contract

August 2016

OLDER ADULTS BEHAVIORAL HEALTH PROFILES

OVERVIEW

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

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

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

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

OLDER ADULTS BEHAVIORAL HEALTH PROFILE

Iowa

Iowa

OLDER ADULTS BEHAVIORAL HEALTH PROFILE

August 2016

IOWA'S POPULATION

Iowa Population by Age Group

Iowa is home to 3,107,126 people. Of these:

- 1,116,700 (35.9 percent) are over age 50.
- 682,741 (22.0 percent) are over age 60.
- 341,647 (11.0 percent) are over age 70.
- 145,168 (4.7 percent) are ages 80 and older.

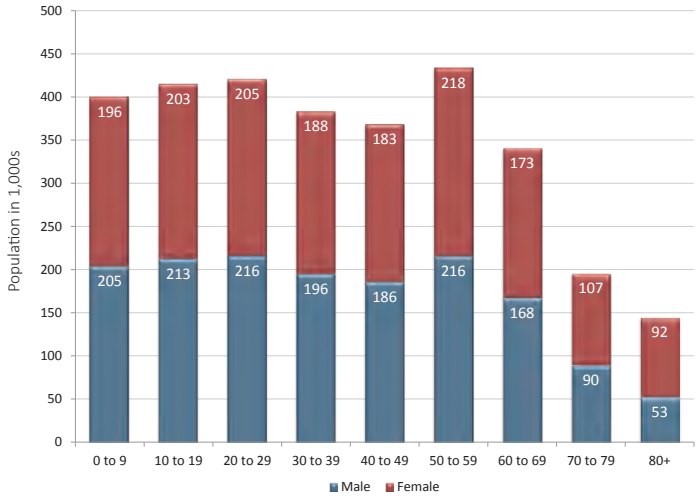
The proportion of women rises fairly steadily in each age group, and women make up 63.4 percent of the 80+ group. The racial/ethnic composition of older Iowans is as follows:

Race/Ethnicity of Iowans Ages 50+

White	AI/AN	Black	Asian	NH/PI	Other	Hispanic
96.6%	0.3%	1.7%	1.0%	0.0%	0.4%	1.9%

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

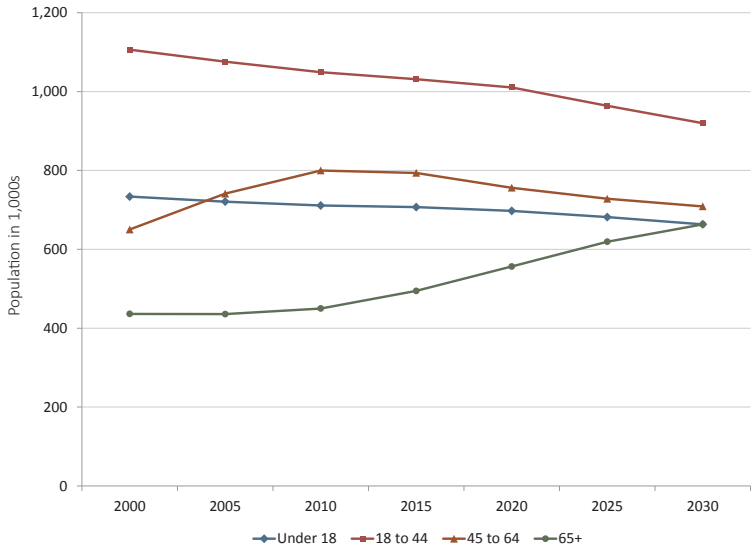
Exhibit 1. Iowa Population by Age Group, 2014



Source: U.S. Census Bureau, 2015

The Number of Older Iowans Is Growing

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



The proportion of Iowa'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 22.4 percent of Iowa's population will be 65 and older by the year 2030, an increase of 34.1 percent from 2015.

Projected Population in Iowa

Age Group	2015	2025	2030
Under 18	23.4%	22.8%	22.4%
18 to 44	34.1%	32.2%	31.1%
45 to 64	26.2%	24.3%	24.0%
65+	16.3%	20.7%	22.4%

Source: U.S. Census Bureau, 2005

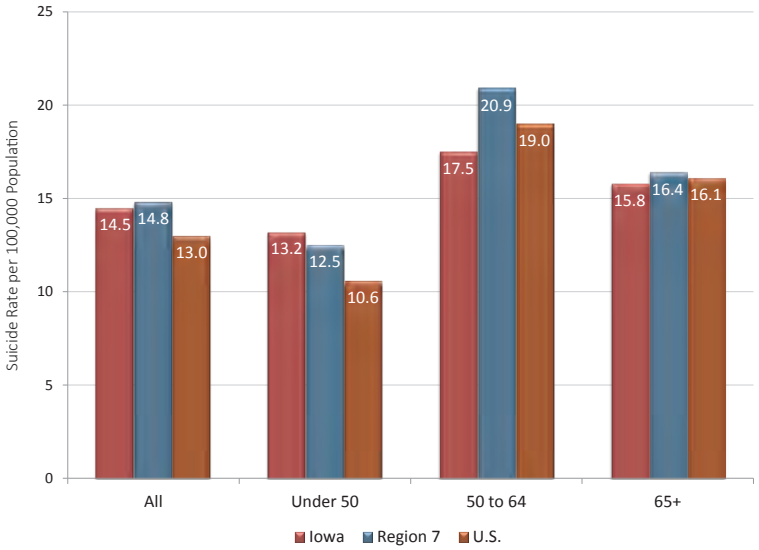
SUICIDE AMONG OLDER IOWANS

Iowa Suicide Rate Compared With Regional and National Rates

The suicide rate among Iowans 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 16.8 per 100,000 people (5.8 for women and 29.1 for men). The rate among those ages 50–64 was lower than both the rate in the region (including Kansas, Missouri, and Nebraska) and the rate in the United States.

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

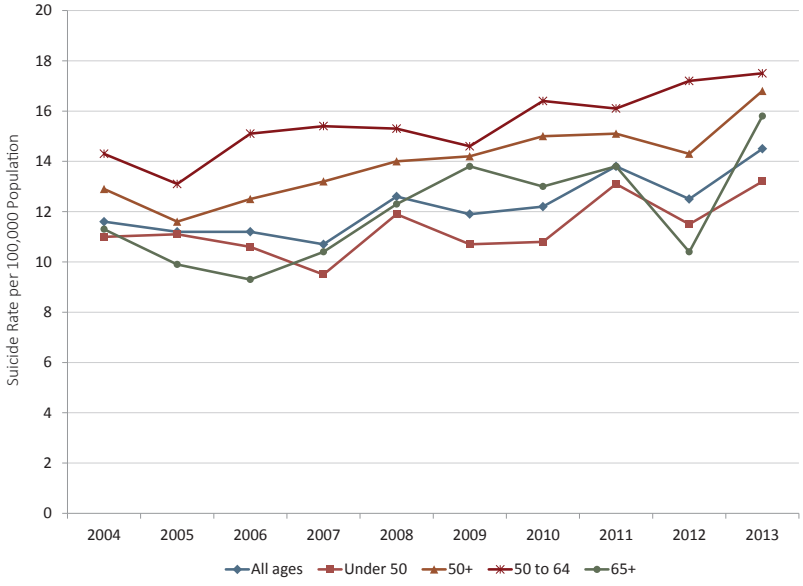
Exhibit 3. Suicide Rates in Iowa, Region 7, and the United States, 2013



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 Iowa

Exhibit 4. Trends in Suicide Rates in Iowa 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 Iowans ages 50+ fluctuated from a low of 11.6 per 100,000 in 2005 to a high of 16.8 per 100,000 in 2013. From 2004 to 2013, the rate was highest among those in the 50–64 age group.

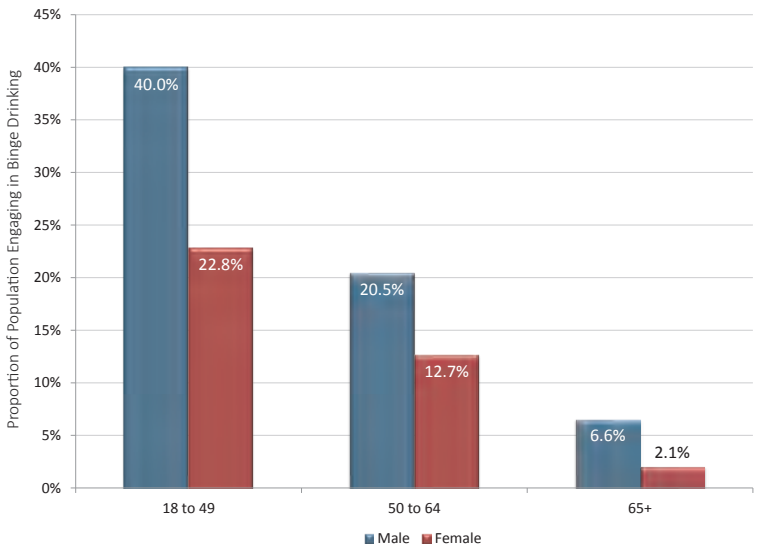
How a state reports suicides can vary from year to year. The number of suicides is generally low, so even a small difference in reported numbers may make the rate fluctuate widely.

SUBSTANCE USE DISORDER AND SUBSTANCE USE DISORDER TREATMENT AMONG OLDER IOWANS

30-Day Binge Drinking Among Older Iowans

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

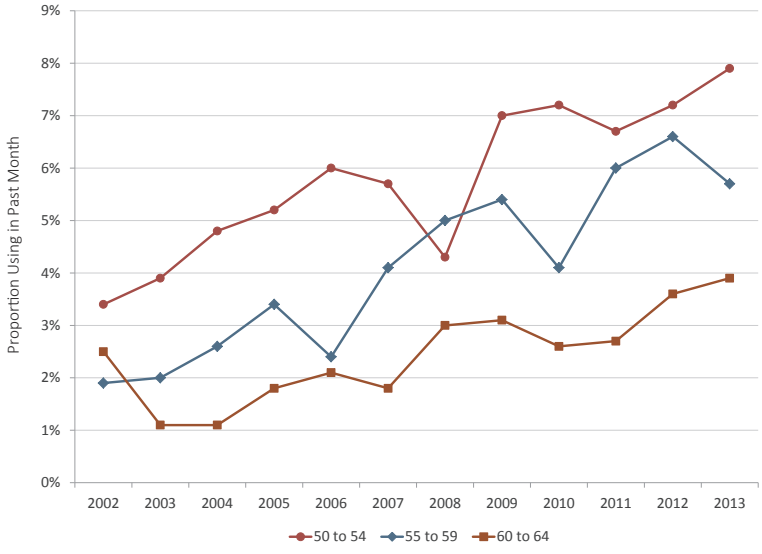
Exhibit 5. Binge Drinking Rates in Iowa by Age Group and Sex, 2013



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 *Iowa 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).

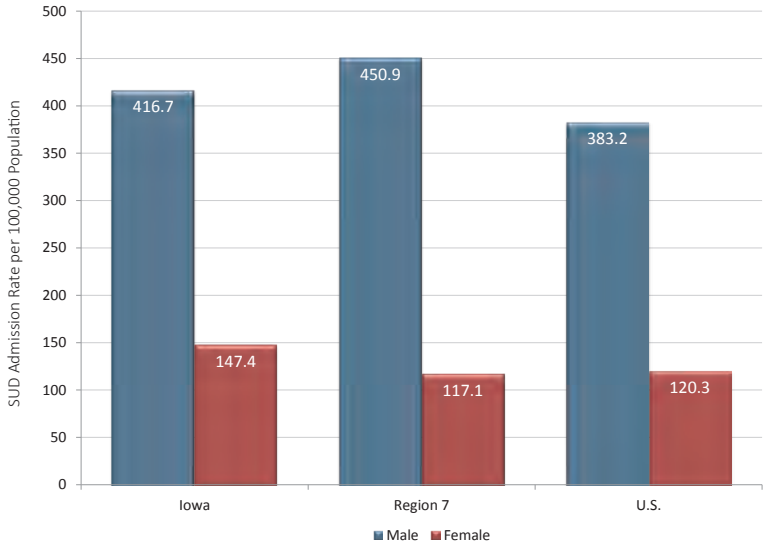
Admissions to Substance Use Disorder Treatment Among Older Iowans

In 2012, there were 3,065 admissions of Iowans ages 50 and older to substance use disorder (SUD) treatment in state-funded treatment programs, a rate of 274.5 per 100,000 people ages 50+. This rate was higher than the regional rate and the national average. Men made up 71.6 percent of these admissions. Of all admissions, 88.6 percent were White/Caucasian 8.2 percent were Black/African American, and 1.9 percent were Hispanic.

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

Self-Referral	Criminal Justice	Other
27.5%	44.7%	27.8%

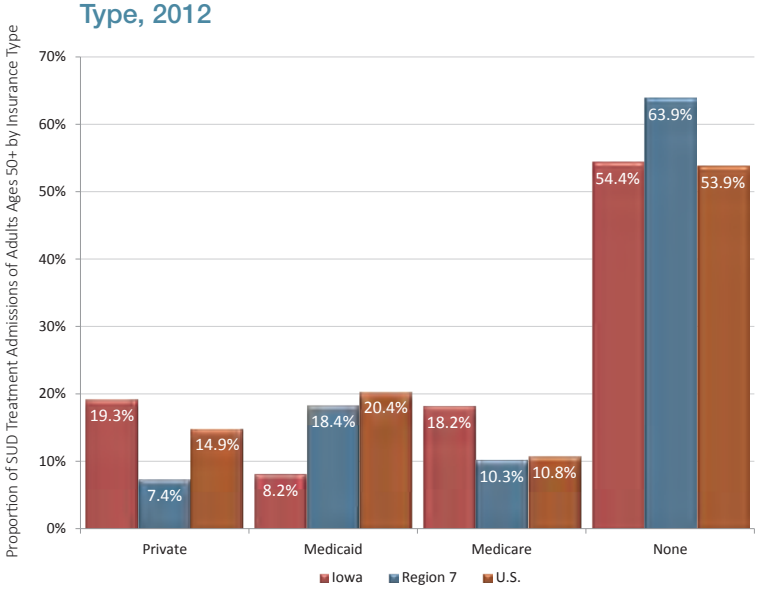
Exhibit 7. SUD Treatment Admissions of Adults Ages 50+ in Iowa, Region 7, and the United States by Sex, 2012



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

SUD Treatment Admissions Among Iowans Ages 50+ by Insurance Type

Exhibit 8. SUD Treatment Admissions of Adults Ages 50+ in Iowa, Region 7, and the United States by Insurance Type, 2012



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

In Iowa, 54.4 percent of older adult admissions to SUD treatment were uninsured, 8.2 percent had Medicaid, 18.2 percent had Medicare, and 19.3 percent had private insurance.

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

Self-Pay	Medicaid	Other
36.4%	11.3%	52.2%

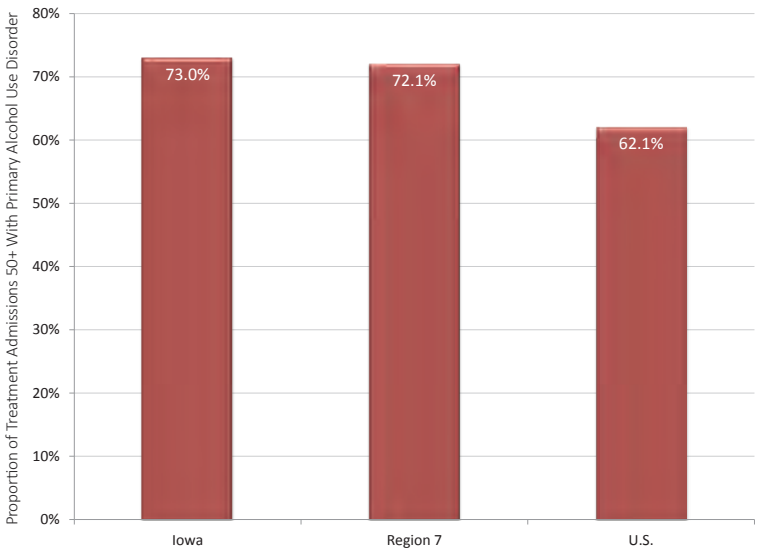
Self-pay data include private insurance.
Exhibit 8 and the accompanying text reflect the type of health insurance (if any) clients had at admission; the table above represents primary sources of payment.

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

Alcohol Use Disorder Treatment Admissions Among Iowans Ages 50+

Alcohol was the most frequently cited substance used by older Iowans in publicly financed SUD treatment in 2012. It was mentioned as a substance of use in 73.0 percent of admissions among those ages 50+. This was higher than the regional and national rates.

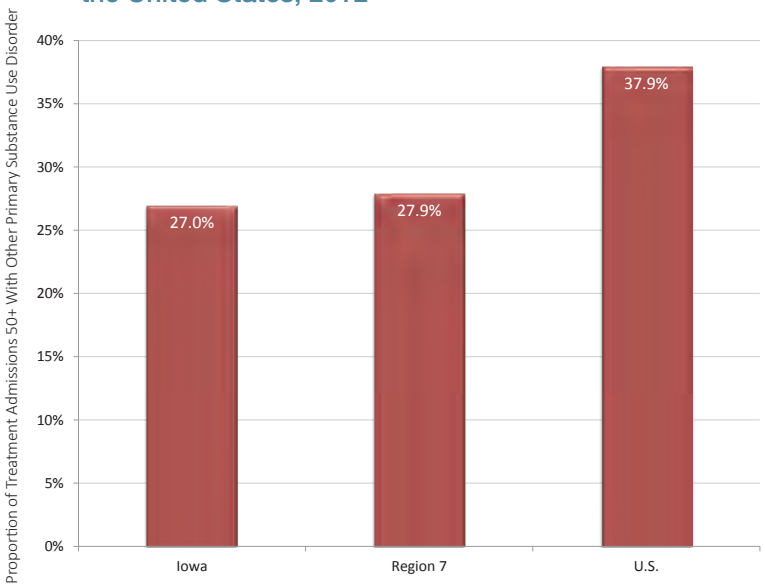
Exhibit 9. Alcohol Use Treatment Admissions of Adults Ages 50+ in Iowa, Region 7, and the United States, 2012



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 Iowa, Region 7, 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 27.0 percent of older adult admissions to publicly funded treatment in Iowa.

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*:

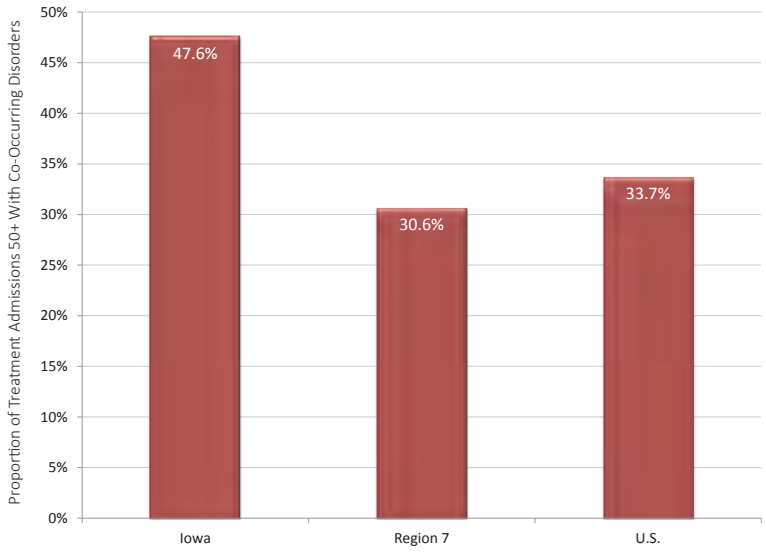
- *In 2004, there were an estimated 115,803 ED visits involving pharmaceutical misuse and abuse by adults aged 50 or older; in 2008, there were 256,097 such visits, representing an increase of 121.1 percent*
- *One fifth (19.7 percent) of ED visits involving pharmaceutical misuse and abuse among older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

Exhibit 11. SUD Treatment Admissions of Adults Ages 50+ With a Co-Occurring Mental Disorder in Iowa, Region 7, 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.

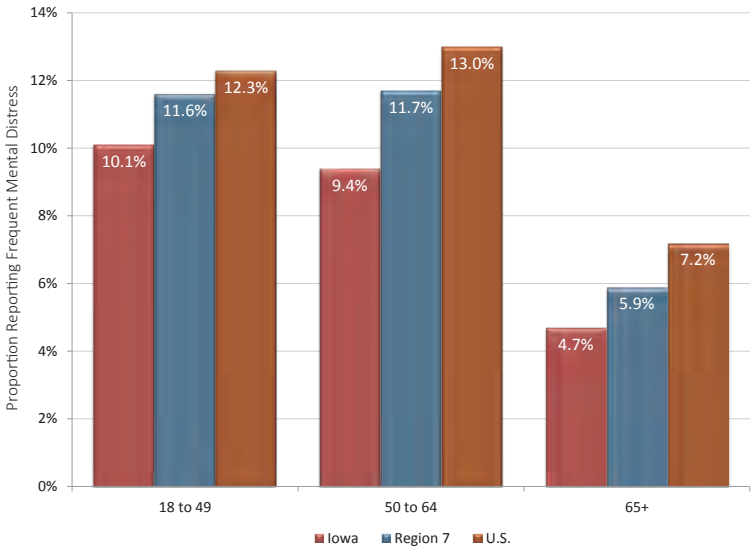
Exhibit 11 shows the proportion of SUD treatment admissions of Iowans ages 50+ with a co-occurring mental disorder. This rate is higher than the regional rate and the national average. However, state reporting practices are a factor in these results.

MENTAL HEALTH

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

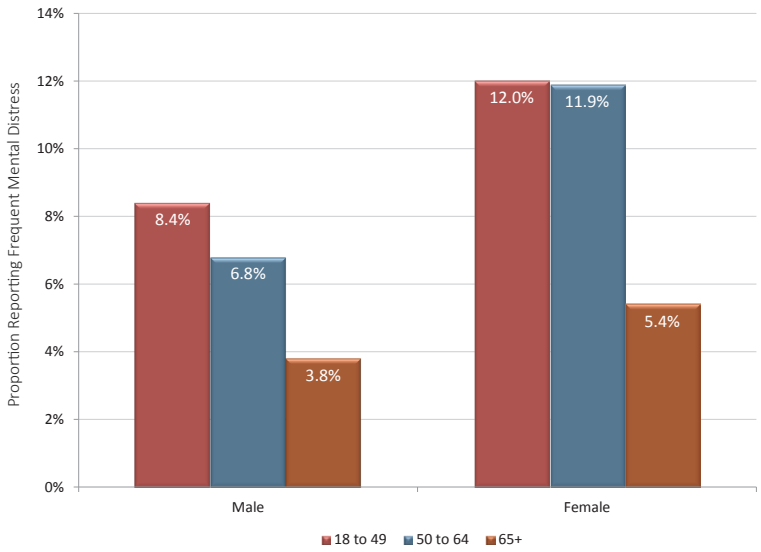
Exhibit 12. Individuals Reporting Frequent Mental Distress in Iowa, Region 7, and the United States, 2013



Source: BRFSS, 2013

Older Iowans Reporting Frequent Mental Distress by Age Group and Sex

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



Source: BRFSS, 2013

Older men in Iowa 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, 11.9 percent of women in the 50–64 age group and 5.4 percent in the 65+ age group reported FMD, while 6.8 percent of men in the 50–64 age group and 3.8 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 Iowans.

Exhibit 14. BRFSS Measures, 2010

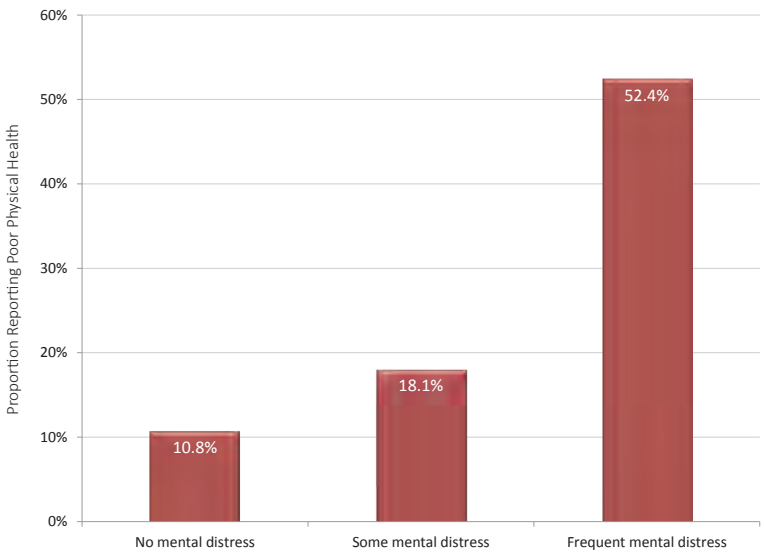
Indicator	Ages 50+	Ages 50–64	Ages 65+
Rarely or never get social or emotional support	7.4%	5.2%	10.2%
Dissatisfied or very dissatisfied	3.8%	4.6%	2.8%

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

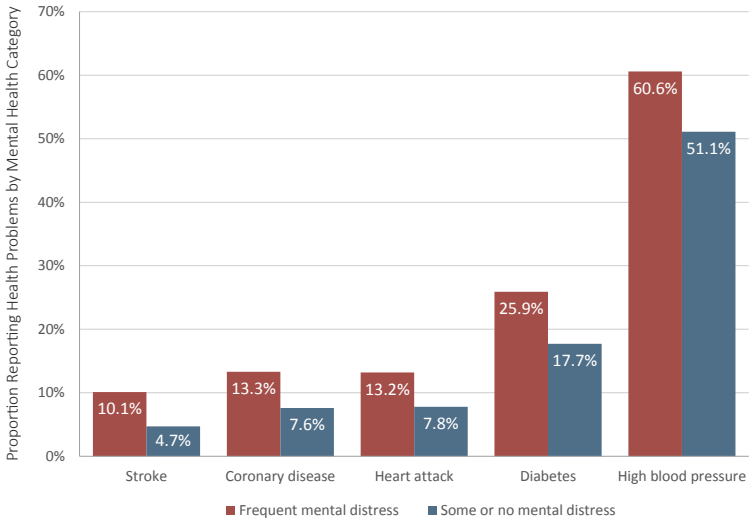


Source: BRFSS, 2013

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 Iowans Admitted to State Mental Health Services

Approximately 2.8 percent of the people served by the Iowa mental health system were ages 65 and older. This represents more than 3,110 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

Kansas

Kansas

OLDER ADULTS BEHAVIORAL HEALTH PROFILE

August 2016

KANSAS' POPULATION

Kansas Population by Age Group

Kansas is home to 2,904,021 people. Of these:

- 976,223 (33.6 percent) are over age 50.
- 583,421 (20.1 percent) are over age 60.
- 284,118 (9.8 percent) are over age 70.
- 119,106 (4.1 percent) are ages 80 and older.

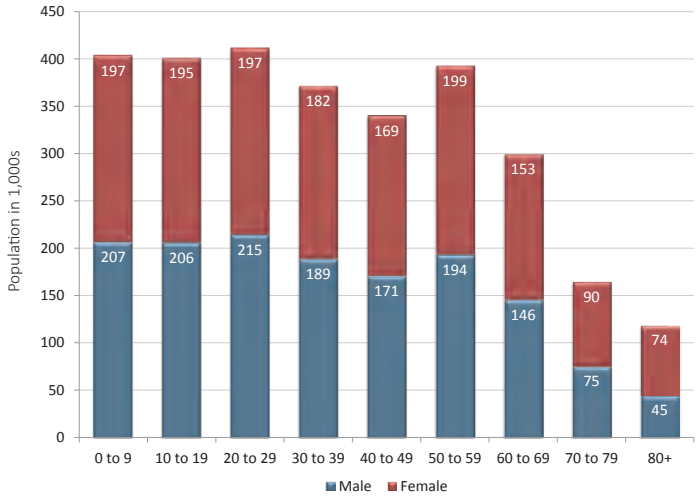
The proportion of women rises fairly steadily in each age group, and women make up 62.5 percent of the 80+ group. The racial/ethnic composition of older Kansans is as follows:

Race/Ethnicity of Kansans Ages 50+

White	AI/AN	Black	Asian	NH/PI	Other	Hispanic
91.8%	0.8%	4.6%	1.7%	0.1%	1.0%	4.7%

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

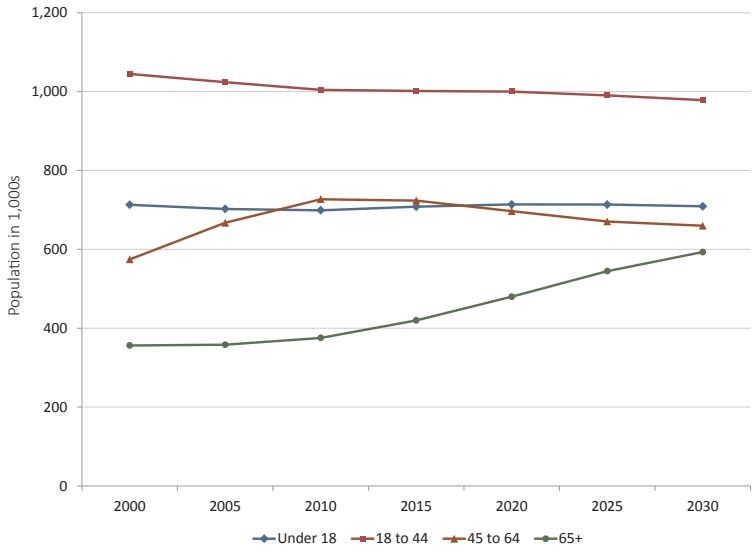
Exhibit 1. Kansas Population by Age Group, 2014



Source: U.S. Census Bureau, 2015

The Number of Older Kansans Is Growing

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



The proportion of Kansas' population that is 65 and older is growing while the proportion that is younger than 65 is shrinking. The U.S. Census Bureau estimates that 20.2 percent of Kansas' population will be 65 and older by the year 2030, an increase of 41.3 percent from 2015.

Projected Population in Kansas

Age Group	2015	2025	2030
Under 18	24.8%	24.4%	24.1%
18 to 44	35.1%	33.9%	33.3%
45 to 64	25.4%	23.0%	22.4%
65+	14.7%	18.7%	20.2%

Source: U.S. Census Bureau, 2005

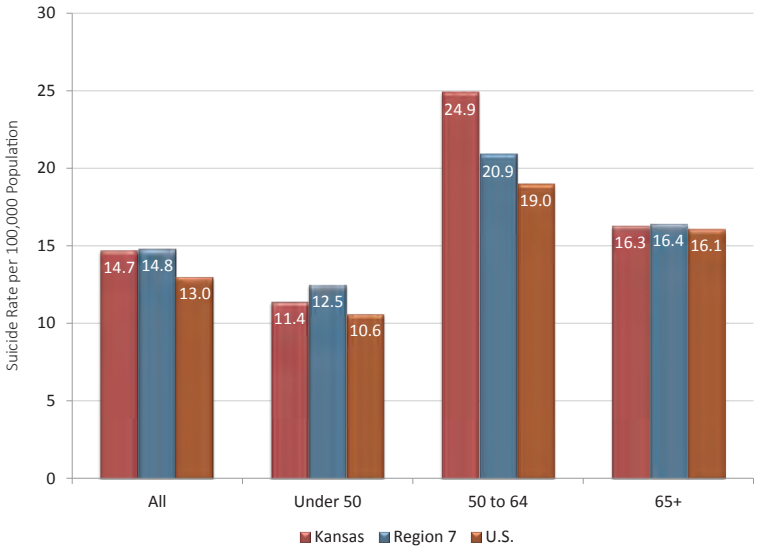
SUICIDE AMONG OLDER KANSANS

Kansas Suicide Rate Compared With Regional and National Rates

The suicide rate among Kansans ages 50 and older is higher than the rate among younger age groups. In 2013, the total suicide rate among all people ages 50+ was 21.3 per 100,000 people (8.6 for women and 35.6 for men). The rate among those ages 50–64 was higher than both the rate in the region (including Iowa, Missouri, and Nebraska) and the rate in the United States.

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

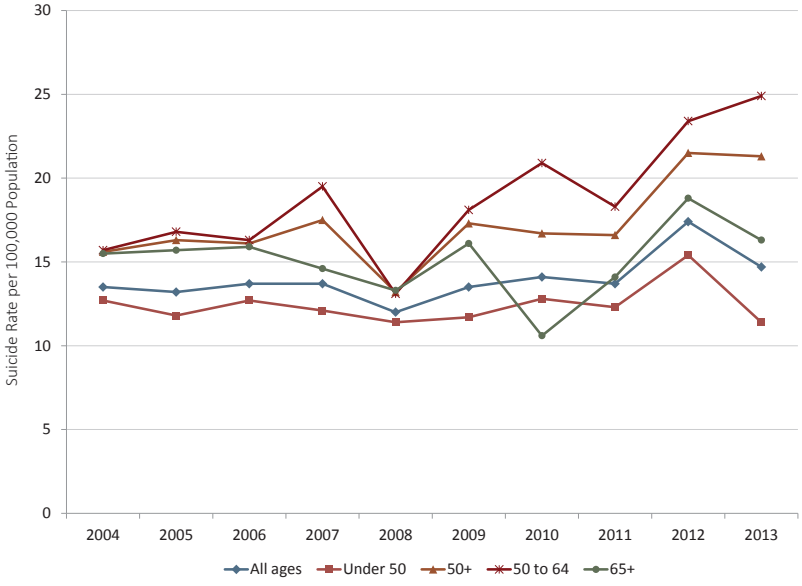
Exhibit 3. Suicide Rates in Kansas, Region 7, and the United States, 2013



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 Kansas

Exhibit 4. Trends in Suicide Rates in Kansas 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 Kansans ages 50+ fluctuated from a low of 13.2 per 100,000 in 2008 to a high of 21.5 per 100,000 in 2012. From 2004 to 2013, the rate was generally highest among those in the 50–64 age group.

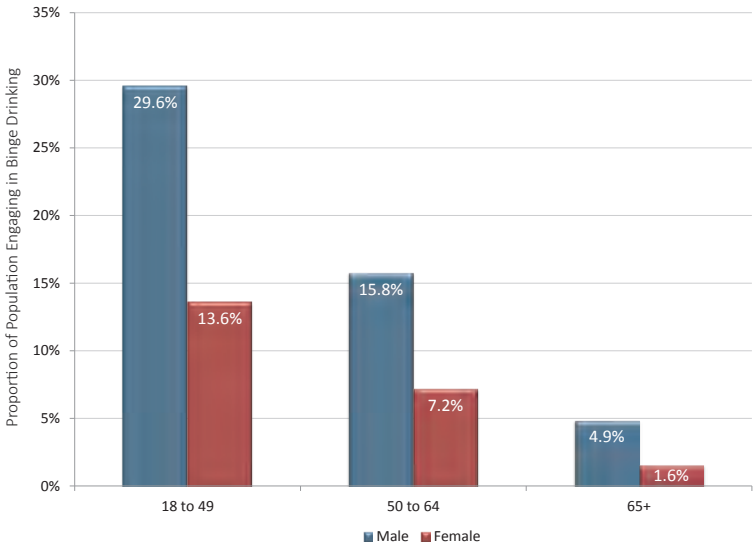
How a state reports suicides can vary from year to year. The number of suicides is generally low, so even a small difference in reported numbers may make the rate fluctuate widely.

SUBSTANCE USE DISORDER AND SUBSTANCE USE DISORDER TREATMENT AMONG OLDER KANSANS

30-Day Binge Drinking Among Older Kansans

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, 15.8 percent of Kansas men ages 50–64 reported binge drinking in the past 30 days, while 4.9 percent of those in the 65+ group reported similar behavior.

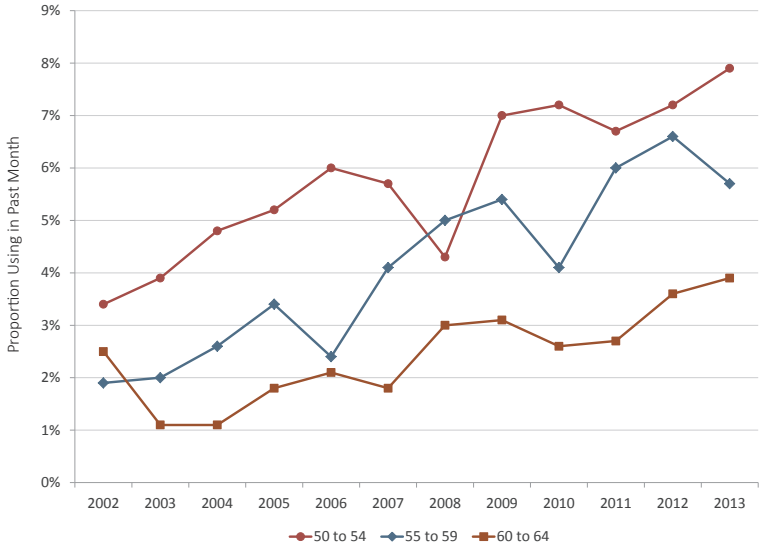
Exhibit 5. Binge Drinking Rates in Kansas by Age Group and Sex, 2013



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 *Kansas 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).

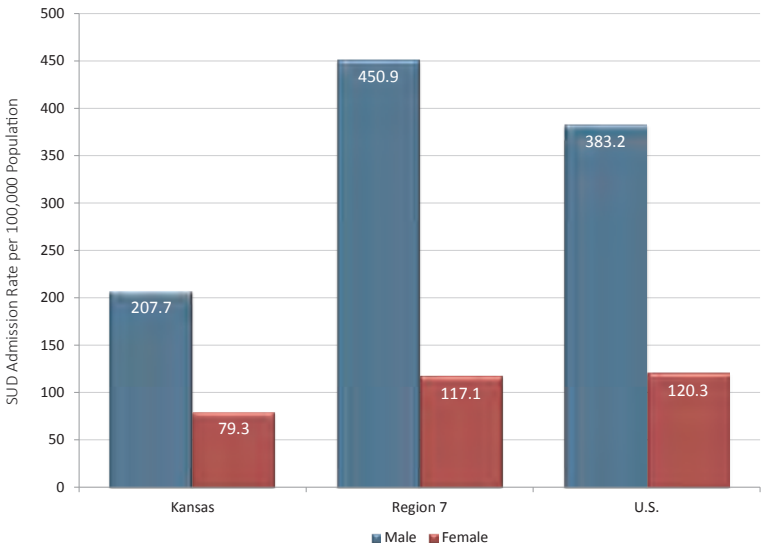
Admissions to Substance Use Disorder Treatment Among Older Kansans

In 2012, there were 1,364 admissions of Kansans ages 50 and older to substance use disorder (SUD) treatment in state-funded treatment programs, a rate of 139.7 per 100,000 people ages 50+. This rate was lower than the regional rate and the national average. Men made up 69.9 percent of these admissions. Of all admissions, 74.9 percent were White/ Caucasian, 19.1 percent were Black/ African American, and 5.2 percent were Hispanic.

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

Self-Referral	Criminal Justice	Other
29.5%	38.3%	32.2%

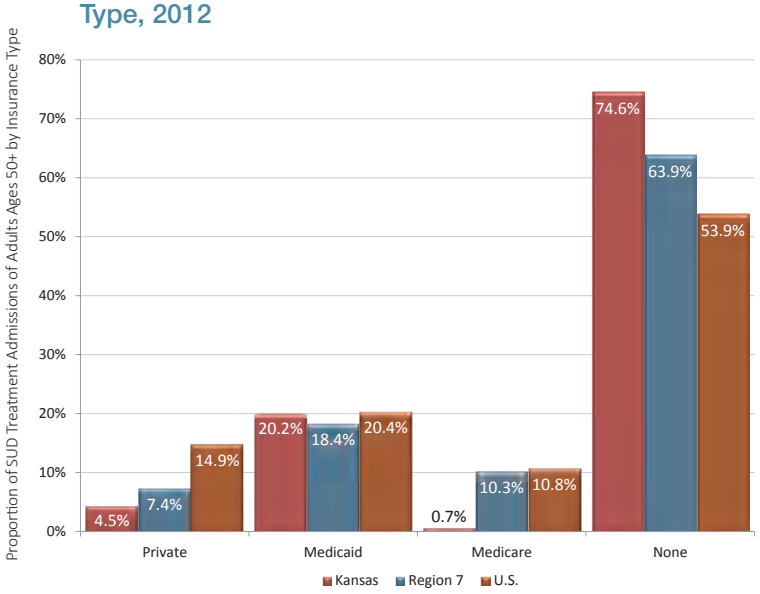
Exhibit 7. SUD Treatment Admissions of Adults Ages 50+ in Kansas, Region 7, and the United States by Sex, 2012



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

SUD Treatment Admissions Among Kansans Ages 50+ by Insurance Type

Exhibit 8. SUD Treatment Admissions of Adults Ages 50+ in Kansas, Region 7, and the United States by Insurance Type, 2012



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

In Kansas, 74.6 percent of older adult admissions to SUD treatment were uninsured, 20.2 percent had Medicaid, 0.7 percent had Medicare, and 4.5 percent had private insurance.

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

Self-Pay	Medicaid	Other
12.8%	20.2%	67.0%

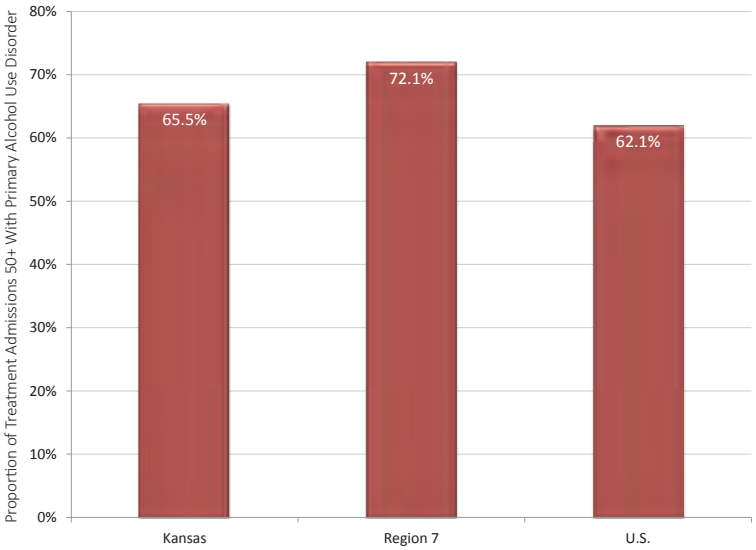
Self-pay data include private insurance.
Exhibit 8 and the accompanying text reflect the type of health insurance (if any) clients had at admission; the table above represents primary sources of payment.

[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 Kansans Ages 50+

Alcohol was the most frequently cited substance used by older Kansans in publicly financed SUD treatment in 2012. It was mentioned as a substance of use in 65.5 percent of admissions among those ages 50+. This was lower than the regional rate and higher than the national rate.

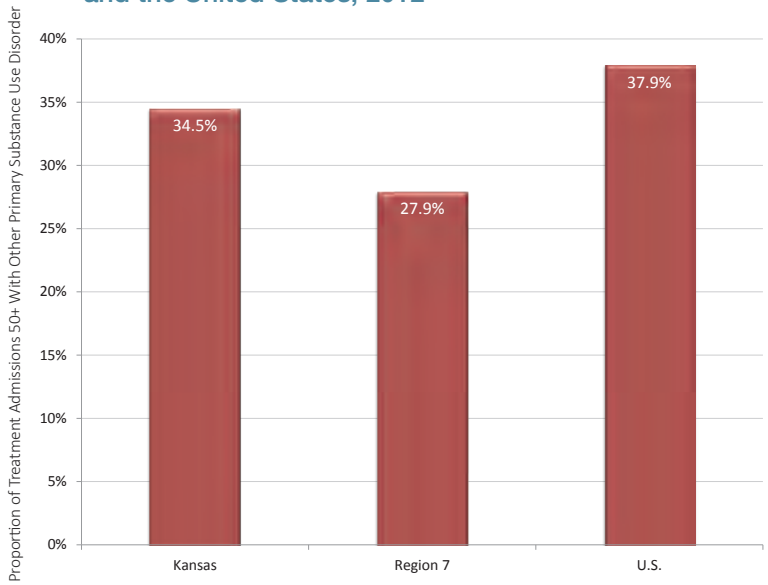
Exhibit 9. Alcohol Use Treatment Admissions of Adults Ages 50+ in Kansas, Region 7, and the United States, 2012



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 Kansas, Region 7, 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 34.5 percent of older adult admissions to publicly funded treatment in Kansas.

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*:

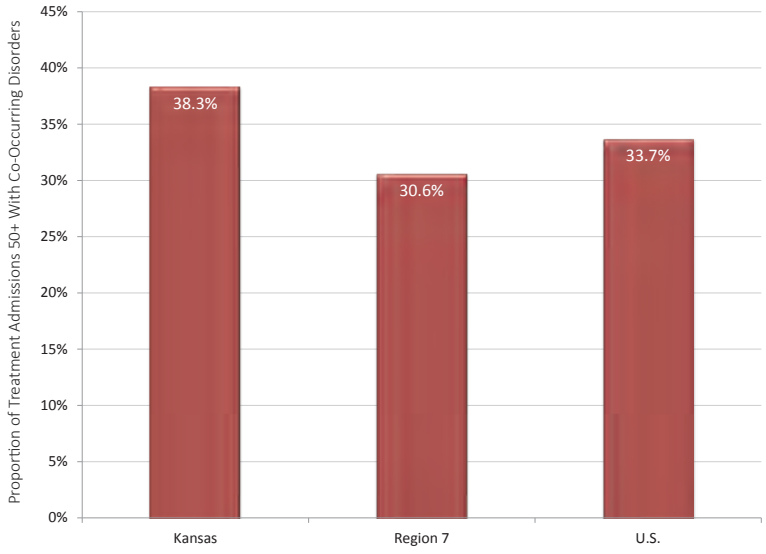
- *In 2004, there were an estimated 115,803 ED visits involving pharmaceutical misuse and abuse by adults aged 50 or older; in 2008, there were 256,097 such visits, representing an increase of 121.1 percent*
- *One fifth (19.7 percent) of ED visits involving pharmaceutical misuse and abuse among older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

Exhibit 11. SUD Treatment Admissions of Adults Ages 50+ With a Co-Occurring Mental Disorder in Kansas, Region 7, 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.

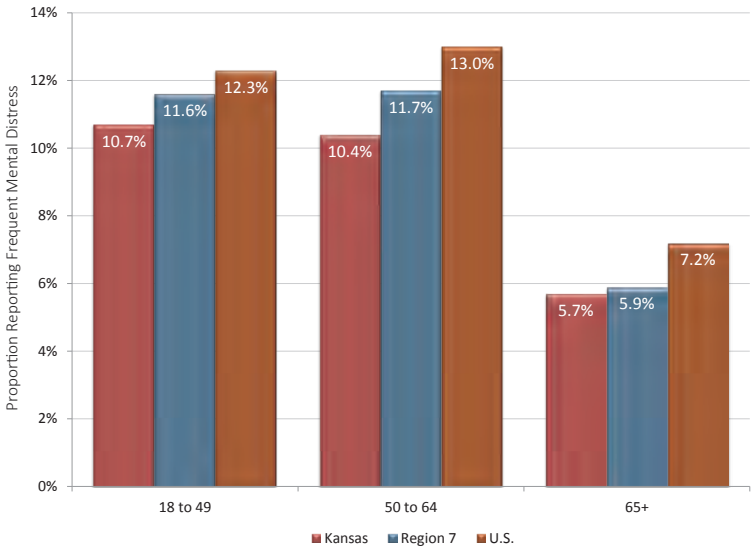
Exhibit 11 shows the proportion of SUD treatment admissions of Kansans ages 50+ with a co-occurring mental disorder. This rate is higher than the regional rate and the national average. However, state reporting practices are a factor in these results.

MENTAL HEALTH

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

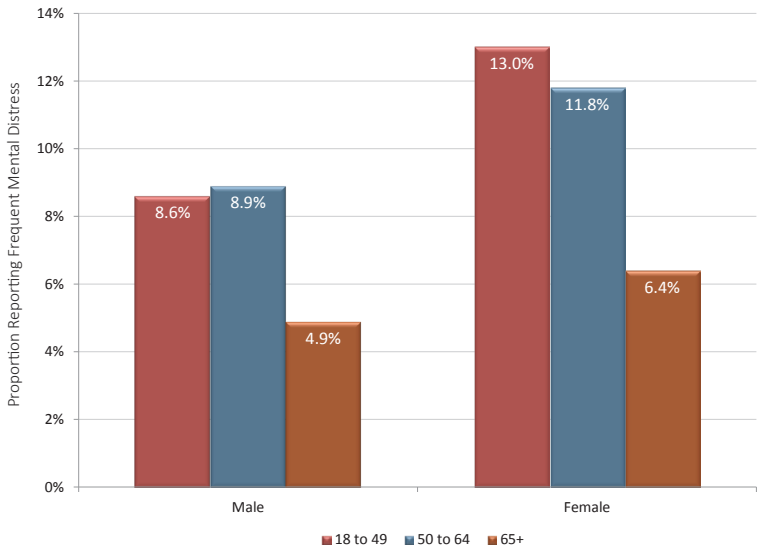
Exhibit 12. Individuals Reporting Frequent Mental Distress in Kansas, Region 7, and the United States, 2013



Source: BRFSS, 2013

Older Kansans Reporting Frequent Mental Distress by Age Group and Sex

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



Source: BRFSS, 2013

Older men in Kansas 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, 11.8 percent of women in the 50–64 age group and 6.4 percent in the 65+ age group reported FMD, while 8.9 percent of men in the 50–64 age group and 4.9 percent in the 65+ age group reported FMD.

Other Measures of Mental Health

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

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

Exhibit 14 presents the results of these surveys among older Kansans.

Exhibit 14. BRFSS Measures, 2010

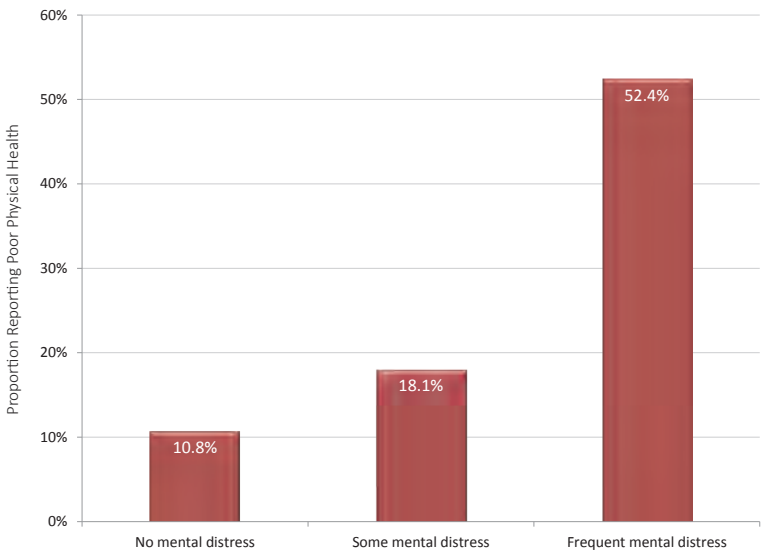
Indicator	Ages 50+	Ages 50–64	Ages 65+
Rarely or never get social or emotional support	6.3%	4.9%	8.5%
Dissatisfied or very dissatisfied	3.9%	4.9%	2.4%

Source: BRFSS, 2010

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

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

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

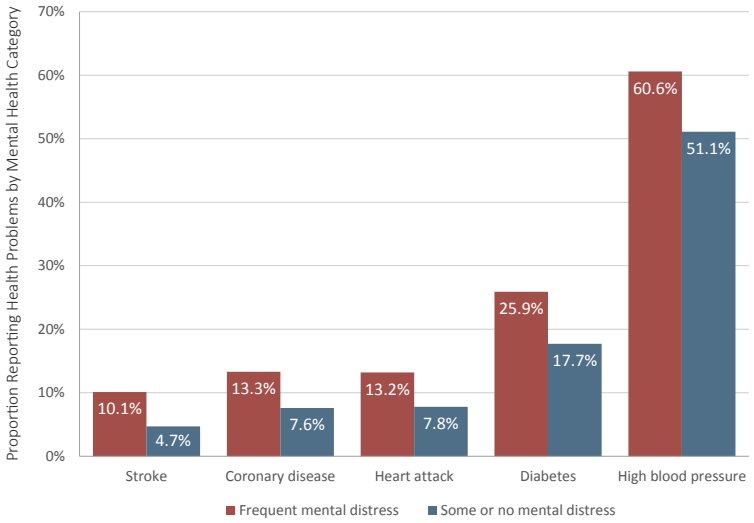


Source: BRFSS, 2013

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

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

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



Source: BRFSS, 2013

Older Kansans Admitted to State Mental Health Services

Approximately 4.7 percent of the people served by the Kansas mental health system were ages 65 and older. This represents more than 6,140 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

Missouri

Missouri

OLDER ADULTS BEHAVIORAL HEALTH PROFILE

August 2016

MISSOURI'S POPULATION

Missouri Population by Age Group

Missouri is home to 6,063,589 people. Of these:

- 2,163,870 (35.7 percent) are over age 50.
- 1,297,985 (21.4 percent) are over age 60.
- 632,091 (10.4 percent) are over age 70.
- 244,450 (4.0 percent) are ages 80 and older.

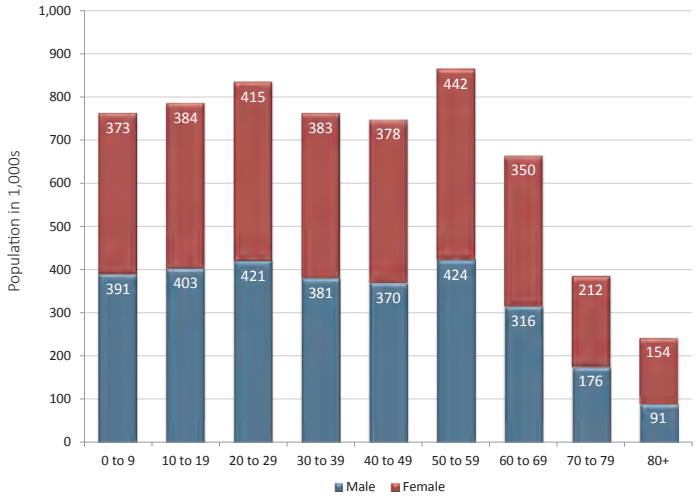
The proportion of women rises fairly steadily in each age group, and women make up 62.9 percent of the 80+ group. The racial/ethnic composition of older Missourians is as follows:

Race/Ethnicity of Missourians Ages 50+

White	AI/AN	Black	Asian	NH/PI	Other	Hispanic
88.4%	0.5%	9.1%	1.2%	0.1%	0.9%	1.7%

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

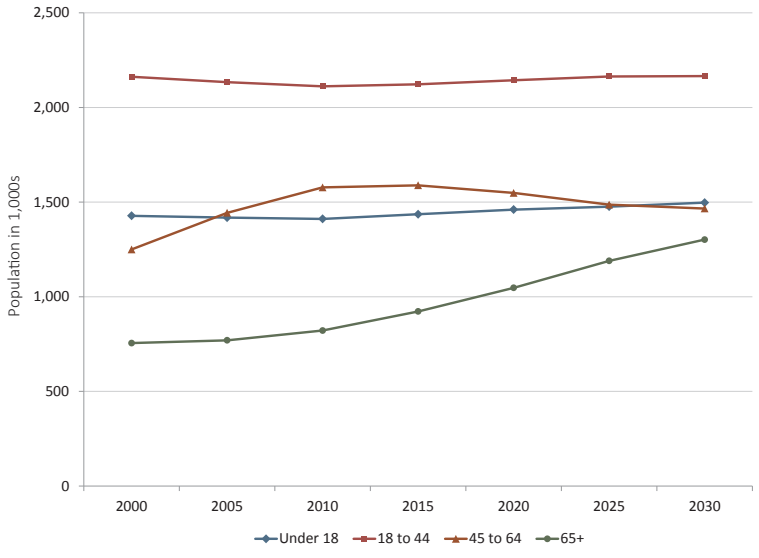
Exhibit 1. Missouri Population by Age Group, 2014



Source: U.S. Census Bureau, 2015

The Number of Older Missourians Is Growing

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



The proportion of Missouri's population that is 65 and older is growing while the proportion that is younger than 65 is shrinking. The U.S. Census Bureau estimates that 20.2 percent of Missouri's population will be 65 and older by the year 2030, an increase of 41.1 percent from 2015.

Projected Population in Missouri

Age Group	2015	2025	2030
Under 18	23.7%	23.4%	23.3%
18 to 44	35.0%	34.3%	33.7%
45 to 64	26.2%	23.5%	22.8%
65+	15.2%	18.8%	20.2%

Source: U.S. Census Bureau, 2005

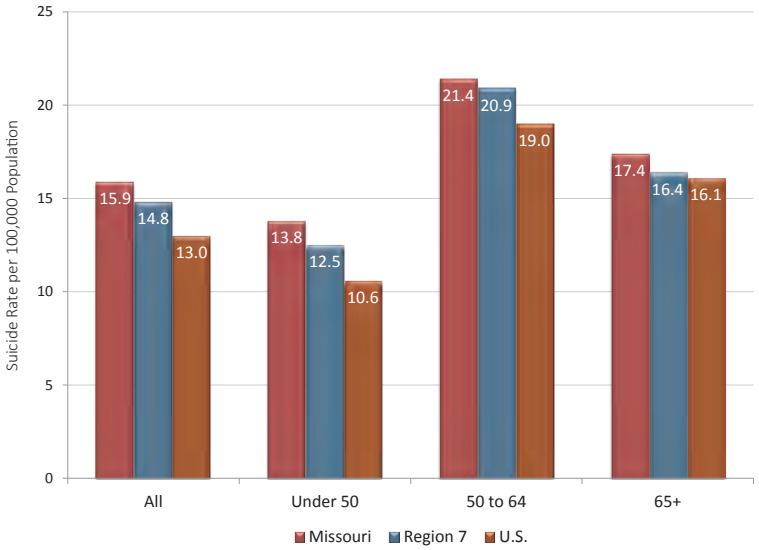
SUICIDE AMONG OLDER MISSOURIANS

Missouri Suicide Rate Compared With Regional and National Rates

The suicide rate among Missourians 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 19.7 per 100,000 people (5.2 for women and 36.4 for men). The rate among those ages 50–64 was higher than both the rate in the region (including Iowa, Kansas, and Nebraska) and the rate in the United States.

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

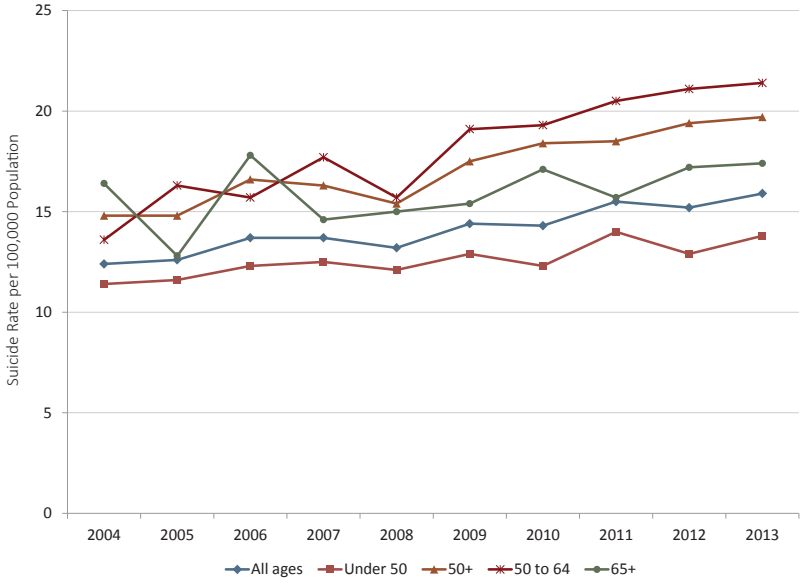
Exhibit 3. Suicide Rates in Missouri, Region 7, and the United States, 2013



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 Missouri

Exhibit 4. Trends in Suicide Rates in Missouri 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 Missourians ages 50+ fluctuated from a low of 14.8 per 100,000 in 2004 and 2005 to a high of 19.7 per 100,000 in 2013. From 2004 to 2013, the rate was generally highest among those in the 50–64 age group.

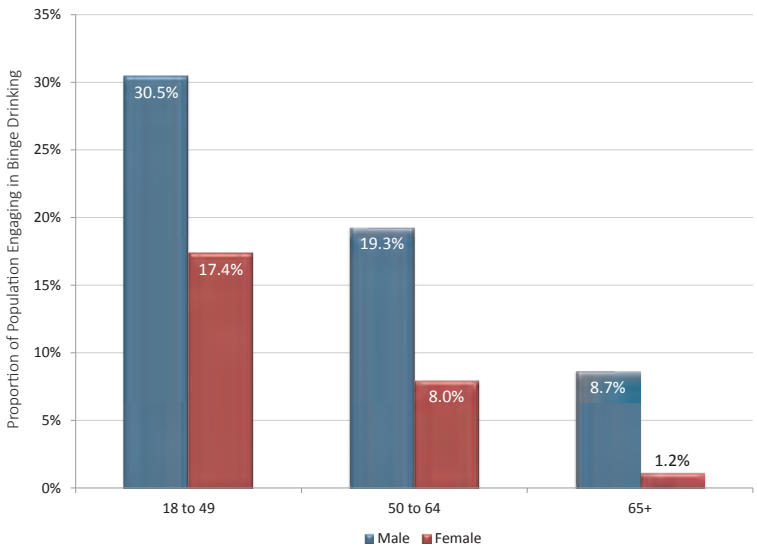
How a state reports suicides can vary from year to year. The number of suicides is generally low, so even a small difference in reported numbers may make the rate fluctuate widely.

SUBSTANCE USE DISORDER AND SUBSTANCE USE DISORDER TREATMENT AMONG OLDER MISSOURIANS

30-Day Binge Drinking Among Older Missourians

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, 19.3 percent of Missouri men ages 50–64 reported binge drinking in the past 30 days, while 8.7 percent of those in the 65+ group reported similar behavior.

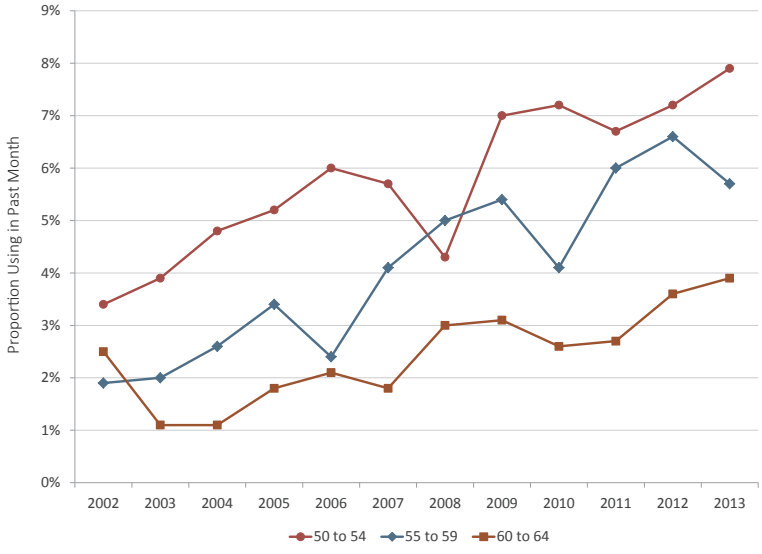
Exhibit 5. Binge Drinking Rates in Missouri by Age Group and Sex, 2013



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 *Missouri 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).

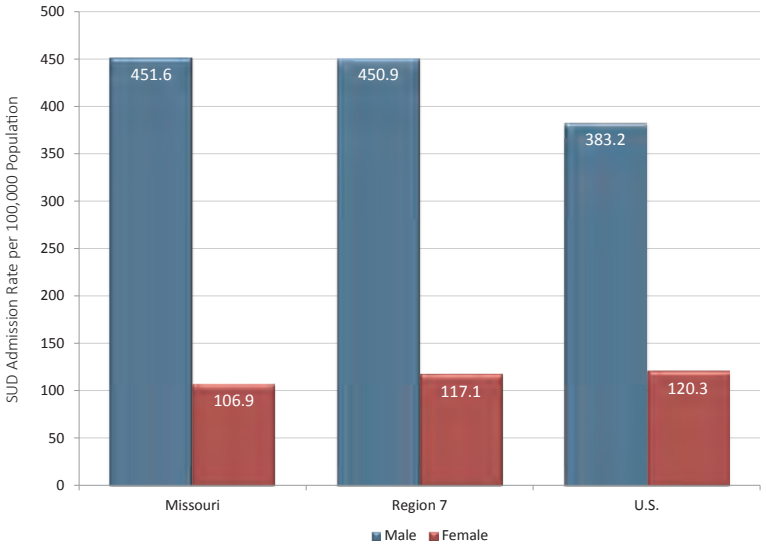
Admissions to Substance Use Disorder Treatment Among Older Missourians

In 2012, there were 5,784 admissions of Missourians ages 50 and older to substance use disorder (SUD) treatment in state-funded treatment programs, a rate of 267.3 per 100,000 people ages 50+. This rate was lower than the regional rate and higher than the national average. Men made up 78.6 percent of these admissions. Of all admissions, 67.2 percent were White/ Caucasian, 29.7 percent were Black/ African American, and 1.2 percent were Hispanic.

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

Self-Referral	Criminal Justice	Other
44.4%	43.8%	11.8%

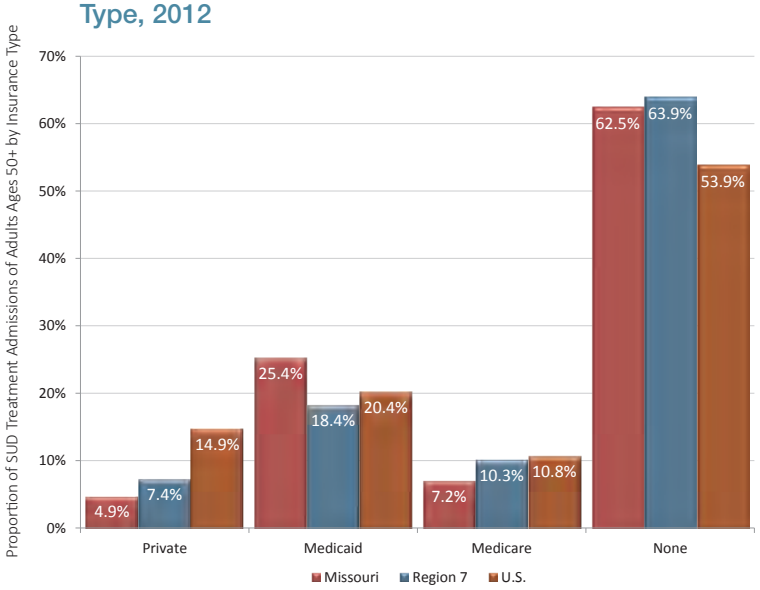
Exhibit 7. SUD Treatment Admissions of Adults Ages 50+ in Missouri, Region 7, and the United States by Sex, 2012



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

SUD Treatment Admissions Among Missourians Ages 50+ by Insurance Type

Exhibit 8. SUD Treatment Admissions of Adults Ages 50+ in Missouri, Region 7, and the United States by Insurance Type, 2012



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

In Missouri, 62.5 percent of older adult admissions to SUD treatment were uninsured, 25.4 percent had Medicaid, 7.2 percent had Medicare, and 4.9 percent had private insurance.

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

Self-Pay	Medicaid	Other
21.5%	20.1%	58.4%

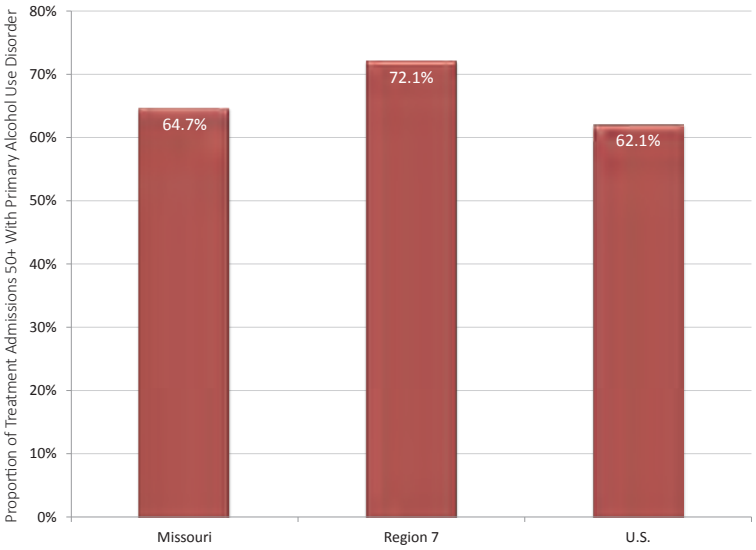
Self-pay data include private insurance.
Exhibit 8 and the accompanying text reflect the type of health insurance (if any) clients had at admission; the table above represents primary sources of payment.

[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 Missourians Ages 50+

Alcohol was the most frequently cited substance used by older Missourians in publicly financed SUD treatment in 2012. It was mentioned as a substance of use in 64.7 percent of admissions among those ages 50+. This was lower than the regional rate and higher than the national rate.

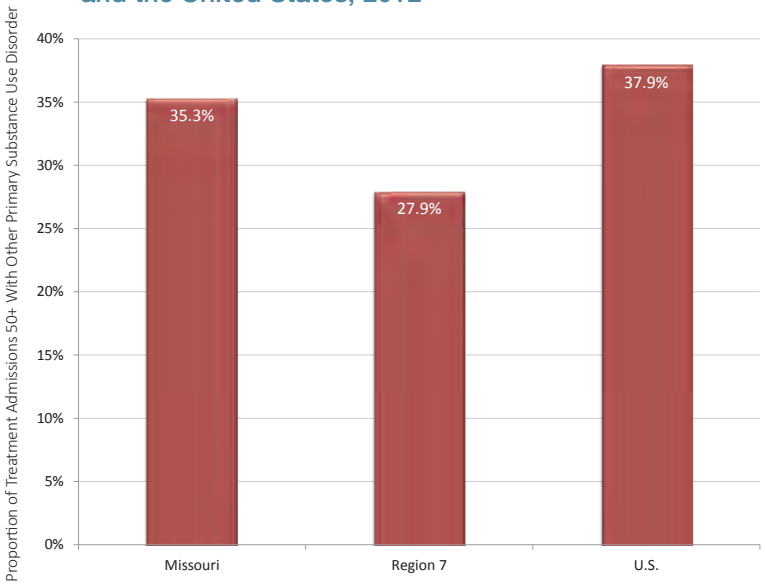
Exhibit 9. Alcohol Use Treatment Admissions of Adults Ages 50+ in Missouri, Region 7, and the United States, 2012



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 Missouri, Region 7, and the United States, 2012



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

Substances other than alcohol were cited as the primary substances of use for 35.3 percent of older adult admissions to publicly funded treatment in Missouri.

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*:

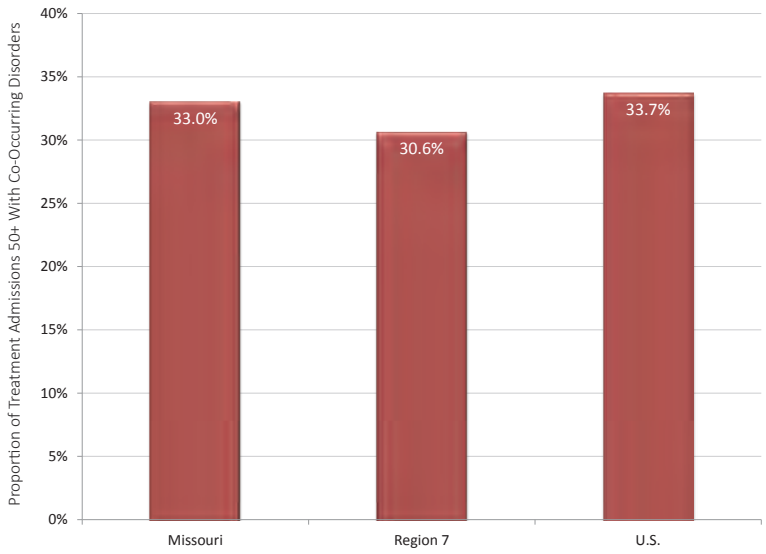
- *In 2004, there were an estimated 115,803 ED visits involving pharmaceutical misuse and abuse by adults aged 50 or older; in 2008, there were 256,097 such visits, representing an increase of 121.1 percent*
- *One fifth (19.7 percent) of ED visits involving pharmaceutical misuse and abuse among older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

Exhibit 11. SUD Treatment Admissions of Adults Ages 50+ With a Co-Occurring Mental Disorder in Missouri, Region 7, 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.

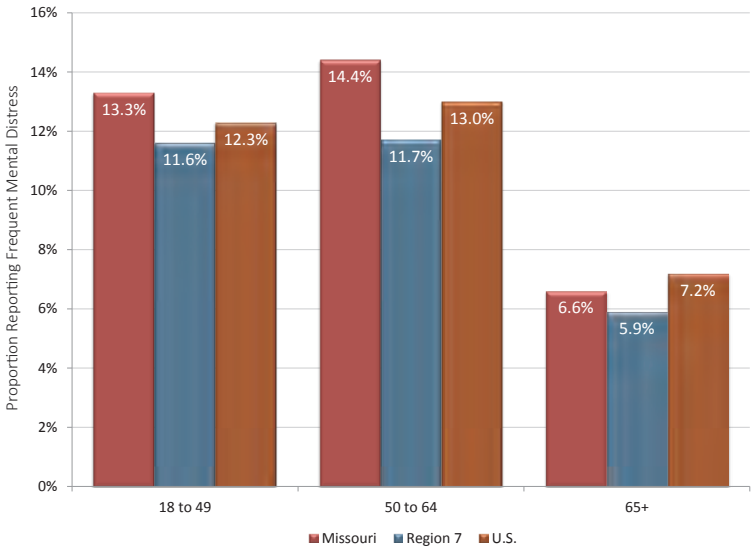
Exhibit 11 shows the proportion of SUD treatment admissions of Missourians ages 50+ with a co-occurring mental disorder. This rate is higher than the regional rate and lower than the national average. However, state reporting practices are a factor in these results.

MENTAL HEALTH

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

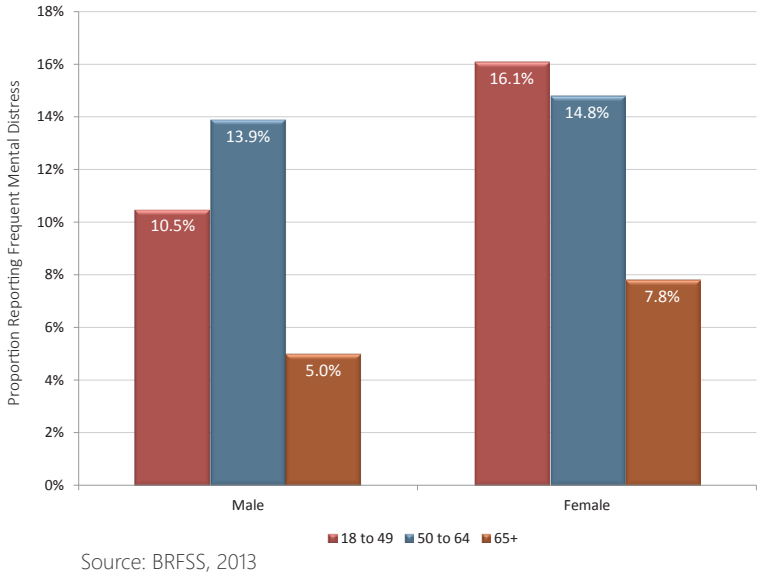
Exhibit 12. Individuals Reporting Frequent Mental Distress in Missouri, Region 7, and the United States, 2013



Source: BRFSS, 2013

Older Missourians Reporting Frequent Mental Distress by Age Group and Sex

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



Source: BRFSS, 2013

Older men in Missouri 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, 14.8 percent of women in the 50–64 age group and 7.8 percent in the 65+ age group reported FMD, while 13.9 percent of men in the 50–64 age group and 5.0 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 Missourians.

Exhibit 14. BRFSS Measures, 2010

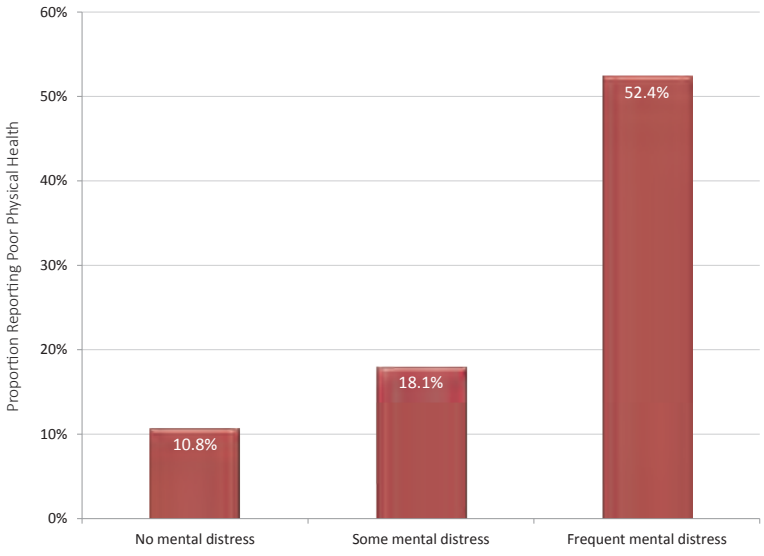
Indicator	Ages 50+	Ages 50–64	Ages 65+
Rarely or never get social or emotional support	8.1%	7.1%	9.6%
Dissatisfied or very dissatisfied	5.3%	6.9%	3.2%

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

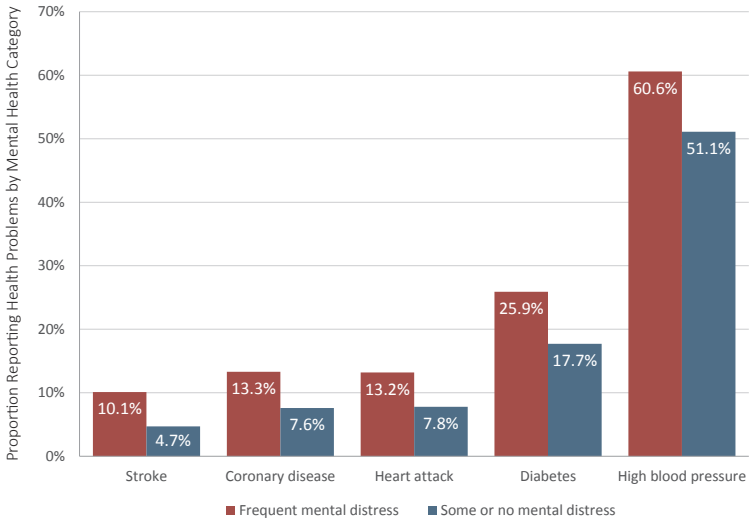


Source: BRFSS, 2013

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 Missourians Admitted to State Mental Health Services

Approximately 3.1 percent of the people served by the Missouri mental health system were ages 65 and older. This represents more than 2,300 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

Nebraska

Nebraska

OLDER ADULTS BEHAVIORAL HEALTH PROFILE

August 2016

NEBRASKA'S POPULATION

Nebraska Population by Age Group

Nebraska is home to 1,881,503 people. Of these:

- 634,423 (33.7 percent) are over age 50.
- 380,707 (20.2 percent) are over age 60.
- 186,461 (9.9 percent) are over age 70.
- 78,726 (4.2 percent) are ages 80 and older.

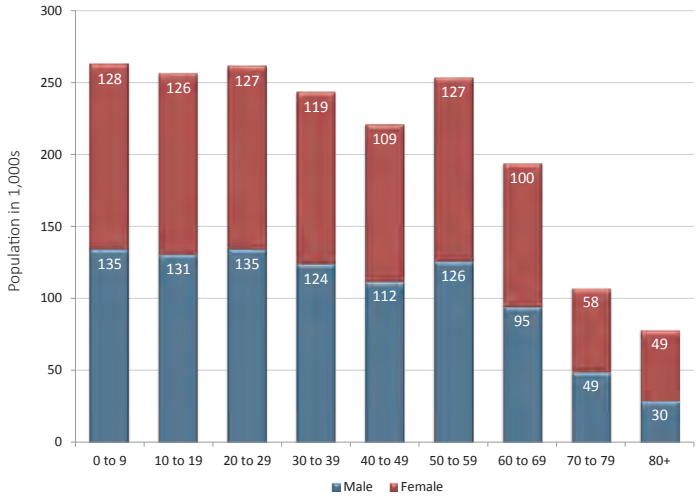
The proportion of women rises fairly steadily in each age group, and women make up 62.5 percent of the 80+ group. The racial/ethnic composition of older Nebraskans is as follows:

Race/Ethnicity of Nebraskans Ages 50+

White	AI/AN	Black	Asian	NH/PI	Other	Hispanic
94.4%	0.7%	3.2%	1.2%	0.1%	0.5%	3.8%

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.

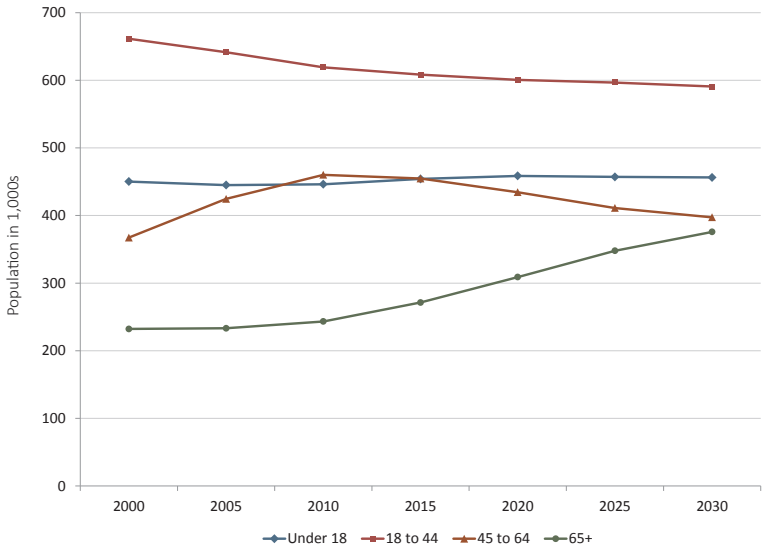
Exhibit 1. Nebraska Population by Age Group, 2014



Source: U.S. Census Bureau, 2015

The Number of Older Nebraskans Is Growing

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



The proportion of Nebraska's population that is 65 and older is growing while the proportion that is younger than 65 is shrinking. The U.S. Census Bureau estimates that 20.6 percent of Nebraska's population will be 65 and older by the year 2030, an increase of 38.5 percent from 2015.

Projected Population in Nebraska

Age Group	2015	2025	2030
Under 18	25.4%	25.2%	25.1%
18 to 44	34.0%	32.9%	32.5%
45 to 64	25.4%	22.7%	21.8%
65+	15.2%	19.2%	20.6%

Source: U.S. Census Bureau, 2005

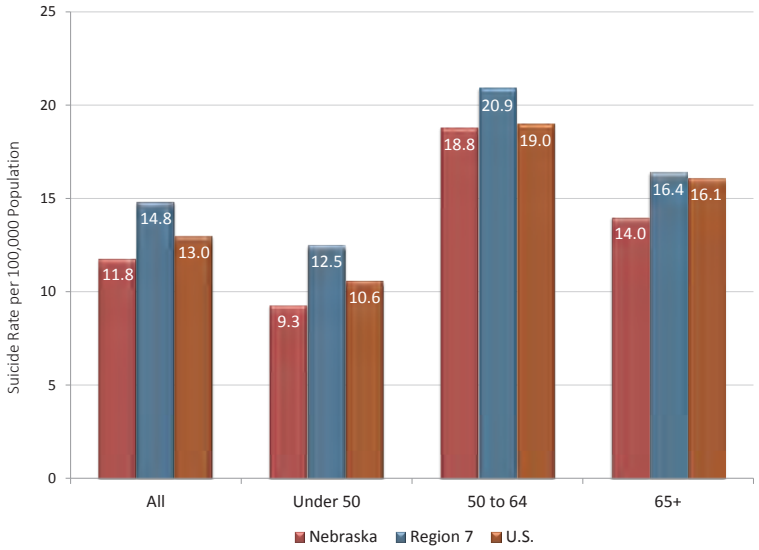
SUICIDE AMONG OLDER NEBRASKANS

Nebraska Suicide Rate Compared With Regional and National Rates

The suicide rate among Nebraskans 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 16.8 per 100,000 people (7.0 for women and 27.8 for men). The rate among those ages 50–64 was lower than both the rate in the region (including Iowa, Kansas, and Missouri) and the rate in the United States.

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

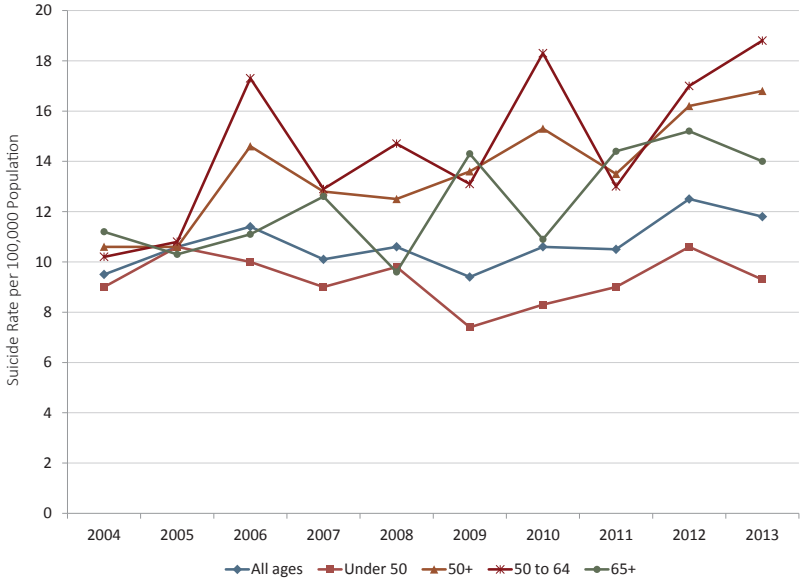
Exhibit 3. Suicide Rates in Nebraska, Region 7, and the United States, 2013



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 Nebraska

Exhibit 4. Trends in Suicide Rates in Nebraska 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 Nebraskans ages 50+ fluctuated from a low of 10.6 per 100,000 in 2004 and 2005 to a high of 16.8 per 100,000 in 2013. From 2004 to 2013, the rate was generally highest among those in the 50–64 age group.

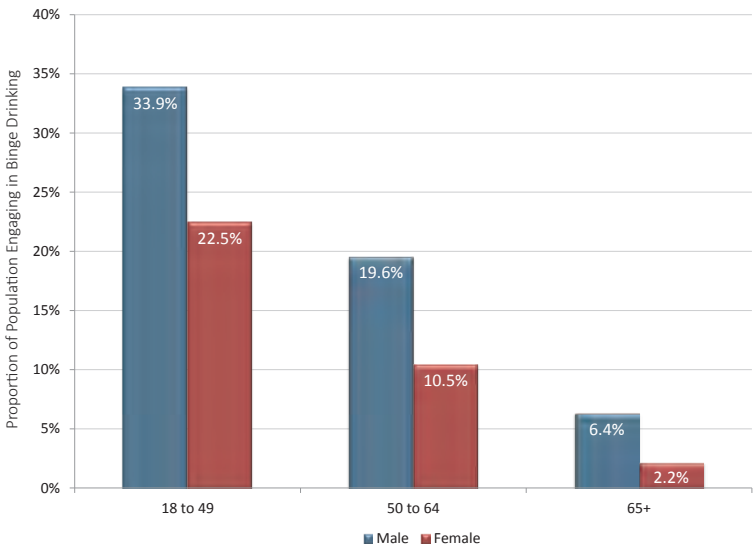
How a state reports suicides can vary from year to year. The number of suicides is generally low, so even a small difference in reported numbers may make the rate fluctuate widely.

SUBSTANCE USE DISORDER AND SUBSTANCE USE DISORDER TREATMENT AMONG OLDER NEBRASKANS

30-Day Binge Drinking Among Older Nebraskans

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

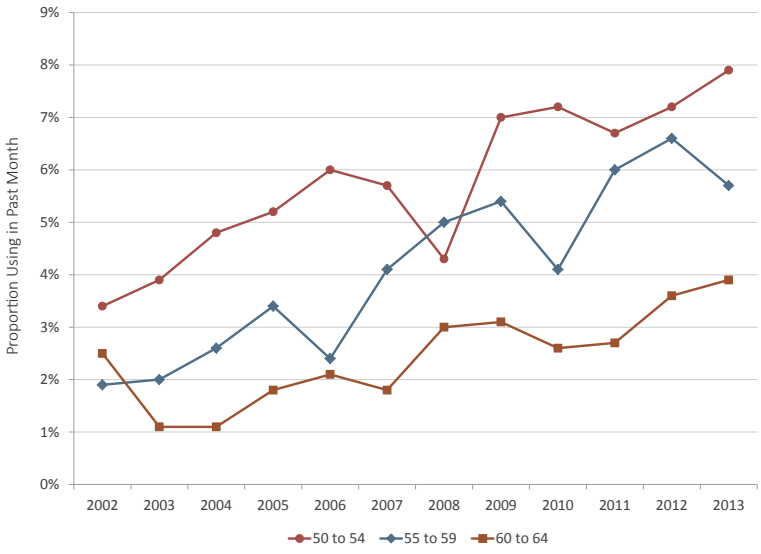
Exhibit 5. Binge Drinking Rates in Nebraska by Age Group and Sex, 2013



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 *Nebraska 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).

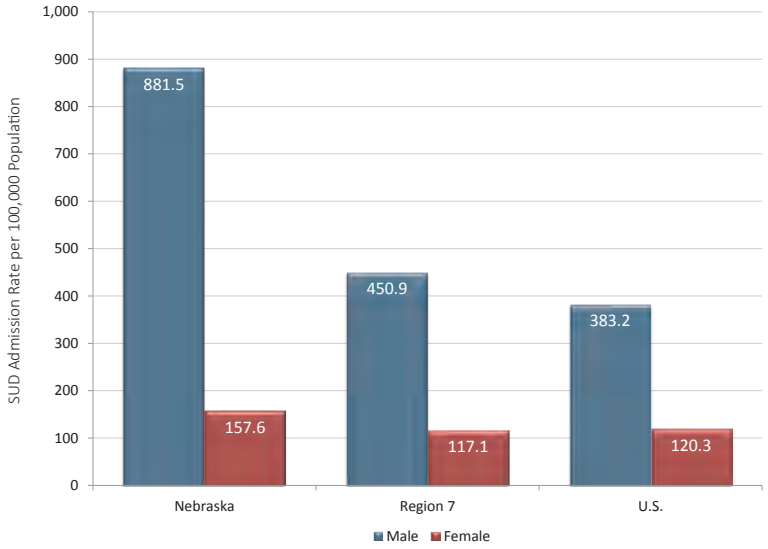
Admissions to Substance Use Disorder Treatment Among Older Nebraskans

In 2012, there were 3,171 admissions of Nebraskans ages 50 and older to substance use disorder (SUD) treatment in state-funded treatment programs, a rate of 499.8 per 100,000 people ages 50+. This rate was higher than the regional rate and the national average. Men made up 83.4 percent of these admissions. Of all admissions, 76.4 percent were White/Caucasian, 14.1 percent were Black/African American, and 3.7 percent were Hispanic.

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

Self-Referral	Criminal Justice	Other
29.8%	56.0%	14.2%

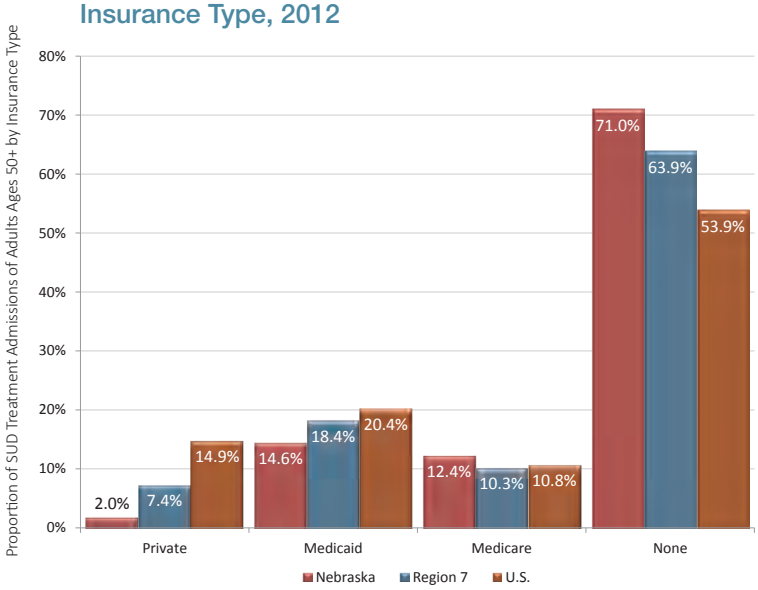
Exhibit 7. SUD Treatment Admissions of Adults Ages 50+ in Nebraska, Region 7, and the United States by Sex, 2012



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

SUD Treatment Admissions Among Nebraskans Ages 50+ by Insurance Type

Exhibit 8. SUD Treatment Admissions of Adults Ages 50+ in Nebraska, Region 7, and the United States by Insurance Type, 2012



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

In Nebraska, 71.0 percent of older adult admissions to SUD treatment were uninsured, 14.6 percent had Medicaid, 12.4 percent had Medicare, and 2.0 percent had private insurance.

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

Self-Pay	Medicaid	Other
5.1%	4.4%	90.5%

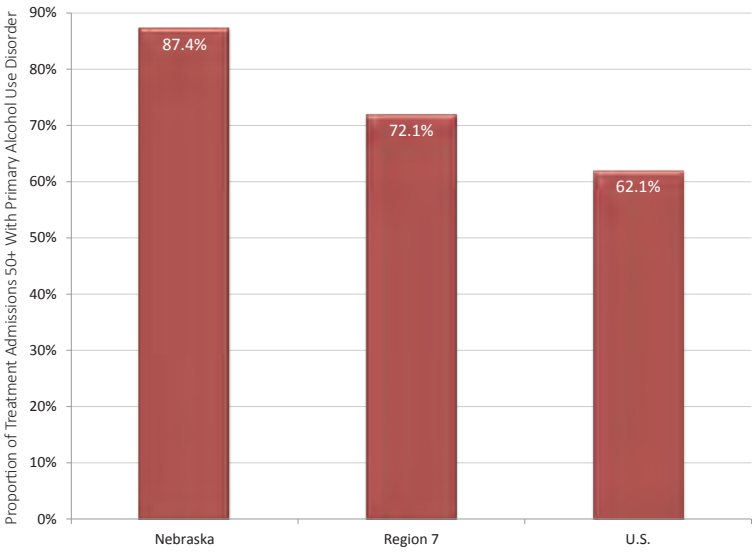
Self-pay data include private insurance.
Exhibit 8 and the accompanying text reflect the type of health insurance (if any) clients had at admission; the table above represents primary sources of payment.

[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 Nebraskans Ages 50+

Alcohol was the most frequently cited substance used by older Nebraskans in publicly financed SUD treatment in 2012. It was mentioned as a substance of use in 87.4 percent of admissions among those ages 50+. This was higher than the regional and national rates.

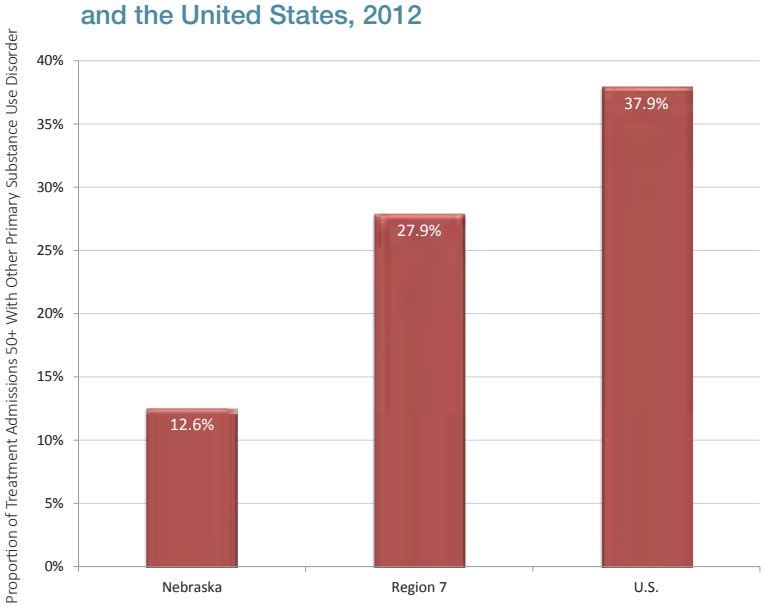
Exhibit 9. Alcohol Use Treatment Admissions of Adults Ages 50+ in Nebraska, Region 7, and the United States, 2012



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 Nebraska, Region 7, 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 12.6 percent of older adult admissions to publicly funded treatment in Nebraska.

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*:

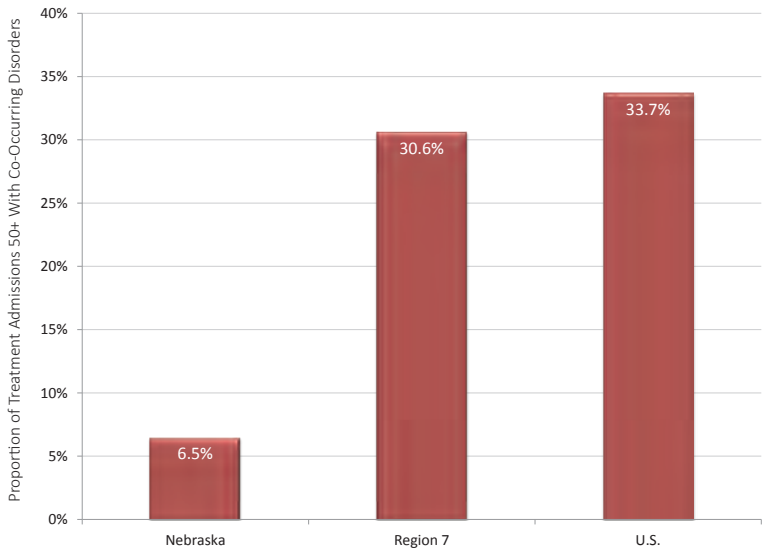
- *In 2004, there were an estimated 115,803 ED visits involving pharmaceutical misuse and abuse by adults aged 50 or older; in 2008, there were 256,097 such visits, representing an increase of 121.1 percent*
- *One fifth (19.7 percent) of ED visits involving pharmaceutical misuse and abuse among older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

Exhibit 11. SUD Treatment Admissions of Adults Ages 50+ With a Co-Occurring Mental Disorder in Nebraska, Region 7, 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.

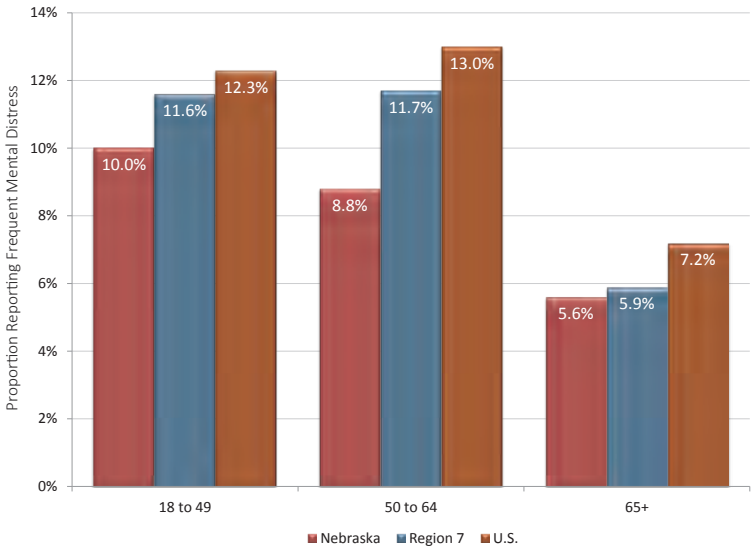
Exhibit 11 shows the proportion of SUD treatment admissions of Nebraskans ages 50+ with a co-occurring mental disorder. This rate is lower than the regional rate and the national average. However, state reporting practices are a factor in these results.

MENTAL HEALTH

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

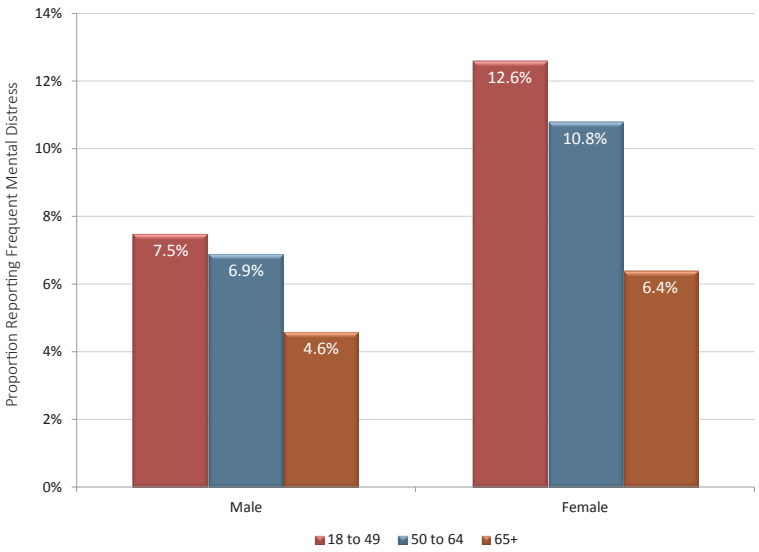
Exhibit 12. Individuals Reporting Frequent Mental Distress in Nebraska, Region 7, and the United States, 2013



Source: BRFSS, 2013

Older Nebraskans Reporting Frequent Mental Distress by Age Group and Sex

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



Source: BRFSS, 2013

Older men in Nebraska were more likely to indulge in binge drinking, but older women were more likely to report that they had FMD (14 days or more per 30-day period). As Exhibit 13 shows, 10.8 percent of women in the 50–64 age group and 6.4 percent in the 65+ age group reported FMD, while 6.9 percent of men in the 50–64 age group and 4.6 percent in the 65+ age group reported FMD.

Other Measures of Mental Health

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

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

Exhibit 14 presents the results of these surveys among older Nebraskans.

Exhibit 14. BRFSS Measures, 2010

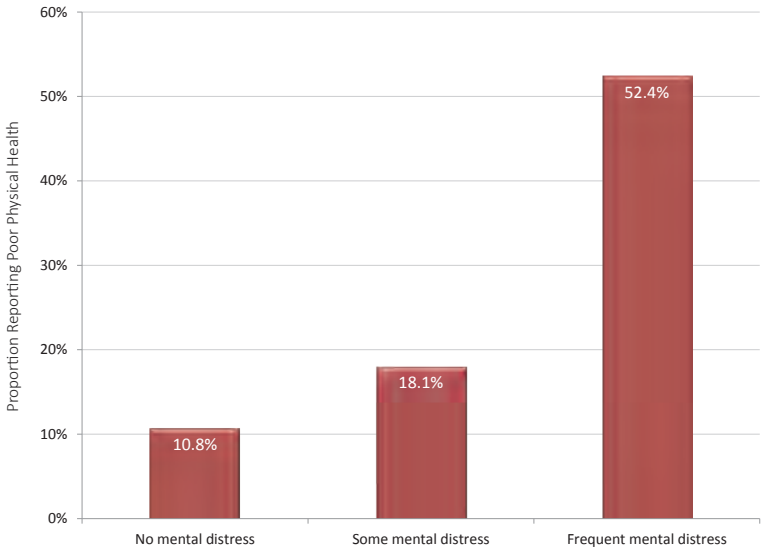
Indicator	Ages 50+	Ages 50–64	Ages 65+
Rarely or never get social or emotional support	9.7%	6.5%	13.9%
Dissatisfied or very dissatisfied	3.8%	4.3%	3.2%

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

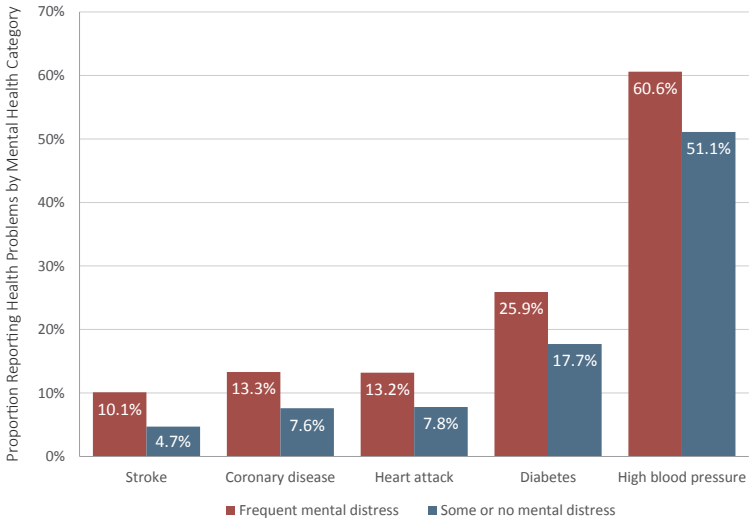


Source: BRFSS, 2013

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 Nebraskans Admitted to State Mental Health Services

Approximately 2.4 percent of the people served by the Nebraska mental health system were ages 65 and older. This represents more than 530 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.