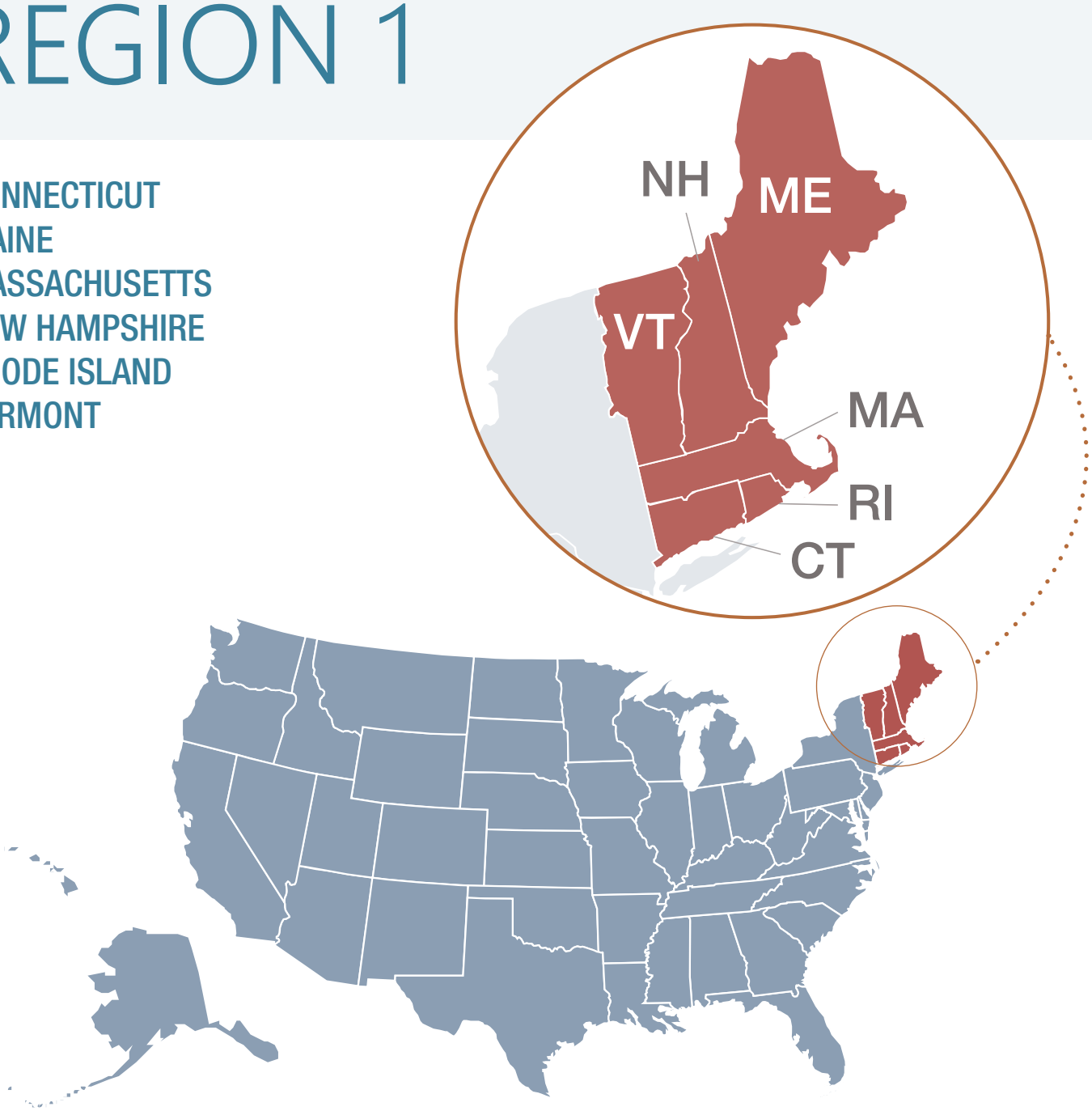
# OLDER ADULTS BEHAVIORAL HEALTH PROFILES

# REGION 1

CONNECTICUT
MAINE
MASSACHUSETTS
NEW HAMPSHIRE
RHODE ISLAND
VERMONT




**A Behavioral Health Resource**

SAMHSA's State Technical Assistance Contract

February 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

# Connecticut

# Connecticut

## OLDER ADULTS BEHAVIORAL HEALTH PROFILE

February 2016

## CONNECTICUT'S POPULATION

### Connecticut Population by Age Group

Connecticut is home to 3,596,677 people. Of these:

- 1,328,275 (36.9 percent) are over age 50.
- 774,577 (21.5 percent) are over age 60.
- 378,820 (10.5 percent) are over age 70.
- 161,457 (4.5 percent) are ages 80 and older.

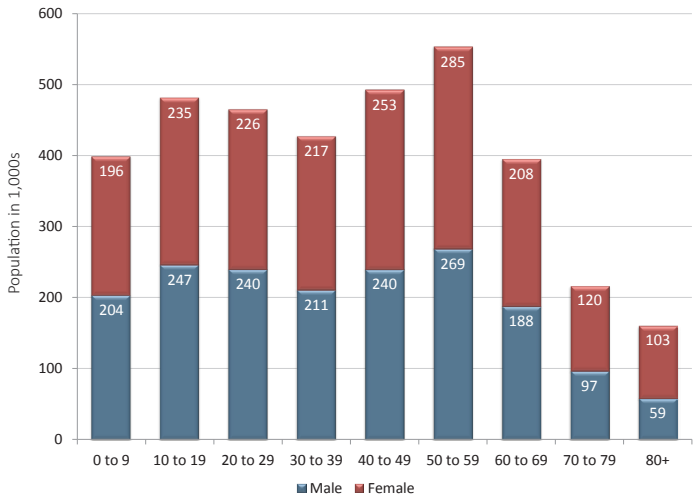
The proportion of women rises fairly steadily in each age group, and women make up 63.7 percent of the 80+ group. The racial/ethnic composition of older Connecticuters is as follows:

*Race/Ethnicity of Connecticuters Ages 50+*

| White | AI/AN | Black | Asian | NH/PI | Other | Hispanic |
|---|---|---|---|---|---|---|
| 88.1% | 0.3% | 8.1% | 2.7% | 0.1% | 0.8% | 7.2% |

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

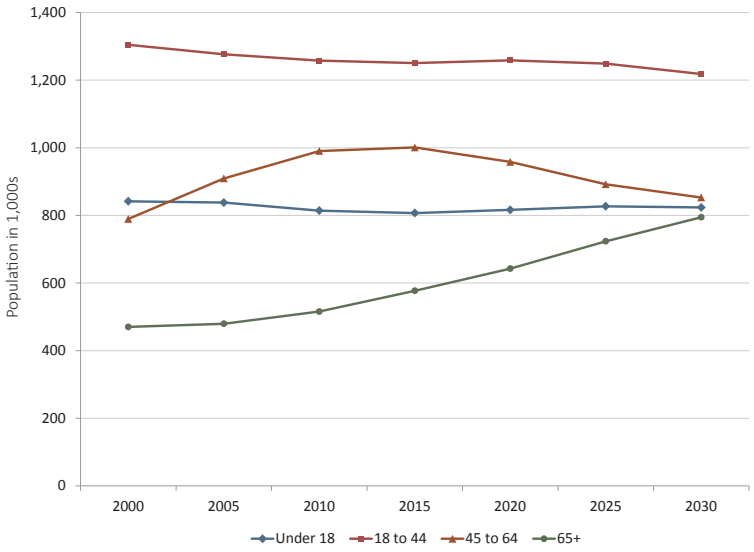
Exhibit 1. Connecticut Population by Age Group, 2014




Source: U.S. Census Bureau, 2015

### The Number of Older Connecticuters Is Growing

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




The proportion of Connecticut'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 21.5 percent of Connecticut's population will be 65 and older by the year 2030, an increase of 37.7 percent from 2015.

*Projected Population in Connecticut*

| Age Group | 2015 | 2025 | 2030 |
|---|---|---|---|
| Under 18 | 22.2% | 22.4% | 22.3% |
| 18 to 44 | 34.4% | 33.8% | 33.0% |
| 45 to 64 | 27.5% | 24.2% | 23.1% |
| 65+ | 15.9% | 19.6% | 21.5% |

Source: U.S. Census Bureau, 2005

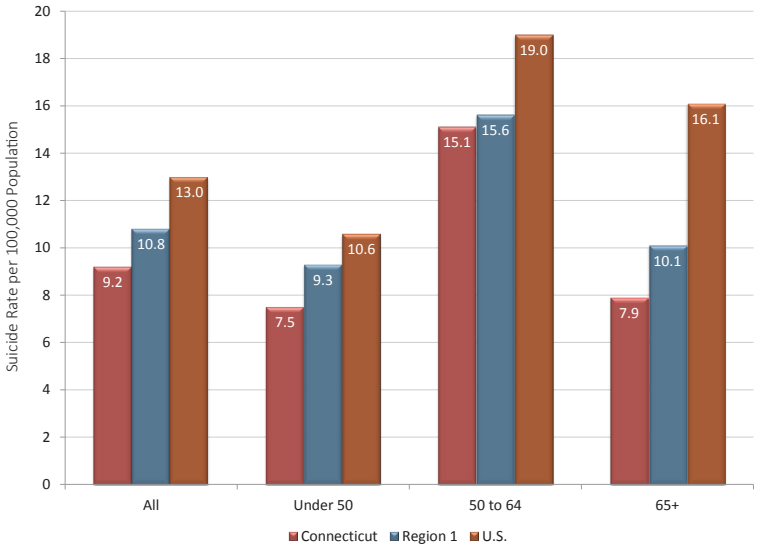
# SUICIDE AMONG OLDER CONNECTICUTERS

## Connecticut Suicide Rate Compared With Regional and National Rates

The suicide rate among Connecticuters ages 50 and older is higher than the rate among younger age groups. In 2013, the total suicide rate among all people ages 50+ was 12.1 per 100,000 people (4.7 for women and 20.7 for men). The rate among those ages 50–64 was lower than both the rate in the region (including Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont) and the rate in the United States.

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

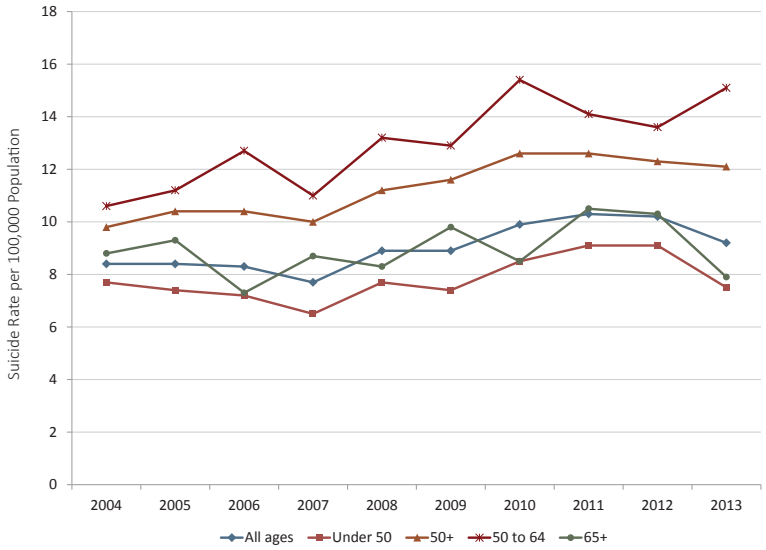
**Exhibit 3. Suicide Rates in Connecticut, Region 1, and the United States, 2013**




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 Connecticut

**Exhibit 4. Trends in Suicide Rates in Connecticut 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 Connecticuters ages 50+ fluctuated from a low of 9.9 per 100,000 in 2004 to a high of 12.6 per 100,000 in 2010. From 2004 to 2013, the rate was highest among those in the 50–64 age group.

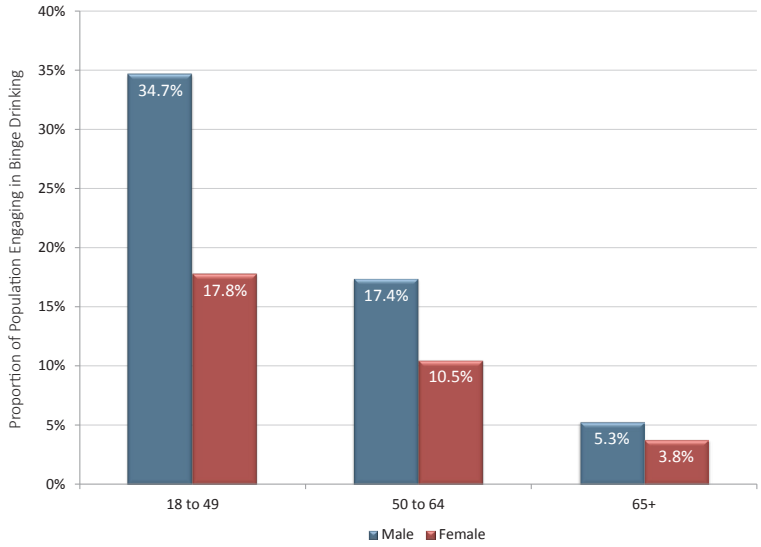
How a state reports suicides can vary from year to year. The number of suicides is generally low, so even a small difference in reported numbers may make the rate fluctuate widely.

# SUBSTANCE USE DISORDER AND SUBSTANCE USE DISORDER TREATMENT AMONG OLDER CONNECTICUTERS

## 30-Day Binge Drinking Among Older Connecticuters

Binge drinking, defined as five or more drinks for men and four or more drinks for women on a single occasion, can lead to serious health problems. Such problems include neurological damage, cardiovascular disease, liver disease, stroke, and poor control of diabetes. Binge drinkers are more likely to take risks such as driving while intoxicated and to experience falls and other accidents. Older people have a lower tolerance for alcohol. Binge drinking decreases with age and occurs more frequently among men than it does among women. As Exhibit 5 shows, 17.4 percent of Connecticut men ages 50–64 reported binge drinking in the past 30 days, while 5.3 percent of those in the 65+ group reported similar behavior.

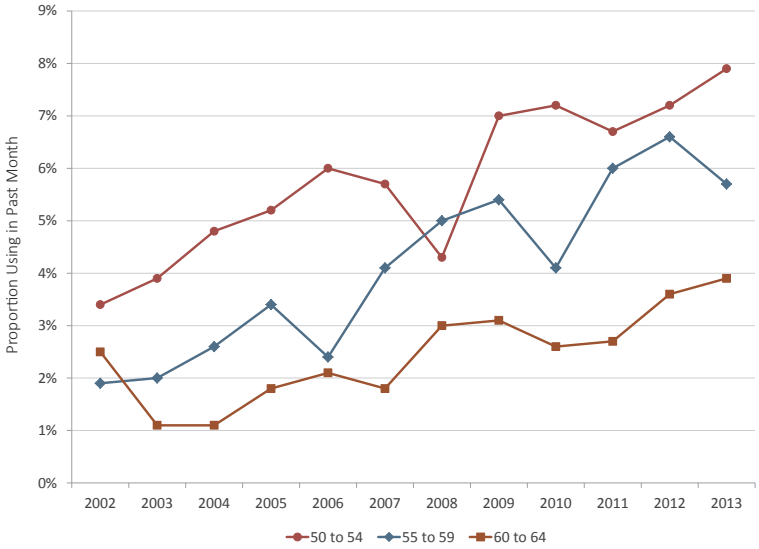
**Exhibit 5. Binge Drinking Rates in Connecticut by Age Group and Sex, 2013**




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 *Connecticut 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).

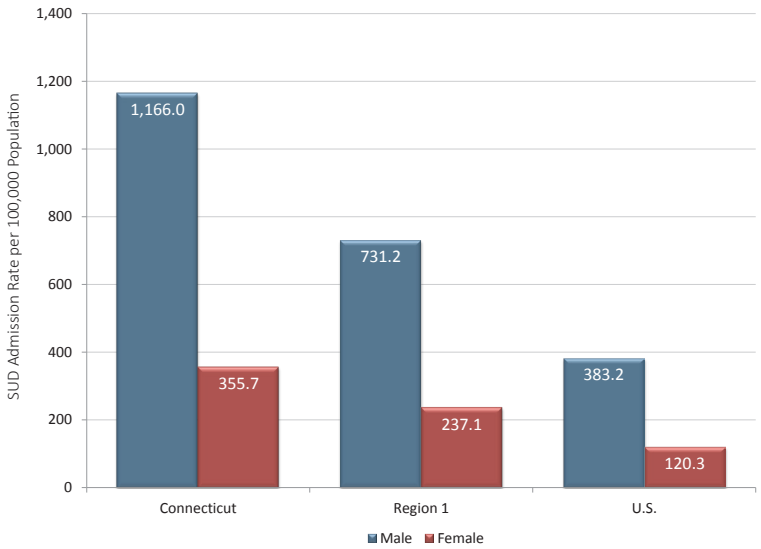
## Admissions to Substance Use Disorder Treatment Among Older Connecticuters

In 2012, there were 9,693 admissions of Connecticuters ages 50 and older to substance use disorder (SUD) treatment in state-funded treatment programs, a rate of 729.7 per 100,000 people ages 50+. This rate was higher than the regional rate and the national average. Men made up 73.8 percent of these admissions. Of all admissions, 65.1 percent were White/Caucasian, 20.5 percent were Black/African American, and 13.7 percent were Hispanic.

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

| Self-Referral | Criminal Justice | Other |
|---|---|---|
| 48.6% | 21.4% | 30.0% |

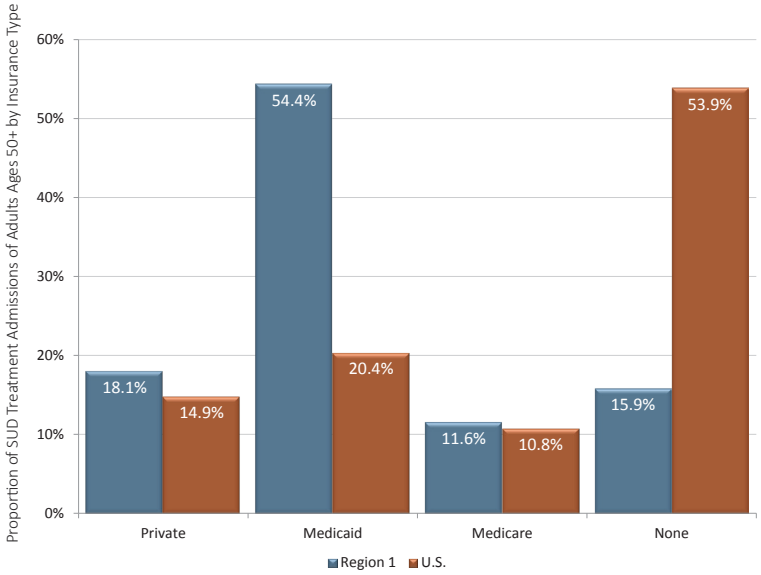
**Exhibit 7. SUD Treatment Admissions of Adults Ages 50+ in Connecticut, Region 1, and the United States by Sex, 2012**




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

## SUD Treatment Admissions Among Individuals in Region 1 Ages 50+ by Insurance Type

**Exhibit 8. SUD Treatment Admissions of Adults Ages 50+ in Region 1 and the United States by Insurance Type, 2012**




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

States may choose not to report some of the fields to TEDS, including information on treatment admission insurance types. These data were not reported by Connecticut in 2012. Therefore, the rates for Region 1 are used instead.

In Region 1, 15.9 percent of older adult admissions to SUD treatment were uninsured, 54.4 percent had Medicaid, 11.6 percent had Medicare, and 18.1 percent had private insurance.

### *SUD Treatment Admissions Among Connecticuters Ages 50+ by Primary Sources of Payment*

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

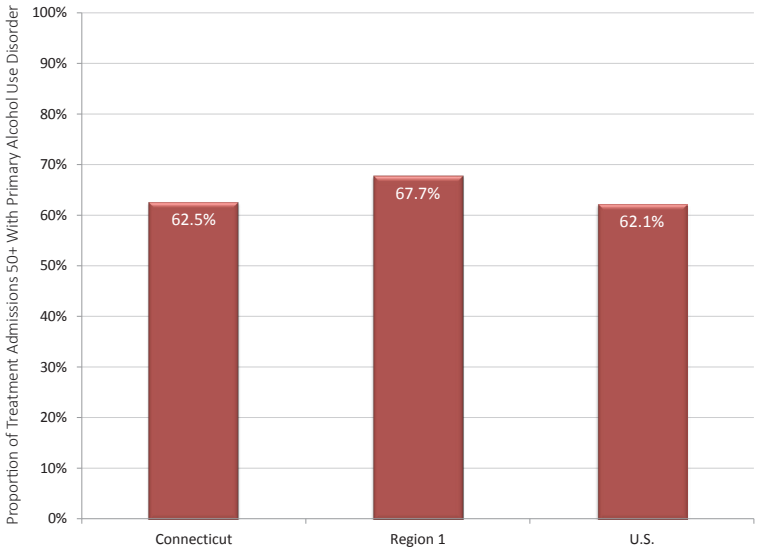
Exhibit 8 and the accompanying text reflect the type of health insurance (if any) clients had at admission; the table above represents primary sources of payment.

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

## Alcohol Use Disorder Treatment Admissions Among Connecticuters Ages 50+

Alcohol was the most frequently cited substance used by older Connecticuters in publicly financed SUD treatment in 2012. It was mentioned as a substance of use in 62.5 percent of admissions among those ages 50+. This was lower than the regional rate and higher than the national rate.

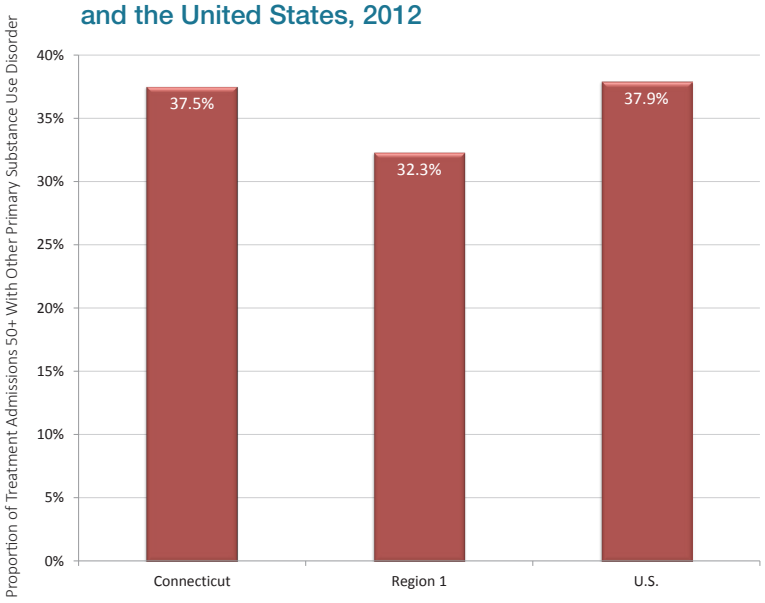
**Exhibit 9. Alcohol Use Treatment Admissions of Adults Ages 50+ in Connecticut, Region 1, and the United States, 2012**




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 Connecticut, Region 1, 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 37.5 percent of older adult admissions to publicly funded treatment in Connecticut.

## Drug-Related Emergency Department Visits Involving Pharmaceutical Misuse and Abuse by Older Adults

SAMHSA periodically releases reports from the Drug Abuse Warning Network (DAWN). DAWN, discontinued in 2011, consisted of a nationwide network of hospital emergency departments (EDs) primarily located in large metropolitan areas. DAWN data consist of professional reviews of ED records to determine the extent to which alcohol and other substance abuse was involved in ED visits. According to the November 25, 2010, *DAWN Report*:

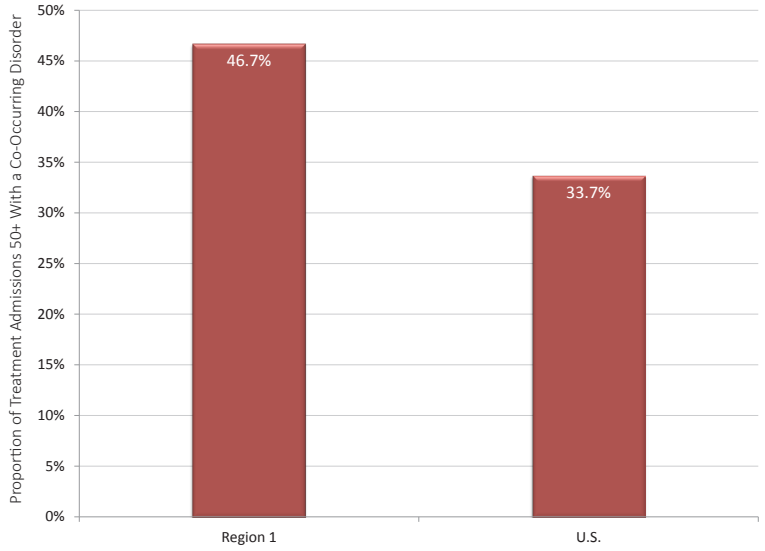
- *In 2004, there were an estimated 115,803 ED visits involving pharmaceutical misuse and abuse by adults aged 50 or older; in 2008, there were 256,097 such visits, representing an increase of 121.1 percent*
- *One fifth (19.7 percent) of ED visits involving pharmaceutical misuse and abuse among older adults were made by persons aged 70 or older*
- *Among ED visits made by older adults, pain relievers were the type of pharmaceutical most commonly involved (43.5 percent), followed by drugs used to treat anxiety or insomnia (31.8 percent) and antidepressants (8.6 percent)*
- *Among patients aged 50 or older who visited the ED for pharmaceutical misuse or abuse, more than half (52.3 percent) were treated and released, and more than one third (37.5 percent) were admitted to the hospital*

Bulleted text in italics above is taken from SAMHSA's Center for Behavioral Health Statistics and Quality. (2010, November 25). ***The DAWN Report: Drug-related emergency department visits involving pharmaceutical misuse and abuse by older adults.*** Rockville, MD: SAMHSA.

# CO-OCCURRING SUBSTANCE USE AND MENTAL DISORDERS

## Older Adults in Region 1 in SUD Treatment With Co-Occurring Mental Disorders

**Exhibit 11. SUD Treatment Admissions of Adults Ages 50+ With a Co-Occurring Mental Disorder in Region 1 and the United States, 2012**




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

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

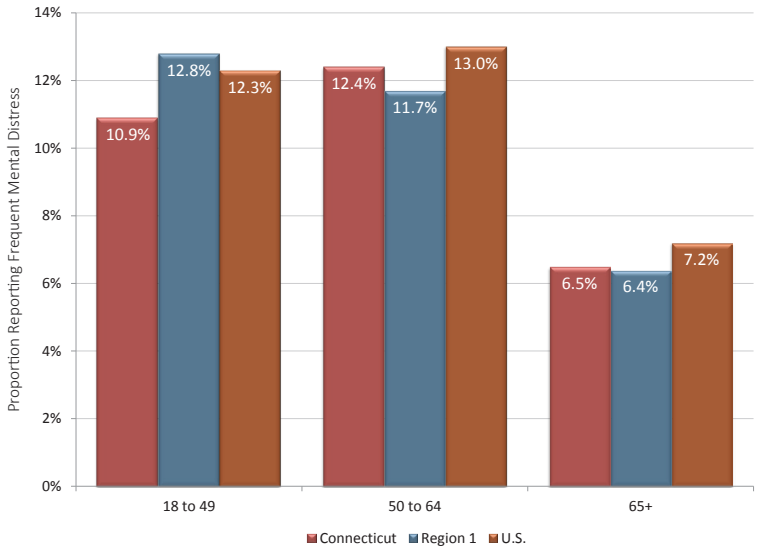
States may choose not to report some of the fields to TEDS, including information on SUD treatment admissions with a co-occurring disorder. These data were not reported by Connecticut in 2012. Therefore, Exhibit 11 shows regional and national figures only.

# MENTAL HEALTH

## Older Connecticuters 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 Connecticuters experience FMD at a rate that is higher than the regional rate and lower than the national rate.

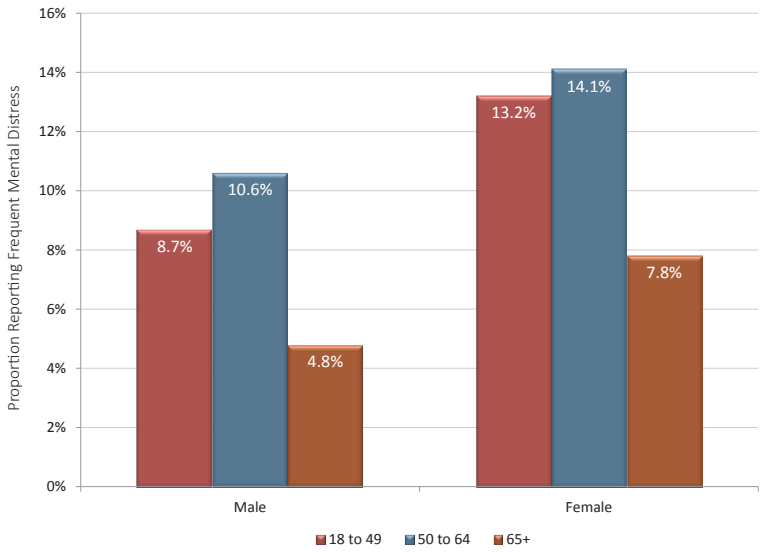
**Exhibit 12. Individuals Reporting Frequent Mental Distress in Connecticut, Region 1, and the United States, 2013**




Source: BRFSS, 2013

## Older Connecticuters Reporting Frequent Mental Distress by Age Group and Sex

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




Source: BRFSS, 2013

Older men in Connecticut 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, 14.1 percent of women in the 50–64 age group and 7.8 percent in the 65+ age group reported FMD, while 10.6 percent of men in the 50–64 age group and 4.8 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 Connecticuters.

**Exhibit 14. BRFSS Measures, 2010**

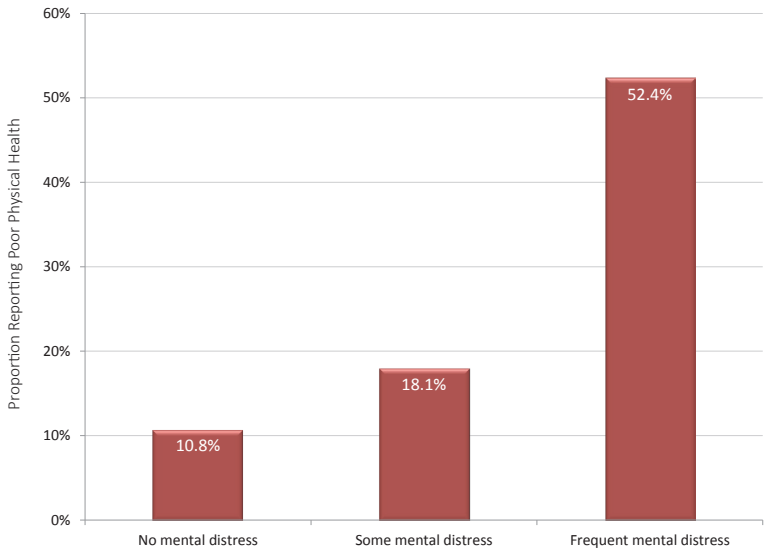
| Indicator | Ages 50+ | Ages 50–64 | Ages 65+ |
|---|---|---|---|
| Rarely or never get social or emotional support | 9.4% | 7.7% | 11.9% |
| Dissatisfied or very dissatisfied | 4.5% | 5.2% | 3.7% |

Source: BRFSS, 2010

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

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

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

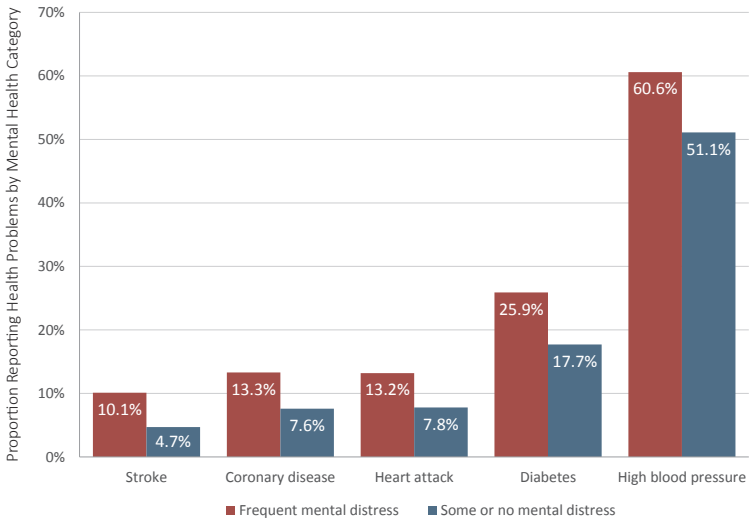



Source: BRFSS, 2013

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

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

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




Source: BRFSS, 2013

## Older Connecticuters Admitted to State Mental Health Services

Approximately 4.4 percent of the people served by the Connecticut mental health system were ages 65 and older. This represents more than 4,085 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

# Maine

# Maine

## OLDER ADULTS BEHAVIORAL HEALTH PROFILE

February 2016

## MAINE'S POPULATION

### Maine Population by Age Group

Maine is home to 1,330,089 people. Of these:

- 557,974 (42.0 percent) are over age 50.
- 341,707 (25.7 percent) are over age 60.
- 161,151 (12.1 percent) are over age 70.
- 62,295 (4.7 percent) are ages 80 and older.

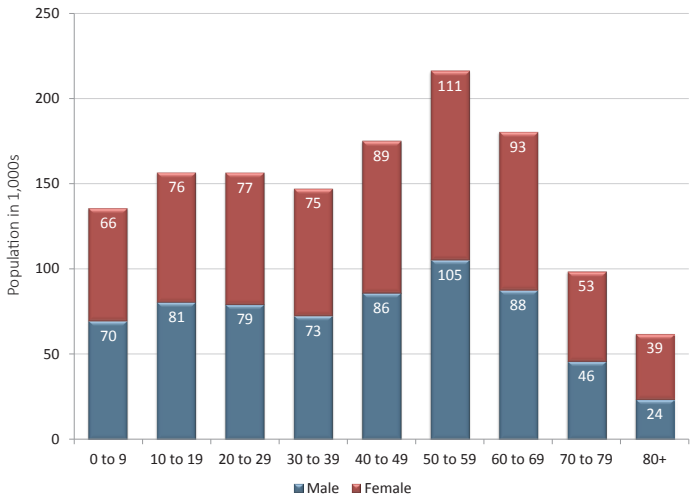
The proportion of women rises fairly steadily in each age group, and women make up 61.9 percent of the 80+ group. The racial/ethnic composition of older Mainers is as follows:

*Race/Ethnicity of Mainers Ages 50+*

| White | AI/AN | Black | Asian | NH/PI | Other | Hispanic |
|---|---|---|---|---|---|---|
| 97.6% | 0.5% | 0.5% | 0.7% | 0.0% | 0.7% | 0.6% |

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

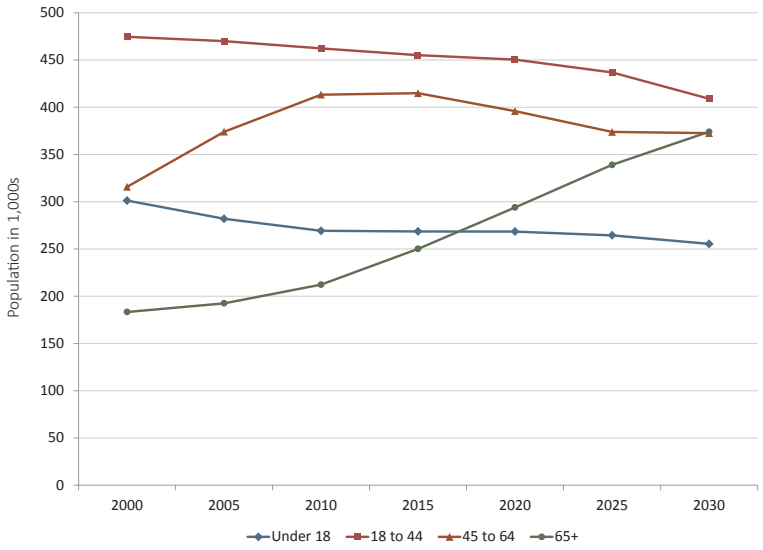
**Exhibit 1. Maine Population by Age Group, 2014**




Source: U.S. Census Bureau, 2015

### The Number of Older Mainers Is Growing

**Exhibit 2. Maine Population by Age Group, 2000–2030**




The proportion of Maine'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 26.5 percent of Maine's population will be 65 and older by the year 2030, an increase of 49.5 percent from 2015.

*Projected Population in Maine*

| Age Group | 2015 | 2025 | 2030 |
|---|---|---|---|
| Under 18 | 19.3% | 18.7% | 18.1% |
| 18 to 44 | 32.8% | 30.9% | 29.0% |
| 45 to 64 | 29.9% | 26.4% | 26.4% |
| 65+ | 18.0% | 24.0% | 26.5% |

Source: U.S. Census Bureau, 2005

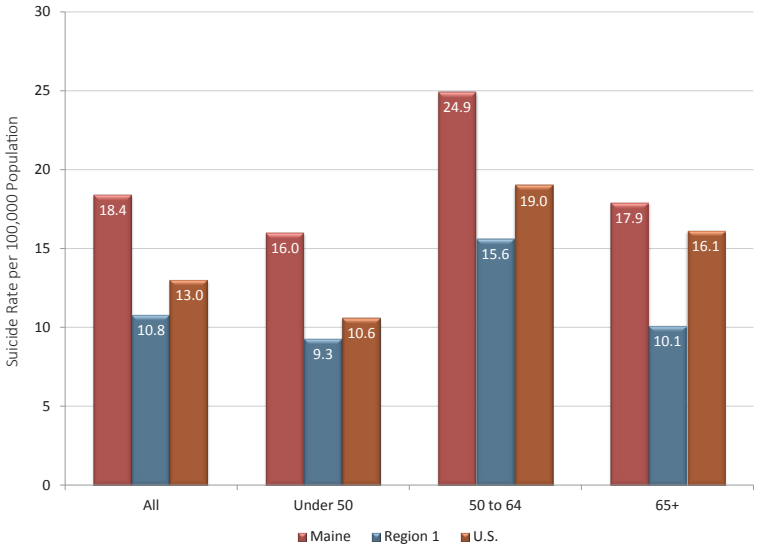
# SUICIDE AMONG OLDER MAINERS

## Maine Suicide Rate Compared With Regional and National Rates

The suicide rate among Mainers 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 21.9 per 100,000 people (8.3 for women and 37.2 for men). The rate among those ages 50–64 was higher than both the rate in the region (including Connecticut, Massachusetts, New Hampshire, Rhode Island, and Vermont) and the rate in the United States.

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

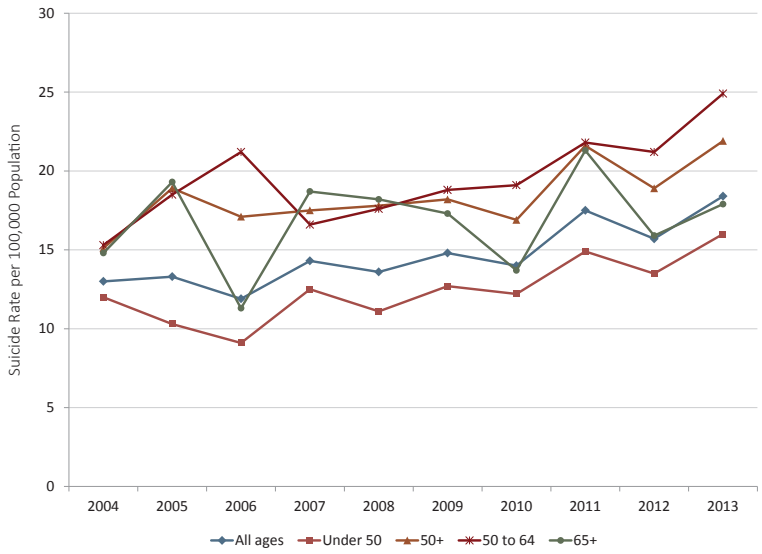
**Exhibit 3. Suicide Rates in Maine, Region 1, and the United States, 2013**




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 Maine

**Exhibit 4. Trends in Suicide Rates in Maine 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 Mainers ages 50+ fluctuated from a low of 15.1 per 100,000 in 2004 to a high of 21.9 per 100,000 in 2013. From 2004 to 2013, the rate was generally highest among those in the 50–64 age group.

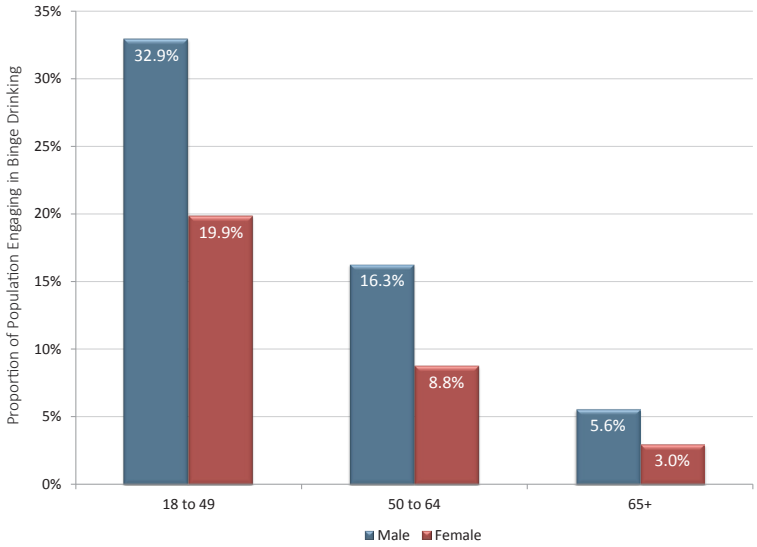
How a state reports suicides can vary from year to year. The number of suicides is generally low, so even a small difference in reported numbers may make the rate fluctuate widely.

# SUBSTANCE USE DISORDER AND SUBSTANCE USE DISORDER TREATMENT AMONG OLDER MAINERS

## 30-Day Binge Drinking Among Older Mainers

Binge drinking, defined as five or more drinks for men and four or more drinks for women on a single occasion, can lead to serious health problems. Such problems include neurological damage, cardiovascular disease, liver disease, stroke, and poor control of diabetes. Binge drinkers are more likely to take risks such as driving while intoxicated and to experience falls and other accidents. Older people have a lower tolerance for alcohol. Binge drinking decreases with age and occurs more frequently among men than it does among women. As Exhibit 5 shows, 16.3 percent of Maine men ages 50–64 reported binge drinking in the past 30 days, while 5.6 percent of those in the 65+ group reported similar behavior.

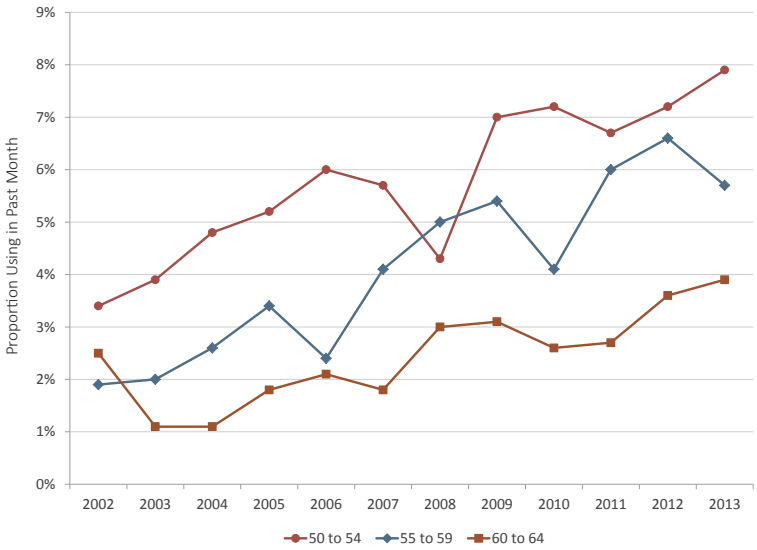
**Exhibit 5. Binge Drinking Rates in Maine by Age Group and Sex, 2013**




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 *Maine 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).

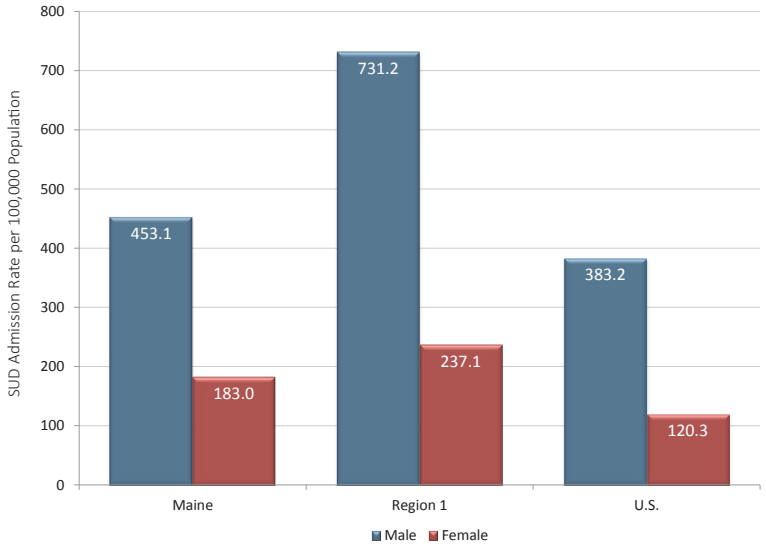
## Admissions to Substance Use Disorder Treatment Among Older Mainers

In 2012, there were 1,731 admissions of Mainers ages 50 and older to substance use disorder (SUD) treatment in state-funded treatment programs, a rate of 310.2 per 100,000 people ages 50+. This rate was lower than the regional rate and higher than the national average. Men made up 68.8 percent of these admissions. Of all admissions, 95.3 percent were White/Caucasian, 2.0 percent were Black/African American, and 1.3 percent were Hispanic.

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

| Self-Referral | Criminal Justice | Other |
|---|---|---|
| 47.7% | 18.8% | 33.4% |

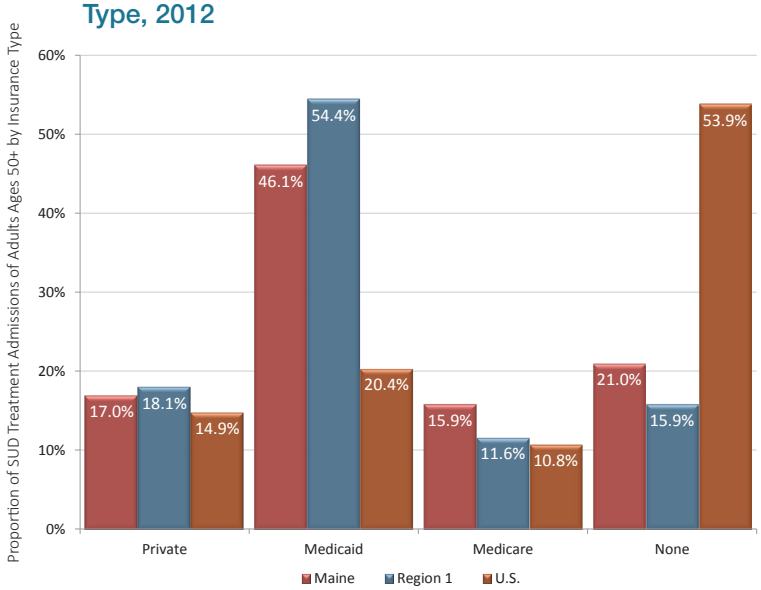
### Exhibit 7. SUD Treatment Admissions of Adults Ages 50+ in Maine, Region 1, and the United States by Sex, 2012




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

## SUD Treatment Admissions Among Mainers Ages 50+ by Insurance Type

### Exhibit 8. SUD Treatment Admissions of Adults Ages 50+ in Maine, Region 1, and the United States by Insurance Type, 2012




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

In Maine, 21.0 percent of older adult admissions to SUD treatment were uninsured, 46.1 percent had Medicaid, 15.9 percent had Medicare, and 17.0 percent had private insurance.

### *SUD Treatment Admissions Among Mainers Ages 50+ by Primary Sources of Payment*

| Self-Pay | Medicaid | Other |
|---|---|---|
| 16.6% | 19.5% | 63.9% |

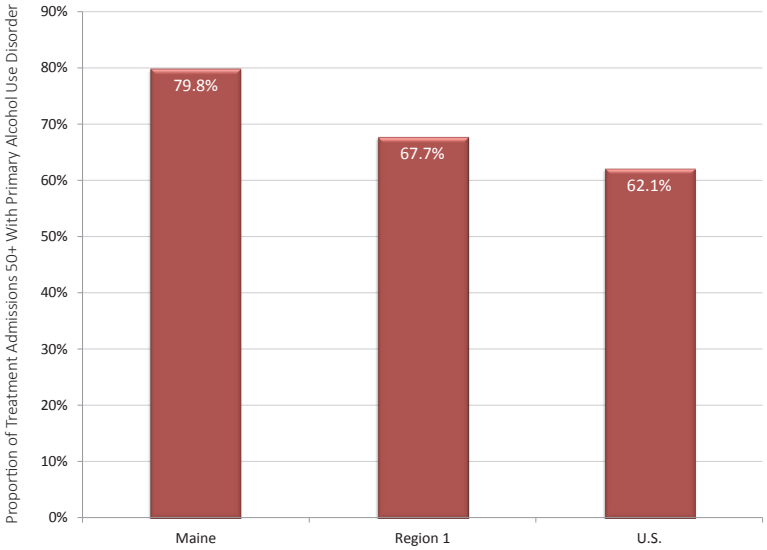
Self-pay data include private insurance.
Exhibit 8 and the accompanying text reflect the type of health insurance (if any) clients had at admission; the table above represents primary sources of payment.

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

## Alcohol Use Disorder Treatment Admissions Among Mainers Ages 50+

Alcohol was the most frequently cited substance used by older Mainers in publicly financed SUD treatment in 2012. It was mentioned as a substance of use in 79.8 percent of admissions among those ages 50+. This was higher than the regional and national rates.

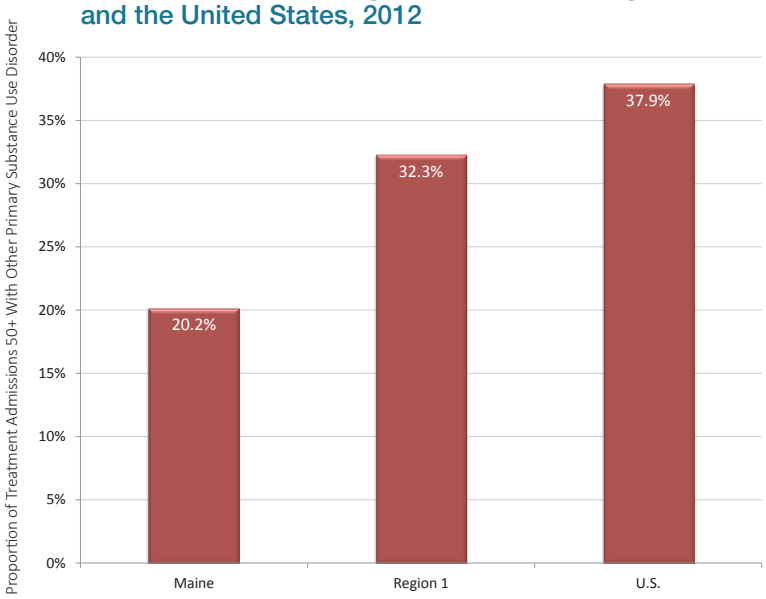
**Exhibit 9. Alcohol Use Treatment Admissions of Adults Ages 50+ in Maine, Region 1, and the United States, 2012**




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 Maine, Region 1, 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 20.2 percent of older adult admissions to publicly funded treatment in Maine.

## 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*:

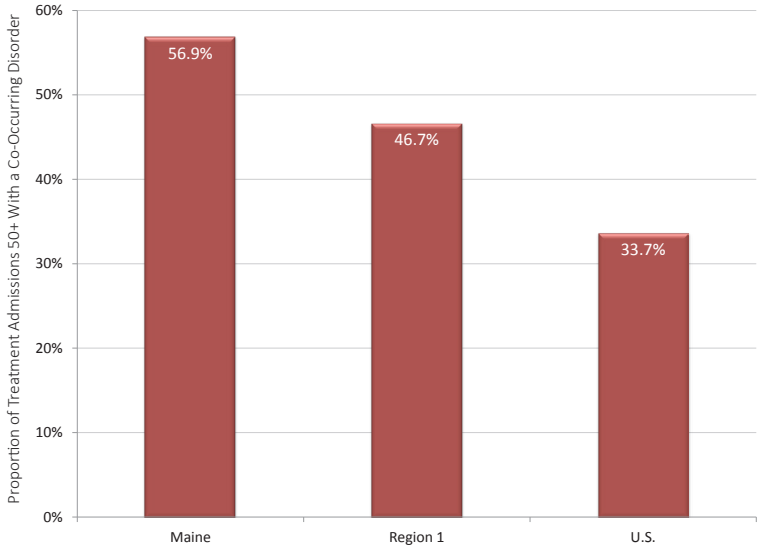
- *In 2004, there were an estimated 115,803 ED visits involving pharmaceutical misuse and abuse by adults aged 50 or older; in 2008, there were 256,097 such visits, representing an increase of 121.1 percent*
- *One fifth (19.7 percent) of ED visits involving pharmaceutical misuse and abuse among older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

**Exhibit 11. SUD Treatment Admissions of Adults Ages 50+ With a Co-Occurring Mental Disorder in Maine, Region 1, 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.

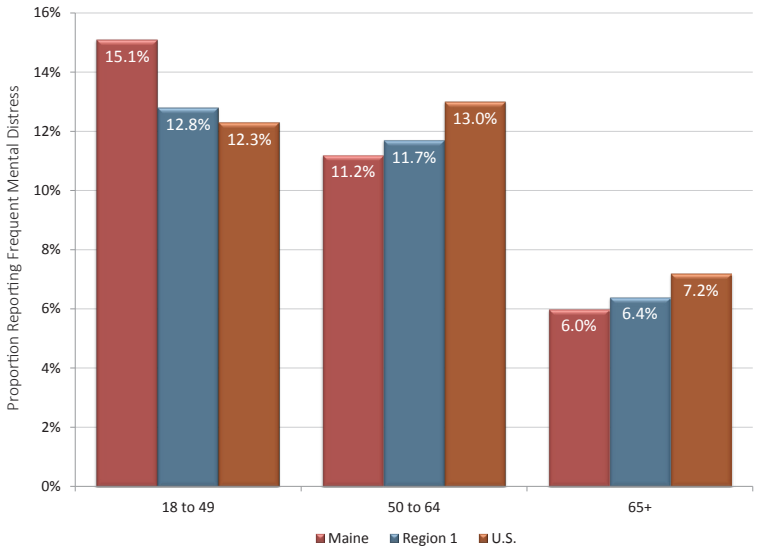
Exhibit 11 shows the proportion of SUD treatment admissions of Mainers ages 50+ with a co-occurring mental disorder. This rate is higher than the regional rate and the national average. However, state reporting practices are a factor in these results.

# MENTAL HEALTH

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

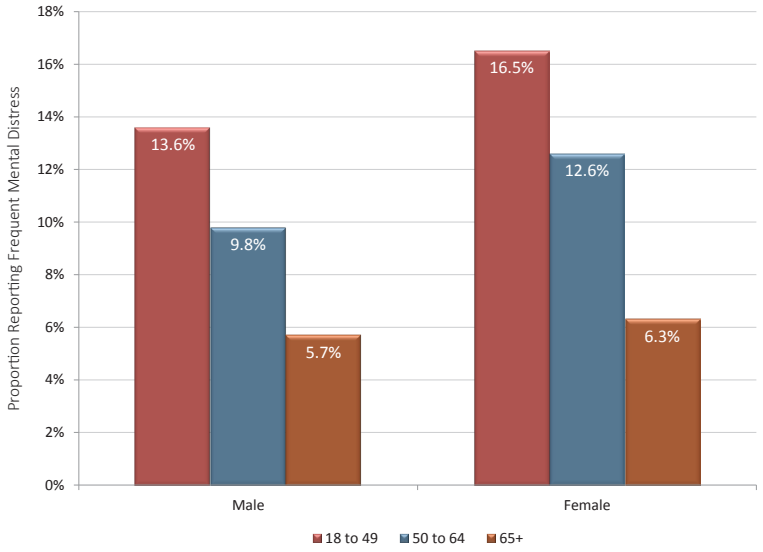
**Exhibit 12. Individuals Reporting Frequent Mental Distress in Maine, Region 1, and the United States, 2013**




Source: BRFSS, 2013

## Older Mainers Reporting Frequent Mental Distress by Age Group and Sex

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




Source: BRFSS, 2013

Older men in Maine were more likely to indulge in binge drinking, but older women were more likely to report that they had FMD (14 days or more per 30-day period). As Exhibit 13 shows, 12.6 percent of women in the 50–64 age group and 6.3 percent in the 65+ age group reported FMD, while 9.8 percent of men in the 50–64 age group and 5.7 percent in the 65+ age group reported FMD.

## Other Measures of Mental Health

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

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

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

**Exhibit 14. BRFSS Measures, 2010**

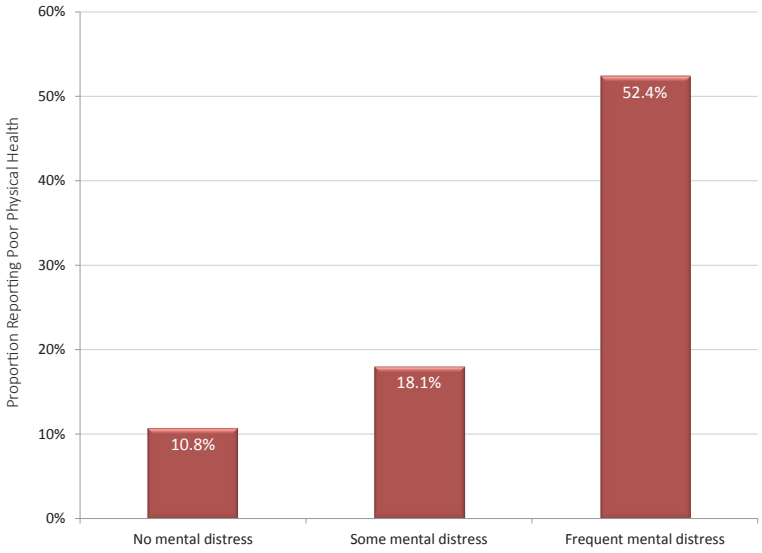
| Indicator | Ages 50+ | Ages 50–64 | Ages 65+ |
|---|---|---|---|
| Rarely or never get social or emotional support | 8.6% | 6.9% | 11.0% |
| Dissatisfied or very dissatisfied | 4.3% | 5.3% | 2.8% |

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**

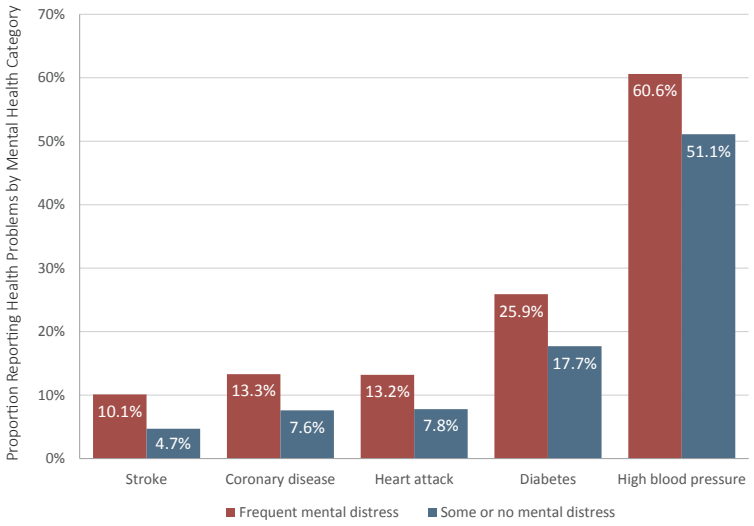



Source: BRFSS, 2013

## 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 Mainers Admitted to State Mental Health Services

Approximately 4.3 percent of the people served by the Maine mental health system were ages 65 and older. This represents more than 2,928 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

# Massachusetts

# Massachusetts

## OLDER ADULTS BEHAVIORAL HEALTH PROFILE

February 2016

## MASSACHUSETTS' POPULATION

### Massachusetts Population by Age Group

Massachusetts is home to 6,745,408 people. Of these:

- 2,412,933 (35.8 percent) are over age 50.
- 1,421,787 (21.1 percent) are over age 60.
- 685,300 (10.2 percent) are over age 70.
- 287,837 (4.3 percent) are ages 80 and older.

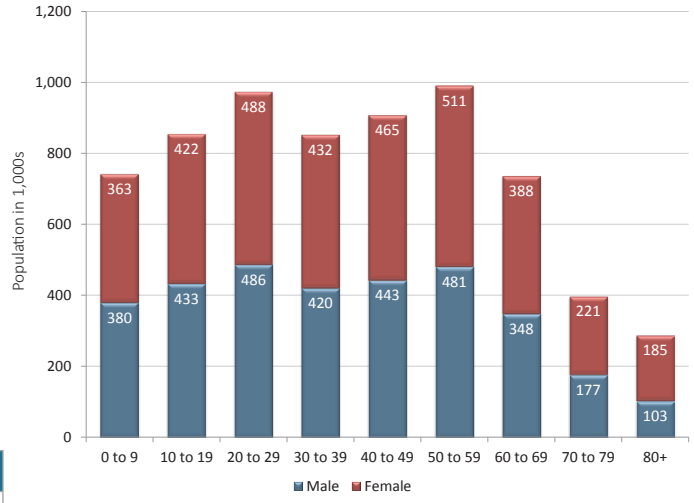
The proportion of women rises fairly steadily in each age group, and women make up 64.2 percent of the 80+ group. The racial/ethnic composition of older Massachusettsans is as follows:

*Race/Ethnicity of Massachusettsans Ages 50+*

| White | AI/AN | Black | Asian | NH/PI | Other | Hispanic |
|---|---|---|---|---|---|---|
| 89.1% | 0.3% | 5.7% | 4.0% | 0.1% | 0.8% | 5.1% |

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

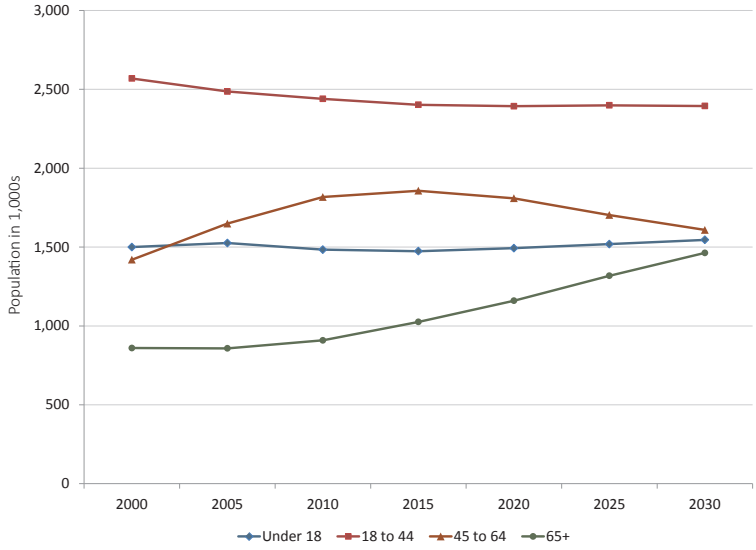
**Exhibit 1. Massachusetts Population by Age Group, 2014**




Source: U.S. Census Bureau, 2015

### The Number of Older Massachusettsans Is Growing

**Exhibit 2. Massachusetts Population by Age Group, 2000–2030**




The proportion of Massachusetts' 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 20.9 percent of Massachusetts' population will be 65 and older by the year 2030, an increase of 42.7 percent from 2015.

*Projected Population in Massachusetts*

| Age Group | 2015 | 2025 | 2030 |
|---|---|---|---|
| Under 18 | 21.8% | 21.9% | 22.0% |
| 18 to 44 | 35.5% | 34.6% | 34.1% |
| 45 to 64 | 27.5% | 24.5% | 22.9% |
| 65+ | 15.2% | 19.0% | 20.9% |

Source: U.S. Census Bureau, 2005

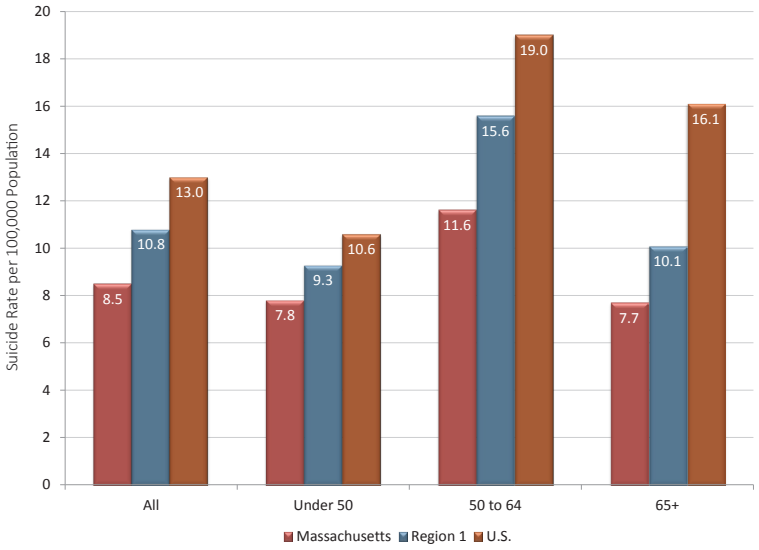
# SUICIDE AMONG OLDER MASSACHUSETTSANS

## Massachusetts Suicide Rate Compared With Regional and National Rates

The suicide rate among Massachusettsans 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 9.8 per 100,000 people (4.9 for women and 15.7 for men). The rate among those ages 50–64 was lower than both the rate in the region (including Connecticut, Maine, New Hampshire, Rhode Island, and Vermont) and the rate in the United States.

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

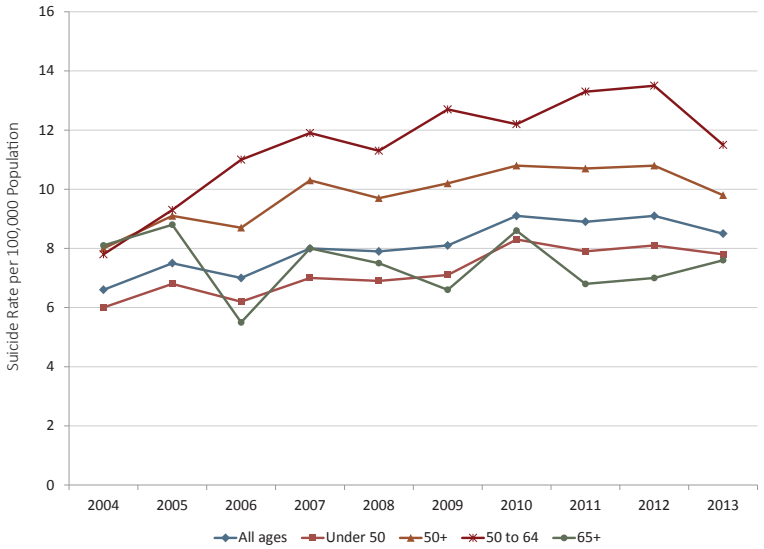
**Exhibit 3. Suicide Rates in Massachusetts, Region 1, and the United States, 2013**




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 Massachusetts

**Exhibit 4. Trends in Suicide Rates in Massachusetts 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 Massachusettsans ages 50+ fluctuated from a low of 8.0 per 100,000 in 2004 to a high of 10.8 per 100,000 in 2010. From 2004 to 2013, the rate was generally highest among those in the 50–64 age group.

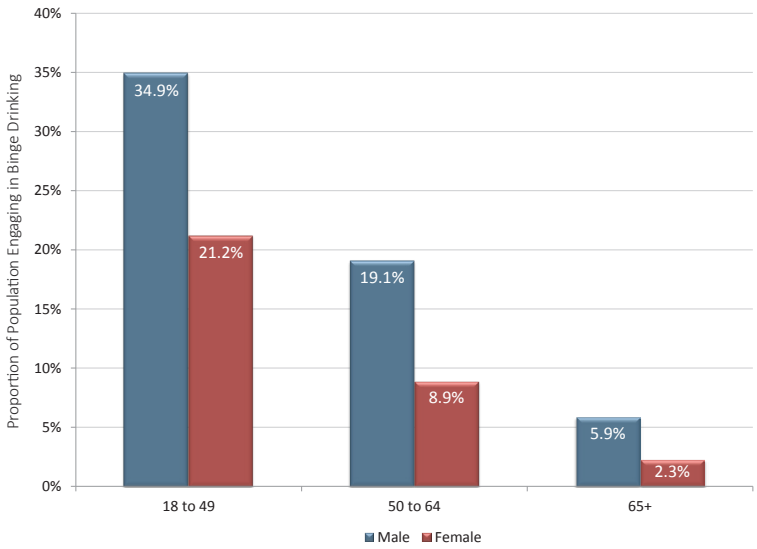
How a state reports suicides can vary from year to year. The number of suicides is generally low, so even a small difference in reported numbers may make the rate fluctuate widely.

# SUBSTANCE USE DISORDER AND SUBSTANCE USE DISORDER TREATMENT AMONG OLDER MASSACHUSETTSANS

## 30-Day Binge Drinking Among Older Massachusettsans

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. Binge drinking decreases with age and occurs more frequently among men than it does among women. Older people have a lower tolerance for alcohol. As Exhibit 5 shows, 19.1 percent of Massachusetts men ages 50–64 reported binge drinking in the past 30 days, while 5.9 percent of those in the 65+ group reported similar behavior.

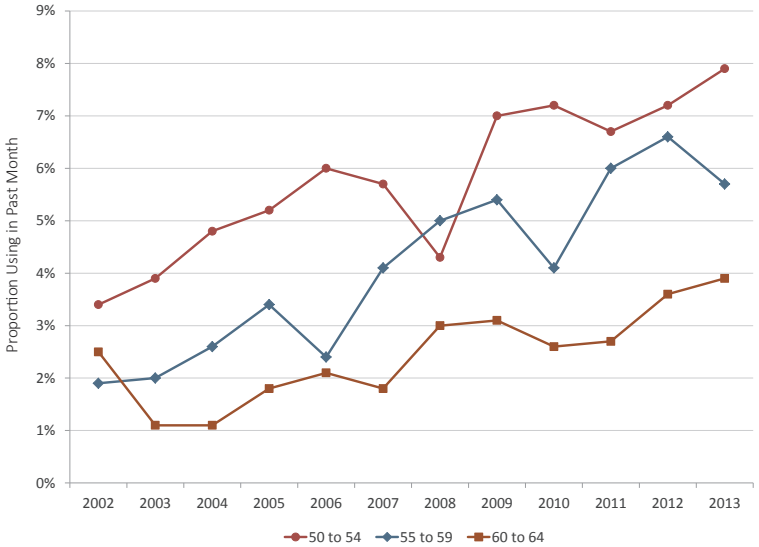
**Exhibit 5. Binge Drinking Rates in Massachusetts by Age Group and Sex, 2013**




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 *Massachusetts 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).

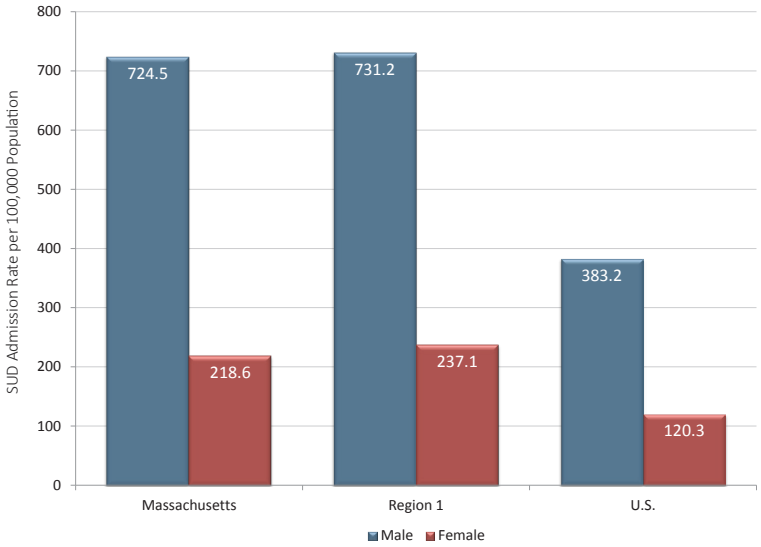
## Admissions to Substance Use Disorder Treatment Among Older Massachusettsans

In 2012, there were 10,883 admissions of Massachusettsans ages 50 and older to substance use disorder (SUD) treatment in state-funded treatment programs, a rate of 451.0 per 100,000 people ages 50+. This rate was lower than the regional rate and higher than the national average. Men made up 73.8 percent of these admissions. Of all admissions, 78.7 percent were White/ Caucasian, 11.8 percent were Black/ African American, and 7.9 percent were Hispanic.

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

| Self-Referral | Criminal Justice | Other |
|---|---|---|
| 51.5% | 22.8% | 25.7 |

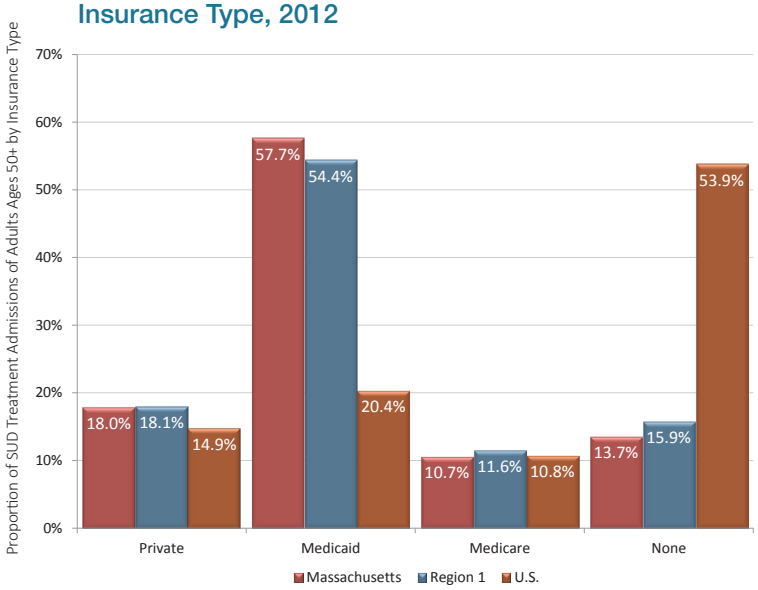
**Exhibit 7. SUD Treatment Admissions of Adults Ages 50+ in Massachusetts, Region 1, and the United States by Sex, 2012**




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

## SUD Treatment Admissions Among Massachusettsans Ages 50+ by Insurance Type

**Exhibit 8. SUD Treatment Admissions of Adults Ages 50+ in Massachusetts, Region 1, and the United States by Insurance Type, 2012**




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

In Massachusetts, 13.7 percent of older adult admissions to SUD treatment were uninsured, 57.7 percent had Medicaid, 10.7 percent had Medicare, and 18.0 percent had private insurance.

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

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

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

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

## Alcohol Use Disorder Treatment Admissions Among Massachusettsans Ages 50+

Alcohol was the most frequently cited substance used by older Massachusettsans in publicly financed SUD treatment in 2012. It was mentioned as a substance of use in 68.5 percent of admissions among those ages 50+. This was higher than the regional and national rates.

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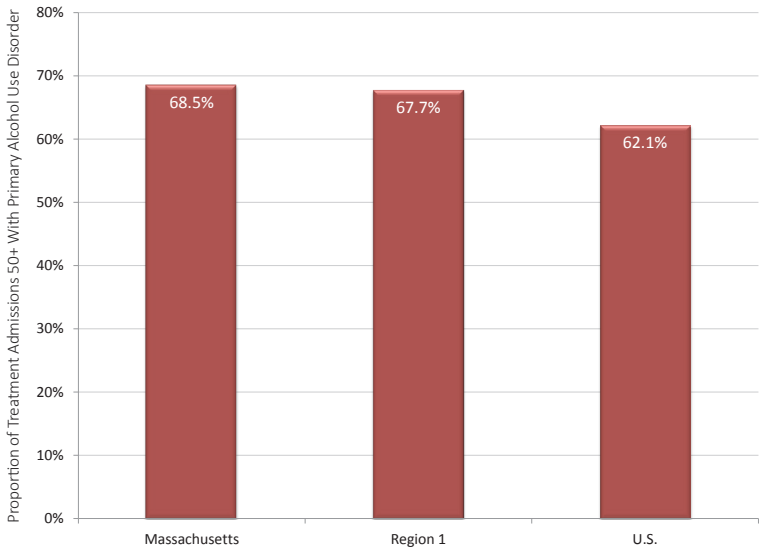
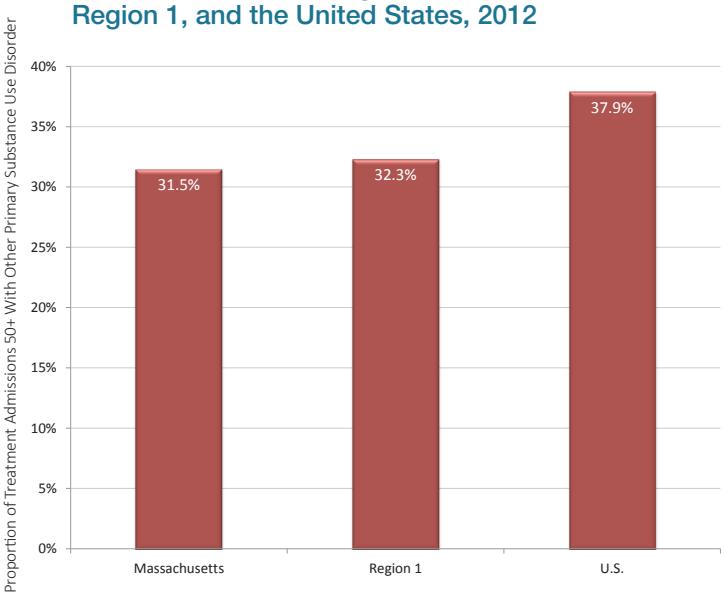



Source: TEDS, 2012
Data include only those clients reported to SAMHSA.

## SUD Treatment Admissions for Non-Alcohol Substance Use

**Exhibit 10. Non-Alcohol Substance Use Treatment Admissions of Adults Ages 50+ in Massachusetts, Region 1, 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 31.5 percent of older adult admissions to publicly funded treatment in Massachusetts.

## 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*:

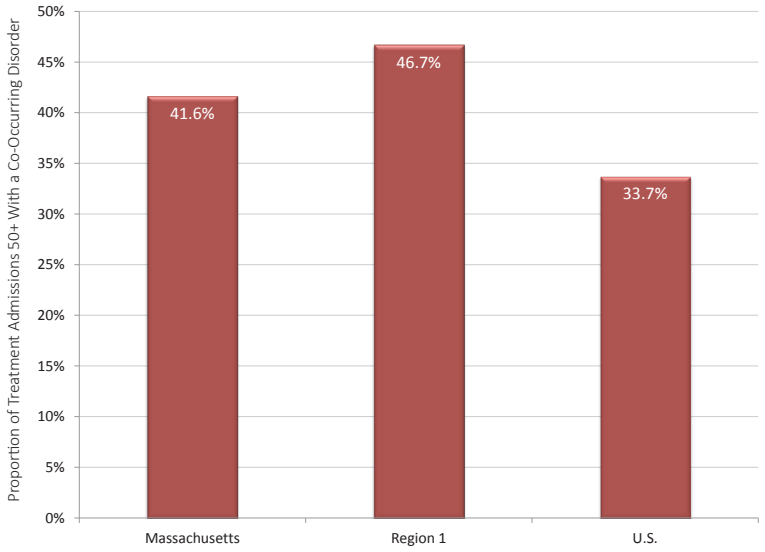
- *In 2004, there were an estimated 115,803 ED visits involving pharmaceutical misuse and abuse by adults aged 50 or older; in 2008, there were 256,097 such visits, representing an increase of 121.1 percent*
- *One fifth (19.7 percent) of ED visits involving pharmaceutical misuse and abuse among older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

**Exhibit 11. SUD Treatment Admissions of Adults Ages 50+ With a Co-Occurring Mental Disorder in Massachusetts, Region 1, 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.

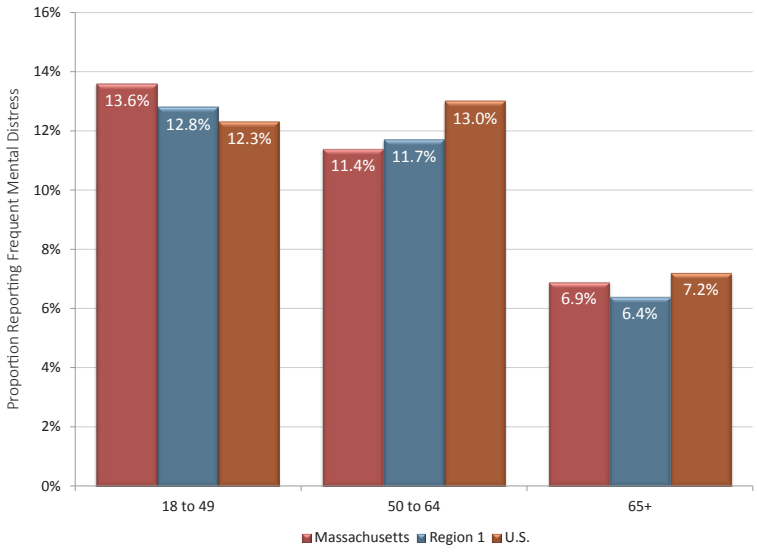
Exhibit 11 shows the proportion of SUD treatment admissions of Massachusettsans ages 50+ with a co-occurring mental disorder. This rate is lower than the regional rate and higher than the national average. However, state reporting practices are a factor in these results.

# MENTAL HEALTH

## Older Massachusettsans 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 Massachusettsans experience FMD at a rate that is roughly similar to the regional rate and lower than the national rate.

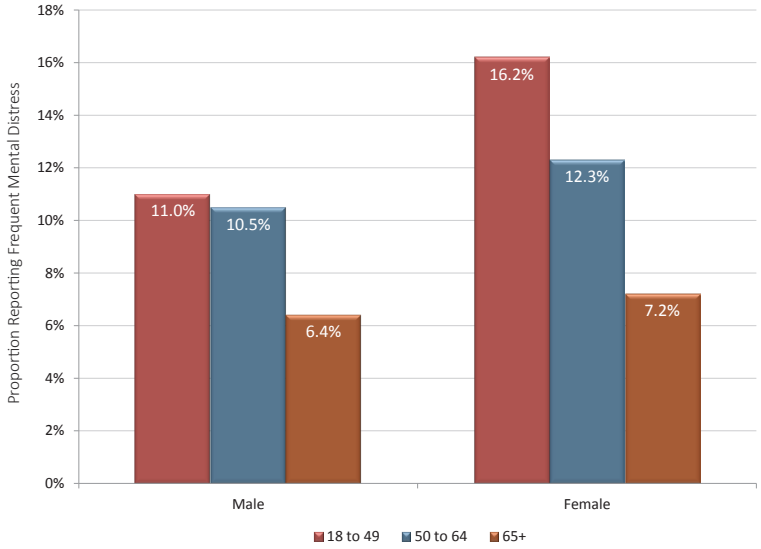
**Exhibit 12. Individuals Reporting Frequent Mental Distress in Massachusetts, Region 1, and the United States, 2013**




Source: BRFSS, 2013

## Older Massachusettsans Reporting Frequent Mental Distress by Age Group and Sex

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




Source: BRFSS, 2013

Older men in Massachusetts were more likely to indulge in binge drinking, but older women were more likely to report that they had FMD (14 days or more per 30-day period). As Exhibit 13 shows, 12.3 percent of women in the 50–64 age group and 7.2 percent in the 65+ age group reported FMD, while 10.5 percent of men in the 50–64 age group and 6.4 percent in the 65+ age group reported FMD.

## Other Measures of Mental Health

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

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

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

**Exhibit 14. BRFSS Measures, 2010**

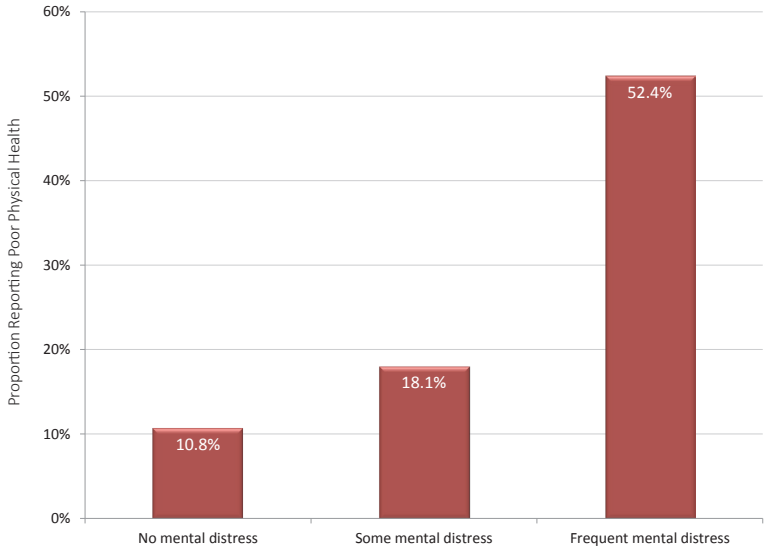
| Indicator | Ages 50+ | Ages 50–64 | Ages 65+ |
|---|---|---|---|
| Rarely or never get social or emotional support | 8.1% | 6.2% | 11.0% |
| Dissatisfied or very dissatisfied with life | 4.6% | 5.3% | 3.7% |

Source: BRFSS, 2010

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

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

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

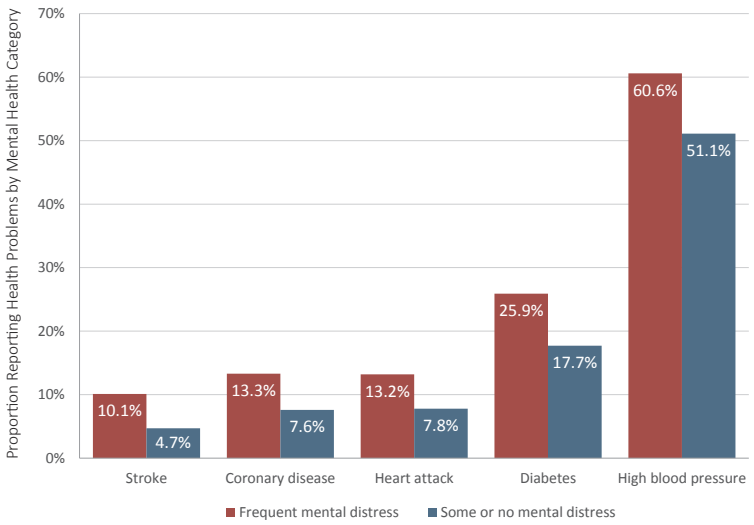



Source: BRFSS, 2013

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

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

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




Source: BRFSS, 2013

## Older Massachusettsans Admitted to State Mental Health Services

Approximately 4.7 percent of the people served by the Massachusetts mental health system were ages 65 and older. This represents more than 1,506 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

# New Hampshire

# New Hampshire

## OLDER ADULTS BEHAVIORAL HEALTH PROFILE

February 2016

## NEW HAMPSHIRE'S POPULATION

### New Hampshire Population by Age Group

New Hampshire is home to 1,326,813 people. Of these:

- 520,980 (39.3 percent) are over age 50.
- 301,008 (22.7 percent) are over age 60.
- 137,340 (10.4 percent) are over age 70.
- 53,353 (4.0 percent) are ages 80 and older.

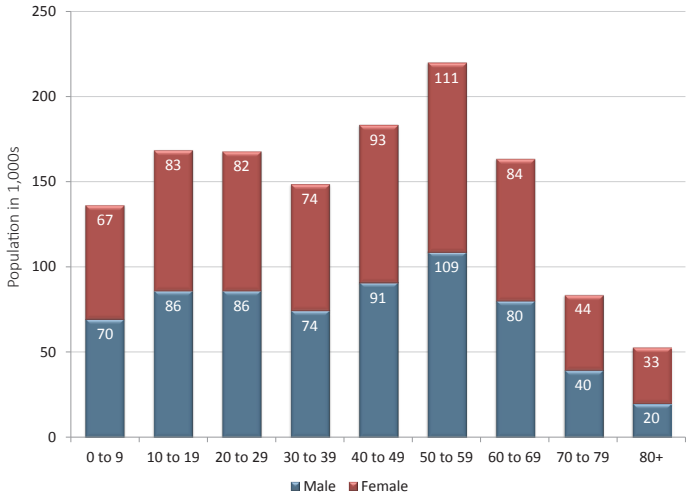
The proportion of women rises fairly steadily in each age group, and women make up 62.2 percent of the 80+ group. The racial/ethnic composition of older New Hampshirites is as follows:

*Race/Ethnicity of New Hampshirites Ages 50+*

| White | AI/AN | Black | Asian | NH/PI | Other | Hispanic |
|---|---|---|---|---|---|---|
| 97.0% | 0.2% | 0.8% | 1.3% | 0.0% | 0.7% | 1.3% |

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

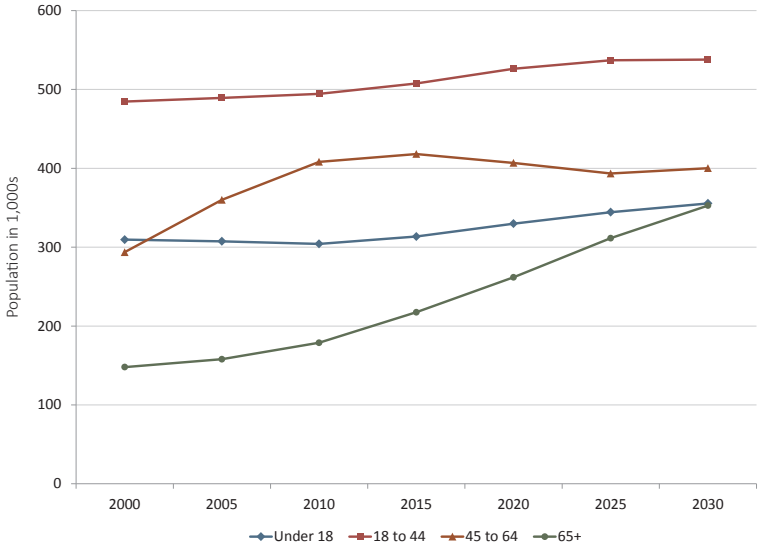
**Exhibit 1. New Hampshire Population by Age Group, 2014**




Source: U.S. Census Bureau, 2015

### The Number of Older New Hampshirites Is Growing

**Exhibit 2. New Hampshire Population by Age Group, 2000–2030**




The proportion of New Hampshire'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 21.4 percent of New Hampshire's population will be 65 and older by the year 2030, an increase of 62.2 percent from 2015.

*Projected Population in New Hampshire*

| Age Group | 2015 | 2025 | 2030 |
|---|---|---|---|
| Under 18 | 21.5% | 21.7% | 21.6% |
| 18 to 44 | 34.8% | 33.9% | 32.7% |
| 45 to 64 | 28.7% | 24.8% | 24.3% |
| 65+ | 14.9% | 19.6% | 21.4% |

Source: U.S. Census Bureau, 2005

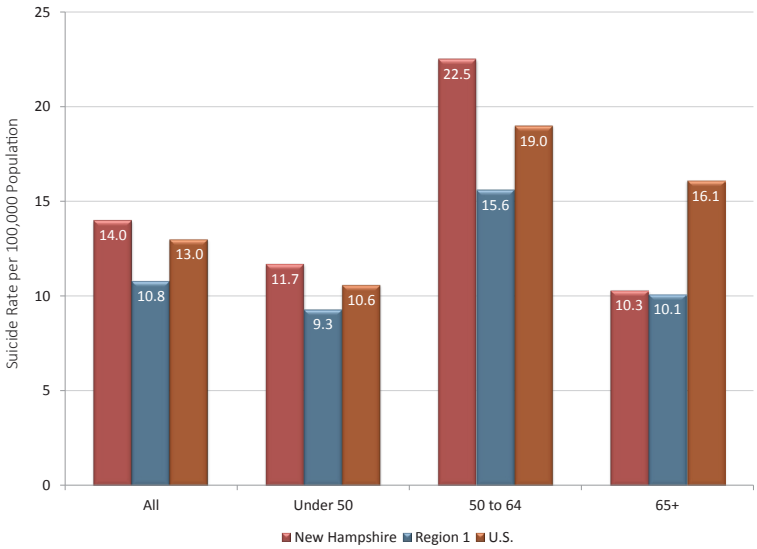
# SUICIDE AMONG OLDER NEW HAMPSHIRITES

## New Hampshire Suicide Rate Compared With Regional and National Rates

The suicide rate among New Hampshirites ages 50 and older is higher than the rate among younger age groups. In 2013, the total suicide rate among all people ages 50+ was 17.7 per 100,000 people (7.9 for women and 28.4 for men). The rate among those ages 50–64 was higher than both the rate in the region (including Connecticut, Maine, Massachusetts, Rhode Island, and Vermont) and the rate in the United States.

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

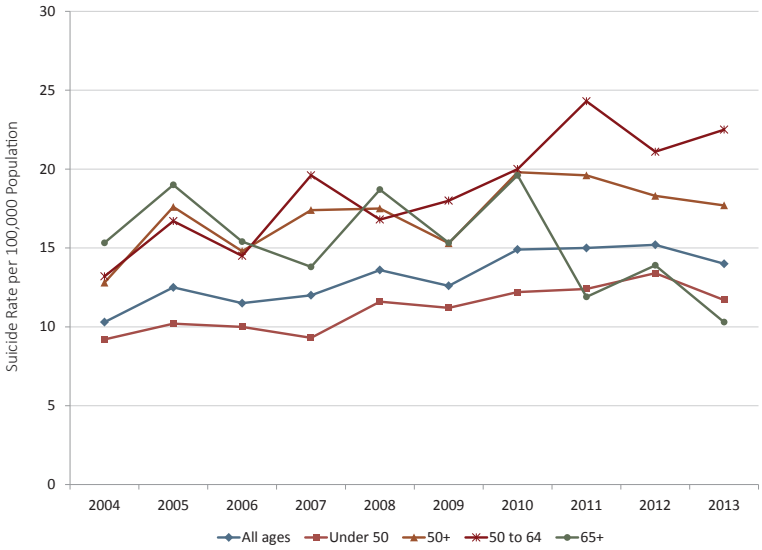
**Exhibit 3. Suicide Rates in New Hampshire, Region 1, and the United States, 2013**




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 New Hampshire

**Exhibit 4. Trends in Suicide Rates in New Hampshire 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 New Hampshirites ages 50+ fluctuated from a low of 12.8 per 100,000 in 2004 to a high of 19.8 per 100,000 in 2010. From 2004 to 2013, the rate was generally highest among those in the 50–64 age group.

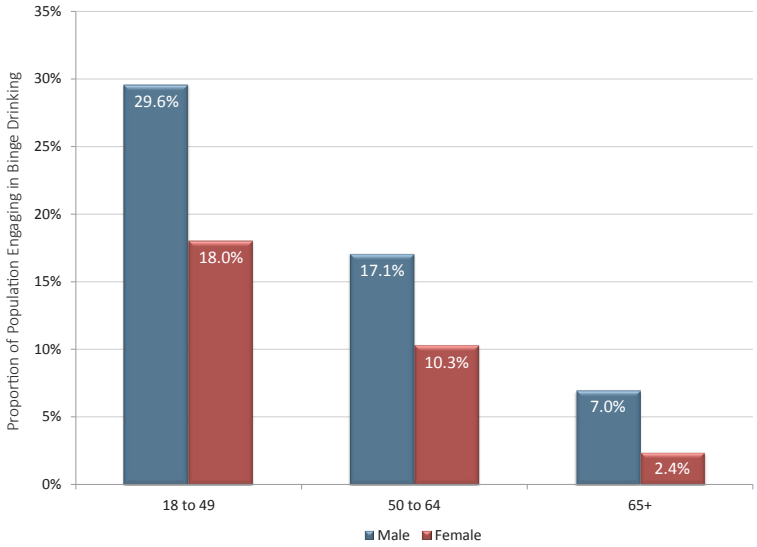
How a state reports suicides can vary from year to year. The number of suicides is generally low, so even a small difference in reported numbers may make the rate fluctuate widely.

# SUBSTANCE USE DISORDER AND SUBSTANCE USE DISORDER TREATMENT AMONG OLDER NEW HAMPSHIRITES

## 30-Day Binge Drinking Among Older New Hampshirites

Binge drinking, defined as five or more drinks for men and four or more drinks for women on a single occasion, can lead to serious health problems. Such problems include neurological damage, cardiovascular disease, liver disease, stroke, and poor control of diabetes. Binge drinkers are more likely to take risks such as driving while intoxicated and to experience falls and other accidents. Older people have a lower tolerance for alcohol. Binge drinking decreases with age and occurs more frequently among men than it does among women. As Exhibit 5 shows, 17.1 percent of New Hampshire men ages 50–64 reported binge drinking in the past 30 days, while 7.0 percent of those in the 65+ group reported similar behavior.

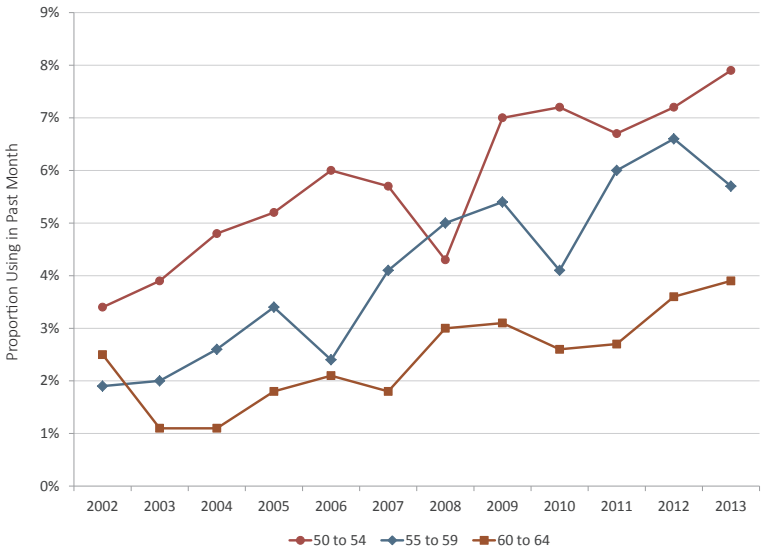
**Exhibit 5. Binge Drinking Rates in New Hampshire by Age Group and Sex, 2013**




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 *New Hampshire 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).

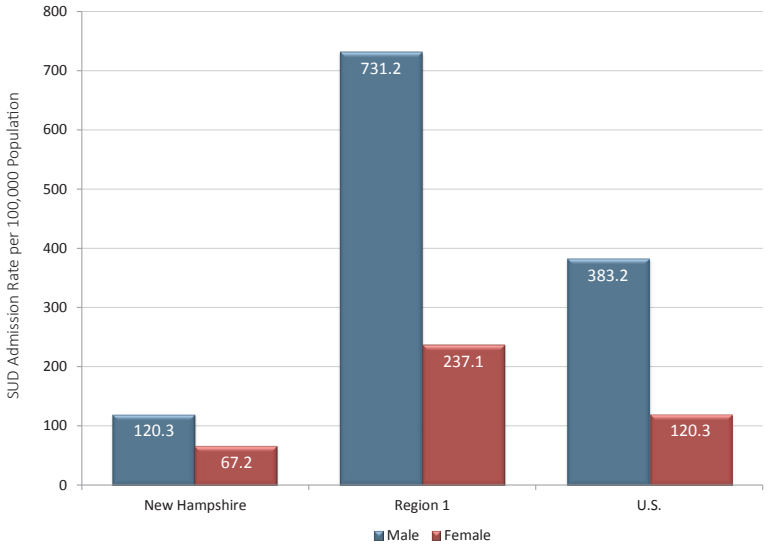
## Admissions to Substance Use Disorder Treatment Among Older New Hampshirites

In 2012, there were 482 admissions of New Hampshirites ages 50 and older to substance use disorder (SUD) treatment in state-funded treatment programs, a rate of 92.5 per 100,000 people ages 50+. This rate was lower than the regional rate and the national average. Men made up 62.0 percent of these admissions. Of all admissions, 96.1 percent were White/Caucasian, 1.2 percent were Black/African American, and 1.5 percent were Hispanic.

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

| Self-Referral | Criminal Justice | Other |
|---|---|---|
| 42.6% | 28.9% | 28.5% |

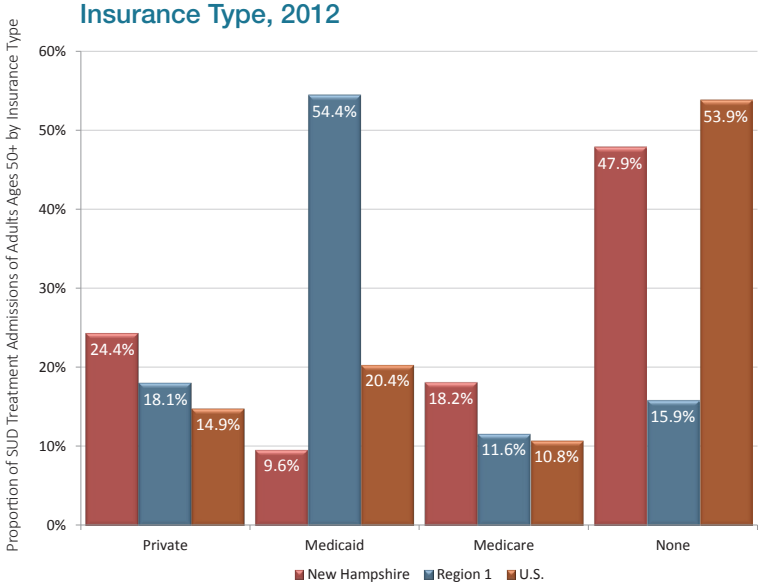
**Exhibit 7. SUD Treatment Admissions of Adults Ages 50+ in New Hampshire, Region 1, and the United States by Sex, 2012**




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

## SUD Treatment Admissions Among New Hampshirites Ages 50+ by Insurance Type

**Exhibit 8. SUD Treatment Admissions of Adults Ages 50+ in New Hampshire, Region 1, and the United States by Insurance Type, 2012**




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

In New Hampshire, 47.9 percent of older adult admissions to SUD treatment were uninsured, 9.6 percent had Medicaid, 18.2 percent had Medicare, and 24.4 percent had private insurance.

*SUD Treatment Admissions Among New Hampshirites Ages 50+ by Primary Sources of Payment*

| Self-Pay | Medicaid | Other |
|---|---|---|
| 67.5% | 3.6% | 28.8% |

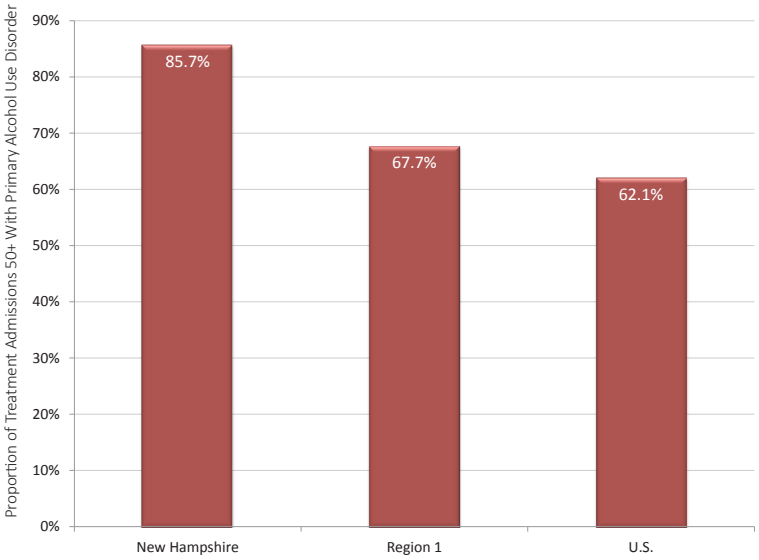
Self-pay data include private insurance.
Exhibit 8 and the accompanying text reflect the type of health insurance (if any) clients had at admission; the table above represents primary sources of payment.

[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 New Hampshirites Ages 50+

Alcohol was the most frequently cited substance used by older New Hampshirites in publicly financed SUD treatment in 2012. It was mentioned as a substance of use in 85.7 percent of admissions among those ages 50+. This was higher than the regional and national rates.

**Exhibit 9. Alcohol Use Treatment Admissions of Adults Ages 50+ in New Hampshire, Region 1, and the United States, 2012**




Source: TEDS, 2012
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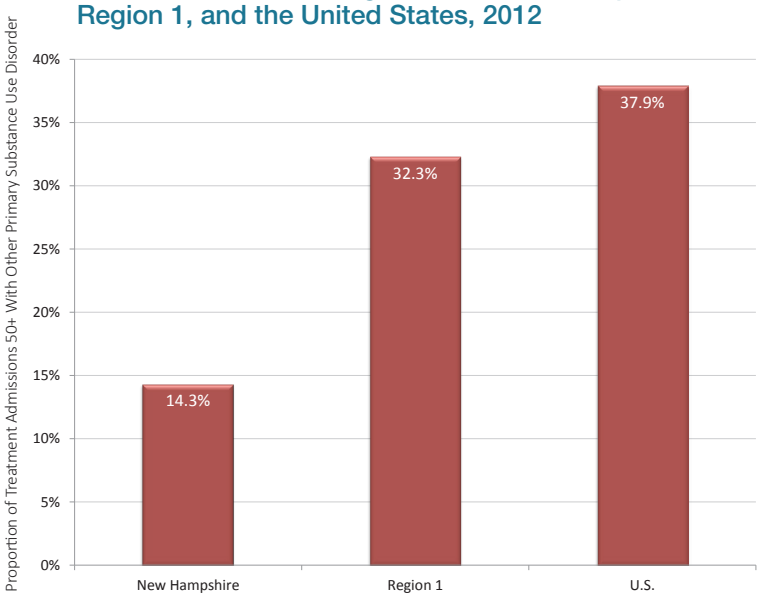


Source: TEDS, 2012
Data include only those clients reported to SAMHSA.

Substances other than alcohol were cited as the primary substances of use for 14.3 percent of older adult admissions to publicly funded treatment in New Hampshire.

## Drug-Related Emergency Department Visits Involving Pharmaceutical Misuse and Abuse by Older Adults

SAMHSA periodically releases reports from the Drug Abuse Warning Network (DAWN). DAWN, discontinued in 2011, consisted of a nationwide network of hospital emergency departments (EDs) primarily located in large metropolitan areas. DAWN data consist of professional reviews of ED records to determine the extent to which alcohol and other substance abuse was involved in ED visits. According to the November 25, 2010, *DAWN Report*:

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# CO-OCCURRING SUBSTANCE USE AND MENTAL DISORDERS

## Older New Hampshirites in SUD Treatment With Co-Occurring Mental Disorders

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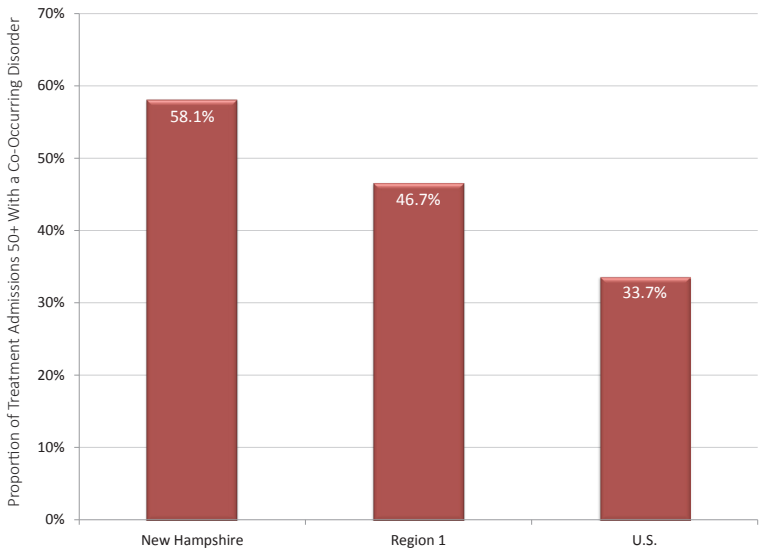


Source: TEDS, 2012
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The national literature shows a strong relationship between substance use and mental disorders. Studies show that 30–80 percent of individuals with a substance use or mental disorder also have a co-occurring disorder.

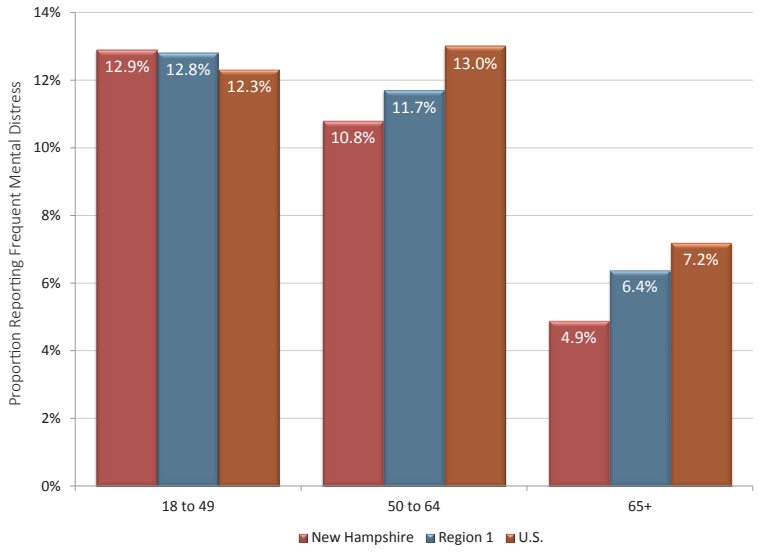
Exhibit 11 shows the proportion of SUD treatment admissions of New Hampshirites ages 50+ with a co-occurring mental disorder. This rate is higher than the regional rate and the national average. However, state reporting practices are a factor in these results.

# MENTAL HEALTH

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

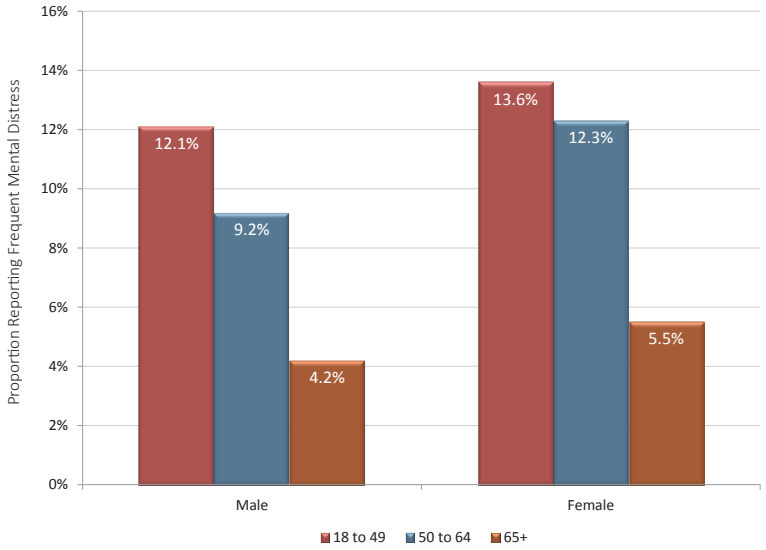
**Exhibit 12. Individuals Reporting Frequent Mental Distress in New Hampshire, Region 1, and the United States, 2013**




Source: BRFSS, 2013

## Older New Hampshirites Reporting Frequent Mental Distress by Age Group and Sex

**Exhibit 13. New Hampshirites Reporting Frequent Mental Distress by Age Group and Sex, 2013**




Source: BRFSS, 2013

Older men in New Hampshire were more likely to indulge in binge drinking, but older women were more likely to report that they had FMD (14 days or more per 30-day period). As Exhibit 13 shows, 12.3 percent of women in the 50–64 age group and 5.5 percent in the 65+ age group reported FMD, while 9.2 percent of men in the 50–64 age group and 4.2 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 New Hampshirites.

**Exhibit 14. BRFSS Measures, 2010**

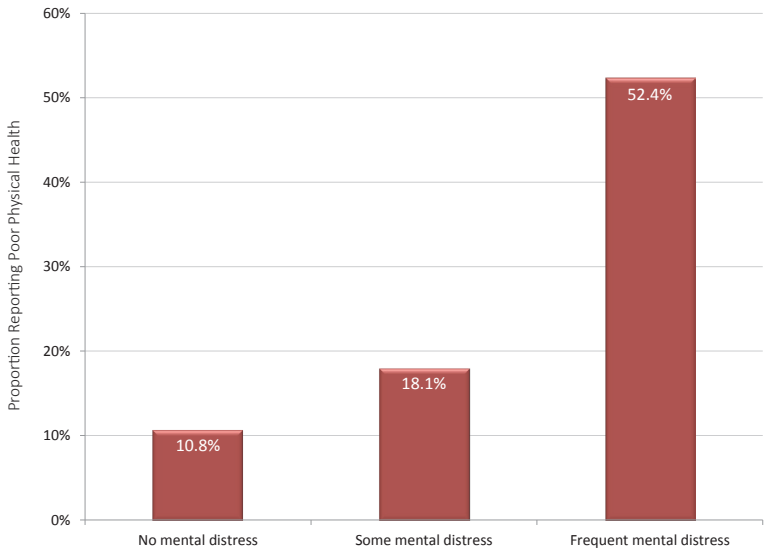
| Indicator | Ages 50+ | Ages 50–64 | Ages 65+ |
|---|---|---|---|
| Rarely or never get social or emotional support | 9.3% | 6.8% | 13.3% |
| Dissatisfied or very dissatisfied with life | 4.7% | 5.8% | 2.9% |

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**

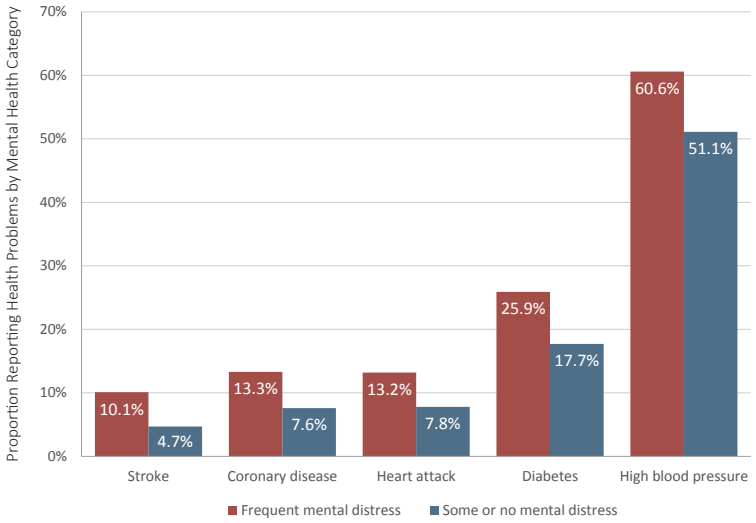



Source: BRFSS, 2013

## 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 New Hampshirites Admitted to State Mental Health Services

Approximately 6.3 percent of the people served by the New Hampshire mental health system were ages 65 and older. This represents more than 2,945 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."

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

OLDER ADULTS BEHAVIORAL HEALTH PROFILE

# Rhode Island

# Rhode Island

## OLDER ADULTS BEHAVIORAL HEALTH PROFILE

February 2016

## RHODE ISLAND'S POPULATION

### Rhode Island Population by Age Group

Rhode Island is home to 1,055,173 people. Of these:

- 388,076 (36.8 percent) are over age 50.
- 231,097 (21.9 percent) are over age 60.
- 113,514 (10.8 percent) are over age 70.
- 49,893 (4.7 percent) are ages 80 and older.

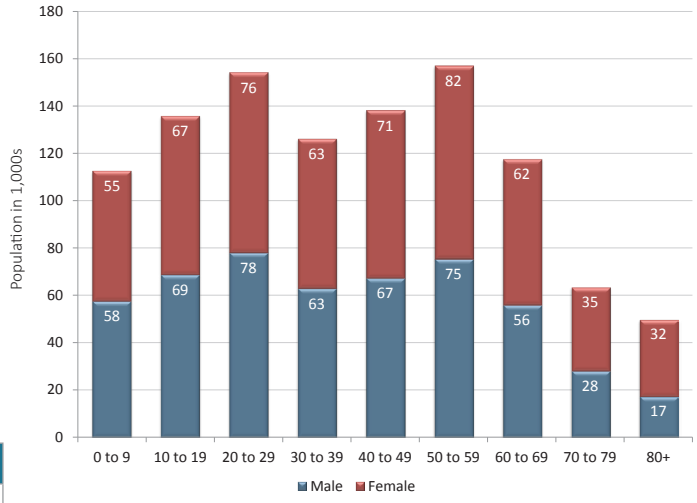
The proportion of women rises fairly steadily in each age group, and women make up 65.1 percent of the 80+ group. The racial/ethnic composition of older Rhode Islanders is as follows:

*Race/Ethnicity of Rhode Islanders Ages 50+*

| White | AI/AN | Black | Asian | NH/PI | Other | Hispanic |
|---|---|---|---|---|---|---|
| 91.8% | 0.6% | 4.7% | 2.0% | 0.1% | 0.9% | 6.3% |

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

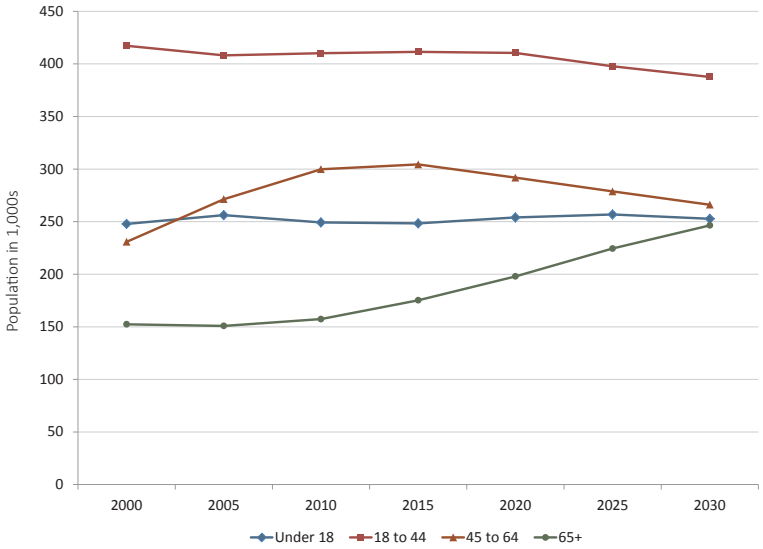
**Exhibit 1. Rhode Island Population by Age Group, 2014**




Source: U.S. Census Bureau, 2015

### The Number of Older Rhode Islanders Is Growing

**Exhibit 2. Rhode Island Population by Age Group, 2000–2030**




The proportion of Rhode Island'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 21.4 percent of Rhode Island's population will be 65 and older by the year 2030, an increase of 40.7 percent from 2015.

*Projected Population in Rhode Island*

| Age Group | 2015 | 2025 | 2030 |
|---|---|---|---|
| Under 18 | 21.8% | 22.2% | 21.9% |
| 18 to 44 | 36.1% | 34.4% | 33.6% |
| 45 to 64 | 26.7% | 24.1% | 23.1% |
| 65+ | 15.4% | 19.4% | 21.4% |

Source: U.S. Census Bureau, 2005

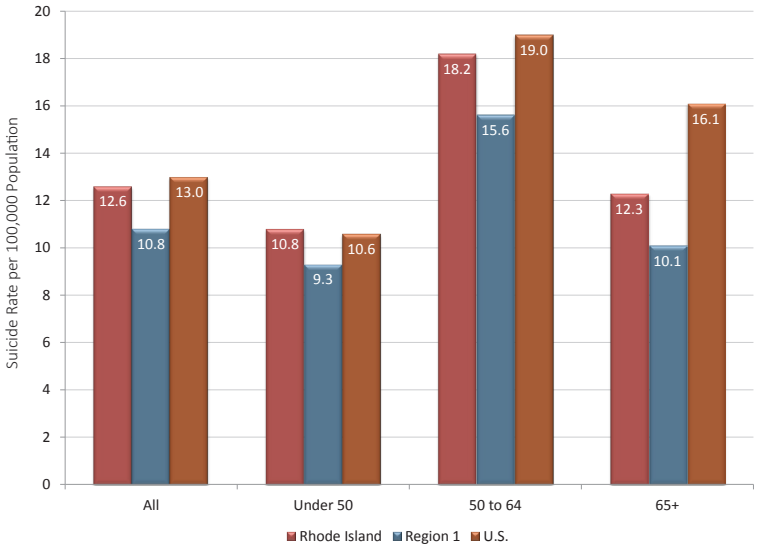
# SUICIDE AMONG OLDER RHODE ISLANDERS

## Rhode Island Suicide Rate Compared With Regional and National Rates

The suicide rate among Rhode Islanders 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 15.7 per 100,000 people (unreliable data for women and 26.4 for men). The rate among those ages 50–64 was higher than the rate in the region (including Connecticut, Maine, Massachusetts, New Hampshire, and Vermont) and lower than the rate in the United States.

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

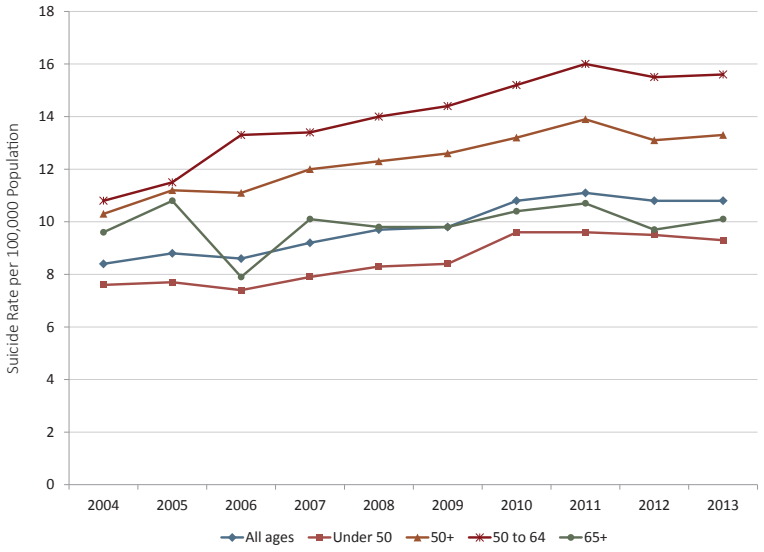
**Exhibit 3. Suicide Rates in Rhode Island, Region 1, and the United States, 2013**




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

## Trends in Suicide Rates in Region 1

**Exhibit 4. Trends in Suicide Rates in Region 1 by Age Group, 2004–2013**




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

Suicide data for Rhode Islanders of various ages were unavailable. Therefore, the rates for Region 1 are used instead.

The suicide rate among individuals in Region 1 ages 50+ fluctuated from a low of 10.4 per 100,000 in 2004 to a high of 13.9 per 100,000 in 2011. From 2004 to 2013, the rate was highest among those in the 50–64 age group.

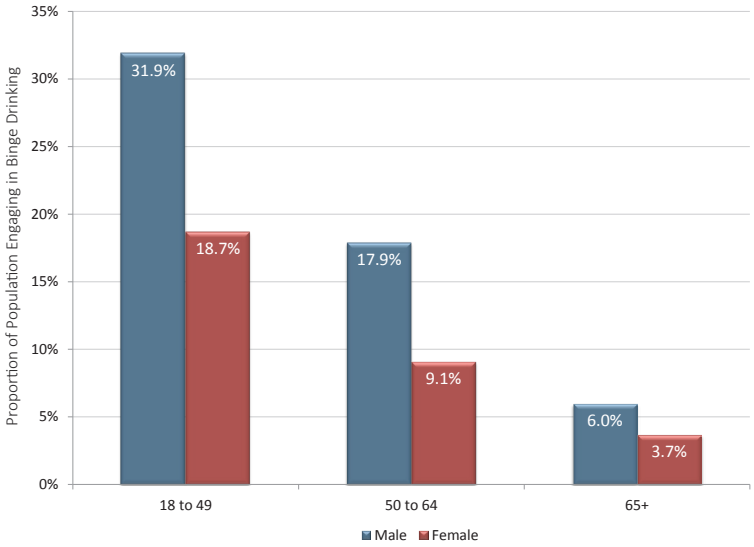
How a state reports suicides can vary from year to year. The number of suicides is generally low, so even a small difference in reported numbers may make the rate fluctuate widely.

# SUBSTANCE USE DISORDER AND SUBSTANCE USE DISORDER TREATMENT AMONG OLDER RHODE ISLANDERS

## 30-Day Binge Drinking Among Older Rhode Islanders

Binge drinking, defined as five or more drinks for men and four or more drinks for women on a single occasion, can lead to serious health problems. Such problems include neurological damage, cardiovascular disease, liver disease, stroke, and poor control of diabetes. Binge drinkers are more likely to take risks such as driving while intoxicated and to experience falls and other accidents. Older people have a lower tolerance for alcohol. Binge drinking decreases with age and occurs more frequently among men than it does among women. As Exhibit 5 shows, 17.9 percent of Rhode Island men ages 50–64 reported binge drinking in the past 30 days, while 6.0 percent of those in the 65+ group reported similar behavior.

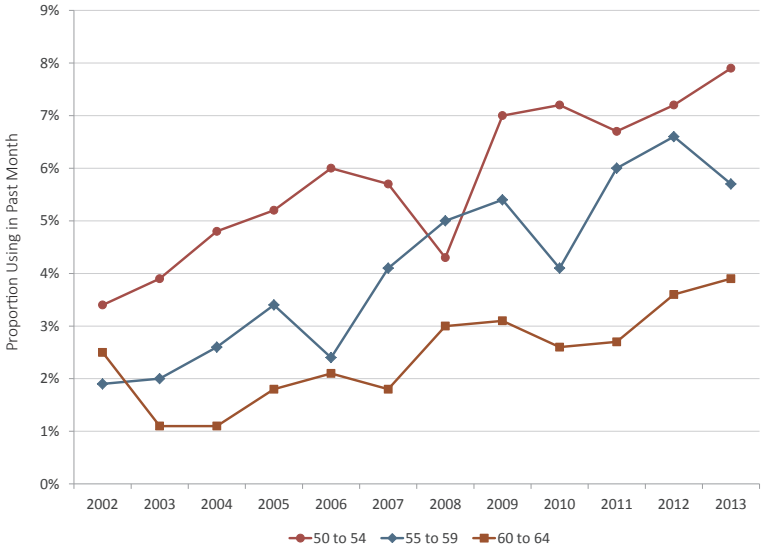
**Exhibit 5. Binge Drinking Rates in Rhode Island by Age Group and Sex, 2013**




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 *Rhode Island 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).

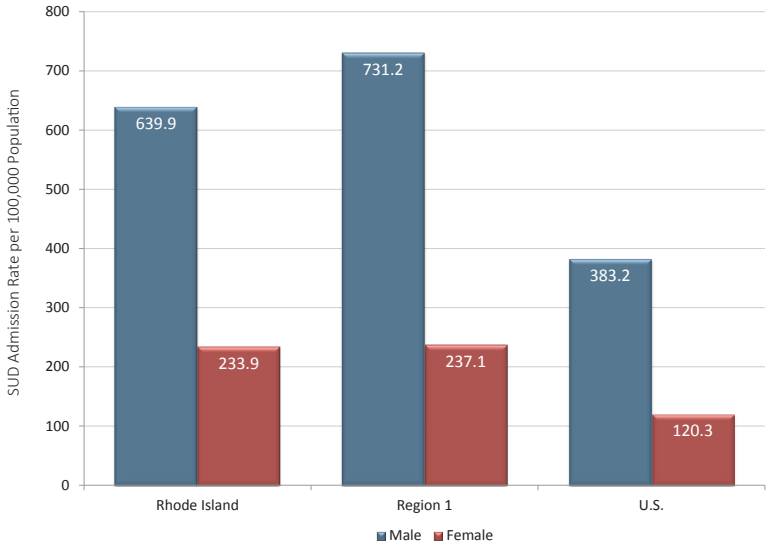
## Admissions to Substance Use Disorder Treatment Among Older Rhode Islanders

In 2012, there were 1,626 admissions of Rhode Islanders ages 50 and older to substance use disorder (SUD) treatment in state-funded treatment programs, a rate of 419.0 per 100,000 people ages 50+. This rate was lower than the regional rate and higher than the national average. Men made up 69.6 percent of these admissions. Of all admissions, 87.8 percent were White/ Caucasian, 10.2 percent were Black/ African American, and 6.3 percent were Hispanic.

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

| Self-Referral | Criminal Justice | Other |
|---|---|---|
| 47.0% | 19.5% | 33.5 |

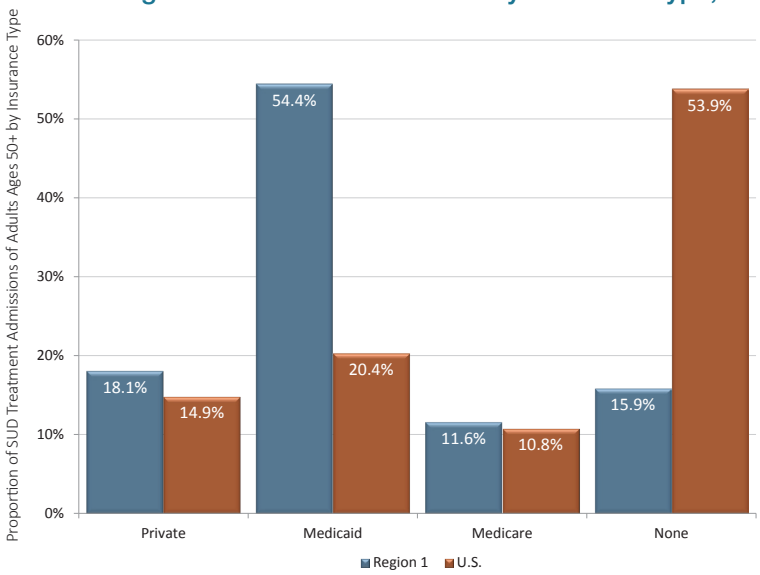
### Exhibit 7. SUD Treatment Admissions of Adults Ages 50+ in Rhode Island, Region 1, and the United States by Sex, 2012




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

## SUD Treatment Admissions Among Individuals in Region 1 Ages 50+ by Insurance Type

### Exhibit 8. SUD Treatment Admissions of Adults Ages 50+ in Region 1 and the United States by Insurance Type, 2012




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

States may choose not to report some of the fields to TEDS, including information on treatment admission insurance types. These data were not reported by Rhode Island in 2012. Therefore, the rates for Region 1 are used instead.

In Region 1, 15.9 percent of older adult admissions to SUD treatment were uninsured, 54.4 percent had Medicaid, 11.6 percent had Medicare, and 18.1 percent had private insurance.

### *SUD Treatment Admissions Among Rhode Islanders Ages 50+ by Primary Sources of Payment*

| Self-Pay | Medicaid | Other |
|---|---|---|
| 35.7% | 20.7% | 43.7% |

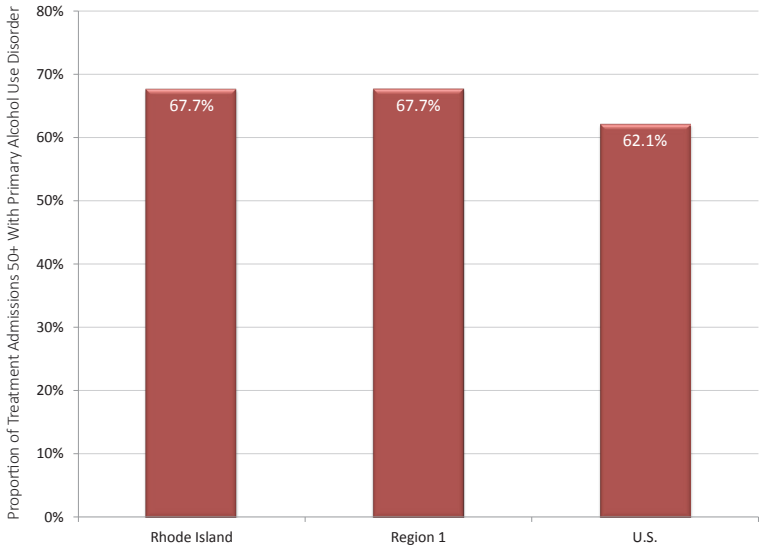
Self-pay data include private insurance.
Exhibit 8 and the accompanying text reflect the type of health insurance (if any) clients had at admission; the table above represents primary sources of payment.

[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 Rhode Islanders Ages 50+

Alcohol was the most frequently cited substance used by older Rhode Islanders in publicly financed SUD treatment in 2012. It was mentioned as a substance of use in 67.7 percent of admissions among those ages 50+. This was equal to the regional rate and higher than the national rate.

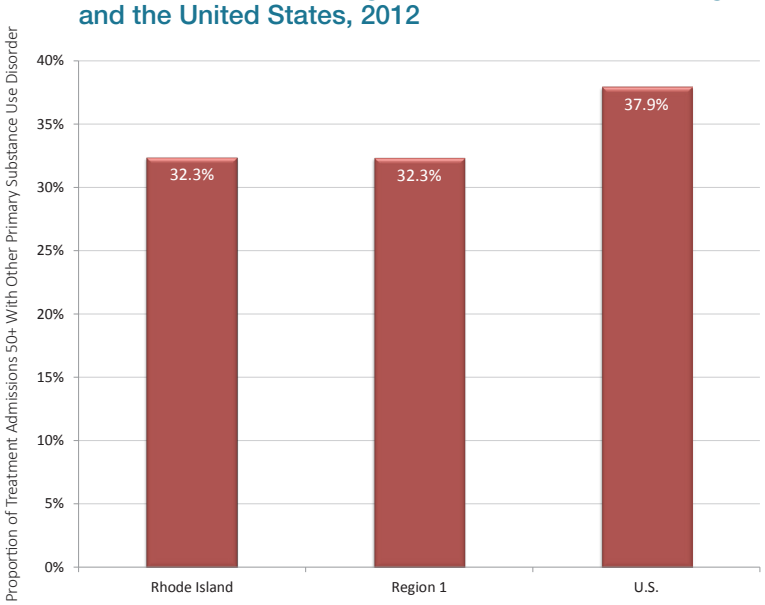
**Exhibit 9. Alcohol Use Treatment Admissions of Adults Ages 50+ in Rhode Island, Region 1, and the United States, 2012**




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 Rhode Island, Region 1, 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 32.3 percent of older adult admissions to publicly funded treatment in Rhode Island.

## 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*:

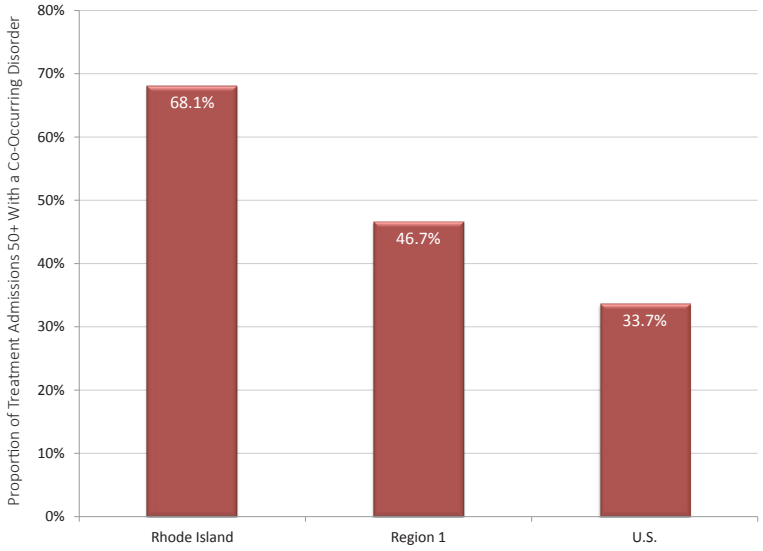
- *In 2004, there were an estimated 115,803 ED visits involving pharmaceutical misuse and abuse by adults aged 50 or older; in 2008, there were 256,097 such visits, representing an increase of 121.1 percent*
- *One fifth (19.7 percent) of ED visits involving pharmaceutical misuse and abuse among older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

**Exhibit 11. SUD Treatment Admissions of Adults Ages 50+ With a Co-Occurring Mental Disorder in Rhode Island, Region 1, 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.

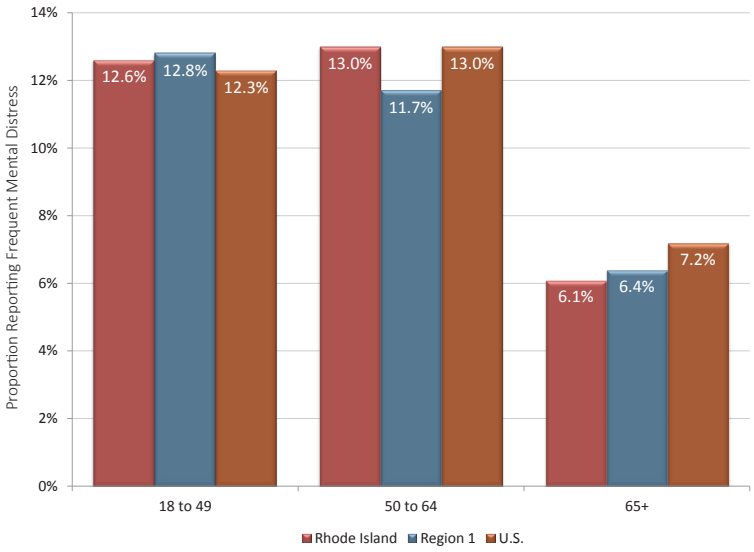
Exhibit 11 shows the proportion of SUD treatment admissions of Rhode Islanders ages 50+ with a co-occurring mental disorder. This rate is higher than the regional rate and the national average. However, state reporting practices are a factor in these results.

# MENTAL HEALTH

## Older Rhode Islanders 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 Rhode Islanders in the 50–64 age group experience FMD at a rate higher than the regional rate and equal to the national rate while those in the 65+ age group experience it at a rate lower than the regional and national rates.

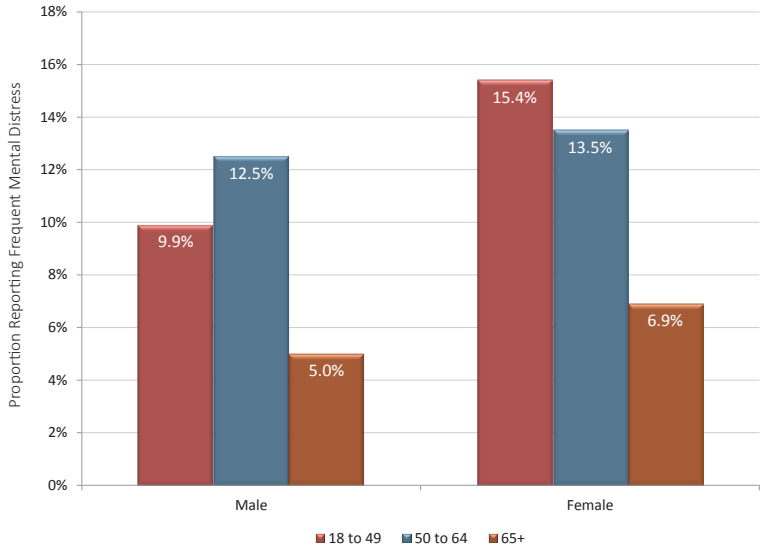
**Exhibit 12. Individuals Reporting Frequent Mental Distress in Rhode Island, Region 1, and the United States, 2013**




Source: BRFSS, 2013

## Older Rhode Islanders Reporting Frequent Mental Distress by Age Group and Sex

**Exhibit 13. Rhode Islanders Reporting Frequent Mental Distress by Age Group and Sex, 2013**




Source: BRFSS, 2013

Older men in Rhode Island 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, 13.5 percent of women in the 50–64 age group and 6.9 percent in the 65+ age group reported FMD, while 12.5 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 Rhode Islanders.

**Exhibit 14. BRFSS Measures, 2010**

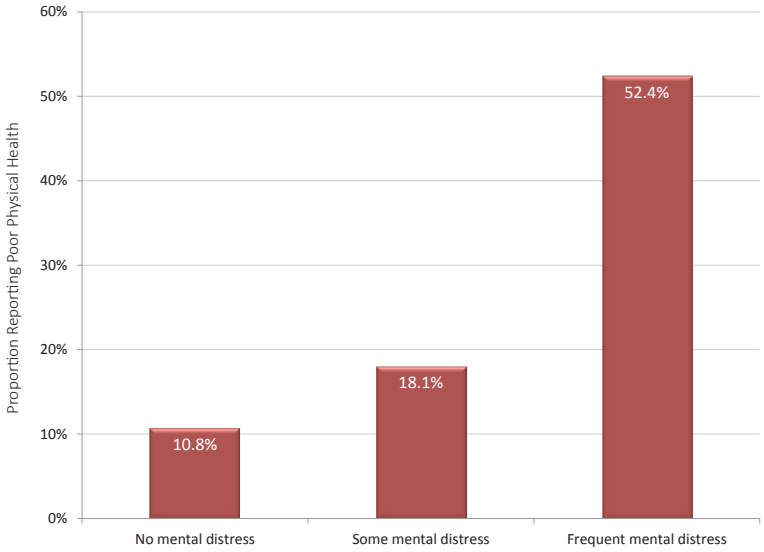
| Indicator | Ages 50+ | Ages 50–64 | Ages 65+ |
|---|---|---|---|
| Rarely or never get social or emotional support | 11.0% | 7.9% | 15.2% |
| Dissatisfied or very dissatisfied with life | 5.0% | 5.7% | 4.1% |

Source: BRFSS, 2010

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

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

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




Source: BRFSS, 2013

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

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

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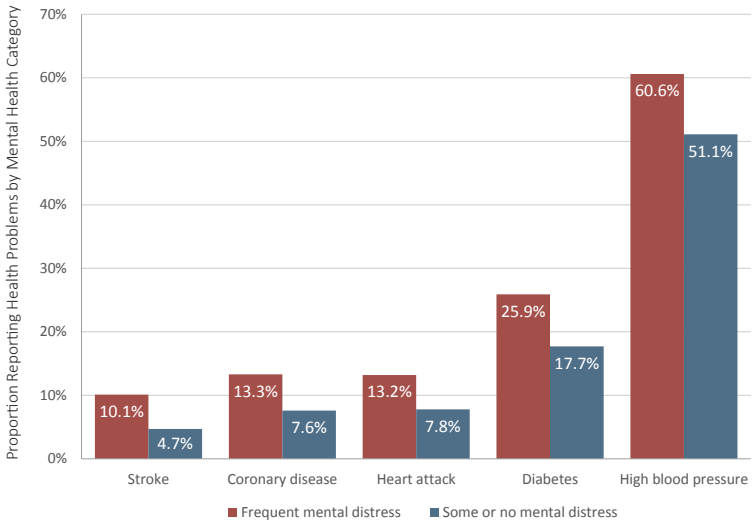


Source: BRFSS, 2013

## Older Rhode Islanders Admitted to State Mental Health Services

Approximately 4.5 percent of the people served by the Rhode Island mental health system were ages 65 and older. This represents more than 1,444 adults.

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

## DATA SOURCES

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

OLDER ADULTS BEHAVIORAL HEALTH PROFILE

# Vermont

# Vermont

## OLDER ADULTS BEHAVIORAL HEALTH PROFILE

February 2016

## VERMONT'S POPULATION

### Vermont Population by Age Group

Vermont is home to 626,562 people. Of these:

- 252,058 (40.2 percent) are over age 50.
- 151,671 (24.2 percent) are over age 60.
- 69,371 (11.1 percent) are over age 70.
- 26,834 (4.3 percent) are ages 80 and older.

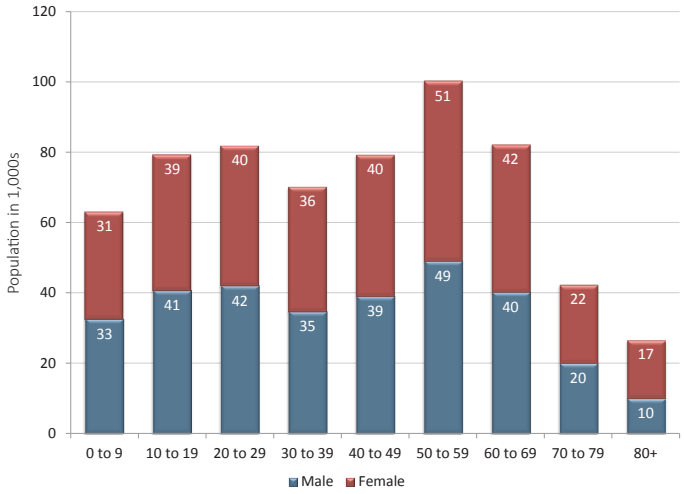
The proportion of women rises fairly steadily in each age group, and women make up 62.3 percent of the 80+ group. The racial/ethnic composition of older Vermonters is as follows:

*Race/Ethnicity of Vermonters Ages 50+*

| White | AI/AN | Black | Asian | NH/PI | Other | Hispanic |
|---|---|---|---|---|---|---|
| 97.5% | 0.3% | 0.5% | 0.8% | 0.0% | 0.9% | 0.8% |

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.

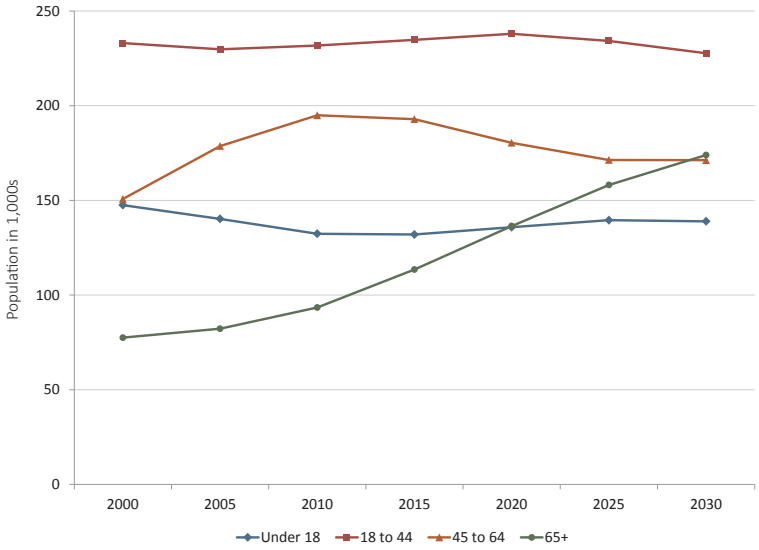
**Exhibit 1. Vermont Population by Age Group, 2014**




Source: U.S. Census Bureau, 2015

### The Number of Older Vermonters Is Growing

**Exhibit 2. Vermont Population by Age Group, 2000–2030**




The proportion of Vermont's population that is 65 and older is growing while the proportion that is younger than 65 is shrinking. The U.S. Census Bureau estimates that 24.4 percent of Vermont's population will be 65 and older by the year 2030, an increase of 53.3 percent from 2015.

*Projected Population in Vermont*

| Age Group | 2015 | 2025 | 2030 |
|---|---|---|---|
| Under 18 | 19.6% | 19.8% | 19.5% |
| 18 to 44 | 34.9% | 33.3% | 32.0% |
| 45 to 64 | 28.7% | 24.4% | 24.1% |
| 65+ | 16.9% | 22.5% | 24.4% |

Source: U.S. Census Bureau, 2005

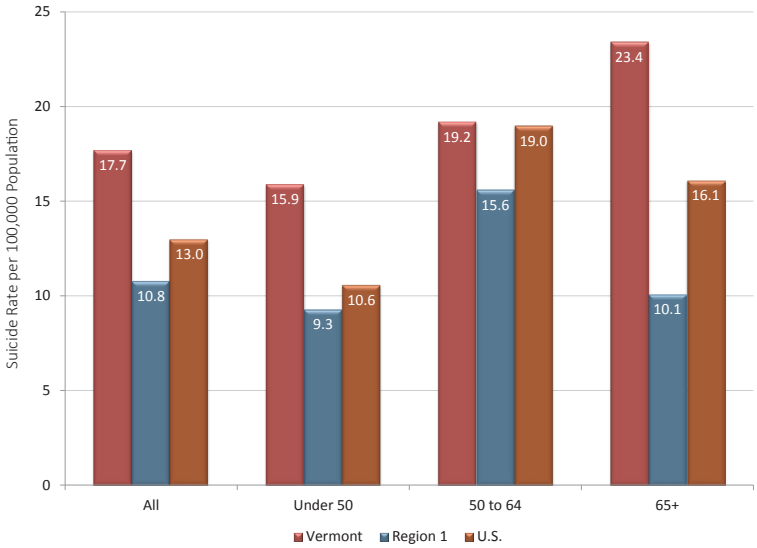
# SUICIDE AMONG OLDER VERMONTERS

## Vermont Suicide Rate Compared With Regional and National Rates

The suicide rate among Vermonters 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 20.9 per 100,000 people (unreliable data for women and 35.6 for men). The rate among those ages 50–64 was higher than both the rate in the region (including Connecticut, Maine, Massachusetts, New Hampshire, and Rhode Island) and the rate in the United States.

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

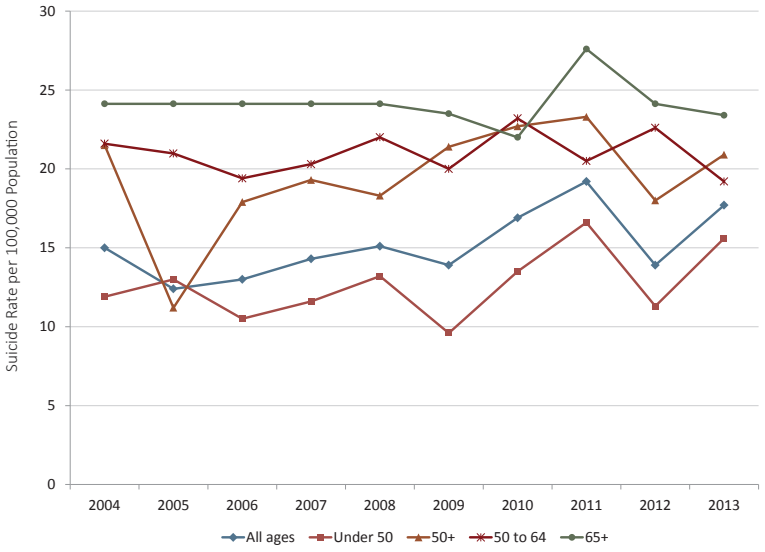
**Exhibit 3. Suicide Rates in Vermont, Region 1, and the United States, 2013**




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 Vermont

**Exhibit 4. Trends in Suicide Rates in Vermont 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 Vermonters ages 50+ fluctuated from a low of 11.2 per 100,000 in 2005 to a high of 23.3 per 100,000 in 2011. From 2004 to 2013, the rate was generally highest among those in the 65+ age group.

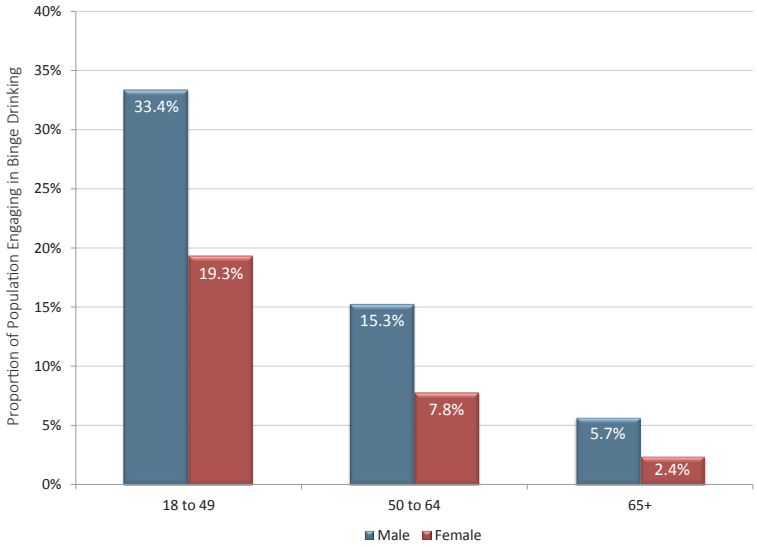
How a state reports suicides can vary from year to year. The number of suicides is generally low, so even a small difference in reported numbers may make the rate fluctuate widely.

# SUBSTANCE USE DISORDER AND SUBSTANCE USE DISORDER TREATMENT AMONG OLDER VERMONTERS

## 30-Day Binge Drinking Among Older Vermonters

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, 15.3 percent of Vermont men ages 50–64 reported binge drinking in the past 30 days, while 5.7 percent of those in the 65+ group reported similar behavior.

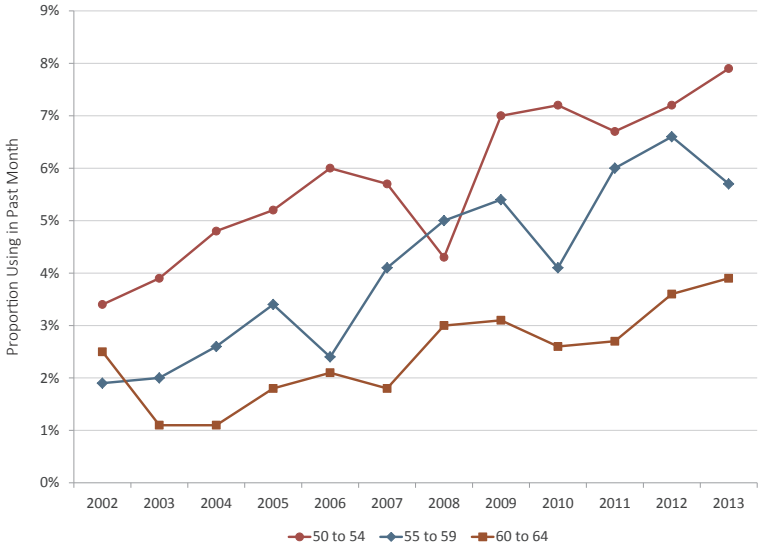
**Exhibit 5. Binge Drinking Rates in Vermont by Age Group and Sex, 2013**




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 *Vermont 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).

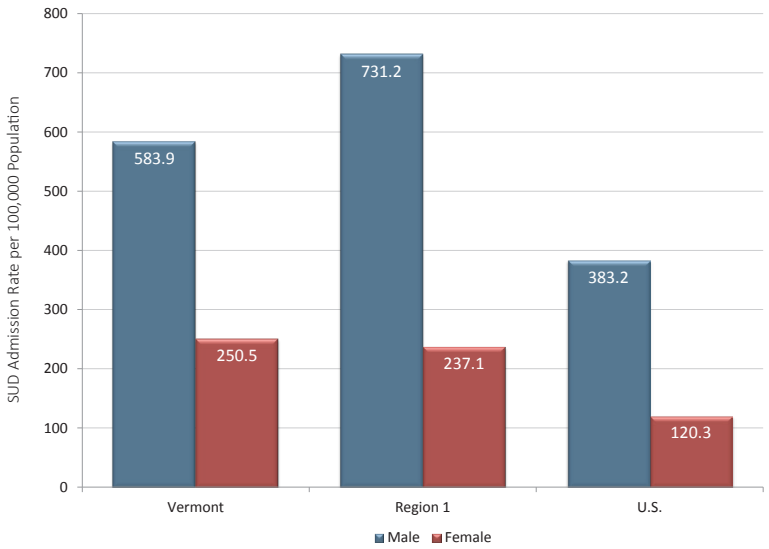
## Admissions to Substance Use Disorder Treatment Among Older Vermonters

In 2012, there were 1,030 admissions of Vermonters ages 50 and older to substance use disorder (SUD) treatment in state-funded treatment programs, a rate of 408.6 per 100,000 people ages 50+. This rate was lower than the regional rate and higher than the national average. Men made up 67.8 percent of these admissions. Of all admissions, 96.7 percent were White/Caucasian, 1.9 percent were Black/African American, and 1.3 percent were Hispanic.

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

| Self-Referral | Criminal Justice | Other |
|---|---|---|
| 38.9% | 23.8% | 37.3% |

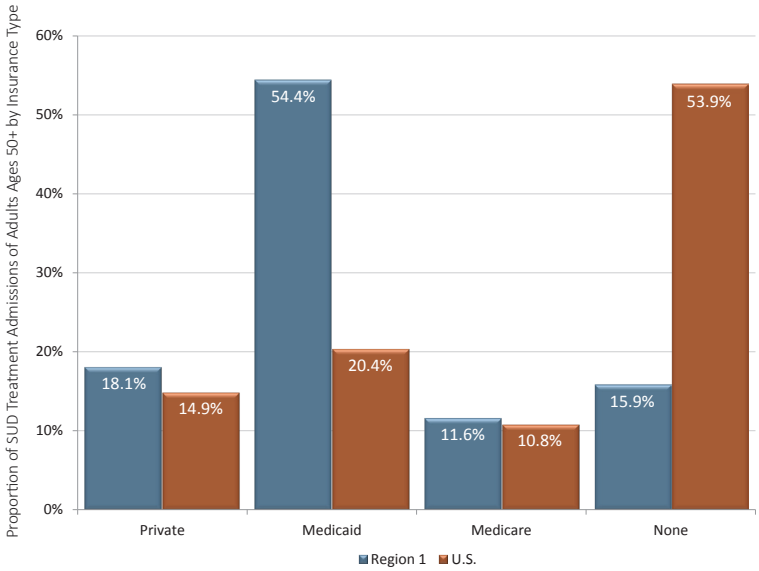
### Exhibit 7. SUD Treatment Admissions of Adults Ages 50+ in Vermont, Region 1, and the United States by Sex, 2012




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

## SUD Treatment Admissions Among Individuals in Region 1 Ages 50+ by Insurance Type

### Exhibit 8. SUD Treatment Admissions of Adults Ages 50+ in Region 1 and the United States by Insurance Type, 2012




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

States may choose not to report some of the fields to TEDS, including information on treatment admission insurance types. These data were not reported by Vermont in 2012. Therefore, the rates for Region 1 are used instead.

In Region 1, 15.9 percent of older adult admissions to SUD treatment were uninsured, 54.4 percent had Medicaid, 11.6 percent had Medicare, and 18.1 percent had private insurance.

### *SUD Treatment Admissions Among Vermonters Ages 50+ by Primary Sources of Payment*

| Self-Pay | Medicaid | Other |
|---|---|---|
| 27.0% | 56.7% | 16.3% |

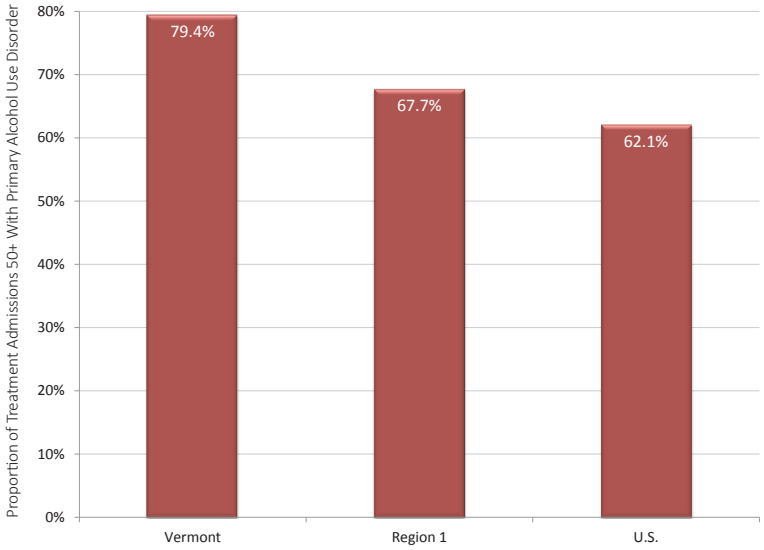
Self-pay data include private insurance.
Exhibit 8 and the accompanying text reflect the type of health insurance (if any) clients had at admission; the table above represents primary sources of payment.

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

## Alcohol Use Disorder Treatment Admissions Among Vermonters Ages 50+

Alcohol was the most frequently cited substance used by older Vermonters in publicly financed SUD treatment in 2012. It was mentioned as a substance of use in 79.4 percent of admissions among those ages 50+. This was higher than the regional and national rates.

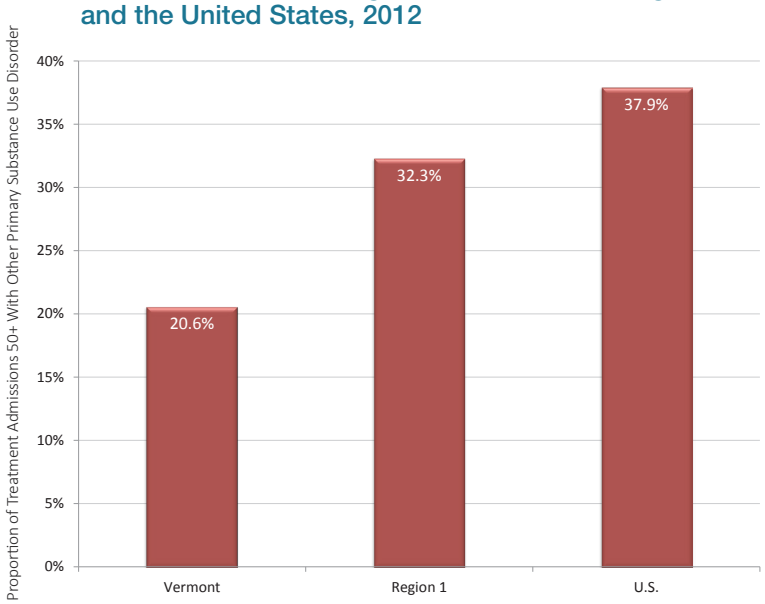
**Exhibit 9. Alcohol Use Treatment Admissions of Adults Ages 50+ in Vermont, Region 1, and the United States, 2012**




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 Vermont, Region 1, 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 20.6 percent of older adult admissions to publicly funded treatment in Vermont.

## Drug-Related Emergency Department Visits Involving Pharmaceutical Misuse and Abuse by Older Adults

SAMHSA periodically releases reports from the Drug Abuse Warning Network (DAWN). DAWN, discontinued in 2011, consisted of a nationwide network of hospital emergency departments (EDs) primarily located in large metropolitan areas. DAWN data consist of professional reviews of ED records to determine the extent to which alcohol and other substance abuse was involved in ED visits. According to the November 25, 2010, *DAWN Report*:

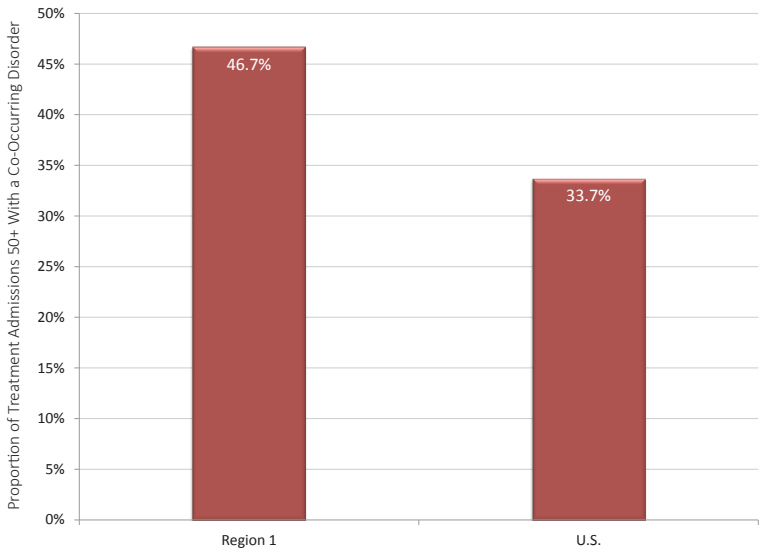
- *In 2004, there were an estimated 115,803 ED visits involving pharmaceutical misuse and abuse by adults aged 50 or older; in 2008, there were 256,097 such visits, representing an increase of 121.1 percent*
- *One fifth (19.7 percent) of ED visits involving pharmaceutical misuse and abuse among older adults were made by persons aged 70 or older*
- *Among ED visits made by older adults, pain relievers were the type of pharmaceutical most commonly involved (43.5 percent), followed by drugs used to treat anxiety or insomnia (31.8 percent) and antidepressants (8.6 percent)*
- *Among patients aged 50 or older who visited the ED for pharmaceutical misuse or abuse, more than half (52.3 percent) were treated and released, and more than one third (37.5 percent) were admitted to the hospital*

Bulleted text in italics above is taken from SAMHSA's Center for Behavioral Health Statistics and Quality. (2010, November 25). ***The DAWN Report: Drug-related emergency department visits involving pharmaceutical misuse and abuse by older adults.*** Rockville, MD: SAMHSA.

# CO-OCCURRING SUBSTANCE USE AND MENTAL DISORDERS

## Older Adults in Region 1 in SUD Treatment With Co-Occurring Mental Disorders

**Exhibit 11. SUD Treatment Admissions of Adults Ages 50+ With a Co-Occurring Mental Disorder in Region 1 and the United States, 2012**




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

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

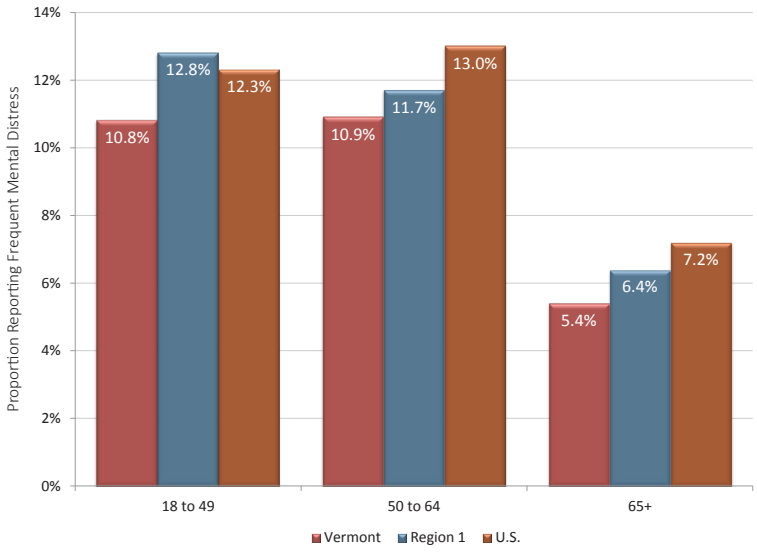
States may choose not to report some of the fields to TEDS, including information on SUD treatment admissions with a co-occurring disorder. These data were not reported by Vermont in 2012. Therefore, Exhibit 11 shows regional and national figures only.

# MENTAL HEALTH

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

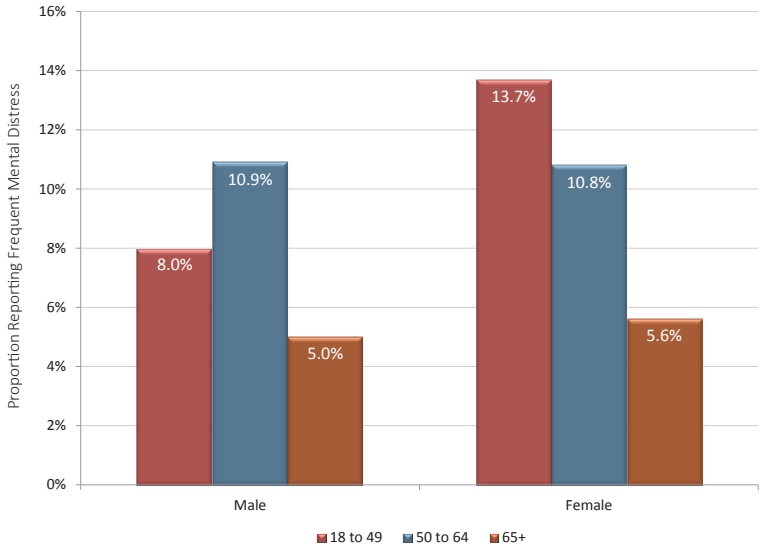
**Exhibit 12. Individuals Reporting Frequent Mental Distress in Vermont, Region 1, and the United States, 2013**




Source: BRFSS, 2013

## Older Vermonters Reporting Frequent Mental Distress by Age Group and Sex

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




Source: BRFSS, 2013

In Vermont, men in the 50–64 age group reported FMD at nearly the same rate as women (14 days or more per 30-day period), in contrast to other states in the region, where women in the same age group reported higher rates of FMD. As Exhibit 13 shows, 10.9 percent of men in the 50–64 age group reported FMD compared with 10.8 percent of women in the 50–64 age group. In the 65+ age group, 5.0 percent of men reported FMD compared with 5.6 percent of women.

## 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 Vermonters.

**Exhibit 14. BRFSS Measures, 2010**

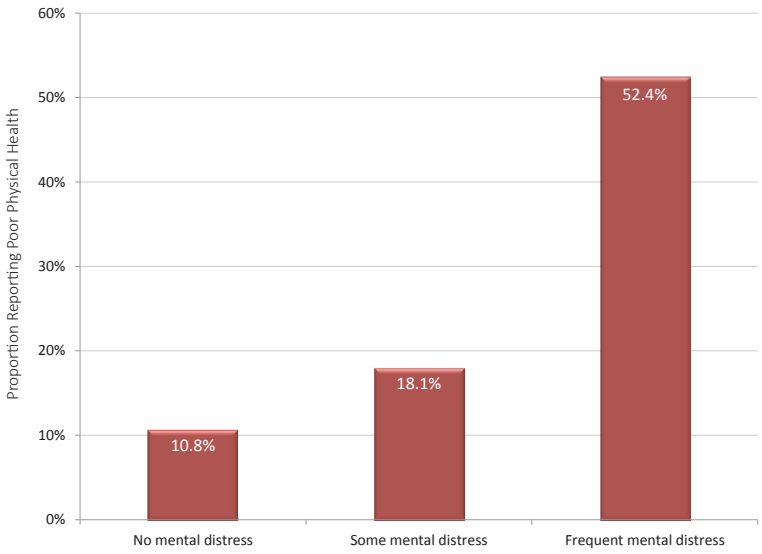
| Indicator | Ages 50+ | Ages 50–64 | Ages 65+ |
|---|---|---|---|
| Rarely or never get social or emotional support | 7.4% | 5.2% | 10.7% |
| Dissatisfied or very dissatisfied with life | 4.1% | 4.8% | 3.0% |

Source: BRFSS, 2010

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

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

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

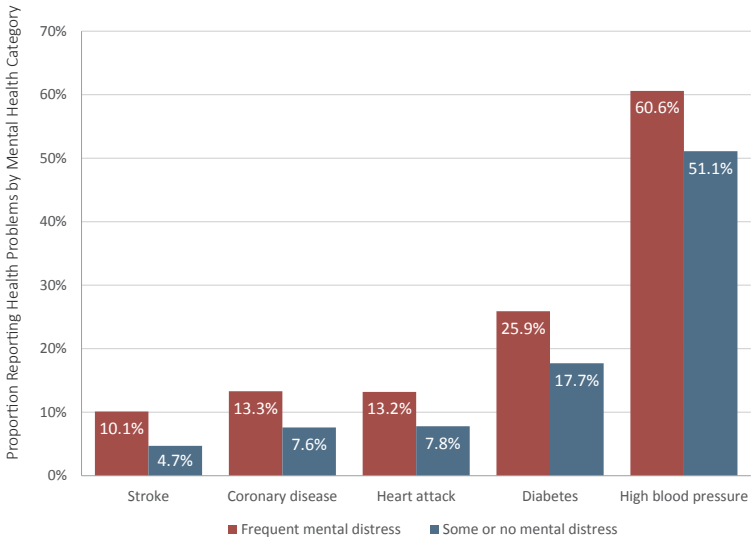



Source: BRFSS, 2013

## 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 Vermonters Admitted to State Mental Health Services

Approximately 5.8 percent of the people served by the Vermont mental health system were ages 65 and older. This represents more than 1,421 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** (http://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.