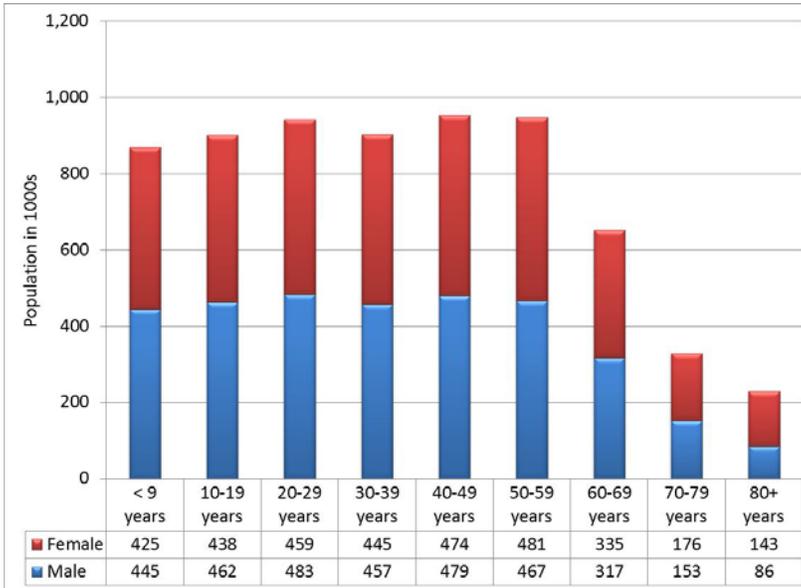


POLICY ACADEMY STATE PROFILE

Washington's Population

WASHINGTON POPULATION (IN 1000S) BY AGE GROUP



Source: U.S. Census Bureau, 2010

Washington is home to more than 6.8 million people. Nearly 2.2 million (32.1 percent) are over 50; more than 1.2 million (18.0 percent) are over 60; more than 557,000 (8.3 percent) are over 70; and more than 228,000 (3.4 percent) are over 80. The proportion of females rises steadily to 62.4 percent of the age group 80 and older. The racial/ethnic composition of Washingtonians is as follows:

Race/Ethnicity of Washingtonians

Age	White	Black	Am Indian AK Native	Other	White not Hispanic
<55	76.3%	3.9%	1.6%	18.2%	69.6%
55+	88.7%	2.2%	1.0%	8.2%	86.8%

Source: U.S. Census Bureau, 2009 Projections

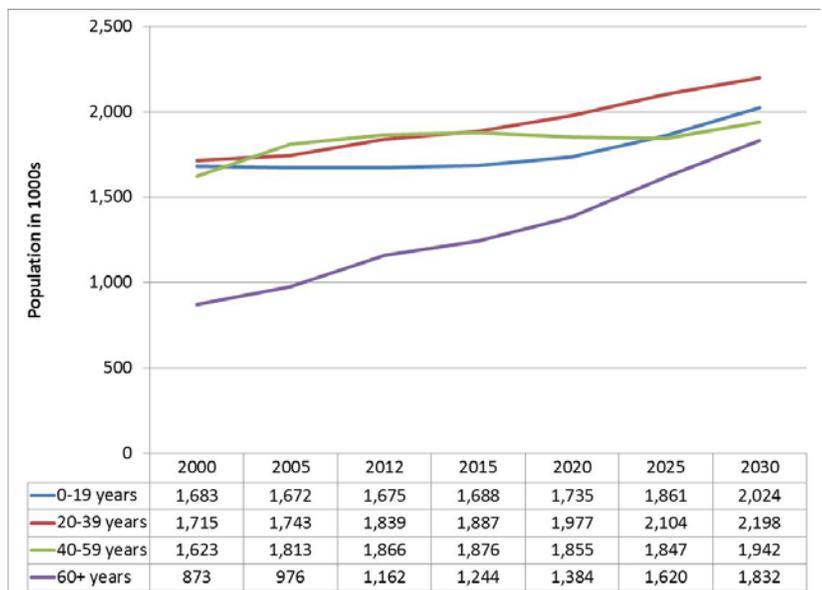
THE NUMBER OF OLDER WASHINGTONIANS IS GROWING (POPULATION IN 1000S)

The proportion of Washington's population that is over 60 is growing more rapidly than other segments of the population. The U.S. Census Bureau estimates that about 23 percent of Washington's population will be over age 60 by the year 2030, an increase of 29 percent from 2012.

Projected Washington Population

Age Group	2012	2020	2030
0 to 19	25.6%	25.0%	25.3%
20 to 39	28.1%	28.4%	27.5%
40 to 59	28.5%	26.7%	24.3%
60+	17.8%	19.9%	22.9%

Source: U.S. Census Bureau, 2009 Projections



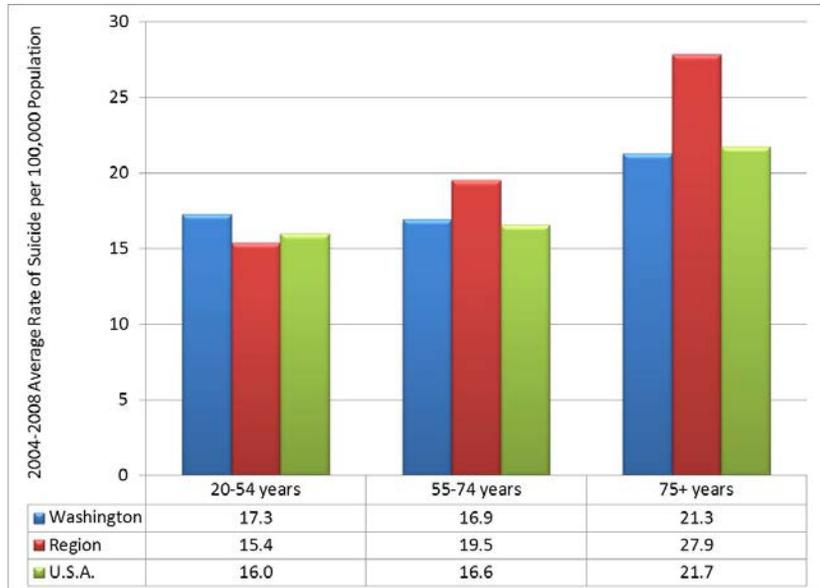
Source: U.S. Census Bureau, 2009 Projections

Suicide Among Older Washingtonians

2004-2008 NATIONAL AND REGIONAL SUICIDE RATE PER 100,000 POPULATION

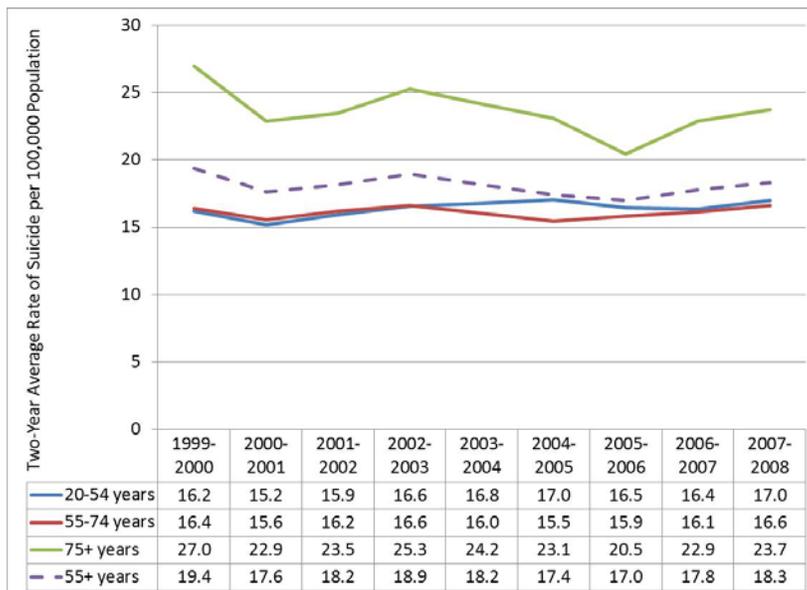
The suicide rate among Washingtonians age 55 and older is slightly higher than the rate among those in the 20-54 year age group. This is primarily due to the high rate in the 75 and older group. Washington suicide rates appear to be roughly akin to rates the National and the surrounding region which includes Alaska, Arizona, California, Hawaii, Idaho, Nevada, and Oregon in addition to Washington.

Please Note: The rate reported here represents the 2004-2008 five-year average rate of suicide per 100,000 in population. Because the number of suicides is small next to the base population number used to calculate rates, a small change in the number of suicides can cause a large apparent swing in the rate. The five-year average rate is presented here because it provides some stability to the apparent rate. States also vary in their reporting practices surrounding suicide deaths. The apparent rate of suicide is influenced by these reporting practices.



Source: Centers for Disease Control, Vital Statistics 2008

WASHINGTON SUICIDE TREND



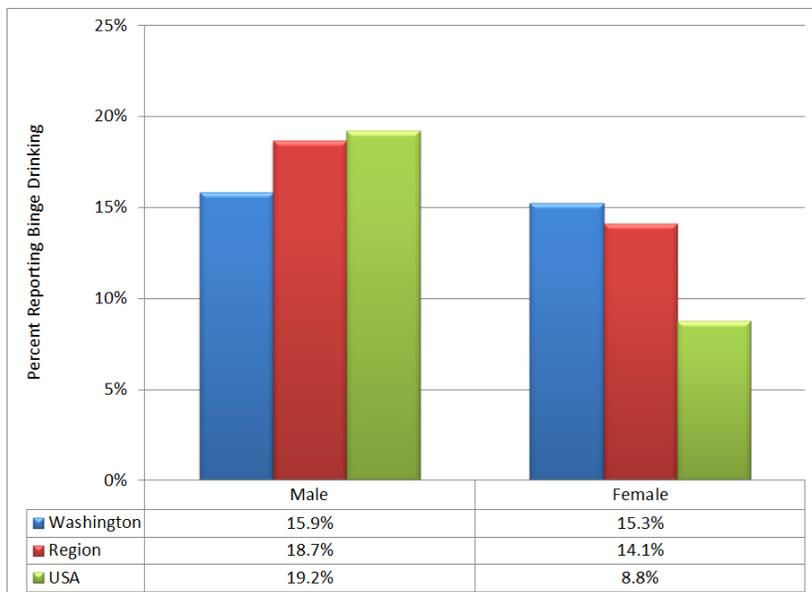
Source: Centers for Disease Control Vital Statistics, 2009

Over the past decade, the two-year moving average rate of suicide among Washingtonians age 55+ and older - shown with the dashed line - has fluctuated from a high of 19.4 to a low of 17.0 per 100,000 in population. This rate has remained consistently above the rate in younger age groups, and consistently highest in the 75 and older group.

Please Note: States may vary in their reporting practices surrounding suicide deaths from year to year within the same state. The number of suicides is generally low, so even a small difference in reported numbers may make the rate appear to fluctuate widely.

Older Washingtonians' Substance Use/Abuse

30-DAY BINGE DRINKING AMONG OLDER WASHINGTONIANS BY GENDER



Source: Behavioral Risk Factor Surveillance System, 2011

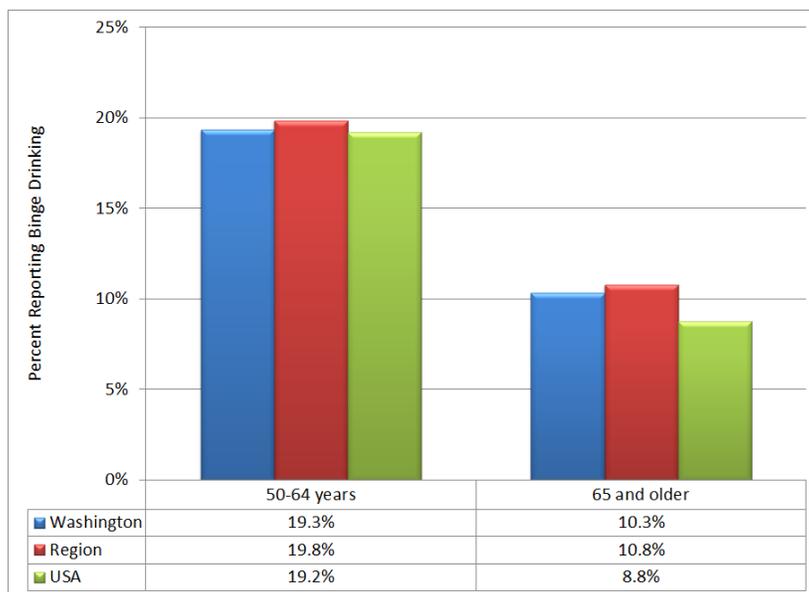
Duke Medicine News (August 17, 2009) notes that binge drinking can cause: “serious problems, such as stroke, cardiovascular disease, liver disease, neurological damage and poor diabetes control.” Binge drinkers are more likely to take risks like driving while intoxicated, and to experience falls and other accidents. Older people have less tolerance for alcohol. Therefore, this table defines a “binge” as 3 or more drinks in one event for women and 4 or more for men. Binge drinking is consistently highest among men. While overall 15.5 percent of Washingtonians age 50 and older reported binge drinking, 19.3 percent of males and 10.3 percent of females did so. The confidence intervals are less than ± 0.2 and ± 2.0 percent for the regional/national and Washington estimates respectively.

30-DAY BINGE DRINKING AMONG OLDER WASHINGTONIANS BY AGE GROUP

Binge drinking tends to decrease with age. 19.3 percent of Washingtonians in the 50-64 year age group reported binge drinking, while 10.3 percent of those in the 65 and older group reported similar behavior. The confidence intervals are less than ± 0.2 and ± 2.0 percent for the regional / national and Washington estimates respectively. The following table provides a breakdown by age and gender:

Washingtonians Reporting Binge Drinking by Age and Gender

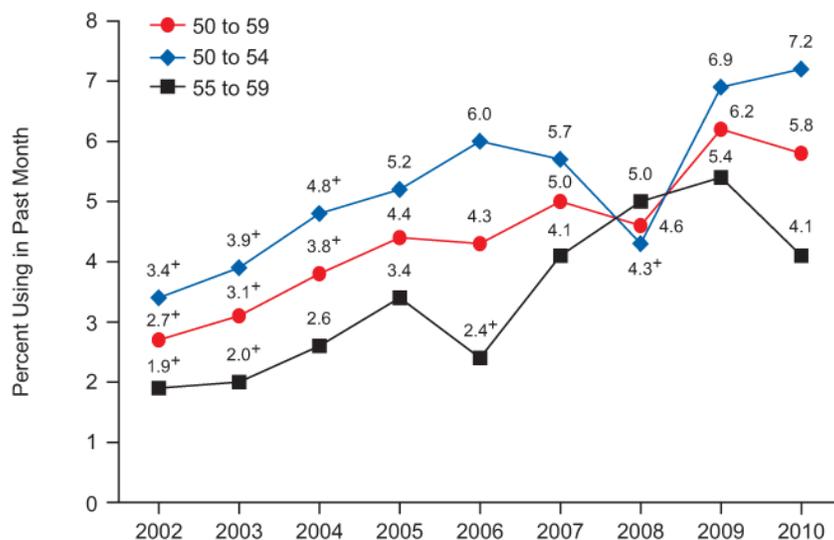
	Male	Female
50-64 years	19.1%	19.5%
65 and older	11.2%	9.7%



Source: Behavioral Risk Factor Surveillance System, 2011

ILLICIT DRUG USE AMONG OLDER AMERICANS

Nationally, illicit drug use has more than doubled among 50-59 year olds since 2002. The rate rose from 3.4 to 7.2 percent among 50-54 year olds and from 1.9 to 4.1 percent among 55-59 year olds. According to the Substance Abuse and Mental Health Services Administration, “These patterns and trends partially reflect the aging into these age groups of members of the baby boom cohort, whose rates of illicit drug use have been higher than those of older cohorts.” Specific data about substance abuse among older Washingtonians are not available; however the SAMHSA NSDUH Report (<http://www.oas.samhsa.gov/2k9state/Cover.pdf>), provides general information about substance use in Washington.



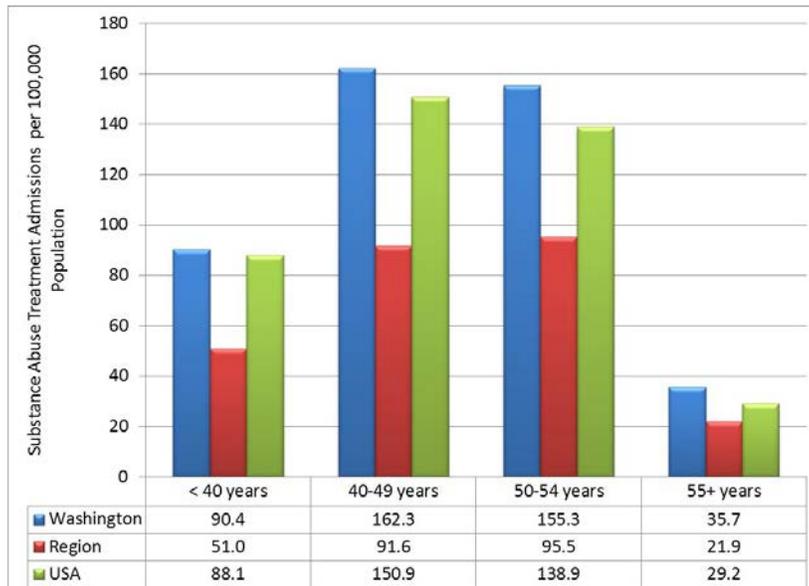
Source: National Survey on Drug Use and Health, 2010
Volume 1. Summary of National Findings

DRUG-RELATED EMERGENCY DEPARTMENT VISITS INVOLVING PHARMACEUTICAL MISUSE AND ABUSE BY OLDER ADULTS

The Substance Abuse and Mental Health Service Administration’s Center for Behavioral Health Statistics and Quality periodically releases reports from the Drug Abuse Warning Network (DAWN). DAWN comprises a nationwide network of hospital emergency rooms (ER) primarily located in large metropolitan areas. DAWN data consist of professional reviews of ER records to determine the likelihood and extent to which alcohol and other drug abuse was involved. The November 25, 2010, DAWN Report showed that (quote):

- *In 2004, there were an estimated 115,803 emergency department (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*

SUBSTANCE ABUSE TREATMENT ADMISSIONS AMONG WASHINGTONIANS AGE 50 AND OLDER

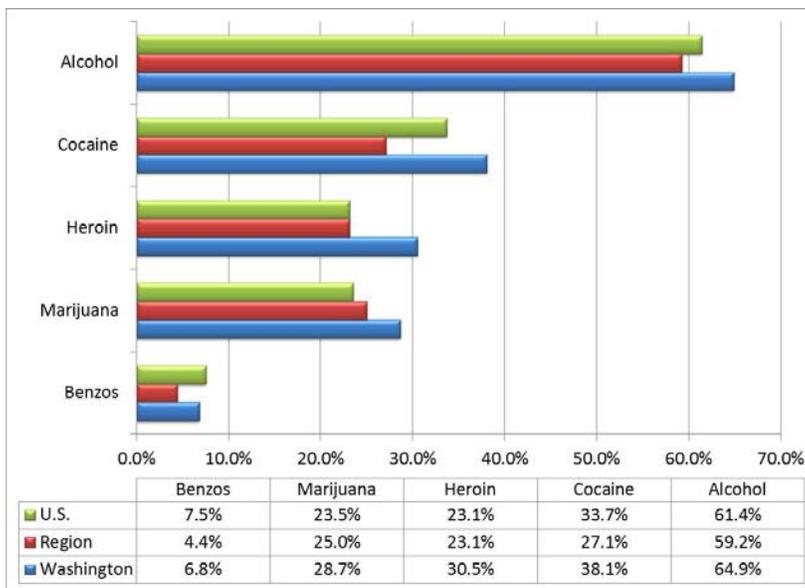


Washingtonians age 50 and older accounted for 1,363 admissions to public substance abuse treatment in 2009. This represented a rate of 63.2 admissions per 100,000 in population. The admission rate was much higher in the 50-54 year than the 55 and older group, and roughly akin to the rate in the 40-49 year age group. The rates are higher than rates in the Western Region but close to the rates in the Nation.

Source; Treatment Episode Data Set, 2009¹
Includes only those clients reported to SAMHSA

AGE 55+ TREATMENT ADMISSIONS - SUBSTANCES USED

Alcohol was - by far - the most frequent drug of use among Washingtonians age 50 and older in publicly financed substance abuse treatment in 2009. Alcohol was mentioned as the primary, secondary or tertiary substance of abuse in nearly 65 percent of admissions in this age group. It was followed by cocaine at 38.1 percent; heroin at 30.5 percent; marijuana at 28.7 percent and benzodiazepines/other tranquilizers at 6.8 percent.



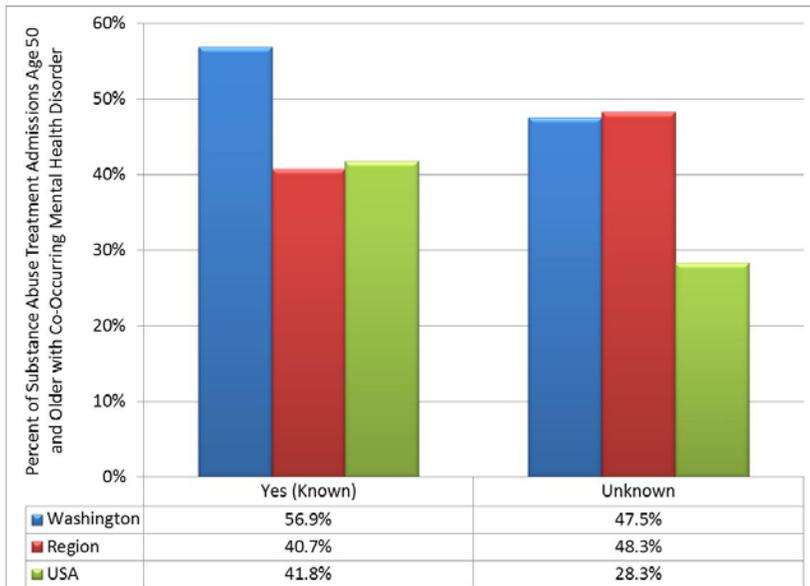
Source; Treatment Episode Data Set, 2009²

Please note: Data include only those clients reported to SAMHSA.

¹ TEDS Limitations: TEDS data are collected by states that accept Substance Abuse Prevention and Treatment (SAPT) Block Grant funds. Guidelines suggest that states should report all clients admitted to publicly financed treatment; however, states are inconsistent in applying the guidelines. States also have freedom to 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.

² TEDS Limitations: TEDS data are collected by states that accept Substance Abuse Prevention and Treatment (SAPI) Block Grant funds. Guidelines suggest that states should report all clients admitted to publicly financed treatment; however, states are inconsistent in applying

CO-OCCURRING MENTAL HEALTH DISORDER



Research shows a strong relationship between substance use and mental health disorders. Studies show 30-80 percent of people with substance abuse or mental health disorders also have a co-occurring substance abuse/mental health disorder. Nearly 60 percent of Washingtonians age 50 and older who were admitted to substance abuse treatment also had a mental health diagnosis. While this rate appears higher than the Nation and the Western Region, reporting practices are a factor in these results.

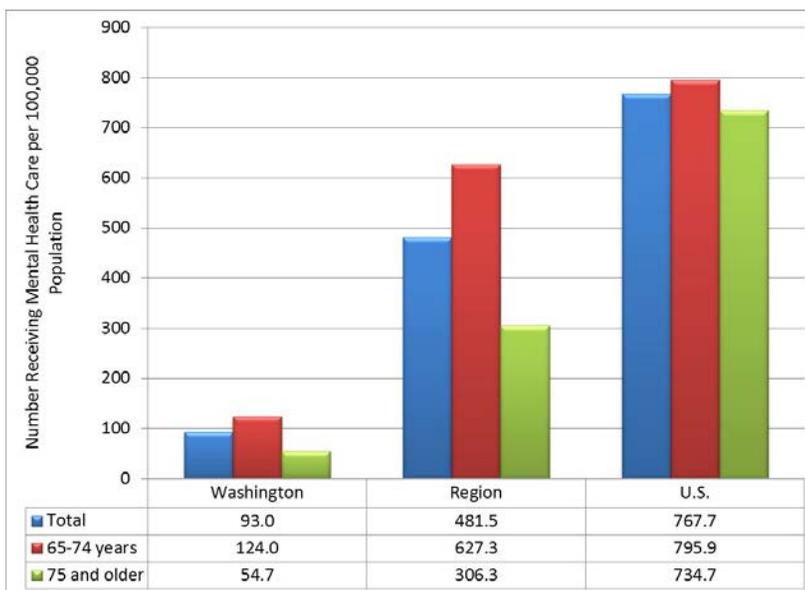
Source: Treatment Episode Data Set, 2009
Includes only those clients reported to SAMHSA

Mental Health

OLDER WASHINGTONS ADMITTED TO STATE MENTAL HEALTH FACILITIES

Nearly 4 percent of the people served by the Washington mental health system were age 65 or older (2.8 percent were age 65 to 74 and 1.0 percent were age 75 or older). This represents a total of approximately 769 people. This and more information about the Washington mental health system can be found at:

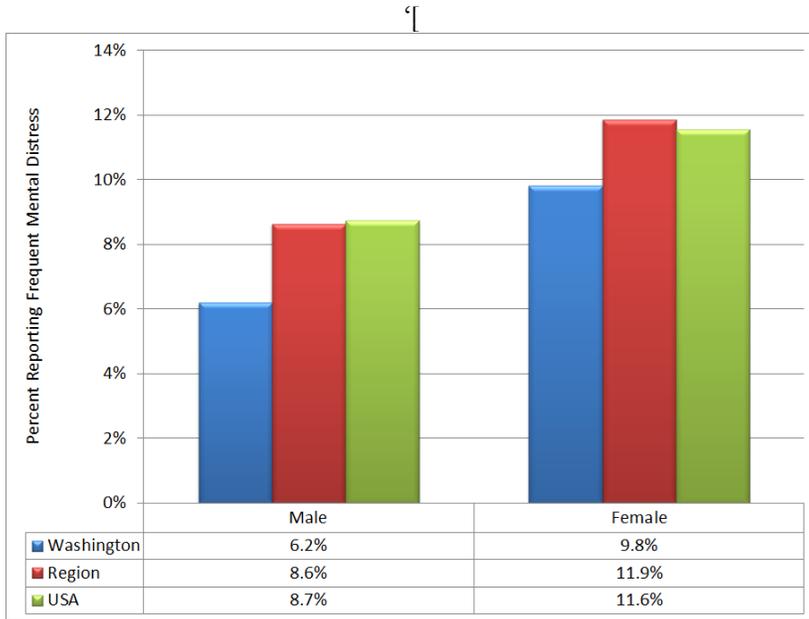
<http://www.samhsa.gov/dataoutcomes/urs/2010/Washington.pdf>



Source: Center for Mental Health Services, Uniform Reporting System, 2010

the guidelines. States also have freedom to 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.

OLDER WASHINGTONIANS REPORTING FREQUENT MENTAL DISTRESS BY GENDER



Source: Behavioral Risk Factor Surveillance System, 2011

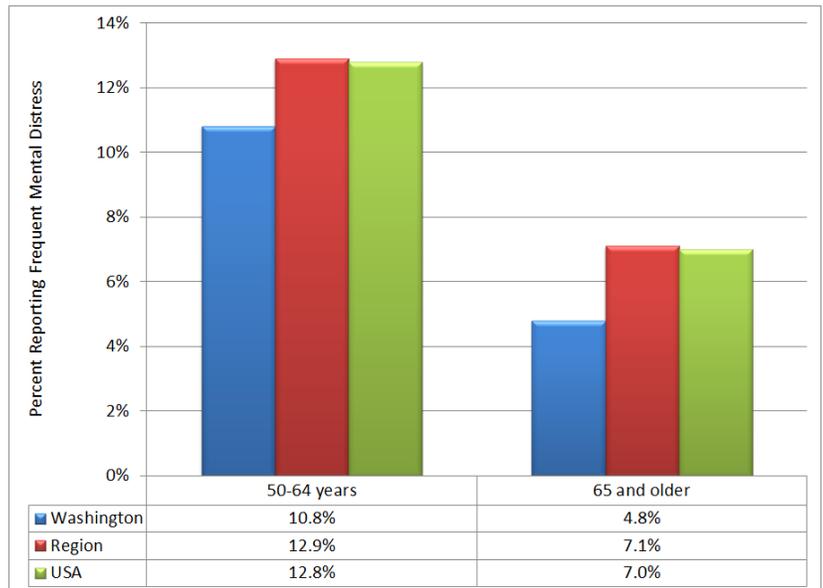
The Behavioral Risk Factor Surveillance System (BRFSS), a household survey conducted in all 50 states and several territories, asks the following question: “Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?” The Centers for Disease Control defines those individuals reporting 14 or more “Yes” days in response to this question as experiencing frequent mental distress (FMD). Females are consistently more likely than males to report FMD. While 8.3 percent of Washingtonians age 50 and older reported FMD, 9.8 percent of females and 6.2 percent of males did so. Confidence intervals around national/regional and Washington estimates are less than ± 0.2 and ± 2.0 percent respectively.

OLDER WASHINGTONIANS REPORTING FREQUENT MENTAL DISTRESS BY AGE GROUP

Individuals in the 65 and older age group are consistently less likely to report FMD. While 10.8 percent of Washingtonians in the 50-64 age group reported FMD, 4.8 percent in the 65 and older group did so. Confidence intervals around national/regional and Washington estimates are less than ± 0.2 and ± 2.0 percent respectively. The following table provides a breakdown by gender and age group:

Older Washingtonians Reporting FMD by Age Group and Gender

	Male	Female
50-64 years	8.0%	13.1%
65 and older	3.7%	5.6%



Source: Behavioral Risk Factor Surveillance System, 2011

OTHER MEASURES OF MENTAL HEALTH

The Behavioral Risk Factor Surveillance System (BRFSS) collected other measures showing risk factors for mental and/or physical illness. These included:

- Social and Emotional Support (2010). The BRFSS asked, “How often do you get the social and emotional support you need?” The responses included: “always,” “usually,” “sometimes,” “rarely” or “never.”
- Life Satisfaction (2010). The BRFSS asked, “In general, how satisfied are you with your life?” The responses included: “Very satisfied,” “Satisfied,” “Dissatisfied” or “Very dissatisfied.”
- Current Depression (2006). In 2006, the BRFSS included a special Anxiety and Depression module which was collected in 38 states and several jurisdictions, including Washington. The measure presented below was derived from this module.
- Lifetime Diagnosis of Depression (2006). The BRFSS asked, “Has a doctor or other healthcare provider EVER told you that you have a depressive disorder (including depression, major depression, dysthymia, or minor depression)?”
- Lifetime Diagnosis of Anxiety Disorder (2006). The BRFSS asked, “Has a doctor or other healthcare provider EVER told you that you have an anxiety disorder (including acute stress disorder, anxiety, generalized anxiety disorder, obsessive-compulsive disorder, panic attacks, panic disorder, posttraumatic stress disorder, or social anxiety disorder)?”

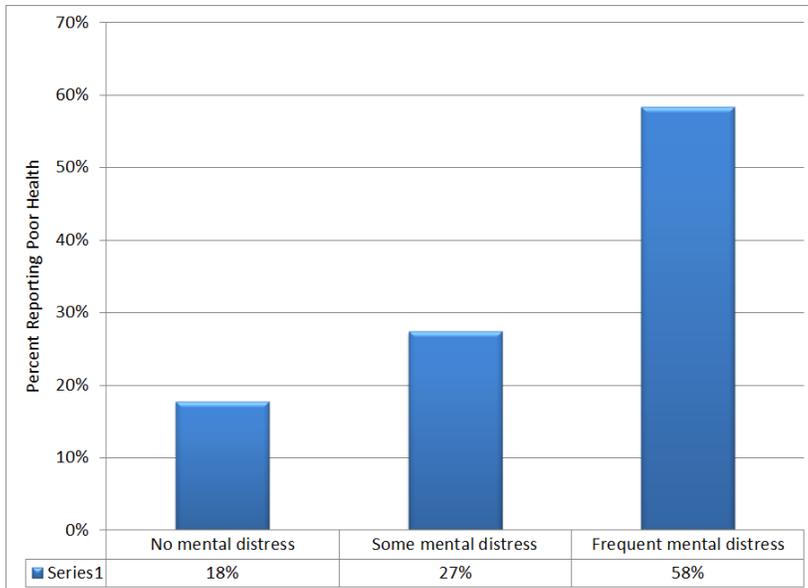
The results of these surveys among older Washingtonians are shown below:

BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM, 2010

Indicator	Age Group					
	Age 50+		Age 50–64		Age 65+	
	Data %	Confidence Interval	Data %	Confidence Interval	Data %	Confidence Interval
Core BRFSS Indicators (2010)						
Rarely or never get social or emotional support (revised)	6.1	(5.8-6.5)	5.2	(4.8-5.5)	7.7	(7.1-8.3)
Very dissatisfied or dissatisfied with life (revised)	4.8	(4.5-5.1)	6.0	(5.6-6.4)	3.0	(2.6-3.3)
Anxiety and Depression Optional Module Indicators (2006) ³						
Current Depression	5.2	(4.5-5.9)	6.1	(5.2-7.2)	3.5	(2.7-4.6)
Lifetime Diagnosis of Depression	19.3	(18.1-20.5)	23.8	(22.1-25.6)	12.2	(10.8-13.7)
Lifetime Diagnosis of Anxiety Disorder	12.0	(11.1-13.1)	13.8	(12.5-15.3)	9.2	(8.0-10.6)

³ Data available at <http://apps.nccd.cdc.gov/MAHA/StateDetails.aspx?State=WA>

PEOPLE WITH FREQUENT MENTAL DISTRESS REPORT POOR PHYSICAL HEALTH



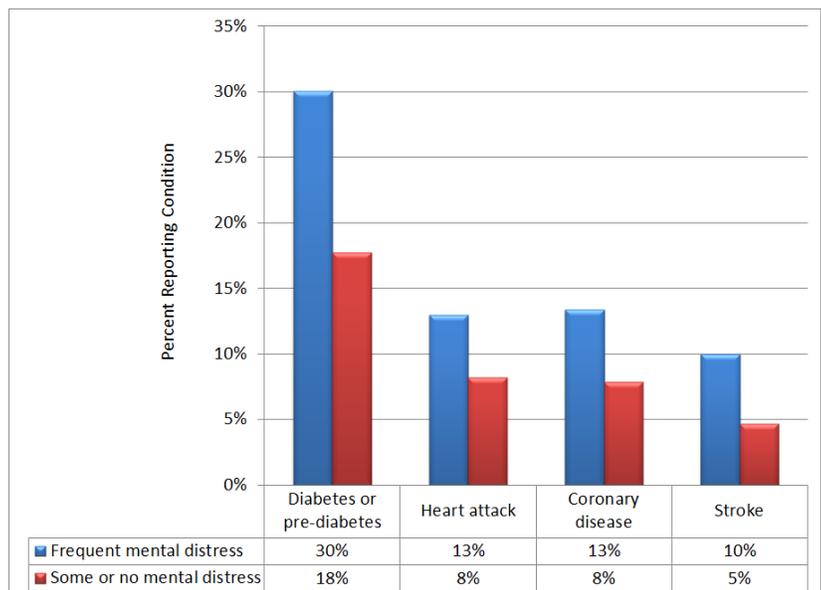
Older Americans who experienced frequent mental distress were more likely to report that their physical health was poor or fair (as opposed to good, very good or excellent). As shown here, while 18 percent of older Americans with no mental distress reported poor or fair physical health, nearly 60 percent – nearly triple the rate – of those with frequent mental distress reported poor/fair health. Older Americans with frequent mental distress were also much more likely to report that they had experienced serious health problems.

These differences are statistically significant.

Source: Behavioral Risk Factor Surveillance System, 2011

RELATIONSHIP BETWEEN MENTAL DISTRESS AND SERIOUS HEALTH PROBLEMS

Older Americans who experience frequent mental distress, such as symptoms of depression or anxiety, are more likely to report that they had chronic health problems. People with frequent mental distress experienced strokes at twice the rate of those with some or no mental distress (10 percent versus 5 percent). They experienced coronary disease, heart attack and diabetes/pre-diabetes at more than 1.5 times the rate of those with some or no mental distress (13 versus 8 percent for coronary disease and heart attack, 30 versus 18 percent for diabetes/pre-diabetes). These differences are statistically significant.



Source: Behavioral Risk Factor Surveillance System, 2011

DATA SOURCES

BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM (<http://www.cdc.gov/brfss/>). Centers for Disease Control and Prevention (CDC). *Behavioral Risk Factor Surveillance System Survey Data*. Atlanta, Georgia: U.S. Department of Health and Human Services, 2010 and 2011. The BRFSS is “the world’s largest, on-going telephone health survey system, tracking health conditions and risk behaviors in the United States yearly since 1984. Currently, data are collected monthly in all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and Guam.” BRFSS data are collected by local jurisdictions and reported to the CDC.

VITAL STATISTICS (<http://www.cdc.gov/nchs/nvss.htm>). Centers for Disease Control and Prevention (CDC), *National Vital Statistics System*, Atlanta, Georgia: U.S. Department of Health and Human Services, 2009. The CDC Web site describes the National Vital Statistics System as “the oldest and most successful example of inter-governmental data sharing in Public Health and the shared relationships, standards, and procedures form the mechanism by which NCHS collects and disseminates the Nation's official vital statistics. These data are provided through contracts between NCHS and vital registration systems operated in the various jurisdictions legally responsible for the registration of vital events – births, deaths, marriages, divorces, and fetal deaths.”

CENTER FOR MENTAL HEALTH SERVICES UNIFORM REPORTING SYSTEM (URS) (<http://www.samhsa.gov/dataoutcomes/urs/>). Center for Mental Health Services (CMHS), *Uniform Reporting System*, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2010. States that receive CMHS Block Grants are required to report aggregate data to the URS. URS reports including information about utilization of mental health services as well as client demographic and outcome information.

NATIONAL SURVEY ON DRUG USE AND HEALTH (NSDUH) (<https://nsduhweb.rti.org/>). United States Department of Health and Human Services. Substance Abuse and Mental Health Services Administration. Center for Behavioral Health Statistics and Quality. National Survey on Drug Use and Health, 2010. ICPSR32722-v1. Ann Arbor, MI: Inter-university Consortium for Political and Social Research [distributor], 2011-12-05. doi:10.3886/ICPSR32722.v1 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 substance abuse treatment. NSDUH data also include information about mental health needs.

TREATMENT EPISODE DATA SET (TEDS) (<http://www.icpsr.umich.edu/icpsrweb/SAMHDA/>). United States Department of Health and Human Services. Substance Abuse and Mental Health Services Administration. Office of Applied Studies. Treatment Episode Data Set -- Admissions (TEDS-A), 2009. ICPSR30462-v2. Ann Arbor, MI: Inter-university Consortium for Political and Social Research [distributor], 2012-07-18. doi:10.3886/ICPSR30462.v2 States that participate in the Substance Abuse Prevention and Treatment (SAPT) Block Grant submit individual client data to the TEDS. The TEDS includes both admission and discharge data sets, and some 1.5 million admissions are reported annually. TEDS includes information about utilization of substance abuse treatment services as well as client demographic and outcome information.

U.S. CENSUS BUREAU (<http://www.census.gov/people/>). Two main sources of Census Bureau data were used in this report: (1) Population estimates, and (2) Population projections. Population projections and estimates were created using 2010 Census Data.

This profile was developed by the Substance Abuse and Mental Health Services Administration in partnership with the U.S. Administration on Aging.