

The TEDS Report

November 15, 2011

Older Adult Admissions Reporting Alcohol as a Substance of Abuse: 1992 and 2009

In Brief

- Treatment admissions aged 50 or older increased from 6.6 percent of all admissions in 1992 to 12.7 percent in 2009
- The proportion of older adult alcohol admissions who reported alcohol as their only substance of abuse decreased from 87.6 percent in 1992 to 58.0 in 2009, while the proportion who reported alcohol in combination with drugs increased from 12.4 to 42.0 percent
- The proportion of older adult alcohol admissions who reported a co-occurring psychiatric problem tripled between 1992 and 2009 (from 10.5 to 31.4 percent)

Although alcohol misuse is a concern for any age group, it poses particular risks for older adults. Alcohol misuse can exacerbate medical problems that are common among this age group (i.e., diabetes, high blood pressure), and long-term abuse can result in chronic medical conditions such as cirrhosis of the liver, heart problems, and certain types of cancer.^{1,2} Additionally, many older adults take prescription or over-the-counter medications, which can be dangerous and potentially life-threatening if used in combination with alcohol.³ Further, the human body metabolizes alcohol more slowly as people age, which can increase sensitivity to alcohol, reduce alcohol tolerance, and ultimately place older adults at a greater risk of cognitive impairment and related accidents and injuries (i.e., falls and motor vehicle

Figure 1. Alcohol Admissions Aged 50 or Older Reporting Alcohol Abuse Only and Combined Alcohol and Drug Abuse: 1992 and 2009



Source: SAMHSA Treatment Episode Data Set (TEDS), 1992 and 2009.

accidents).⁴ Social changes, such as the loss of loved ones, retirement, and greater social isolation, may increase older adults' risk of co-occurring alcohol abuse and mental health problems.⁵

As the large baby boom cohort (persons born between 1946 and 1964) continues to move into older adulthood, the number of older adults with alcohol use disorders is expected to increase. Recent projections indicate that the number of older adults with a substance use disorder (alcohol or illicit drugs) will double from an annual average of 2.8 million between 2002 and 2006 to 5.7 million in 2020.⁶ Alcohol, which is by far the most common substance of abuse, will contribute to these increases.⁷ In addition, baby

boomers may have patterns of substance use that differ from previous cohorts (e.g., greater likelihood of combined alcohol and illicit drug use), which may impact their treatment service needs.^{8,9} Older adults with alcohol problems are likely to place increasing demands on the substance abuse treatment system over the next decade, and it is critical that the treatment system be prepared to meet the growing and changing needs of this population.

Data from the Treatment Episode Data Set (TEDS) can be used to monitor substance abuse treatment admissions aged 50 or older (hereafter referred to as "older adults") over time. TEDS collects data on the primary substance of abuse and up to two additional substances of abuse at time of

admission to substance abuse treatment. This report focuses on older adult admissions who reported primary, secondary, or tertiary abuse of alcohol (hereafter referred to as "any alcohol abuse"); data for 1992 and 2009 are used to compare the characteristics of admissions in these 2 years.

Overview

Treatment admissions aged 50 or older increased from 6.6 percent of all admissions in 1992 to 12.7 percent in 2009. In both years, the majority of older adult treatment admissions reported any alcohol abuse; however, alcohol admissions represented a smaller proportion of older adult admissions in 2009 than 1992 (73.4 vs. 88.3 percent).

Admissions who reported any alcohol abuse can be divided into two subgroups—those that reported alcohol as their only substance of abuse and those that reported combined alcohol and drug abuse. The distribution of admissions in these two subgroups shifted significantly between 1992 and 2009. Specifically, the proportion of older adult alcohol admissions who reported alcohol as their *only* substance of abuse decreased from 87.6 percent in 1992 to 58.0 percent in 2009, while the proportion of those who reported abuse of alcohol and drugs increased from 12.4 to 42.0 percent (Figure 1). Admissions reporting abuse of alcohol and cocaine increased from 4.6 percent in 1992 to

14.1 percent in 2009, and those reporting abuse of alcohol and marijuana increased from 3.0 to 8.9 percent (Figure 2).

Demographic Characteristics

The proportions of older adult alcohol admissions who were female increased from 16.9 percent in 1992 to 22.2 percent in 2009, and the proportions who were non-Hispanic Black increased from 18.3 to 25.1 percent (Figure 3).

Co-occurring Psychiatric Problems

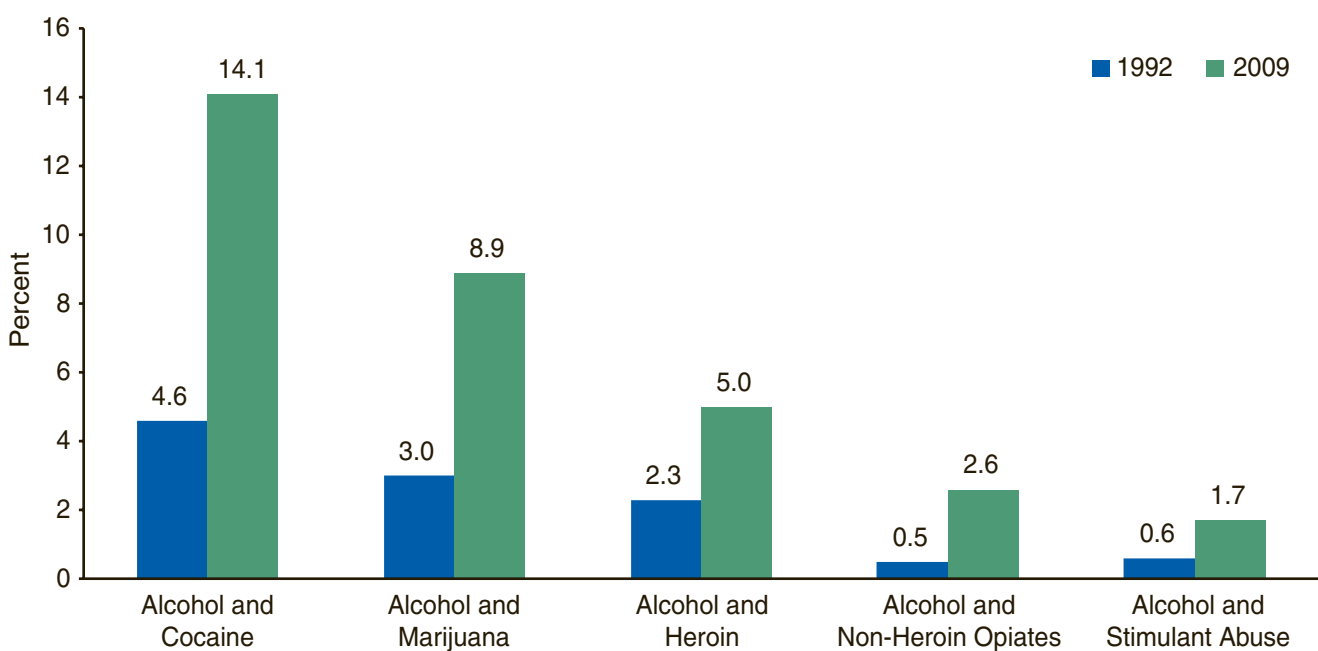
The proportion of older adult alcohol admissions who reported a co-occurring psychiatric problem tripled

between 1992 and 2009 (from 10.5 to 31.4 percent).¹⁰ Increases were seen among both genders and all race/ethnicities (Figure 4). For example, 9.1 percent of male alcohol admissions aged 50 or older had a co-occurring psychiatric problem in 1992 compared with 27.3 percent in 2009; percentages among female admissions aged 50 or older increased from 17.2 to 44.9 percent.

Previous Treatment Admissions

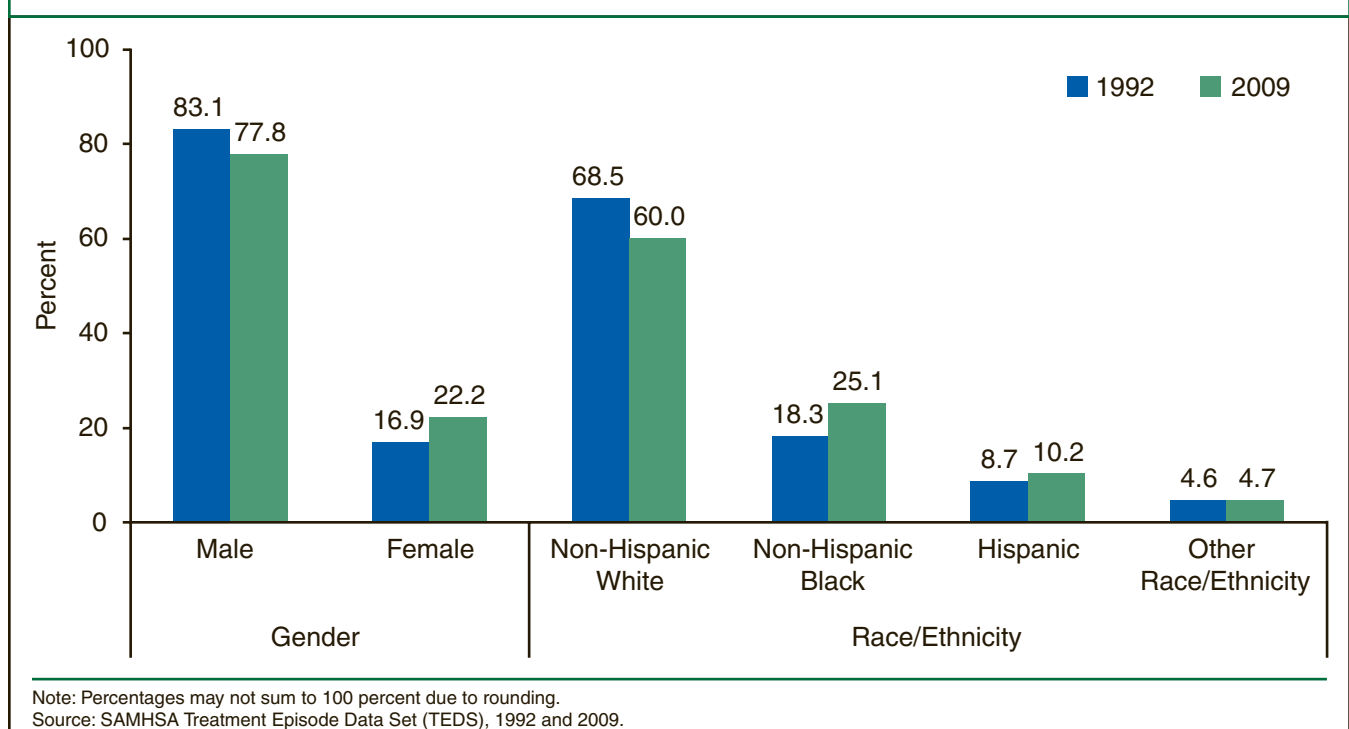
In both 1992 and 2009, the majority of older adult alcohol admissions had previous treatment admissions; however, the proportion who reported previous admissions increased during this time. Among older

Figure 2. Admissions Aged 50 or Older, by Selected Alcohol-Drug Combinations: 1992 and 2009



Source: SAMHSA Treatment Episode Data Set (TEDS), 1992 and 2009.

Figure 3. Alcohol Admissions Aged 50 or Older, by Gender and Race/Ethnicity: 1992 and 2009



adult alcohol admissions, 57.0 percent had at least one previous admission in 1992 compared with 63.2 percent in 2009. The percentage with three or more admissions increased from 26.3 to 31.2 percent.

Discussion

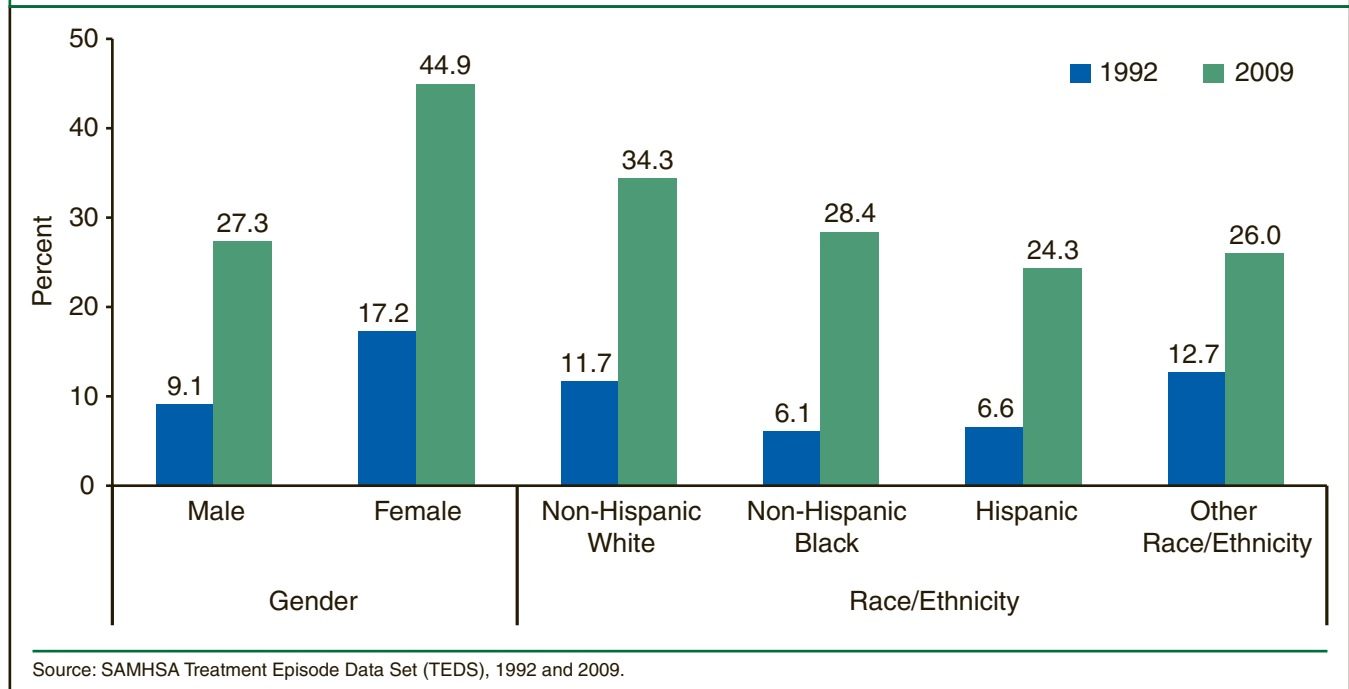
As TEDS data show, the number of older adult treatment admissions for abuse of alcohol has increased over time. Moreover, in 2009, older adult alcohol admissions were more likely than those in 1992 to have additional problems that could complicate treatment and recovery (i.e., drug abuse or co-occurring mental health problems). While older adult admissions in 2009 were less

likely to report alcohol as their only substance of abuse, the proportion of older adult admissions that reported alcohol abuse in combination with drugs more than tripled between 1992 and 2009. As more baby boomers enter older adulthood, these upward trends are likely to continue. Furthermore, the leading edge of the baby boom cohort—those born in 1946—will have turned 65 in 2011 with increased likelihood of developing the physical health problems associated with aging. Given the multiple and complex needs of older adult alcohol admissions, a continuum of care that includes substance abuse treatment, mental health services, and physical health

care as well as a variety of supportive services (e.g., case management, transportation, and social support) may improve their chances of recovery.

Identifying older adults with alcohol problems is also important. Screening for alcohol misuse as well as brief interventions or referrals to appropriate substance abuse treatment should be considered as routine components of primary health care. Physicians and other health care providers can advise their older patients about medical conditions that can be exacerbated by drinking and about the dangers of using certain medications with alcohol. Adult children and other caregivers can also

Figure 4. Co-occurring Psychiatric Problems among Alcohol Admissions Aged 50 or Older, by Gender and Race/Ethnicity: 1992 and 2009



be instrumental in recognizing the signs of alcohol abuse, helping older adults to obtain the services they need, and supporting them through recovery efforts.

End Notes

¹ Blow, F. C. (Ed., Consensus Panel Chair). (1998). *Substance abuse among older adults* (DHHS Publication No. SMA 98-3179, Treatment Improvement Protocol [TIP] Series 26). Rockville MD: Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment.

² Boffetta, P., Hashibe, M., La Vecchia, C., Zatonski, W., & Rehm, J. (2006). The burden of cancer attributable to alcohol drinking. *International Journal of Cancer*, 119(4), 884-887.

³ Simoni-Wastila, L., & Yang, H. K. (2006). Psychoactive drug abuse in older adults. *American Journal of Geriatric Pharmacotherapy*, 4(4), 380-394.

⁴ Geriatric Mental Health Foundation. (2006). *Substance abuse and misuse among older adults: Prevention, recognition and help*. Retrieved from http://www.gmhfonline.org/gmhf/consumer/factsheets/substnabuse_factsheet.html

⁵ Blow, F. C., Serras, A. M., & Barry, K. L. (2007). Late-life depression and alcoholism. *Current Psychiatry Reports*, 9(1), 14-19.

⁶ Han, B., Gfroerer, J. C., Colliver, J. D., & Penne, M. A. (2009). Substance use disorder among older adults in the United States in 2009. *Addiction*, 104(1), 88-96.

⁷ Substance Abuse and Mental Health Services Administration. (2011). *Results from the 2010 National Survey on Drug Use and Health: Summary of national findings* (NSDUH Series H-41, HHS Publication No. (SMA) 11-4658). Rockville, MD.

⁸ Patterson, T. L., & Jeste, D. V. (1999). The potential impact of the baby-boom generation on substance abuse among elderly persons. *Psychiatric Services*, 50, 1184-1188.

⁹ Gfroerer, J. C., Penne, M. A., Pemberton, M. R., & Folsom, R. E. (2002). Chapter 5: The aging baby boom cohort and future prevalence of substance abuse. In S. P. Korper & C. L. Council (Eds.), *Substance use by older adults: Estimates of future impact on the treatment system* (OAS Analytic Series #A-21, DHHS Publication No. (SMA) 03-3763). Rockville, MD: Substance Abuse and Mental Health Services Administration.

¹⁰ *Psychiatric problem in addition to alcohol or drug problem* is a Supplemental Data Set item. The 17 States in which it was reported for at least 75 percent of all admissions aged 12 or older in 1992 and 2009—CA, HI, IA, ID, KS, LA, MA, MD, ME, MO, ND, NE, NM, OK, RI, SC, and TN—accounted for 30.0 percent of all substance abuse treatment admissions in both 1992 and 2009.

Suggested Citation

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Findings from SAMHSA's Treatment Episode Data Set (TEDS) for 1992 and 2009

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The Treatment Episode Data Set (TEDS) is a compilation of data on the demographic characteristics and substance abuse problems of those aged 12 or older admitted for substance abuse treatment. TEDS is one component of the Drug and Alcohol Services Information System (DASIS), an integrated data system maintained by the Center for Behavioral Health Statistics and Quality (CBHSQ), Substance Abuse and Mental Health Services Administration (SAMHSA). TEDS information comes primarily from facilities that receive some public funding. Information on treatment admissions is routinely collected by State administrative systems and then submitted to SAMHSA in a standard format. TEDS records represent admissions rather than individuals, as a person may be admitted to treatment more than once. State admission data are reported to TEDS by the Single State Agencies (SSAs) for substance abuse treatment. There are significant differences among State data collection systems. Sources of State variation include completeness of reporting, facilities reporting TEDS data, clients included, and treatment resources available. See the annual TEDS reports for details. TEDS received approximately 2.0 million treatment admission records from 49 States and Puerto Rico for 2009.

Definitions for demographic, substance use, and other measures mentioned in this report are available in the following publication: Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (December 11, 2009). *The TEDS Report: TEDS Report Definitions*. Rockville, MD.

The TEDS Report is prepared by the Center for Behavioral Health Statistics and Quality, SAMHSA; Synectics for Management Decisions, Inc. (Arlington, VA); and RTI International (Research Triangle Park, NC). **Information and data for this issue are based on data reported to TEDS through November 3, 2010.**

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