

# Greater Portland Community Health Assessment and Source Book

## INTRODUCTION

The Greater Portland Partners for Health (GPPH) is pleased to present *The Greater Portland Community Health Assessment and Source Book*.

**The purposes of this compendium are to:**

- establish a common body of information about the health status of the Portland area population;
- facilitate a community dialogue about health and human service needs and priorities;
- initiate a process whereby key indicators of community health status receive critical review, modification or validation, and receive interpretation;
- and, exhibit existing issue-based data with an eye to improving health information infrastructure.

The Greater Portland Partners for Health (GPPH) began in 1993 with discussions among nine organizations invested in improving the health of the Portland area population. To address the need for accessible information, in 1994 the GPPH commissioned the production of a *Community Health Profile of the Greater Portland Region*, which synthesized existing health data into one common report. Following the release of the 1994 report, the GPPH undertook a process to prioritize health issues, utilizing a series of citizen study circles. Two key issues emerged from this process: tobacco prevention and control, and comprehensive school health education. With advocacy by the GPPH and the greater Portland community, considerable progress has been made on both of these priorities.

In 1998 the GPPH commenced the production of an expanded health assessment, with the goals of: tracking trends over the past five years; benchmarking local health conditions against the state and the nation; and, setting or re-establishing baselines for indicators to follow in the future. While this new production provides updated information on many of the indicators from the 1994 profile, it broadens that set with new data on health outcomes and behavioral risk factors. Additionally, *The Greater Portland Community Health Assessment and Source Book* is organized to parallel the nation's Healthy People 2010 initiative and to prepare for future updates comparing our local health status to Healthy People and Healthy Maine goals for the year 2010.

We hope that *The Greater Portland Community Health Assessment and Source Book* will be received in the true spirit of applied epidemiology — the basic science of public health.

*Epidemiology* is: a) a quantitative basic science built on working knowledge of probability, statistics, and sound research methods; b) a method of causal reasoning based on developing and testing hypotheses pertaining to occurrences and prevention of morbidity and mortality; and c) a tool for public health action to promote and protect the public's health based on science, causal reasoning, and a dose of practical common sense.<sup>1</sup>

While the primary goal of this *Source Book* is to provide health information, we are also hopeful that its usefulness will extend beyond the network of health service providers to our affiliates in the areas of: economics, education, environmental protection, physical infrastructure, recreation, and governance. We hope the information we share here will have application across sectors to all areas of education, intervention, program planning, and resource allocation. To this end, the City of Portland's Department of Health and Human Services plans to use this *Source Book* as an invaluable tool for evaluating programs and developing priorities for the future. We encourage all of our area's communities to join in regional planning as well as to develop unique local priorities.

With the issuance of *The Greater Portland Community Health Assessment and Source Book*, we invite you to use the information, join us in the effort to advance our information infrastructure; and work with us to improve the health of our community. We welcome your ideas, your energy and your commitment. Together, the future is ours to shape, and to keep in shape.

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<sup>1</sup> *Principles of Epidemiology*, CDC, U.S. Department of Health and Human Services, 1998.

# Greater Portland Community Health Assessment and Source Book

## OVERVIEW

The *Greater Portland Community Health Assessment and Source Book* has three parts:

- Part I** — *Greater Portland Health Report Card*
- Part II** — *Source Book: Healthy People 2000 to Healthy People 2010*
- Part III** — *Appendices*

### ***Part I — Greater Portland Health Report Card***

Using a summary set of indicators, the *Health Report Card* points to areas of strength and areas needing attention in the health of the Greater Portland population. In this list of health indicators, we compare rates in the Greater Portland area to state and national rates, and to state and national goals set by Healthy Maine 2000 and Healthy People 2000.

The “grades” given for each indicator represent the sum of these comparisons. Caution should be used in drawing conclusions or taking action simply on the basis of these “grades.” In some instances, conditions demanding improvement emerge; in other cases, differences in rates may be the result of limitations with the data itself. Importantly, what appear to be notable differences in rates may or may not be statistically significant, although the rates themselves are valid descriptive baselines.

This grading exercise is intended to highlight areas most immediately calling for follow up, e.g. review of the more in-depth information provided in the *Source Book*, and solicitation of additional information from service providers and the community.

### ***Part II — Source Book: Healthy People 2000 to Healthy People 2010***

**Overview** - The *Source Book* is a transitional work, from Healthy People 2000 to Healthy People 2010. Up until the year 2000, health data was collected to measure progress on indicators defined during the Healthy People 2000 initiative, and so the data presented here correspond to those indicators. The organization of the book, however, follows the Surgeon General’s Healthy People 2010 publication. In addition to updated national goals, Healthy People 2010 comprises forward-looking priorities, revised objectives, and updated indicators.

The 2010 goals are:

- to increase the quality and years of healthy life;
- to eliminate health disparities.

To provide descriptive information about the population in the Greater Portland Area, the *Source Book's* opening chapter is on demographics and includes special sections on diversity and poverty. The remainder of the book is a compilation of graphically displayed descriptive statistics on a wide range of the health improvement objectives in Healthy People 2010:

- reduce mortality and increase life expectancy
- promote healthy behaviors
- promote healthy and safe communities
- improve systems for personal and public health
- prevent and reduce disease and disorders

Individual chapters present information on:

- mortality
- tobacco use
- environmental health
- injury
- violence
- access to health care
- maternal, infant and child health and family planning
- chronic disease and risk factors
- HIV/AIDS, STDs and sexual risk behaviors
- immunization and infectious disease
- mental health and mental disorders
- substance abuse

Each chapter begins with a table of local rates that are benchmarked to state and national rates, as well as to state and national goals set by Healthy Maine 2000 and Healthy People 2000. Whenever possible (and meaningful), we disaggregate the data by age and sex, and also present trends over time.

**Disparity and Minority Health** — In developing the *Source Book*, we faced a dilemma in both our local area and state, with respect to our national health mission. While the overriding focus of Healthy People 2010 is to eliminate disparities identified during the Healthy People 2000 endeavor, our local experience of disparity is not captured in the analysis of national health statistics. This is because analysis of national health statistics exposes “race” as a key category within which disparity can be witnessed. In fact, the U.S. Department of Health and Human Services has selected the Office of Minority Health to lead the President’s special initiative to eliminate racial and ethnic disparities in six key health areas: infant mortality, cancer screening and management, cardiovascular disease, diabetes, HIV infection, and child and adult immunizations.

In the Greater Portland Area and in Maine, combining “disparity” and “minority health” runs huge risks of at best giving both of these important areas short shrift, and at worst doing a disservice to our community. Analyzing our population by traditional racial categories does not necessarily permit exposure of meaningful minority health issues, nor does this exercise reveal many important subpopulation disparities. As minority individuals living in Maine, the state with the lowest proportion of minority individuals in the nation, members of our community are positioned to reflect aspects of the minority experience in a unique manner. Specifically, we have the rare opportunity to explore the experience of “identifying with a minority demographic group” distinct from the consequences of living in a marginalized, high-risk social environment. We consider the unique experiences of minority members of our community to be worthy of exploring in a process designed to produce lessons not only for our own community, but for the national dialogue on minority health as well.

Likewise, local disparities may be missed completely were we to borrow the national picture. We submit that serious work needs to be done on identifying local disparities, based on a variety

of demographic features including race. In 1998, the GPPH commissioned special analyses of data from the Uniform Hospital Discharge Data Set (UHDDS), the Maine Cancer Registry, and the BRFSS to explore local observations of health disparities in the Greater Portland Area. Comparing populations residing in the City of Portland, the suburban Inner Towns, and the rural Outer Towns discerned one layer of local disparities, and these results are presented throughout the *Source Book*. This effort by the GPPH represents an important first step in the endeavor to ascertain subpopulation disparity in the Greater Portland Area.

Though it is not in our community's interest to superimpose the national picture of combined minority health and disparity on our population, still the already-identified national-level list of disparities remains informative, disturbing, and thought provoking. Therefore, the introductory page of each chapter of the *Source Book* lists the population groupings for which disparities of  $\geq 25\%$  have been identified at the national level. We hope that key areas of disparity at the state and local level will one day be identified; and, we see developing the information systems capacity to form this local picture to be a critical community objective. Equally as compelling is our need, as a community, to understand important minority health issues. Neither descriptive nor inferential statistics can substitute for the qualitative explorations necessary to assure that our work benefits us all.

### ***Part III — Appendices***

Following the first appendix, *acronyms*, we include detailed demographic tables in the second appendix. These tables provide information about the composition of the population by age, sex and racial category, which can be used flexibly in creating meaningful population denominators. To examine demographic change over the past decade, we include tables showing the components of population change in our area and throughout Maine.

As the third appendix we include data with 95% confidence intervals from the Pregnancy Risk Assessment Monitoring System (PRAMS), a surveillance project of the CDC and the Maine Bureau of Health. PRAMS collects state-specific, population-based data on maternal attitudes and experiences prior to, during, and immediately following pregnancy. Indicators from this surveillance system are included in individual chapters of the *Source Book* as they present valuable descriptive baselines.

We include data with 95% confidence intervals from the Behavioral Risk Factor Surveillance System (BRFSS) as the fourth appendix. The largest continuously conducted telephone health survey in the world, the BRFSS enables the Centers of Disease Control and Prevention (CDC), state health departments, and other health and education agencies to monitor risk behaviors related to chronic diseases, injuries and death. The GPPH commissioned special analysis of BRFSS data from the Greater Portland Area because information from the BRFSS may be some of the most vital data in this report — changing people's individual behaviors has the potential to bring about substantial improvements in the health of the community.

Sources for the data used in the book's indicators are referenced in each chapter. The majority of this data, aggregated at the state and national levels, is available on the world wide web. The final appendix is a comprehensive list of web-based health information resources. We hope that this resource list will prove useful in keeping us all up to date on the latest information pertaining to healthy people and healthy communities.

## *The Greater Portland Area as a Geographic Unit*

In the 1994 *Community Health Profile of the Greater Portland Region*, the “Greater Portland Region” was defined using the boundaries of the Portland Hospital Service Area (HSA). The Portland HSA comprises the City of Portland and the 25 surrounding suburban and rural towns. It includes most of Cumberland County, and parts of York and Oxford Counties. In the 1998 GPPH-commissioned studies of the Greater Portland Area, analysis of data from the Uniform Hospital Discharge Data Set (UHDDS), the BRFSS, and the Maine Cancer Registry, were used to compare health disparities existing between populations residing in the City of Portland, the suburban Inner Towns, and the rural Outer Towns. The unit of analysis in these studies was the Portland HSA with the addition of Freeport to the group of Inner Towns. For many indicators, local-level data is only available for county units. When this is the case, we use Cumberland County to proxy for the Greater Portland Area (*see map on page xvii*).

## *Data Issues*

This publication is primarily a compilation of descriptive statistics from secondary sources. In an effort to avert neglecting important indicators and topics for which there are no available local data, state and national data are sometimes used as informative placeholders (e.g. prevalence rates for mental health conditions). Similarly, pertinent emerging issues revealed in the academic literature that have not yet made their way into bureaucratic monitoring systems are pointed to using factoids in boxes (e.g. the link between animal cruelty and interpersonal violence). We traded-off presenting the most current data, with presenting a thorough compilation. Though updated data points may be available for some of the indicators presented in this report, seldom do drastic changes take place in health indicators over the short run. The GPPH is planning a community health forum to produce a parsimonious set of indicators for immediate updating, and for long term monitoring.

What this book does not offer is actual data interpretation, for two primary reasons. First, local data is sparse, and where it does exist, small numbers often preclude the drawing of conclusive inferences. Second, the GPPH are confident that the community forum process itself will complement the *Source Book* as an information-rich venture. Rather than construing our community partners as an audience for whom we display health information, we instead conceive our roles to be synergistic. The *Source Book* may be approached as a photo-essay – except that in this case, the photos are simple graphs. What this essay “means” is a text we must write collaboratively. At the same time, our collaborative effort must be approached in the spirit of individual learning and science ...

*“The hardest lesson for any agent to learn, apparently, is how to learn from its own mistakes. In order to learn from them, one has to be able to contemplate them, and this is no small matter. ... Science, however, is not just a matter of making mistakes, but of making mistakes in public — making mistakes for all to see, in the hopes of getting the others to help with the corrections.”*

—Daniel C. Dennett  
Philosopher of Science,  
Director of Center for Cognitive Studies, Tufts University

Please submit all corrections to: [healthassess@ci.portland.me.us](mailto:healthassess@ci.portland.me.us)

# Greater Portland Community Health Assessment and Source Book

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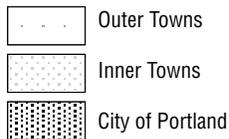
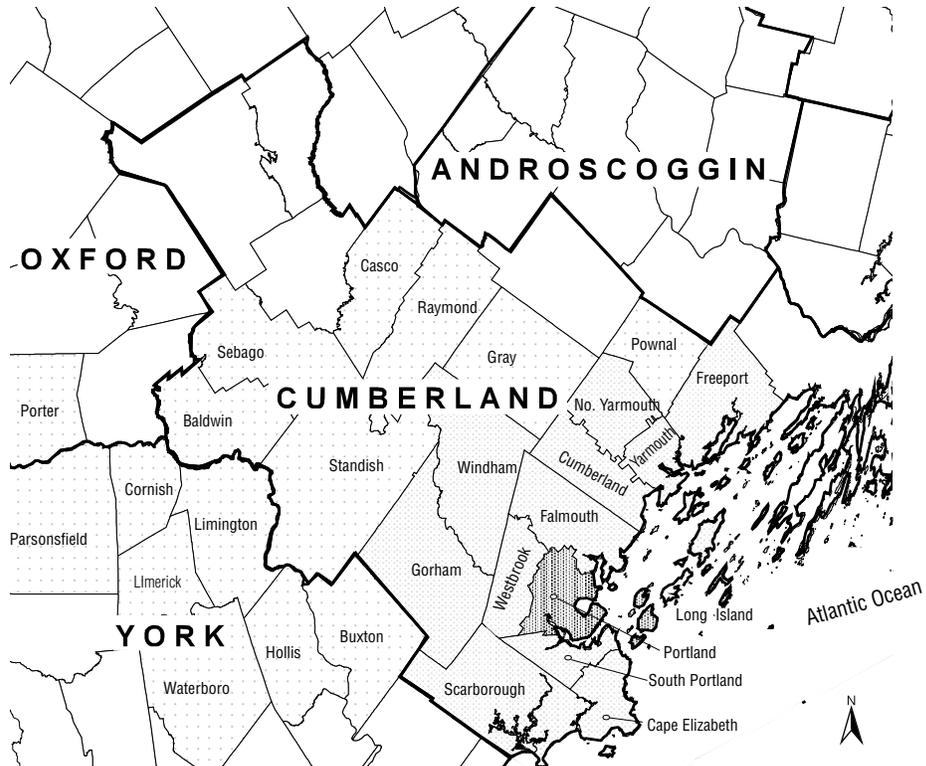
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Greater Portland Area	
Inner Towns	Outer Towns
Cape Elizabeth	Baldwin
Cumberland	Buxton
Gorham	Casco
Falmouth	Cornish
Freeport	Gray
North Yarmouth	Hollis
Scarborough	Limerick
South Portland	Limington
Standish	Long Island
Westbrook	Parsonfield
Windham	Porter
Yarmouth	Pownal
	Raymond
	Sebago
	Waterboro

Map produced  
by Rosemary Mosher, Windham, ME

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# Greater Portland Community Health Assessment and Source Book

## APPENDIX A

# ACRONYMS

AAPCC	American Association of Poison Control Centers
ACF	Administration for Children and Families
ADM	alcohol, drug and mental
AFDC	aid to families with dependent children
AHRQ	Agency for Healthcare Research and Quality (formerly AHCPR)
AIDS	acquired immunodeficiency syndrome
AMHI	Augusta Mental Health Institute
AOA	Administration on Aging
AOD	alcohol and other drugs
APHA	American Public Health Association
BJS	Bureau of Justice Statistics
BLE	Bureau of Liquor Enforcement
BMHI	Bangor Mental Health Institute
BMI	Body Mass Index
BOH	Bureau of Health
BRFSS	Behavioral Risk Factor Surveillance System
CAAN	Child Abuse Action Network
CAN	Child Abuse and Neglect
CB	Children's Bureau
CDC	Centers for Disease Control and Prevention
CFS	Child and Family Services
CI	confidence interval
CIHD	chronic ischemic heart disease
CODES	Crash Outcome Data Evaluation System
CPS	Child Protective Services
CPSC	Consumer Product Safety Commission (an independent Federal regulatory agency)
CSTAT	Center for Substance Abuse Treatment
CWLA	The Child Welfare League of America
DACH	Division of Adult and Community Health
DASH	Division of Adolescent and School Health
DDC	Division of Disease Control
DEET	diethyl toluamide (active ingredient in many insect repellants)
DEP	Department of Environmental Protection
DHAP	Divisions of HIV / AIDS Prevention
DHHS	Department of Health and Human Services
DHS	Department of Human Services
DMHMRSAS	Department of Mental Health, Mental Retardation and Substance Abuse Services

DOA	Department of Agriculture
DOE	Department of Education
DOJ	Department of Justice
DOT	Department of Transportation
DPS	Department of Public Safety
DRG	diagnosis-related group
DRH	Division of Reproductive Health
DTBE	Division of Tuberculosis Elimination
DVP	Division of Violence Prevention
EPA	Environmental Protection Agency
ESL	English as a Second Language
ETS	environmental tobacco smoke
FARS	Fatality and Analysis Reporting System (formerly the Fatal Accident Reporting System)
FBI	Federal Bureau of Investigation
FYI	for your information
GAF	Global Assessment of Functioning
GPPH	Greater Portland Partners for Health
HAART	highly active antiretroviral therapy
HARS	HIV / AIDS Reporting System
HHS	Health and Human Services
HIV	human immunodeficiency virus
HM	Healthy Maine
HP	Healthy People
HPV	human papilloma virus
HSA	Hospital Service Area
ICD-9	The International Classification of Diseases, 9th Revision
ICE	The International Collaborative Effort (on Injury Statistics)
ICF	Intermediate Care Facility
IDU	injection drug use
IPV	interpersonal violence
JAMA	Journal of the American Medical Association
LEP	limited English proficient
LF	labor force
MCSC	Maine Center for State Courts
ME	Maine
MMAF	Maine Medical Assessment Foundation
MSA	metropolitan statistical area
MSM	men who have sex with men
NCANDS	National Child Abuse and Neglect Data System
NCCDPHP	National Center for Chronic Disease Prevention and Health Promotion
NCHS	National Center for Health Statistics
NCHSTP	National Center for HIV, STD and TB Prevention
NCIPC	National Center for Injury Prevention and Control
NCPCA	National Committee for Prevention of Child Abuse
NCSA	The National Center for Statistics and Analysis
NCSC	National Center for State Courts
NCVS	National Crime Victimization Survey
NDAS	National Data Analysis System
NEAIS	National Elder Abuse Incidence Survey
NEISS	National Electronic Injury Surveillance System

NHANES	National Health and Nutrition Examination Survey
NHCS	National Health Care Survey
NHIS	National Health Interview Survey
NHSDA	National Household Survey of Drug Abuse
NHTSA	National Highway Traffic Safety Administration
NIA	National Institute on Aging
NIDA	National Institute on Drug Abuse
NIH	National Institutes of Health
NIP	National Immunization Program
NIS	National Immunization Survey
NTIES	National Treatment Improvement Evaluation Study
NVSS	National Vital Statistics System
OAS	Office of Applied Statistics
ODPHP	Office of Disease Prevention and Health Promotion
OHDPM	Offices of Health Data and Program Management
OJP	Office of Justice Programs
OPHS	Office of Public Health and Science
OSA	Office of Substance Abuse
OUI	operating under the influence
PHD	Public Health Division
PHRG	Public Health Resource Group
PRAMS	Pregnancy Risk Assessment Monitoring System
PROP	People's Regional Opportunity Program
PTSD	post-traumatic stress disorder
SAMHSA	Substance Abuse and Mental Health Services Administration
SMRMHB	Southern Maine Regional Mental Health Board
SPMI	severe and persistent mental illness
SRB	sexual risk behaviors
SSI	Supplemental Security Income
TANF	Temporary Assistance for Needy Families
TAP	The AIDS Project
TESS	Toxic Exposure Surveillance System
UCRS	Uniform Crime Reporting System
UHDDS	Uniform Hospital Discharge Data Set
URI	upper respiratory infection
US	United States
USM	University of Southern Maine
VP	Vice President
VPD	vaccine preventable disease
WIC	Women, Infants and Children
WISQARS	Web-based Injury Statistics Query and Reporting System
WONDER	single point of access to a wide variety of CDC public health data and information
YRBSS	Youth Risk Behavior Surveillance System



# Greater Portland Community Health Assessment and Source Book

## Demographics of the Greater Portland Area

### The Psalm of Life

by Henry Wadsworth Longfellow, 1807-1882;  
poet, Portland resident

Tell me not, in mournful numbers,  
Life is but an empty dream!  
For the soul is dead that slumbers,  
And things are not what they seem.

Life is real! Life is earnest!  
And the grave is not its goal;  
Dust thou art, to dust returnest,  
Was not spoken of the soul.

Not enjoyment, and not sorrow,  
Is our destined end or way;  
But to act, that each tomorrow  
Find us farther than today.

Art is long, and Time is fleeting,  
And our hearts,  
though stout and brave,  
Still, like muffled drums, are beating  
Funeral marches to the grave.

In the world's broad field of battle,  
In the bivouac of Life,  
Be not dumb, driven cattle!  
Be a hero in the strife!

Trust no Future, howe'er pleasant!  
Let the dead Past bury its dead!  
Act,~act in the living Present!  
Heart within, and God o'erhead!

Lives of great men all remind us  
We can make our lives sublime,  
And, departing, leave behind us  
Footprints on the sands of time;

Footprints, that perhaps another,  
Sailing o'er life's solemn main,  
A forlorn and shipwrecked brother,  
Seeing, shall take heart again.

Let us, then, be up and doing,  
With a heart for any fate;  
Still achieving, still pursuing,  
Learn to labor and to wait.

### CONTENTS

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#### 10 Diversity

#### 14 Poverty



“Society is indeed a contract. It is a partnership in all science; a partnership in all art; a partnership in every virtue, and in all perfection. As the ends of such a partnership cannot be obtained in many generations, it becomes a partnership not only between those who are living, but between those who are living, those who are dead, and those who are to be born.”

— Edmund Burke



# Greater Portland Community Health Assessment and Source Book

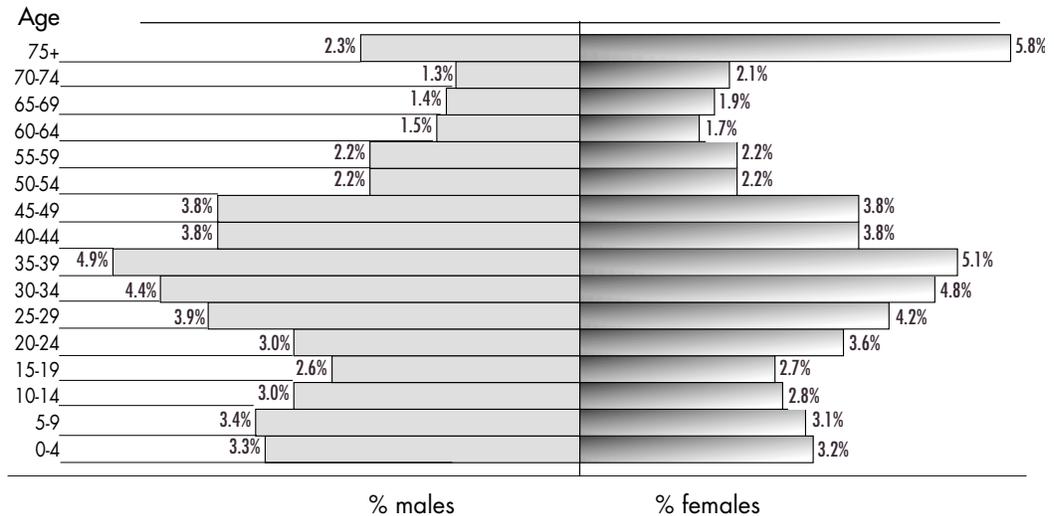
## DESCRIPTION

### Demographic Description of the Greater Portland Area is based on the 1990 Census with 1998 Census Estimates

The Greater Portland area is demographically unique. Approximately 30% of its population are residents of Maine's largest urban center (Portland); about 50% reside in the relatively affluent suburbs (Inner Towns); and around 20% are residents of the rural outskirts (Outer Towns). Analyses that lump these three units permit the experience of the more populous Inner Towns to diminish the experiences of both Portland and the Outer Towns. The problem is particularly profound for the City of Portland since the Outer Towns are more similar to the state as a whole. For the most part, the Outer Towns mirror the state with respect to health status while the Inner Towns consistently demonstrate superior health outcomes which is expected given the higher income and education levels of their residents. Portland, on the other hand, proves to have health issues that are unique and relate to its demographically urban character.<sup>i</sup>

### ■ City of Portland Population (62,989 = 30% of the HSA) — Age and Sex Structure

- Urban Portland has a large proportion of young working age individuals living side by side with older residents. The senior population (of mostly women) is comprised of long-time residents and individuals living in housing that serve the elderly. The proportion of children in Portland is lower than either the Inner or the Outer Towns.

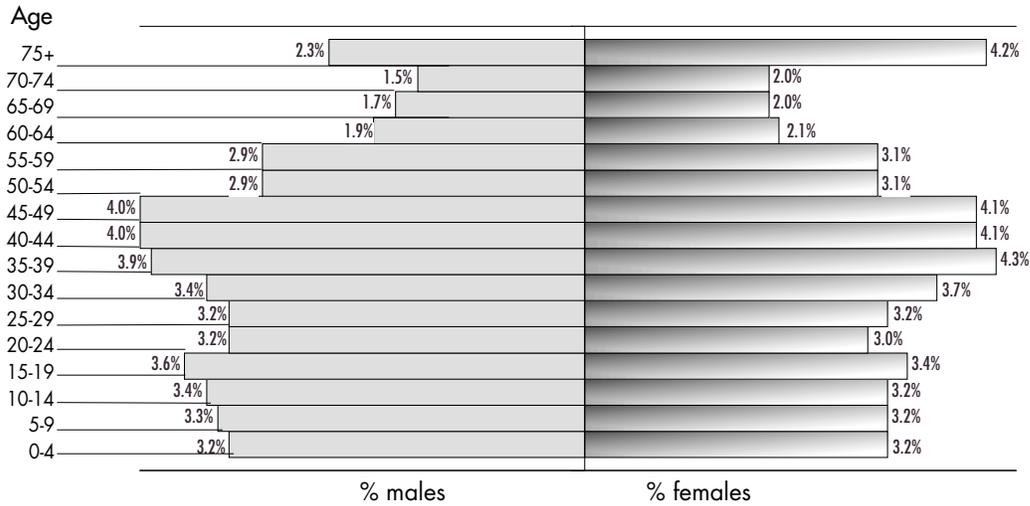


Source: U.S. Census estimates for 1998 provided by Hannaford Brothers and Equifax.

■ **Inner Town Population (123,833= 50% of the HSA) —**

**Age and Sex Structure**

- The population distribution of the suburban Inner Towns shows older, established residents along side the growing population of young families with children.

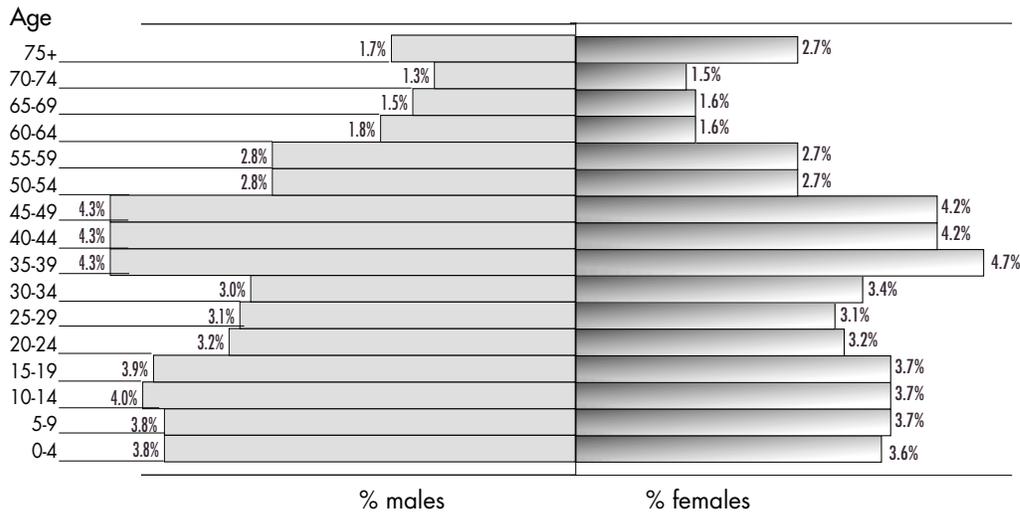


Source: U.S. Census estimates for 1998 provided by Hannaford Brothers and Equifax.

■ **Outer Towns Population (51,821= 20% of the HSA) —**

**Age and Sex Structure**

- The population distribution of the rural Outer Towns shows the relatively recent expansion of young families to this area. Proportionally, few older residents live in the Outer Towns.



Source: U.S. Census estimates for 1998 provided by Hannaford Brothers and Equifax.

## ■ Summary Population Descriptive Statistics:

### City of Portland, Inner Towns and Outer Towns

- The mean age in the Greater Portland area is about 36 years old. Looking at extremes of age reveals that Portland, compared to the Inner and

	City of Portland	Inner Towns	Outer Towns
total population	62,989	123,833	51,821
mean age	37.63	37.62	35.06
% < 20 years	24.1%	26.5%	30.2%
% 75 + years	8.1%	6.4%	4.4%
% 85+ years	2.3%	1.5%	1.0%
per capita income	\$19,963	\$23,577	\$16,772
median household income	\$32,500	\$47,160	\$40,000

*Source: U.S. Census estimates for 1998 provided by Hannaford Brothers and Equifax.*

Outer Towns, has a larger proportion of people, women in particular, over 75 and over 85 years old.

- The Inner Towns have both the highest median household income and per capita income. The Outer Towns have the lowest per capita income while Portland has the lowest median household income. Median household income is a clearer indicator of poverty than per capita income. Since per capita income is an average, derived by dividing total income by total population including children, it gives too much weight to a small percentage of cases where earnings are either extremely high or low. The median household income, on the other hand, is the value in the center of the income distribution and is not, therefore, disproportionately influenced by the few extreme cases.

## ■ Dependency Ratios: City of Portland, Inner Towns, Outer Towns, Maine and U.S.

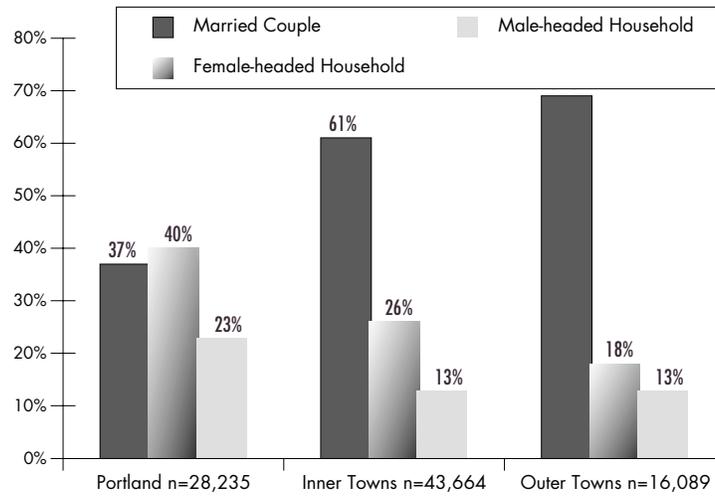
	City of Portland	Inner Towns	Outer Towns	Maine	U.S.
total dependency ratio	0.64	0.67	0.68	0.70	0.71
0 - 19 dependency ratio	0.39	0.44	0.51	0.45	0.49
65 + dependency ratio	0.24	0.23	0.17	0.25	0.22

*Source: U.S. Census estimates for 1998 provided by Hannaford Brothers and Equifax.*

- The dependency ratio<sup>3</sup> is an important summary measure of the social and economic impact of different population age structures. It is the ratio of the dependent-age population (the young and the old) to the working-age population. The higher the ratio is, the more people each worker is having to support. Support may take the form of public health, transportation and education infrastructure. It may take the form of maintaining a Social Security and Medicaid system. Frequently, it takes the form of innumerable responsibilities assumed by the working-age population to assist family and loved-ones in activities of daily living.
- The total dependency ratio in the Greater Portland area averages about .65 — for every three working-age persons, there are approximately two non-working age persons. Desegregating the three areas, as well as old and young age dependents, reveals that Portland, the Inner and Outer Towns experience this dependency very differently.
- Portland has about 39 children and 24 seniors per 100 working-age adults. The Outer Towns have about 50 children but only 17 seniors per 100 working-age adults. The Inner Towns have about 44 children and 23 seniors per 100 working-age adults.

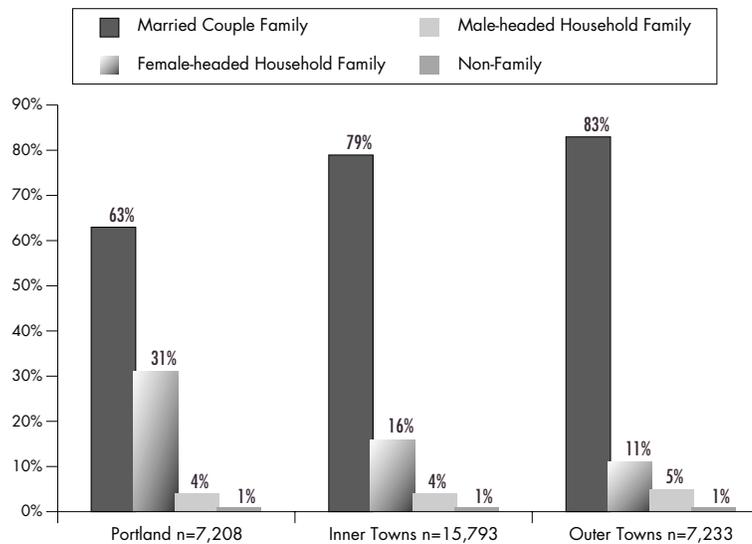
### ■ Households by Type — Greater Portland Area: 1990

- More than 60% of Portland's households are headed by single people — 40% of them being women. In contrast, married-couple headed households dominate the Inner Towns (over 60%), and the Outer Towns (close to 70%).



### ■ Households with Children, by Type — Greater Portland Area: 1990

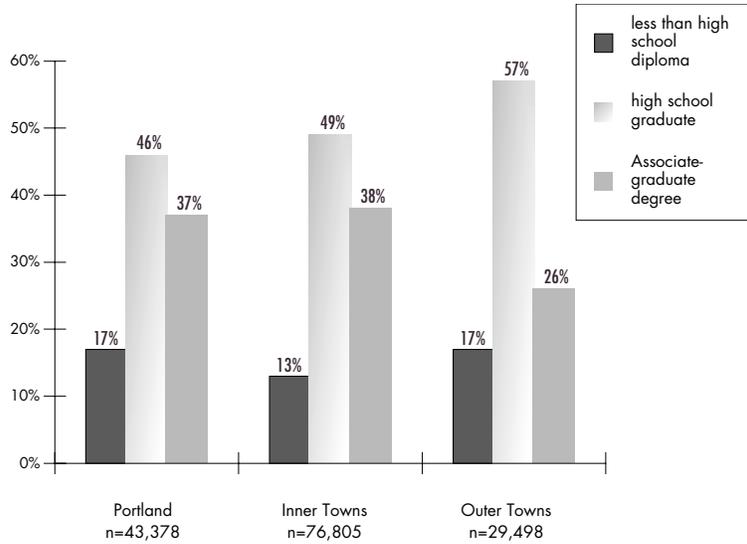
- Of the households with children, more than a third are headed by a single parent in Portland. One in five households with children are headed by a single parent in the Inner Towns, and less than one in six are headed by single parents in the Outer Towns.



Source: U.S. Census Bureau.

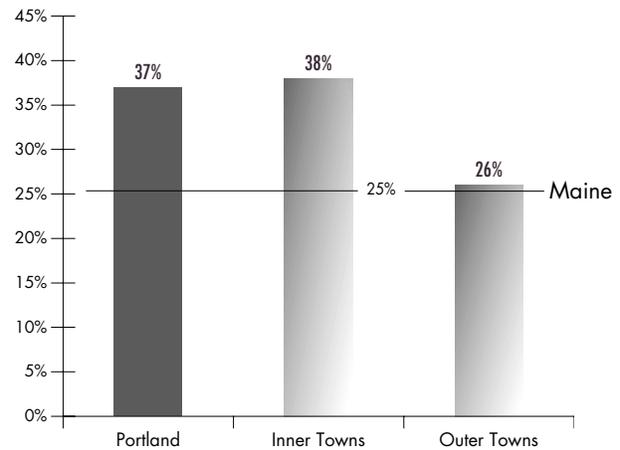
■ **Educational Attainment — Greater Portland Area: 1990**

• While Portland is similar to the Inner Towns with respect to people with higher educational degrees, it is also similar to the Outer Towns with respect to the percentage of people with less than a high school diploma.



■ **Educational Attainment beyond High School — Greater Portland Area and Maine: 1990**

• Higher Educational attainment is notably higher in Portland and the Inner Towns than it is in either the Outer Towns, or the State. This reflects the urban character of Portland and the surrounding suburbs.



Source: U.S. Census Bureau.

## Greater Portland Demographic Characteristics

(totals may exhibit rounding errors)

	Portland		Inner Towns		Outer Towns	
	persons	percentage	persons	percentage	persons	percentage
<b>Population Trends</b>						
2003	63,226		129,265		55,024	
1998	62,989		123,833		51,821	
1990	64,358		116,174		46,663	
<b>Persons by Sex (1998 estimates)</b>						
female	33,498	53.2%	64,125	51.8%	26,093	50.4%
male	29,491	46.8%	59,708	48.2%	25,728	49.6%
<b>Age Distribution (1998 estimates)</b>						
under 5 years	4,100	6.5%	7,951	6.4%	3,835	7.4%
5 - 9 years	4,119	6.5%	8,087	6.5%	3,900	7.5%
10 - 14 years	3,628	5.8%	8,215	6.6%	3,963	7.6%
15 - 17 years	1,896	3.0%	5,109	4.1%	2,444	4.7%
18 - 20 years	2,129	3.4%	5,256	4.2%	2,220	4.3%
21 - 24 years	3,426	5.4%	5,886	4.8%	2,586	5.0%
25 - 29 years	5,095	8.1%	7,941	6.4%	3,191	6.2%
30 - 34 years	5,839	9.3%	8,786	7.1%	3,298	6.4%
35 - 39 years	6,349	10.1%	10,171	8.2%	4,655	9.0%
40 - 49 years	9,511	15.1%	19,996	16.1%	8,858	17.1%
50 - 59 years	5,543	8.8%	14,729	11.9%	5,735	11.1%
60 - 64 years	1,984	3.1%	4,879	3.9%	1,824	3.5%
65 - 69 years	2,110	3.3%	4,567	3.7%	1,601	3.1%
70 - 74 years	2,141	3.4%	4,283	3.5%	1,431	2.8%
75 years and over	5,121	8.1%	7,977	6.4%	2,279	4.4%
<b>Highest Level of Education (1990 census)</b>						
persons 25 years and over	43,379		76,805		29,498	
less than 9th grade	2,888	6.7%	3,221	4.2%	1,676	5.7%
9th to 11 grade, no diploma	4,402	10.1%	6,835	8.9%	3,409	11.6%
high school graduate	12,488	28.8%	24,181	31.5%	11,404	38.7%
some college, no degree	7,530	17.4%	13,459	17.5%	5,361	18.2%
Associate degree	3,227	7.4%	7,021	9.1%	2,184	7.4%
Bachelor's degree	8,723	20.1%	14,671	19.1%	3,708	12.6%
Grad. or professional degree	4,120	9.5%	7,418	9.7%	1,755	6.0%
<b>School Enrollment (1990 census)</b>						
persons enrolled in school	14,137		28,723		12,147	
preschool - primary	1,351	9.6%	2,389	8.3%	983	8.1%
elementary - high school	7,600	53.8%	18,762	65.3%	8,785	72.3%
college	5,185	36.7%	7,572	26.4%	2,379	19.6%
<b>Employment Status (1990 census)</b>						
persons 16 years and over	52,977		91,115		34,959	
unemployed	2,423	4.6%	7,098	7.8%	1,542	4.4%
employed	33,457	63.2%	56,480	62.0%	23,276	66.6%
not in the labor force	17,097	32.3%	27,537	30.2%	10,141	29.0%

	Portland		Inner Towns		Outer Towns	
	persons	percentage	persons	percentage	persons	percentage
<b>Female Labor Force Participation by Offspring Age (1990 census)</b>						
females 16 years and over	29,059		48,025		17,819	
w/children 0 - 5: working	1,355	4.7%	2,761	5.7%	1,245	7.0%
w/children 0 - 5: not working	146	0.5%	121	0.3%	119	0.7%
w/children 0 - 5: not in LF	959	3.3%	1,187	2.5%	498	2.8%
w/children 6 - 17: working	2,212	7.6%	6,342	13.2%	2,652	14.9%
w/children 6 - 17: not working	172	0.6%	192	0.4%	201	1.1%
w/children 6 - 17: not in LF	794	2.7%	1,425	3.0%	707	4.0%
w/children 0 - 5 and 6 - 17: working	654	2.3%	1,835	3.8%	809	4.5%
w/children 0 - 5 and 6 - 17: not working	30	0.1%	71	0.1%	44	0.2%
w/children 0 - 5 and 6 - 17: not in LF	518	1.8%	958	2.0%	570	3.2%
no children: working	12,260	42.2%	17,962	37.4%	5,843	32.8%
no children: not working	715	2.5%	707	1.5%	308	1.7%
no children: not in LF	9,244	31.8%	14,464	30.1%	4,822	27.1%
<b>Marital Status (1990 census)</b>						
persons 18 years and over and married persons 16 -17 years	53,483		92,597		35,416	
never-married male	9,760	18.2%	11,961	12.9%	4,156	11.7%
never-married female	9,872	18.5%	10,575	11.4%	3,431	9.7%
married	22,002	41.1%	54,707	59.1%	23,022	65.0%
previously-married male	3,534	6.6%	4,540	4.9%	1,730	4.9%
previously-married female	8,316	15.5%	10,814	11.7%	3,076	8.7%
<b>Population by Household Type (1990 census)</b>						
total population	64,358		116,175		46,664	
pop. in family households	44,021	68.4%	97,687	84.1%	42,039	90.1%
pop. in non-family households	18,265	28.4%	15,558	13.4%	4,125	8.8%
pop. group quarters	2,072	3.2%	2,930	2.5%	500	1.1%
<b>Households by Type (1990 census)</b>						
total households	28,235		43,664		16,090	
single male	3,772	13.4%	3,152	7.2%	1,065	6.6%
single female	6,189	21.9%	6,003	13.7%	1,293	8.0%
married couple	10,489	37.1%	26,459	60.6%	11,149	69.3%
family: male-headed	768	2.7%	1,129	2.6%	534	3.3%
family: female-headed	3,450	12.2%	4,085	9.4%	1,263	7.8%
non-family: male-headed	1,855	6.6%	1,533	3.5%	466	2.9%
non-family: female-headed	1,713	6.1%	1,304	3.0%	320	2.0%
<b>Households with Children (1990 census)</b>						
total households with children	7,208		15,793		7,234	
family: married couple	4,544	63.0%	12,495	79.1%	6,012	83.1%
family: male headed	317	4.4%	587	3.7%	330	4.6%
family: female-headed	2,241	31.1%	2,545	16.1%	820	11.3%
non-family	106	1.5%	166	1.1%	72	1.0%

	Portland		Inner Towns		Outer Towns	
	persons	percentage	persons	percentage	persons	percentage
<b>Households by Persons Per Unit (1990 census)</b>						
total households	28,235		43,665		16,091	
one person units	9,962	35.3%	9,155	21.0%	2,358	14.7%
two person units	9,479	33.6%	15,312	35.1%	5,305	33.0%
three person units	4,267	15.1%	8,252	18.9%	3,171	19.7%
four person units	2,894	10.3%	7,372	16.9%	3,411	21.2%
five person units	1,110	3.9%	2,621	6.0%	1,284	8.0%
six person units	339	1.2%	692	1.6%	400	2.5%
seven + person units	184	0.7%	261	0.6%	160	1.0%
<b>Families by Number of Workers (1990 census)</b>						
total families	14,819		31,951		13,189	
no workers	2,111	14.2%	3,164	9.9%	1,221	9.3%
one worker	3,931	26.5%	7,440	23.3%	3,093	23.5%
two workers	7,074	47.7%	16,659	52.1%	6,873	52.1%
three + workers	1,702	11.5%	4,688	14.7%	2,002	15.2%
<b>Households by Income (1998 estimates)</b>						
total households	28,338		48,034		18,192	
\$150,000 or more	604	2.1%	2,379	5.0%	267	1.5%
\$100,000 - \$149,999	910	3.2%	2,790	5.8%	572	3.1%
\$ 75,000 - \$ 99,999	1,854	6.5%	5,300	11.0%	1,308	7.2%
\$ 50,000 - \$ 74,999	4,999	17.6%	11,221	23.4%	4,295	23.6%
\$ 35,000 - \$ 49,999	4,861	17.2%	8,924	18.6%	3,814	21.0%
\$ 25,000 - \$ 34,999	3,778	13.3%	6,074	12.6%	3,029	16.7%
\$ 15,000 - \$ 24,999	4,617	16.3%	5,772	12.0%	2,409	13.2%
\$ 5,000 - \$ 15,999	5,552	19.6%	4,763	9.9%	2,175	12.0%
under \$ 5,000	1,162	4.1%	812	1.7%	323	1.8%

Source: U.S. Census estimates for 1998 provided by Hanniford Brothers and Equifax.

## Diversity

### ■ Population by Standard Racial Categories: —

Greater Portland Area: 1998 Estimates (see appendix A)

(totals may exhibit rounding errors)

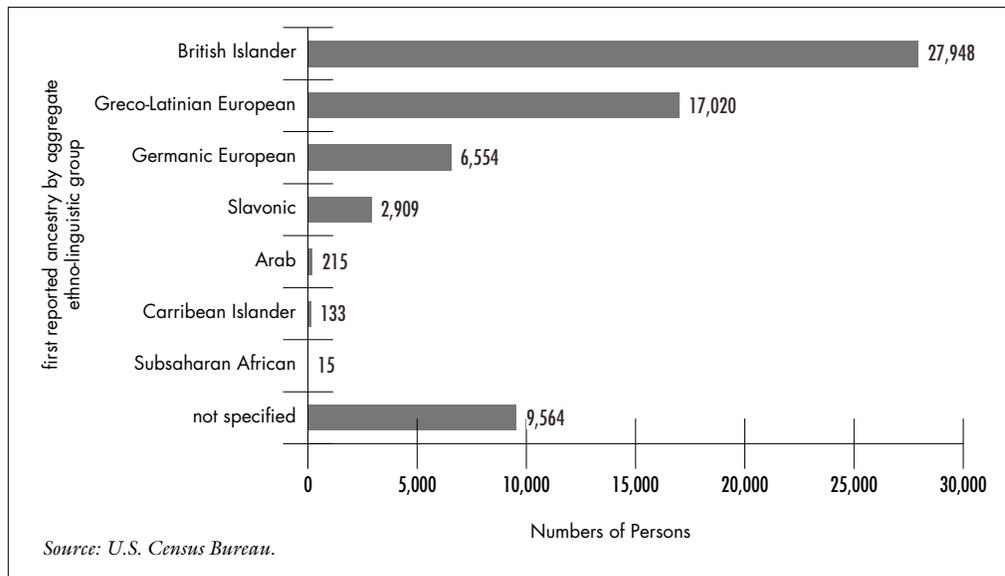
- Though standard racial categories do not adequately reflect racial and ethnic diversity found in the Greater Portland area, they still indicate the extent to which the Greater Portland area, including Portland, has a sparse number of minority individuals compared to the rest of the nation.<sup>iii</sup>

	Portland		Inner Towns		Outer Towns		US
	persons	%	persons	%	persons	%	1990 %
Total Persons	62,922		123,833		51,524		248,709,873
Euro-American: white	60,379	96.0%	12,2150	98.6%	51,132	99.2%	80.3%
African-American: black	769	1.2%	382	0.3%	111	0.2%	12.0%
Native-American: Indian, Eskimo, or Aleut	*	*	*	*	*	*	0.8%
Asian-American: Asian and Pacific Islander	1,343	2.1%	863	0.7%	155	0.3%	2.9%
Other ethnic/racial groups	430	0.7%	437	0.4%	127	0.2%	3.9%

Source: U.S. Census estimates for 1998 provided by Hanniford Brothers and Equifax.

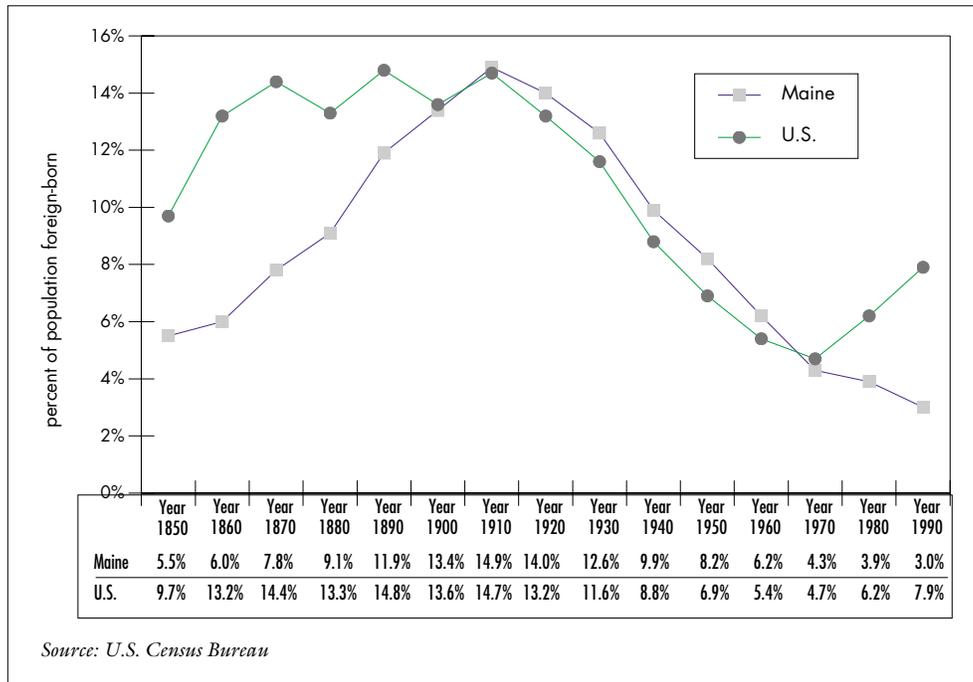
### ■ First Reported Ancestry<sup>iv</sup> — City of Portland Population: 1990

- The Population of the City of Portland, though primarily comprised of Euro-Americans, exhibits a complex immigration history and a diversity of cultural traditions.



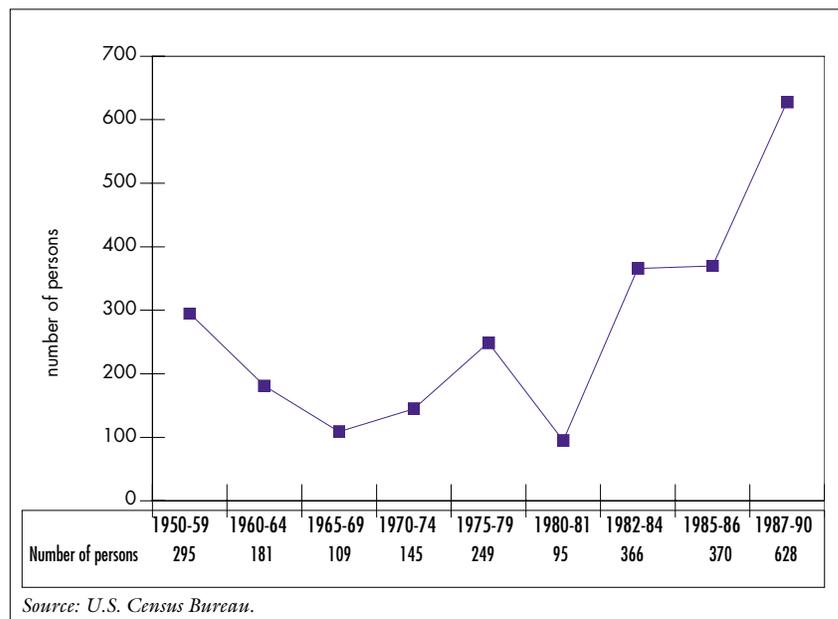
**Percentage of Total Population Foreign Born —  
Maine and U.S.: 1850-1990**

- In terms of percentage of population foreign born, Maine’s immigration experience paralleled the nation’s between 1900 and 1970. Before and after these decades, immigrants have been a much smaller proportion of Maine’s population than that of the U.S. overall.



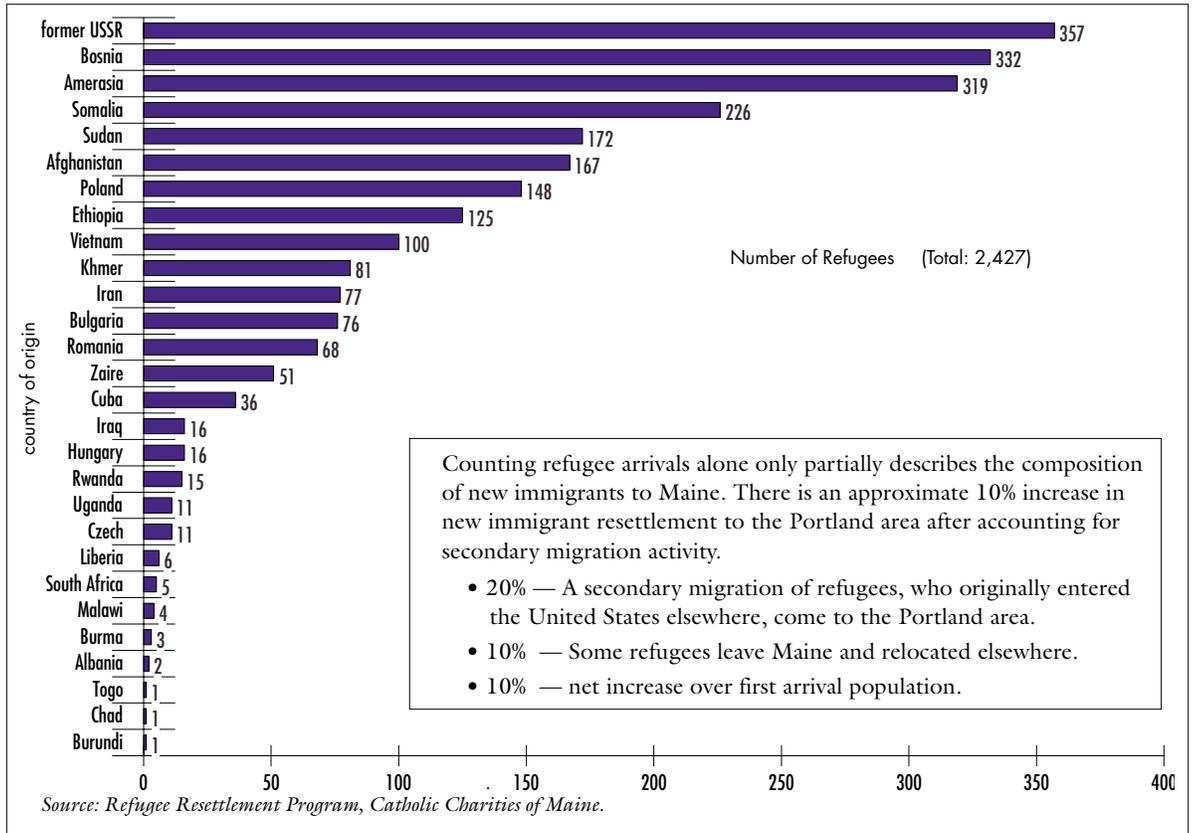
**Number of Foreign-born City of Portland Residents by Year of Entry into the U.S. — 1990**

- Considering the City of Portland, sheer numbers of immigrants have been rapidly increasing since the mid 1980s, heightening the local perception of ethnic diversity. Most of these recent immigrants are refugees from global post-Soviet, post-colonial conflicts.



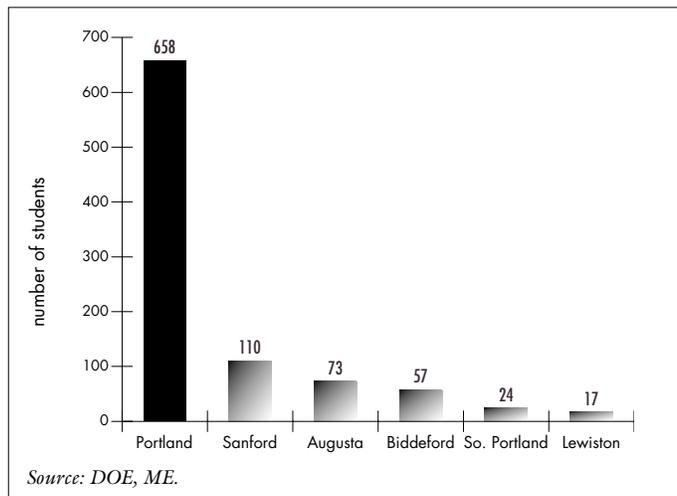
**■ Refugee Settlement in Maine: 1986-1998**

- Spreading the effects of immigration, the U.S. Department of State coordinates with Catholic Charities to resettle refugees in Maine. Since 1976, Catholic Charities has assisted over 5,000 individual refugees resettle in Maine. Cumberland County serves as the residence for an estimated 63% of these immigrants.
- The majority (54%) of refugees who resettle in Maine are “white,” which highlights how inadequate U.S. standard racial categories are for describing ethnic diversity.



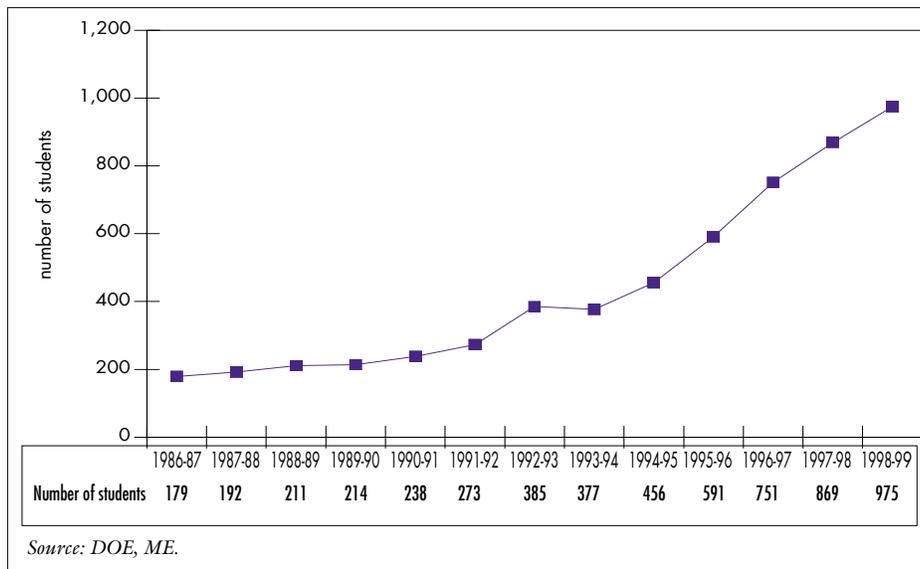
**■ School Enrollment of Language Minority Students Who are Limited English Proficient from Multiple Language Groups: 1996-1997**

- The Portland Public School District has the largest number of Language Minority students who are Limited English Proficient Students (LEPS) in the state.



### ■ Language Minority Students — Portland Public Schools: 1986 - 1998

- The number of Language Minority Students (students for whom English is not their primary language) in Portland Public Schools has been increasing rapidly over the past 15 years, reaching 975 for the 1998-1999 school year.



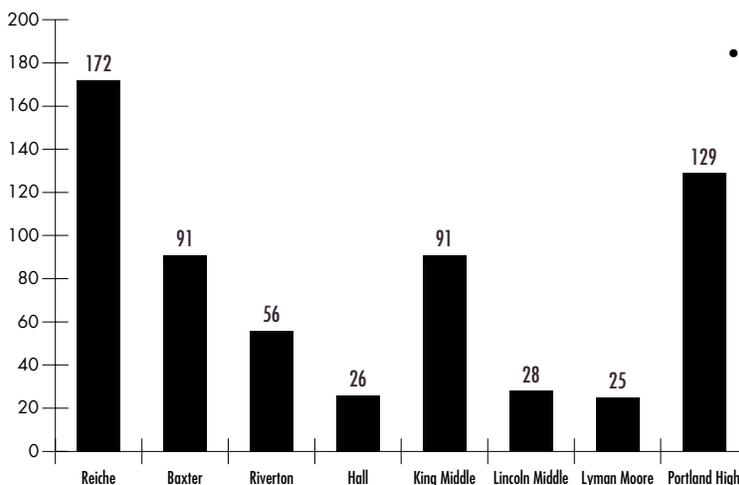
### ■ Language Minority Students — Portland Public Schools: 1998-1999

- About 63% of the Language Minority students in Portland Public Schools in 1998-1999 were LEPS.
- Additionally, Portland's Adult Education ESL Program enrolled 485 non-native students from 50 countries in the same academic year.

<b>Total Students</b>	<b>8,001</b>	
<b>Students whose primary language is not English</b>		
Language Minority Students	975	12%
Limited English Proficiency Students	618	8%
<b>Number of Languages</b>	<b>33</b>	

Source: Portland Public Schools.

### ■ Portland Public Schools' Limited English Proficient Students Enrolled through the Multilingual Intake Center: 1998-1999



- During the 1998-1999 school year, Portland Public Schools' Multilingual Intake Center enrolled the following LEPS:
  - 345 primary school students
  - 144 middle school students
  - 129 high school students

Source: Portland Public Schools.

# Poverty

## ■ 1998 Federal Poverty Thresholds

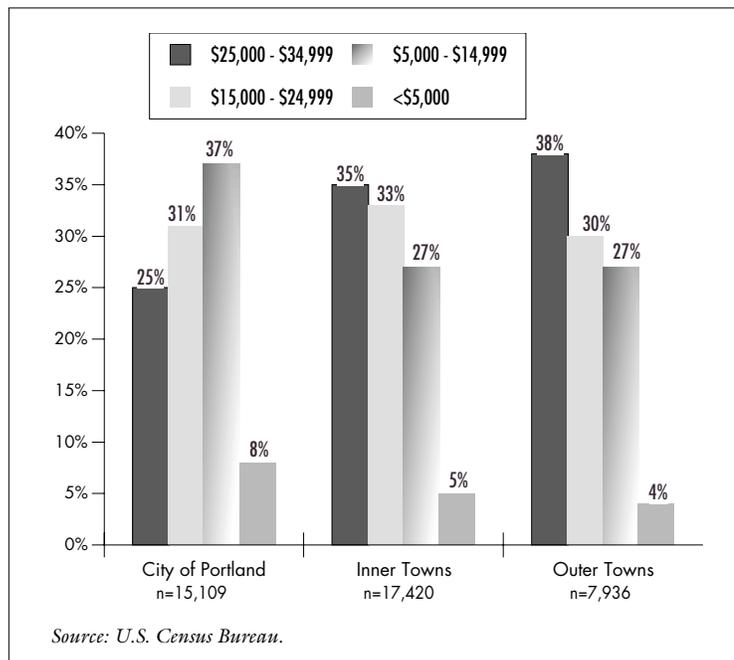
- Based on Federal Poverty Guidelines, approximately one third of Portland’s population is considered ‘working poor,’ which means their income from all sources is 185% or less of the Federal poverty guideline. Fourteen percent of Portland’s population lives in poverty, with 35% of these at less than half the poverty level. Approximately one third of the people living in poverty are less than 18 years old; 40% of these are under 5 years old (*see detailed table*).

Percentage of 1998 Federal Poverty Guidelines							
family size	50%	100%	125%	150%	175%	185%	200%
1	\$4,240	\$8,480	\$10,600	\$12,720	\$14,840	\$15,688	\$16,960
2	\$5,458	\$10,915	\$13,644	\$16,373	\$19,101	\$20,193	\$21,830
3	\$6,560	\$13,120	\$16,400	\$19,680	\$22,960	\$24,272	\$26,240
4	\$8,265	\$16,530	\$20,663	\$24,795	\$28,928	\$30,581	\$33,060
5	\$9,727	\$19,453	\$24,316	\$29,180	\$34,043	\$35,988	\$38,906
6	\$10,890	\$21,780	\$27,225	\$32,670	\$38,115	\$40,293	\$43,560
7	\$12,198	\$24,395	\$30,494	\$36,593	\$42,691	\$45,134	\$48,790
8	\$13,410	\$26,820	\$33,525	\$40,230	\$46,935	\$49,617	\$53,640

*Source: U.S. Census Bureau.*

## ■ Low Income Households – Greater Portland Area: 1990

- Of the low income households in the Greater Portland Area, Portland’s are the poorest, with almost double the proportion making under \$5,000 per year.



■ Poverty Status in the City of Portland (1990 Census)

Persons below Poverty	Number	% of Age Group	% of Total Persons in Poverty	
all persons	8,783	14%		
under 5 years old	1,030	24%		12%
5 years old	216	26%		2%
6 - 11 years old	889	23%		10%
12 - 17 years old	615	17%		7%
18 - 64 years old	4,789	12%		55%
65 - 74 years old	581	12%		7%
75 years and older	663	16%		8%

Persons below Poverty by Age and Household Type						
	15 - 64 years old	% of total persons in poverty	65 - 74 years old	% of total persons in poverty	75 years and older	% of total persons in poverty
married couple family	1,176	13.4%	41	0.5%	43	0.5%
male householder family (no wife present)	194	2.2%	0	0.0%	0	0.0%
female householder family (no husband present)	3,403	38.7%	26	0.3%	17	0.2%
unrelated family household	310	3.5%	11	0.1%	0	0.0%
related nonfamily household	465	5.3%	11	0.1%	8	0.1%
unrelated nonfamily household	874	10.0%	35	0.4%	5	0.1%
group quarters	250	2.8%	37	0.4%	43	0.5%
alone	867	9.9%	420	4.8%	547	6.2%

Families below Poverty	number of families in poverty	% of all families in poverty
all families	1,578	
all families with children	1,344	85.2%
married couple with children	204	12.9%
female householder with children (no husband present)	1,083	68.6%
male householder with children (no wife present)	57	3.6%

Ratio of Income to Poverty Level	Persons	% of Persons
200% and over	42,486	67.9%
185% - 199%	1,933	3.1%
175% - 184%	918	1.5%
150% - 174%	3,170	5.1%
125% - 149%	2,578	4.1%
100% - 124%	2,732	4.4%
75% - 99%	2,806	4.5%
50% - 74%	2,925	4.7%
under 50%	3,052	4.9%

Source: U.S. Census Bureau.

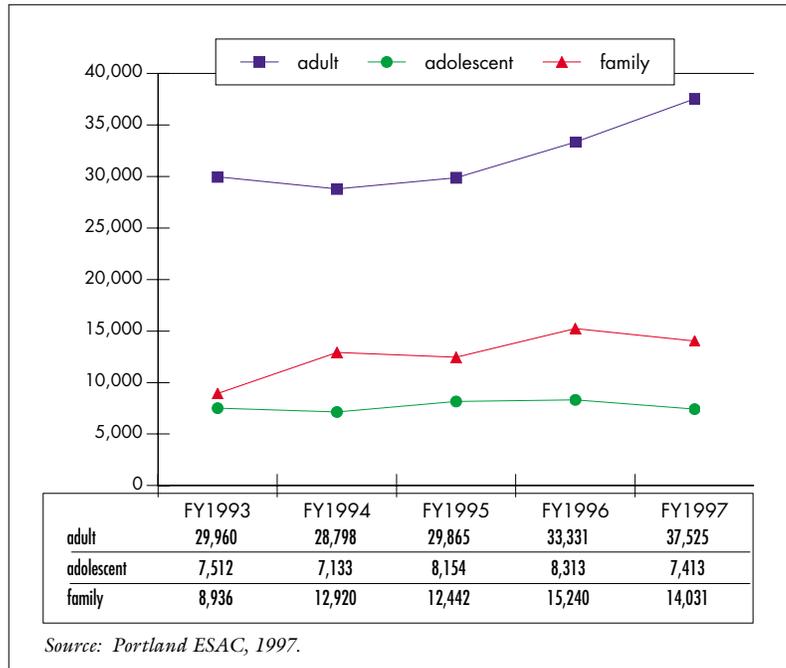
## ■ Additional Poverty Indicators — Portland and Cumberland County

- Portland residents account for about a half of Cumberland County's beneficiaries of public assistance, though they constitute about a quarter of the County's population.

<i>(See endnote v for definitions)</i>	Cumberland County			Portland		
	cases	recipients	<18 yrs	cases	recipients	<18 yrs
<b>AFDC/ TANF participants</b>						
<b>Temporary Assistance for Needy Families (TANF)</b>						
October 1997 .....	2,662	7,080	4,649	1,283	3,471	2,297
October 1998 .....	2,296	6,136	4,098	1,106	3,011	2,023
<b>Food Stamps</b>						
October 1997 .....	8,171	16,172		4,241	7,732	
October 1998 .....	7,926	15,398		4,079	7,311	
<b>Medicaid</b>						
total January 1997 .....	14,697	22,098		6,689	10,027	
AFDC (TANF) & related clients .....	10,955			4,997		
SSI & related clients .....	5,094			2,636		
nursing home clients .....	1,268			520		
total December 1998 .....	14,964	22,383		6,591	9,701	
AFDC (TANF) & related clients .....	12,400			5,186		
SSI & related clients .....	6,790			3,332		
nursing home clients .....	1,162			424		
<b>PROP Services for 11/30/97 - 12/1/98</b>						
	Cumberland County			Portland		
	Households/Individuals			Households/Individuals		
WIC,-Women, Infants and Children .....	1,663	3,325		690	1,379	
Fuel Assistance .....	1,766	4,062		652	1,500	
Child Development						
(Head Start & Child Care) .....	390	897		125	288	
Foster Grandparents (over age 60) .....		159			90	
Transportation .....	967	2,224		483	1,111	
Peer Leader						
(a service in Portland Housing) .....				202		
Central Intake (# of people seen or called) ...						
PROP Total Contacts .....	2,882	6,882		1,085	1,927	
Referrals to Other Services .....		11,099			3,203	
<b>Students from Low Income Families 1998-1999</b>						
total Portland Public School students receiving free or reduced lunch .....				3,036	38%	
students receiving free lunch .....				2,716	34%	
students receiving reduced lunch .....				320	4%	

■ **Number of Emergency Shelter Beds Used by Adults, Adolescents and Families — Portland: Fiscal Year 1993 - Fiscal Year 1997**

- In Portland and the U.S. overall, two trends are largely responsible for the rise in homelessness over the past 15-20 years: a growing shortage of affordable rental housing and a simultaneous increase in poverty.<sup>vi</sup>
- Other factors contributing to homelessness are: domestic violence, lack of substance abuse disorder services, and inadequate mental health services. (See specific sections for details: *Violence, Access to Health Care, Mental Health and Mental Disorders, and Substance Abuse*)



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## Endnotes

- i The Portland Metropolitan Statistical Area (MSA) has an urban population of 120,271. This compares to the Lewiston-Auburn MSA with an urban population of 88,074, and the Bangor MSA with an urban population of 61,374.
- ii The dependency ratio compares the number of people at dependent ages to the number of people in the economically active ages (people ages 0-19 & 65+/people ages 20-64).
- iii The inadequacy of standard racial categories to depict population diversity has been receiving increasing national attention in the past decade.
- iv Groups identified specifically in the 1990 Census questions on race and Hispanic origin (for example, Japanese, Laotian, Mexican, Cuban, and Spaniard), in general, are not shown separately in ancestry tabulations. (*see* <http://www.census.gov/td/stf3/appendb.html#ANCESTRY>).
- British Islander: English, Irish, Scottish, Welsh, Canadian of British decent;
  - Greco-Latinian European: Greek, Italian, French, French Canadian, Spanish, Portuguese;
  - Germanic European: German, Swedish, Dutch, Norwegian, Danish, Swiss, Austrian, Belgian, Finnish (Finnish is not technically part of the Germanic group but included here for convenience);
  - Slavonic: Polish, Russian, Lithuanian, Slovak, Hungarian, Ukranian, Romanian, Czech, Yugoslavian (Hungarian and Romanian are technically not part of the Slavonic group but are included here for convenience).
- v Medicaid is for people over 65 or under 21 years of age, disabled persons, single parents with children or two-parent families with children but one or more parent is unemployed (and other criteria).
- School lunch assistance requirements: 130% of federal poverty for free lunch, and up to 185% of federal poverty for reduced cost lunch.
- WIC provides assistance to: pregnant, post-partum and breastfeeding mothers, and children to 5 years old, at up to 185% of federal poverty.
- Fuel assistance requirements: 125% of federal poverty; if adult over 60 or child under 2 up to 150% of federal poverty.
- Foster Grandparents: 150% of federal poverty to qualify for stipend.
- Peer Leader: serves kids 5 to 18, no income guidelines but primarily children living in assisted housing sites.
- Central Intake: includes all services above plus calls, contracts and referrals.
- vi Most studies of homelessness are limited to counting people who are literally homeless — that is, in shelters or on the streets. This underestimates homelessness since many people who lack stable, permanent residence are not found in shelters. In addition to living with family or friends in crowded, temporary arrangements and substandard housing, some common places “unsheltered homeless” people are found include: vehicles, camp grounds, and makeshift shelters. This is especially true in rural areas where there are far fewer shelters. The following two methods are generally used for measuring homelessness:
- point-in-time counts - Attempting to count all the people who are found in shelters on a given night, this method can help depict the composition of the homeless population but it overestimates the people who are chronically homeless (particularly those with mental and substance abuse disorders). Counting bed usage each night over a period, say a year, improves on this method by controlling for seasonality and some level of contingency.
  - period prevalence counts – Since, in most cases, homelessness is a temporary condition, the number of people using shelters over a given period of time is a more appropriate measure of the magnitude of homelessness, keeping in mind that it will underestimate reality.

# Greater Portland Community Health Assessment and Source Book Mortality

Healthy People 2010 Mortality Goal *Increase quality and years of healthy life.*

## National Health Disparities

### MORTALITY

#### Race

- infant deaths
- fetal deaths
- maternal mortality
- coronary heart disease deaths
- stroke deaths
- colorectal cancer deaths
- oral cancer deaths
- breast cancer deaths
- cervical cancer deaths
- diabetes deaths
- cirrhosis deaths
- unintentional injury deaths
- drowning deaths
- residential fire deaths
- motor-vehicle crash deaths
- alcohol-related motor vehicle deaths
- drug-related deaths
- firearm-related deaths
- suicide
- homicide

#### Socioeconomic Status

- work-related injury deaths

#### Gender

- oral cancer deaths
- unintentional injury deaths
- drowning deaths
- suicide
- homicide

#### Age

- residential fire deaths
- drowning deaths
- motor vehicle crash deaths
- alcohol-related motor vehicle deaths
- homicide

## CONTENTS

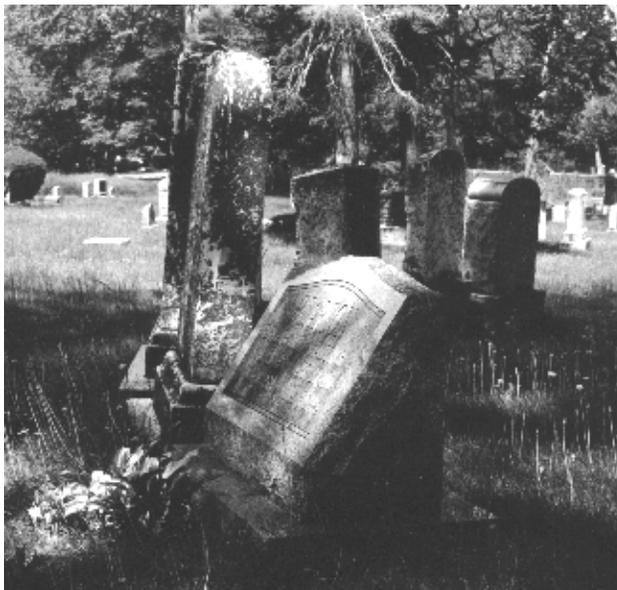
**24 Total Mortality**

**25 Premature Mortality**

**27 Cause-Specific Mortality**

**30 Motor Vehicle-Related Mortality**

**31 Site of Death**



MORTALITY

“To be or not to be isn’t the question.  
The question is how to prolong being.”  
— Tom Robbins



# Greater Portland Community Health Assessment and Source Book

## MORTALITY

GREATER PORTLAND AREA, MAINE and U.S. RATES with YEAR 2000 OBJECTIVES

*Rates are per 100,000 population, unless otherwise noted and are age adjusted to the 1940 population.*

Cause of Death	Portland HSA Rate <sup>i</sup>	Maine Rate <sup>ii</sup>	U. S. Rate <sup>ii</sup>	HM 2000 Goal	HP 2000 Goal
All Causes	468.2	501.2	503.9	■	■
Heart Disease	124.9	100.2	138.3	100.0	100.0
Cancer - all	134.3	142.7	130.0	130.0	130.0
Lung Cancer	43.5	41.9	38.3	40.0	42.0
Colorectal Cancer	13.2	14.2	12.8	13.2	13.2
Breast Cancer	19.6	20.6	21.0	18.0	20.6
Prostate Cancer	6.7	7.3	■	■	■
Cerebrovascular Disease	24.4	23.6	26.7	20.0	20.0
COPD	24.4	23.7	20.8	25.0	25.0
Diabetes <sup>iii</sup>	<small>Cumberland County</small> 11.7	13.4	13.3	■	12.0
Chronic Liver Disease and Cirrhosis	7.0	6.6	7.6	■	6.0
Accidents and Adverse Affects	20.8	26.7	30.5	22.0	29.3
Motor Vehicle-related	10.1	13.0	15.9	■	14.2
Suicide	<small>Cumberland County</small> 9.0	11.5	11.3	■	10.5
Homicide	2.1	1.8	9.4	■	7.2

■ = data not available

Source: 1995 rates from CDC Wonder; Portland HSA 1992-1995 combined crude rates are from Vital Statistics, DHDP, BOH, ME and are adjusted by PHD, HHS, City of Portland.

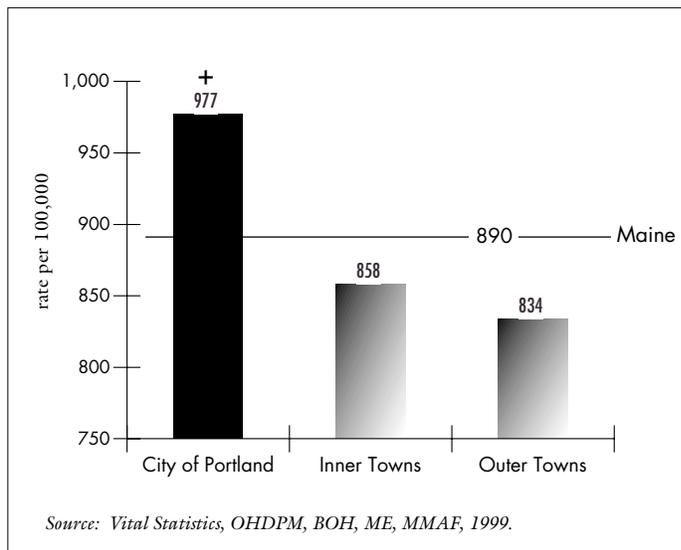
## Total Mortality

### ■ Mortality<sup>iv</sup> —

#### Greater Portland Area and Maine: 1995-1996

(Rates are per 100,000 population and are adjusted to Maine's 1996 population.)

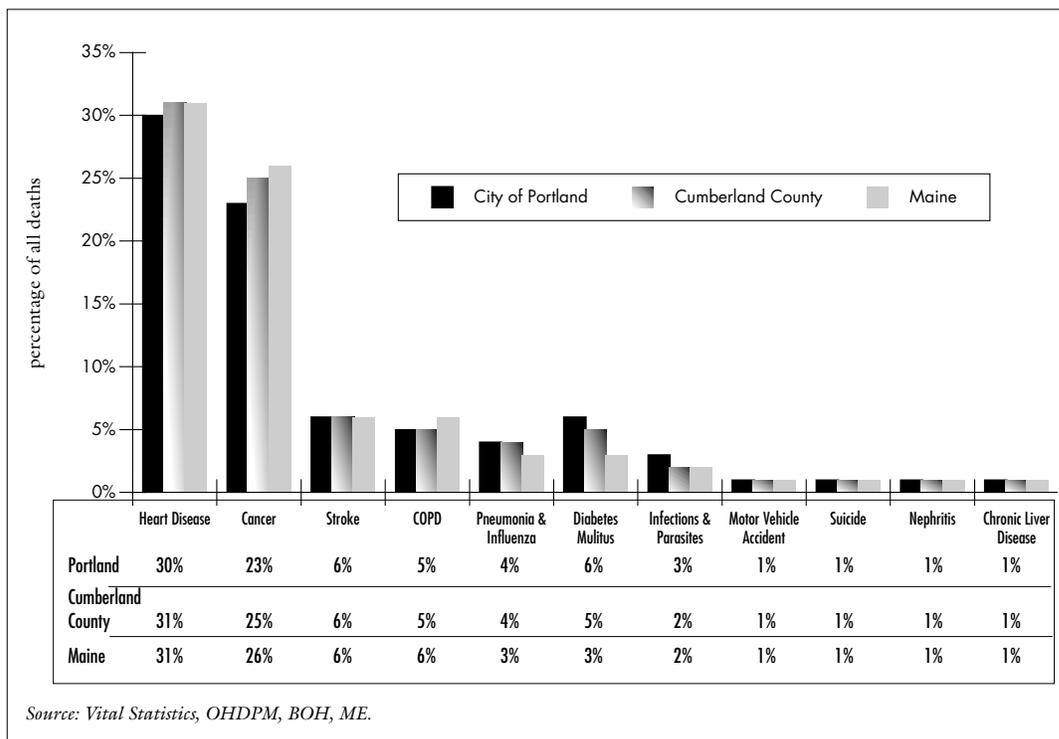
- While the Portland HSA average overall mortality rate for 1992-1995 is comparable to both Maine and U.S. 1995 rates, analysis of the Greater Portland Area reveals the Portland-specific rate to be significantly higher than the others ( $p \leq .05$ ).



### ■ Leading Causes of Death —

#### Portland, Cumberland County and Maine: 1995

- Heart disease and cancer are the leading causes of all deaths in the City of Portland, Cumberland County and Maine.



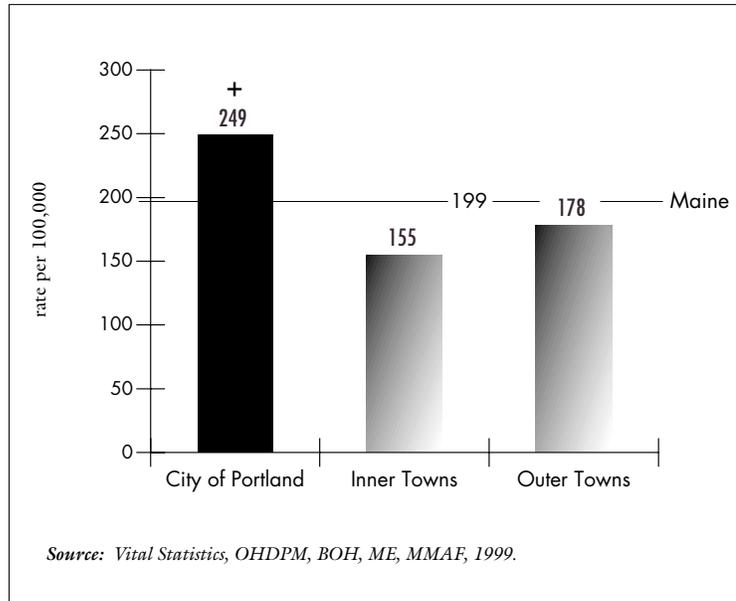
## Premature Mortality

### ■ Premature Mortality Rates (death to persons ages 0-64) —

Greater Portland Area and Maine: 1995-1996 combined

(Rates are per 100,000 population and are adjusted to Maine's 1996 population.)

- Premature mortality is significantly higher in the City of Portland when compared to the rest of the Greater Portland Area and the state ( $p \leq .05$ ).

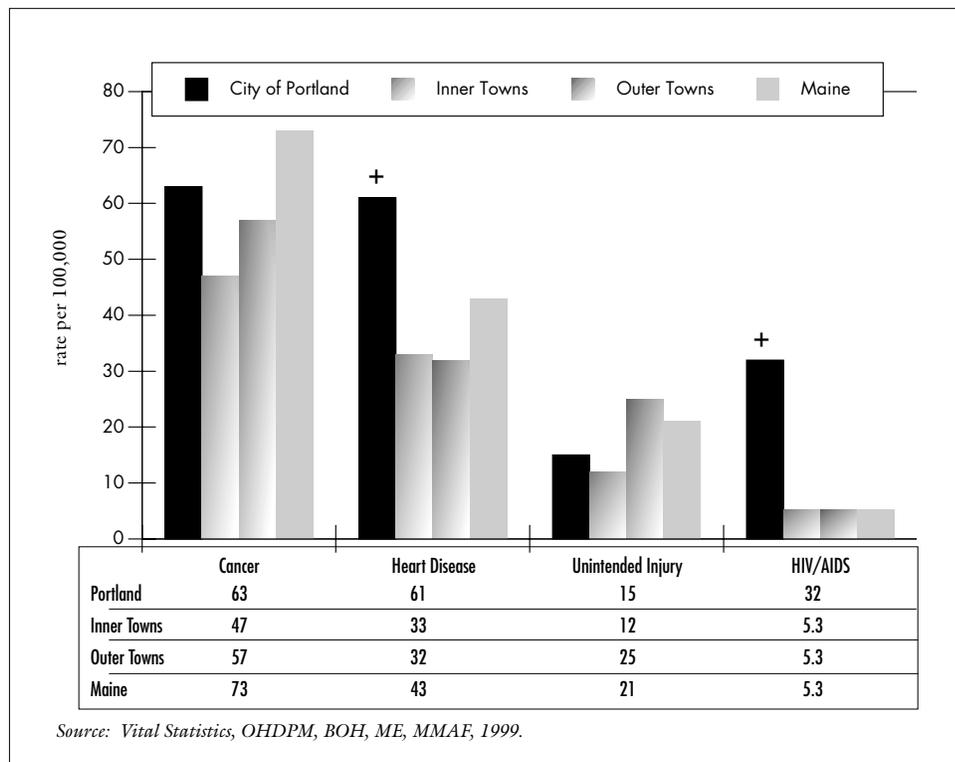


### ■ Leading Causes of Premature Mortality —

Greater Portland Area and Maine: 1995-1996 combined

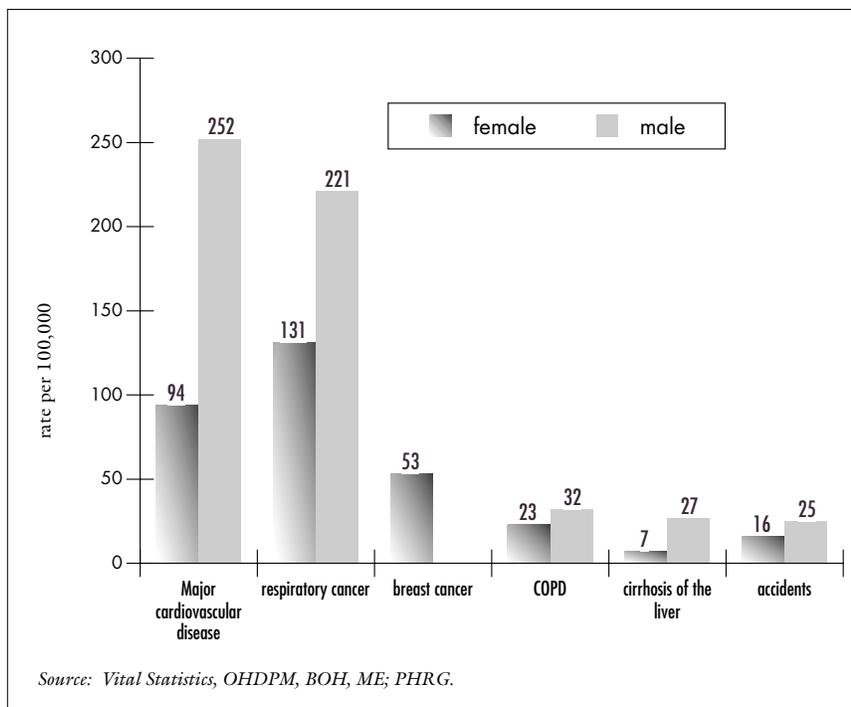
(Rates are per 100,000 population and age-adjusted to Maine's 1996 population.)

- Much of Portland's higher premature mortality is accounted for by significantly higher heart disease and HIV/AIDS deaths ( $p \leq .05$ ).



■ **Death Rates, Persons 45-64 —**  
 Portland HSA: 1992-1995 combined

- Most premature mortality occurs to men between the ages of 45 and 64.  
 In the Portland HSA 1992-1995, the top three causes of death at these ages were: major cardiovascular disease, respiratory cancer and breast cancer.



■ **Actual Causes of Preventable Deaths — U.S.: 1990**

- In 1990, tobacco and diet/activity patterns accounted for 66% of all preventable deaths.

Cause	Estimated Number	Percentage of Total
• total .....	1,060,000 .....	100.0%
• tobacco .....	400,000 .....	37.7%
• diet/activity patterns .....	300,000 .....	28.3%
• alcohol .....	100,000 .....	9.4%
• toxic agents .....	90,000 .....	8.5%
• microbial agents .....	60,000 .....	5.7%
• firearms .....	35,000 .....	3.3%
• sexual behavior .....	30,000 .....	2.8%
• motor vehicles .....	25,000 .....	2.4%
• illicit use of drugs .....	20,000 .....	1.9%

Source: McGinnis, Foegen, "Actual Causes of Death in the United States." JAMA 270(18):2207-2212, 1993.

## Cause-Specific Mortality

### ■ Cause-Specific Mortality by Age — Portland HSA: 1992-1995 combined

- In the Portland HSA, accidents, motor vehicle in particular, are the leading cause of death to persons ages 5 to 44.

Age	Cause of Death	Rate
0-4	Certain Conditions Orig. in Perinatal Period	54.6
	Congenital Anomalies	17.8
	Diseases of the Heart	9.6
	Homicides and Legal Intervention	6.8
	Total Accidents	5.5
	Malignant Neoplasms	2.7
	<i>Digestive Organs and Peritoneum</i>	1.4
	Diseases of Pulmonary Circulation	1.4
	Cerebrovascular Disease	1.4
	Pneumonia	1.4
5 - 17	<b>Total Accidents</b>	9.0
	Malignant Neoplasms	2.5
	<i>Lymphatic and Hematopoietic Cancer</i>	1.0
	Diabetes Mellitus	0.5
	Diseases of the Heart	0.5
	Suicide	0.5
18 - 44	<b>Total Accidents</b>	22.5
	Malignant Neoplasms	19.8
	<i>Respiratory Cancer</i>	3.1
	<i>Lymphatic and Hematopoietic Cancer</i>	3.1
	<i>Lung Cancer</i>	2.9
	<i>Female Genital Organ Cancer</i>	2.9
	<i>Breast Cancer</i>	2.5
	<i>Digestive Organs and Peritoneum</i>	2.3
	<i>Cancer of Other and Unspecified Sites</i>	2.3
	<i>Cervical Cancer</i>	1.9
	AIDS / HIV	15.5
	Diseases of the Heart	12.0
	Suicide	11.4
	Homicides and Legal Intervention	3.3
	Cirrhosis of the Liver	2.3
	Cerebrovascular Disease	1.4
	Pneumonia	1.2
Diabetes Mellitus	1.0	

—continued

Cause-Specific Mortality by Age — Portland HSA: 1992-1995 (continued)

Age	Cause of Death	Rate
45 - 64	Malignant Neoplasms	239.6
	<i>Respiratory Cancer</i>	88.1
	<i>Lung Cancer</i>	86.8
	<i>Breast Cancer</i>	27.2
	<i>Colorectal Cancer</i>	22.0
	<i>Lymphatic and Hematopoietic Cancer</i>	19.9
	<i>Female Genital Organ Cancer</i>	12.1
	<i>Digestive Organs and Peritoneum</i>	7.5
	<i>Urinary Organs</i>	7.3
	Diseases of the Heart	148.1
	Chronic Obstructive Pulmonary Disease (COPD)	27.2
	Total Accidents	20.3
	Diabetes Mellitus	18.1
	Cirrhosis of the Liver	16.4
	Cerebrovascular Disease	14.7
	Suicide	10.4
	AIDS / HIV	7.8
	Pneumonia	6.5
Emphysema	6.0	
Nephritis, Nephrotic Syndrome, and Nephrosis	6.0	
65 - 74	Malignant Neoplasms	936.8
	<i>Respiratory Cancer</i>	366.7
	<i>Lung Cancer</i>	361.7
	<i>Digestive Organs and Peritoneum</i>	203.3
	<i>Colorectal Cancer</i>	88.6
	<i>Lymphatic and Hematopoietic Cancer</i>	73.6
	<i>Male Genital Organ Cancer</i>	53.6
	<i>Prostate Cancer</i>	53.6
	<i>Breast Cancer</i>	41.2
	<i>Female Genital Organ Cancer</i>	37.4
	<i>Urinary Organs</i>	34.9
	<i>Buccal Cavity and Pharynx</i>	17.5
	Diseases of the Heart	663.6
	Chronic Obstructive Pulmonary Disease (COPD)	198.3
	Cerebrovascular Disease	132.2
	Diabetes Mellitus	74.8
	Other Diseases of the Circulatory and Pulmonary System	54.9
	Cirrhosis of the Liver	44.9
	Pneumonia	32.4
	Total Accidents	32.4
	Emphysema	31.2
Nephritis, Nephrotic Syndrome, and Nephrosis	20.0	
Suicide	17.5	

—continued

Cause-Specific Mortality by Age — Portland HSA: 1992-1995 (continued)

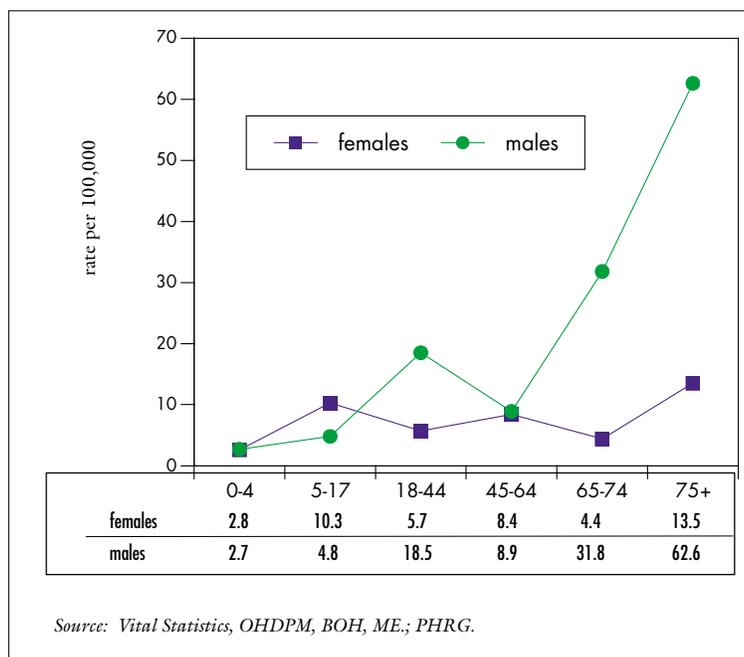
Age	Cause of Death	Rate
75 +	Diseases of the Heart	2,860.3
	Malignant Neoplasms	1,603.3
	<i>Digestive Organs and Peritoneum</i>	409.0
	<i>Respiratory Cancer</i>	382.2
	<i>Lung Cancer</i>	374.7
	<i>Colorectal Cancer</i>	213.5
	<i>Male Genital Organ Cancer</i>	170.2
	<i>Prostate Cancer</i>	170.2
	<i>Lymphatic and Hematopoietic Cancer</i>	152.3
	<i>Breast Cancer</i>	116.4
	<i>Urinary Organs</i>	80.6
	<i>Female Genital Organ Cancer</i>	70.2
	<i>Buccal Cavity and Pharynx</i>	7.5
	Cerebrovascular Disease	715.1
	Chronic Obstructive Pulmonary Disease (COPD)	449.4
	Pneumonia	403.1
	Diabetes Mellitus	171.7
	Total Accidents	155.3
	Other Diseases of the Circulatory and Pulmonary System	152.3
	Nephritis, Nephrotic Syndrome, and Nephrosis	106.0
Arteriosclerosis	94.1	
Emphysema	85.1	
Cirrhosis of the Liver	31.4	
Suicide	14.9	

*Source: Vital Statistics, OHDPM, BOH, ME; PHRG.*

## Motor Vehicle-Related Mortality

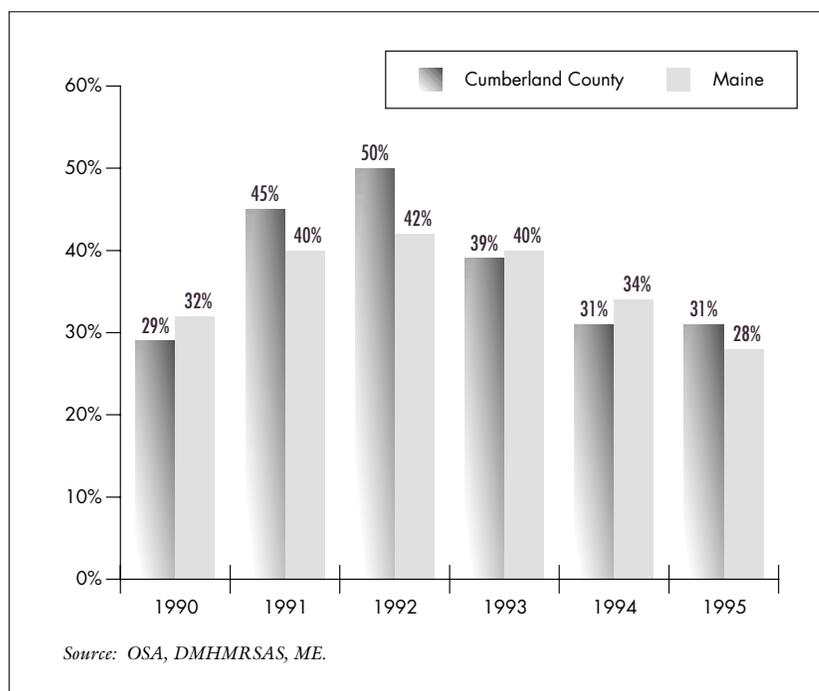
### ■ Age and Sex - Specific Motor Vehicle Death Rates — Portland HSA: 1992-1995 combined

- Motor vehicle age and sex-specific death rates exhibit a typical peak for males between the ages of 18 and 44 and then show a dramatic and continuous increase for males in the older ages.



### ■ Percentage of Motor Vehicle Deaths that are Alcohol-Related — Cumberland County and Maine: 1990 - 1995

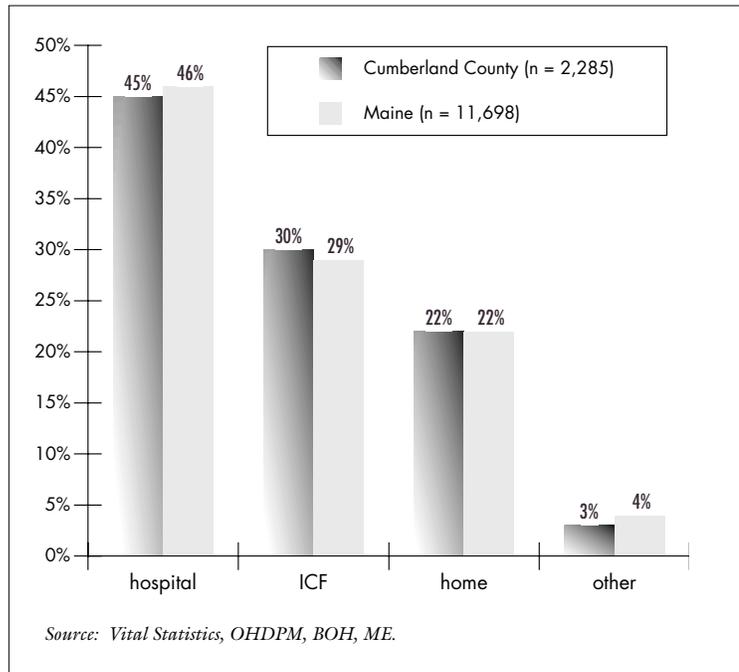
- Alcohol is consistently the underlying cause of death in at least one out of three motor vehicle fatalities in Cumberland County and Maine.



## Site of Death

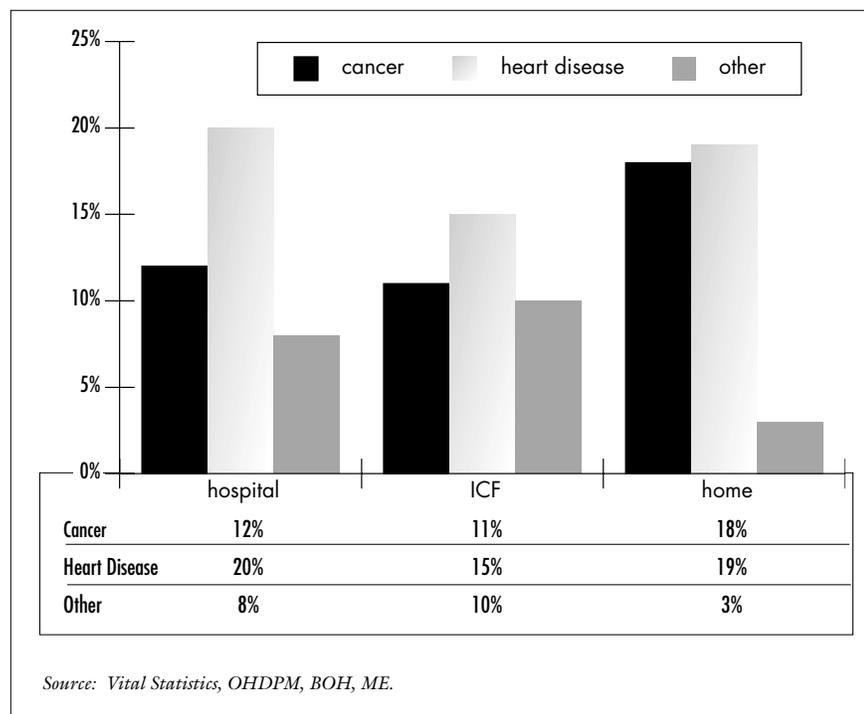
### ■ Deaths by Site of Death — Cumberland County and Maine: 1995

- Nearly half of all Cumberland County and Maine residents in 1995 died in the hospital. Just over a quarter of the same residents died in intermediate care facilities and just less than another quarter died at home.



### ■ Deaths by Selected Cause and Site — Cumberland County: 1995

- Close to two out of five deaths at home were to people with heart disease and/or cancer.



## Endnotes

- <sup>i</sup> Portland HSA, 1992 - 1995 averages. Data from PHRG developed using death certificates from Maine vital statistics. Adjustment to 1940 by Portland Public Health Division.
- <sup>ii</sup> Maine and U.S. rates are 1995 data from CDC Wonder.
- <sup>iii</sup> The diabetes mortality national goal is from Health People 2010. HP 2010 uses the 1995 rate of 13.3 as a baseline and we include this as the national rate. This is because the HP 2000 goal was for diabetes-related mortality at 34.0. The state and local rates are based on combined data from 1990-1996 and were provided by the State of Maine.
- <sup>iv</sup> Mortality rates provided by the MMAF were adjusted to Maine's 1996 population estimates and are therefore incomparable to other state and federal figures.

<b>Cause of Death</b>	<b>ICD-9 Code</b>
AIDS / HIV	042-044
Cancer — all	140-208
Buccal Cavity and Pharynx	140-149
Digestive Organs and Peritoneum cancer	150-159
Colorectal Cancer	153-154
Respiratory Cancer	160-165
Lung Cancer	162.2-162.9
Cancer of Other and Unspecified Sites	170-173
Breast Cancer	174
Female Genital Organ Cancer	179-184
Cervical Cancer	180
Male Genital Organ Cancer	186-187
Prostate Cancer	185
Urinary Organs	188-189
Lymphatic and Hematopoietic Cancer	200-208
Diabetes	250
Major Cardiovascular Disease	390-459
Heart Disease	390-398, 402, 404-429
Diseases of Pulmonary Circulation	415-417
Cerebrovascular Disease	430-438
Arteriosclerosis	440
Other Diseases of the Circulatory and Pulmonary System	441-459
Pneumonia	480-486
COPD	490-496
Emphysema	492
Chronic Liver disease & Cirrhosis	571
Nephritis, Nephrotic Syndrome and Mephrosis	580-589
Congenital Anomalies	740-759
Certain Conditions Orig. in Perinatal Period	750-779
Accidents & Adverse Affects	800-949
Motor Vehicle-related	810- 825
Suicide	950-959
Homicide	960-978

# Greater Portland Community Health Assessment and Source Book

## Tobacco Use

### Healthy People 2010 Tobacco Use Goal

*Reduce illness, disability, and death related to tobacco use and exposure to secondhand smoke.*

#### National Health Disparities TOBACCO USE

##### Race

cigarette smoking  
smokeless tobacco use

##### Socioeconomic Status

cigarette smoking  
smoking initiation by children  
smoking initiation by adolescents  
smoking cessation during pregnancy

##### Gender

smokeless tobacco use

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**36 Adult Smoking**

**38 Perinatal Smoking**

**39 Youth Student Smoking**



“The tendency is to blame the smoker.  
But the smoker isn’t the problem.  
The drug is the problem.”

— Dr. Richard Hurt,  
Director of the Mayo Clinic’s  
Nicotine Dependence Center



# Greater Portland Community Health Assessment and Source Book

## Tobacco Use

GREATER PORTLAND AREA, MAINE and U.S. RATES with YEAR 2000 OBJECTIVES

Rates are per 100,000 population, unless otherwise noted.

Indicators	Greater Portland Rate	Maine Rate	U. S. Rate	HM 2000 Goal	HP 2000 Goal
Adult smoking prevalence <sup>1</sup>	Portland HSA				
ever smoked	54.7%	54.0%	52.0%	■	■
currently smoke	22.5%	22.7%	23.2%	15.0%	15.0%
currently smoke ages, 18-35	32.6%	31.1%	28.3%	<i>see notes</i>	■
Perinatal smoking prevalence <sup>2</sup>				<i>see notes</i>	<i>see notes</i>
Percent of women who smoked	Cumberland County				
before pregnancy	26.1%	32.6%	31.6%	■	■
during pregnancy	15.2%	19.7%	20.0%	■	■
after pregnancy	17.8%	24.7%	25.0%	■	■
Average hours per day of newborns' exposure to smoke (babies of smokers)	4.4	4.7	■	■	■
High school student smoking prevalence <sup>3</sup>	City of Portland			<i>see notes</i>	<i>see notes</i>
tried cigarettes	69.0%	61.0%	70.2%	■	■
current smoker	40.0%	39.0%	36.4%	■	■
frequent smoker	22.0%	22.0%	16.7%	■	■
Percent of high school student who bought own cigarettes	13.0%	11.0%	29.8%	■	■
Percent of high school students who tried cigarettes before age 13	■	30.0%	24.8%	■	■
■ = data not available					
<i>For Source Notes, see next page</i>					
<b>Smoking Status Definitions:</b>					
• <i>ever</i> — tried even one puff over lifetime					
• <i>current</i> — smoked at least one cigarette in the past 30 days					
• <i>frequent</i> — smoked on 20 or more days in the past 30 days					
• <i>regular</i> — smokes daily					

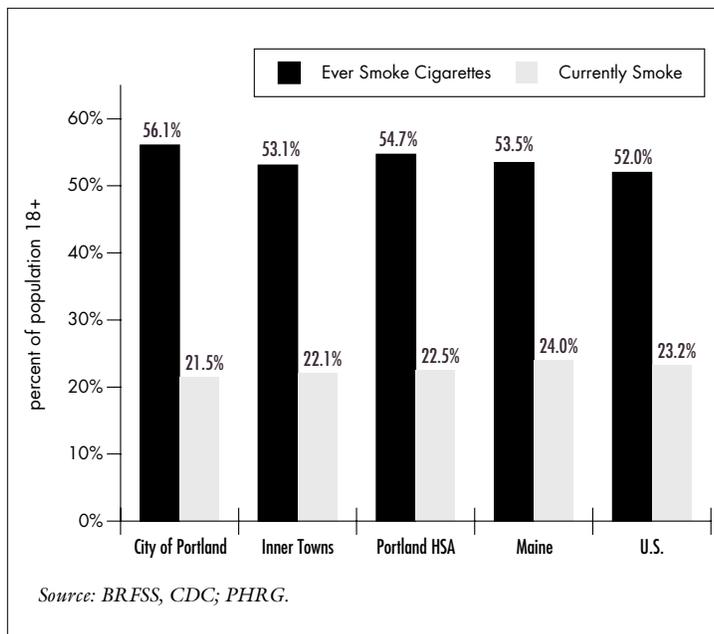
source number	Greater Portland Area	Maine	U.S.	notes
1	1996 - 1997 BRFSS CDC	1997 BRFSS CDC	1997 BRFSS CDC	BRFSS data for the Portland HSA was prepared by the PHRG.  HM 2000 has a goal of reducing smoking rates of 18-24 year olds to 15%.
2	1996 - 1977 PRAMS CDC	1996 PRAMS CDC	1996 PRAMS CDC	Both HP and HM 2000 have a goal of reducing smoking in women of reproductive age to 12%. HM 2000 has a goal of reducing the percent of high-risk, low-income women to 27%. HP 2000 has a goal of a 10% smoking rate in pregnant women; and, 60% quit/abstinence rate among women who smoke who are pregnant.
3	1998 PHRG for PHD, HHS, City of Portland	1997 YRBS CDC	1997 YRBS CDC	The Portland rate is from "Assessment of Smoking Prevalence and Patterns among Youth in Portland, Maine." This City of Portland-commissioned PHRG study surveyed Portland's two public high schools.  HP 2000 has a goal of reducing smoking rates of high school seniors to 15%

## Adult Smoking

### ■ Adult Smoking Prevalence —

Greater Portland Area,  
Maine and the U.S.: 1997

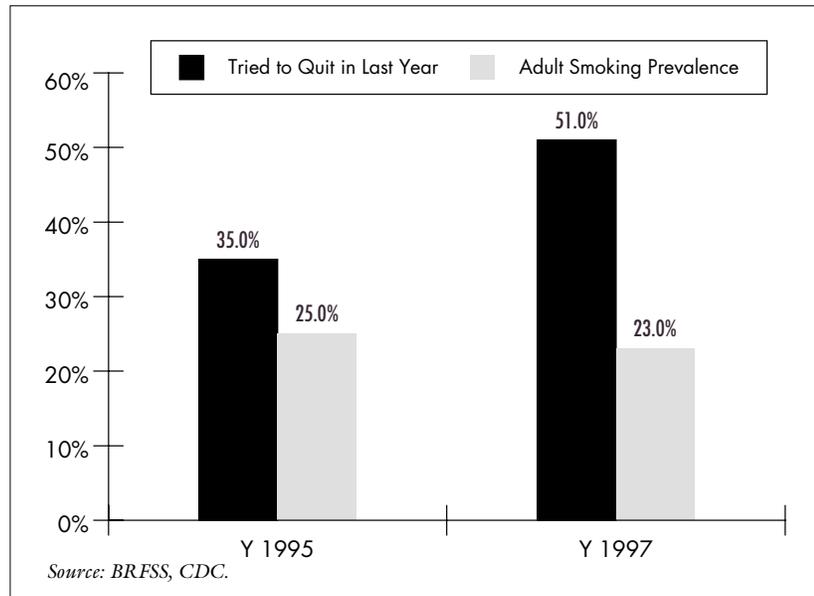
• In Portland, 56% of the adult population has tried smoking cigarettes, and more than one in five adults currently smoke. These rates are similar to or higher than Maine and the U.S.



## ■ Adults Smokers Trying to Quit —

Maine: 1995 and 1997

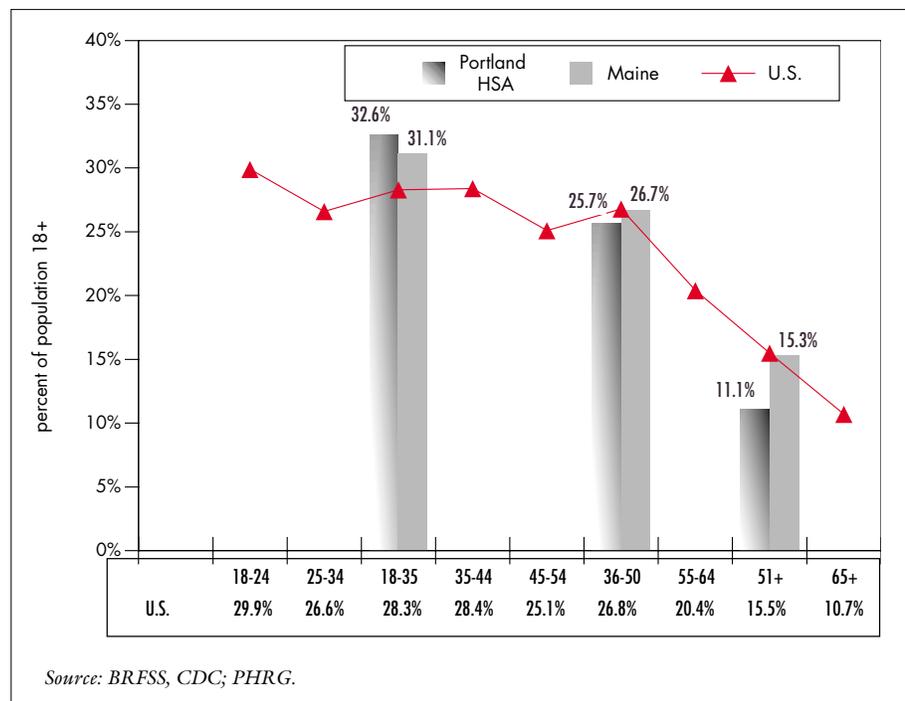
- Though smoking prevalence has not changed notably between 1995 and 1997, more than 50% of smokers made a quit attempt in 1997 versus 35% in 1995.



## ■ Adults who Currently Smoke, by Age —

Portland HSA, Maine and the U.S.: 1997

- In the Portland HSA, a full third of the population ages 18 to 35 smoke. This is higher than the state and national rates for this age group.

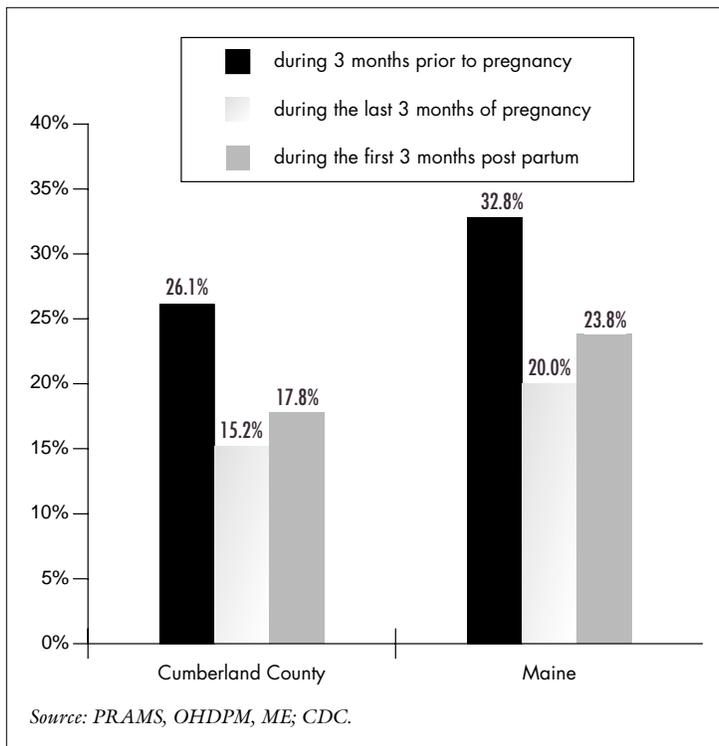


## Perinatal Smoking

### ■ Perinatal Smoking Prevalence —

Cumberland County and Maine: 1996-1997 combined

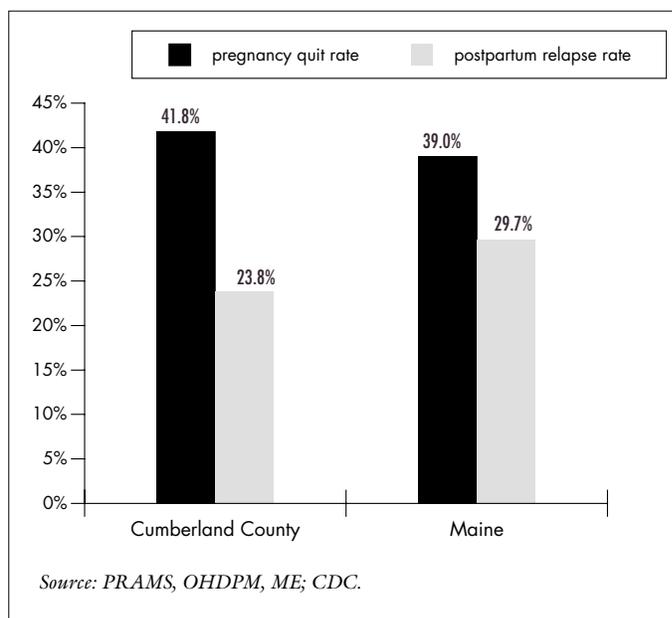
- In Cumberland County, more than one in four women smoke cigarettes just prior to pregnancy. In Maine overall, one in three women smoke before becoming pregnant.
- In Cumberland County and Maine, three fifths of the women who smoke before pregnancy, continue to smoke during pregnancy.
  - At three months postpartum, relapse smoking by women who quit during pregnancy is already advancing.



### ■ Perinatal Spontaneous Quit and Relapse Rates —

Cumberland County and Maine: 1996-1997 combined

- Approximately 41.8% of women who smoke quit when pregnant in Cumberland County. Similarly in Maine, 39% of women who smoke quit during pregnancy.
- In Cumberland County 23.8% and in Maine 29.7% of the women who had quit smoking during pregnancy, relapsed during the first three months postpartum.

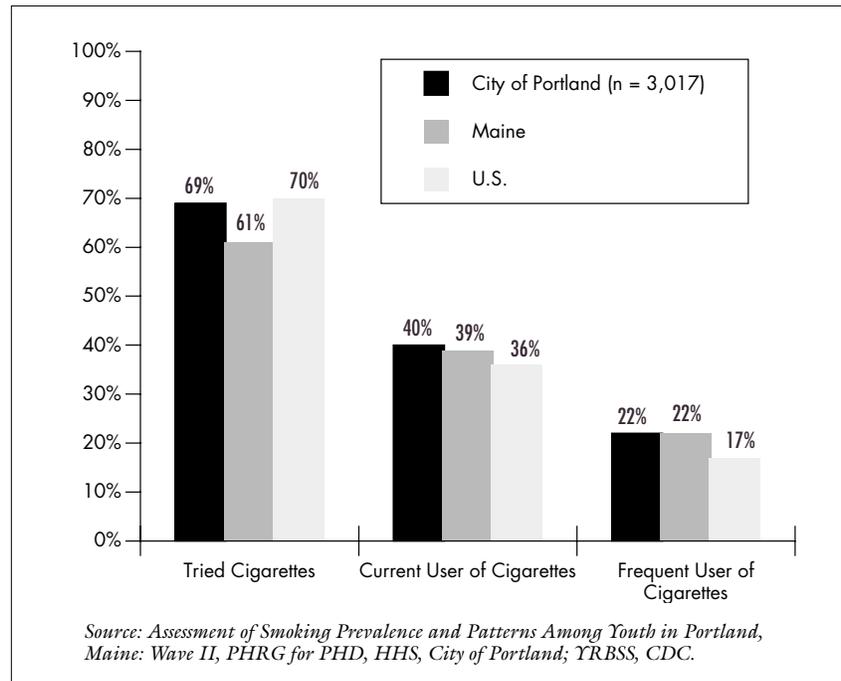


## Youth Smoking

### ■ Smoking in High School —

City of Portland, Maine, and the US: 1997

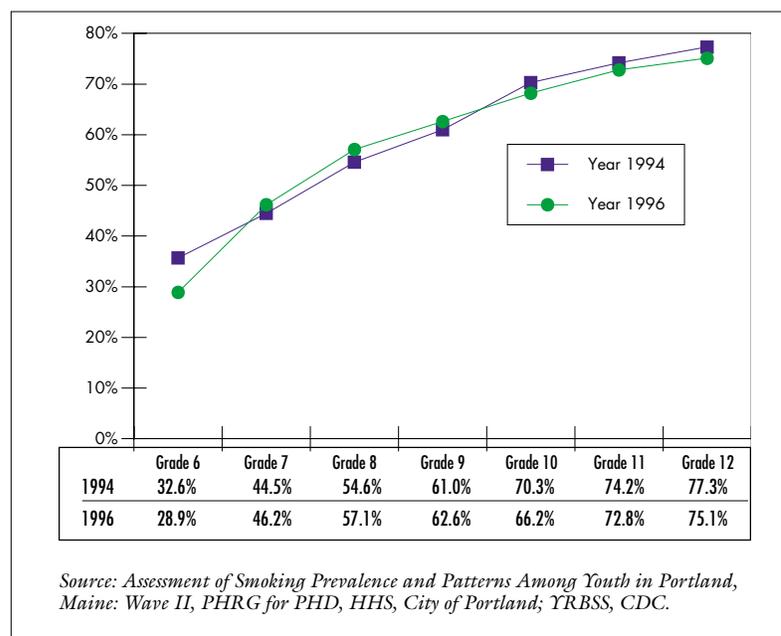
- Portland and the state of Maine remain above the national average for prevalence of smoking in high school. Although nationally more students have tried cigarettes, Maine students are 5% more likely to become frequent users. (There is not a significant difference between the rate of smoking between male and female students.)



### ■ Students Who Have Ever Tried Cigarettes, by Grade —

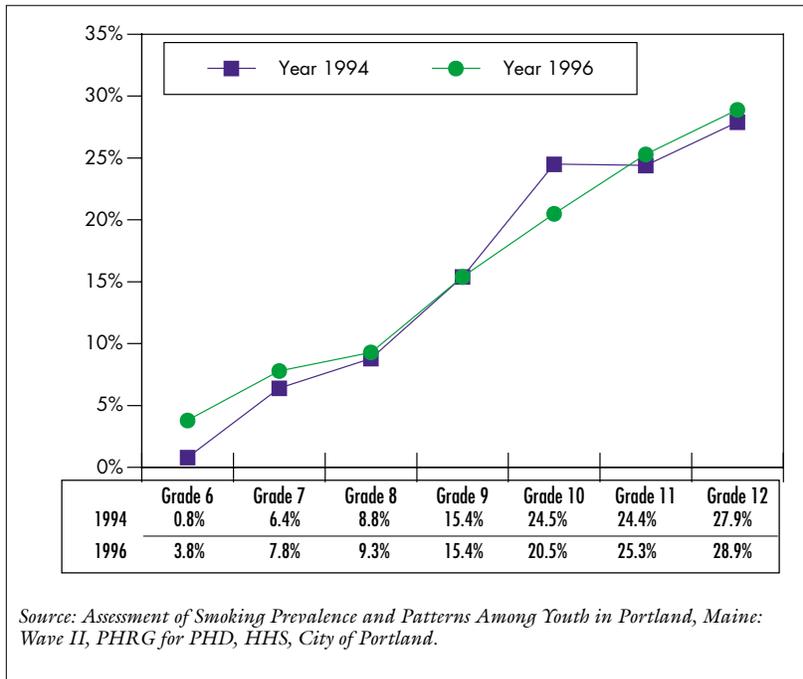
City of Portland: 1994 and 1996

- Between 1994 and 1996, the average grade in which students first tried cigarettes became lower.
- A third of all sixth graders and three fourths of all seniors have tried cigarettes. The high rate of exposure to cigarettes in the Portland high schools has resulted in a smoking rate for seniors (29%) that is higher than the adult population (22%).



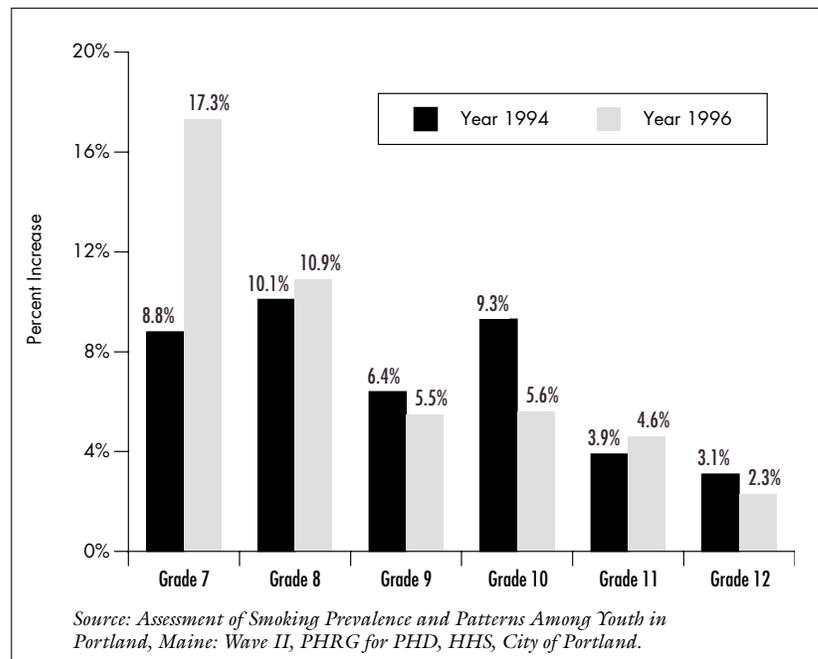
■ **Students Who Frequently Smoked Cigarettes, by Grade —**  
**City of Portland: 1994 and 1996**

- An increasing percentage of frequent smoking in the lower grades is evident between 1994 and 1996.



■ **Percentage Increase from Previous Grade in the Number of Students Smoking Regularly —**  
**City of Portland: 1994 and 1996**

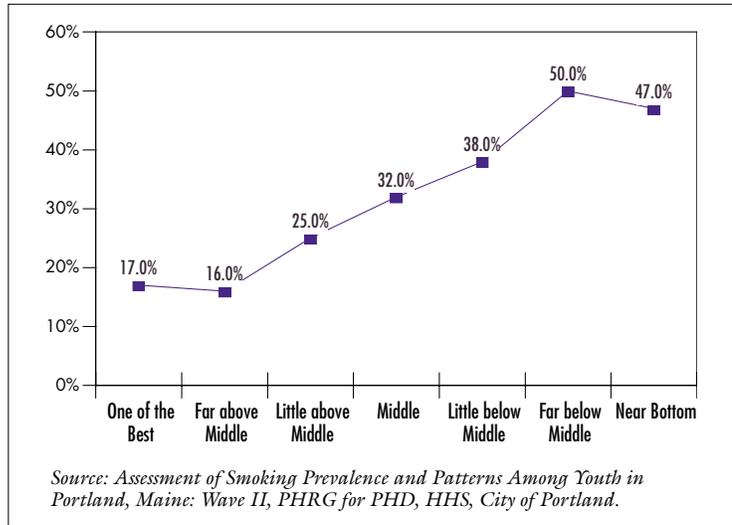
- The number of students who are regular users of cigarettes increases every year in high school, with the largest increases occurring during the junior high school grades of seven and eight.



■ **Regular Smokers by Self-Perceived Rank in Class —**

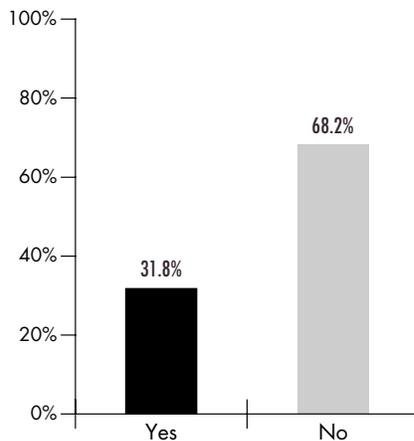
Portland: 1996

• Students demonstrating low self esteem by ranking themselves near the bottom of their class, were three times more likely to be regular smokers than students who ranked themselves among the best in the class.



■ **High School Students who Reported Discussing Cigarettes with a Medical Provider —**

City of Portland: 1996

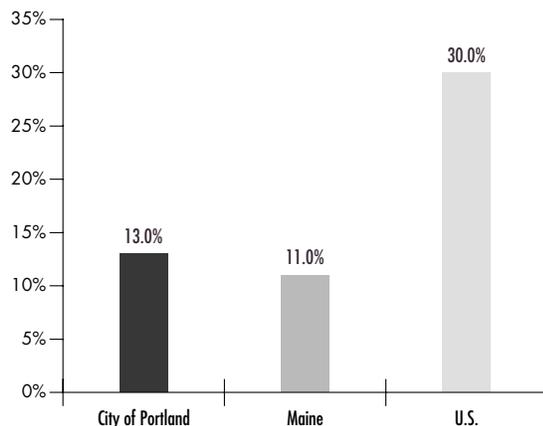


• Less than one third of high school students in Portland reported discussing the effects of cigarette smoking with a doctor, dentist or nurse. ( In contrast, statewide over 80% of pregnant mothers reported having discussions about cigarette smoking with a health care provider. See *Maternal, Infant and Child Health and Family Planning*.)

Source: Assessment of Smoking Prevalence and Patterns Among Youth in Portland, Maine: Wave II, PHRG for PHD, HHS, City of Portland.

■ **High School Students who Bought Own Cigarettes —**

City of Portland, Maine and the US: 1996



• Eleven percent of Maine high school students are able to purchase cigarettes for themselves. Out of the students who did purchase cigarettes only 8.6% were asked to show identification. Maine State law requires proof of age over 18 in order to purchase cigarettes.

Source: Assessment of Smoking Prevalence and Patterns Among Youth in Portland, Maine: Wave II, PHRG for PHD, HHS, City of Portland; YRBSS, CDC.



## Environmental Health

Healthy People 2010 Environmental Health Goal

*Promote health for all through a healthy environment*

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**46 Air Quality**

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**52 Toxics and Wastes**



“We shape ourselves  
through decisions  
that shape  
the environment.”

— René Dubos

“It isn’t pollution that’s  
harming the environment.  
It’s the impurities in our air  
and water that are doing it.”

— Dan Quayle



# Greater Portland Community Health Assessment and Source Book

## Environmental Health

GREATER PORTLAND AREA, MAINE and U.S. RATES with YEAR 2000 OBJECTIVES

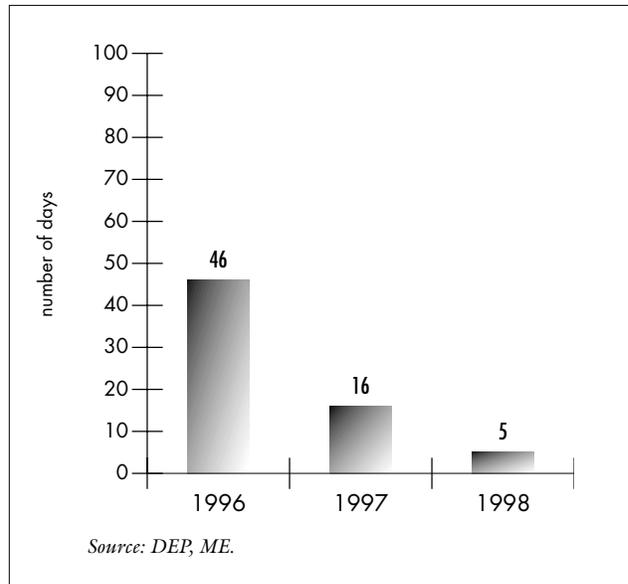
Rates are per 100,000 population, unless otherwise noted.

Indicators	City of Portland	Maine Rate	U. S. Rate	HM 2000 Goal	HP 2000 Goal
Asthma hospitalizations <sup>1</sup>	130.0	109.0	194.0	■	160.0
Blood lead levels among children <sup>2</sup>					
• estimated percent of children with lead levels exceeding 10 µg/dL	■	■	4.4%	4.0%	2.0%
• percent of children screened with lead levels exceeding 10 µg/dL <sup>i</sup>	15.9%	9.1%	■	■	■
• children with lead levels exceeding 15 µg/dL <sup>ii</sup>	■	■	1.4%	■	1.5%
• percent of children screened with lead levels exceeding 20 µg/dL <sup>1</sup>	2.0%	1.1%	■	■	■
Proportion of homes tested for radon <sup>3</sup>	<5.0%	<5.0%	11.0%	■	40.0%
■ = data not available For Source Notes, see below					

source number	Greater Portland Area	Maine	U.S.	notes
1	1996 - 1997 UHDDS, MMAF	1996 - 1997 UHDDS, MMAF	1995 HP 2000 MMAF adjust rates to the Maine 1996 population.	
2	1996-1998 BOH, ME	1996-1998 BOH, ME	1994 NHANES III, NCHS, CDC	HP 2000 goal is 300,000 children with blood levels greater than 15 (g/dl). Portland PHD calculated a percentage using the 1994 U.S. Census estimate for children 0-5 and adjusting to the higher standard of 10 (g/dl).
3	1993 -1998 DEP, ME	1993 -1998 DEP, ME	1994 HP 2000	

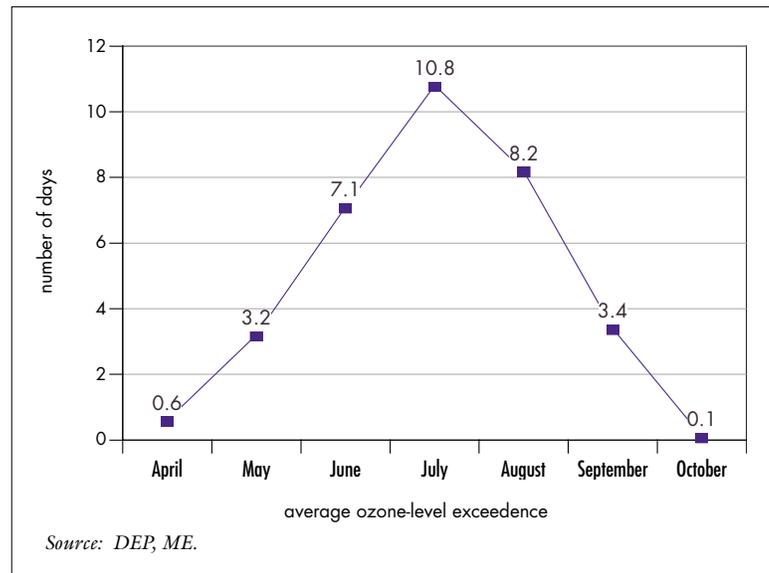
### ■ Annual Number of Days with Unhealthy Air Quality — Cumberland County: 1996 – 1998

- In Cumberland County, the annual number of days with unhealthy air (based on concentrations of ground-level ozone<sup>iii</sup>) decreased between 1996 and 1998.



### ■ Average Ozone Health Warning Level Exceedence, by Month — Maine: 1980 - 1996 combined

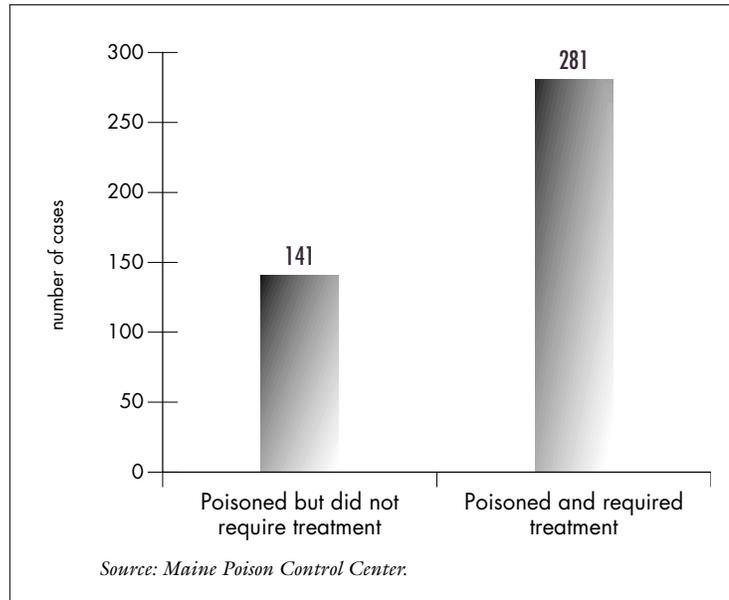
- Ozone levels exceed health warnings in the warmest months, peaking in June, July and August.



## Air Quality — Indoor

### ■ Carbon Monoxide Poisonings — Maine: 1998

- A notable number of carbon monoxide poisonings occurred in Maine in the winter of 1998 due to the use of unventilated kerosene heaters following prolonged power outages from an ice storm.



### Secondhand Smoke Exposure

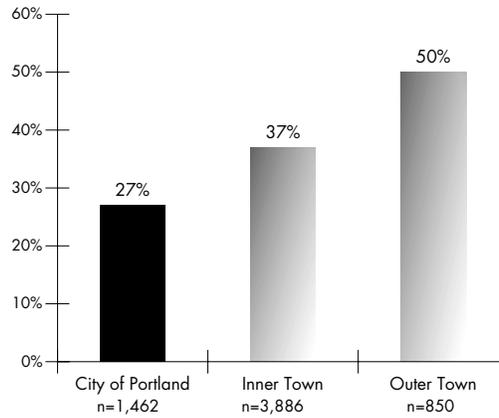
“Those most affected by secondhand smoke are children. Because their bodies are still developing, exposure to the poisons in secondhand smoke puts children in danger of severe respiratory diseases and can hinder the growth of their lungs. On top of that, the effects can last a lifetime.

Questionnaire data from NHANES III on reported exposure to Environmental Tobacco Smoke (ETS) show that 43% of U.S. children (aged two months to eleven years) lived in a home with at least one smoker.”

Source: NHANES III, NCHS, CDC.

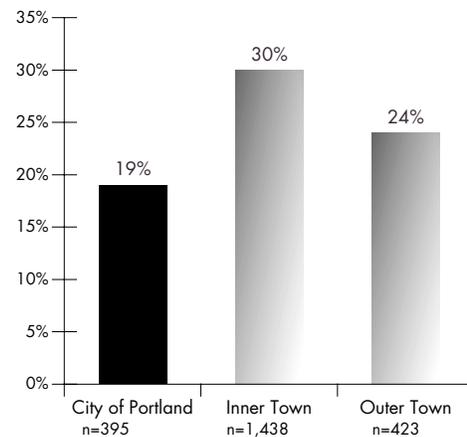
■ **Percentage of Homes Tested, with Radon Levels Exceeding EPA Standards —**

Greater Portland Area:  
1993 – 1998 combined<sup>iv</sup>



■ **Percentage of Homes with Radon Levels Exceeding EPA Standards, Rectifying the Problem —**

Greater Portland Area:  
1993 – 1998 combined



- Of the homes tested in the Greater Portland area, about one in four homes in the City of Portland, two out of five homes in the Inner Towns, and half the homes in the Outer Towns had elevated radon levels.
- Homes that yield test results in excess of federal action levels are recommended to take steps to reduce radon levels. Of the households with high radon test results, only 21% in the Greater Portland area have taken steps to address the problem.

Source: BOH, ME.

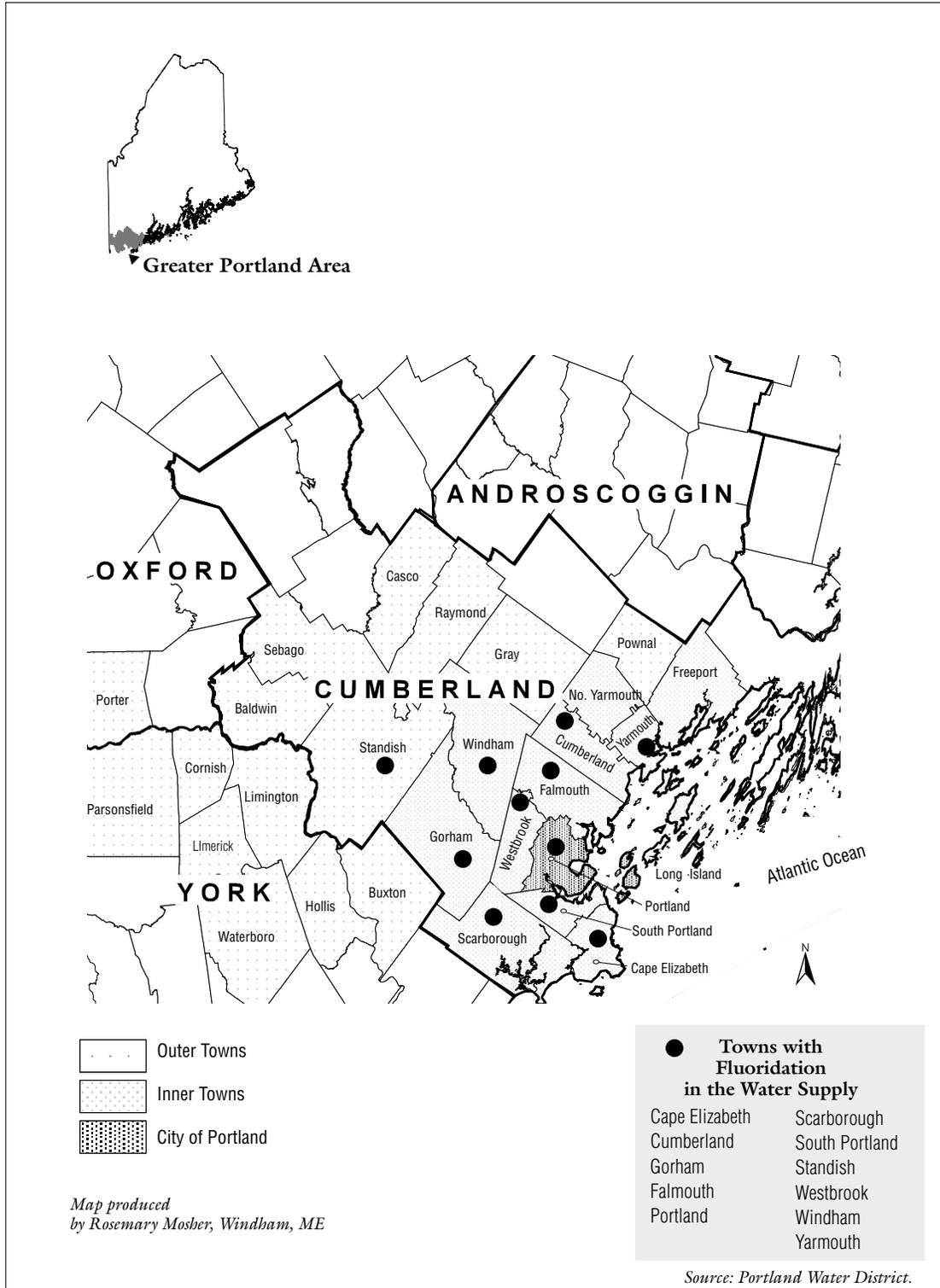
“According to the National Cancer Institute, up to one-tenth of U.S. lung cancer deaths may be caused by radon in homes.”

—HP 2000, US DHHS

# Water Quality

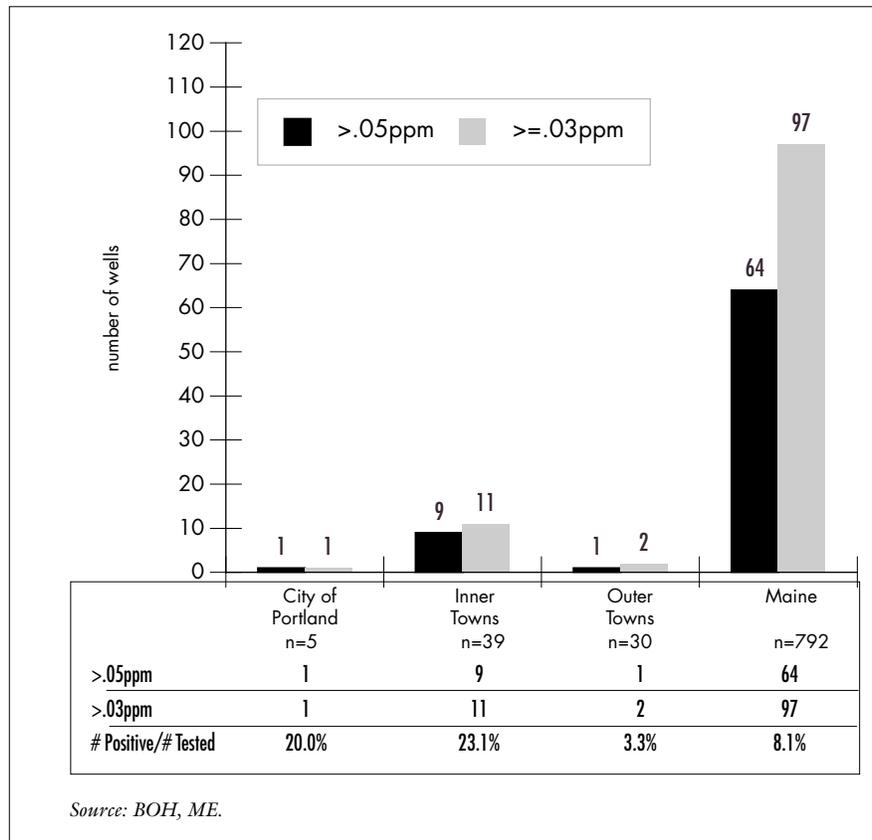
## ■ Towns with and without Fluoridation in Public Water Supply — Portland Water District: 1999

- The Portland Water District began fluoridation of its public water supply in August 1997, following a public referendum vote. The Yarmouth Water District also fluoridates its public water supply. Private wells in these districts are not fluoridated.



■ **Private Wells Tested for Arsenic Problems and Number with Elevated Results<sup>v</sup>**  
 — Greater Portland Area: 1993 -1998 combined

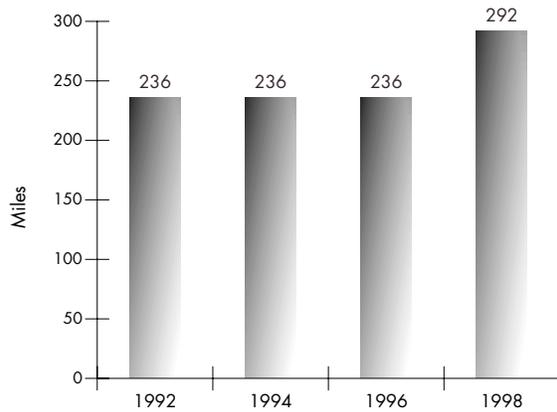
- Only 74 private wells in the Greater Portland area have been tested for arsenic. Of the wells tested, only a small number exhibited elevated arsenic levels. Because so few homes have had their wells tested, it is impossible to know the extent of arsenic contamination in the state.



### ■ Miles of River Unsuitable for Fish Consumption Due to Dioxin —

Maine: 1992 – 1998

- While the dioxin levels found in Maine fresh water fish have decreased since 1984, the number of miles of rivers still unsuitable for fish consumption due to dioxin has increased since 1992. This increase is due to improved monitoring from the Maine Department of Environmental Protection and revisions of the Bureau of Health's consumption advisory.

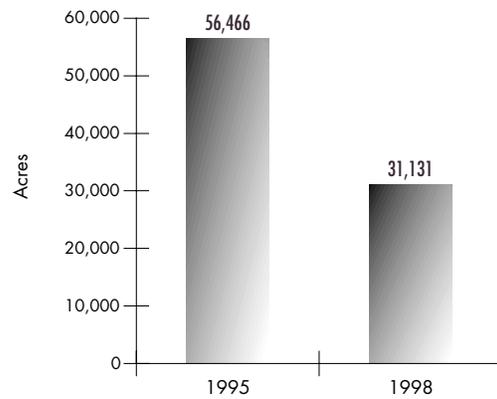


Source: DEP, ME.

### ■ Acres of Clam Flats Closed to Shellfish Harvesting —

Casco Bay: 1995 and 1998

- Shellfish beds are closed to shellfish harvesting due to sewage discharge, non-point source pollution, and marine biotoxins.
- Since 1995, more than half of Casco Bay's previously closed shellfish beds have been re-opened, representing an improvement in marine water quality.

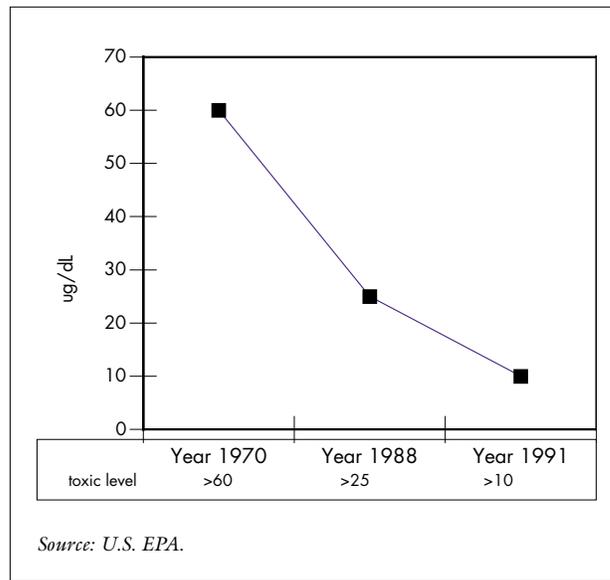


Source: DMR, ME.

## Toxics and Wastes

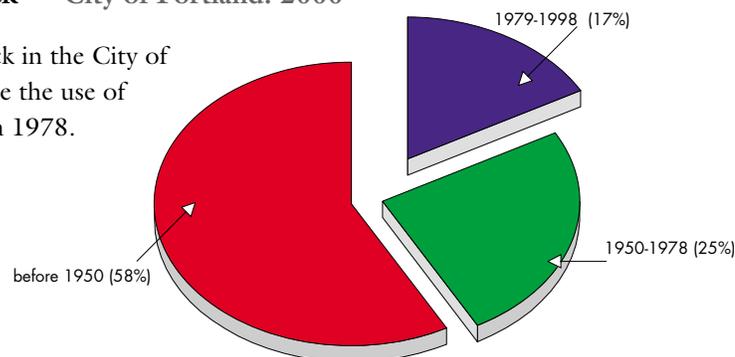
### ■ Changes in Lead Poisoning Standards — U.S. 1970 - 1991

- The level at which lead in the blood is considered to be toxic has decreased dramatically since 1970. By 1992, medical research demonstrated that at (and possibly below) 10  $\mu\text{g}/\text{dL}$ , lead levels are high enough in the body of children to adversely affect neurological development, including intelligence and a child's ability to manage their impulses and behavior.



### ■ Age of Housing Stock — City of Portland: 2000

- 83% of the housing stock in the City of Portland was built before the use of lead paint was banned in 1978.

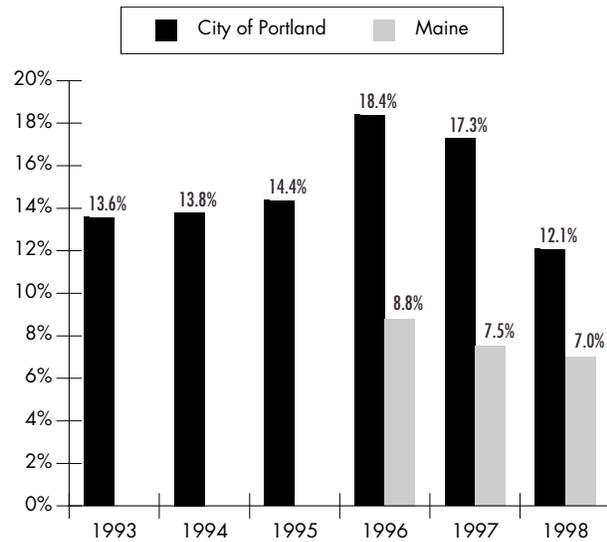


Source: Assessor's Office, City of Portland.

**■ Percent of Children, Ages 6 months to 6 Years, Screened for Elevated Blood Lead Levels — Portland and Maine: 1993 - 1998**

- In 1998 only 12% of the children 6 months to 6 years old in Portland were screened for elevated blood lead levels. Statewide 7% of the at risk children were screened. Portland and Maine screening rates are too low to estimate the prevalence of lead poisoning in the population.

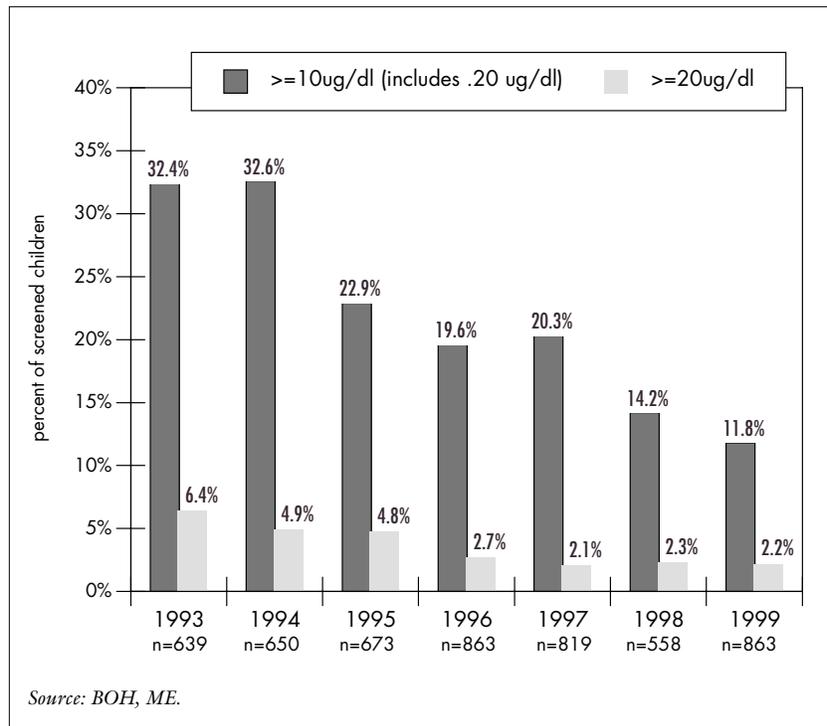
Source: BOH, ME.



**■ Percent Screened with Elevated Blood Lead Levels, Children Ages 0-6, — Portland: 1993 - 1998**

- Of the blood samples tested from Portland between 1993 and 1998, a decreasing proportion had blood lead levels above the 10- $\mu\text{g}/\text{dL}$  mark.

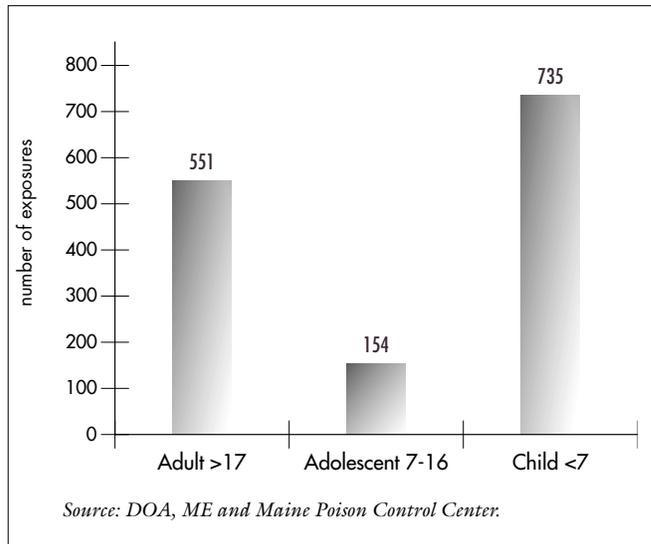
Source: BOH, ME.



## Pesticide Exposure

### ■ Acute Pesticide Poisonings in Adults, Adolescents, and Children — Maine: 1993 - 1996 combined

- More than half of the acute pesticide poisonings reported to the Maine Poison Center are of children under age seven.
- The most common pesticide responsible for poisonings is DEET, an insect repellent. Other common pesticides include insecticides, rodenticides, herbicides, fungicides, wood preservatives, snail and slug products, and mammal repellents.



## Endnotes

- Maine's (and Portland's) lead screening programs target children who are identified to be at high risk for lead poisoning; therefore, rates are not directly comparable to HP 2000 goals and U.S. rates which are proportions of the total population ages 0-five years old.
- Based on CDC's National Health and Nutrition Examination Survey III (NHNES III) the percentage of young children with elevated blood lead levels has been reduced to 4.4%. This is in large part the result of controlling exposure to lead through the elimination of the use of leaded gasoline and lead in paint.
- The state standard for ozone exceedance days changed between 1997 to 1998. Originally, Maine calculated the number of hours per month that the ozone level was  $>.081$  ppm. Now, following the federal standard, the state monitors ozone by calculating the maximum 8 hour average, per month, at  $>.085$  ppm. The low number in 1998 is partially due to a cool June, usually a higher ozone month.
- According to the US Environmental Protection Agency (EPA), radon levels in excess of 4.0 picocuries per liter (pCi./L) are unacceptable. Radon is a colorless, odorless, radioactive gas found in most soils. It comes from the natural decay of uranium and moves through the ground, into the air, and often seeps into buildings through cracks in the foundation. Nearly one out of every five homes in the US is estimated to have elevated levels of indoor radon, regardless of whether it is a new or old, well sealed or drafty, or with or without a basement. The U.S. Environmental Protection Agency recommends that all homes be tested for radon, regardless of geographic location. The only way to determine if a house has elevated indoor radon is to test.  
Tests for household radon levels, done by the Maine's Radiation Control Program, are conducted on only a small proportion of the homes in the state (less than 5%) usually at the time of a real estate transaction.
- Arsenic is a naturally occurring metal found in bedrock. As water flows through rocks, arsenic dissolves and gets into well water. Long term exposure to arsenic can lead to cancers and cause other symptoms associated with many common diseases.

# Injury

## Healthy People 2010 Injury Goal

*Reduce disabilities, injuries, and deaths due to unintentional injuries.*

### National Health Disparities

#### INJURY

##### Race

unintentional injury deaths  
motor vehicle crash deaths  
drowning deaths  
residential fire deaths

##### Socioeconomic Status

work-related injury deaths  
nonfatal work-related injuries

##### Gender

unintentional injury deaths  
drowning deaths  
hip fractures among adults  
(65 years and older)  
non-fatal spinal cord injuries

##### Age

motor vehicle crash deaths  
fall-related deaths  
drowning deaths  
residential fire deaths  
hip fractures among adults  
(65 years and older)  
non-fatal poisoning

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**66 Other Accidental Injuries**



“Chance generally favors the prudent.”

— Joseph Joubert

“Stay out of the road, if you want to grow old.”

— Pink Floyd



# Greater Portland Community Health Assessment and Source Book

## INJURY

GREATER PORTLAND AREA, MAINE and U.S. RATES with YEAR 2000 OBJECTIVES

Rates are per 100,000 population, unless otherwise noted. Morality is adjusted to 1940.

Indicators	Portland HSA Rate	Maine Rate	U. S. Rate	HM 2000 Goal	HP 2000 Goal
<b>Unintentional Injury</b>					
Unintentional injury mortality <sup>1</sup>	20.8	25.3	30.5	22.0	29.3
Unintentional injury hospitalizations <sup>2</sup>	■	1,071.0	635.0	910.0	754.0
Unintentional injury mortality, not including motor vehicle-related <sup>1</sup>	Cumberland County 10.2	11.3	14.2	■	■
<b>Motor Vehicle-Related Injury</b>					
Motor vehicle-related mortality <sup>1</sup>	10.1	13.9	16.3	■	14.2
ages 15- 24	Cumberland County 18.2	26.0	29.5	■	26.8
Alcohol-related motor vehicle mortality <sup>3</sup> (in keeping with HP 2000, this rate is not adjusted)	4.9	4.3	6.5	5.8	5.5
<b>Safety Behaviors</b>					
Vehicle restraint usage					
Percentage of adults at risk for injury because of inadequate seat belt use <sup>4</sup>	31.1%	30.4%	30.6%	■	■
Percentage of adults who always wore a seat belt in the past year <sup>4</sup>	68.5%	69.5%	69.3%	■	85.0%
Percentage of children (> 16 years old) who always used appropriate restraints in the car in the past year <sup>4</sup>	97.8%	96.3%	85.4%	■	85.0%
Percent of children < 4 years old who use child protective equipment <sup>2</sup>	■	90.0%	60.0%	15.0% increase	70.0%
Percentage of children (5 - 15 years old) who always wore a helmet when bike riding in the past year <sup>4</sup>	61.3%	32.2%	49.6%	■	50.0%
<b>Other Injury</b>					
Fall-related injury					
fall-related mortality <sup>1</sup>					
ages 65-84	19.1	17.8	19.9	■	14.4
ages 65 - 74	Cumberland County 4.4	7.5	9.5	■	■
ages 75 - 84	43.0	34.5	36.9	■	■
ages 85+	169.3	138.5	159.6	■	■
Intentional injury					
Intentional injury mortality <sup>1</sup>	11.3	13.2	20.5	■	■
homicide	2.3	1.8	9.5	■	7.2
suicide	9.0	11.5	11.3	■	10.5
Firearm-related injury					
firearm-related mortality <sup>5</sup>	5.9	8.4	12.8	■	11.6
males	10.6	15.2	22.3	■	■
females	1.6	2.3	3.3	■	■
■ = data not available					
For Source Notes, see next page					

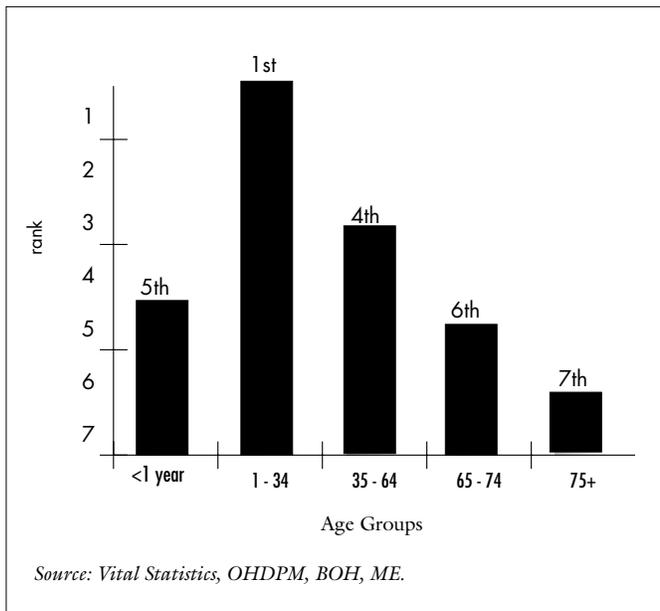
source number	Greater Portland Area	Maine	U.S.	notes
1	1992-1995 Vital Statistics, OHDP, ME	1995 CDC Wonder	1995 CDC Wonder	Portland HSA cause-specific crude rates were provided by the PHRG. Crude rates were adjusted to the 1940 standard population by PHD, HHS, City of Portland.
2		1995 HP 2000	1995 HP 2000	
3	1990-1995 Vital Statistics, OHDP, ME (6-year n = 73 deaths)	1995 Vital Statistics, OHDP, ME (n = 53 deaths)	1995 FARS, NHTSA, U.S. DOT	This is the only mortality rate in HP 2000 that is not age adjusted. HM 2000 goal is stated as <72 per year which = a rate of 5.8 per hundred thousand in 1995
4	1996-1997 BRFSS, CDC	1997 BRFSS, CDC	1997 BRFSS, CDC	BRFSS data for the Portland HSA was prepared by the PHRG.
5	1993-1997 Vital Statistics, OHDP, ME	1996 CDC Wonder	1996 CDC Wonder	Portland HSA rates were age adjusted to the 1940 standard population by PPH, HHS, City of Portland.

## Unintentional Injury

### ■ Unintentional Injury Ranked as Leading Cause of Death, by Age —

Maine: 1995

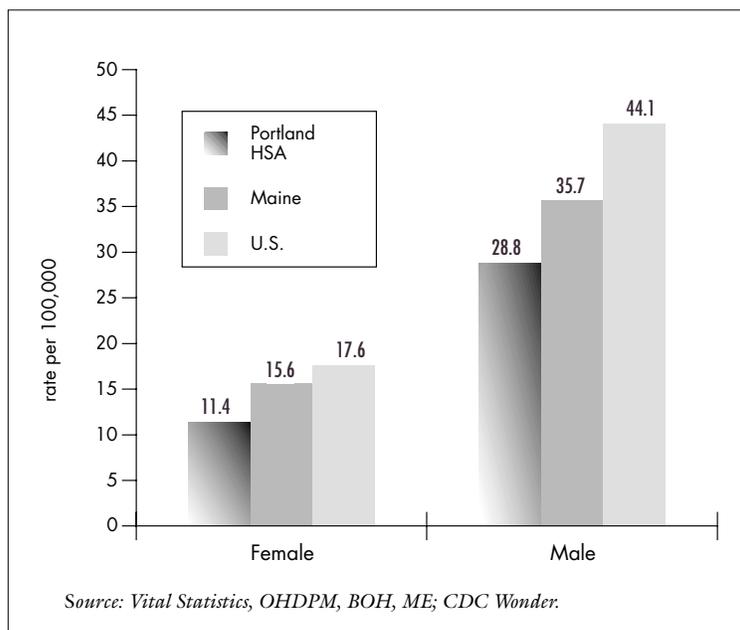
- For ages 1 - 34, accidents rank as the leading cause of death.
- Accidents rank among the top seven causes of death for all age groups.



### ■ Unintentional Injury Mortality, by Sex —

Portland HSA<sup>i</sup>, Maine and U.S.: 1995

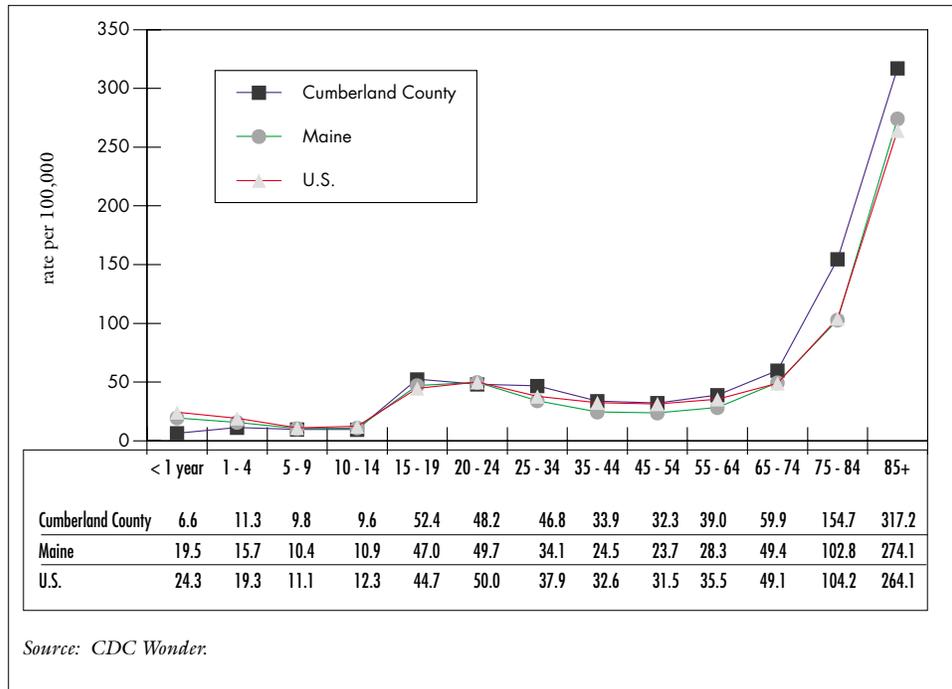
- Unintentional Injury mortality was twice as high for males as it was for females at the local, state and national levels.



## ■ Unintentional Injury Mortality, by Age —

Cumberland County, Maine and U.S.: 1979 - 1996 combined

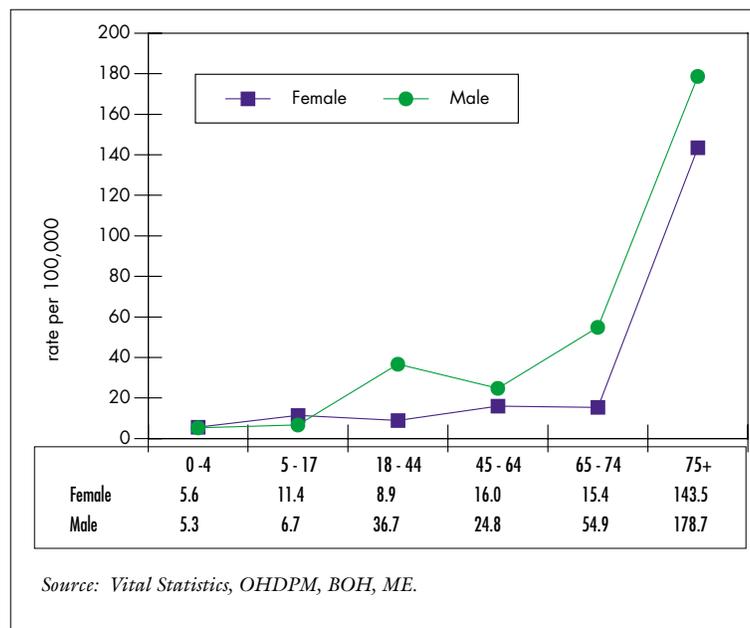
- At ages 25 and older, unintentional injury mortality rates are higher in Cumberland County than they are in either Maine or the U.S.



## ■ Unintentional Injury Mortality Rates, by Age and Sex —

Portland HSA: 1992-1995 combined

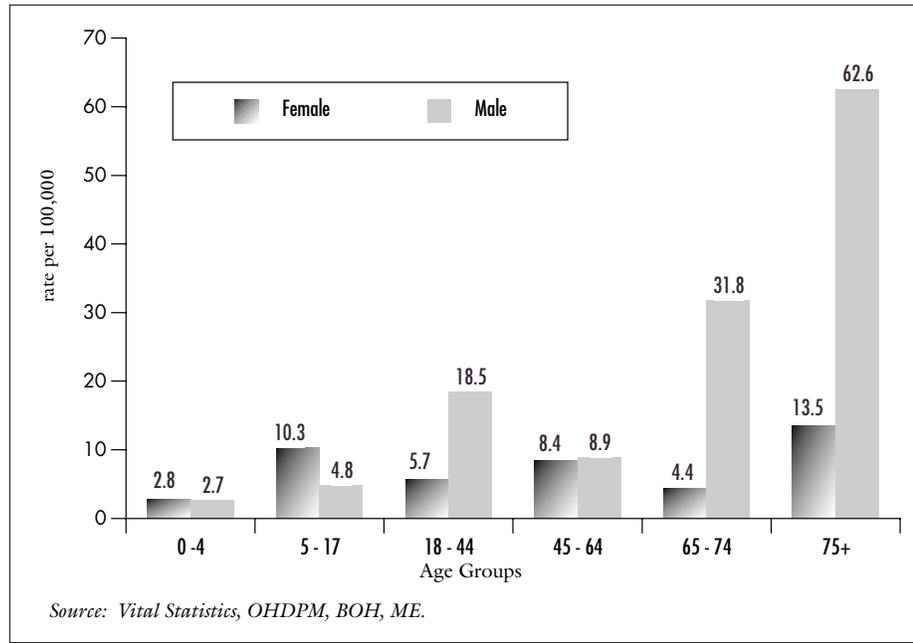
- Mortality rates for unintentional injury were five times higher for people over 75 than they were for people between the ages 65 and 74. Males between the ages of 18 - 44 and 65 - 74 experienced notably higher unintentional injury mortality compared to females.



## Motor Vehicle-Related Injury

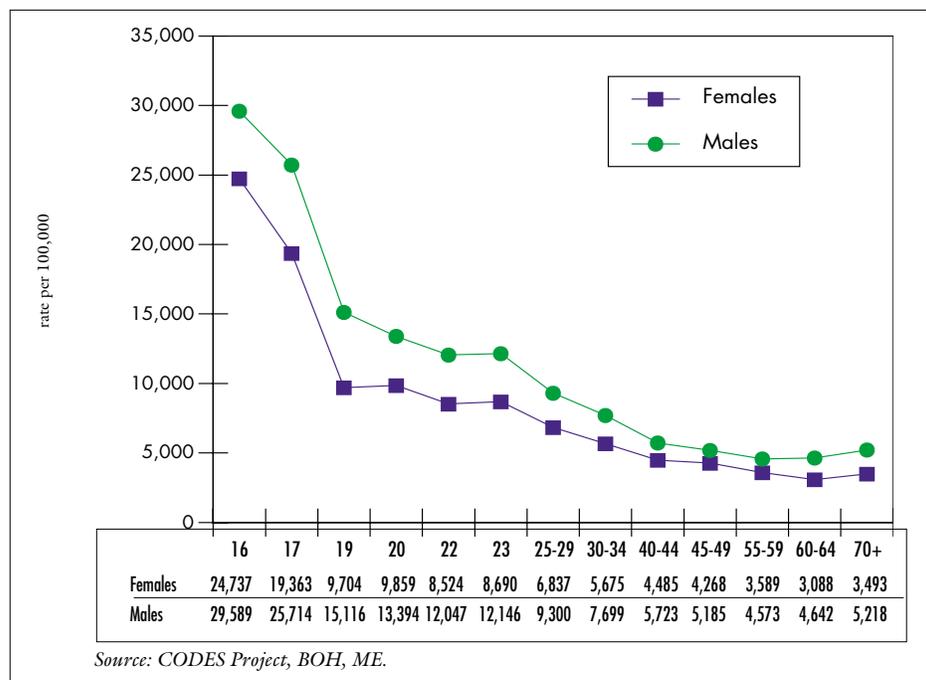
### ■ Motor Vehicle-Related Mortality, by Age and Sex — Portland HSA: 1992-1995 combined

- Age-specific motor vehicle-related mortality rates were consistently higher for males than females, at ages 18 and older. These death rates for men more than tripled between the age groups of 45 - 64 and 65 - 74 and doubled again at ages 75 and older.



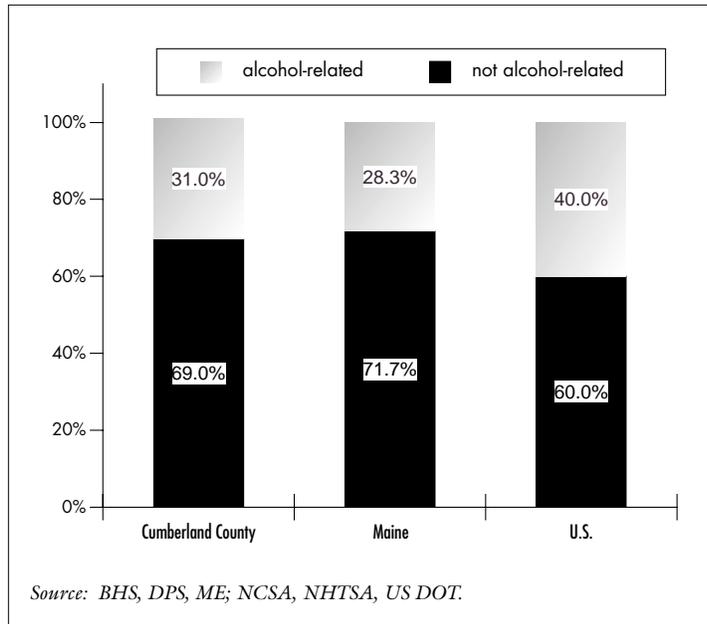
### ■ Rate of Driver Crash Involvement, by Age and Sex<sup>ii</sup> — Maine: 1997

- Maine's youngest licensed drivers, ages 16-18, had an extremely high rate of motor vehicle accidents in 1997. These rates decreased steadily with driver experience until after age 60 when the rates began to increase.

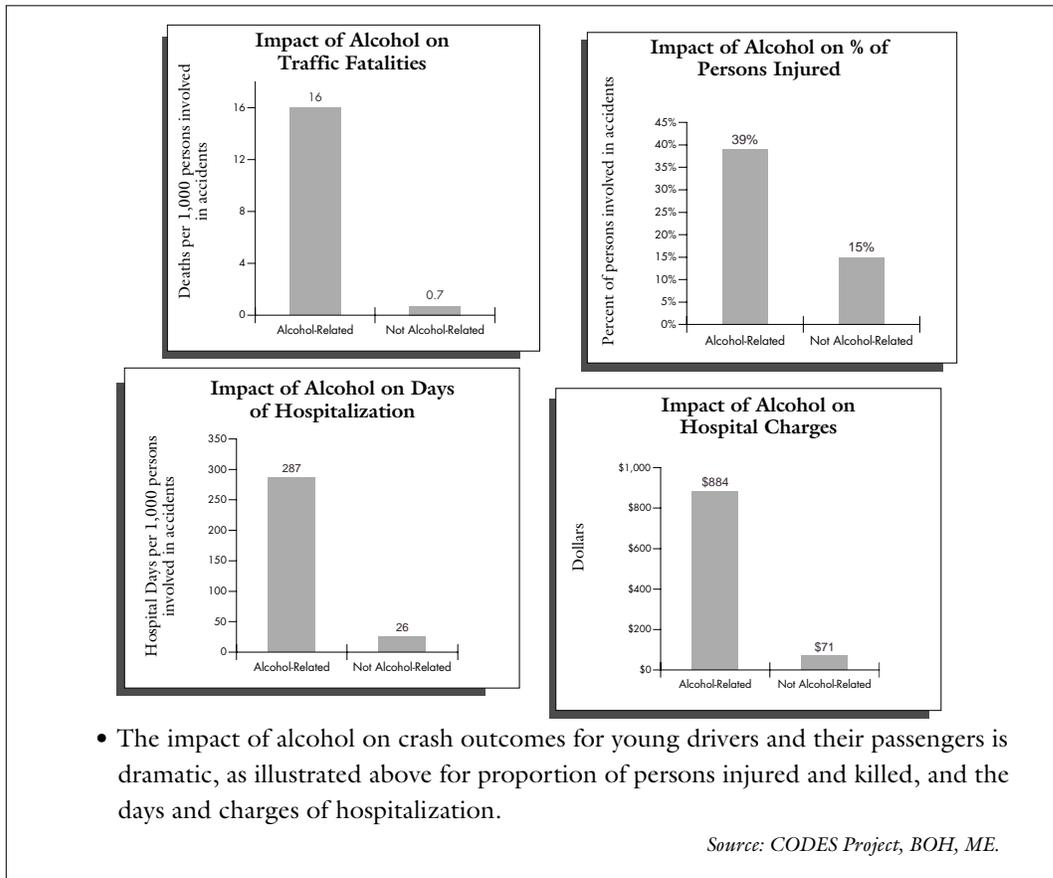


■ **Percentage of Total Traffic Fatalities that are Alcohol-Related —  
Cumberland County, Maine and U.S.: 1995**

- In 1995, alcohol was involved in about one third of all traffic fatalities in Cumberland County. This was less than the national percentage but higher than the state's.



■ **Impact of Alcohol on Crash Outcomes for Younger Drivers, Ages 16 - 24 —  
Maine: 1997**

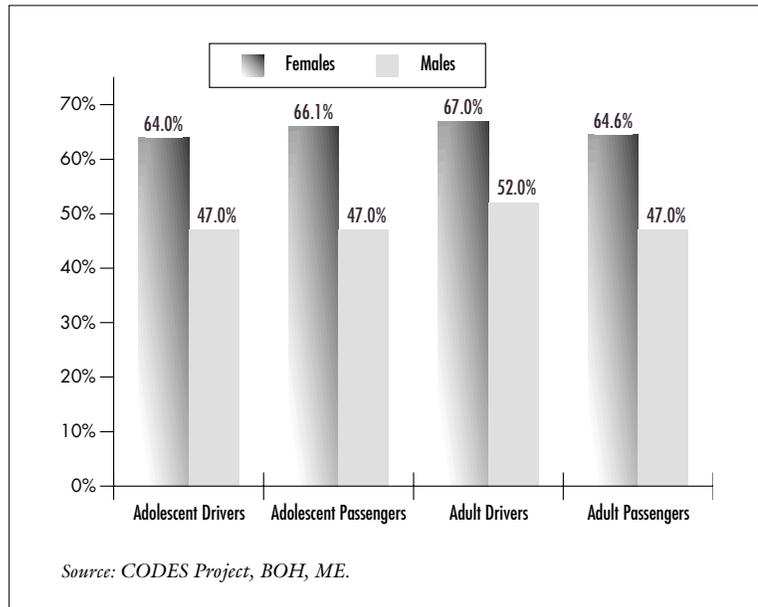


- The impact of alcohol on crash outcomes for young drivers and their passengers is dramatic, as illustrated above for proportion of persons injured and killed, and the days and charges of hospitalization.

## Safety Behaviors

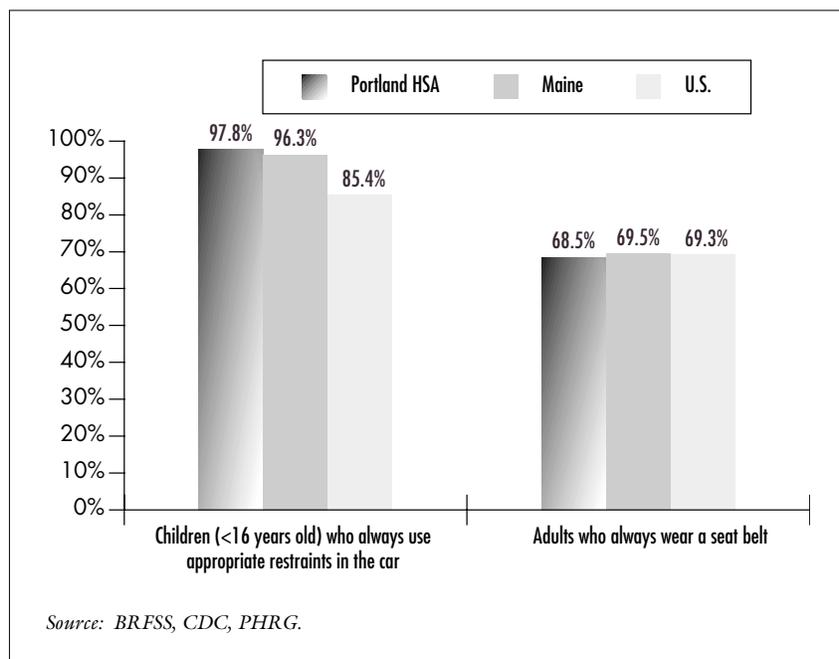
### ■ Percentage of Vehicle Occupants, Less than 14 Years old, Using Seat Belts — Maine: 1997

- Maine females used seat belts at a notably higher rate than males, at all ages above 14 years old.



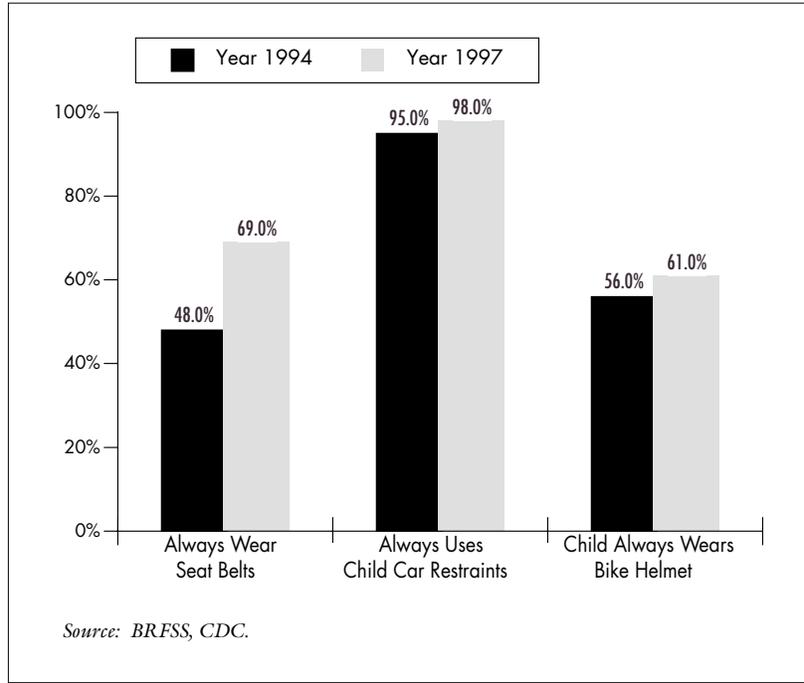
### ■ Percentage of People Using Seat Belts and Appropriate Restraints in the Car — Portland HSA,<sup>iv</sup> Maine and U.S.: 1997

- Over one third of adults in the Portland HSA, Maine and the U.S., are at risk of injury due to inadequate seat belt use.



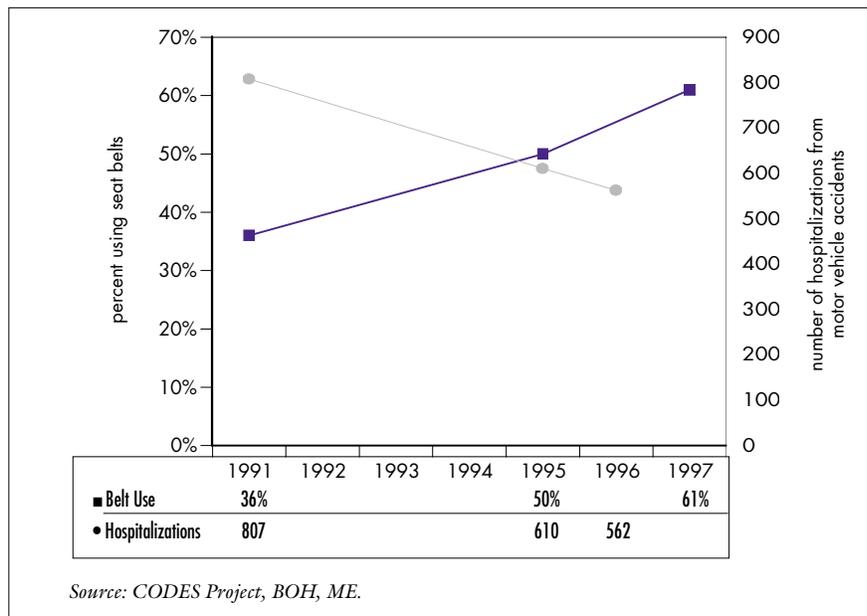
■ **Use of Safety Devices — Portland HSA: 1994 and 1997<sup>v</sup>**

- Between 1994 and 1997, the percentage of people in the Portland HSA reporting that they always use safety belts, restraints and helmets has increased.



■ **Percentage of People Using Seat Belts Compared to the Number of Hospitalizations from Motor Vehicle Accidents — Maine: 1991 - 1997**

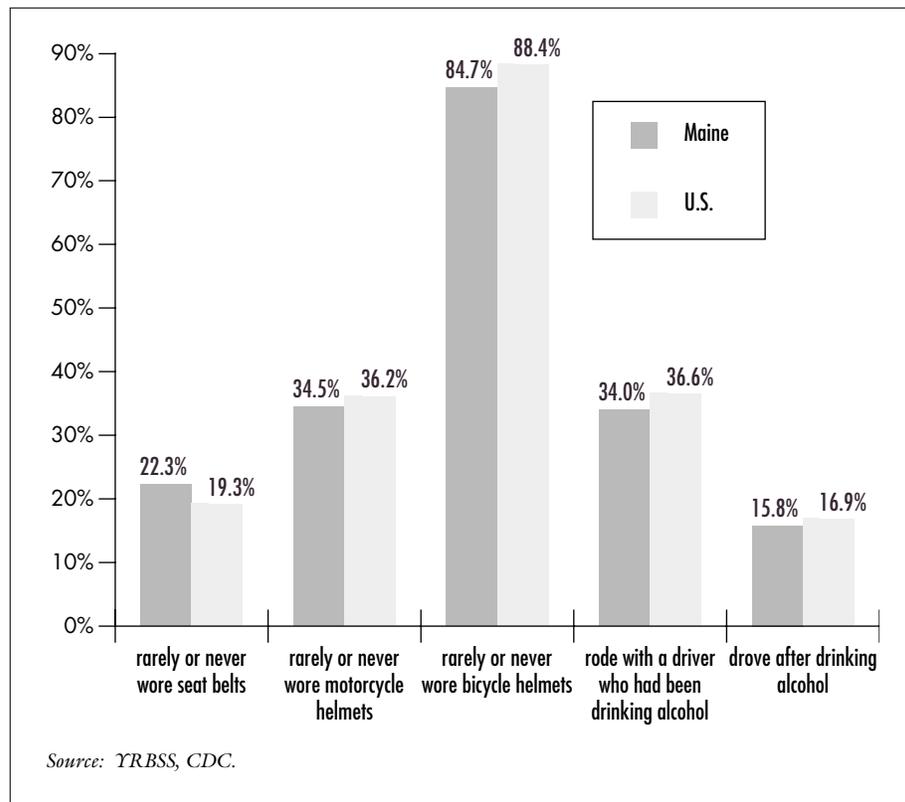
- In Maine between 1991 and 1997, the seat belt use rate increased from 36% to 61%. Simultaneously, the number of hospitalizations from motor vehicle crashes decreased from 807 to 562.



**■ Percentage of High School Students Engaging in Behaviors that Contribute to Unintentional Injuries — Maine and the U.S.: 1997**

In Maine:

- more than one in five high school students had rarely or never worn seat belts when riding in a car or truck driven by someone else;
- more than one in three high school students, who had ridden a motorcycle in the 12 months preceding the survey, rarely or never wore a motorcycle helmet;
- more than four out of five, who had ridden a bicycle in the 12 months preceding the survey, rarely or never wore a bicycle helmet;
- more than one in three high school students, during the 30 days preceding the survey, had ridden one or more times with a driver who had been drinking alcohol;
- and, almost one in six high school students, during the 30 days preceding the survey, had driven a vehicle one or more times after drinking alcohol.



## Other Accidental Injury

### ■ Accidental Injury and Poisoning Mortality —

Cumberland County and Maine: 1979 - 1996 combined

(Rates are per 100,000 and adjusted to the 1940 population)

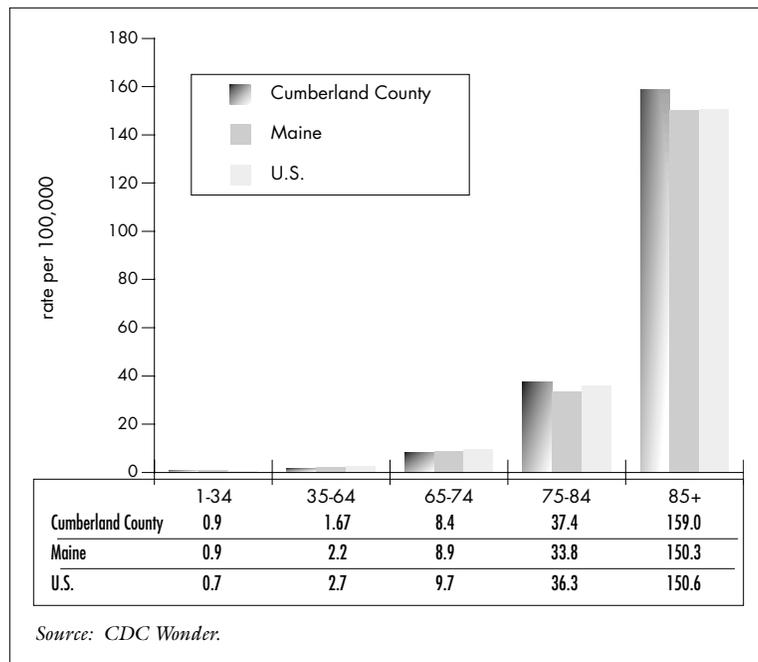
- In Cumberland County, Maine and the U.S., the leading causes of unintentional injury mortality, not including motor vehicle-related are: falls, poisoning, fire, and drowning.
- In the U.S., for every injury death there are about 19 hospitalizations, 233 emergency department visits and 450 office-based physician visits for injuries.

	Cumberland County		Maine	
	number	rate	number	rate
falls	237	2.5	1,174	2.6
poisoning	62	1.4	261	1.0
fire	61	1.4	476	2.0
drowning	44	1.1	316	1.4

Source: CDC Wonder.

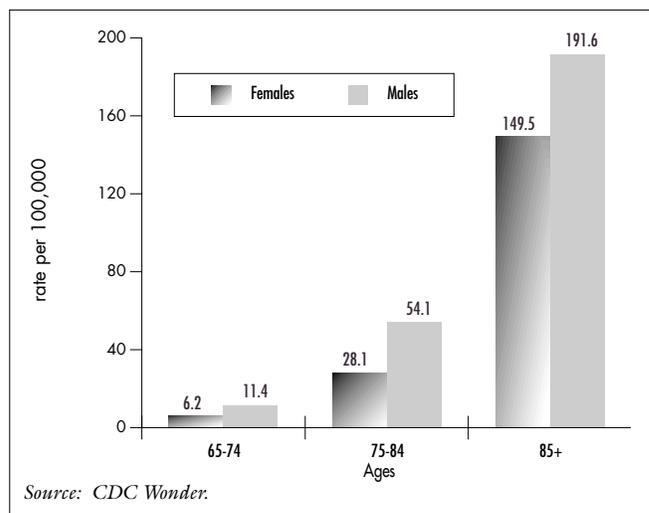
### ■ Fall-Related Mortality by Age — Cumberland County, Maine and U.S.: 1979 - 1996 combined

- After 64 years old, fall-related mortality rates increase with age.<sup>vi</sup>



### ■ Fall-Related Mortality by Age and Sex — Cumberland County: 1979 - 1996 combined

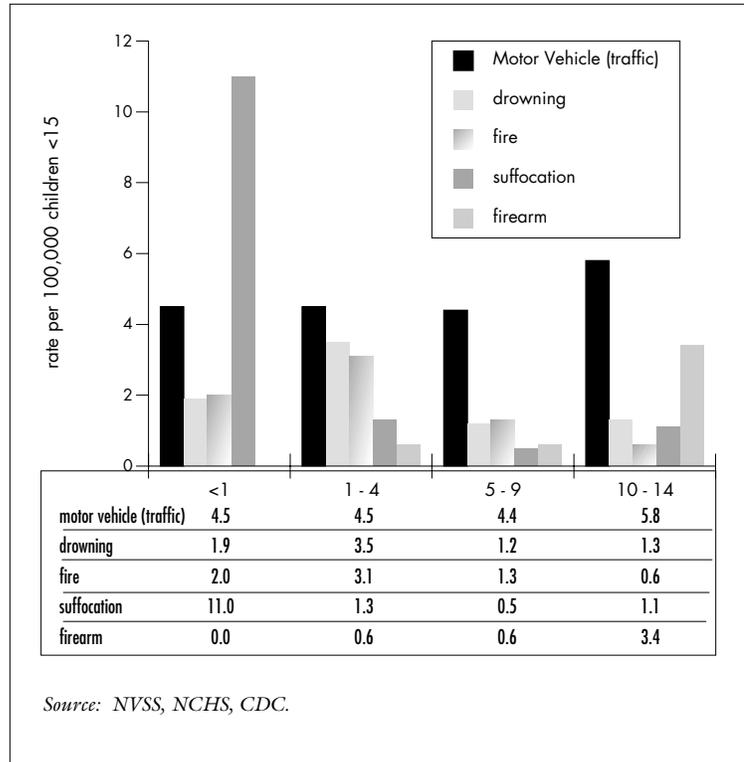
- Fall-related mortality rates are higher for males than females, and increase with age.



## ■ Leading Causes of Injury, Children Less than 15 Years Old — U.S.: 1995

- Suffocation was the leading cause of death, followed by motor vehicle (traffic) deaths, among infants in the U.S. The suffocation rate among infants was ten times the rates experienced by children 1 - 4 and 10 - 14 years. Seventy percent of the suffocations among infants were due to mechanical means, such as: a plastic bag, bedding, or lack of air in an enclosed space.

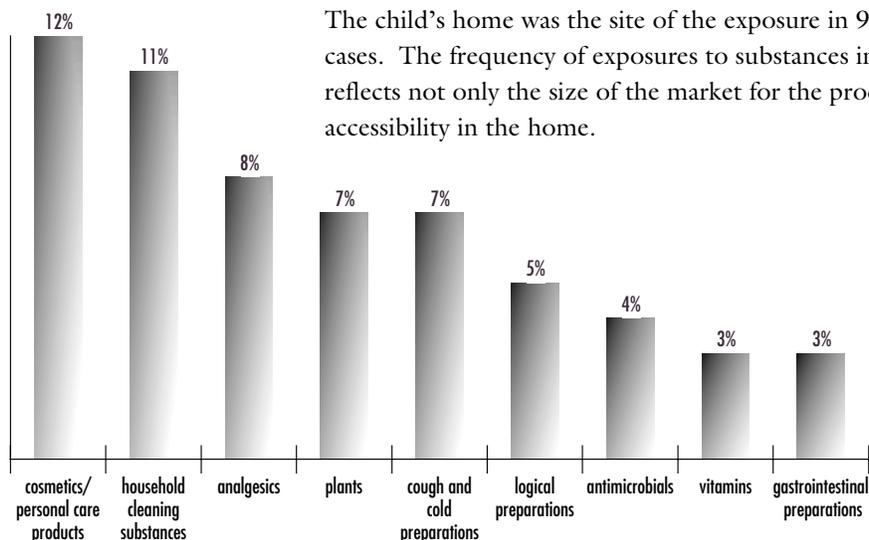
- The leading cause of all deaths (not just injury) among children ages 1 - 14 was motor vehicle (traffic) injuries.
- Firearms were the second leading cause of death among children aged 10 - 14 years. The rate at ages 10 - 14 years was nearly six times the rate for children ages 1 - 9 years. Forty-eight percent of the firearm deaths among children 10 - 14 years of age were homicides and 29% were suicides.



## ■ Leading Exposures Managed by Poison Control Centers, Children Less than Six Years Old — U.S.: 1995

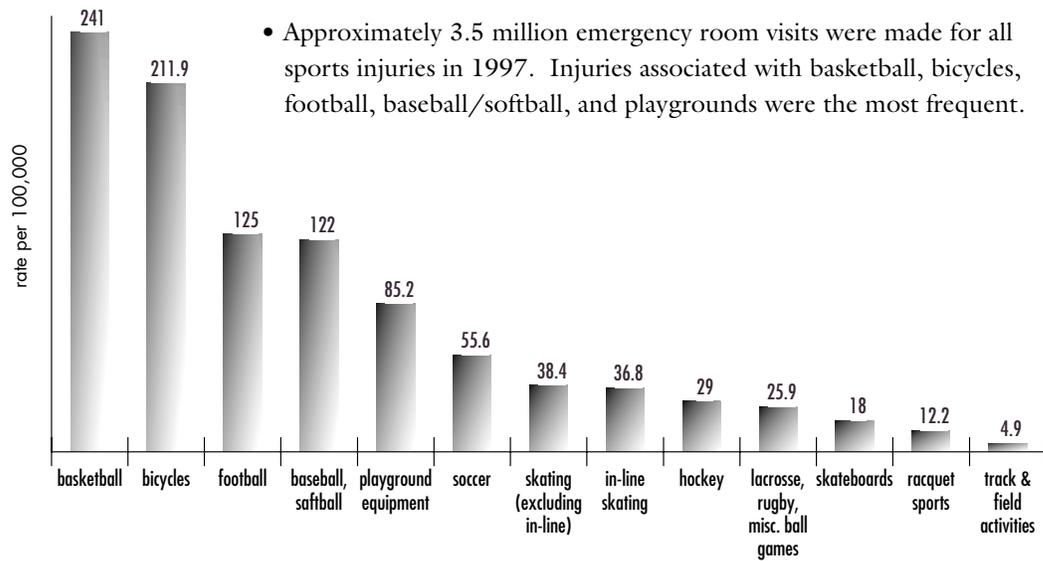
- Poison control centers managed over 1 million exposures among children under six years of age, accounting for 53% of all human poisoning exposures.

The child's home was the site of the exposure in 94% of reported cases. The frequency of exposures to substances in this age group reflects not only the size of the market for the product, but its accessibility in the home.



Source: TESS, AAPCC.

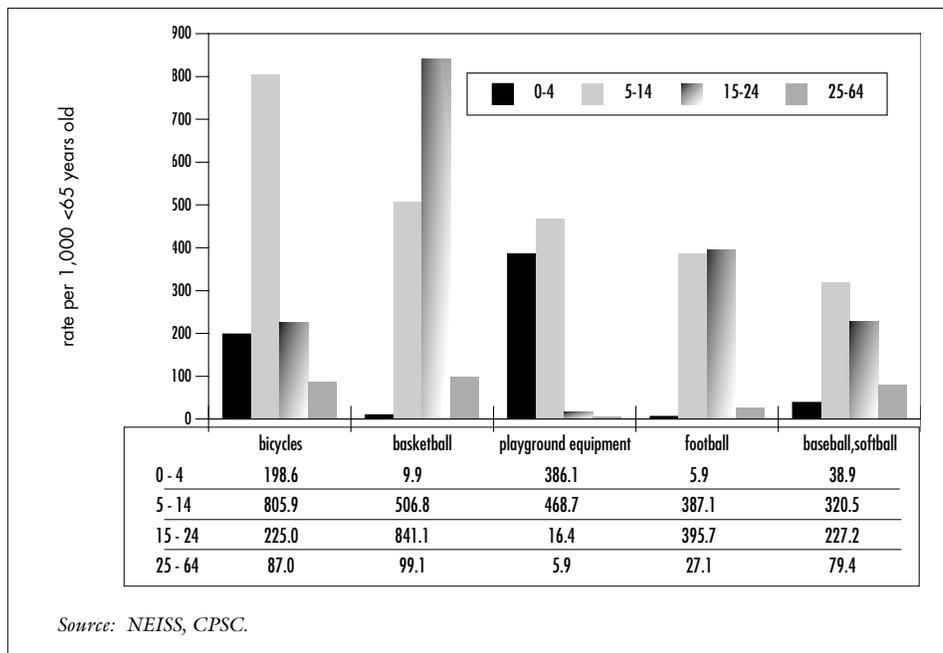
■ **Estimated Rate of Emergency Room Visits for Sports Injuries, by Sport — U.S.: 1997**



Source: NEISS, CPSC.

■ **Estimated Rate of Emergency Room Visits for Sports Injuries, by Age, Persons Less than 65 — U.S.: 1997**

- The highest injury rates for children under 5 years of age are associated with playground equipment. Injury rates for children 5 - 14 years of age are the highest in every sports category (virtually tied for first place in football) except for basketball; however, basketball is the second leading sports-related injury category for this age group. Basketball constitutes the leading category of sports injury for people ages 15 - 64.



Source: NEISS, CPSC.

■ **Exerpts from Playground Injuries Fact Sheet** — U.S.: 1990 - 1997

- One child is injured on a playground every 2.5 minutes.
- About 35% of all injuries are severe (e.g., fractures, internal injuries, concussions, dislocations, amputations, crushes).
- Public playgrounds account for about 70% of injuries related to playground equipment.
- In schools, most injuries to students five through fourteen years old occur on playgrounds.
- Most injuries occur when children fall off monkey bars, swings, climbers, or slides.
- Each year, nine to seventeen children die because of playground-related injuries (47% die of strangulation; and 31% of injuries sustained in falls).
- In 1995, the costs associated with playground-related injury were \$1.2 billion for children younger than 15 years old.

*Source: NCIPC, CDC.*

## Endnotes

- <sup>i</sup> Portland HSA is an average of 1992-1995. Rates are adjusted to the 1940 standard population.
- <sup>ii</sup> Female licensed drivers = 437,928; Male licensed drivers = 435,785.
- <sup>iii</sup> Percentages are based on observational studies that adjust for over-reporting. Female drivers = 2,316 and female passengers = 2,536. Male drivers = 3,152 and male passengers = 2,724.
- <sup>iv</sup> Portland HSA rates are 1996-1997 averages.
- <sup>v</sup> Results from the 1994 Market Decisions survey were reported in the *Community Health Profile of the Greater Portland Region, 1994*. The 1994 analysis differs from the 1996-1997 analysis in that Freeport was not included as an Inner Town, nor as a member of the area (HSA), in 1994.
- <sup>vi</sup> In the U.S. overall, the trend in hospitalizations for hip fractures among people aged 65 and older has moved away from the national target. Hip fractures are the cause of severe disability in the elderly, half of whom never return to independent living after suffering such an injury.

Condition / Indicator	ICD-9 Code	Notes
Unintentional injury	E800 - E949.9	
Unintentional injury, not motor vehicle	E800 - E807 and E826 - E949.9	
Motor vehicle related injury	E810 - E825.9	
Fall-related injury	E880 - E888.9	
Poisoning	E850 - E869.9	
Drowning	E910 - E910.9	
Fire	E890 - E899.9	
Suffocation	E911 - E913.9	
Intentional injury	E950 - E978	
Homicide	E960 - E978	
Suicide	E950 - E959	
Firearm-related injury	E922 - E922.3; E922.8 - E922.9; E955 - 955.4; E965 - E965.4; E970; E985 - E985.4	
Sports injuries	E813.6, E819.6, E820.0, E821.0, E826.1, E828.2, E830.0, E830.4, E831.1, E831.3, E831.4, E831.9, E832.1, E832.3, E832.9, E835.4, E838.4, E838.5, E842.0, E848.0, E883.0, E884.0, E886.0, E902.2, E910.0, E910.1, E910.2, E910.8, E917.0	Estimates are conservative because they only use ICD - 9 codes that are specific to sports or recreational activities. None of the codes that are partially sports-related were included in the analysis.

# Violence

## Healthy People 2010 Violence Goal

*Reduce disabilities, injuries, and deaths due to violence.*

National Health  
Disparities  
VIOLENCE

**Race**  
homicide  
firearm-related death

**Gender**  
homicide  
firearm-related death

**Age**  
homicide  
firearm-related death

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“If humanity is to evolve beyond the propensity towards violence, then it can only do so by recognizing the extent to which the patriarchal code of honor and shame generates and obligates male violence.”

— Dr. James Gilligan



# Greater Portland Community Health Assessment and Source Book

## VIOLENCE

### GREATER PORTLAND AREA, MAINE and U.S. RATES with YEAR 2000 OBJECTIVES

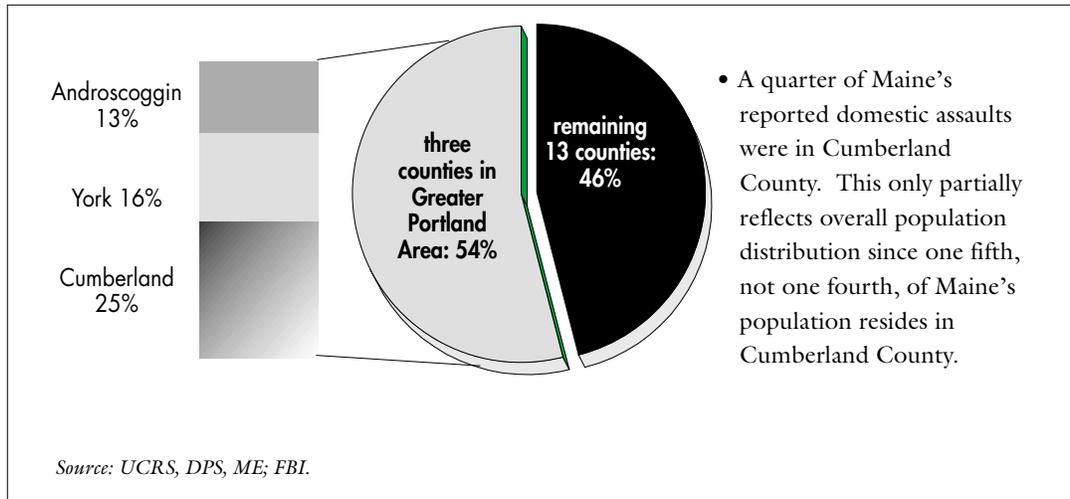
Rates are per 100,000 population, unless otherwise noted. Mortality rates are adjusted to the 1940 population.

Indicators	Greater Portland Area	Maine Rate	U. S. Rate	HM 2000 Goal	HP 2000 Goal
<b>Domestic Violence</b>					
Domestic violence arrest rate <sup>1</sup>	City of Portland 939.0	317.0	■	decrease 15.0%	■
Substantiated child abuse and neglect incidence rate <sup>2</sup> (per 1,000 children ages 0-17)	■	19.5	15.0	■	■
Intimate Partner Violence (IPV) incidence rate	■	■	■	■	■
Elder Abuse Incidence Estimated Rate <sup>3</sup> (per 100,000 age 60 +)	■	■	1,023.0	■	■
<b>Youth Violence</b>					
Violent crimes arrest rate, juvenile <sup>1</sup> (murder, rape, robbery, assault; per 1,000 children ages 10-17)	City of Portland 362.0	133.0	412.0		
Physical fighting among high school students <sup>4</sup>	■	32.5%	36.6%	■	■
Weapon-carrying by high school students <sup>4</sup>	■	22.0%	18.3%	■	■
<b>Violent Crime</b>					
Violent crimes arrest rate, adults <sup>1</sup> (rape, murder, robbery, assault)	City of Portland 704.0	119.0	611.0	■	■
Forcible rape arrest rate, adults <sup>1</sup>	106.0	20.5	35.9	■	■
Rape victimization estimated rate <sup>6</sup> (persons ages 12 and older)	■	■	90.0	■	55.0
Homicide arrest rate, adults <sup>1</sup>	6.5	1.6	7.4		
Homicide mortality rate <sup>5</sup>	Cumberland County 2.3	1.8	9.3	■	7.2
<b>Firearms</b>					
Firearm-related mortality <sup>7</sup>	Portland HSA 5.9	8.4	12.8	■	11.6
Males	10.6	15.2	22.3	■	■
Females	1.6	2.3	3.3	■	■
■ = data not available					
<i>For Source Notes, see next page</i>					

source number	Greater Portland Area	Maine	U.S.	notes
1	1997 UCRS, DPS, ME	1997 UCRS, DPS, ME	1997 UCRS, FBI	Because state and local data are currently unavailable from the NCVS, we include data from UCRS for comparative purposes.
2		1997 CPS, DHS, ME	1997 NCANDS, ACF, DHHS	
3			1996 NEAIS	
4		1997 YRBS, CDC	1997 YRBS, CDC	
5	1992 - 1995 CDC Wonder	1995 CDC Wonder	1995 CDC Wonder	Comparing the county-wide homicide mortality rate and the city of Portland's homicide arrest rate suggests the extent to which Portland's surrounding areas mask its urban problems when looked at in the aggregate.
6			1997 NCVS, BJS	<p>The National Crime Victimization Survey captures self-reported victimization while the Uniform Crime Report is a count of offenses handled by the police.</p> <p>Data on rape and attempted rape of females ages 12 and older became incomparable to the HP2000 goal and baseline because of the 1992 redesign of the NCVS. Therefore, we have substituted the HP2010 goal and 1997 data for the HP2000 goal and national baseline, respectively. These rates are per persons ages 12 and older and have been converted from rates per 1,000 to rates per 100,000 in order to allow comparison with UCRS.</p> <p>Calculating the difference between self-reported offenses and police arrests for rape suggests that as many as seven rapes go unreported for each one that involves the police.</p>
7	1993-1997 Vital Statistics, OHDP, ME	1996 CDC Wonder	1996 CDC Wonder	Portland HSA rate was age adjusted to the 1940 standard population by PPH, HHS, City of Portland.

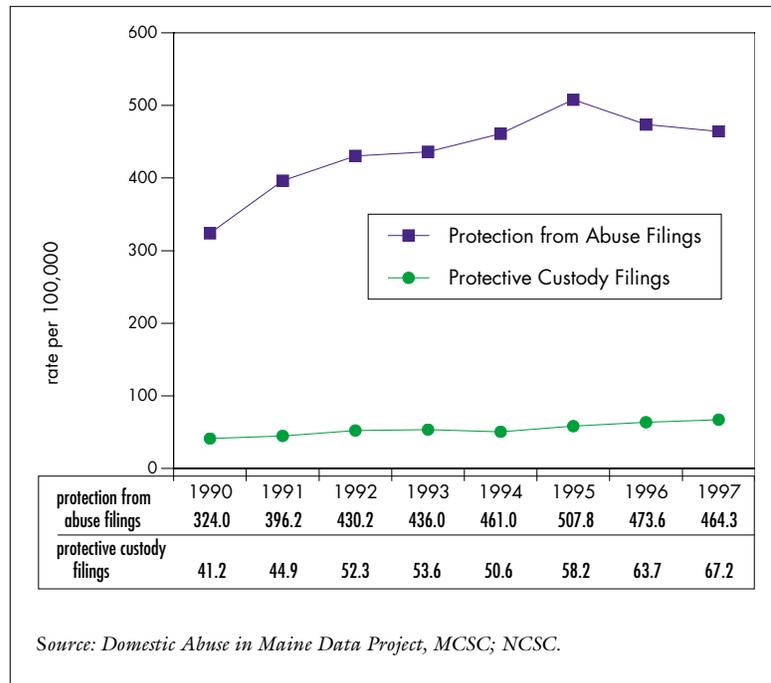
## Domestic Violence — Overview

### ■ Percentage of Reported Domestic Assaults, by County — Maine: 1994-1995 combined



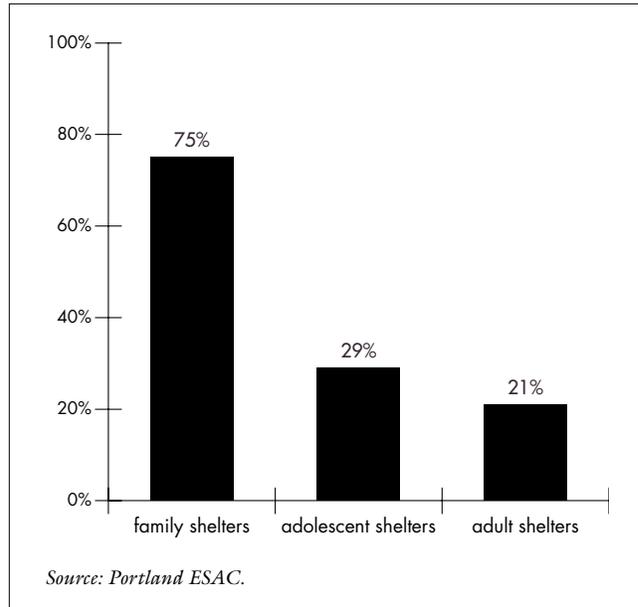
### ■ Domestic Violence Filings — Maine: 1990 - 1997

- Domestic Violence filings are the fastest growing civil court cases in Maine. The rate of protection from abuse orders increased 43%, between 1990 and 1997, largely as a result of law enforcement and policy improvements.



## ■ Percent of Emergency Shelter Users Who Are Victims of Domestic Violence, by Shelter Type — City of Portland: 1997

- Three quarters of the family emergency shelter population and one third of the adolescent shelter population are victims of domestic violence. About one in five individuals found in adult shelters are there because of domestic violence.



### **Animal Cruelty and Interpersonal Violence Linked**

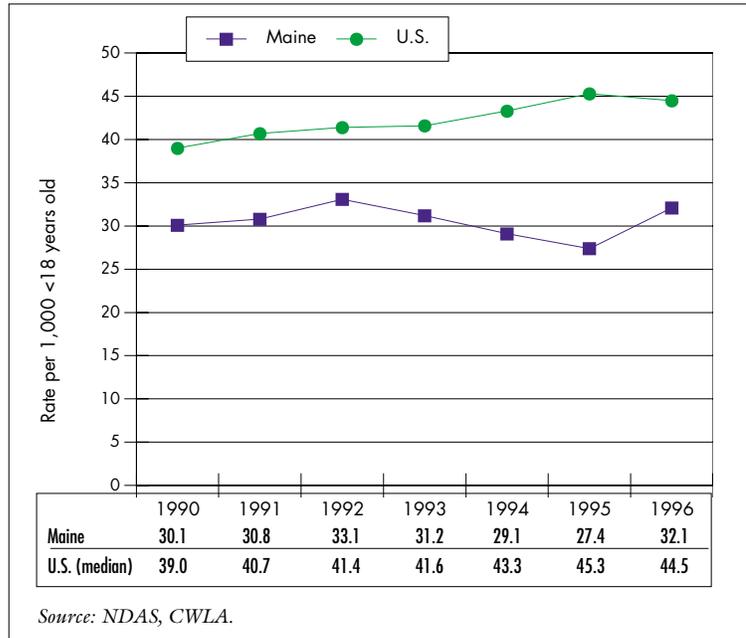
Recent research in violence prevention has made an explicit link between animal cruelty and interpersonal violence. Animal cruelty is often a precursor to other acts of violence including child, spouse or partner and elder abuse. Violence prevention experts have identified acts of animal maltreatment as an important early detector of potential violence against people, as well as an atrocity of its own accord.

*Cruelty to Animals and Interpersonal Violence: Readings in Research and Application*, editors Randall Lockwood and Frank R. Ascione, Purdue University Press, 1998.

## Domestic Violence — Child Maltreatment

### ■ Rate of Child Protective Services (CPS) Reports Alleging Maltreatment Referred for Investigation<sup>i</sup> — Maine and U.S.: 1990 - 1996

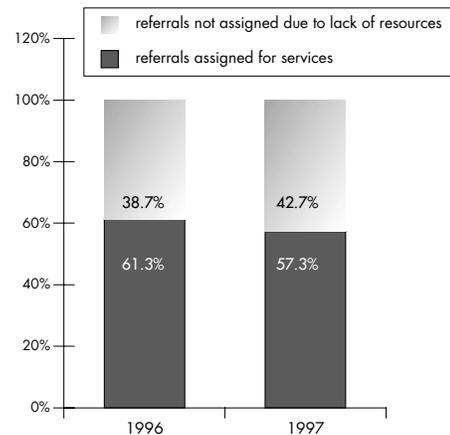
- Maine did not improve its rate of referring CPS reports for investigation, during 1990-1996; while the U.S. has shown some minor improvement.



### ■ Percent of Appropriate CPS Referrals Assigned for Services — Maine: 1996 and 1997

- Percentage of appropriate CPS referrals not assigned for services due to lack of resources, increased between 1996 and 1997.

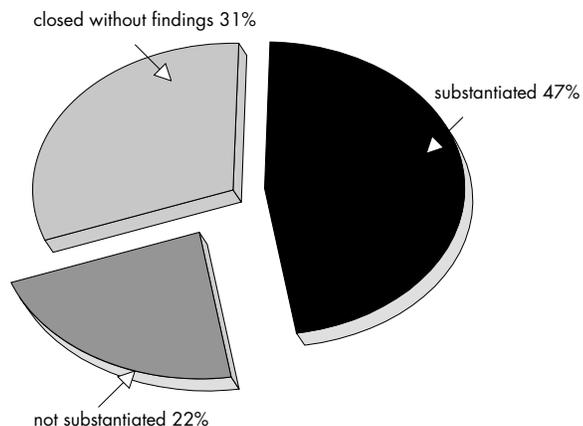
Source: NDAS, CWLA.



### ■ Children Investigated by Child Protective Services (CPS), by Disposition — Maine: 1996

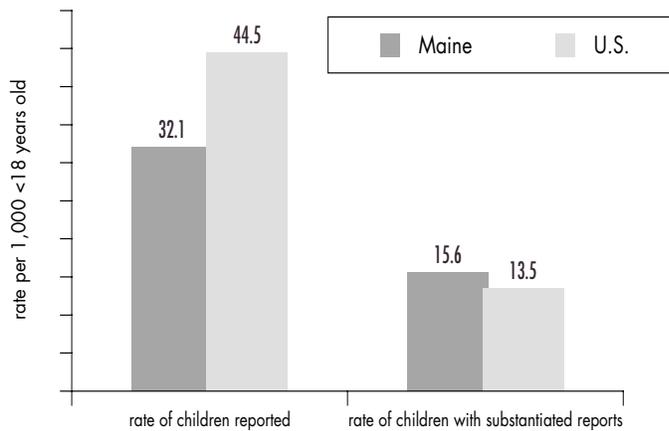
- The majority of children who were investigated for maltreatment in 1996 were substantiated abuse victims.

Source: NDAS, CWLA.



■ **Rate of Children Reported to CPS and Rate of Substantiation —**  
**Maine and U.S.: 1996**

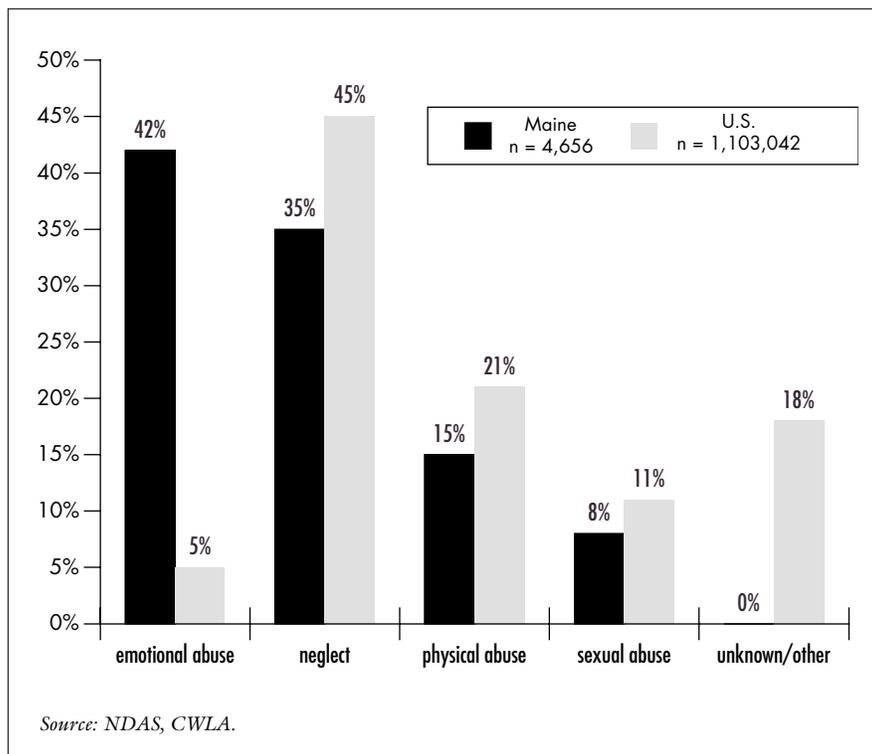
- Maine’s rate of children reported for maltreatment is lower than the overall U.S. rate. Maine’s rate of children with substantiated reports is about the same as the U.S. rate.



Source: NDAS, CWLA.

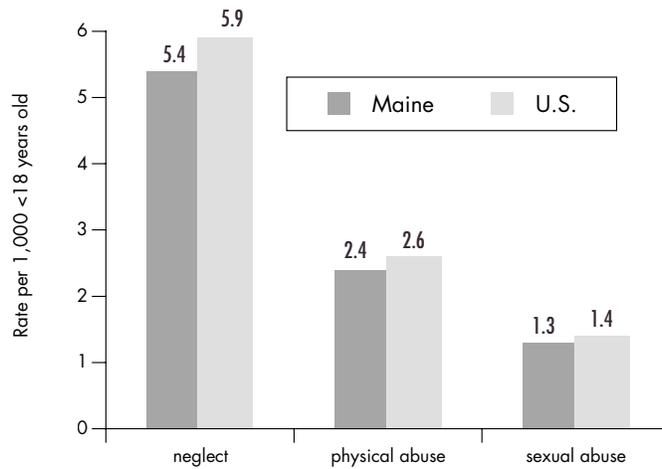
■ **Percent of Children with Substantiated Abuse Reports, by Maltreatment Type —**  
**Maine and U.S.: 1996**

- Maine identifies more than 40% of its substantiated child maltreatment as emotional/psychological abuse, while the U.S. overall identifies 5% of maltreated children to be emotionally abused. This discrepancy aside, Maine follows the overall U.S. pattern with the largest percentage of maltreated children identified as neglected. In Maine and the U.S. overall, a considerable number of children are both physically and sexually abused.



Source: NDAS, CWLA.

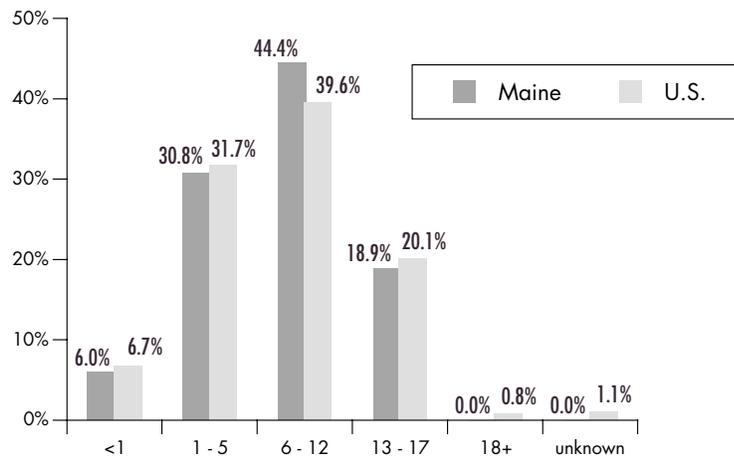
■ **Rate of Children with Substantiated Reports of Physical Abuse, Sexual Abuse and Neglect — Maine and the U.S: 1996**



- Maine looks very similar to the U.S. overall with respect to rates of children being neglected, physically and sexually abused.

Source: NDAS, CWLA.

■ **Estimated Percentages of Children Substantiated as Abused or Neglected, by Age Groups — Maine and the U.S.: 1996**



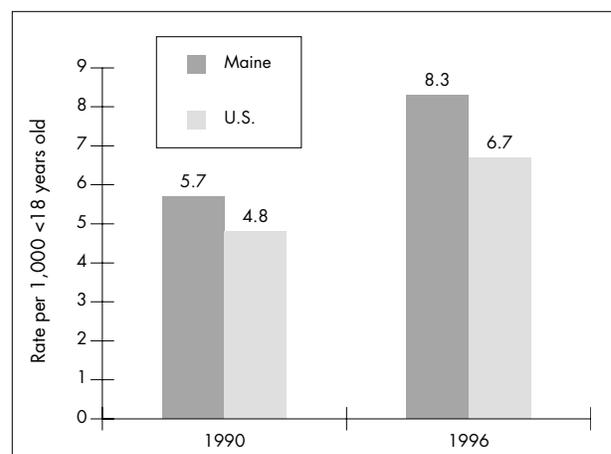
- Maine follows the overall U.S. age-group distribution of child maltreatment.
- Maine's percentage of children maltreated between the ages of six to twelve years old is notably higher than the U.S. percentage.

Source: NDAS, CWLA.

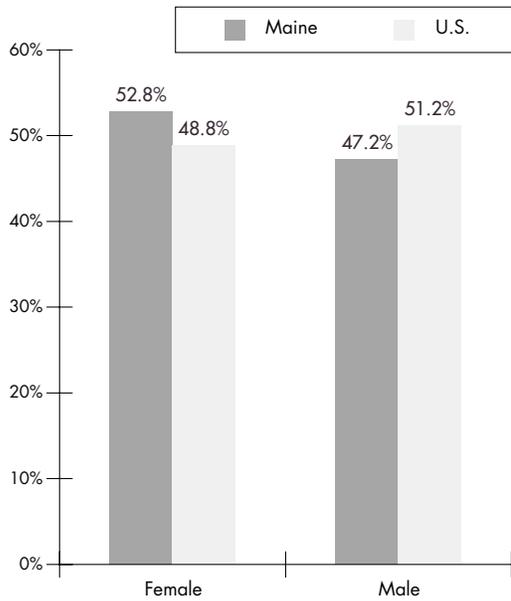
■ **Rate of Children in Out-of-Home Care — Maine and the U.S.: 1990 and 1996**

- Maine's rate of children in out-of-home care increased 46% between 1990 and 1996. The U.S. rate increased by 40% in the same years.

Source: NDAS, CWLA.



■ **Percent of Children in Out-of-Home Care, by Sex — Maine and the U.S.: 1996<sup>ii</sup>**

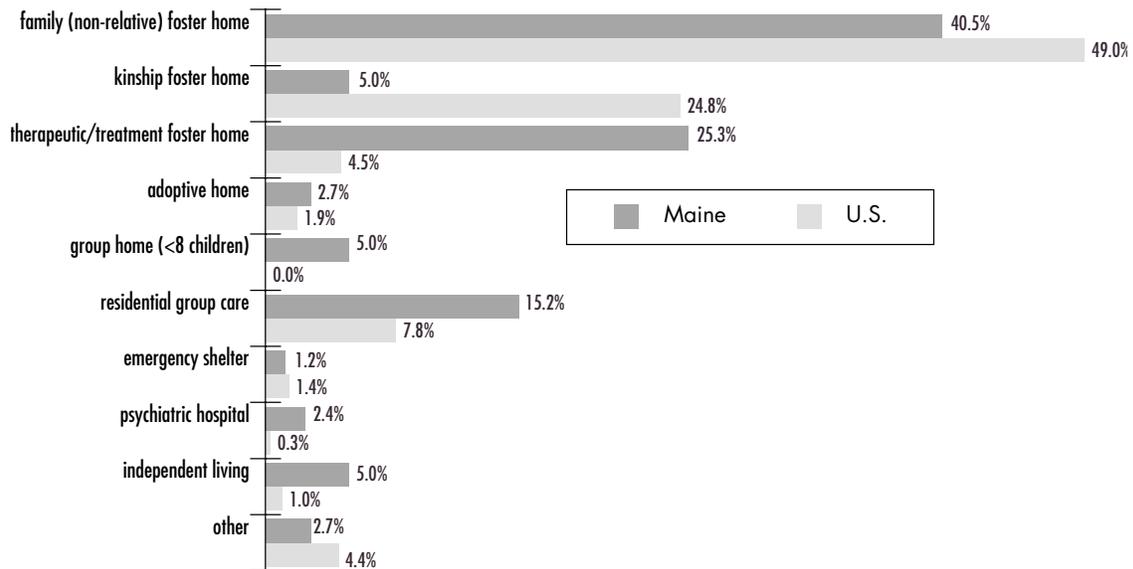


- The percent of male and female children in out-of-home care, in both Maine and the U.S., is evenly distributed.

Source: NDAS, CWLA.

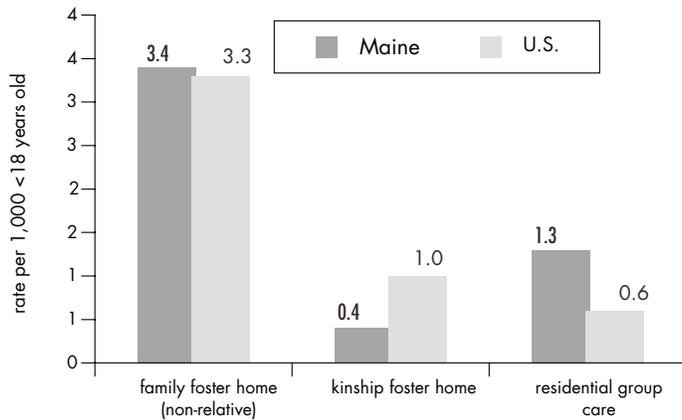
■ **Percent of Children in Out-of-Home Care, by Placement Type — Maine and the U.S.: 1996**

- Though Maine has a smaller proportion of children in out-of-home care residing in family and kinship foster homes, the percentage of Maine children in therapeutic foster home care is nearly six times the U.S. percentage. Maine is also higher than the U.S. for the percentage of children in residential group care, psychiatric hospitals, and independent living.



Source: NDAS, CWLA.

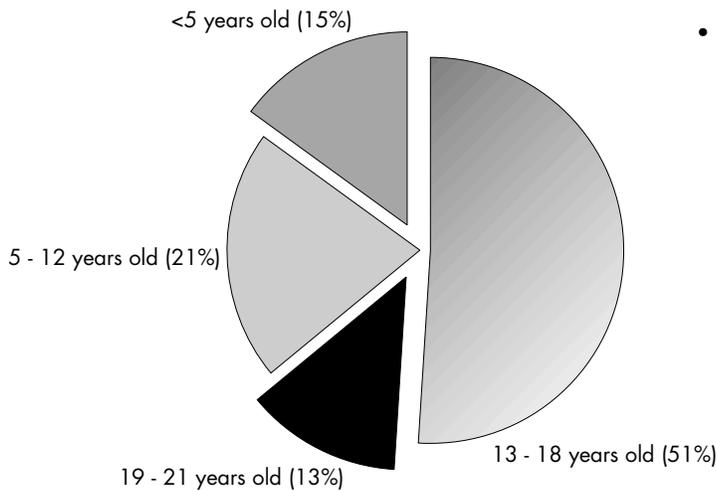
■ **Rate of Children in Family Foster Homes, Kinship Foster Homes and Residential Group Care — Maine and the U.S.: 1996**



- Maine’s rate of children in family foster homes mirrors the national rate. Maine has a lower rate of children in kinship foster homes and a higher rate of children in residential group care than in the U.S. overall.

Source: NDAS, CWLA.

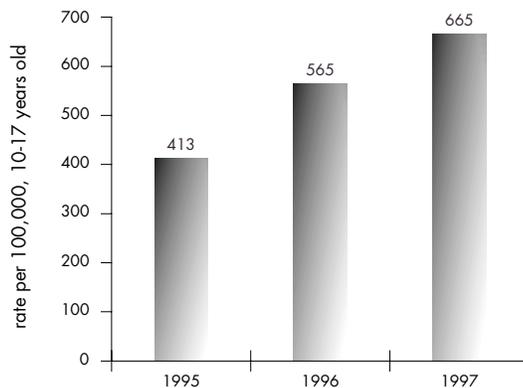
■ **Percent of Homeless Youth, by Age Groups — Maine: 1996-1997 combined**



- Most homeless youth are between the ages of 13 and 18 years old. Some youth living in residential or institutional placements become homeless upon discharge – they may be too old for foster care but are discharged with no housing or income support.

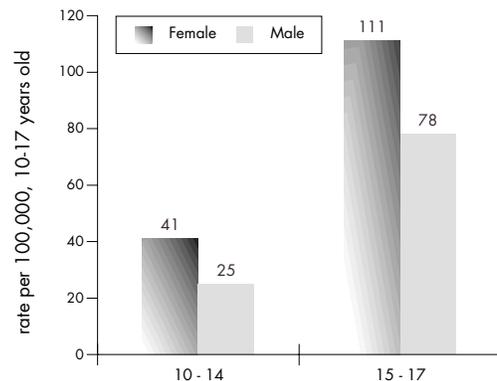
Source: Portland ESAC.

■ **Arrest Rate for Runaways, Ages 10-17 — Cumberland County: 1995-1997**



Source: UCRS, DPS, ME.

■ **Arrest Rate for Runaways, Ages 10-14 and 15-17 — Cumberland County: 1995-1997 (combined)**



- The rate of arrests for runaways has increased between 1996 and 1997. Most runaways are between the ages of 15 and 17 years old. Females run away at a higher rate than males.

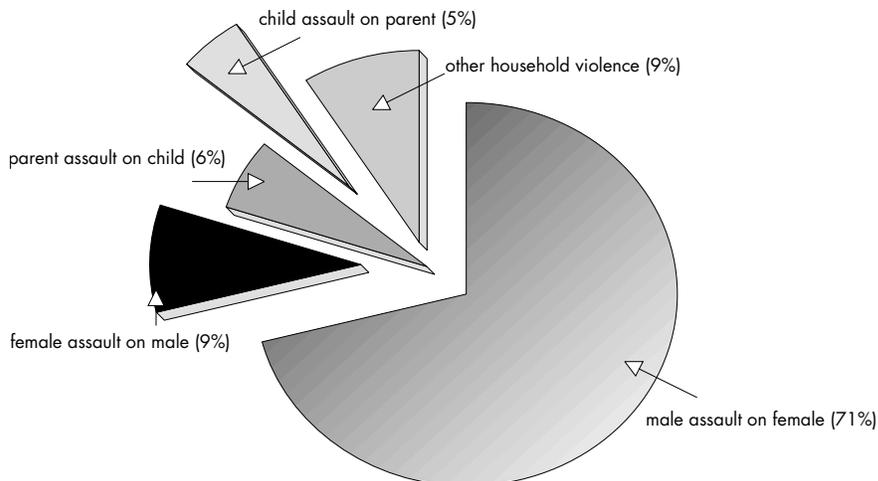
**National IPV Facts from the CDC**

- Nearly 1 million incidents of non-lethal IPV occurred each year from 1992 to 1996; 85% of victims were women.
- In 1996, 30% of all female murders were perpetrated by husbands, ex-husbands, or boyfriends. Three percent of all male murder victims were killed by wives, ex-wives, or girlfriends.
- Women account for 84% of those treated for IPV injuries.
- Psychological consequences for victims of IPV include: depression, suicidal thoughts and attempts, lowered self-esteem, alcohol and other drug abuse, and post-traumatic stress disorder.
- Each year more than 10 million American children witness IPV within their families. Witnessing violence is stressful and it is a risk factor for long-term physical and mental health problems such as alcohol and substance abuse, child abuse and IPV.
- A national study of the co-occurrence of IPV against mothers and children found that the most chronically violent husbands had a nearly 100% probability of also abusing their male children (the gender most often physically abused).
- Likewise, men who have a family history of observing or experiencing abuse are more likely to inflict abuse, violence and sexual aggression.
- Witnessing IPV as a child or adolescent, or experiencing violence from caregivers as a child are the risk factors which have been most consistently identified with perpetration of IPV.

Source: NCIPC, CDC.

■ **Domestic Violence Assaults, by Assailant-Victim Relationship — Maine: 1997**

- The vast majority, over 70%, of all domestic assaults in Maine are intimate partner violence perpetrated by males against females.



Source: UCRS, DPS, ME.

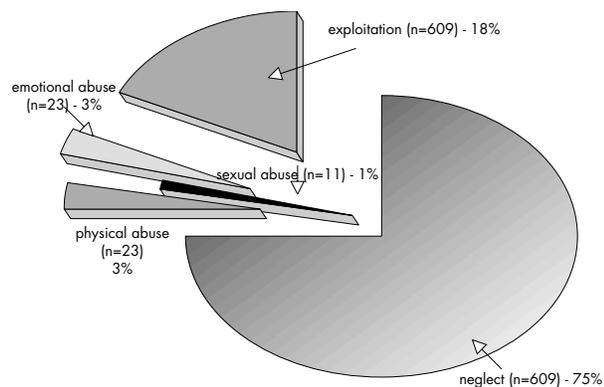
## Domestic Violence — Elder Abuse<sup>iv</sup>

“The results of the National Elder Abuse Incidence Study (NEAIS) confirm the validity of the “iceberg” theory of elder abuse that has been accepted in the aging research community for 20 years or more. ... one can conclude that over five times as many new incidents of abuse and neglect were unreported than those that were reported to and substantiated by Adult Protective Services (APS) agencies in 1996.”<sup>iv</sup>

Source: NEAIS, US AOA.

### ■ Substantiated Elder Abuse, by Maltreatment Type — Maine: 1993 - 1994 combined

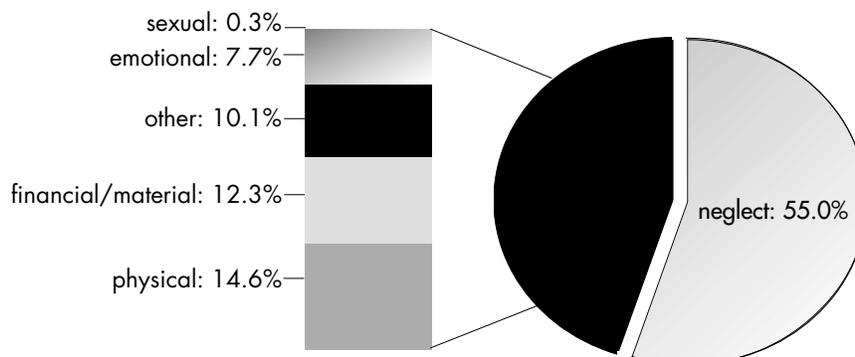
- Elder abuse in Maine (and nationwide) is poorly identified and documented. Of the 3,448 reports that were filed in Maine between 1993 and 1994, only 824 were investigated. Of the reports that were investigated, 47% were substantiated.



Source: Domestic Elder Abuse Survey, BEAS, DHS, ME.

### ■ Elder Abuse, by Maltreatment Type — U.S.: 1996

- Nationally, about half of elder abuse takes the form of neglect. The other half is spread over a variety of types including: physical, emotional, sexual and exploitation.

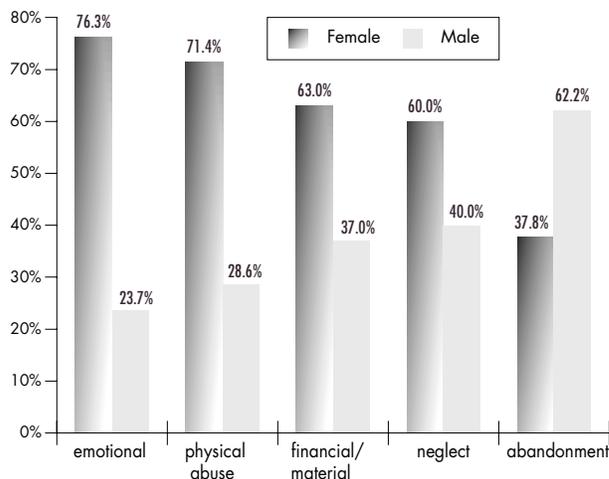


Source: NEAIS, US AOA.

### ■ Elder Abuse, by Victim's Sex and Maltreatment Type — U.S.: 1996

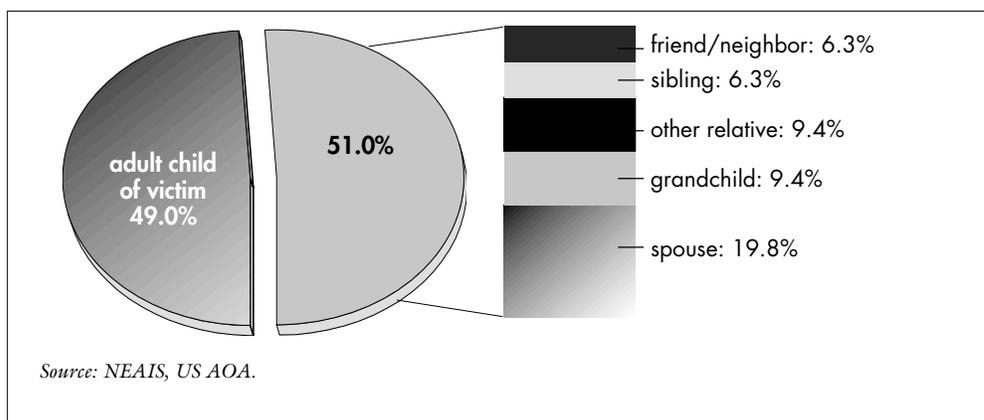
- Except in cases of abandonment, females are far more likely than males to be the victims of elder abuse.

Source: NEAIS, US AOA.



### ■ Elder Abuse, Relationship of Perpetrators to Victims — U.S.: 1996

- The vast majority of elder abuse is perpetrated by the adult children of victims. One in five cases are perpetrated by a spouse.

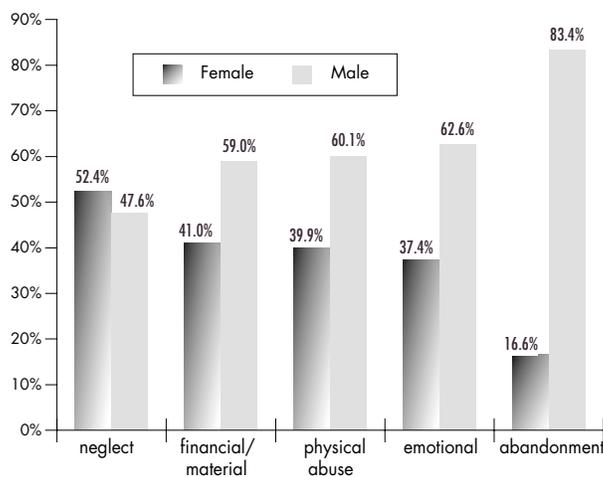


Source: NEAIS, US AOA.

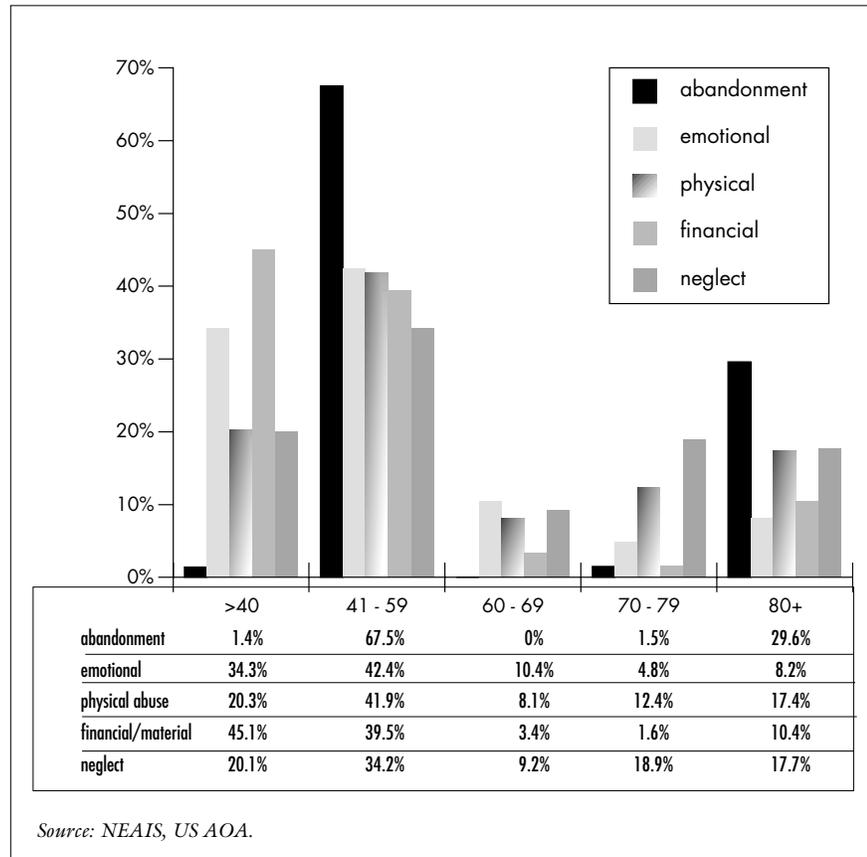
### ■ Perpetrators of Elder Abuse, by Sex and Type of Maltreatment — U.S.: 1996

- Neglect is the only type of maltreatment that was committed with approximately equal frequency by females and males. For all other types of maltreatment, males were more likely to be perpetrators.

Source: NEAIS, US AOA.



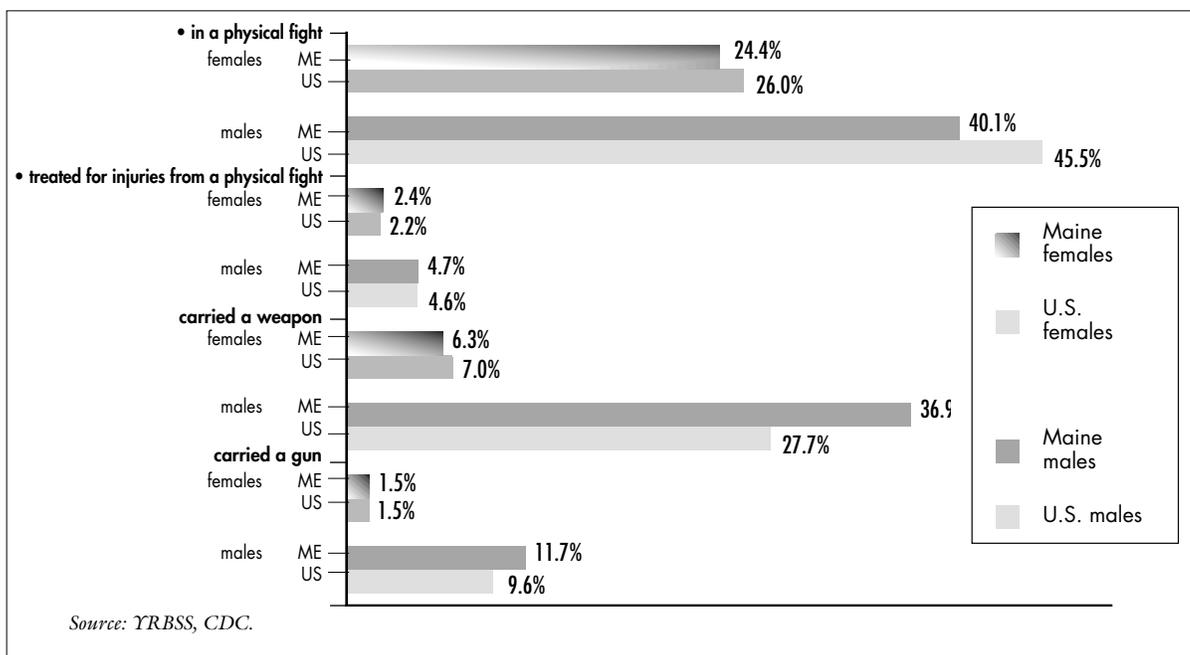
■ Perpetrators of Elder Abuse, by Age and Type of Maltreatment — U.S.: 1996



- The majority of elder abuse perpetrators are in the youngest age groups; however, there is a relatively large proportion of perpetrators in the oldest age group.
- Perpetrators of neglect are relatively evenly distributed across ages. Perpetrators of emotional abuse and financial exploitation are evenly distributed in the youngest ages. Physical abuse is primarily concentrated in the age group 41-59 and secondarily in the less than 40 group. Approximately two-thirds of the abandonment perpetrators were between the ages of 41 and 59, while the remainder were over 80 years of age.

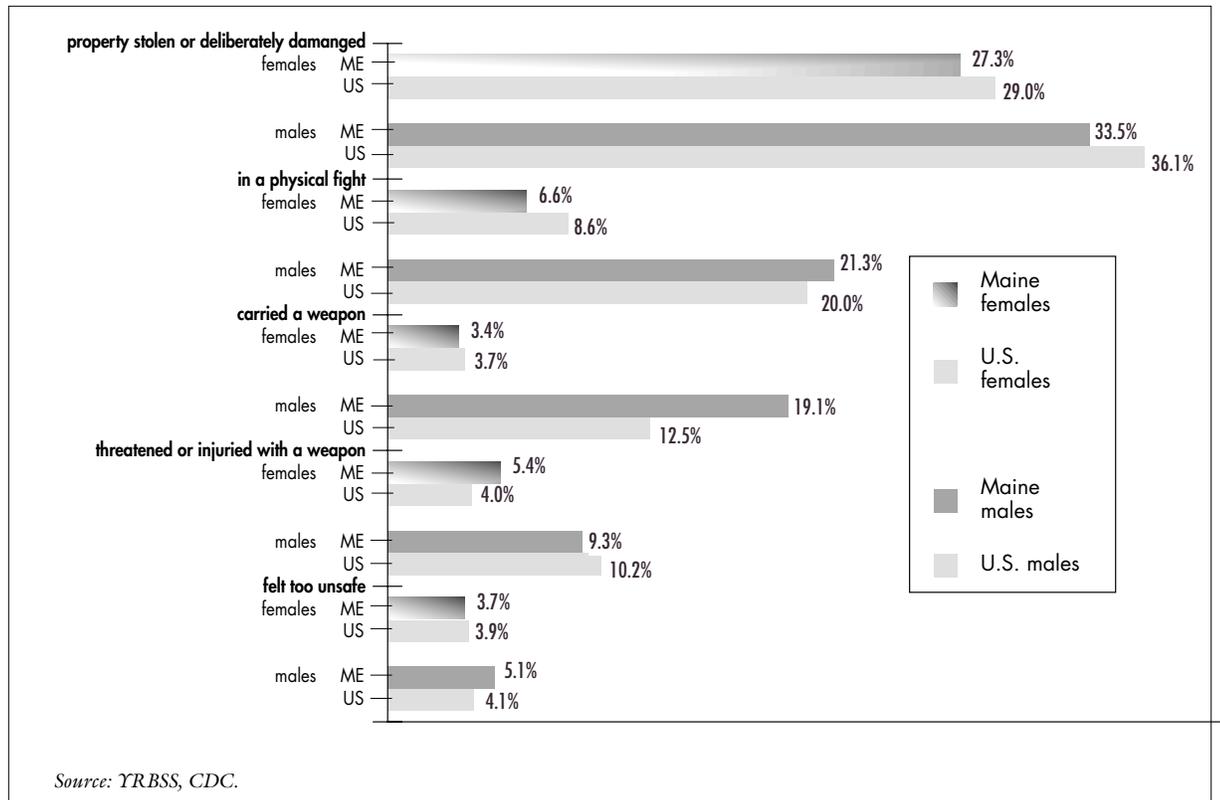
## Youth Violence

### ■ Percentage of High School Students Engaging in Violent Behaviors, Past 12 Months, by Sex — Maine and the U.S.: 1997



- A full 40% (2 out of 5) of Maine’s male high school students had been in a physical fight at least once in the past year. Nearly one in four females also reported being in at least one physical fight in the past year.
- Close to 5% of Maine’s male high school students and 2.4% of Maine’s female high school students were treated for injuries sustained in a physical fight in the past year.
- In Maine, the rate of male weapon-carrying was substantially higher than the national rate. Maine’s female weapon-carrying rate was similar to the national rate.
- Gun-carrying by Maine’s male high school students was also higher than the national rate. Maine’s female high school student gun-carrying rate was similar to the nation’s.

## ■ Violence on School Property — Maine and U.S.: 1997



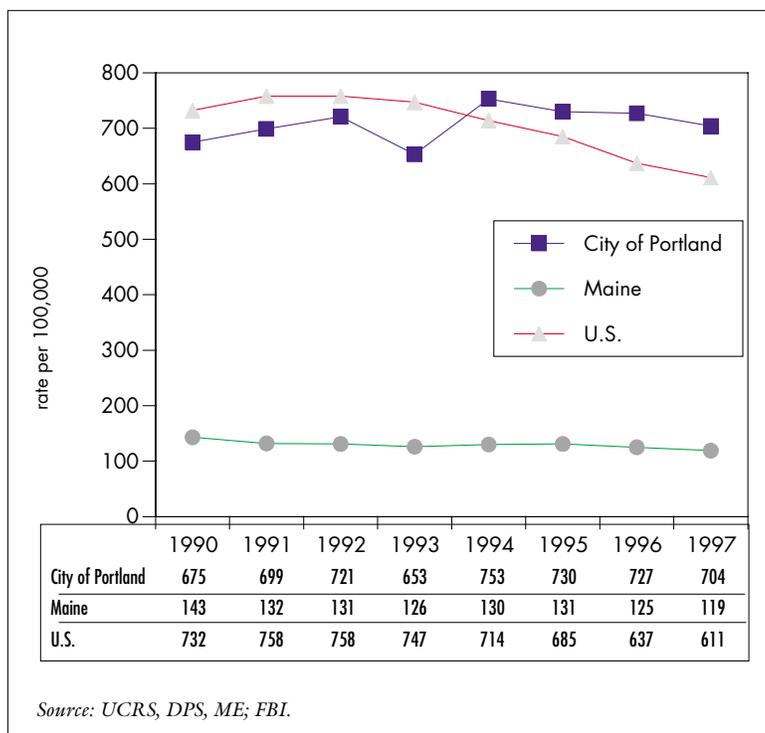
- More than one quarter of high school students in Maine had property stolen or deliberately damaged on school property at least once during the year preceding the survey. Males were more likely than females to have their property damaged.
- About one in five males had been in a physical fight on school property at least once during the year preceding the survey. Males were three times more likely to have been in a fight than females.
- Approximately one in five males carried a weapon on school property, on at least one of the 30 days preceding the survey. Maine's 19.9% prevalence of male weapon-carrying on school property is notably higher than the national rate of 12.5%. Maine's female weapon-carrying prevalence, 3.4%, looks similar to the national rate of 3.7%.
- The rate of Maine's males being threatened or injured with a weapon on school property at least once during the year preceding the survey (9.3%) was slightly lower than the national rate (10.2%). Maine's females had a victimization rate (5.4%) that was higher than the national rate (4.0%).
- In Maine and nationally, approximately 4% (male/female average) of students missed at least one day of school, during the 30 days preceding the survey, because they had felt unsafe at school or when traveling between school and home.

## Violent Crime

### ■ Violent Crime<sup>v</sup> Rate, Ages 18+ —

City of Portland, Maine and U.S.: 1990 - 1997

- Between 1994 and 1997, the City of Portland has had a higher rate of violent crime than the national average. Throughout the 1990s, the City of Portland has had a rate of violent crime six times higher than the rest of Maine.



### ■ Violent Crime Rate, Ages 18+, by Component Crimes —

Portland and Bangor Maine; Lawrence, Massachusetts and the U.S.: 1997

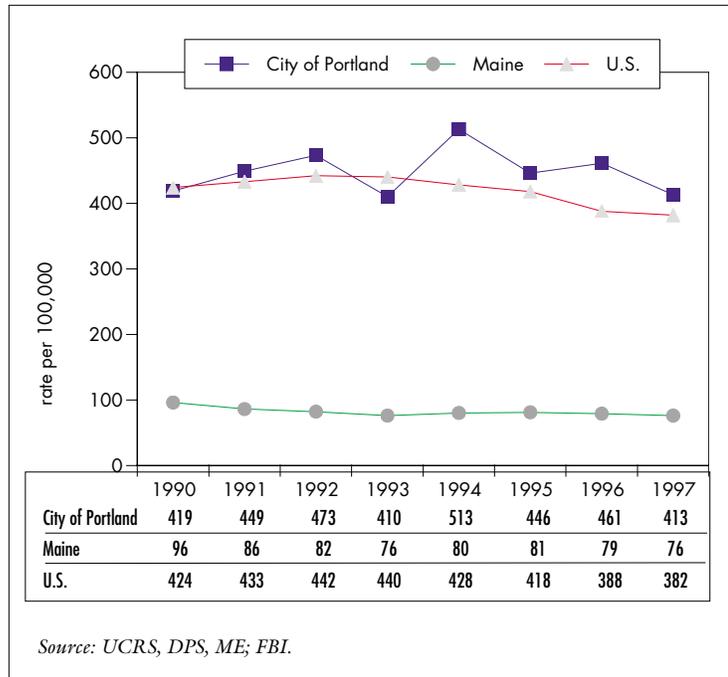
Crimes per 100,000 pop	Portland, ME	Bangor, ME	Lawrence, MA	U.S. Average
Population	63,919	32,054	62,989	
Total Violent Crimes	705.1	174.7	704.0	634.1
Homicide	6.5	6.2	4.7	7.4
Forcible Rape	106.5	43.7	32.9	36.1
Assault	412.0	74.9	1703.7	382.2
Robbery	179.1	49.9	397.4	244.1

Source: UCRS, DPS, ME; FBI.

- It is difficult to compare Portland to other cities because of its unique demographic status. Though Portland is Maine's largest city, it is relatively small in contrast to other urban centers across the country. Comparing Portland to Bangor (another metropolitan area in Maine but with about half the population) and Lawrence, MA (an urban area in New England with a similar population size), reveals that Portland has a higher arrest rate for rapes but a lower rate of arrest for robbery.

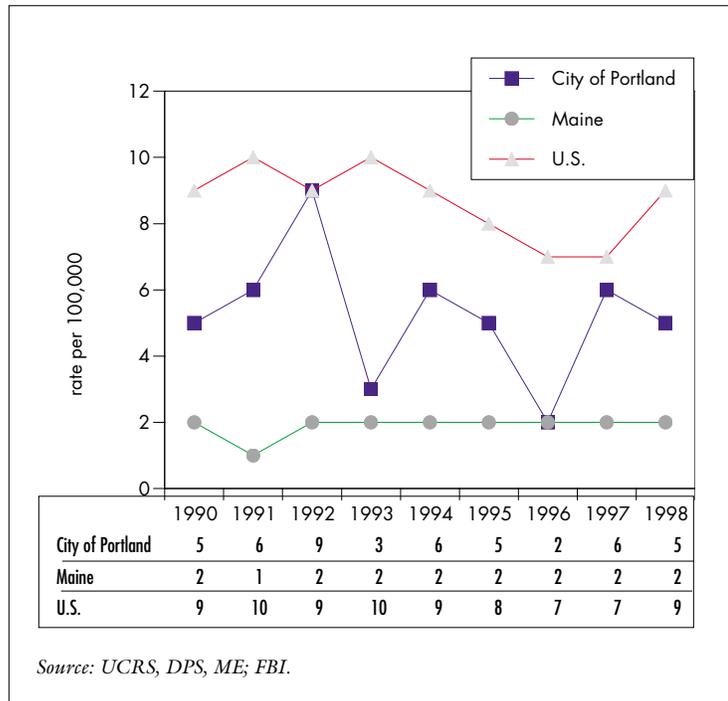
### ■ Assault Arrest Rate, Ages 18+, — Portland, Maine and the U.S.: 1990-1997

- Over the past five years, the rate of assault in the City of Portland has exceeded the national average, and remained more than five times the state rate.



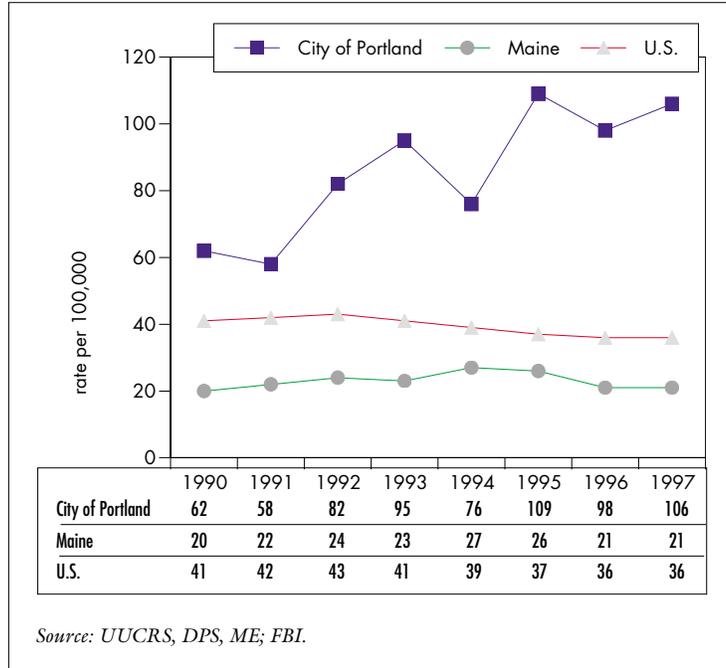
### ■ Homicide Arrest Rate, Ages 18+ — Portland, Maine and the U.S.: 1990-1997

- The homicide rate for the City of Portland remained below the national average but above the average for the state, during the 1990s.



■ **Rape Arrest Rate, Ages 18+ — Portland, Maine and the U.S.: 1990-1997**

- Portland's rape arrest rate was three times the national rate by 1997, and more than five times the state rate. The Portland Police Department and local providers of sexual assault services concur that the high rate is attributable to greater receptivity and response on the part of Police, as opposed to an exceptionally high incidence rate.

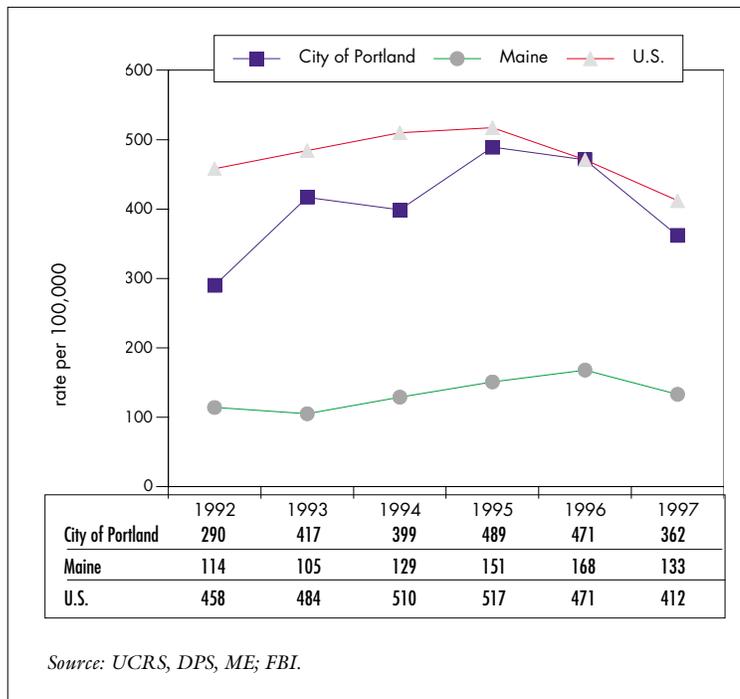


An alarming 36% of youth in shelters and street outreach programs reported having been forced to have sex in their lifetimes.

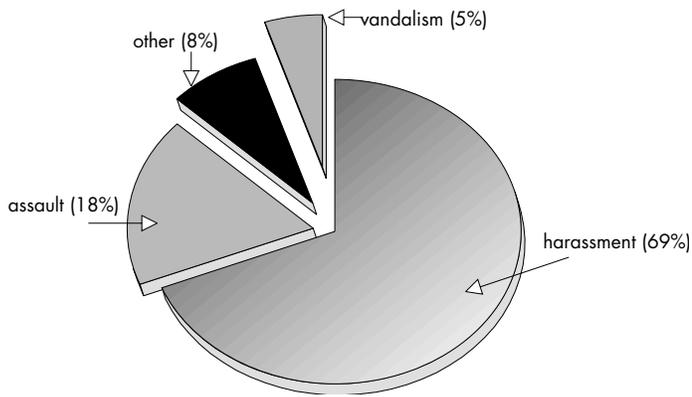
Source: DOE, ME, 1999.

■ **Violent Crime Rate, Ages 10 – 17 — City of Portland, Maine and the U.S.: 1990 - 1997**

- Portland is close to the national average, but four times higher than the state average, on the juvenile violent crime index.



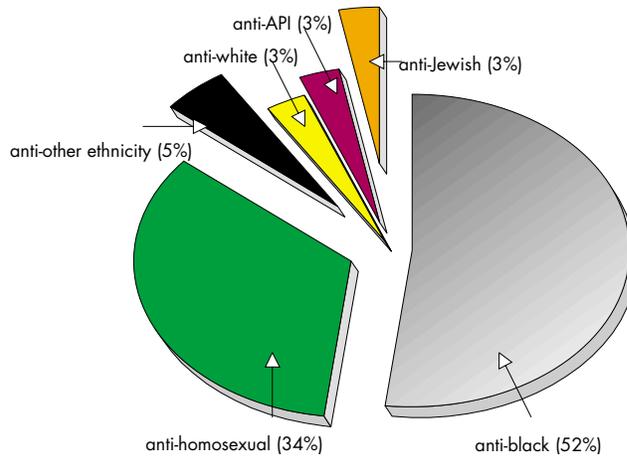
■ Hate Crimes<sup>vii</sup>, by Offense Type — Portland: 1995



- Almost 40% (38 out of 97) of hate crimes committed in the State of Maine occurred in Portland. The majority of Portland’s hate crimes were harassment; while close to 20% of these were violent assaults.

Source: UCRS, DPS, ME.

■ Hate Crimes, by Bias Motivation — Portland: 1995



- Hate Crimes in Portland were primarily committed against black and homosexual individuals.<sup>viii</sup>

Source: UCRS, DPS, ME.

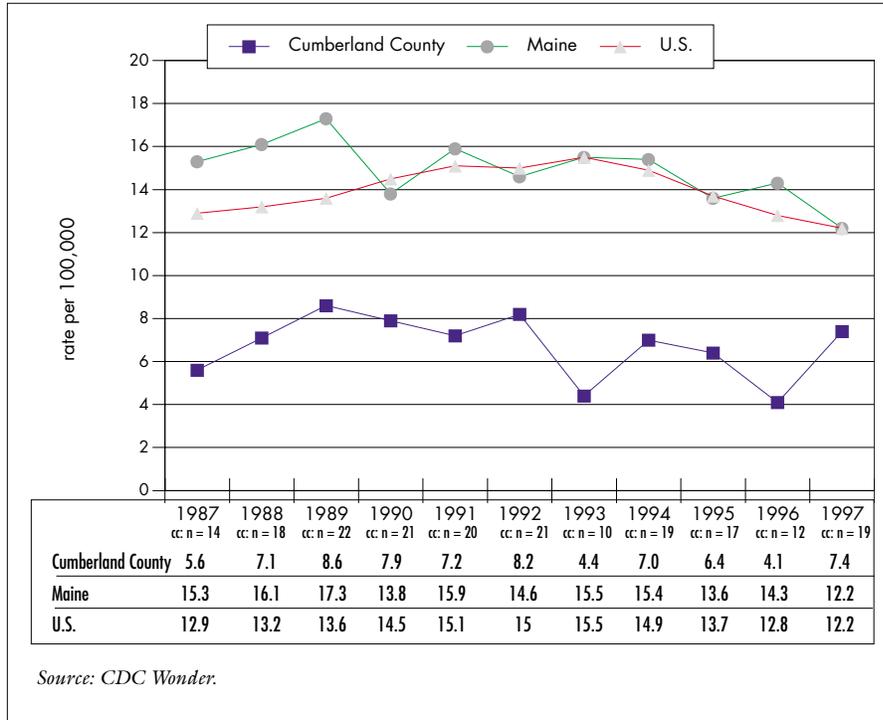
# Firearms

## ■ Firearm Mortality Rates —

Cumberland County, Maine and the U.S: 1987 - 1997

(Rates are per 100,000 population and adjusted to the 1940 population.)

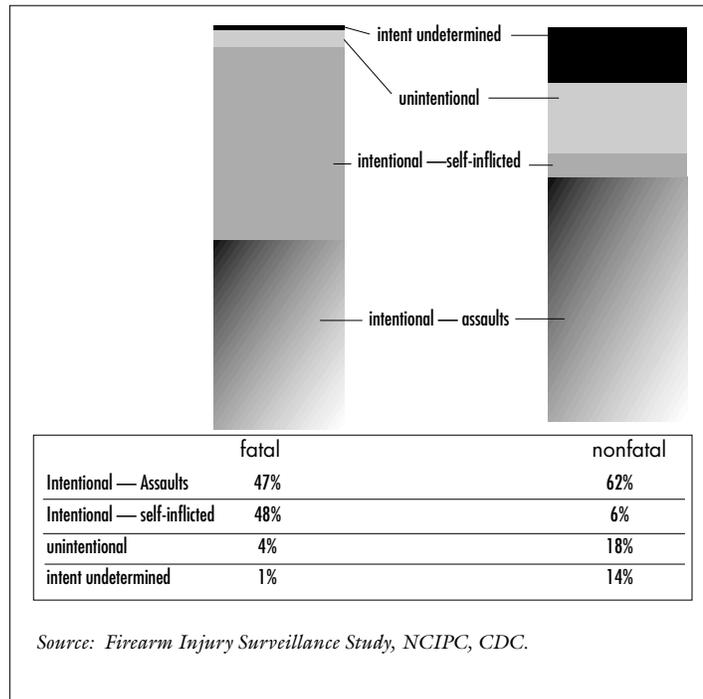
• Efforts at raising public consciousness with respect to the dangers of firearms have not affected discernable change in firearm mortality over the last ten years.



## ■ Fatal and Nonfatal Firearm Injury Rates, by Intent — US: 1992-1994 combined

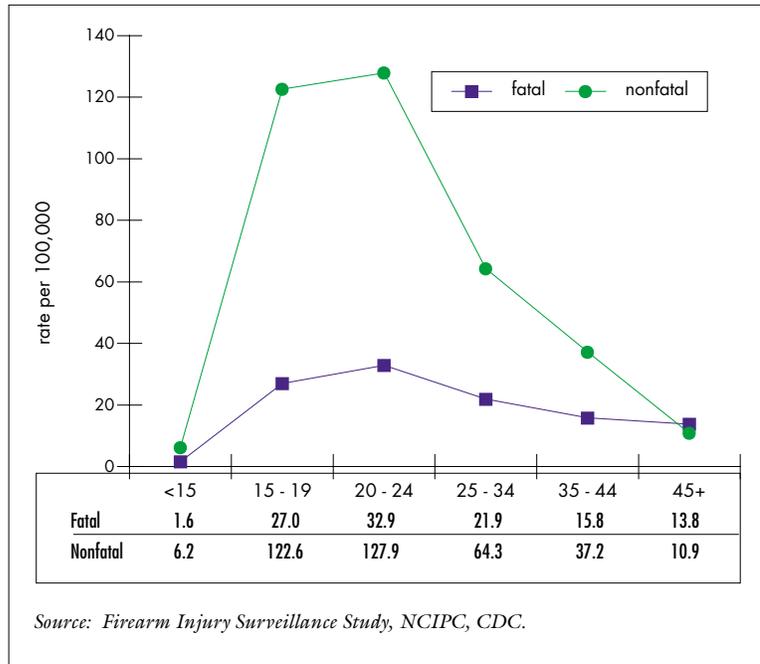
• Homicide and suicide account for most firearm fatalities. The majority of nonfatal firearm injuries are assaults.

• Four percent of firearm fatalities are unintentional while close to one in five nonfatal firearm injuries are unintentional.



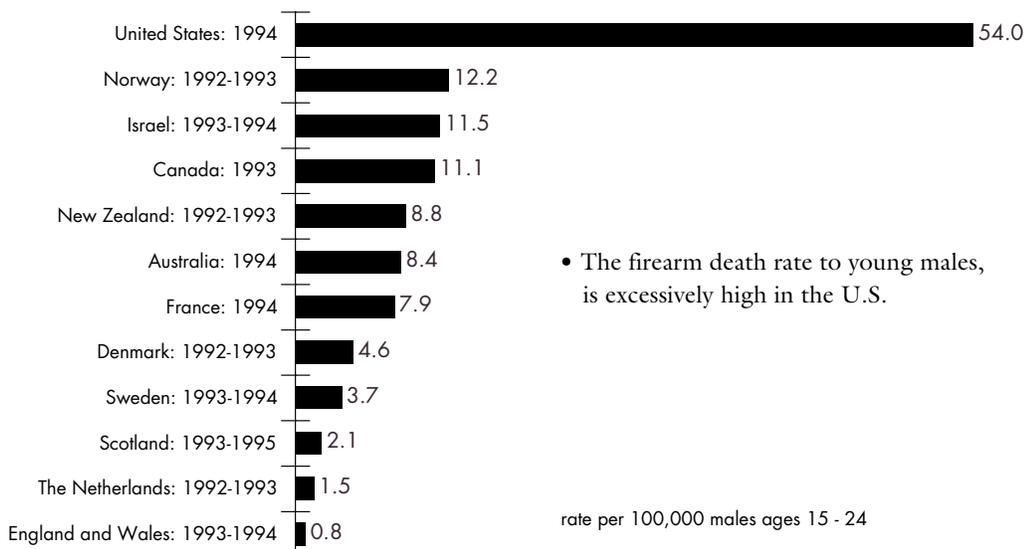
## ■ Nonfatal Firearm Emergency Department-Treated Injury Rates and Death Rates, by Age — US: 1992-1994 combined

- Overall, about 2.6 times the number of persons who died from firearm injuries were treated for nonfatal firearm injuries in U.S. emergency departments during calendar years 1992 and 1993. For people aged 15-24 years, the nonfatal rate was four times the firearm death rate. At ages 45 years and over, the nonfatal firearm injury rate was similar to the firearm death rate.



- From ages 10 - 74 years old, firearm injury was second only to motor vehicle injury as the leading cause of injury death.
- For people ages 15-24, about 66% of the nonfatal injuries as well as fatal injuries resulted from assaults. The assault rate for this age group (985 per 100,000) was 4.4 times the firearm homicide rate for these young people.
- At ages 45 years and over, suicides comprised 75% of firearm deaths with suicide attempts being less than 20% of nonfatal firearm injuries. The number of persons 45 years of age and over who died as a result of firearm suicide was five times the number who were treated for firearm-related suicide attempts.

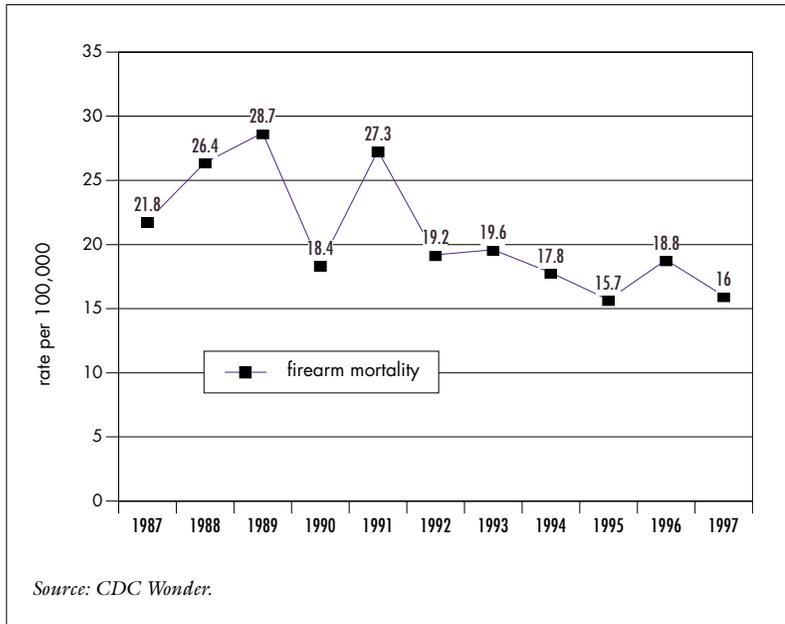
## ■ Firearm Death Rates to Males Ages 15 - 24 — Selected Countries and Years: 1992-1995



Source: Firearm Injury Surveillance Study, NCIPC, CDC.

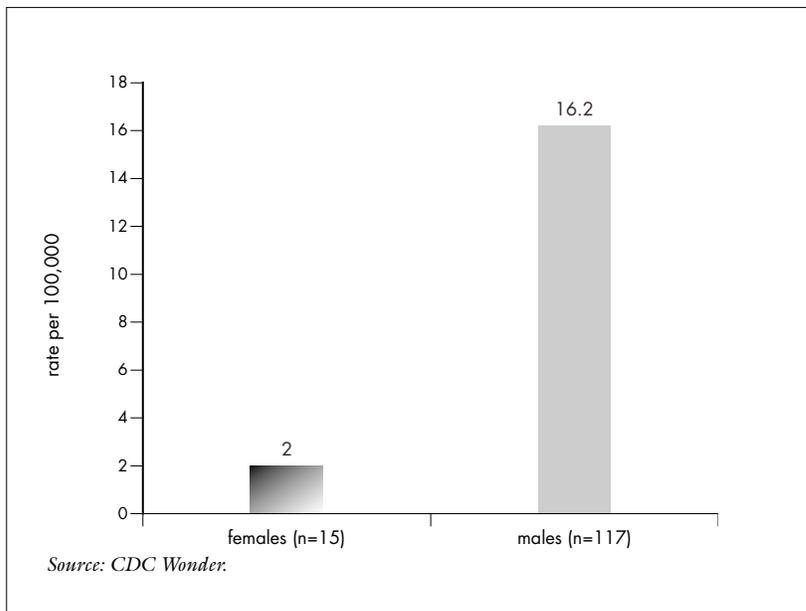
■ **Firearm Mortality, Males, Ages 15 - 34 — Maine: 1987 - 1997**

- Firearm mortality rates for males in Maine, between the ages of 15 and 34, show a similar trend to the national rates over the last ten years.



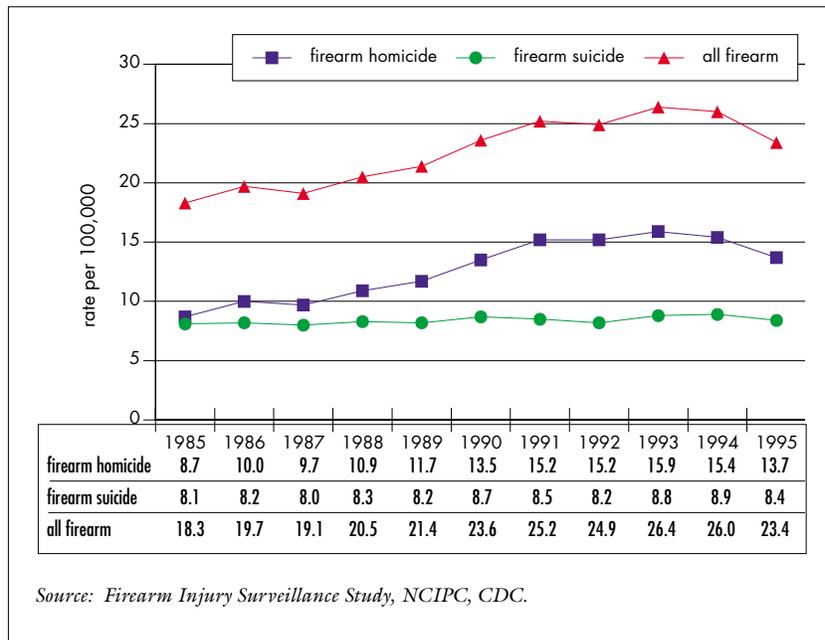
■ **Firearm Mortality, by Sex, Ages 15 - 34 — Cumberland County: 1979 - 1997 combined**

- Firearm mortality in Cumberland County is eight times higher for males than females.



■ **Firearm Injury Death Rates, by Manner of Death, Persons 15-34 Years of Age — U.S.: 1985-1995**

- From 1985 to 1993 the firearm injury death rate for persons 15-34 years of age increased 44% (from 18.3 to 26.4 per 100,000 population); from 1993 to 1995 the rate declined 11%.
- Changes in firearm homicide rates for persons 15-34 years of age have contributed more to the changes in total firearm mortality than have firearm suicide or unintentional firearm injury death rates. In this age group, the firearm homicide rate increased 83% from 1985 to 1993, followed by a 14% decline by 1995.
- For most of this period, firearm homicide rates for males were about six to seven times the rates for females.



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## Endnotes

- <sup>i</sup> The Maine State system does not yet have the capacity to provide unduplicated counts of incidents or victims (children).
- <sup>ii</sup> Count done on last day of the year.
- <sup>iii</sup> Intimate Partner Violence (IPV) is actual or threatened physical or sexual violence, or psychological/emotional abuse. Intimate partners include current or former spouses, boyfriends or girlfriends (heterosexual and/or homosexual).
- <sup>iv</sup> In 1992, under the Family Violence Prevention and Services Act, Congress required that a study of the national incidence of abuse, neglect, and exploitation of elderly persons be conducted. Accordingly, the National Elder Abuse Incidence Study (NEAIS) was conducted and the findings recently released. The national sample included 20 counties, one of which was York County, Maine.
- <sup>v</sup> The violent crime index combines: murder, manslaughter, rape and assault.
- <sup>vi</sup> The National Violence Against Women Survey found that the annual prevalence of rape is 296 per 100,000 women. This 1996 telephone survey indicated that nationally, only 1 in every 8 rapes involves the police. Comparing the arrest rate by the Portland Police Department to the national average would suggest that 1 in 3 rapes occurring in Portland result in an arrest. (This analogy assumes that the higher incidence of rape arrests in Portland are all the result of rapes being reported, rather than a higher occurrence of rape.)
- <sup>vii</sup> Commencing in 1992, law enforcement officers are to report hate crimes as a supplementary report to the UCRS program. Under Title 25, Section 1544, hate crimes are defined as those that “manifest evidence of prejudice based on race, religion, sexual orientation or ethnicity...”
- <sup>viii</sup> API stands for Asian and Pacific Islander.

## ICD-9 Codes

<b>Condition / Indicator</b>	<b>ICD-9 Code</b>
Homicide	E960 - E978
Suicide	E950 - E959
Firearm-related Injury	E922 - E922.3, E922.8 - E922.9, E955 - E955.4, E965 - E965.4, E970, E985 - E985.4



# Greater Portland Community Health Assessment and Source Book

## Access to Health Care

### Healthy People 2010 Access to Health Care Goal

*Improve access to comprehensive, high-quality health care services.*

#### National Health Disparities ACCESS TO HEALTH CARE

##### Race

preventive services receipt  
tetanus booster in last 10 years  
asthma hospitalization  
senior immunization

##### Socioeconomic Status

breast cancer screening

##### Age

cervical cancer screening  
tetanus booster in last 10 years  
asthma hospitalization

##### Geographic Location

preventive services receipt

#### National Health Disparities ORAL HEALTH

##### Race

dental caries  
diagnosis/treatment of dental caries  
gingivitis  
regular dental visits

##### Socioeconomic Status

diagnosis/treatment of dental caries  
complete tooth loss  
(for 65 years and older)

##### Geographic Location

regular dental visits

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“The healthy, the strong individual, is the one who asks for help when it is needed, whether an abscess on the knee or in the soul.”

— Rona Barrett



# Greater Portland Community Health Assessment and Source Book

## Access to Health Care

GREATER PORTLAND AREA, MAINE and U.S. RATES with YEAR 2000 OBJECTIVES

Indicators	Portland HSA Rate	City of Portland Rate	Inner Towns Rate	Maine Rate	U. S. Rate	HM 2000 Goal	HP 2000 Goal
Percentage of adults with no medical coverage <sup>1</sup>	12.0%	13.1%	10.3%	12.0%	12.0%	■	0.0%
Percentage of children less than 18 years of age with no medical coverage <sup>2</sup>	■	■	■	10.0%	15.4%	■	0.0%
Percentage of adults, without health care coverage, who have been without coverage for 5+ years <sup>1</sup>	30.0%	29.0%	30.0%	34.0%	25.0%	■	■
Percentage of adults who have not had a physical checkup within the past 5 years <sup>1</sup>	11.4%	14.0%	9.5%	8.7%	8.3%	■	■
Percentage of adults who claim cost prevented a visit to the doctor within the past year <sup>1</sup>	8.5%	10.4%	7.2%	10.4%	9.9%	■	■
Percentage of people, 18+ years, who do not have a dentist <sup>3</sup>	26.0%	32.0%	22.0%	■	■	■	■
	<b>Portland Schools</b>						
Percentage of children ages 6-8 with no dental caries <sup>4</sup>	■	62.0%	■	59.6%	4.8%	5.5%	6.5%
Percentage of children ages 6-8 with untreated caries <sup>4</sup>	3rd grade: 13.0% 5th grade: 8.0%			15.0%	31.0%	15.0%	20.0%
Percentage of children, age 8, with sealant on permanent teeth <sup>4</sup>	■	61.0%	■	55.0%	21.0%	60%	50%
■ = data not available							
<i>For Source Notes, see next page</i>							

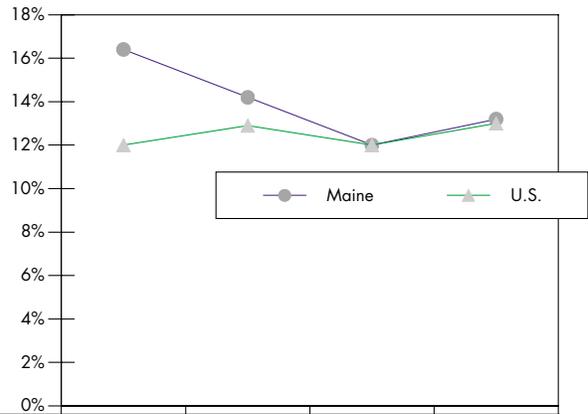
source number	Greater Portland Area	Maine	U.S.	notes
1	1996 - 1997 BRFSS, CDC	1997 BRFSS, CDC	1997 BRFSS, CDC	Greater Portland Area rates were prepared by the PHRG.
2	■	1997 Health Insurance Coverage Among Maine's Children: The Results of a Household Survey, Institute for Health Policy, Edmund S. Muskie School of Public Service, USM, 1997	1996 HP 2010	
3	1994 Community Health Profile of the Greater Portland Region, GPPH	■	■	
4	1996 - 1998 PHD, HHS, City of Portland	1995 HP 2000	1988 - 1991 HP 2000	Rates for Portland schools pertain to the following: <ul style="list-style-type: none"> <li>• 1996 - 1998: % of 5th grade students who were screened and did not have caries</li> <li>• 1997 - 1998: % of students who were screened and found to have untreated caries</li> <li>• 1997 - 1998: 5th grade students screened who had sealant on their permanent teeth</li> </ul>

## Insurance Coverage

### ■ Percentage of Adults without Health Insurance —

Maine and U.S.: 1995-1998

- Though initially well above the national percentage, Maine's uninsured adult population fell to the national level in 1997. However, data from 1998 shows an increase in the uninsured both nationally and in the state, with Maine's percentage once again exceeding the nation's.



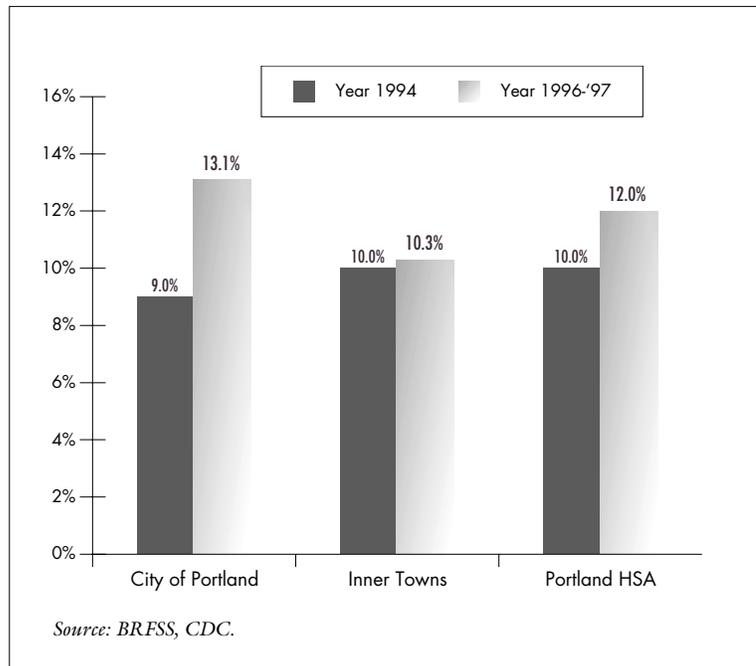
	1995	1996	1997	1998
Maine	16.4	14.2	12.0	13.2
U.S.	12.0	12.9	12.0	13.0

Source: BRFSS, CDC.

### ■ Percentage of Adults without Health Insurance —

City of Portland, Inner Towns and Portland HSA : 1994 and 1996-1997 combined

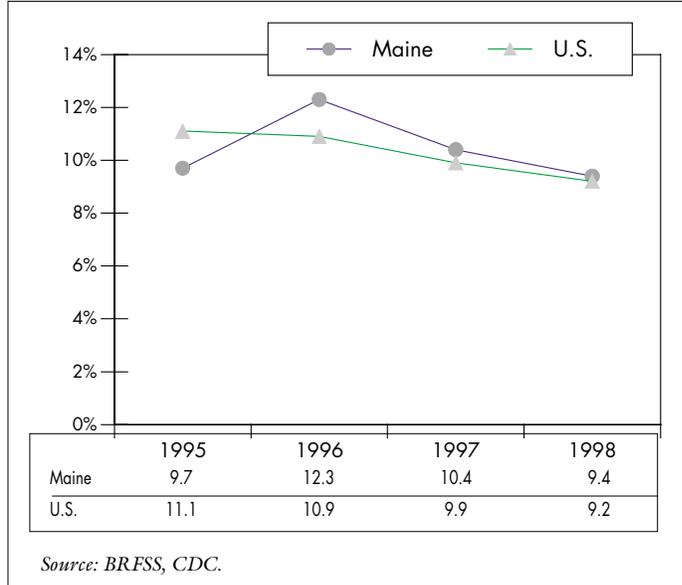
- In the City of Portland alone, there was a 45% increase in the uninsured adult population between 1994 and 1996/1997.



## Health Care Utilization

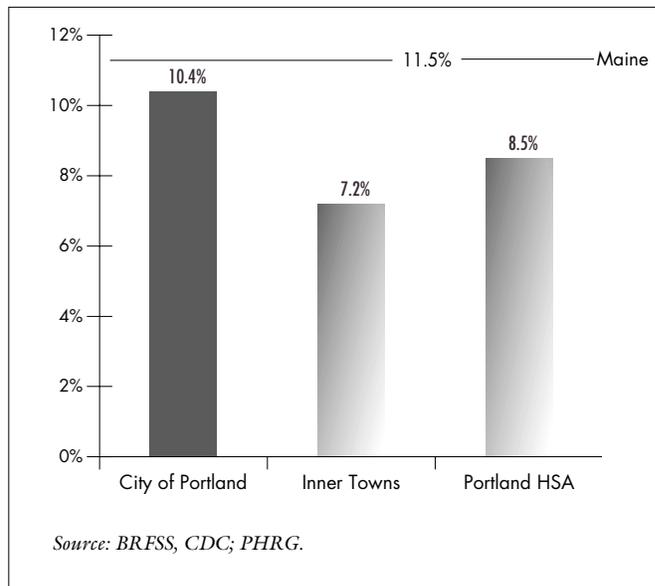
### ■ Percentage of Adults who Did Not Visit a Doctor because of Cost within the Past 12 Months — Maine and U.S.: 1995-1998

- Since 1996, Maine's percentage of adults who claim they could not afford a doctor within the past year, has been higher than the nation's.



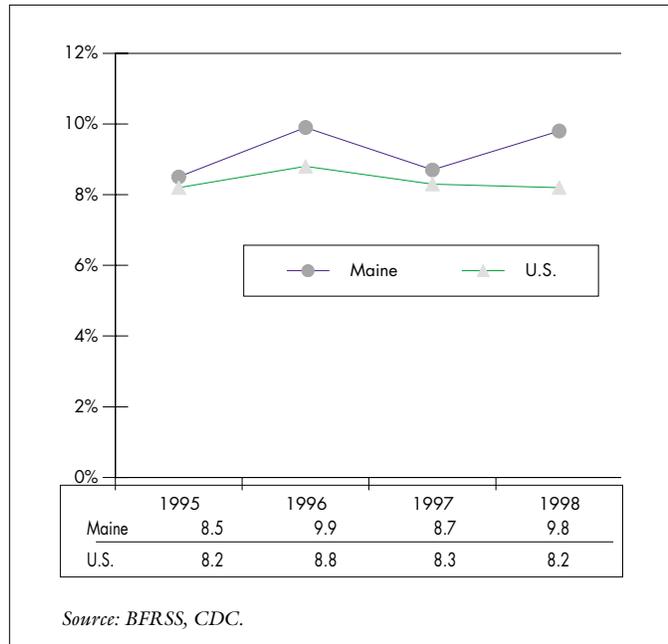
### ■ Percentage of Adults Who Did Not Visit a Doctor because of Cost within the Past 12 Months — City of Portland, Inner Towns and Portland HSA: 1996-1997 combined

- While the percentage of adults who felt they could not afford to see a doctor in the past year is notably lower in the Portland HSA than the state as a whole, this is not true when considering the City of Portland separately.



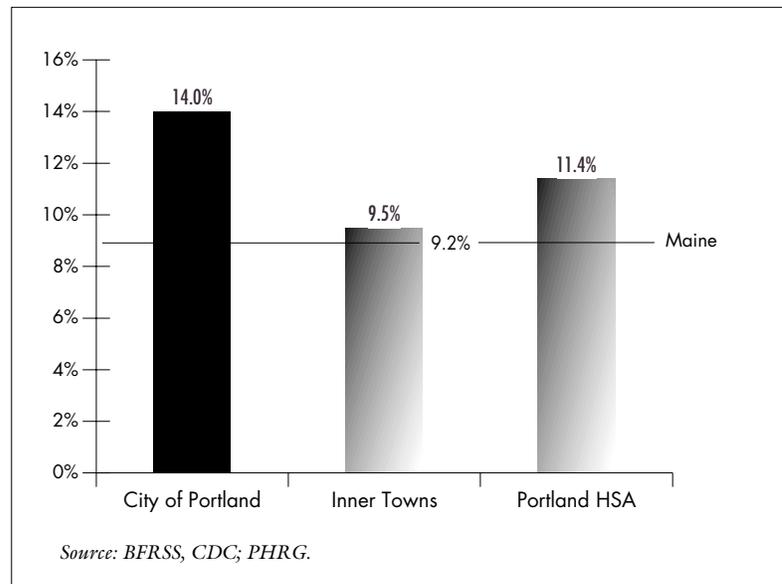
**Percentage of Adults Who Have Not Had a Routine Physical Exam in the Past Five Years — Maine and U.S.: 1995-1998**

- The percentage of adults who have not had a routine physical exam in the last five years is consistently higher in Maine than the U.S. overall.



**Percentage of Adults Who Have Not Had a Routine Physical Exam in the Past Five Years — City of Portland, Inner Towns and Portland HSA: 1996-1997 combined**

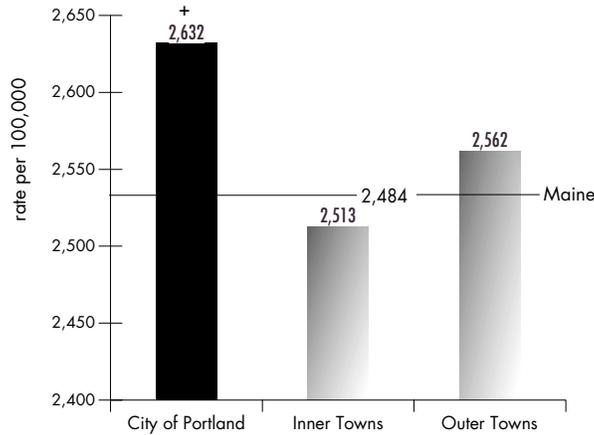
- Compared to the state as a whole, a higher percentage of adults had not had a routine physical exam in the last five years in the Portland HSA. The high percentage in the City of Portland accounts for much of the HSA's elevated rate.



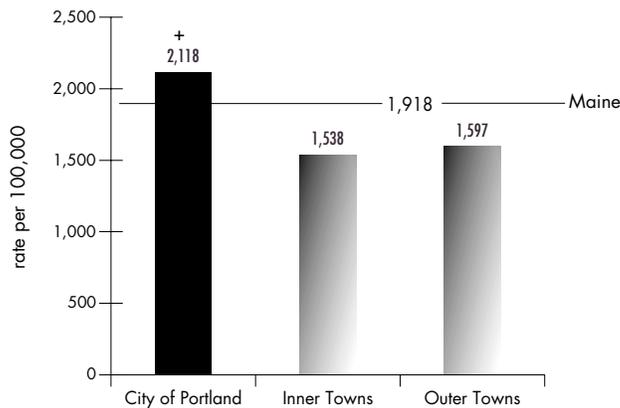
## Hospital Admissions Indicators<sup>i</sup>

- Comparing the Greater Portland Area to the State of Maine, the City of Portland exhibits a significantly higher hospital discharge rate for all three sets of “health system sensitive” health status indicators ( $p \leq .05$ ). (Rates are adjusted to Maine’s 1996 population.)

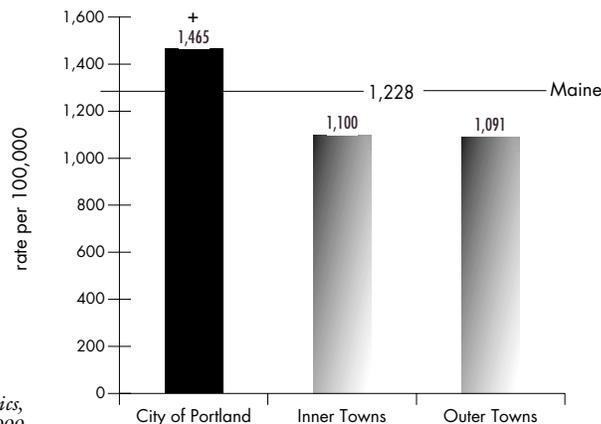
### ■ Hospital Discharges for Conditions Amenable to Medical Treatment Greater Portland Area and Maine: 1996-1997 combined



### ■ Hospital Discharges for Ambulatory Care Sensitive Conditions Greater Portland Area and Maine: 1996-1997 combined



### ■ Hospital Discharges for Potentially Avoidable Hospitalizations Greater Portland Area and Maine: 1996-1997 combined



Source: UHDDS, Maine Health Data Organization; Vital Statistics, OHDP, BOH, ME; MMAF, 1999.

■ **Leading Hospital Discharge Rates for Ambulatory Care Sensitive Conditions, by Age** — Portland HSA: 1995-1996 combined

Age Group	Condition	Hospital Admission Rate (per 100,000)
0 - 17	Bronchitis and Asthma	350.1
	Pneumonia	95.7
	Otitis Media and URI	49.2
	Cellulitis	34.7
	Diabetes	27.4
	Respiratory Infections and Inflammations	9.1
	COPD	2.8
18 - 44	Chest Pain	108.6
	Bronchitis and Asthma	84.8
	Cellulitis	68.6
	Pneumonia	64.6
	Diabetes	43.9
	Otitis Media and URI	22.2
	COPD	20.2
	Angina Pectoris	14.1
	Respiratory Infections and Inflammations	10.4
	Heart Failure and Shock	4.1
	Hypertension	1.5
45 - 64	Chest Pain	425.7
	COPD	265.4
	Pneumonia	202.9
	Heart Failure and Shock	172.8
	Cellulitis	142.7
	Angina Pectoris	122.0
	Bronchitis and Asthma	68.9
	Diabetes	59.4
	Respiratory Infections and Inflammations	42.2
	Otitis Media and URI	17.2
	Hypertension	14.0
	Cardiac Arrest	2.2
	65+	Heart Failure and Shock
Pneumonia		1,349.7
COPD		1,087.4
Chest Pain		695.9
Respiratory Infections and Inflammations		337.3
Angina Pectoris		315.7
Cellulitis		206.3
Diabetes		143.5
Bronchitis and Asthma		133.9
Otitis Media and URI		47.9
Hypertension		23.3
Cardiac Arrest		5.1

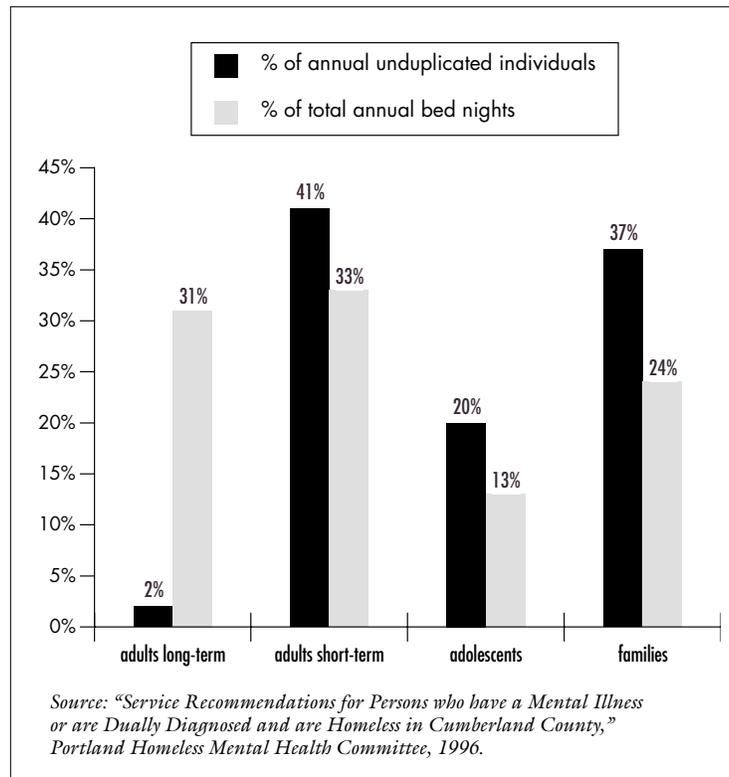
*Source: Vital Statistics, OHDPM, BOH, ME; PHRG.*

## Additional Access Indicators

### ■ Annual Emergency Shelter Usage, by Population Characteristics; Unduplicated Individuals versus Bed-Nights Used<sup>ii</sup> — Portland HSA: 1997

Inadequate mental health services are indicated by this discrepancy:

- The long-term homeless comprise only 2% of the shelter-using population; yet, they occupy 31% of the shelter beds annually. Long-term shelter dwelling adults generally suffer from a mental disorder, an addiction disorder, or both (dually diagnosed).
- According to the Federal Task Force on Homelessness and Severe Mental Illness (1992), only 5-7% of homeless persons with mental illness need to be institutionalized; most can live in the community with appropriate supportive services.
- Evidence from recent research undertakings demonstrate that treatment is an effective antidote to homelessness for those with addictive disorders and that services customized to the unique needs and life circumstances of those without homes can resolve both their addictive disorder and their homeless condition. In 1997, the percentage of clients reporting homelessness in the past 12 months dropped over 40%, among those served by the Center for Substance Abuse Treatment (CSTAT) programs, according to the National Treatment Improvement Evaluation Study (NTIES). (*Impact of Substance Abuse Treatment on Homelessness*).



#### The Key Emerging Access to Health Care Issue: Cost of Prescription Medication

Cost of prescription medications is escalating. While community safety nets are making free and low-cost health services available to individuals who lack adequate resources, health-condition management cannot be achieved without access to required treatments.

## Endnotes

- i “+” indicates that according to statistical testing, the rate is significantly higher than the benchmark.
- ii Approximately 50 people make shelters their long-term home while another 2,000 people annually are using emergency shelters on a short-term, truly emergency basis. Annually, approximately 834 adults (not including the long-term shelter dwellers), 403 adolescents, and 763 individuals in families use emergency shelters.

Considering that families are generally women with their children, approximately 40% of the shelter-using population are under 18 years of age.

Condition	Ages	DRG Codes
Angina Pectoris	45+	140
Bronchitis and Asthma	0 - 17	98
	18+	96, 97
Cardiac Arrest	45+	129
Cellulitis	0 - 17	279
	18+	277, 278
Chest Pain	45+	143
COPD	18+	88
Diabetes	0 - 35	295
	36+	294
Heart Failure and Shock	45+	127
Hypertension	45+	134
Otitis Media and URI	0 - 5	70
	18+	68, 69
Pneumonia	0 - 17	91
	18+	89, 90
Respiratory Infections and Inflammations	0 - 17	81
	18+	79, 80



# Maternal, Infant and Child Health and Family Planning

Healthy People 2010 Maternal, Infant and Child Health (MICH) Goal

*Improve the health and well-being of women, infants, children, and families.*

Healthy People 2010 Family Planning Goal

*Improve pregnancy planning and spacing and prevent unintended pregnancy.*

## National Health Disparities MICH

### Race

infant deaths  
fetal deaths  
maternal mortality  
prenatal care in the  
first trimester  
severe complications  
of pregnancy  
low birth weight  
fetal alcohol syndrome  
breast-feeding in the  
first six months  
growth retardation  
(among low-income children)

## Socioeconomic Status

smoking cessation  
during pregnancy

## National Health Disparities FAMILY PLANNING

### Race

teen pregnancies  
planned pregnancies  
infertility

## CONTENTS

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**117 Pregnancy Conditions and Outcomes**

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“Adults are obsolete children.”

— Dr. Seuss



# Greater Portland Community Health Assessment and Source Book

## Maternal, Infant and Child Health, and Family Planning

GREATER PORTLAND AREA, MAINE and U.S. RATES with YEAR 2000 OBJECTIVES

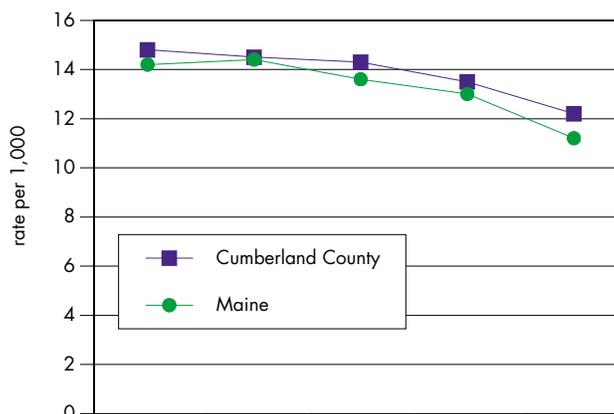
Indicators	Cumberland County Rate	Maine Rate	U. S. Rate	HM 2000 Goal	HP 2000 Goal
<b>Birth Rates and Family Planning</b>					
birth rate (per 1,000 population) <sup>1</sup>	12.2	11.2	14.8	■	■
teen pregnancy rate, ages 15 – 17 <sup>1</sup> (per 1,000, ages 15-17)	Portland HSA 32.6	30.4	71.7	35.0	50.0
percentage of pregnancies mistimed <sup>2</sup>	22.7%	25.9%	42.6%	■	30.0%
<b>Prenatal Care</b>					
percentage receiving 1st trimester prenatal care <sup>3</sup>	92.8%	88.6%	82.5%	90.0%	90.0%
percent receiving adequate prenatal care <sup>4</sup>	86.3%	■	■	■	■
<b>Pregnancy Conditions and Outcomes</b>					
quit rate for prenatal smokers <sup>2</sup> (smokers who quit during pregnancy)	41.8%	39.0%	34.0%	54.0%	60.0%
postnatal relapse rate <sup>2</sup> (relapse by smokers who quit during pregnancy)	23.8	29.7%	15.0%	■	■
percent of pregnant women who drank alcohol during pregnancy <sup>2</sup>	9.8%	5.6%	5.5%	■	■
percentage of women who reported being victims of intimate partner violence during pregnancy <sup>2</sup>	2.9%	2.9%	4.3%	■	■
low weight births (% of births) <sup>1</sup> < 2,500 grams	Portland HSA 5.7%	6.1%	7.4%	5.0%	5.0%
very low weight births: (% of births) <sup>1</sup> < 1,500 grams	0.9%	1.9%	1.4%	■	1.0%
infant mortality per 1,000 live births <sup>5</sup>	6.5	6.3	7.2	6.0	7.0
<b>Breast Feeding</b>					
percentage of post partum women who never breast fed <sup>2</sup>	24.2%	31.2%	50.0%	25.0%	25.0%
■ = data not available					
<i>For Source Notes, see next page</i>					

source number	Greater Portland Area	Maine	U.S.	notes
1	1995 Vital Statistics, OHDPM, ME	1995 Vital Statistics, OHDPM, ME	1996 NVSS, NCHS	U.S. teen birth rate is for 1995 and comes from the HP 2000 review, 1999.
2	1996-1997 PRAMS, OHDPM, ME; CDC	1996-1997 PRAMS, OHDPM, ME; CDC	1996-1997 PRAMS, OHDPM, ME; CDC	
3	1995 - 1996 Vital Statistics, OHDPM, ME	1995 - 1996 Vital Statistics, OHDPM, ME	1997 Monthly Vital Statistics Report, Vol. 46, No. 11, Supplement	
4	1995 - 1996 PHRG	■	1998 HP 2010	"Adequacy of care" is grouped into four categories based on the Kessner Index, which measures the total number of prenatal care visits in relation to the duration of the pregnancy and the gestational age at the time of the first visit.
5	1995 - 1996 CDC Wonder	1995 CDC Wonder	1996 CDC Wonder	

## Birth Rates and Family Planning

### ■ Birth Rate — Cumberland County and Maine: 1988 - 1995

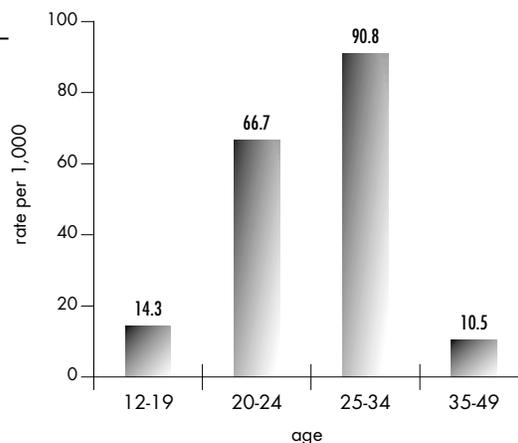
- Cumberland County's birth rate is consistently higher than the state's, though both have declined.



	1988	1989	1991	1992	1995
Cumberland County	14.8	14.5	14.3	13.5	12.2
Maine	14.2	14.4	13.6	13.0	11.2

### ■ Birth Rate by Maternal Age — Portland HSA: 1992 - 1995 combined

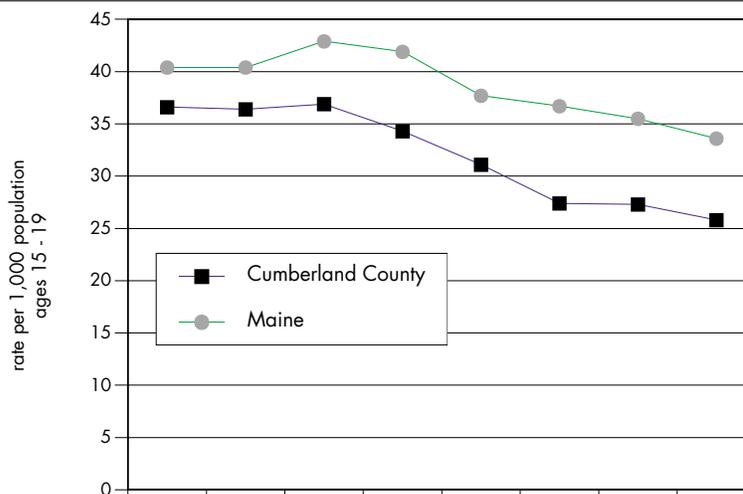
- The birth rate in the Portland HSA is highest among women between 25 and 34 years of age.



Source: Vital Statistics, OHDP, BOH, ME; PHRG.

### ■ Teen Birth Rate, Females Age 15 - 19 — Cumberland County and Maine: 1988-1995

- The teen birth rate has declined in both Cumberland County and Maine.

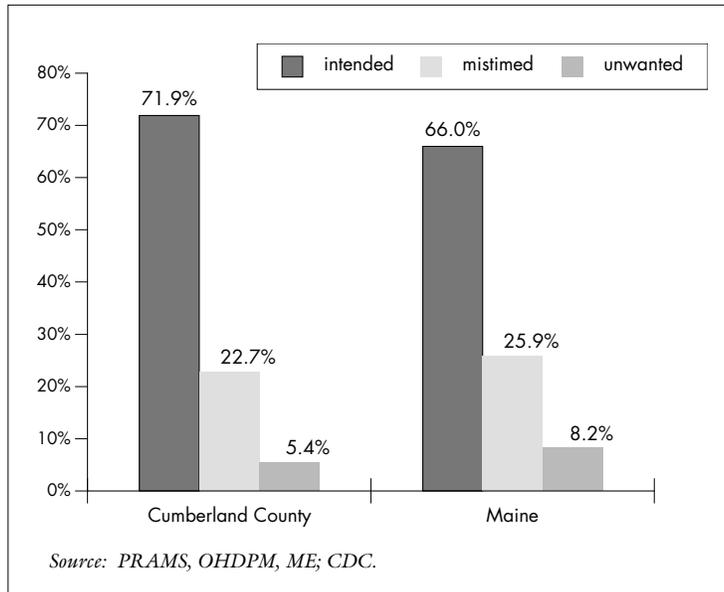


	1988	1989	1990	1991	1992	1993	1994	1995
Cumberland County	36.6	36.4	36.9	34.4	31.1	27.4	27.3	25.8
Maine	40.4	40.4	42.9	41.9	37.7	36.7	35.5	33.6

Source: Vital Statistics, OHDP, BOH, ME.

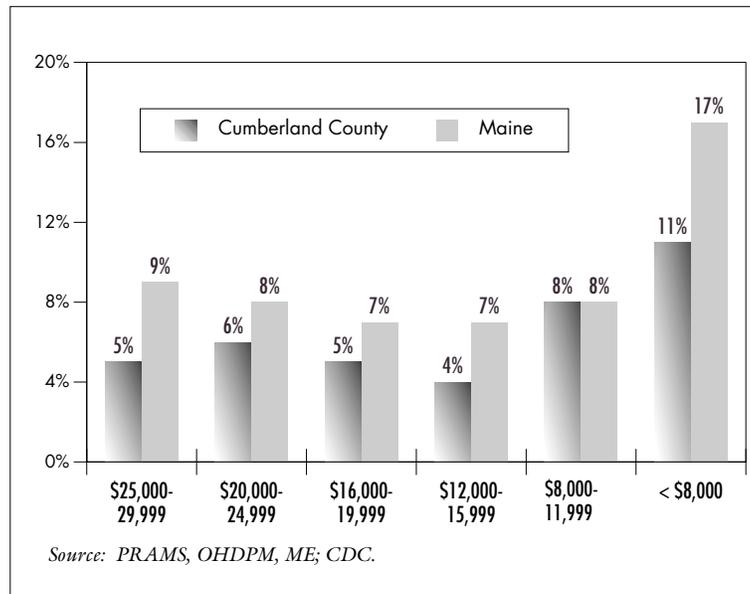
■ **Percentage of Pregnancies Intended, Mistimed and Unwanted —  
Cumberland County and Maine: 1996 - 1997 combined**

- About a quarter of all pregnancies in both Cumberland County and Maine are mistimed.
- In Cumberland County and Maine, approximately one in fifteen pregnancies are unwanted.



■ **Births to Low Income Families, by Household Income –  
Cumberland County and Maine: 1996-1997 combined**

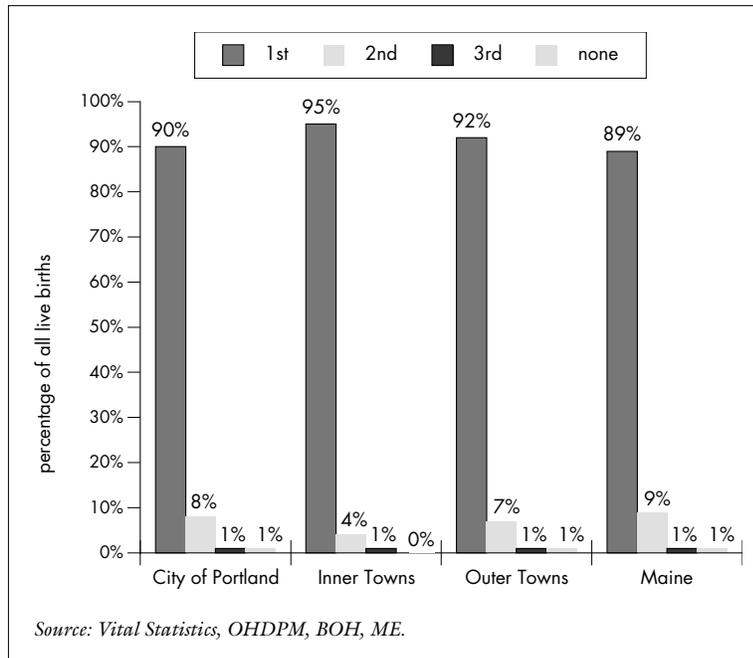
- More than one third of all births in Cumberland County and more than half of all births in Maine are to low income families.<sup>i</sup>
- With the mean number of dependents per household in both the county and the state being 3.27, the majority of births to low income families are to households living below the federal poverty level.



## Prenatal Care

### ■ Trimester of Entry into Prenatal Care —

Greater Portland Area and Maine: 1995 - 1996 combined

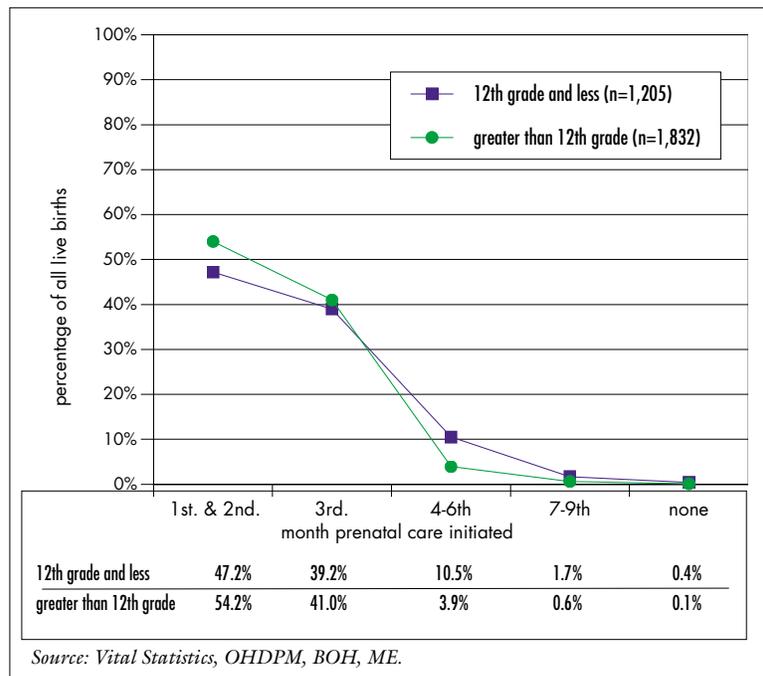


- The majority of women in the Greater Portland Area and Maine enter prenatal care during the first trimester of pregnancy.

### ■ Month Prenatal Care Began by Mothers Education —

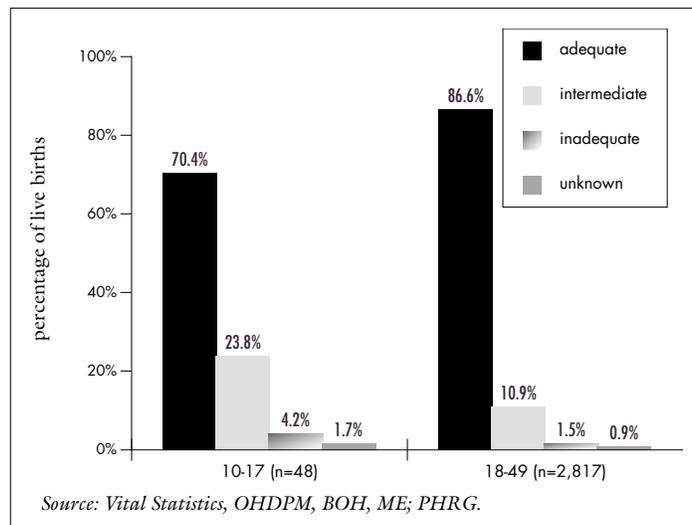
Cumberland County: 1995

- There is a tendency for women with a high school education or less to begin prenatal care later than women with more than a high school education.



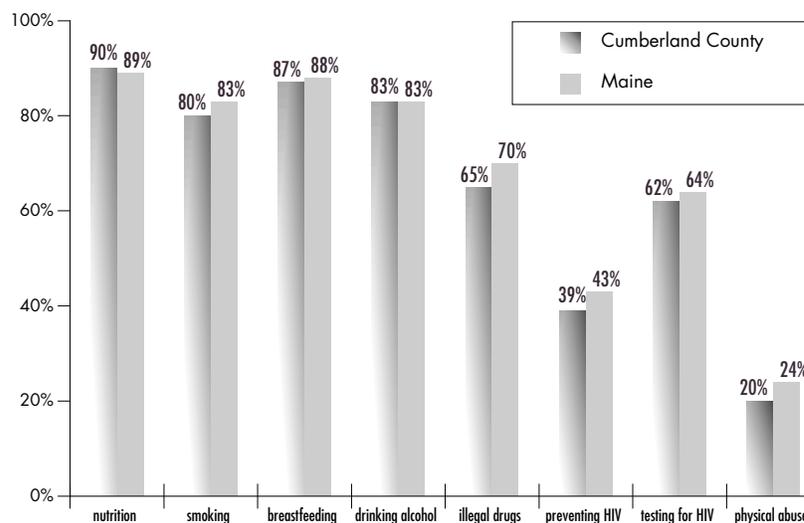
**■ Adequacy of Prenatal Care by Age Group —  
Portland HSA: 1992-1995 combined<sup>ii</sup>**

- Though most women enter prenatal care in their first trimester of pregnancy, the percentage of women receiving adequate care is below 90%. Teen mothers' prenatal care is less adequate than the care received by women over 18 years old.



**■ Percentage who Received Advice by a Health Care Professional<sup>iii</sup> on Key Issues during Pregnancy — Cumberland County and Maine: 1996 - 1997 combined**

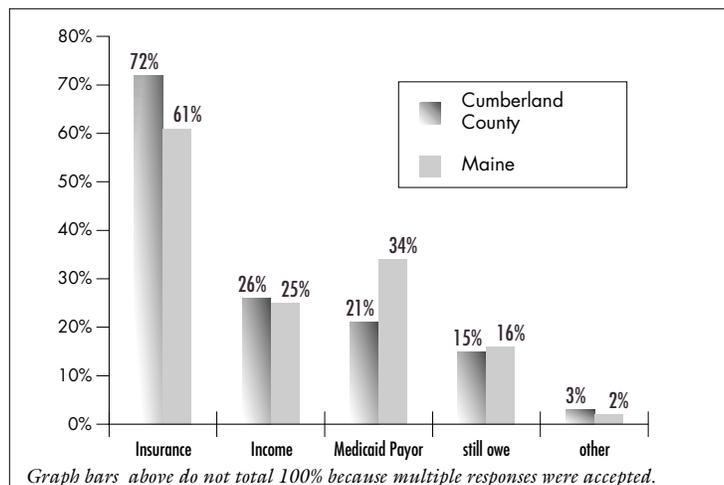
- Although a large percentage of women receive counseling on key health issues related to pregnancy, the percentage of women not receiving counseling ranges from 10% to 80%, depending on the issue.



**■ Percentage of Prenatal Care by Payor —  
Cumberland County and Maine: 1996-1997 combined**

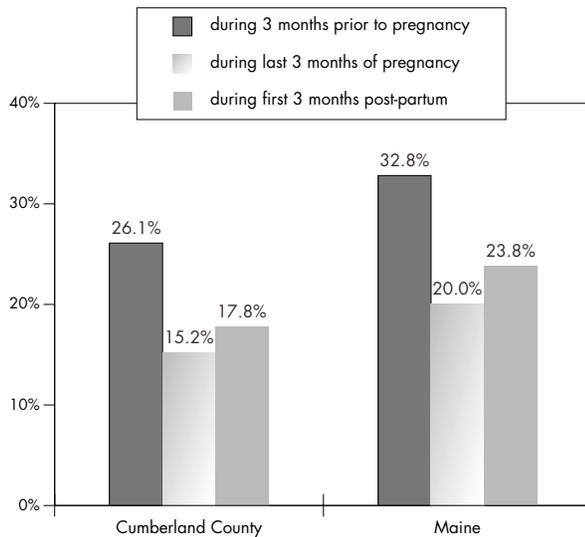
- In Cumberland County, approximately one in five pregnant women use Medicaid to pay for prenatal care.
- In Maine, more than one in three pregnant women use Medicaid to pay for prenatal care.

Source: PRAMS, OHDP, ME; CDC.



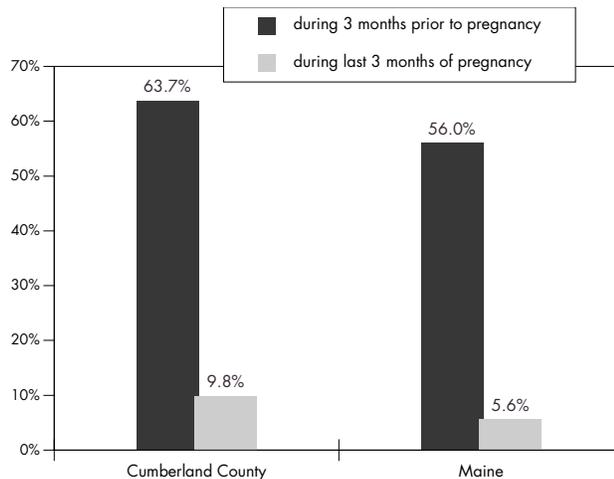
## Pregnancy Conditions and Outcomes

### ■ Percentage of Women who Smoked Cigarettes before, during and after Pregnancy — Cumberland County and Maine: 1996 - 1997 combined (also see Tobacco Section)



- In Cumberland County, more than one in four women smoked cigarettes just prior to their pregnancies. Approximately three out of five of these women continued to smoke during their pregnancies.
- In Cumberland County, at least one in five women who quit smoking during pregnancy relapse by three months postpartum. Overall, around one in five Cumberland County women with newborns smoke cigarettes; their babies are exposed to approximately 4.4 hours of second-hand smoke daily. In Maine, where nearly a quarter of new mothers are smokers, the mean number of exposure hours for babies to second-hand smoke is 4.7 hours per day.

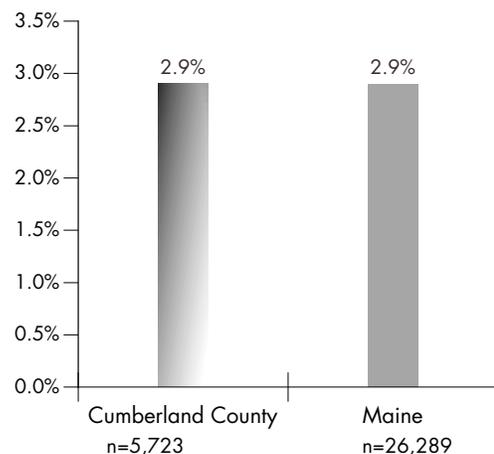
### ■ Percentage of Women who Drank Alcohol before and during Pregnancy — Cumberland County and Maine: 1996 - 1997 combined



- About 60% of women in Cumberland County and Maine reported drinking alcohol just prior to getting pregnant.
- In Cumberland County, around one in ten women reported drinking alcohol during pregnancy. In Maine, one in eighteen reported drinking alcohol during pregnancy.

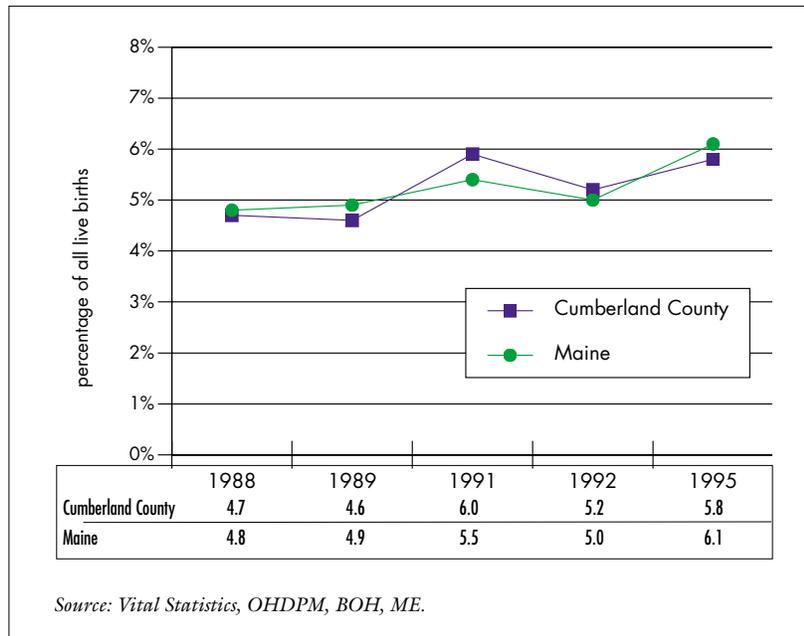
### ■ Physical Abuse During Pregnancy — Cumberland County and Maine: 1996 - 1997 combined

- During this two-year period, in Cumberland County, approximately 165 women reported being physically abused by their partners during their pregnancies; and in Maine, approximately 752 women reported being physically abused by their partners during pregnancy.

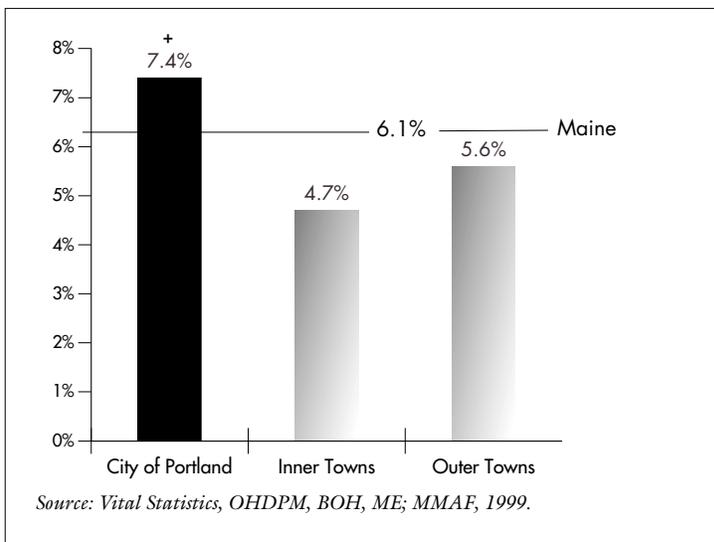


Source: PRAMS, OHDP, ME; CDC.

■ **Trends in Low Birth Weight (<2500 grams) —**  
**Cumberland County and Maine: 1988 - 1995**



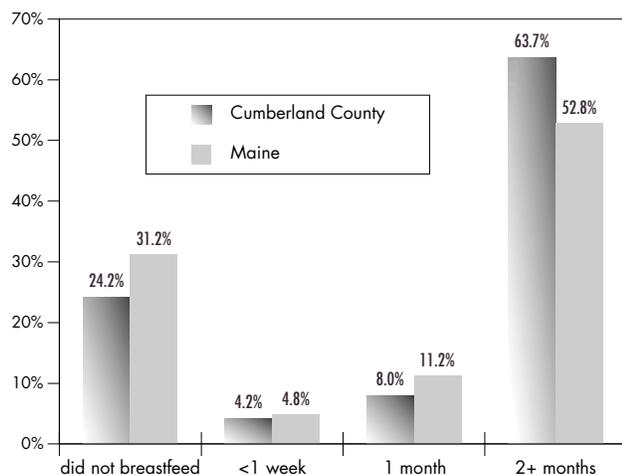
■ **Low Birth Weight Births as a Percentage of all Live Births — Greater Portland Area: 1995-1996 combined and Maine: 1995**



- Cumberland County nearly parallels the state with respect to the slightly increasing trend in low birth weight babies. Disaggregating Portland from the Greater Portland Area, however, shows a significantly ( $p \leq 0.05$ ) higher percentage of low birth weight babies in the City of Portland.

## Breastfeeding

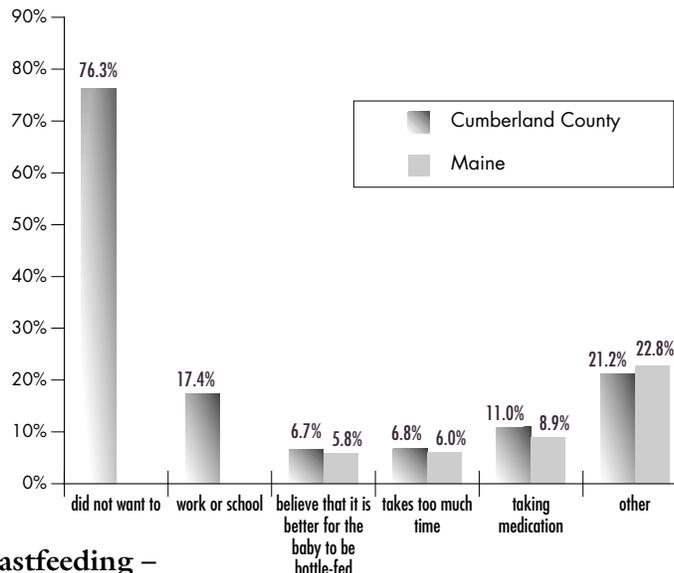
### ■ Duration of Breastfeeding — Cumberland County and Maine: 1996 – 1997 combined



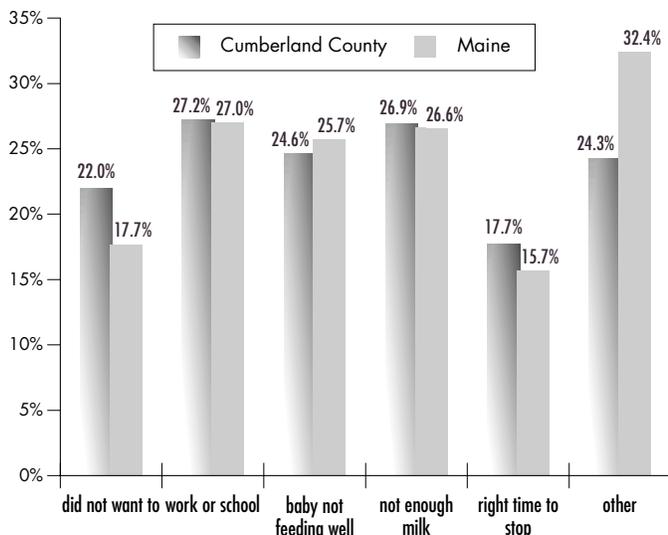
- In Cumberland County, about one in four women did not breastfeed her infant at all. Of those who did breastfeed, about one in six did so for one month or less.
- In Maine, about one in three women did not breastfeed her infant at all. Of those who did breastfeed, about one in four did so for one month or less.

### ■ Reasons for Not Breastfeeding – Cumberland County and Maine: 1996 - 1997 combined

- Three quarters of the women in Cumberland County and Maine, who did not breastfeed their babies, did not have the motivation to do so.



### ■ Reasons for Discontinuing Breastfeeding – Cumberland County and Maine: 1996 - 1997 combined



- In Cumberland County and Maine, women reported discontinuing breastfeeding for the following reasons:
  - more than one in four felt their babies were not feeding well, or that their milk supply was inadequate;
  - more than one in four felt breastfeeding conflicted with work and/or school;
  - about one in five lost the motivation to continue.

Graph bars above do not total 100% because multiple responses were accepted.

Source: PRAMS, OHDP, ME; CDC.

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## Endnotes

- <sup>i</sup> With the mean number of dependents per household in both Cumberland County and Maine being 3.27, we use <200% of the Federal Poverty Guideline for a family size of four to designate “low income.”
- <sup>ii</sup> Adequacy of care is grouped into four categories based on the Kessner Index. The Kessner Index is a measure that is based on the total number of prenatal care visits in relation to the duration of the pregnancy and the gestational age at the time of the first visit. Healthy People 2010 has a goal of 90% receiving adequate care using the Kessner Index.
- <sup>iii</sup> A health care professional could be a doctor, nurse, midwife, physician assistant, or other allied health professional serving perinatal women in a health care setting.

# Greater Portland Community Health Assessment and Source Book Chronic Disease and Risk Factors

## Healthy People 2010 Goals

**Heart Disease and Stroke** — *Improve cardiovascular health and quality of life through the prevention, detection, and treatment of risk factors; early identification and treatment of heart attacks and strokes; and prevention of recurrent cardiovascular events.*

**Respiratory Disease** —  
*Promote respiratory health through better prevention, detection, treatment, and education.*

**Diabetes** —  
*Through prevention programs, reduce the disease and economic burden of diabetes, and improve the quality of life for all persons who have or are at risk for diabetes.*

**Cancer** —  
*Reduce the number of new cancer cases as well as the illness, disability, and death caused by cancer.*

### National Health Disparities CHRONIC DISEASE and RISK FACTORS

#### Race

- cancer deaths
- breast cancer deaths
- cervical cancer deaths
- colorectal cancer deaths
- diabetes deaths
- diabetes prevalence
- coronary heart disease deaths
- stroke deaths
- end-stage renal disease
- asthma hospitalization
- cigarette smoking
- overweight
- sedentary lifestyle
- preventive services receipt

#### Socioeconomic Status

- limitation in major physical activity
- vigorous physical activity
- sedentary lifestyle
- cigarette smoking
- breast cancer screening

#### Physical Disability

- sedentary lifestyle
- overweight

#### Age

- cervical cancer screening
- asthma hospitalizations
- sedentary lifestyle

#### Geographic Location

- preventive services receipt

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- 126 Risk Factors**
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- 136 Diabetes**
- 139 Cancer**



“If I’d known I was gonna live this long,  
I’d have taken better care of myself.”

— Eubie Blake (at age 100)



# Greater Portland Community Health Assessment and Source Book

## Chronic Disease and Risk Factors

GREATER PORTLAND AREA, MAINE and U.S. RATES with YEAR 2000 OBJECTIVES

*Rates are per 100,000 population unless otherwise noted. Mortality is adjusted to 1940.*

Indicators	Portland HSA Rate	Maine Rate	U. S. Rate	HM 2000 Goal	HP 2000 Goal
<b>Chronic Disease Risk Factor Prevalence</b>					
Cigarette smoking prevalence in the adult population (currently smoke) <sup>1</sup>	22.5%	22.7%	23.2%	15.0%	15.0%
population 18-35 <sup>1</sup>	32.6%	28.9%	28.3%	■	■
youth, grades 9- 12 <sup>2</sup>	40.0%	39.0%	36.4%	■	■
Percentage of adults at risk of health problems related to being overweight (using BMI) <sup>1</sup>	26.1%	30.2%	31.1%	■	■
Percentage of adults engaging in no or inadequate physical activity <sup>3</sup>	54.6%	60.5%	58.1%	■	■
Percentage of adults who have had their blood pressure checked within the past 2 years <sup>1</sup>	92.0%	94.6%	94.2%	90.0%	90.0%
Percentage of adults who have been diagnosed with high blood pressure <sup>1</sup>	22.5%	22.8%	■	■	20.0%
Percentage of adults who have had their cholesterol checked within the past 5 years <sup>1</sup>	69.0%	69.0%	68.6%	75.0%	75.0%
Percentage of adults who have been diagnosed with high cholesterol <sup>1</sup>	22.2%	24.9%	28.8%	■	■
<b>Cardiovascular Disease Mortality</b>					
Heart disease mortality <sup>4</sup>	124.9	100.0	138.3	100.0	100.0
Cerebrovascular disease mortality <sup>4</sup>	24.4	23.6	26.7	20.0	20.0
<b>COPD mortality<sup>4</sup></b>	24.4	23.7	20.8	25.0	25.0
<b>Diabetes Prevalence and Mortality</b>					
Diagnosed diabetes prevalence per 1,000 population <sup>5</sup>	31.4	32.0	30.8	■	<25.0
Diabetes mortality <sup>6</sup>	11.7	13.4	13.3	■	12.0
	<small>Cumberland County</small>				
<b>Cancer Screening and Mortality</b>					
Percentage of women who have had a mammogram <sup>1</sup>					
40-49 years old, past 2 years	■	69.5%	63.2%	70.0%	■
50+ years old, past year	60.9%	64.8%	59.8%	55.0%	■
Percentage of adults, age 50+ years, who have ever had a sigmoidoscopy or proctoscopic exam <sup>1</sup>	52.0%	43.4%	40.9%	40.0%	40.0%
Cancer mortality — all <sup>4</sup>	134.3	142.7	130.0	130.0	130.0
Breast cancer mortality <sup>4</sup>	19.6	20.6	21.0	18.0	20.6
Lung cancer mortality <sup>4</sup>	43.5	41.9	38.3	40.0	42.0
Colorectal cancer mortality <sup>4</sup>	13.2	14.2	12.8	13.2	13.2

■ = data not available. For Source Notes, see next page.

source number	Greater Portland Area	Maine	U.S.	notes
1	1996 - 1997 BRFSS, CDC	1997 BRFSS, CDC	1997 BRFSS, CDC	Greater Portland Area rates prepared by the PHRG.
2	1998 PHRG for PHD, HHS, City of Portland	1997 YRBS, CDC	1997 YRBS, CDC	The Portland rate is from "Assessment of Smoking Prevalence and Patterns among Youth in Portland, Maine." This City of Portland-commissioned PHRG study surveyed Portland's two public high schools.
3	1996 BRFSS, CDC	1996 BRFSS, CDC	1996 BRFSS, CDC	Greater Portland Area rates prepared by the PHRG.
4	1992 - 1995 Vital Statistics, OHDP, ME, Suicide	1995 CDC Wonder	1995 CDC Wonder	Portland HSA cause-specific rates were provided by the PHRG. Crude rates were adjusted to the 1940 standard population by PHD, HHS, City of Portland.  State and local rates represent prevalence in the total population.
5	1990 - 1996 BOH, ME	1990 - 1996 BOH, ME	1994 HP 2010	The national goal is taken from the HP 2010 document.  State and local rates for homicide and suicide are unstable because of the small number of deaths.
6	1990 - 1996 BOH, ME FYI: Portland: 18.9	1990 - 1996 BOH, ME	1995 CDC Wonder	We use HP 2010 goal for diabetes mortality.  HP 2010 uses the 1995 rate of 13.3 as a baseline and we include this as the national rate. This is because the HP 2000 goal was for "diabetes-related" mortality at 34.0 (not diabetes as the underlying cause of death).

## Overview

### ■ Number and Percent of Deaths due to Four Chronic Diseases —

United States: 1995

Cause of Death	Number of Deaths	Percent
four chronic diseases .....	1,656,199 .....	71.6%
total cardiovascular diseases .....	955,591 .....	41.2%
all cancers .....	538,455 .....	23.3%
COPD .....	102,899 .....	4.5%
diabetes .....	59,254 .....	2.6%
other .....	655,933 .....	28.4%
Total deaths .....	2,312,132 .....	100.0%

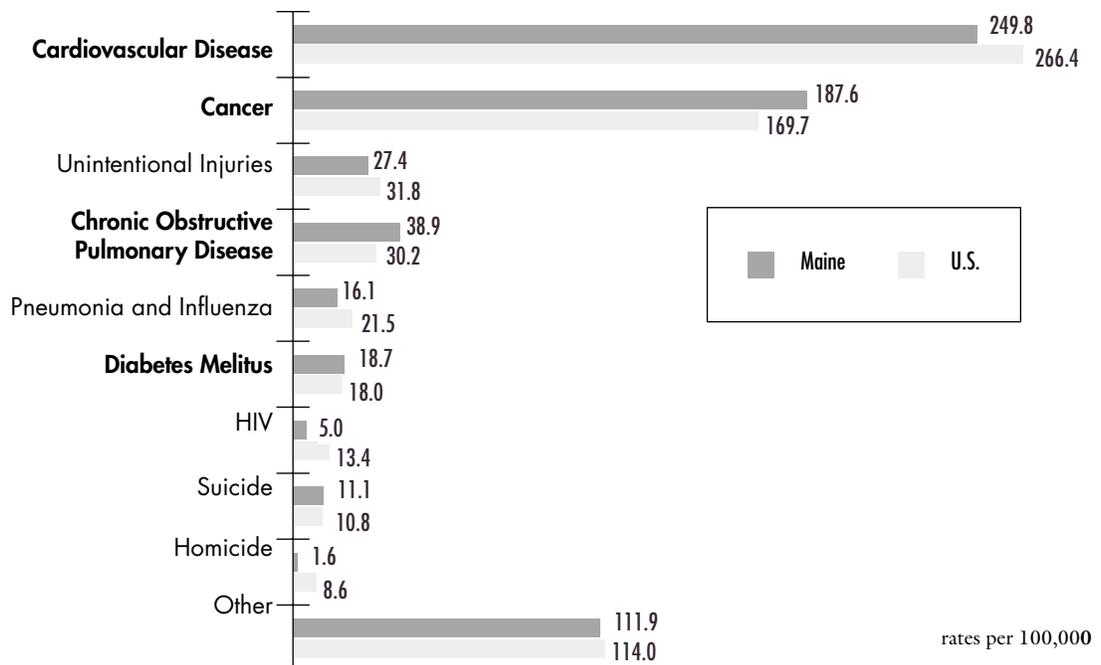
Source: *Chronic Disease and their Risk Factors: The Nation's Leading Causes of Death, CDC, 1998.*

- Total cardiovascular diseases, principally ischemic heart disease and stroke, are the most common causes of death in the U.S. All cancers are the second most common cause of death in the United States; one of every four is from cancer. Cardiovascular disease and cancer together account for almost two-thirds of all deaths nationwide. Chronic obstructive pulmonary disease (COPD) is the fourth most common cause of death, and diabetes is the sixth.

### ■ Mortality Rates for the Leading Causes of Death —

Maine and U.S.: 1995 (Rates are per 100,000 and adjusted to the U.S. 1970 population.)

- Maine's death rates for cancer, COPD and diabetes were higher than the U.S. rates in 1995. COPD was the third leading cause of death in Maine though it was the fourth leading cause in the U.S. overall.



Source: *Chronic Disease and Their Risk Factors: The Nation's Leading Causes of Death, CDC, 1998.*

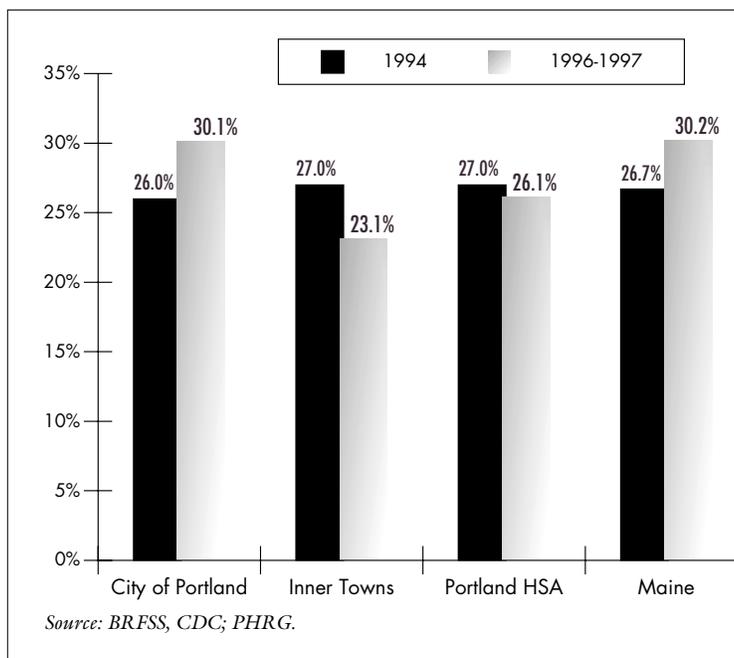
## Risk Factors<sup>ii</sup>

Smoking is the leading cause of preventable deaths in the U.S. and a major risk factor for chronic disease. Data about smoking is presented in its own devoted section.

(see *Tobacco, Section III*)

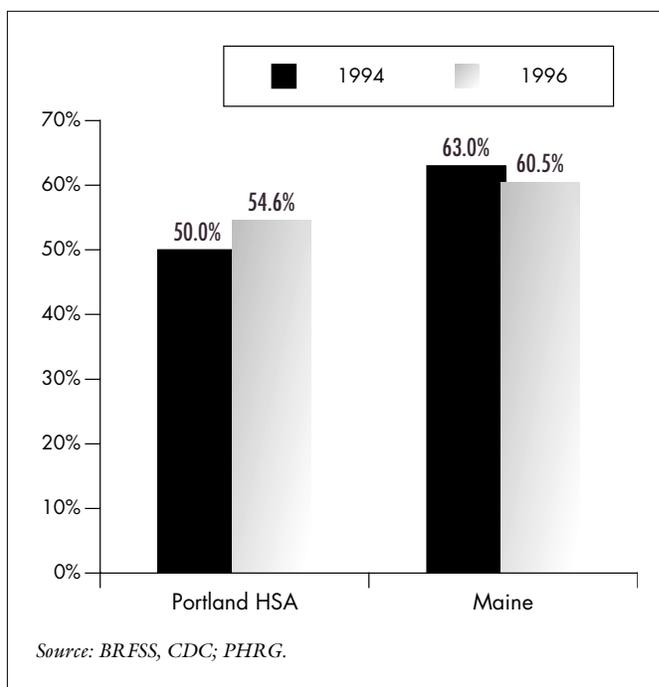
### ■ Percentage of Adults at Risk of Health Problems Related to Being Overweight<sup>i</sup> — Greater Portland Area and Maine: 1994 and 1996-1997 combined

- Portland and Maine both show increasing obesity health risks. Though the overall Portland HSA appears to be improving on this parameter, the locus of improvement is the Inner Towns.



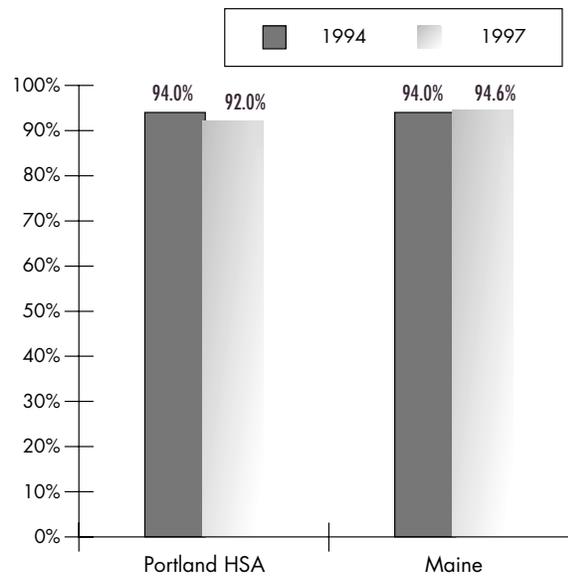
### ■ Percentage of Adults at Risk of Health Problems Related to Inadequate Physical Activity — Greater Portland Areas and Maine: 1994 and 1996<sup>iii</sup>

- At the state level, the percentage of adults engaged in no or inadequate physical activity has decreased. However, in the Portland HSA, this percentage has increased.

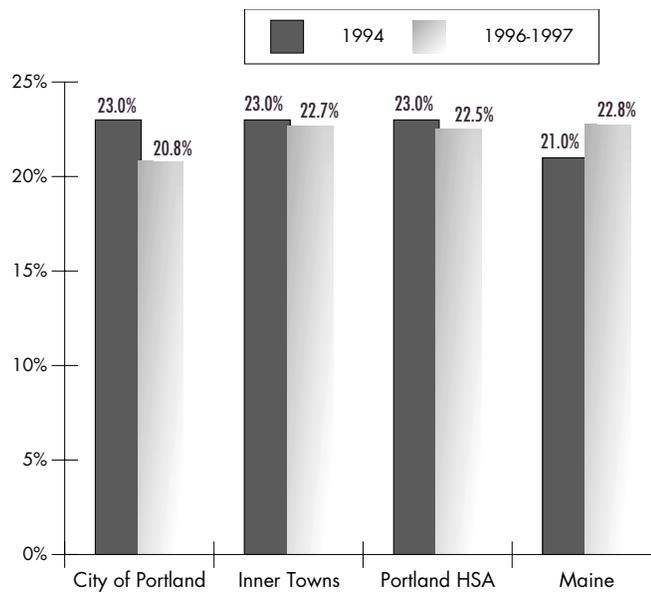


- In the Portland HSA, there was a corresponding decrease in the percentage of people who had their blood pressure checked within the past two years, and the percentage of people who reported being diagnosed with high blood pressure. In Maine, both of these numbers increased<sup>ii</sup>.

■ **Percentage of Adults Who Reported Having Their Blood Pressure Checked within the Past Two Years —**  
Portland HSA and Maine: 1994 and 1997

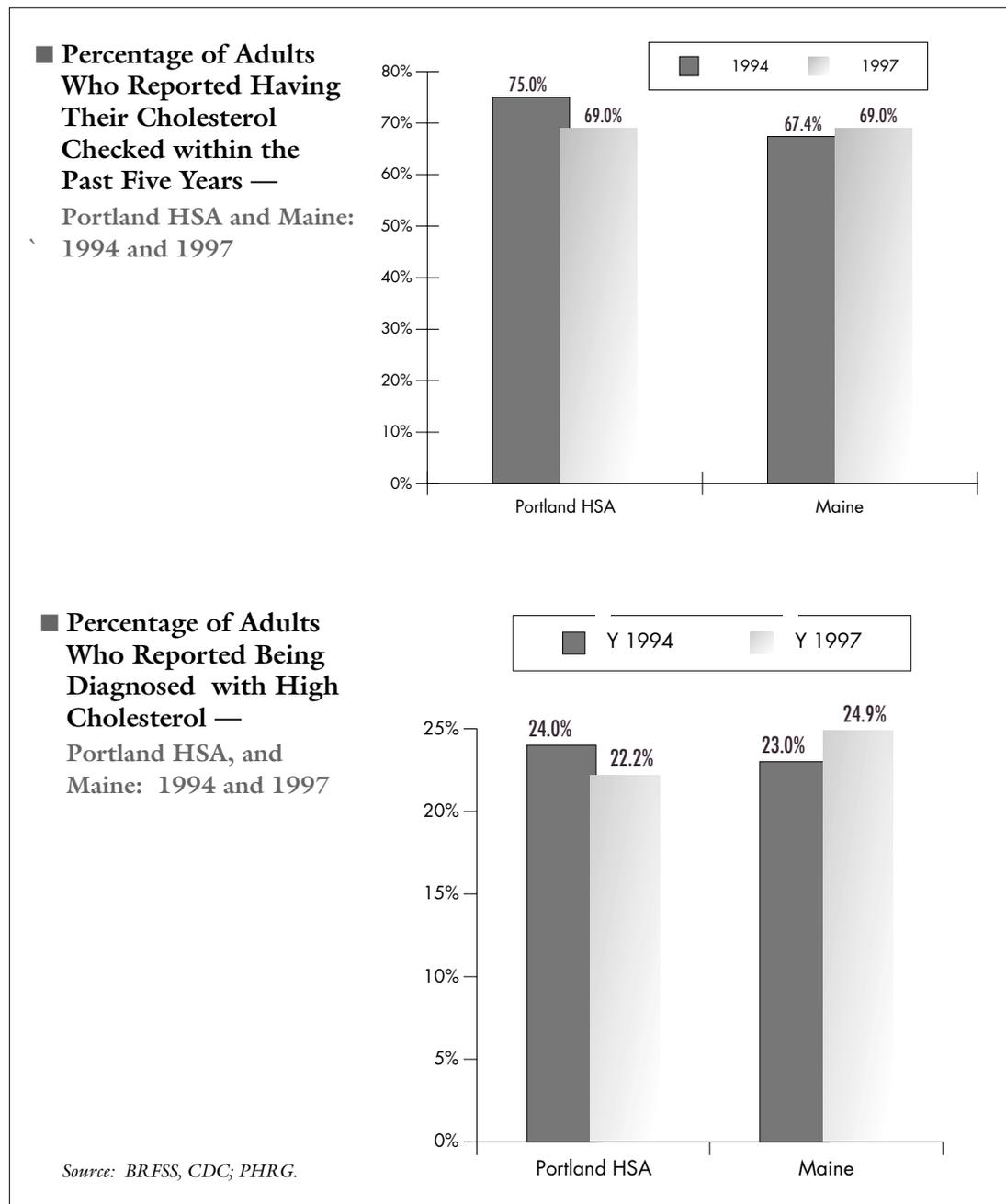


■ **Percentage of Adults Who Reported Being Diagnosed with High Blood Pressure —**  
Greater Portland Area and Maine: 1994 and 1996-1997 combined



Source: BRFSS, CDC; PHRG.

- The percentage of people in the Portland HSA who reported being diagnosed with high cholesterol decreased between 1994 and 1997, as did screening rates. In Maine between 1994 and 1997, there was a corresponding increase in the percentage of people who had cholesterol checked within the past five years, and the percentage of people who reported being diagnosed with high cholesterol<sup>ii</sup>.



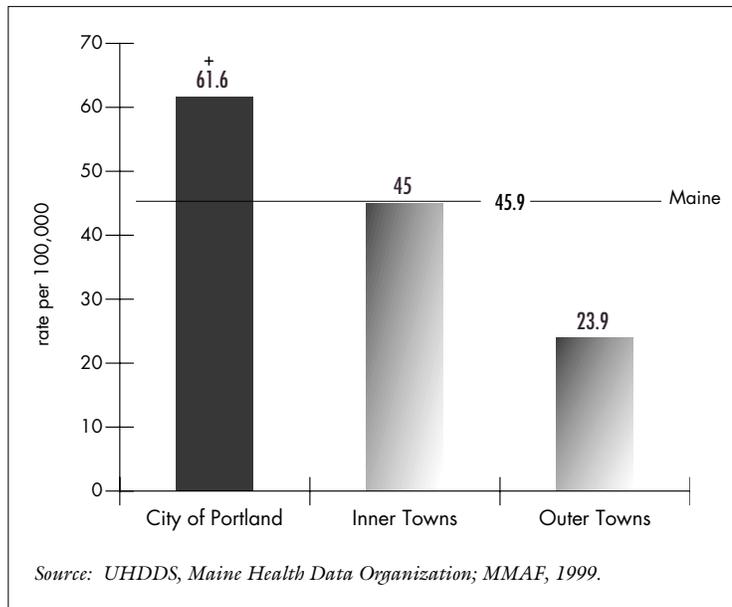
## Cardiovascular Disease

### ■ Hospital Discharge Rates for High Blood Pressure —

Greater Portland Area and Maine: 1996-1997 combined

(Rates are adjusted to Maine's 1996 population.)

- Portland's hospital discharge rate for hypertension, or high blood pressure, (which increases the risk of a heart attack or stroke) was significantly higher ( $p=.01$ ) than the state's. The Outer Town's rate was significantly lower.

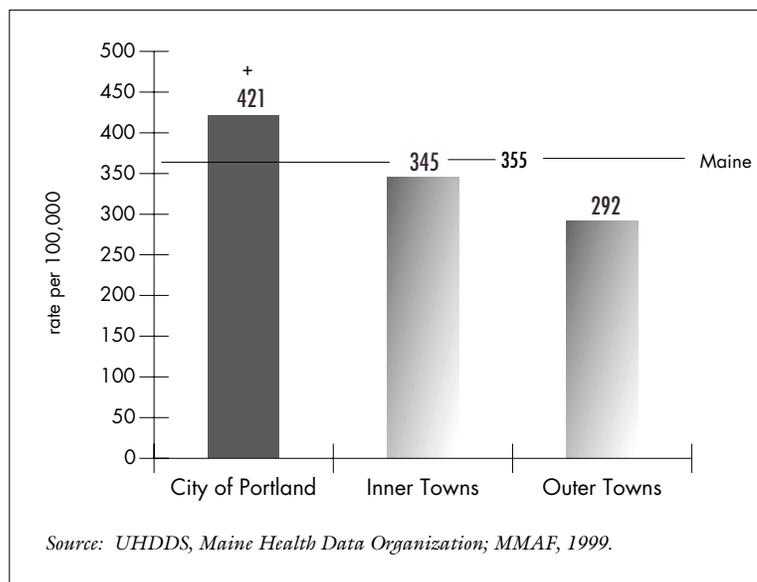


### ■ Hospital Discharge Rates for Congestive Heart Failure —

Greater Portland Area and Maine: 1996-1997 combined

(Rates are adjusted to Maine's 1996 population.)

- Portland's hospital discharge rate for congestive heart failure was significantly higher ( $p=.001$ ) than the state's. The Inner Towns' rate mirrored the state's while the Outer Towns' rate was significantly lower ( $p=.01$ ).

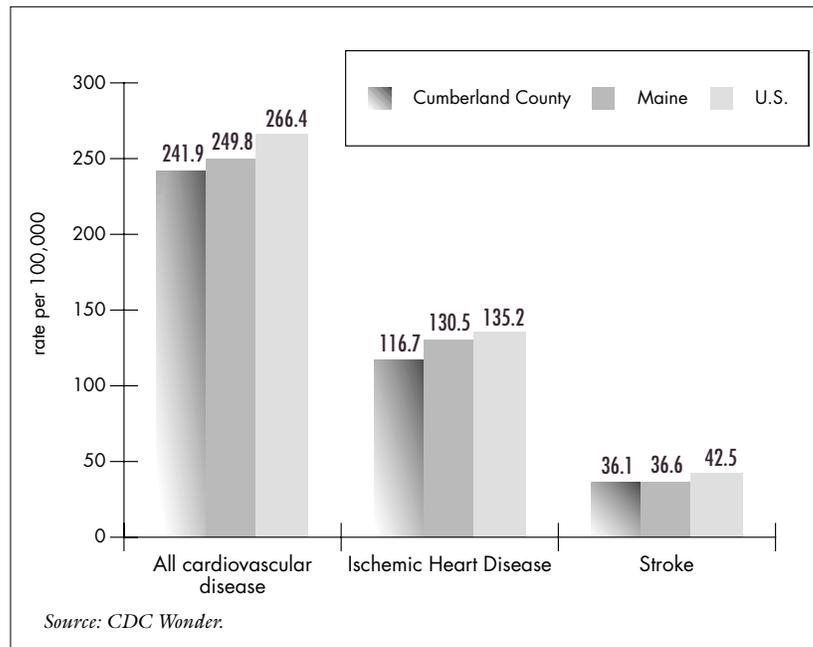


## ■ Cardiovascular Disease Mortality Rates —

Cumberland County, Maine, U.S.: 1995

(Rates are adjusted to the U.S. 1970 population.)

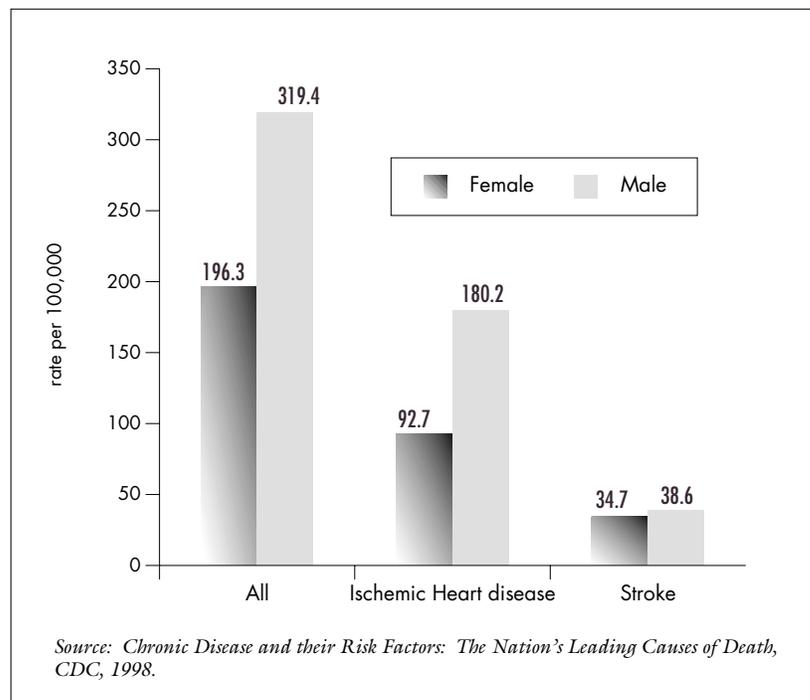
- Maine's death rates due to all cardiovascular diseases, ischemic heart disease, and stroke compare favorably to U.S. rates. Likewise, Cumberland County compares favorably to Maine with respect to these rates.



## ■ Cardiovascular Disease Death Rates, by Sex —

Maine: 1995 (Rates are adjusted to the U.S. 1970 population.)

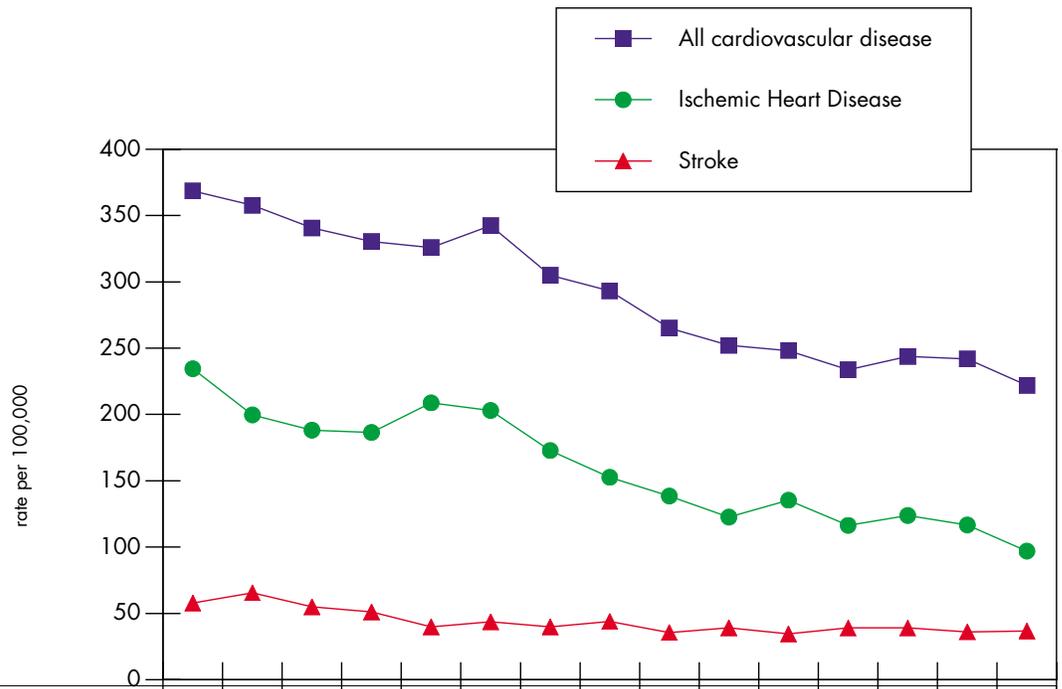
- Cardiovascular diseases are the most common causes of death in Maine, accounting for 37% of all deaths. Men are more likely than women to die of heart disease, which accounts for men's overall higher death rate due to all cardiovascular diseases.



■ **Death Rates of Total Cardiovascular Diseases, Ischemic Heart Disease and Stroke — Cumberland County: 1979 – 1996**

(Rates are adjusted to the 1970 population.)

- In Cumberland County, though mortality rates due to total cardiovascular diseases and ischemic heart disease have declined in the past 17 years, stroke mortality rates have not notably changed.



	1979	1980	1981	1983	1984	1985	1986	1987	1989	1990	1991	1992	1993	1995	1996
all cardiovascular disease	368.5	357.7	340.6	330.4	325.8	342.5	305.0	293.1	265.1	252.1	248.2	233.7	243.8	241.9	222.0
ischemic heart disease	234.5	199.7	188.2	186.4	206.7	203.0	172.8	152.6	138.5	122.6	135.5	116.4	123.8	116.7	97.0
stroke	57.9	65.6	55.0	51.1	39.9	43.6	39.8	43.9	35.5	39.2	34.5	36.8	39.0	36.1	38.8

Source: CDC Wonder.

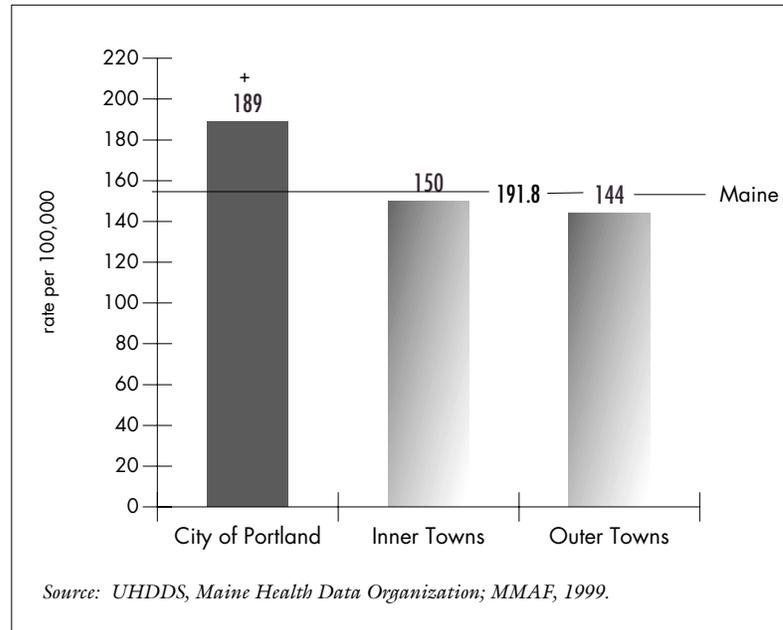
## Respiratory Disease

### ■ Hospital Discharge Rates for Chronic Bronchitis/Emphysema —

Greater Portland Areas and Maine: 1996-1997 combined

(Rates are adjusted to Maine's 1996 population.)

- Portland's hospital discharge rate for chronic bronchitis/emphysema was significantly higher ( $p=.001$ ) than the state's. The Inner and Outer Towns' rates were similar to the state's rates.

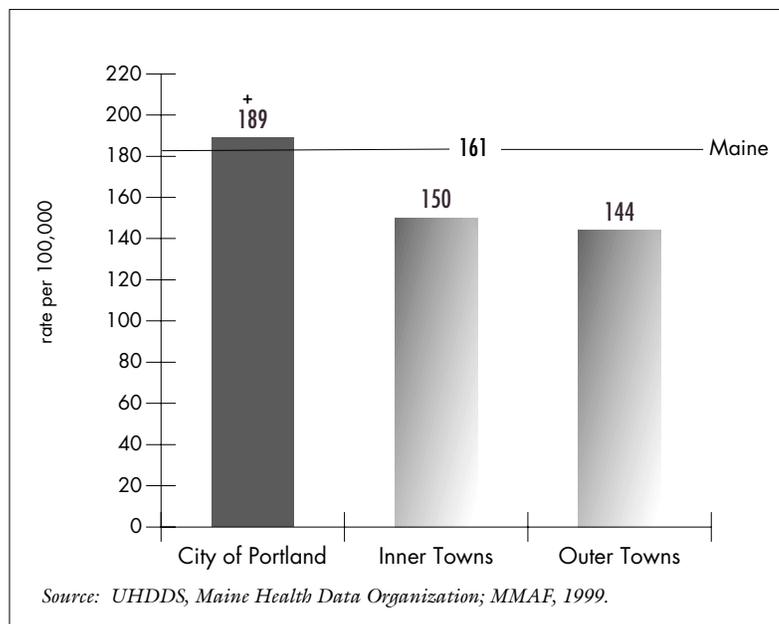


### ■ Hospital Discharge Rates for Pediatric Asthma —

Greater Portland Area and Maine: 1996-1997 combined

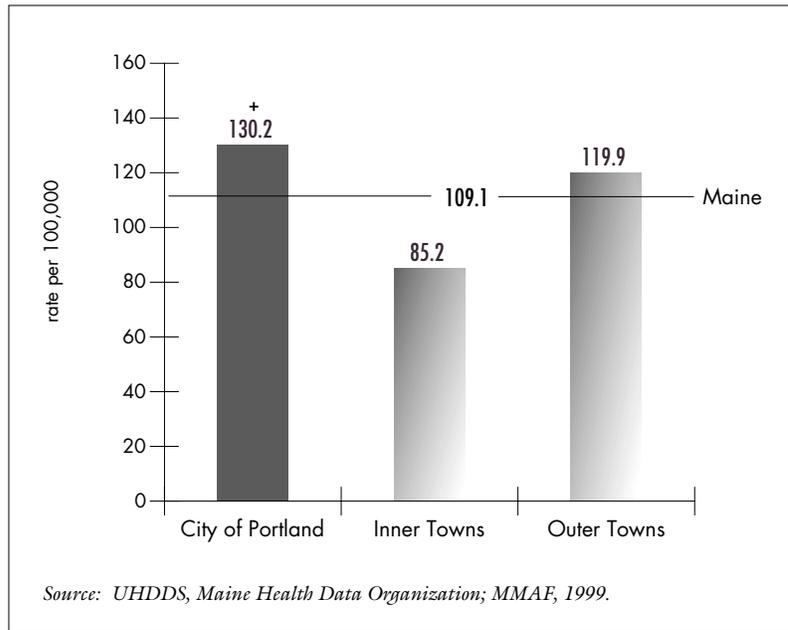
(Rates are adjusted to Maine's 1996 population.)

- Portland's hospital discharge rate for pediatric asthma was the highest of the three Greater Portland areas, and 17% above the state's. The Inner and Outer Town rates fell well below the state's.



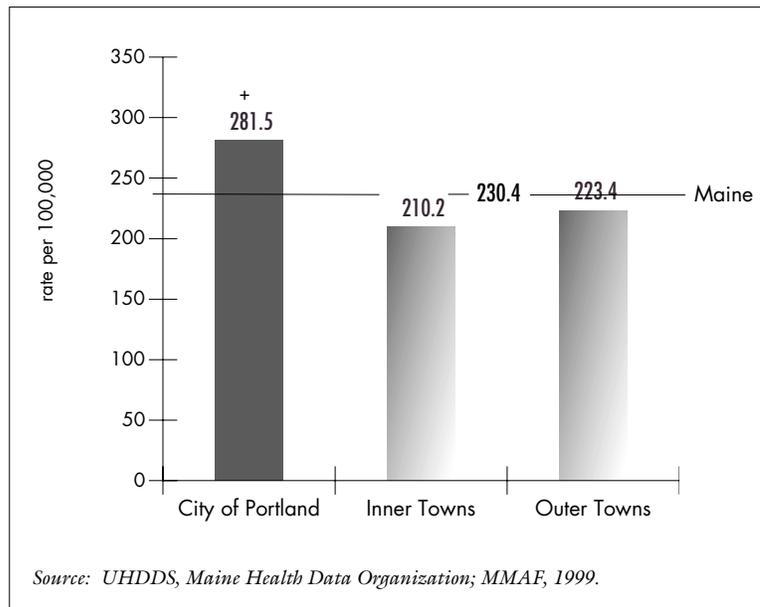
■ **Hospital Discharge Rates for Asthma —**  
**Greater Portland Area and Maine: 1996-1997**  
*(Rates are adjusted to Maine's 1996 population.)*

- Portland's hospital discharge rate for asthma was significantly higher ( $p=.05$ ) than the state's. The Outer Towns' rate mirrored the state's while the Inner Towns' rate was significantly lower ( $p=.001$ ).



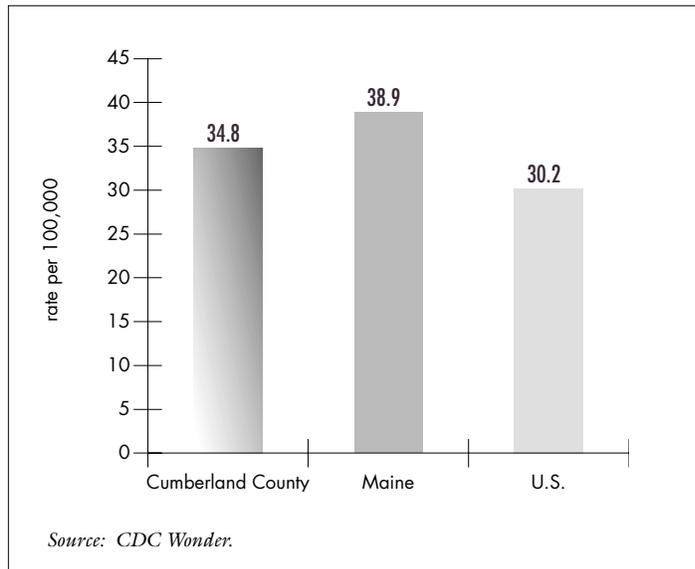
■ **Hospital Discharge Rates for COPD —**  
**Greater Portland Areas and Maine: 1996-1997**  
*(Rates are adjusted to Maine's 1996 population.)*

- Portland's hospital discharge rate for COPD was significantly higher ( $p=.001$ ) than the state's. The Outer Towns' rate mirrored the state's while the Inner Towns' rate was significantly lower ( $p=.05$ ).



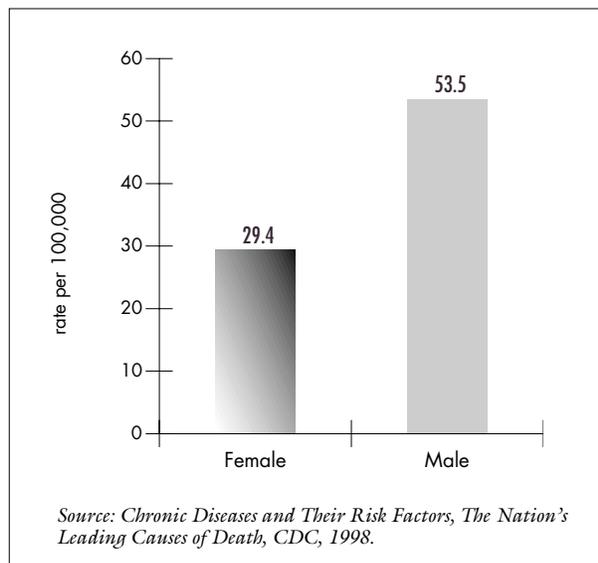
■ **Chronic Obstructive Pulmonary Disease (COPD) Death Rates —**  
**Cumberland County, Maine and U.S.: 1995**  
*(Rates are adjusted to the U.S. 1970 population.)*

- Cumberland County's COPD mortality rate is higher than the national rate and so is Maine's.



■ **COPD Death Rates, by Sex —**  
**Maine: 1995** *(Rates are adjusted to the U.S. 1970 population.)*

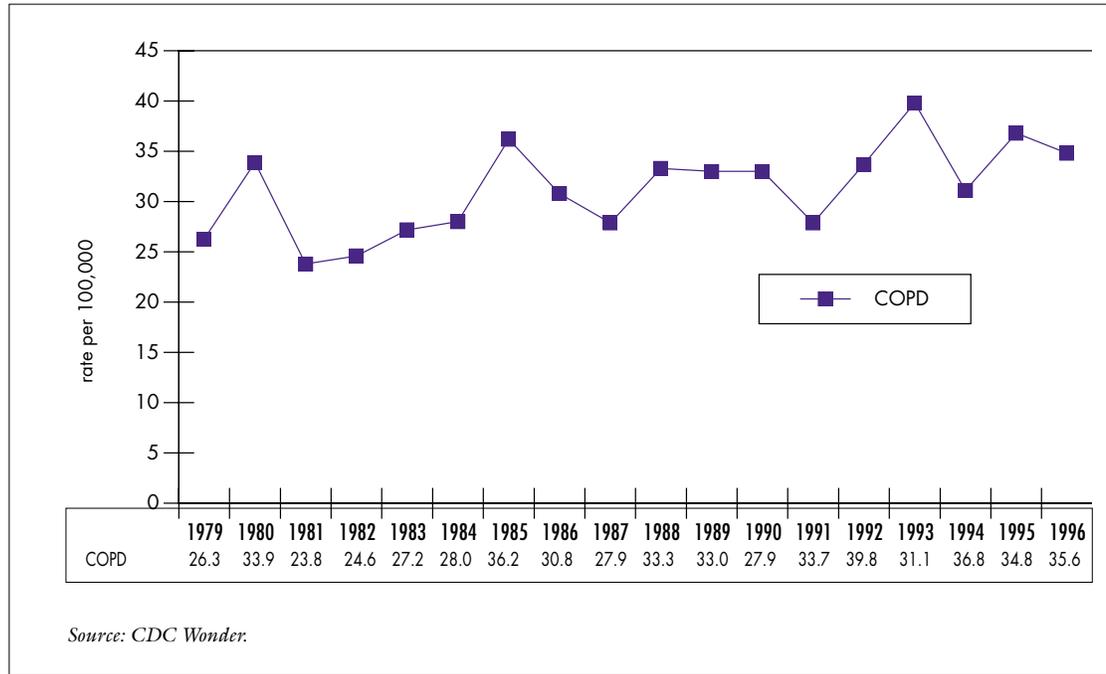
- The COPD mortality rate was higher for males than for females in 1995.



■ **COPD Death Rate — Cumberland County: 1982 – 1996**

(Rates are adjusted to the U.S. 1970 population.)

- Between 1979 and 1996, the COPD mortality rate Cumberland County increased by 35%.



# Diabetes

## ■ Estimated Prevalence of Adult Diabetes (diagnosed and undiagnosed) — Greater Portland Area and Maine: 1999

(Rates are per 1,000 and estimated to Maine's 1996 population.)

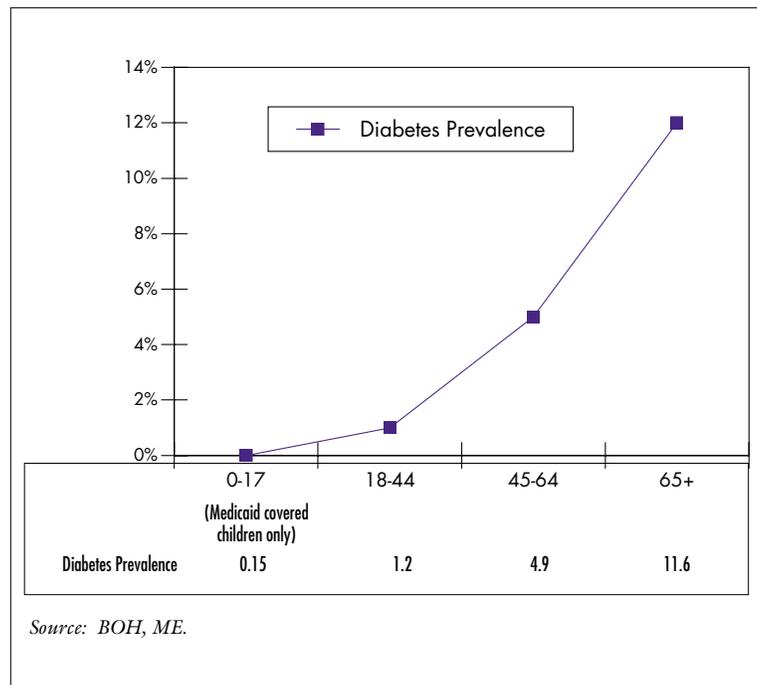
- Much diabetes exists in the population, undiagnosed.

population	undiagnosed		diagnosed		undiagnosed & diagnosed	
	number	rate	number	rate	number	rate
City of Portland .... 63,357 .....	998	15.8	1,996	31.50	2,994	47.3
Inner Towns ..... 122,500 .....	1,987	16.2	3,973	32.43	5,960	48.7
Outer Towns ..... 42,374 .....	594	14.0	1,187	28.01	1,781	42.0
Total HSA ..... 228,231 .....	3,578	15.7	7,156	31.35	10,734	47.0

Source: Maine Diabetes Control Project, BOH, ME.

## ■ Estimated Percent of Maine Residents with Diabetes (diagnosed and undiagnosed) by Age — Maine: 1995-1997 combined

- Diabetes prevalence sharply increases and continues increasing in the population over 40 years old.

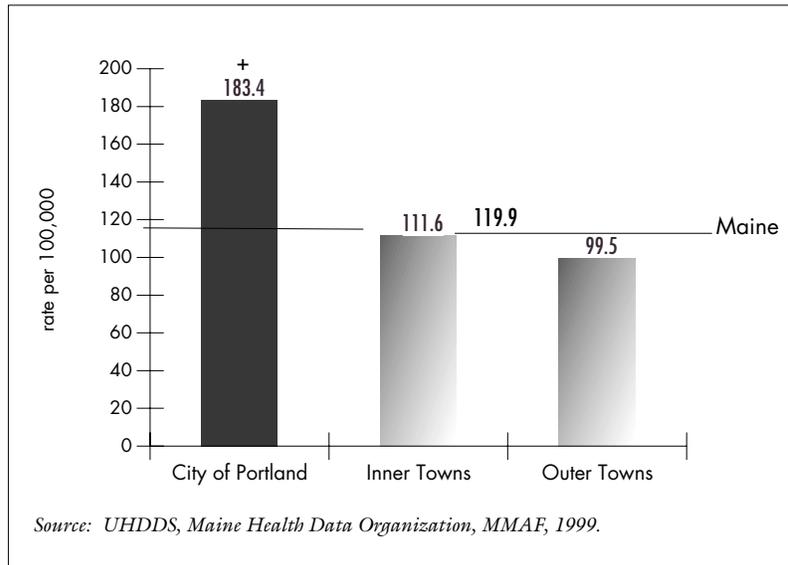


■ **Hospital Discharge Rates for Diabetes —**

Maine and Greater Portland Area: 1996-1997

(Rates are adjusted to Maine's 1996 population.)

- Diabetes hospital discharges for City of Portland residents occurred at a significantly higher rate ( $p = .001$ ) than the state and the surrounding towns.
- Hospital discharge rates for diabetes are likely to be undercounted because diabetes may be a contributing factor to hospitalization but will not necessarily be listed as the principle diagnosis.

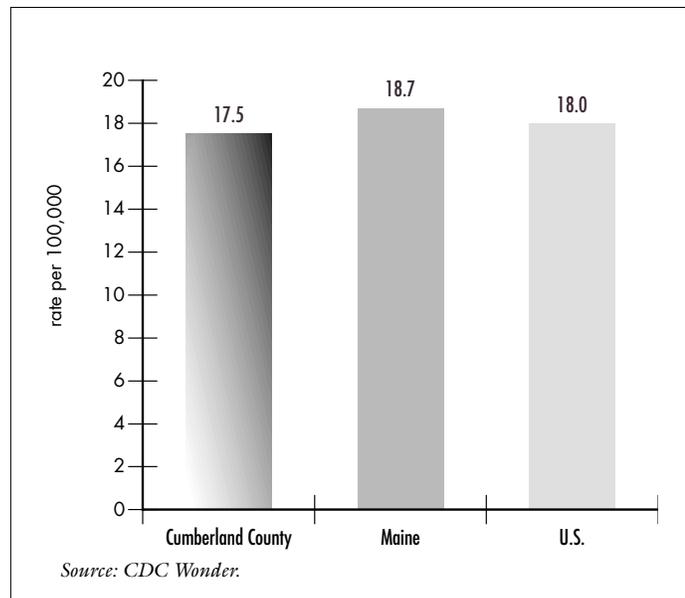


■ **Diabetes Mortality Rates —**

Cumberland County, Maine and U.S.: 1995

(Rates are adjusted to the U.S. 1970 population.)

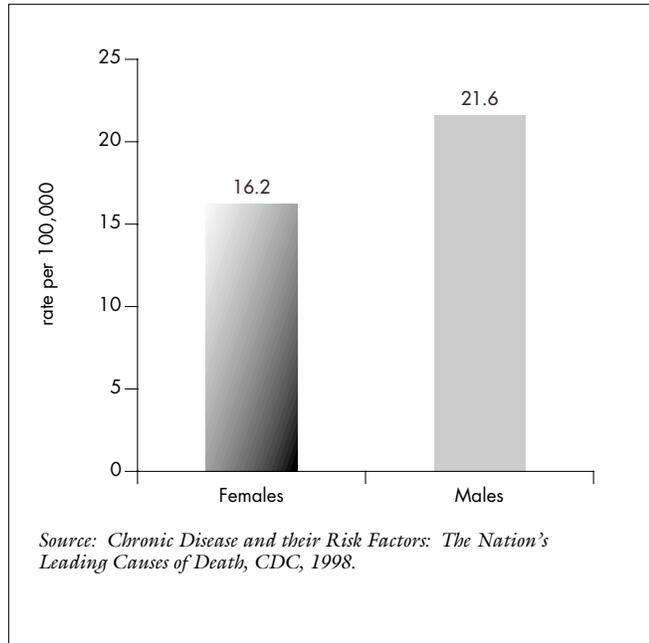
- Cumberland County's diabetes mortality rate appeared lower than the national rate and Maine's appeared higher. However, diabetes is believed to be underreported on death certificates so this data is inconclusive.



■ **Diabetes Mortality, by Sex — Maine: 1995<sup>iv</sup>**

(Rates are adjusted to the U.S. 1970 population.)

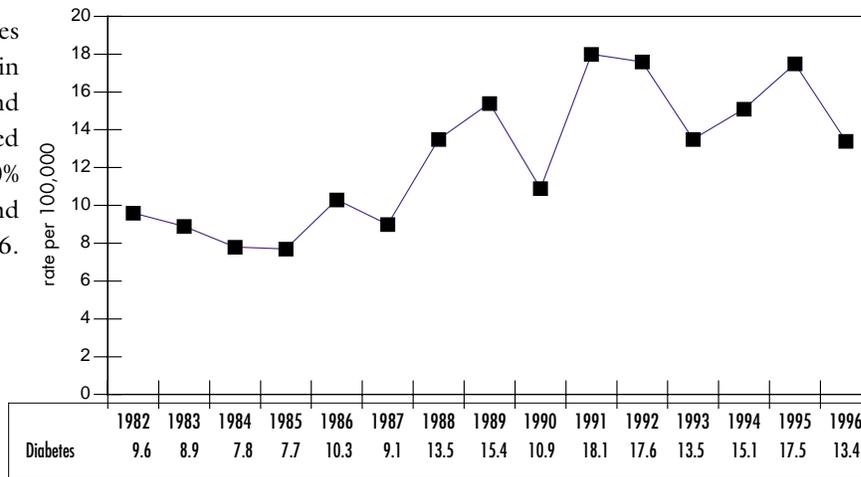
• Diabetes, the fifth most common cause of death in Maine, has a higher mortality rate for males than females.



■ **Diabetes Mortality Rates — Cumberland County: 1982 – 1996**

(Rates are adjusted to the U.S. 1970 population.)

• Diabetes mortality in Cumberland County increased by nearly 40% between 1982 and 1996.



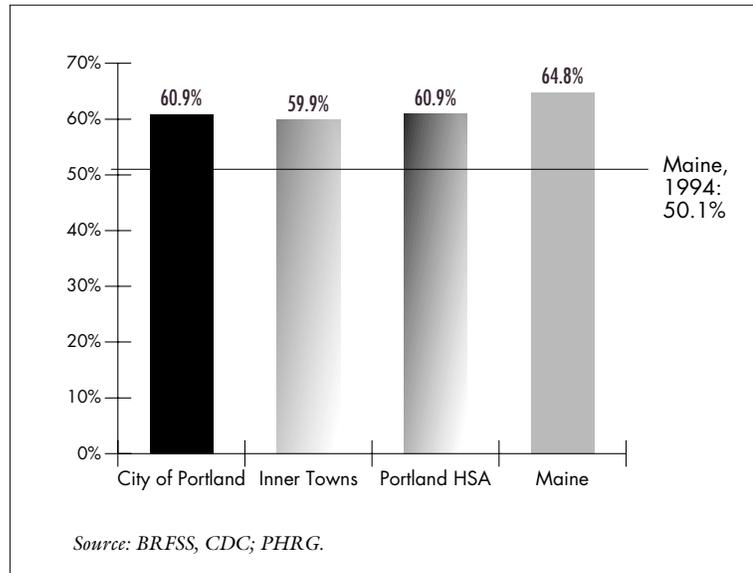
Source: CDC Wonder.

## Cancer

### ■ Percentage of Women, Age 50+, Who Have Had a Mammogram in the Past Year —

Greater Portland Area and Maine: 1996 - 1997 combined (with 1994 Maine benchmark)<sup>v</sup>

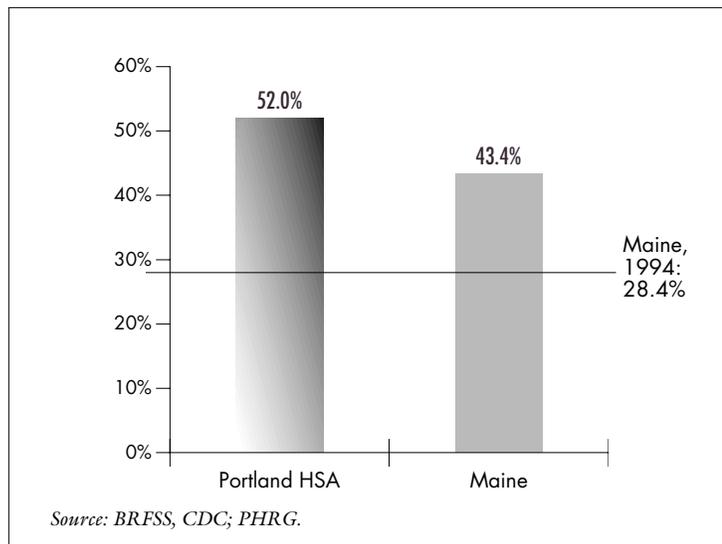
- The Greater Portland Area and the state have increased breast cancer screening rates for women age 50 years and older.



### ■ Percentage of Adults, Age 50+, Who Have Ever Had a Sigmoidoscopy or Proctoscopic Exam —

Portland HSA and Maine: 1997 (with 1994 Maine benchmark)

- Colorectal cancer screening rates have improved considerably since 1994 in both the Portland HSA and Maine.

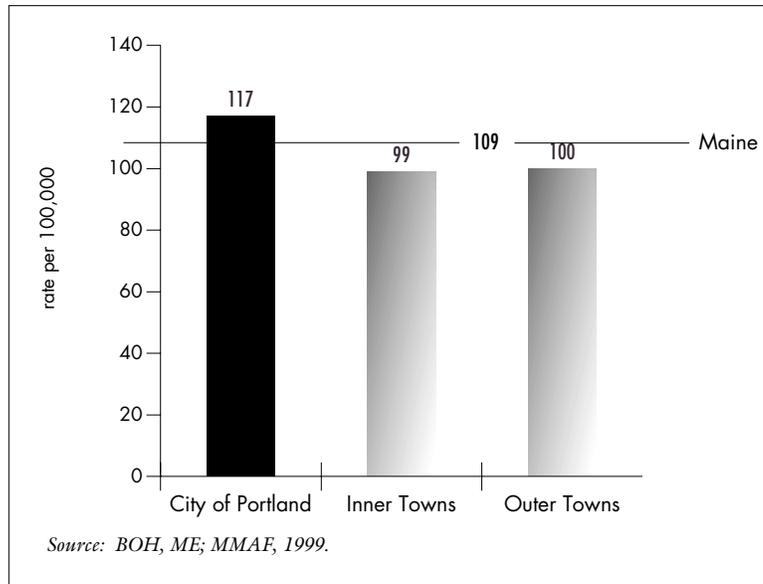


■ **Breast Cancer Incidence Rates —**

**Greater Portland Area: 1993-1994 combined**

*(Rates are adjusted to Maine's 1992-1993 population.)*

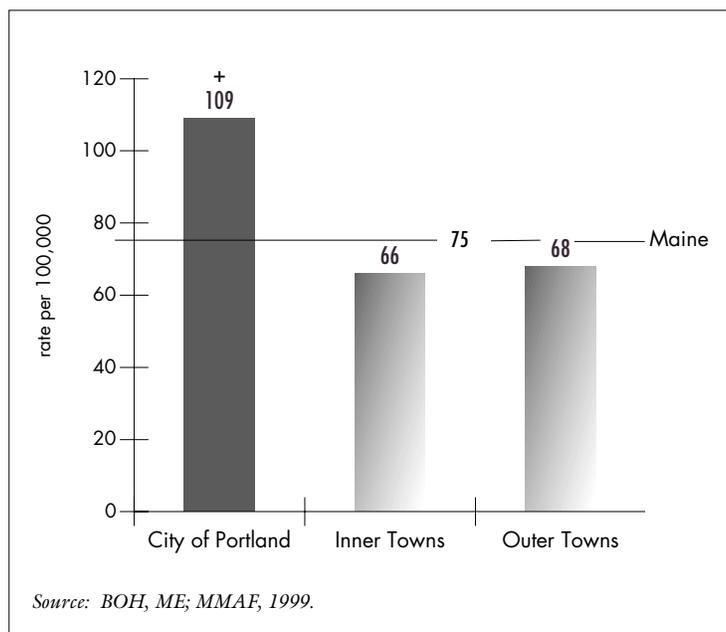
- The City of Portland's incidence rate for breast cancer is higher than the state's. This is not true of the rest of the Greater Portland Area.
- Early detection was most often achieved among residents of the Inner Towns (92% detected before stage 3). In Portland, 86% of cases were detected at this early stage, and in the Outer Towns, 78% were detected early.<sup>vi</sup>



■ **Lung Cancer Incidence Rates — Greater Portland Area: 1993-1994 combined**

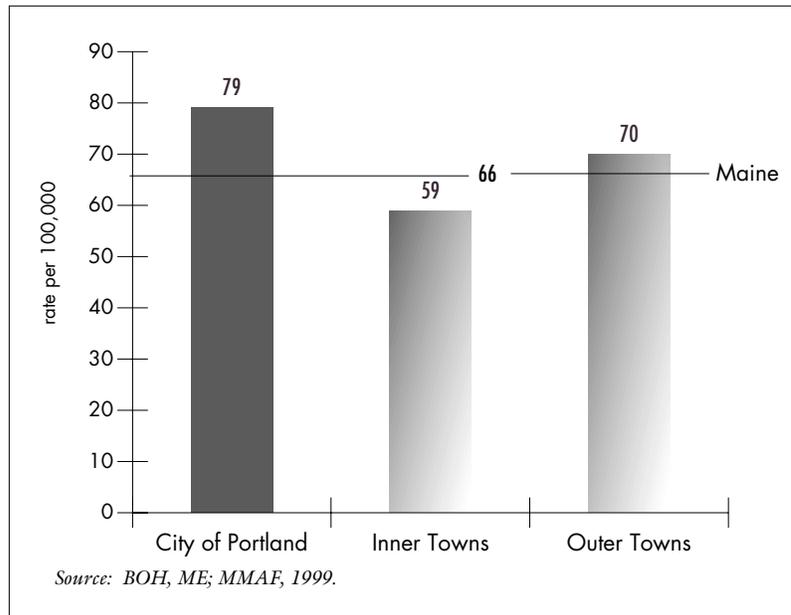
*(Rates are adjusted to Maine's 1992-1993 population.)*

- The City of Portland's lung cancer incidence rate is significantly higher than the state's rate (p=.001).
- The majority (69%) of lung cancer cases were detected at a late stage (stage 3 or later).



■ **Colorectal Cancer Incidence Rates — Greater Portland Area: 1993-1994 combined**  
(Rates are adjusted to Maine's 1992-1993 population.)

- Portland's colorectal cancer incidence rate is higher than the state's.<sup>vii</sup> Both Inner and Outer Towns exhibit rates very similar to the state's.

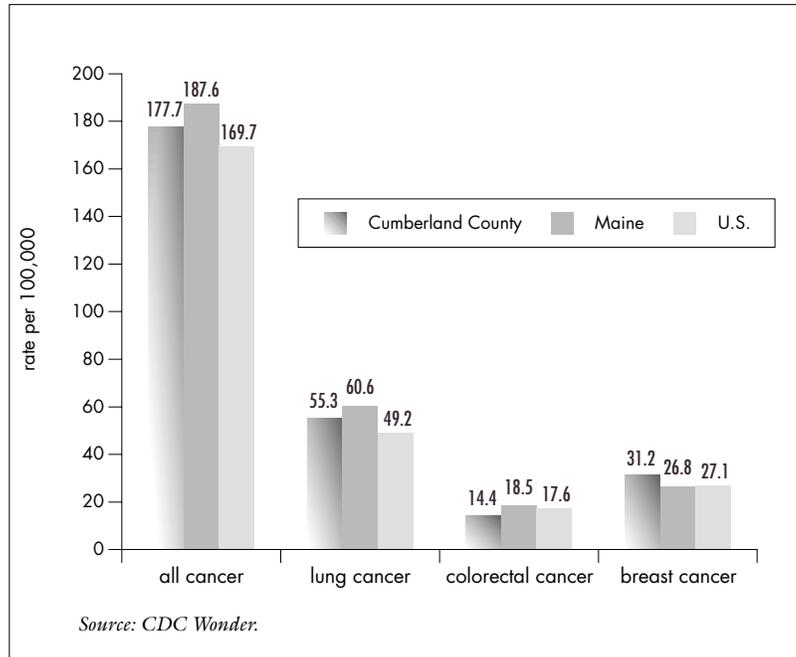


## ■ Cancer Mortality Rates —

### Cumberland County, Maine and U.S.: 1995

(Rates are adjusted to the U.S. 1970 population.)

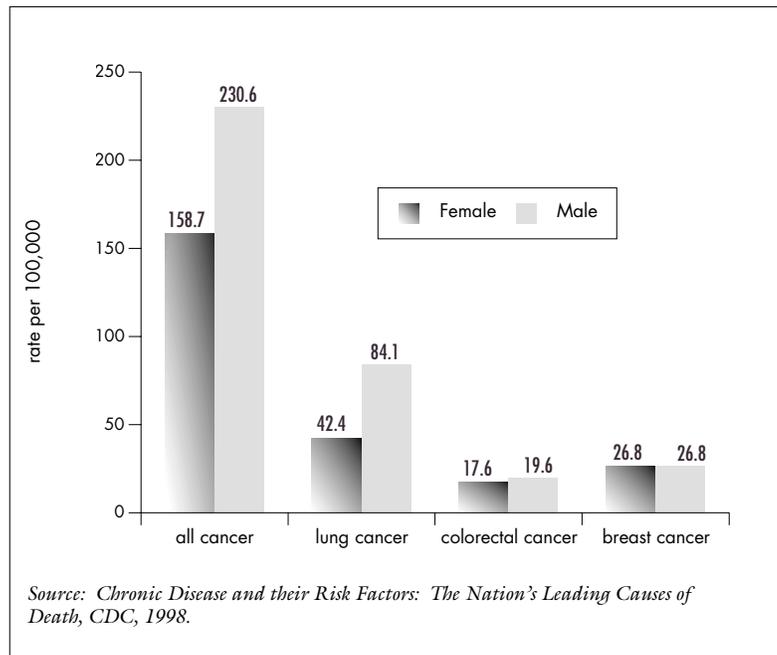
- Maine ranks sixth highest in the nation for deaths due to all cancers and third highest in the nation for deaths due to lung cancer. For all cancers and lung cancer, Cumberland County's rates fall between the nation's and the state's. Though lower than the nation and state for colorectal cancer, Cumberland County's breast cancer rate is higher than both.



## ■ Cancer Mortality Rates, by Sex — Maine: 1995

(Rates are adjusted to the U.S. 1970 population.)

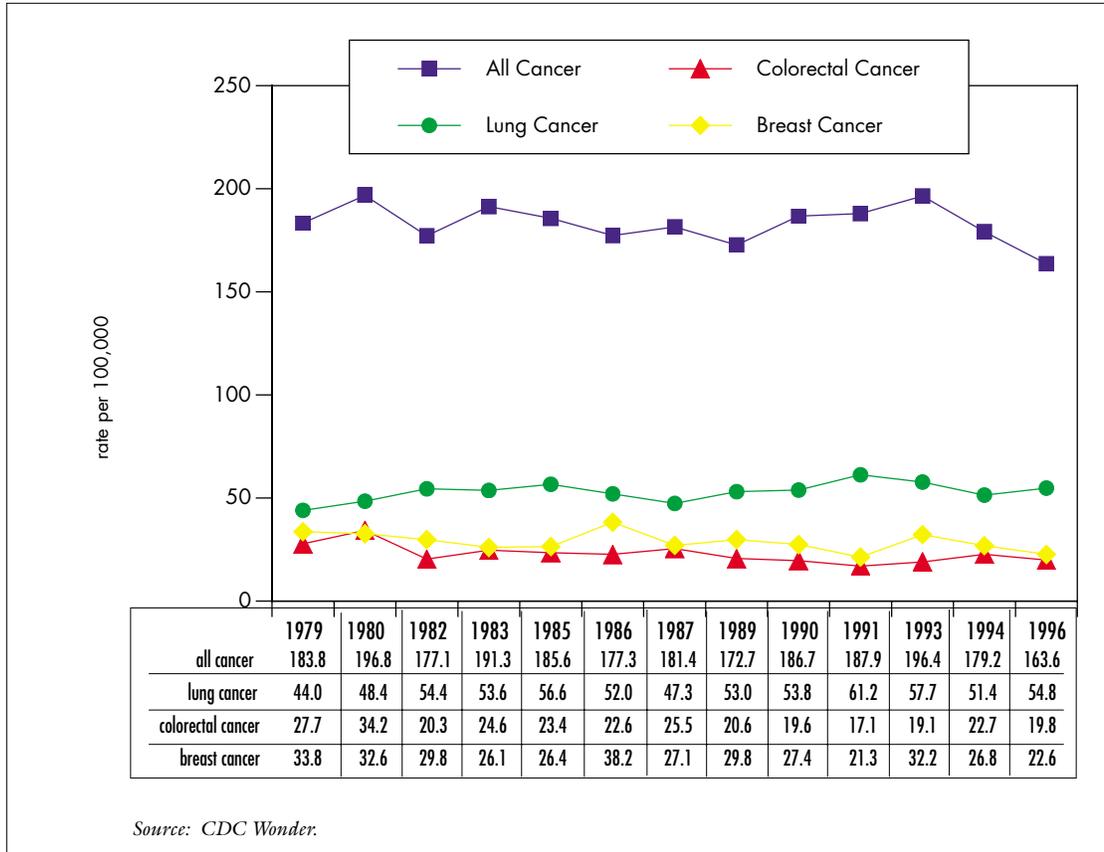
- Cancer accounted for 28% of all deaths in Maine in 1995. In general, more males than females die of cancer, particularly lung cancer.



■ **Cancer Mortality Trend — Cumberland County: 1979 – 1996**

(Rates are adjusted to the U.S. 1970 population.)

- In Cumberland County, mortality rates for all cancers, colorectal cancer, and breast cancer have declined between 1979 and 1996. The lung cancer mortality rate, however, has increased.



## Endnotes

- i “Overweight” as defined by Body Mass Index (BMI); BMI=kilograms/(meters<sup>2</sup>). Males with a BMI≥27.8 and females with a BMI≥27.3 are considered at risk.
- ii 1997 Maine data is from the CDC’s BRFSS web site. Local data combines 1996-1997 from the BRFSS and was prepared by the PHRG. 1994 data was collected by Market Decisions in a survey that mimicked the BRFSS. Results from this survey were reported in the *Community Health Profile of the Greater Portland Region, 1994*. The 1994 analysis differs from the 1996-1997 analysis in that Freeport was not included as an Inner Town, nor as a member of the region (HSA), in 1994.
- iii The state figure is not available for 1994 so we substitute the 1992 rate, as found in the 1994 *Community Health Profile of the Greater Portland Region*. The 1994 Market Decisions survey of the Portland HSA was conducted in July and August. This may result in higher than normal reported activity levels since the BRFSS is conducted year round to eliminate the seasonal effect.
- iv Maine’s Bureau of Health has been conducting an extensive epidemiological analysis of diabetes in Maine. Comparing age-adjusted mortality rates they note that while Maine’s diabetes prevalence is lower than the nation’s, Maine’s mortality from diabetes is higher than the nation’s. Currently, Maine’s Diabetes Control Project is participating in a national study that will lend insight into the issue of whether or not Maine residents with diabetes are dying at a rate higher than such residents in two other New England states. The study will follow the vital status of individuals who are known to have diabetes, thus eliminating the problem of underreporting diabetes on the death certificate.
- v 1994 data was collected by Market Decisions in a survey that mimicked the BRFSS. Results from this survey were reported in the *Community Health Profile of the Greater Portland Region, 1994*. The 1994 analysis differs from the 1996-1997 analysis in that Freeport was not included as an Inner Town, nor as a member of the region (HSA), in 1994.
- vi This excludes stage O (DCIS) cancers.
- vii Although statistical testing does not determine the difference to be significant, obs/exp case ratio shows Portland at 21% higher than expected.

Conditions	ICD-9 Code	ICD-9 Codes used in MMAF’s analysis of ambulatory care sensitive conditions
all cardiovascular conditions	390 – 459	
heart disease	390-398, 402, 404-429	
ischemic Heart Disease	410 – 414	
congestive heart failure		428, 402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93
cerebrovascular disease (stroke)	430-438	
hypertension		401-405
COPD	490-496	490-496
chronic bronchitis and emphysema		491-492
asthma		493
diabetes	250	250
cancer - all	140-208	
breast cancer	174	
lung cancer	162.2-162.9	
colorectal cancer	153-154	

# HIV/AIDS, Other Sexually Transmitted Diseases (STDs), and Sexual Risk Behaviors (SRBs)

## Healthy People 2010 HIV Goal

*Prevent HIV transmission and its related illness and death.*

## Healthy People 2010 STD Goal

*Promote responsible sexual behaviors, strengthen community capacity, and increase access to quality services to prevent STDs.*

National Health  
Disparities  
HIV/AIDS, STDs and  
SEXUAL RISK BEHAVIORS

### Race

HIV infection  
gonorrhea infection  
syphilis infection  
pelvic inflammatory disease  
adolescent sexual intercourse

### Sex

HIV infection

### Age

gonorrhea infection  
pelvic inflammatory disease

## CONTENTS

**150 AIDS and HIV**

**155 STDs**

**157 SRBs**



“It takes two to get one in trouble.”

— Mae West

“We are shaped and fashioned by  
what we love.”

— Goethe



# Greater Portland Community Health Assessment and Source Book

## HIV / AIDS<sup>1</sup>; Other Sexually Transmitted Diseases (STDs); and Sexual Risk Behaviors (SRBs)

GREATER PORTLAND AREA, MAINE and U.S. RATES with YEAR 2000 OBJECTIVES

Rates are per 100,000 population unless otherwise noted.

Indicators	Portland HSA RATE	Maine Rate	U. S. Rate	HM 2000 Goal	HP 2000 Goal
<b>HIV / AIDS</b>	Cumberland County				
AIDS death rate <sup>1</sup>	6.4	3.9	11.9	■	■
ages 25-44	14.2	9.2	27.0	■	■
males, ages 25-44	26.8	16.7	46.2	■	■
AIDS prevalence rate <sup>2</sup> (persons reported to be living with AIDS)	City of Portland				
adults / adolescents	98.4	30.8	105.7	■	■
children < 13 years old	■	36.4	128.7	■	■
children < 13 years old	■	3.3	6.9	■	■
AIDS incidence rate <sup>2</sup>	15.9	3.4	17.1	5.0	43.0
HIV infection estimated prevalence rate <sup>3</sup> (persons living with HIV infection)	■	89.8	284.2	■	■
Percentage of adults who have been tested for HIV <sup>4</sup>	36.1%	36.6%	42.6%	■	■
percent tested and received test results	30.3%	30.0%	37.0%	■	■
percent tested, received test results and received post-test counseling	12.0%	11.9%	12.9%	■	■
Percentage of adults who report changing their sexual behavior in the last 12 months, due to knowledge of HIV <sup>4</sup>	11.0%	8.4%	9.9%	■	■
percentage who now have sexual intercourse with only one partner	8.3%	6.7%	7.9%	■	■
percentage who now always use condoms for protection	7.4%	5.1%	5.5%	■	■
Percentage of adults who believe they are not at risk of getting infected with the HIV virus <sup>4</sup>	63.6%	66.2%	65.9%	■	■
Percentage of adults who believe HIV/AIDS education should begin before high school <sup>4</sup>	91.8%	91.1%	94.5%	■	■
Percentage of high school students who were taught about HIV/AIDS in school <sup>4</sup>	■	93.0%	91.5%	■	■
males	■	91.0%	91.6%	■	■
females	■	95.0%	91.3%	■	■
Percentage of high school students who talked about HIV/AIDS with parents or other adult family members <sup>4</sup>	■	62.3%	62.8%	■	■
males	■	55.7%	59.1%	■	■
females	■	69.4%	67.4%	■	■

■ = data not available For Source Notes, see page 140.

GREATER PORTLAND AREA, MAINE and U.S. RATES with YEAR 2000 OBJECTIVES

Rates are per 100,000 population unless otherwise noted.

	Cumberland County Rate	Maine Rate	U. S. Rate	HM 2000 Goal	HP 2000 Goal
<b>Other STDs</b>					
Gonorrhea incidence rate <sup>5</sup>	10.0	5.0	123.0	10.0	225.0
Primary and secondary syphilis incidence rate <sup>5</sup>	<1.0	<1.0	3.2	1.0	10.0
Chlamydia incidence rate <sup>5</sup>	116.0	86.0	207.0	170.0	■
adolescents (age 15 - 19)	■	538.0	■	■	■
<b>Sexual Risk Behaviors</b>					
Percentage of high school students who are currently sexually active <sup>6</sup>	■	36.2%	34.8%	■	■
males	■	34.0%	33.4%	■	■
females	■	38.3%	36.5%	■	■
Percentage of high school students who have ever had sexual intercourse <sup>6</sup>	■	51.6%	48.4%	■	■
males	■	52.9%	48.9%	■	■
females	■	50.1%	47.7%	■	■
Percentage of adolescents who had first sexual intercourse by age 15 <sup>6</sup>	■	34.0%	■	■	15.0%
Percentage of high school students who had first sexual intercourse by age 13 <sup>6</sup>	■	6.8%	7.2%	■	■
males	■	9.2%	9.4%	■	■
females	■	4.3%	4.5%	■	■
Percentage of high school students who have had 4 or more sexual partners <sup>6</sup>	■	12.5%	16.0%	■	■
males	■	13.2%	17.6%	■	■
females	■	11.9%	14.1%	■	■
Percentage of high school students who used a condom at last sexual intercourse <sup>6</sup>	■	50.7%	56.8%	■	■
males	■	56.6%	62.5%	■	75.0%
females	■	44.8%	50.8%	■	60.0%
Percentage of high school students who were using alcohol or other drugs at last sexual intercourse <sup>6</sup>	■	24.2%	24.7%	■	■
males	■	31.2%	30.5%	■	■
females	■	18.5%	17.2%	■	■
Percentage of adults who would encourage sexually active teenagers to use condoms <sup>4</sup>	■	92.3%	90.0%	■	■
■ = data not available    For Source Notes, see page 140.					

source number	Greater Portland Area	Maine	U.S.	notes
1	1990-1997 CDC Wonder	1990-1997 CDC Wonder	1990-1997 CDC Wonder	
2	1999 HARS, BOH, ME	1999 HARS, BOH, ME	1999 HIV/AIDS Surveillance Report, CDC	
3	■	1999 BOH, ME	1999 HP 2010	We use the midpoint of the estimated range to represent prevalence rate.  <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;"> <u>range</u>            Maine: 950-1,300         </div> <div style="text-align: center;">           —         </div> <div style="text-align: center;"> <u>midpoint</u>            1,125         </div> </div> U.S.: 650,000 -900,000 — 775,000
4	1996-1997 BRFSS, CDC	1997 BRFSS, CDC	1997 BRFSS, CDC	Greater Portland Area rates prepared by the PHRG.
5	1997 BOH, ME	1997 BOH, ME	1997 CDC Wonder	
6	■	1997 YRBS, CDC	1997 YRBS, CDC	

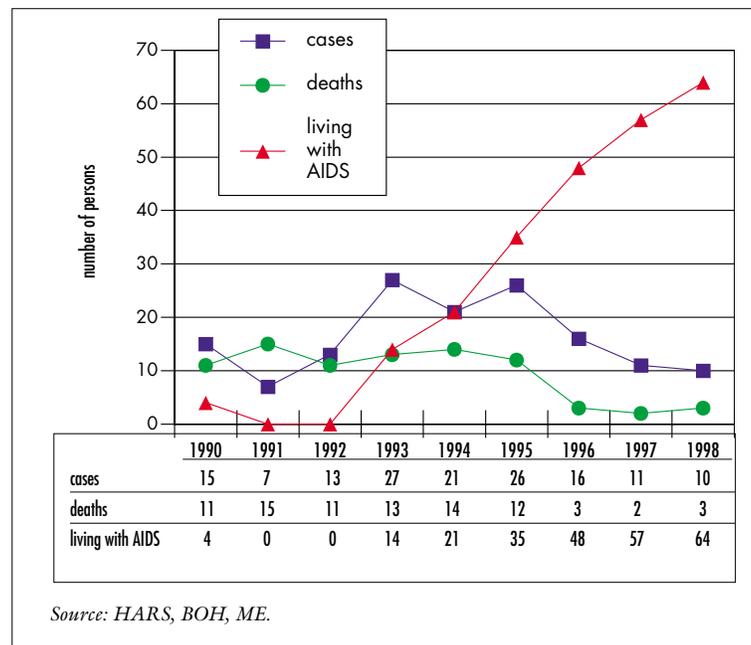
## On the Status of AIDS<sup>i</sup> in the United States

Currently, HIV/AIDS has been reported in virtually every racial and ethnic population, every age group, and every socioeconomic group in every state and most large cities in the United States. Initially identified among men who have sex with men on the East and West Coasts, the AIDS epidemic is composed of diverse multiple subepidemics that vary by region and community. By the end of 1998, more than 680,000 cases of AIDS had been reported, and nearly 410,800 people had died from HIV disease or AIDS.

—Healthy People 2010

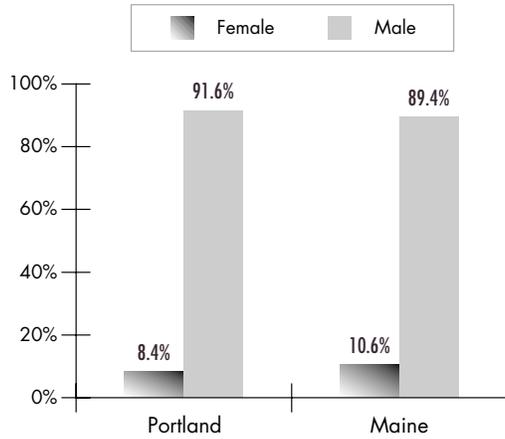
## ■ AIDS Cases, Deaths and Prevalence — City of Portland: 1990-1998

- While the incidence of new AIDS cases has declined since its peak in the mid 1990s, the number of individuals living with AIDS has increased, due to new highly active antiretroviral therapy (HAART).
- Because of the long period of time from initial HIV infection to AIDS (often 8 to 10 years or more), and the retarding of progression from HIV infection to AIDS (along with increased AIDS survivorship) due to HAART, AIDS incidence is no longer an indicator of the status of the HIV epidemic.
- Reporting of HIV and AIDS is based on residence of the client at the time of testing or diagnosis. Therefore, people with HIV or AIDS who have come to our area since testing or diagnosis, are not represented in the data.<sup>ii</sup>



**■ AIDS Cases, by Sex — Portland and Maine: 1984-1998 combined**

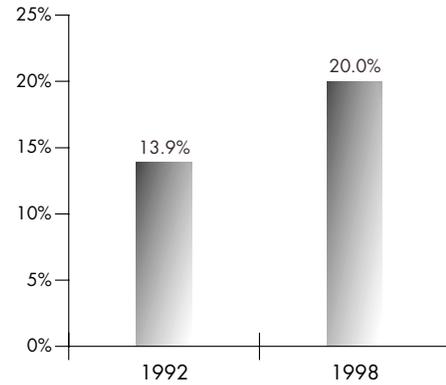
- The percentage of female AIDS cases in the City of Portland, as in Maine overall, is very low.



Source: HARS, BOH, ME.

**■ Women as a Percent of Persons Over Age 13 Living with AIDS — U.S.: 1992 and 1998**

- Nationally, women, as a proportion of people over 13 years old living with AIDS, increased by 44% between 1992 and 1998.

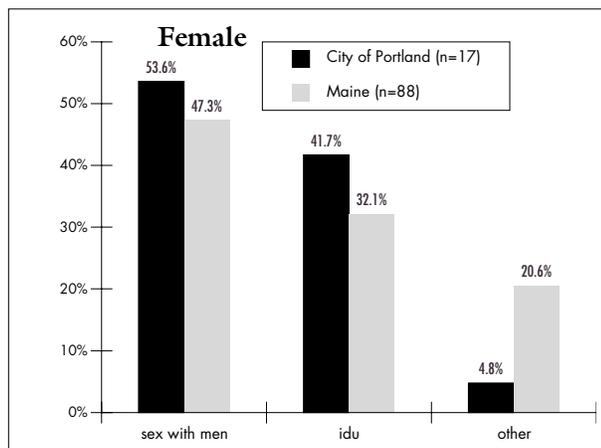
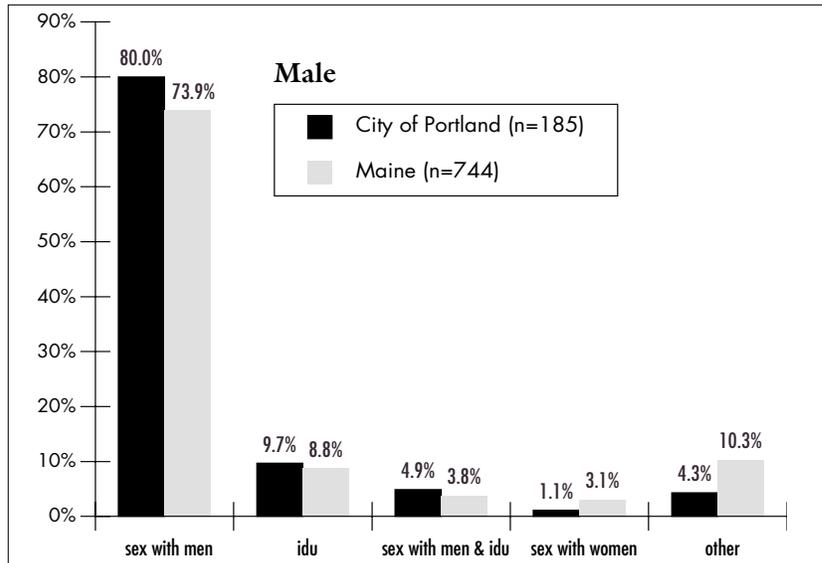


Source: HP 2010, US DHHS.

**■ AIDS Cases, by Transmission Category<sup>iii</sup> —**

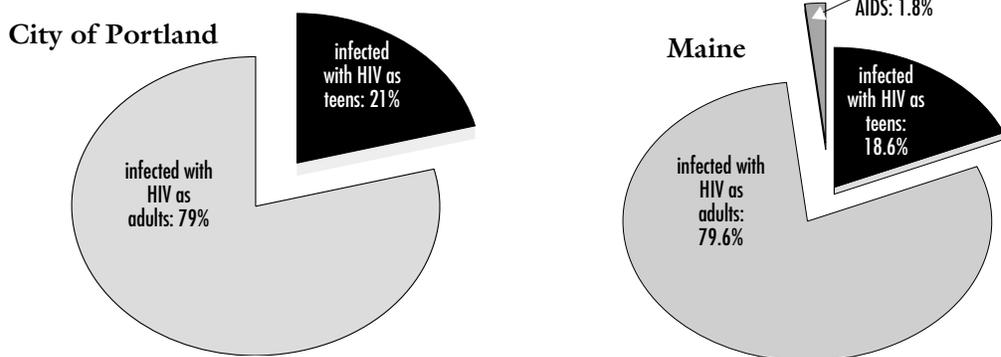
City of Portland and Maine: 1984-1998 combined

- Unprotected sex with men, and sharing drug-injection equipment with an HIV-infected individual, account for most HIV transmissions and cases of AIDS in Portland and in Maine overall (as well as nationwide).



Source: HARS, BOH, ME.

■ **Percent of AIDS Cases by Age at HIV Infection —**  
**Portland and Maine: 1984 – 1998 combined**

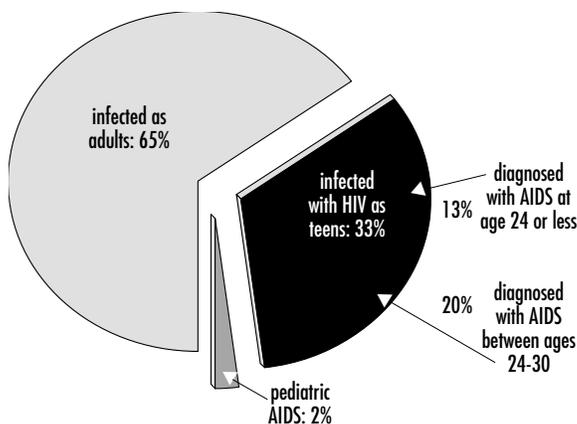


Source: HARS, BOH, ME.

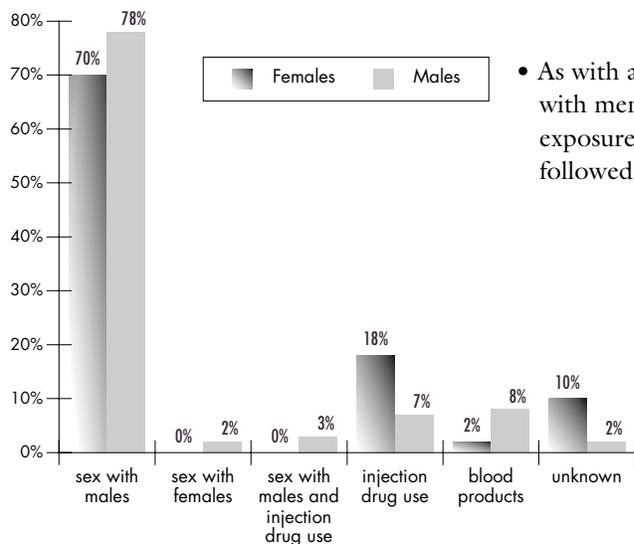
- Since 1984 in the City of Portland and in Maine, around 20% of reported AIDS diagnosis occurred among individuals who were less than 30 years old, meaning they were infected with HIV in their teens or early 20s.

■ **Percent of Female AIDS Cases by Age at HIV Infection —**  
**Maine: 1984 - 1998 combined**

- In Maine, 33% of AIDS diagnosis among women occurred in individuals under 30 years old, (meaning that many were infected in their teens or early 20s.) Thirteen percent were under 24 years old when they received their AIDS diagnosis.



■ **Mode of Exposure to HIV by Teens<sup>iv</sup> —**  
**Maine: 1984 – 1998 combined**

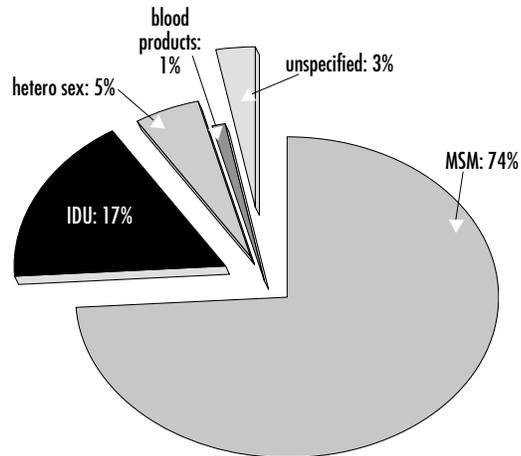


- As with adults, unprotected sex with men is the primary mode of exposure to HIV for teens, followed by injection drug use.

Source: HARS, BOH, ME.

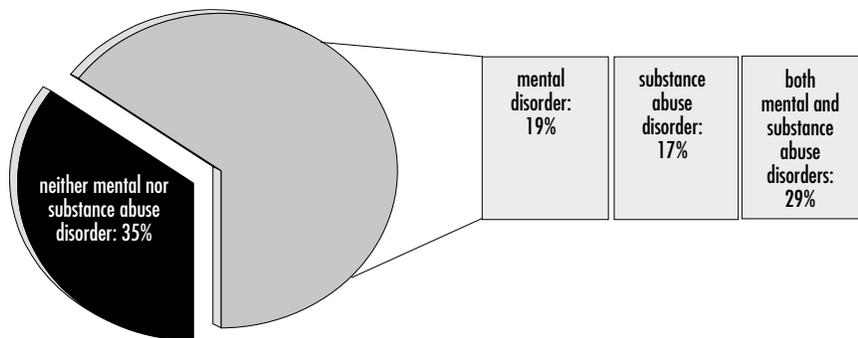
■ **HIV Infection by Transmission Category<sup>v</sup> — City of Portland: 1984- September 1998 combined (n=202 AIDS cases)**

- In the City of Portland, the vast majority of HIV transmission occurs by men having sex with men (MSM), though a substantial proportion of transmissions occurs through injection drug use (IDU).



Source: HARS, BOH, ME.

■ **HIV-Infected Persons — Served by Portland Agencies: 1997 (n=304)**

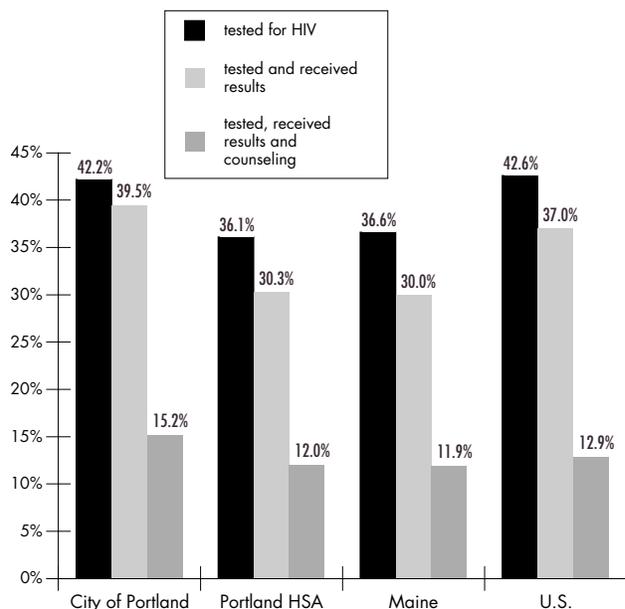


Source: "Community Plan for Comprehensive Services for Individuals With HIV Infection Whose Functioning Is Impaired By Mental Illness and/or Substance Abuse," PHD, HHS, 1998.

- Of the 304 HIV-infected persons served by Portland agencies in 1997, 71% had an alcohol, drug, and/or mental (ADM) disorder. Additional factors observed in the HIV-positive population with ADM disorders include:
  - ✓ physical disorders affecting cognition;
  - ✓ moderate to severe rating on the GAF<sup>vi</sup> scale;
  - ✓ threat to self or others;
  - ✓ violent behavior;
  - ✓ incarceration experience;
  - ✓ psychiatric crisis intervention needs;
  - ✓ impaired communication or judgement;
  - ✓ homelessness;
  - ✓ poor social support;
  - ✓ lack of primary care.

■ **Percent of Population, Ages 18+, Tested for HIV, Received HIV Test Results, and Received Post-HIV Test Counseling —**

City of Portland, Portland HSA, Maine and the U.S.: 1997

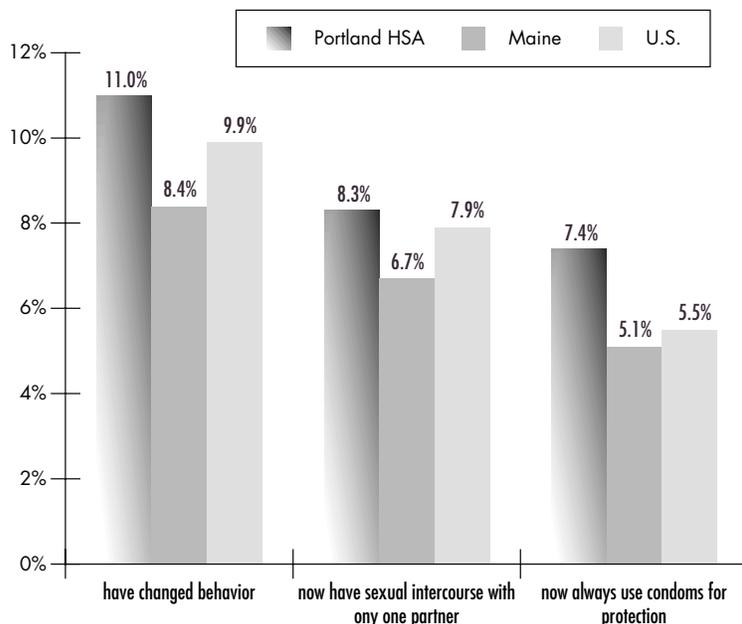


- Locally, just over a third of the adult population has learned their HIV status. According to national estimates, approximately one third of HIV-infected individuals are not aware of their serostatus. Because of a lack of awareness of HIV serostatus, some populations do not perceive themselves to be at risk of becoming infected with HIV. In Portland, Maine, and the U.S., over 60% of adults believe they are not at risk of becoming infected with the HIV virus.

Source: BRFSS, CDC; PHRG.

■ **Adults Who Report Changing Their Sexual Behavior in the Last 12 Months, due to Knowledge of HIV — Portland HSA, Maine and the U.S.: 1997**

- Though behavioral interventions are still the primary activities employed in HIV prevention, only a very small proportion of the population reports changing sexual behavior based on knowledge of HIV.

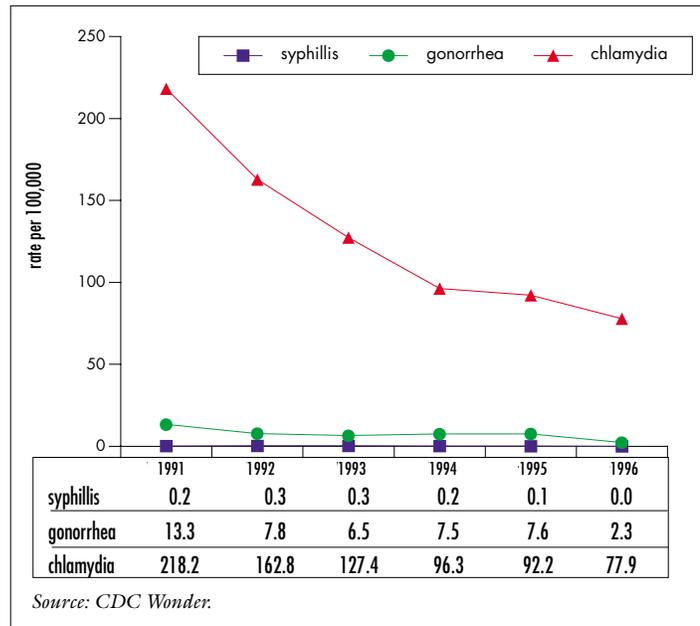


Source: BRFSS, CDC; PHRG.

## Other Sexually Transmitted Diseases (STDs)

### Reportable STD Incidence Rates — Maine: 1991-1996

- The most prevalent reportable STD in Maine is chlamydia trachomatis.
- Gonorrhea and syphilis have very low incidence rates in Maine, nearly the lowest in the United States.

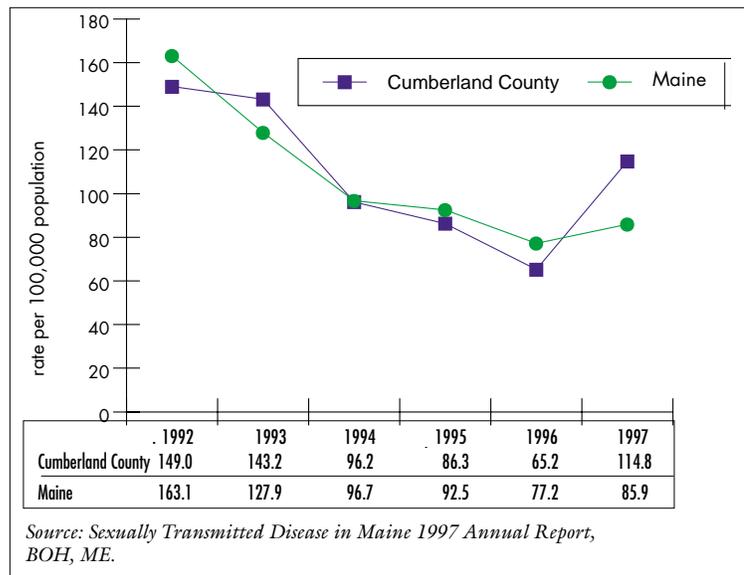


Data indicate that the presence of other STDs substantially increases the risk of HIV transmission by making it easier to both get and to give HIV infection. Treating other STDs reduces the spread of HIV. U.S. STD rates are high, and STD clinical services are inadequate in the face of a changing HIV epidemic.

—Healthy People 2010

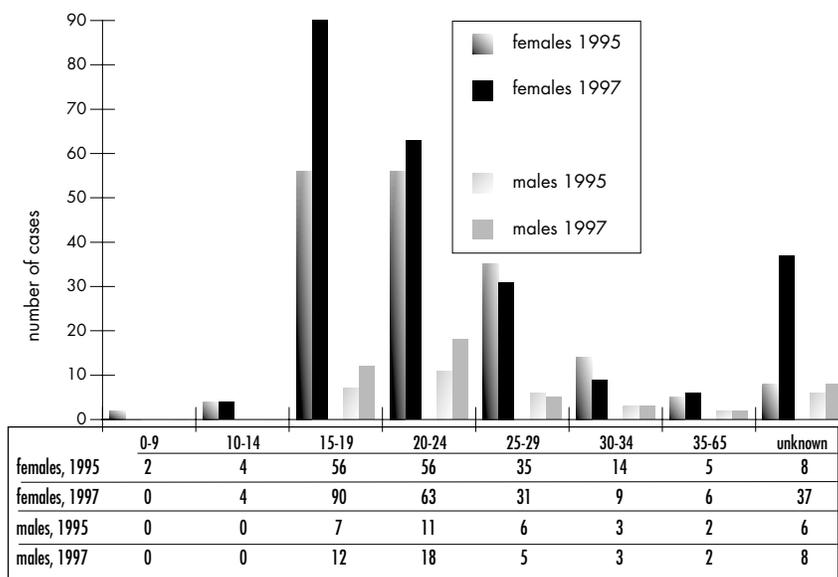
### Chlamydia Incidence Rates — Cumberland County and Maine: 1992-1997

- Widespread screening for chlamydia in Maine began at the end of the 1980s. The rate of reported cases in Maine and Cumberland County dropped steadily through 1996, as screenings resulted in early diagnosis and treatment of infected persons. However, in 1997 the rate increased, particularly in Cumberland County.
- Cumberland was the county with the highest number of chlamydia cases (289) in Maine in 1997. Between 1992 and 1996, the chlamydia incidence rate in Cumberland County looked very similar to the overall state rate.



## ■ Chlamydia Cases, by Age and Sex — Cumberland County: 1995 and 1997

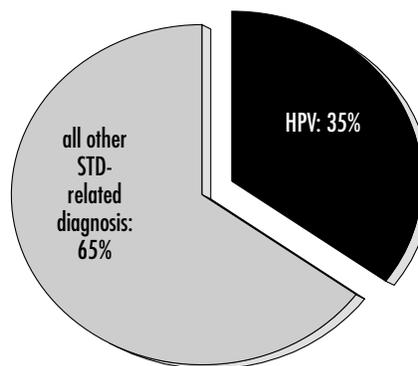
- Chlamydia diagnosis is highest for females between the ages of 15 and 19 followed by 20 to 24. For males, diagnosed chlamydia is highest between the ages of 20 and 24.
- High rates of chlamydia infection among teenage girls is especially disturbing since chlamydia infection is an indicator of unprotected sexual activity.



Source: BOH, ME.

## ■ Percent of Initial STD Clinic Visits Diagnosed for Human Papilloma Virus (HPV) — Portland Public Health Division: 1997-1998 (n = 505)

- Though not a reportable STD, Human Papilloma Virus (HPV), or genital warts, was the most commonly diagnosed condition among Portland STD clinic clients, accounting for more than one third of all initial visits.
- HPV has been linked to cervical cancer, and several types of abnormal cells can be detected by a Pap smear from women with HPV.



Source: STD Clinic Report, PHD, HHS, City of Portland.

## ■ STD-related Diagnosis at STD Clinics — Portland Public Health Division: 1997-1998 combined

	STD-Related Diagnosis	Incidence	Percent
	HPV or genital warts	177	35.0%
	cervicitis/vaginitis	122	24.2%
	urethritis	89	17.6%
✓	contact to STD	73	14.5%
	HSV or genital herpes	23	4.6%
✓	chlamydia	15	3.0%
✓	gonorrhea	3	0.6%
✓	syphilis	3	0.6%
	<b>Total</b>	<b>505</b>	<b>100.0%</b>
✓	<b>= reportable</b>		

- In Portland, the most frequently diagnosed STD is HPV, although it is not reportable. The most prevalent reportable STD is chlamydia. Cervicitis/vaginitis, urethritis, and herpes are all commonly diagnosed STDs that are not reportable.

Source: STD Clinic Report, PHD, HHS, City of Portland.

## Sexual Risk Behaviors, with a Focus on Youth

Risks	Maine high school students	Maine youth in shelters and street outreach programs	Inferences
Ever had sexual intercourse	52%	86%	Most teens are sexually active. Out of home youth are more likely to be sexually active.
Of those who are sexually active, only one sexual partner in the past three months	20%	53%	In-school sexually active youth are more likely than youth in shelters and street outreach programs to have multiple sex partners.
Have had 4 or more sexual partners	13%	■	
Had first sexual intercourse by age 13	7%	■	Out of school youth are more likely to have their first sexual experience before age 13.
Average age at first sexual intercourse	■	13.5	
Used alcohol before last sexual experience	■	21%	More than 1 in 5 youths are having sex with their judgement impaired by the use of alcohol and/or drugs.
Used drugs before last sexual experience	■	29%	
Used alcohol or drugs at last sexual intercourse	24%	■	
Used a condom at last sexual intercourse	57%	53%	Nearly half of the sexually active youth are not using condoms.
Forced to have sex at some time	13%	36%	An alarmingly high percentage of youth have been forced to have sex in their lifetimes. Youth in shelters and street outreach programs are especially vulnerable to sexual exploitation.
Females forced to have sex at some time	20%	■	
Males forced to have sex at some time	5%	■	
Ever injected substances <sup>viii</sup>	3%	13%	Youth in shelters and street outreach programs are much more likely than youth in school to have injected substances.
■ = data not available			

Source: YRBSS, CDC; Data on Maine youth in shelters and street outreach programs is based on a survey conducted by DOE, ME, 1999.

---

## Endnotes

- <sup>i</sup> The infectious disease AIDS, or acquired immunodeficiency syndrome, was identified in the United States beginning in 1981. Several years later, researchers discovered the causative agent, human immunodeficiency virus (HIV).
- <sup>ii</sup> HIV AIDS Reporting System (HARS) is a national database to which each state submits resident data. Most states notify each other when a non-resident is diagnosed in their state and the state of residence includes that person in their HARS data. An example of a state that does not participate in HARS information reciprocity (by policy) is New York. HIV positive tests are listed by county of residence based on the lab slip at time of testing.
- <sup>iii</sup> IDU = injection drug use. “Other” transmission categories comprise: hemophilia/coagulation disorder; transfusion, blood/components; children of parent at risk for AIDS; and unspecified cases.
- <sup>iv</sup> Teen HIV infection is based on AIDS cases diagnosed at less than 30 years old, given that there are around 10 years between HIV infection and AIDS diagnosis.
- <sup>v</sup> MSM = men having sex with men.
- <sup>vi</sup> GAF = Global Assessment of Functioning.
- <sup>vii</sup> See *Substance Abuse* Section.

## Immunization and Infectious Disease

### Healthy People 2010 Goal

*Prevent disease, disability and death from infectious diseases, including vaccine-preventable diseases.*

#### National Health Disparities

#### IMMUNIZATION and INFECTIOUS DISEASE

##### Race

viral hepatitis  
tuberculosis cases  
senior immunizations  
tetanus booster (last 10 years)

##### Age

tetanus booster (last 10 years)

### CONTENTS

**163 Immunization and Vaccine Preventable Diseases**

**165 Other Infectious Diseases**



“Dad always thought laughter was the best medicine, which I guess is why several of us died of tuberculosis.”

— Jack Handey



# Greater Portland Community Health Assessment and Source Book

## Immunization and Infectious Disease<sup>1</sup>

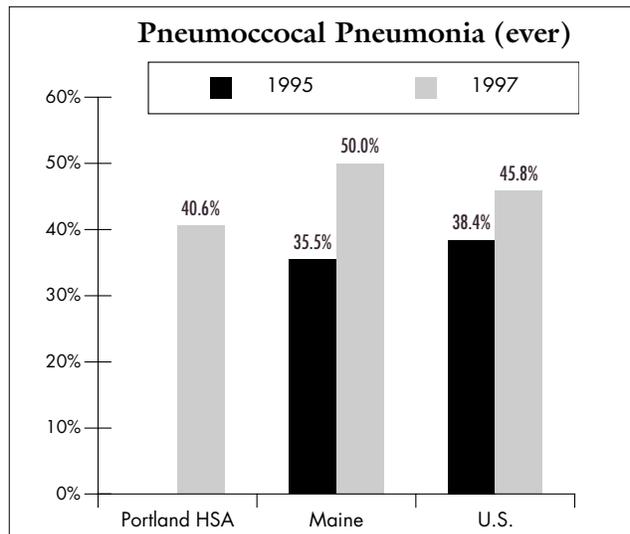
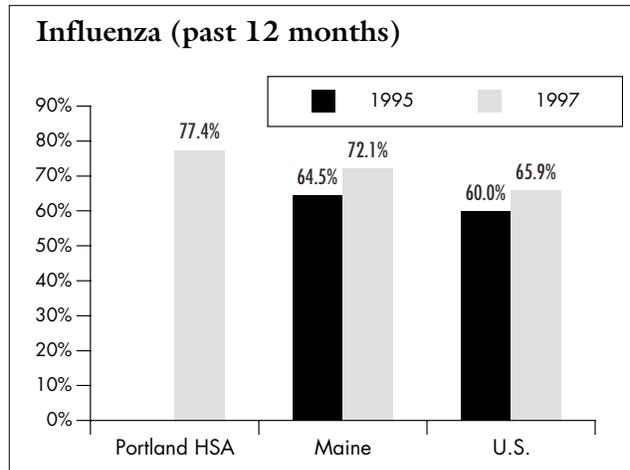
GREATER PORTLAND AREA, MAINE and U.S. RATES with YEAR 2000 OBJECTIVES

Indicators	Portland HSA Rate	Maine Rate	U.S. Rate	HM 2000 Goal	HP 2000 Goal
<b>Immunization</b>					
Percentage of children 19-35 months, who are fully immunized <sup>1</sup>	Cumberland County 84.0%	87.0%	78.0%	90.0%	90.0%
Percentage of noninstitutionalized population ages 65 + who were immunized for influenza in the past 12 months <sup>2</sup>	77.4%	72.1%	65.9%	70.0%	60.0%
Percentage of noninstitutionalized population ages 65 + who were ever immunized for pneumococcal pneumonia <sup>2</sup>	40.6%	50.0%	45.8%	■	60.0%
<b>Cases of Vaccine Preventable Diseases (VPDs)<sup>2</sup></b>					
Measles	0	0	309	0	0
Diphtheria	0	0	0	0	0
Tetanus (people ages ≤ 25)	0	0	5	0	0
Rubella	0	0	128	0	0
Congenital Rubella Syndrome	0	0	6	0	0
Pertussis (Whooping Cough)	5	27	5,137	0	1,000
Polio (Wild-Type Virus)	0	0	0	0	0
Mumps	0	4	906	4	500
Hemophilus Influenza Type B (Hib)	1	3	■	3	■
<b>Infectious Disease Incidence Rates <sup>3</sup></b>					
Tuberculosis	Cumberland County 0.8	1.1	6.8	2.0	3.5
Hepatitis B	1.6	0.4	3.9	1.4	40.0
Lyme disease	1.6	0.9	■	1.2	■
Neisseria Meningitides (a Meningococcal Disease)	0.0	0.0	■	0.0	0.0
■ = data not available					
<i>For Source Notes, see next page.</i>					

source number	Greater Portland Area	Maine	U.S.	notes
1	1998 BOH, ME	1998 BOH, ME	1997 DTBE, NIS, CDC	Immunization rates are for the 4:3:1 series coverage (four or more doses of Diphtheria, Tetanus Toxoid and Pertussis vaccine; three or more doses of Poliovirus vaccine; and, one ore more doses of Measles-Mumps-Rubella vaccine). U.S. and Maine rates are for children 19-35 months old; Cumberland County rates are for children 24 months old.
2	1996-1997 BRFSS, CDC	1997 BRFSS, CDC	1997 BRFSS, CDC	Greater Portland Area rates prepared by PHRG.
3	1998 BOH, ME	1998 BOH, ME	1998 DTBE, NCHSTP, CDC	Infectious Disease Incidence Rates are per 100,000 population

## Immunization and Vaccine Preventable Diseases (VPDs)

### ■ Percent Immunized, Uninstitutionalized Population Ages 65+ — Portland HSA, Maine and U.S.: 1995 and 1997

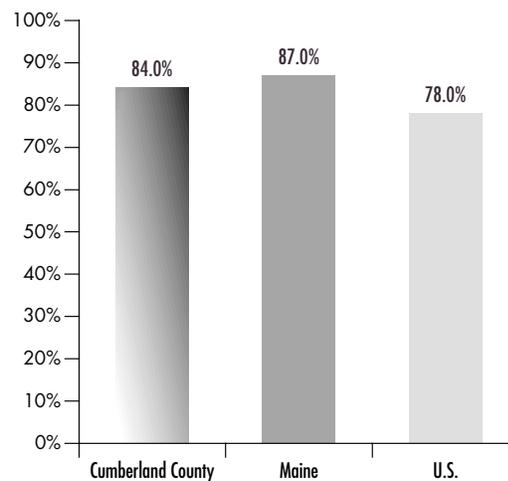


- Adults ages 65+ are at increased risk of serious illness from influenza and pneumonia infections. In 1997, Maine (though not the Greater Portland Area) immunized a higher percentage of the population ages 65+ against influenza and pneumonia than the national average. Despite this success, a nearly equal proportion of the population remains at risk to diseases that can be prevented through low cost vaccines.

Source: BRFS, CDC; PHRG.

### ■ Percentage of Children, 19-35 Months, Who Are Fully Immunized<sup>ii</sup> — Cumberland County, Maine and the U.S.: 1998

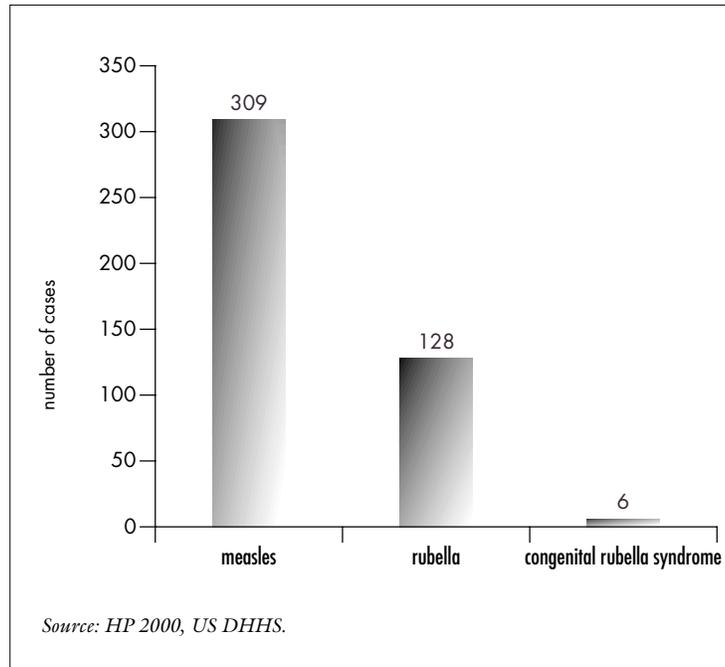
- While immunization coverage levels are at record high levels, the year 2000 goal of 90% has not been met. Coverage levels of 90% are, in general, sufficient to prevent circulation of viruses and bacteria that cause vaccine-preventable diseases.<sup>iii</sup>



Source: BOH, ME.

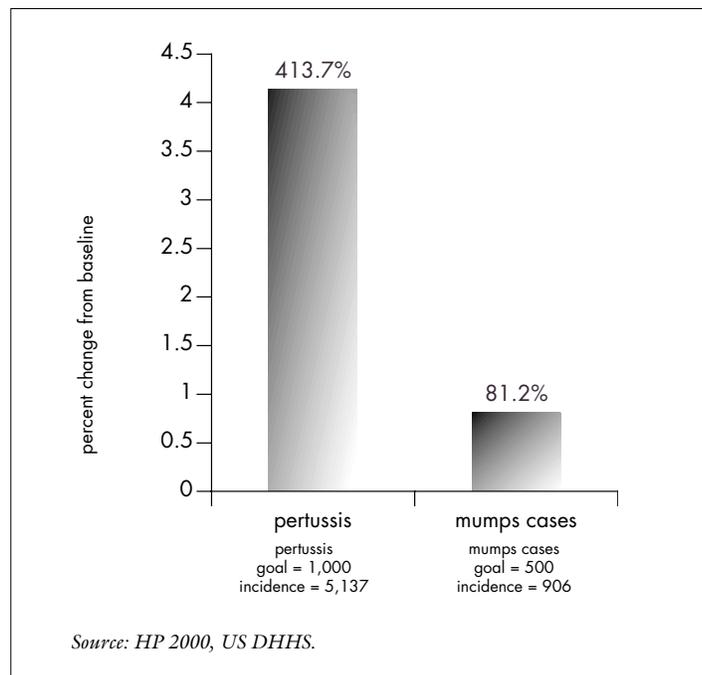
■ **Indigenous Incidence of Vaccine Preventable Diseases for which the Year 2000 Target is 0 – U.S.: 1995**

- The Healthy People 2000 target of “0” was met for diphtheria (among people 25 and younger) and for polio (wild-type virus). Despite high vaccination coverage levels, the measles incidence rate demonstrates that achievement of high coverage levels cannot always prevent outbreaks.



■ **Percent Over Year 2000 Goal for Pertussis and Mumps Incidence — U.S.: 1995**

- Cases of mumps have declined from baseline while cases of pertussis have increased from baseline. Neither is close to its target.

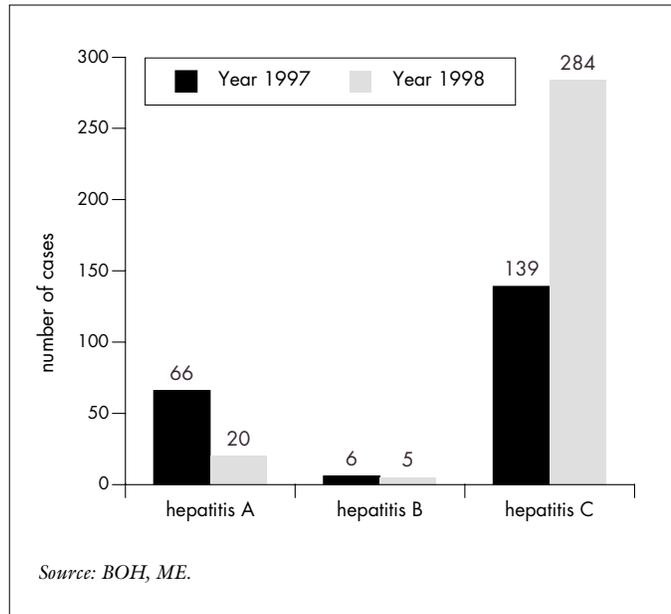


## Other Infectious Diseases

### Hepatitis

#### ■ Hepatitis Incidence — Maine: 1997 and 1998

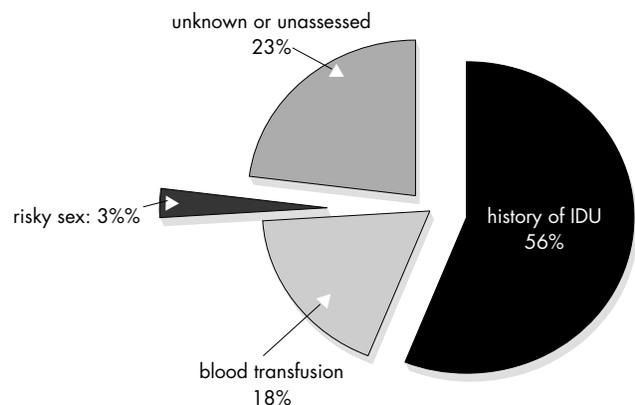
- Hepatitis is a viral infection that causes inflammation in the liver. Hepatitis A, which does not progress to chronic infection, is transmitted through contact with infected individuals, usually through fecal contamination of food and water.
- Hepatitis B and C are transmitted sexually, perinatally, through blood transfusion, and by sharing needles. Development to chronic infection and liver disease often results in cirrhosis (scarring) of the liver.
- More than 85% of persons infected with Hepatitis C develop chronic liver infection and 70% of infected persons develop chronic liver disease. Before 1992, the blood transfusion supply was not tested for Hepatitis C, resulting in a substantial number of transmissions. Many of these infections occurred before 1992 and are only now being discovered.



#### ■ Hepatitis C Transmission-Risk Categories –

City of Portland: Cases Diagnosed in 1997 - 1998 combined

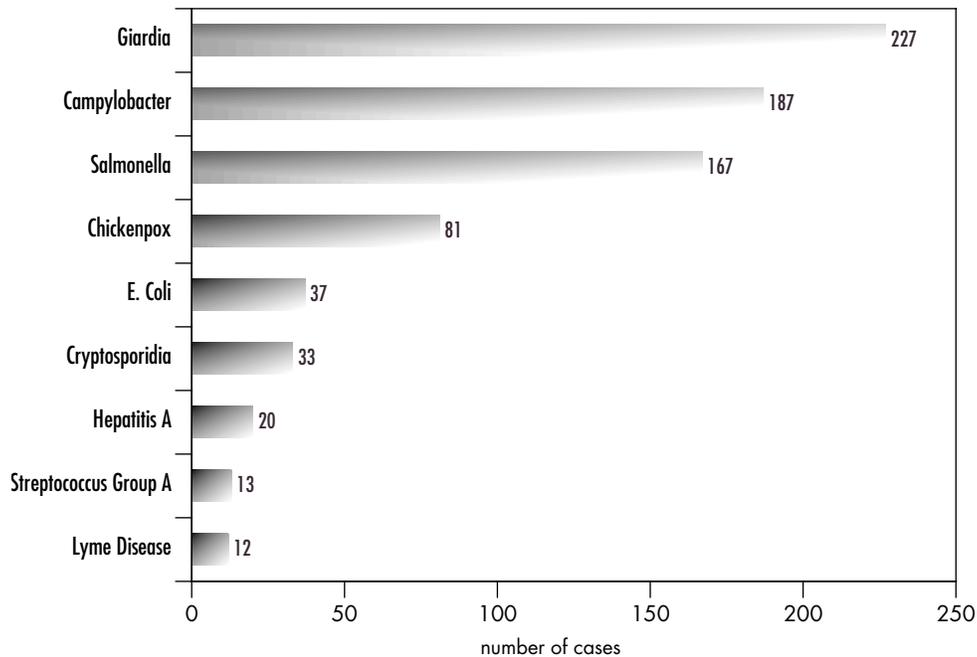
- In the City of Portland, the majority of individuals diagnosed with Hepatitis C have a history of injection drug use. Many of these individuals did not realize that they were at risk for Hepatitis C because they had only experimented with injection drugs once or twice, 15 to 20 years before being tested.



Source: BOH, ME.

## ■ Infectious Disease Incidence, Top Ten — Maine: 1997

- In 1997 most cases of infectious disease were the result of contact with water or food born, enteritis-causing bacteria and amoebas. In the City of Portland (like the state), the amoeba Giardiasis and the bacteria Salmonella and Campylobacter, accounted for most infectious disease incidence, with 18, 12, and 9 cases respectively.



Source: BOH, ME.

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## Endnotes

- <sup>i</sup> Infectious or communicable diseases are those that can be transmitted from one person to another. STDs and HIV/AIDS are communicable diseases; they are treated in their own chapter. Despite the small number of cases, non-sexually transmitted infectious diseases remain a significant health threat due to the potential for broader outbreaks.
- <sup>ii</sup> Immunization rates are for the 4:3:1 series coverage (four or more doses of diphtheria, tetanus toxoid and pertussis vaccine; three or more doses of polio virus vaccine; and, one or more doses of measles-mumps-rubella vaccine). U.S. and Maine rates are for children 19-35 months old; Cumberland County rates are for children 24 months old.
- <sup>iii</sup> Orenstein, W.H.; Hinman, A.R.; and Rodewald, L.E. Public Health Considerations in the United States. In: Plotkin, S.A. and Orenstein, W.A. (eds.), *Vaccines*. 3<sup>rd</sup> ed. Philadelphia, PA: W.B. Saunders Company, 1999, 1006-1032.

# Mental Health and Mental Disorders

## Healthy People 2010 Goal

*Improve mental health and ensure access to appropriate, quality mental health services.*

### National Health Disparities

#### MENTAL HEALTH and MENTAL DISORDERS

Race  
suicide

Socioeconomic Status  
cumulative trauma disorders

Gender  
suicide  
depression

## CONTENTS

**171 Prevalence**

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**178 Dual Diagnosis of Mental Disorders  
and Substance Abuse Disorders**



“No excellent soul is exempt from a mixture of madness.”

— Aristotle



# Greater Portland Community Health Assessment and Source Book

## Mental Health and Disorders

GREATER PORTLAND AREA, MAINE and U.S. RATES with YEAR 2000 OBJECTIVES

Indicators	Cumberland County Rate	Maine Rate	U. S. Rate	HM 2000 Goal	HP 2000 Goal
<b>Suicide</b>					
suicide deaths (per 100K population) <sup>1</sup>	9.0	11.5	11.3	■	10.5
youth 15-19 years old	3.1	5.9	10.5	■	8.2
males 20-34 years old	20.9	25.0	26.3	■	21.4
white males 65+ years old	27.4	48.9	38.7	■	39.2
Suicide attempts among adolescents, grades 9 – 12	■	6.0%	7.7%	8.0%	■
Injurious suicide attempts among adolescents, <sup>2</sup> grades 9 – 12	■	2.8%	2.6%	■	1.8%
females	■	5.0%	3.4%	■	2.0%
<b>Mental Health Disorder Prevalence</b>					
percentage of children, ages 6-17, with emotional, developmental, and/or behavioral disorders <sup>3</sup>	■	■	20.0%	■	17.0%
percentage of people 18-54 reporting symptoms of mental health disorders (1-month prevalence) <sup>3</sup>	■	■	12.6%	■	10.7%
percentage of people 18-54 with depressive (affective) disorders (1-month prevalence) <sup>3</sup>	■	■	5.1%	■	4.3%
women	■	■	6.6%	■	5.5%
percentage of adults reporting that their mental health was not good for 3+ days in the past month <sup>4</sup>	Portland HSA 16.6%	18.6%	20.9%	■	■
males	14.6%	15.8%	16.6%	■	■
females	18.8%	21.1%	24.6%	■	■
■ = data not available					
<i>For Source Notes, see next page</i>					

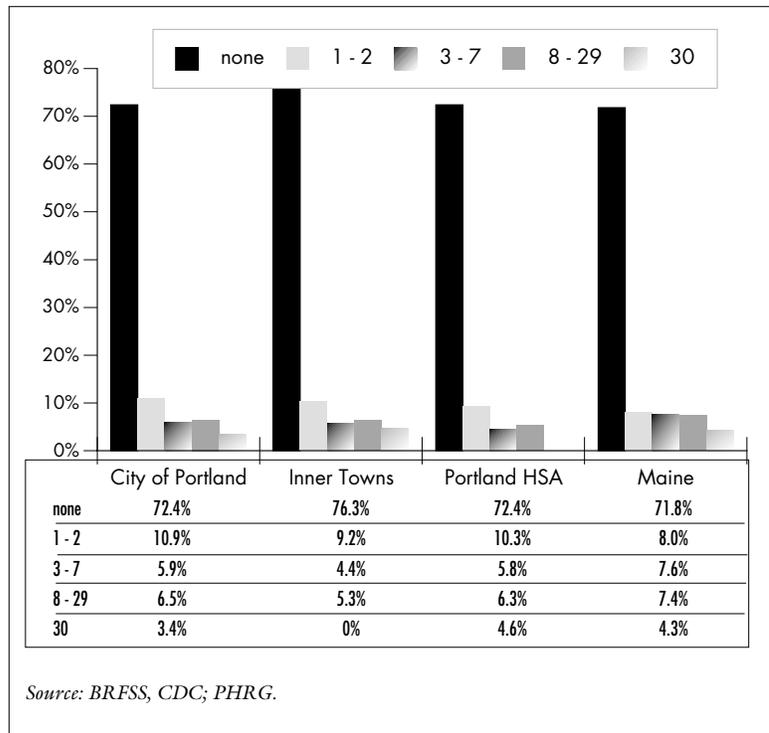
source number	Greater Portland Area	Maine	U.S.	notes
1	1992 - 1995 CDC Wonder	1995 CDC Wonder	1995 CDC Wonder	
2	■	1997 YRBS, CDC	1997 YRBS, CDC	
3	■	1995 HP 2000	1995 HP 2000	
4	1996 - 1997 BRFSS, CDC	1997 BRFSS, CDC	1997 BRFSS, CDC	BRFSS data for the Portland HSA prepared by the PHRG.

## Prevalence

### ■ Percentage of Adults, Ages 18+, Reporting Number of Days Mental Health Not Good (past 30 days) —

City of Portland, Inner Towns, Portland HSA, and Maine: 1996-1997 combined

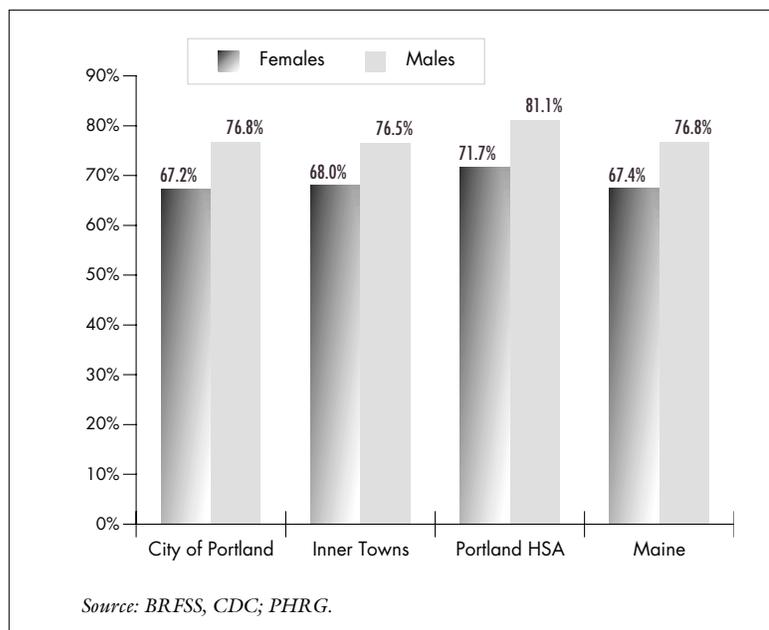
- Locally and statewide, just over 70% of the adult population reported being in good mental health every day in the past 30 days.
- Conversely, about one in three people had one or more days in which they felt their mental health was not good.



### ■ Percentage of Adults, Ages 18+, Reporting Mental Health Good Everyday (past 30 days), by Sex —

City of Portland, Inner Towns, Portland HSA, and Maine: 1996-1997 combined

- Consistently, fewer women than men reported being in good mental health everyday in the past 30 days.



■ **Severe and Persistent Mental Illness (SPMI) Prevalence Estimates<sup>i</sup> —**  
 City of Portland, Cumberland County and Maine: 1996

	All SPMI	AMHI Class Members	Same acuity but not AMHI Class Members
<b>Portland</b>	3,191	621	1,824
<b>Cumberland County</b>	4,255	829	2,431
<b>Maine</b>	21,489	3,069	12,279

*Source: Insufficient Mental Health Services in Our Communities: a Report Commissioned by the Mental Health Planning Forum of the City of Portland, 1996.*

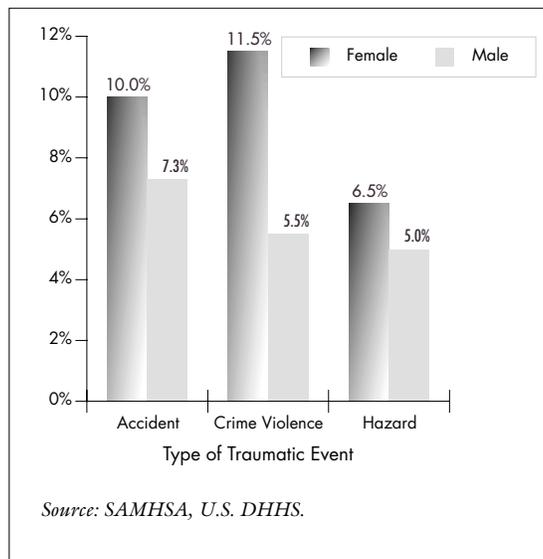
- Maine’s Department of Mental Health Mental Retardation and Substance Abuse Services (DMHMRSAS) estimates that 1.75% of the total population are adults with SPMI, whereas about 1% of the population have SPMI with needs and acuity comparable to Augusta Mental Health Institute (AMHI) Class Members. Portland’s Mental Health Planning Forum estimates that only 14% of individuals with SPMI are AMHI Class Members.
- According to the Southern Maine Regional Mental Health Board (SMRMHB), 75% of Cumberland County’s total residents with SPMI (including 75% of Cumberland County’s AMHI Class Members), live in the city of Portland. Portland’s Mental Health Planning Forum estimates that 27% of all AMHI Class Members reside in Cumberland County.

## Mental Disorder Prevalence Estimates<sup>ii</sup> — Illustrative Examples

Age Group	Condition	estimated prevalence rate	estimated number in Portland	estimated number in Cumberland County	estimated number in Maine	
0-5	developmental or emotional/ behavioral disabilities and severe developmental delays <sup>iii</sup>	7.7%	394	1,557	8,000	
6-20	severe emotional disturbances <sup>iv</sup>	5.4%	557	2,591	14,000	
	attention deficit disorder <sup>v</sup>	4.0%	415	1,919	10,433	
	anxiety disorder <sup>vi</sup>	5.4%	560	2,591	14,084	
15-54 <sup>vii</sup>	<b>ANY ANXIETY DISORDER</b>					
	life time	24.9%	9,698	35,721	173,686	
	per year	17.2%	6,699	24,675	119,976	
	panic disorder					
	life time	3.5%	1,363	5,021	24,414	
	per year	2.3%	896	3,300	16,043	
	agoraphobia without panic disorder					
	life time	5.3%	2,064	7,603	36,969	
	per year	2.8%	1,091	4,017	19,531	
	social phobia					
	life time	13.3%	5,180	19,080	92,772	
	per year	7.9%	11,333	3,077	55,105	
	simple phobia					
	life time	11.3%	4,401	16,211	78,821	
	per year	8.8%	3,427	12,624	61,383	
	generalized anxiety disorder					
	life time	5.1%	1,986	7,316	35,574	
	per year	3.1%	1,207	4,447	21,624	
	<b>ANY AFFECTIVE DISORDER</b>					
	life time	19.3%	1,986	7,316	35,574	
	per year	11.3%	1,207	4,447	21,624	
	major depressive episode					
	life time	17.1%	6,660	24,531	119,278	
	per year	10.3%	4,012	14,776	71,846	
	manic episode					
	life time	1.6%	623	2,295	11,161	
	per year	1.3%	506	1,865	9,068	
dysthymia						
life time	6.4%	2,493	9,181	44,642		
per year	2.5%	974	3,586	17,438		
<b>ANTISOCIAL PERSONALITY</b>						
life time	3.5%	1,363	5,021	24,414		
<b>NON AFFECTIVE PSYCHOSIS<sup>viii</sup></b>						
life time	0.7%	273	1,004	4,883		
per year	0.5%	195	717	3,488		
65 +	<b>ANY MENTAL DISORDER<sup>ix</sup></b>					
	DEPRESSIVE SYMPTOMS <sup>x</sup>	15.0%	1,147	4,761	24,506	
	<b>DEMENTIAS<sup>ix</sup></b>					
	dementia <sup>ix</sup>	16.3%	1,577	5,173	26,630	
	pseudodementias <sup>xi</sup>	5.0%	484	1,587	8,169	
	Alzheimers					
	65-74	3.0%	147	531	2,748	
	75-84	18.7%	642	1,970	10,013	
85+	47.2%	633	1,659	8,603		

## ■ Post-Traumatic Stress Disorder (PTSD) Prevalence, by Stressful Events, Persons Ages 18+ — U.S.: 1992

- Victims of violence and accidents are more likely to experience post-traumatic stress disorder than victims of natural disasters. See section entitled “Violence” for information on the pervasiveness of violence, family and domestic violence in particular, in our everyday lives.<sup>xii</sup>
- Many refugees have experienced a combination of traumatic events related to war including: physical assault and / or torture, exposure to famine conditions, displacement, and the tragic deaths of family and friends. Mental health problems, such as PTSD, display wide cross-cultural variation in expression and interpretation.

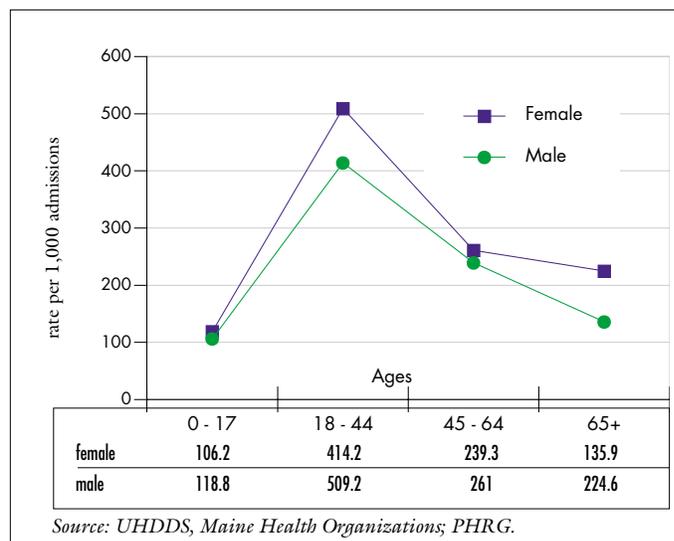


## Outcomes

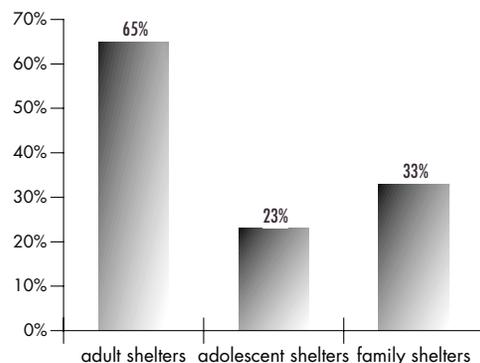
### ■ Hospital Discharges for Psychosis, by Age and Sex —

Portland HSA:  
1995 - 1996 combined

- Hospitalization rates for mental disorders are higher for females than males at all ages.
- The peak age range for mental disorder hospitalization is 18 to 44.



### ■ Percent of Emergency Shelter Users Who Have a Serious Mental Disorder, by Shelter Type — City of Portland: 1996



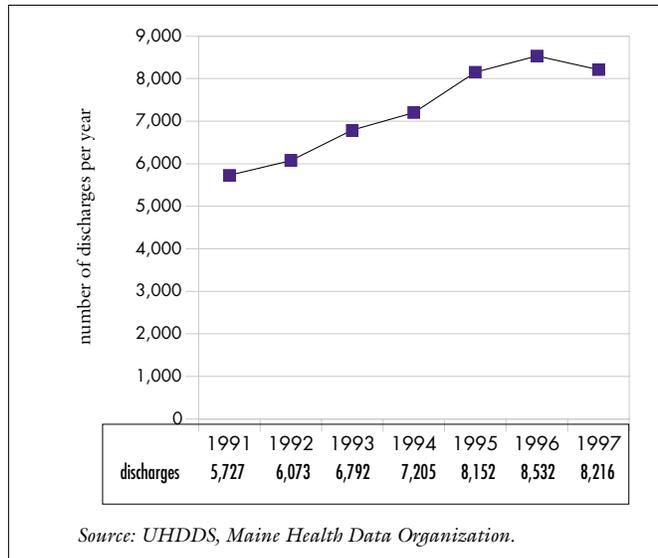
- Well over half of the adult emergency shelter population has a serious mental disorder. More than one in five occupants of adolescent shelters, and one in three occupants of family shelters also have serious mental disorders.

Source: Portland ESAC.

■ **Hospital Discharges with a Major Diagnostic Category of Mental Illness —**

Maine: 1991 – 1997<sup>xiii</sup>

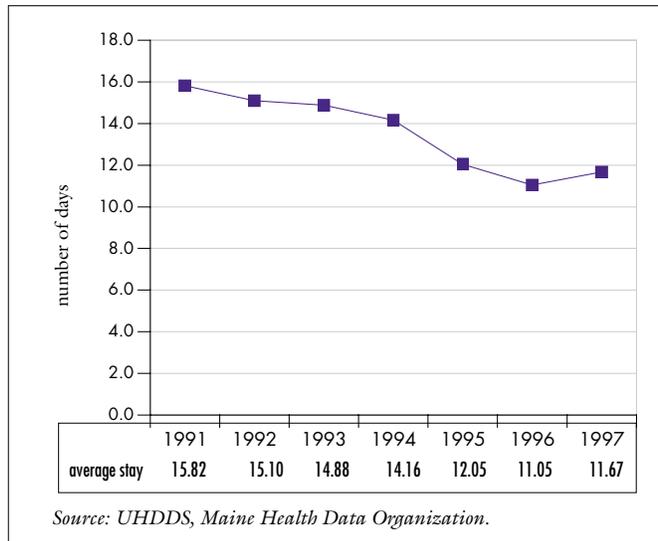
- Statewide, there has been an increase in number of patient discharges for mental illness between 1991 and 1997. This needs to be understood in terms of efforts made to decrease the number of AMHI and BMHI patients.



■ **Average Hospital Stay for Patients Discharged with a Diagnosis for Mental Illness**

Maine: 1991 – 1997<sup>xiii</sup>

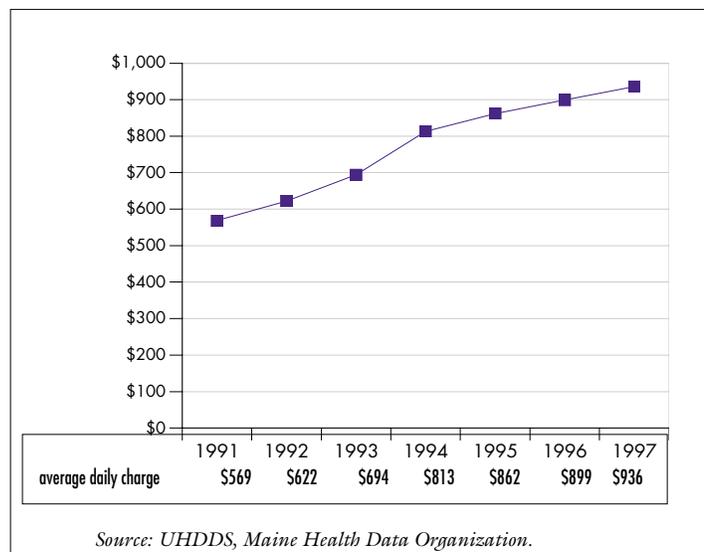
- The average number of days spent in the hospital, for patients with mental illness, has been declining since 1991 in Maine.



■ **Average Daily Charge for Patients Discharged with a Diagnosis for Mental Illness —**

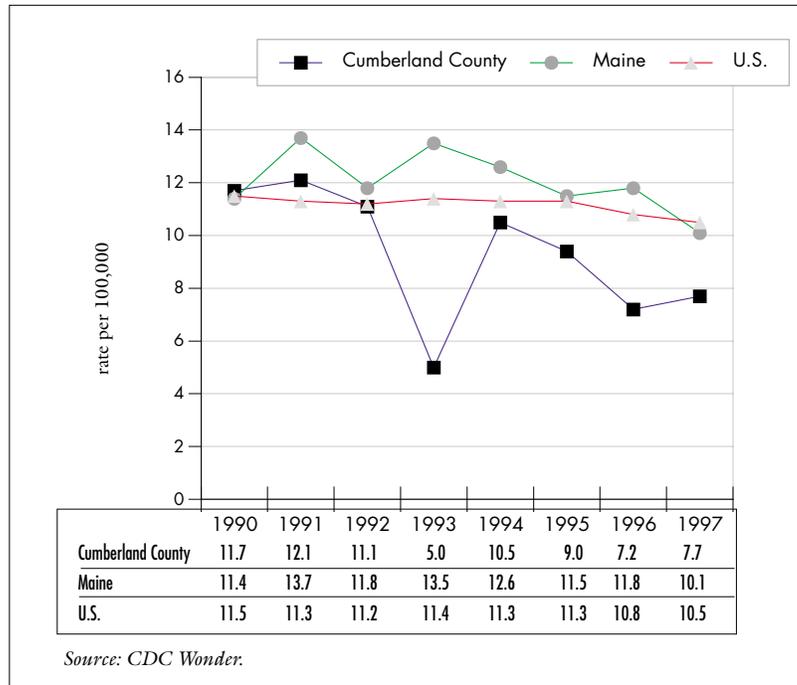
Maine: 1991 – 1997<sup>xiii</sup>

- In Maine, the average daily charge for patients hospitalized for mental illness has increased from \$569 to \$936 since 1991.

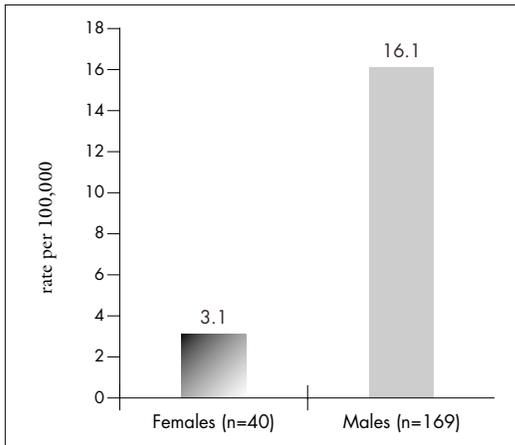


■ **Suicide Rate — Cumberland County, Maine and the U.S.: 1990 - 1997**

- The suicide rate in Maine has been consistently higher than the national rate throughout the 1990s. Cumberland County's suicide rate dropped below Maine's rate in 1991 and has remained below ever since.



■ **Suicide Rate, by Sex — Cumberland County: 1990 – 1997 combined**



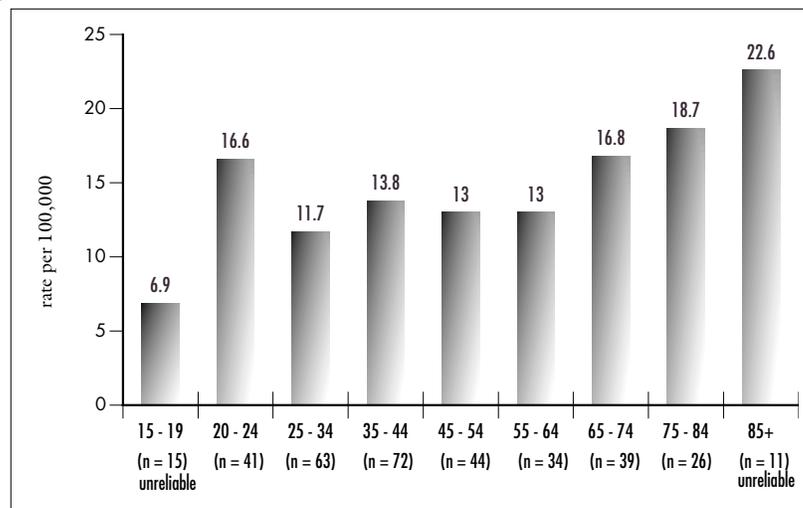
- During the 1990s, in Cumberland County, the suicide rate for males was more than 5 times higher than it was for females.

Source: CDC Wonder.

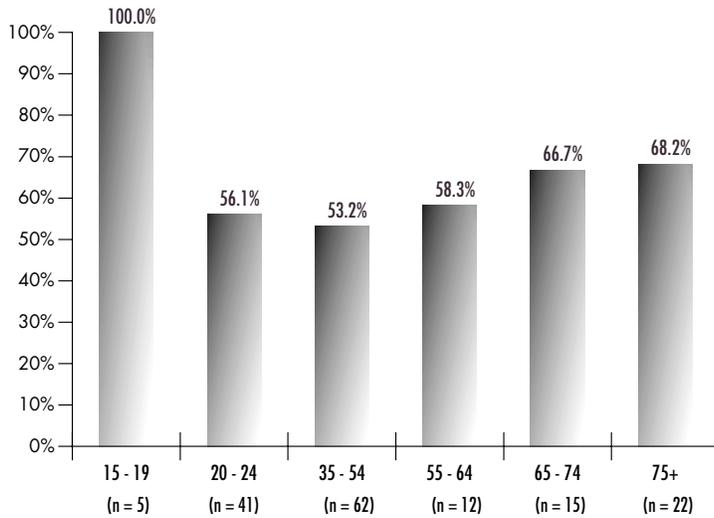
■ **Suicide Rate, by Age — Cumberland County: 1985 – 1997 combined**

- Over the past 12 years in Cumberland County, suicide rates peaked for young adults between the ages of 20 and 24, and then steadily climbed after age 65.

Source: CDC Wonder.



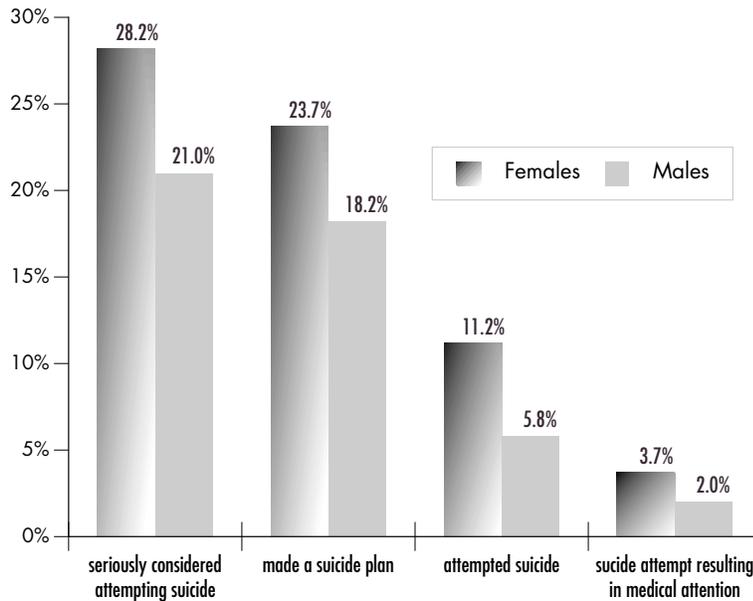
■ **Percentage of Suicide Deaths by Firearms, by Age — Maine: 1995**



- In Maine (and the U.S.) the majority of all suicides are by firearms, at all ages. Using 1995 as an example, at the youngest ages (15-19), all suicides were accomplished with firearms.

Source: Vital Statistics, OHDPM, BOH, ME.

■ **Depression and Suicide among High School Students — Maine: 1997**

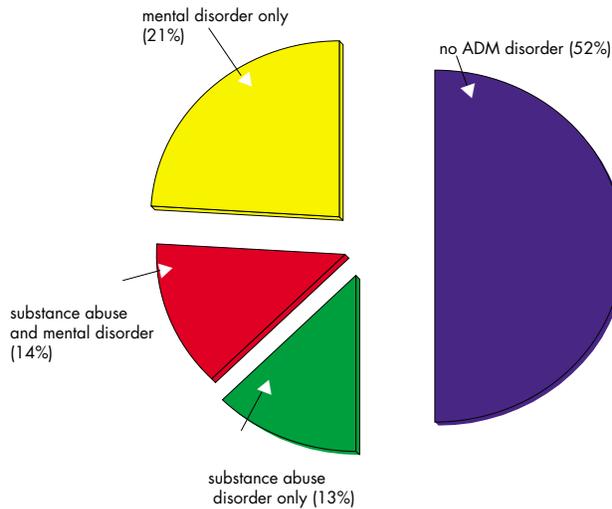


Source: YRBSS, CDC.

- Nearly one in three female, and one in four male high school students seriously thought about committing suicide.
- Far more female than male high school students made a suicide plan and/or attempted suicide.

## Dual Diagnosis

### ■ Prevalence of Comorbid Alcohol, Drug and Mental (ADM) Disorders — U.S.: 1991



- Approximately half of the U.S. population experiences an alcohol, drug and/or mental (ADM) disorder within their lifetimes.
- Of those with a lifetime ADM disorder, just under half experience a mental disorder only, a quarter experience a substance abuse disorder only, and another quarter experience comorbid mental and substance abuse disorders.

Source: SAMHSA, U.S. DHHS.

### ■ Prevalence Estimates of Comorbid Alcohol, Drug and Mental (ADM) Disorders — City of Portland, Maine and Cumberland County: 1996

- The Cumberland County Dual Diagnosis Collaborative, in an ongoing effort to address the issues of dual diagnosis, investigated Cumberland County and found that at least 70% of persons with SPMI have substance abuse issues as well as mental illness.

	SPMI	Dually Diagnosed
City of Portland	3,191	2,234
Cumberland County	4,255	2,957
Maine	21,489	15,042

Source: *Insufficient Mental Health Services in Our Communities: a Report Commissioned by the Mental Health Planning Forum of the City of Portland, 1996.*

## Comorbid ADM Disorder Prevalence Estimates<sup>ii</sup>

### Illustrative Examples

Age Group	Condition	estimated prevalence rate	estimated number in City of Portland	estimated number in Cumberland County	estimated number in Maine
15-54	COMORBIDITY (DUAL+ DIAGNOSIS) <sup>vii</sup>				
	any ADM disorder				
	life time	48.0%	18,695	68,860	334,816
	one	21.0%	8,179	30,126	146,482
	two	13.0%	5,063	18,650	90,679
	three	14.0%	5,453	20,084	97,655
	past year	29.5%	11,489	42,320	205,773
	any mental disorder				
	life time	35.1%	13,631	50,210	244,137
	past year	22.9%	8,919	32,852	159,735
	mental disorder only				
	life time	21.4%	8,179	30,126	146,482
	past year	18.2%	7,088	26,109	126,951
	any addictive disorder				
	life time	26.6%	10,516	38,734	188,334
	past year	11.3%	4,401	16,211	78,821
	addictive disorder only				
	life time	12.9%	5,063	18,650	90,679
past year	6.6%	2,571	9,468	46,037	
mental and addictive disorders					
life time	13.7%	5,453	20,084	97,655	
past year	4.7%	1,831	6,743	32,784	

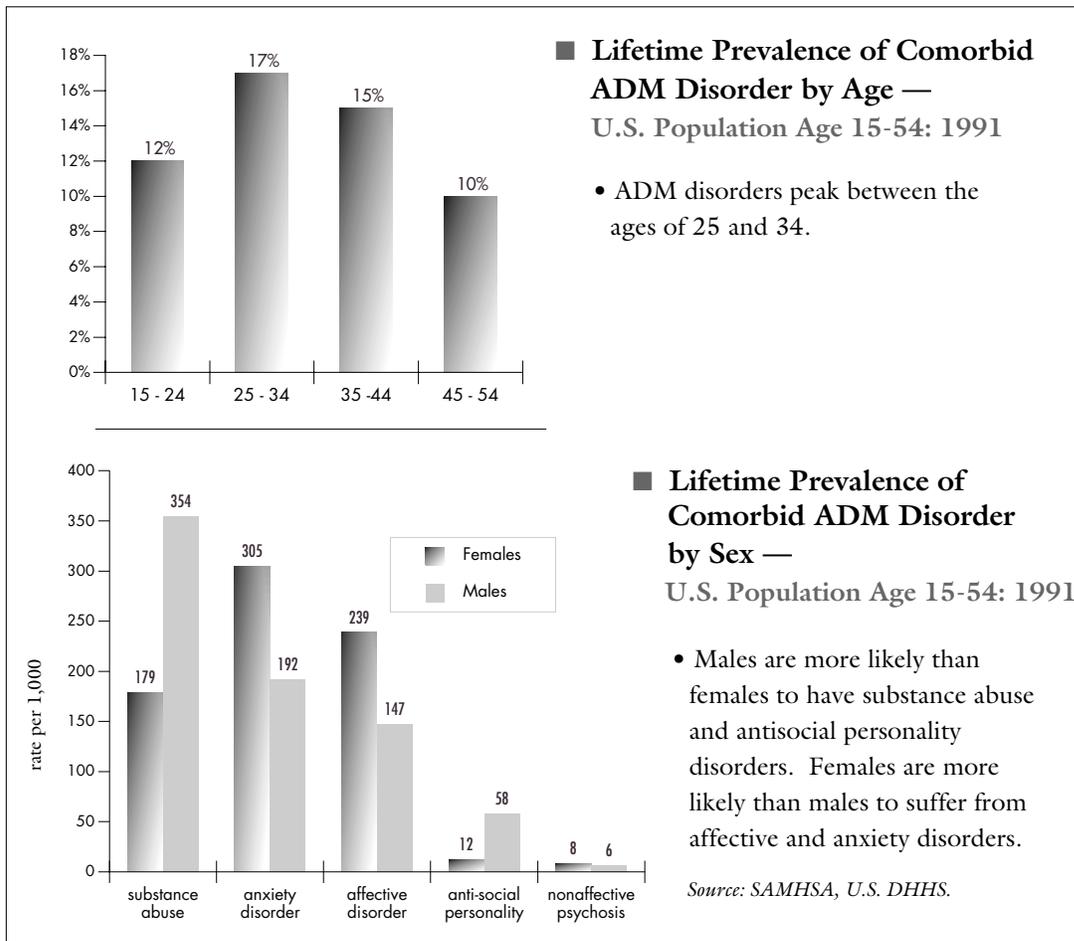
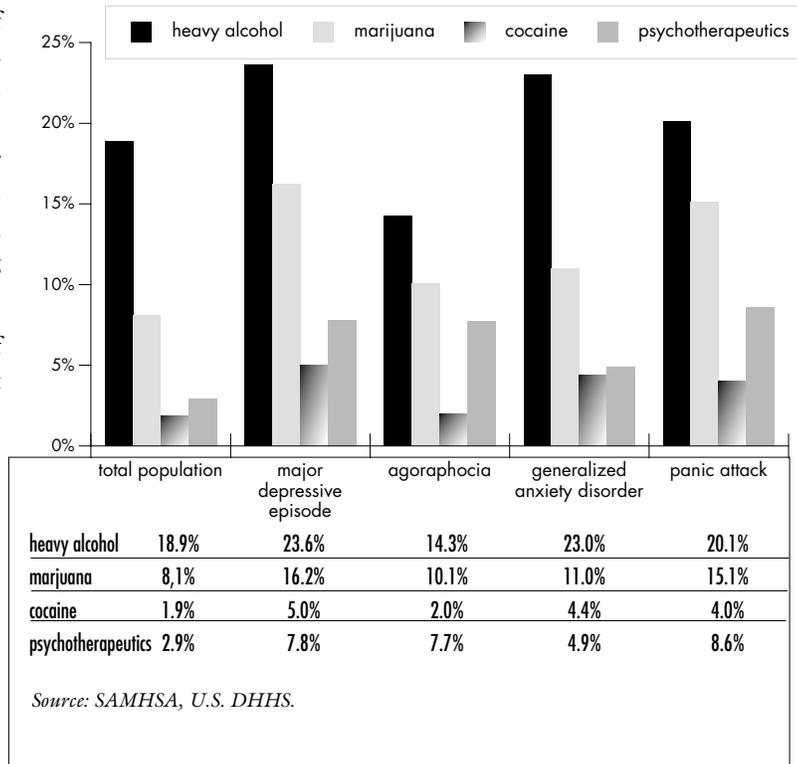
- Forty eight percent of the U.S. population age 15-54 reported experiencing an ADM disorder.
- Of the population age 15-54 ever experiencing an ADM disorder, more than half, 56%, experienced a mental disorder with a co-occurring alcohol or drug disorder.
- Twenty-seven percent of those ever experiencing an ADM disorder (or 13% of the total population age 15-54) experienced a drug or alcohol disorder without a co-occurring mental disorder.
- Of those ever experiencing an ADM disorder, about 29% (14% of the population age 15-54) has had both substance abuse and mental disorder in their lifetimes.
- On average, about 14% of the population between ages 15 and 54 will have co-existing mental and substance abuse disorders during their lifetimes.

## ■ Past-Year Substance Use by Mental Syndrome —

U.S. Population Age 18 and Older: 1996

- Many sufferers of common mental disorders attempt to self-medicate with drugs, such as alcohol. Ironically, alcohol and other drugs both exacerbate the original mental condition, and create compounding addictive disorders.

- A higher prevalence of substance abuse was present among persons with major depressive episode, generalized anxiety disorder, and panic attack than in the general population. Those diagnosed with major depressive episode and generalized anxiety disorder had the highest prevalence of heavy alcohol use.



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## Endnotes

- i Augusta Mental Health Institute (AMHI) and the 1996 Implementation of the Consent Decree — Maine’s reorganized system for addressing the needs of people with ADM disorders has been shaped by the de-institutionalized needs of AMHI class members. The resulting service structure is, at times, two-tiered, often leaving non-AMHI class members with constrained access to services.
- ii Prevalence is estimated by multiplying the population (usually age-specifically) by the national prevalence rates obtained from various diagnosis-specific studies.
- iii Data from Alliance for the Mentally Ill - Maine; cited in *Maine Health 1998: A Health Planning Resource*, Bureau of Health, Maine Department of Human Services, 1998, p. 272.
- iv Severe emotional disturbances means suffering from problems including schizophrenia, developmental disabilities, major affective disorders and conduct disorders. Maine estimates are from Alliance for the Mentally Ill - Maine; cited in *Maine Health 1998: A Health Planning Resource*, Bureau of Health, Maine Department of Human Services, 1998, p. 272. Local estimates are from the Bureau of Children with Special Needs in the Maine Department of Mental Health and Mental Retardation; cited in *A Profile of Cumberland County’s Children 1995*, p. 20.
- v *Diagnosis and Treatment of Attention Deficit Hyperactivity Disorder*. NIH Consensus Statement Online 1998 Nov. 16-18; 16(2): in press. The Bureau of Children with Special Needs in the Maine Department of Mental Health and Mental Retardation uses 1%; cited in *A Profile of Cumberland County’s Children 1995*, p. 20.
- vi Data from the Bureau of Children with Special Needs in the Maine Department of Mental Health and Mental Retardation; cited in *A Profile of Cumberland County’s Children 1995*, p. 20.
- vii For citation of studies used to determine prevalence rates and definitions see: *Substance Abuse and Mental Health Statistics Source Book, 1998*, Analytic Series: A-4. Office of Applied Studies, Substance Abuse and Mental Health Service Administration (SAMHSA), U.S. Department of Health and Human Services.
- viii Nonaffective Psychosis includes: schizophrenia, schizophreniform disorder, delusional disorder, and atypical psychosis.
- ix *Mental Health of the Elderly*, American Psychiatric Association, 1992.  
  
Dementia is frequently caused by: cardiovascular disease, Parkinson’s disease, Huntington’s disease and/or Creutzfeldt-Jakob disease. Pseudodementias are symptoms that mimic dementia that are caused by such issues as: drug reactions or interactions, poor diet, heart and/or lung diseases, and/or diseases of the adrenal, thyroid, pituitary or other glands.
- x *Diagnosis and Treatment of Depression in Late Life*. NIH Consensus Statement Online 1991 Nov 4-6: cited Jan. 5, 1999; 9(3): 1-27.
- xi Evans, D.A., Funkenstein, H.H., Albert, M.S., et.al. “Prevalence of Alzheimer’s Disease in a Community Population of Older Persons: Higher Than Expected.” *JAMA* v.262(18): 2551-2556, Nov. 10, 1989.
- xii Accidents include injury-causing motor vehicle accidents or tragic deaths of relatives or close friends.  
Crime/violence includes the experience of robbery, physical assault, or sexual assault.  
Hazard includes the experience of a fire, disaster, or hazards such as hurricanes or tornadoes.
- xiii Number of discharges includes repeat visits by the same patient. Augusta Mental Health Institute (AMHI) and Bangor Mental Health Institute (BMHI) are not included in this data set.



## Substance Abuse

### Healthy People 2010 Substance Abuse Goal

*Reduce substance abuse to protect the health, safety, and quality of life for all, especially children.*

**National Health  
Disparities  
SUBSTANCE ABUSE**

**Race**

alcohol-related  
motor vehicle deaths  
cirrhosis deaths  
drug-related deaths  
fetal alcohol syndrome

**Age**

alcohol-related  
motor vehicle deaths

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**192 Youth Prevalence and Outcomes**



“Complete abstinence is easier than perfect moderation.”

— St. Augustine



# Greater Portland Community Health Assessment and Source Book

## Substance Abuse

GREATER PORTLAND AREA, MAINE and U.S. RATES with YEAR 2000 OBJECTIVES

Indicators	Cumberland County Rate	Maine Rate	U.S. Rate	HM 2000 Goal	HP 2000 Goal
Alcohol-Related Motor Vehicle Deaths <sup>1</sup> (rate per 100,000 persons)	4.9	4.3	6.5	5.8	5.5
Percentage of Total Traffic Fatalities that are Alcohol-Related <sup>2</sup>	31.3%	28.3%	■	■	■
Rate of Adult OUI Arrests (persons 18+ years per 1,000 pop 18+)	8.7	7.4	■	■	■
Percentage who used substance in the past 30 days <sup>4</sup>					
Adolescents					
alcohol	41.2%	37.1%	21.0%	■	13.0%
marijuana	25.7%	18.8%	8.2%	■	3.0%
High School Seniors					
binge drinking	37.3%	28.2%	30.0%	■	28.0%
Young Adults					
alcohol	54.5%	56.4%	54.6%	■	29.0%
marijuana	12.1%	12.9%	12.0%	■	8.0%
College Students					
binge drinking	36.3%	25.7%	40.0%	■	32.0%
Rate of alcohol sales outlets <sup>5</sup> (persons per liquor-licensed outlet)	294.0	318.0	■	■	■
Rate of alcohol-related arrests, ages 10-14 <sup>3</sup> (per 1,000 pop. 10-14)	0.4	0.4	■	■	■
Rate of alcohol violation arrests, ages 10-17 <sup>3</sup> (per 1,000 pop. 10-17)	344.0	396.0	■	■	■
Rate of adult arrests for alcohol-related crimes <sup>3</sup> (persons 18 + years per 100,000 pop 18+)	1,029.4	929.0	■	■	■
Rate of drug law violation arrests, ages 10-17 <sup>3</sup> (per 100,000 pop. 10-17)	332.0	285.0	■	■	■
Rate of adult arrests for drug-related crimes <sup>3</sup> (persons 18 + years per 100,000 pop 18+)	265.5	281.9	■	■	■
Rate of adults in AOD treatment <sup>6</sup> (persons 18 + years per 1,000 pop 18+)	6.8	7.0	■	■	■
Rate of pregnant women in state-supported AOD treatment <sup>6</sup> (per 1,000 live births)	0.3	0.5	■	■	■
■ = data not available Source Notes next page					

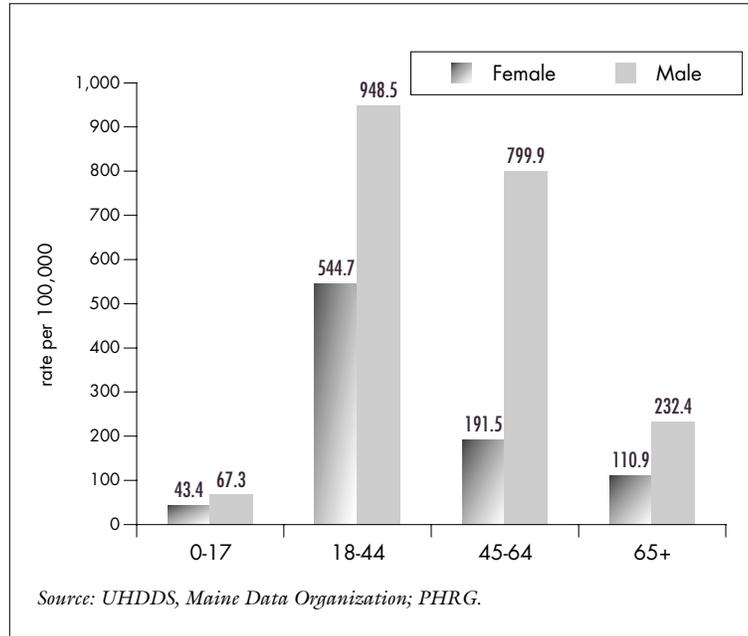
source number	Cumberland County	Maine	U.S.	notes															
1	1990-1995 Vital Statistics, OHDP, ME (6-year = 73 deaths)	1995 Vital Statistics, OHDP, ME (n = 53 deaths)	1995 FARS, NHTSA, U.S. DOT	HM 2000 goal is stated as <72 per year which = a rate of 5.8 per 100,000 in 1995. This is the only mortality rate in HP 2000 that is not age adjusted.															
2	1995 OSA, DMHMRSAS, ME	1995 OSA, DMHMRSAS, ME	■	OSA Survey results are reported in Substance Abuse Prevention: Maine's 1997 Data Report, December, 1997															
3	1995 UCRS	1995 UCRS, DPS, ME	■	■															
4	1996 OSA, DMHMRSAS, ME	1996 OSA, DMHMRSAS, ME	1995 NHSDA, SAMHSA and Monitoring the Future (High School Senior Survey), NIH, NIDA	OSA Survey results are reported in Substance Abuse Prevention: Maine's 1997 Data Report December, 1997  <table border="1"> <thead> <tr> <th colspan="3">Definition Discrepancies</th> </tr> <tr> <th></th> <th>Cumberland County and Maine</th> <th>U.S. and HP2000</th> </tr> </thead> <tbody> <tr> <td>adolescents</td> <td>6th - 12th graders</td> <td>12 - 17 year olds</td> </tr> <tr> <td>high school seniors</td> <td>9th - 12th graders</td> <td>12th graders</td> </tr> <tr> <td>young adults</td> <td>18 - 25 year olds</td> <td>18 - 20 year olds</td> </tr> </tbody> </table>	Definition Discrepancies				Cumberland County and Maine	U.S. and HP2000	adolescents	6th - 12th graders	12 - 17 year olds	high school seniors	9th - 12th graders	12th graders	young adults	18 - 25 year olds	18 - 20 year olds
Definition Discrepancies																			
	Cumberland County and Maine	U.S. and HP2000																	
adolescents	6th - 12th graders	12 - 17 year olds																	
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young adults	18 - 25 year olds	18 - 20 year olds																	
5	1992 BLE, DPS, ME	1992 BLE, DPS, ME	■	■															
6	1994 OSA, DMHMRSAS, ME	1994 OSA, DMHMRSAS, ME	■	Office of Substance Abuse's data system does not include data from Mercy Hospital.															

Prevalence of Substance Use — Selected Counties and Maine: 1995 - 1997						
	Maine State Rate	Cumberland Co. Rate	York Co. Rate	Oxford Co. Rate	County with Highest Rate	County with Lowest Rate
Have used alcohol in the past 30 days:						
6th - 8th graders	24.3%	25.0%	25.7%	24.0%	Sagadahoc 31.1%	Waldo 14.3%
9th - 12th graders	50.8%	59.2%	47.0%	51.4%	Cumberland 59.2%	Waldo 40.8%
persons 18 years and older	53.4%	58.9%	56.9%	61.6%	Sagadahoc 65.9%	Somerset 35.0%
Have binge drunk in the past 2 weeks (five or more drinks in a row):						
6th - 8th graders	9.5%	6.9%	9.4%	13.0%	Sagadahoc 13.5%	Hancock 5.0%
9th - 12th graders	28.2%	37.3%	25.2%	32.4%	Cumberland 37.3%	Lincoln and Somerset 22.9%
persons 18 years and older	9.7%	11.7%	10.4%	13.7%	Hancock 19.3%	Franklin 3.4%
Have used marijuana in the past month:						
6th - 8th graders	9.4%	11.2%	7.3%	9.1%	Sagadahoc 15.0%	Hancock 2.0%
9th - 12th graders	28.8%	41.7%	29.4%	28.6%	Cumberland 41.7%	Penobscot 19.6%
persons 18 years and older	3.1%	3.3%	1.5%	6.6%	Oxford 6.6%	Washington 0.7%
Have used inhalants in the past month:						
6th - 8th graders	10.6%	9.1%	12.7%	15.6%	Aroostock 18.0%	Lincoln 4.9%
9th - 12th graders	5.9%	4.1%	6.3%	8.1%	Penobscot 8.8%	Washington 3.3%
response totals: 6th - 12th grades - 13,832; adults - 2,196						

Source: Substance Abuse Prevention: Maine's 1997 Data Report, Maine Department of Mental Health, Mental Retardation and Substance Abuse Services, December, 1997. Data from: (1) State of Maine Alcohol and Drug Use: An Assessment of Students in Grades 6-12, Risk and Protective Factors, surveys 1995 and 1996 combined; and, (2) Maine Office of Substance Abuse Household Survey, 1995-1996.

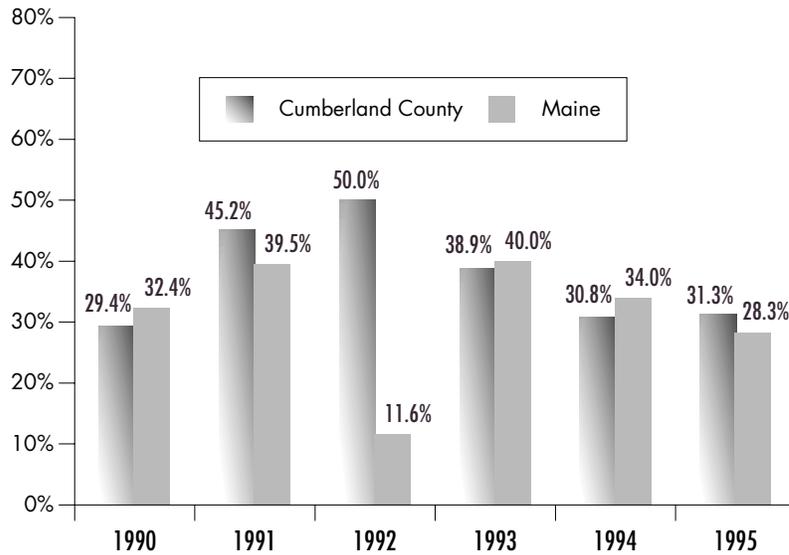
■ **Hospital Discharges for Substance Abuse — Portland HSA: 1995-1996 combined**

- Hospital discharges for substance abuse are higher for males than females at each age. These discharges peak for males between the ages of 18 and 44, then males 45 to 64 and third for females between the ages of 18 and 44.



■ **Percentage of Total Traffic Fatalities that are Alcohol-Related — Cumberland County and Maine: 1990 - 1995**

- In Maine and Cumberland County, alcohol contributed to about one out of three traffic fatalities between 1990 and 1995.

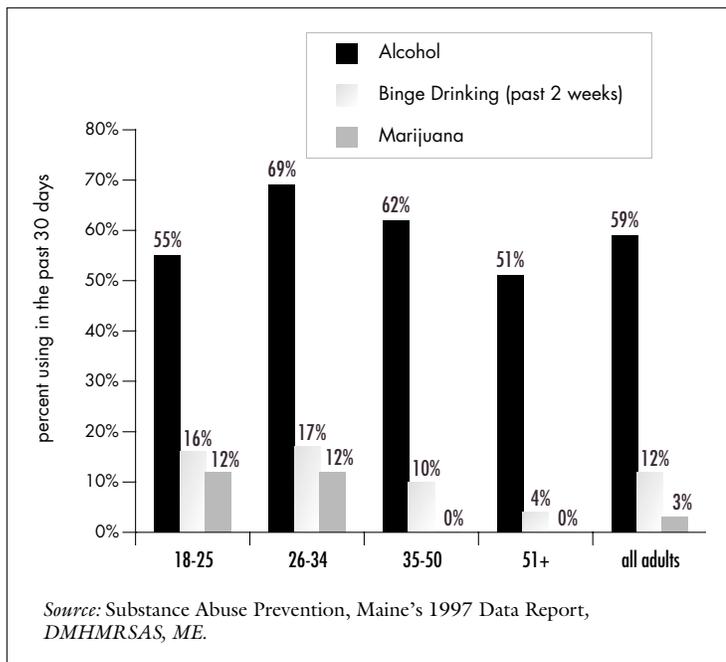


Source: Substance Abuse Prevention, Maine's 1997 Data Report, DMHMRAS, ME.

## Adult Prevalence and Outcomes

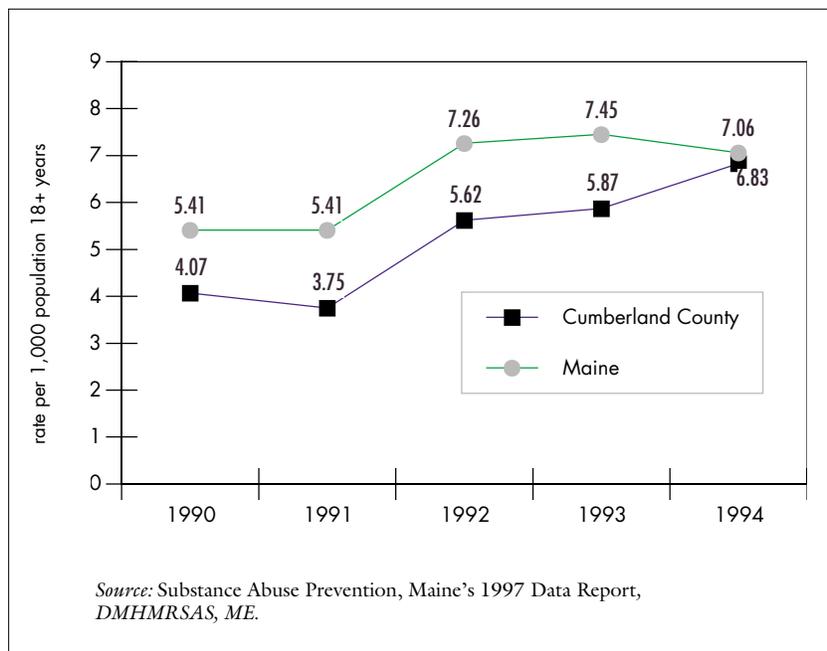
### ■ Substance Abuse Prevalence, Adults — Cumberland County: 1996

- More than 50% of all adults at all ages consumed alcohol in the past 30 days.
- Almost one in five adults between the ages of 18 and 34 binge drank in the past two weeks



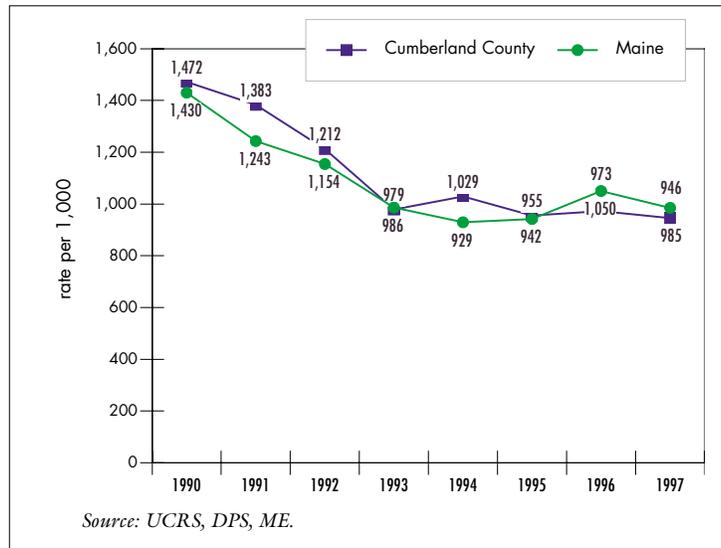
### ■ Rate of Adults in State-Supported AOD Treatment — Cumberland County and Maine: 1990 - 1994

- The rate of adults in state-supported AOD treatment increased, in both Cumberland County and Maine, in the early 1990s. By 1994, the rate in Cumberland County almost matched the state rate.



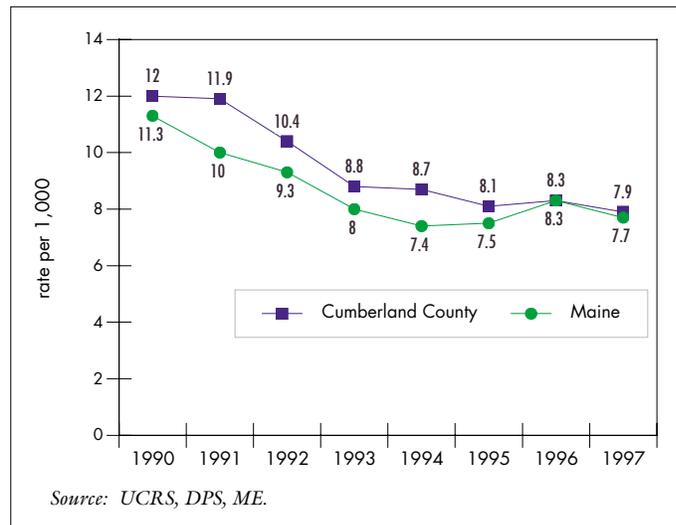
■ **Rate of Arrests for Alcohol-Related Crimes, Persons 18+ — Cumberland County and Maine: 1990 - 1997**

- The adult arrest rate for alcohol laws has decreased slightly since 1990, in both Cumberland County and Maine.



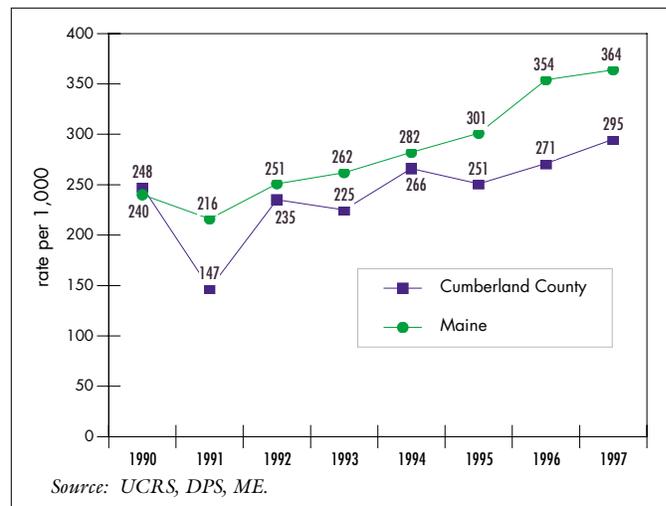
■ **Rate of Arrests for OUI, Persons 18+ — Cumberland County and Maine: 1990 - 1997**

- Between 1990 and 1997, adult arrests for OUI declined in both Cumberland County and Maine; and, Cumberland County's rate dropped down to the state's level.



■ **Rate of Arrest for Drug-Related Crimes, Persons 18+ — Cumberland County and Maine: 1990-1997**

- Arrests for drug law violations showed a steady increase in both Cumberland County and Maine in the 1990s.



■ **Substance Abuse by Adult Probationers at Time of Offenses — U.S.: 1995**

• Nation-wide, alcohol is present in about one in three criminal cases. Looking at violent crimes, alcohol is present in two out of five cases.

Most Serious Current Offense	any substance	alcohol only	illicit drugs only	both
All offenses	49%	18%	17%	14%
Violent offenses	49%	21%	12%	16%
Property offenses	53%	18%	21%	14%
Drug offenses	44%	8%	26%	10%
Public order offenses	50%	31%	10%	9%

*Source: Substance Abuse Prevention, Maine's 1997 Data Report, DMHMRSAS, ME.*

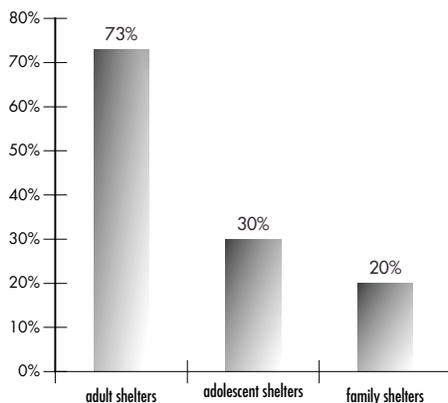
■ **Homeless People with Substance Abuse Problems<sup>i</sup> — Portland Shelters: 1997**

	all homeless with substance abuse problems	long-term homeless with substance abuse problems
average length of homelessness (in years)	4.86	9.75
average age of initial substance use	13.05	11.37
average age person left home	14	16

*Source: Recommendations from the Adult Homeless Substance Abuse Steering Committee, 1997.*

• Over half of Portland's shelter-dwelling population with substance abuse problems reported having mental health problems (dual diagnosis), and reported being incarcerated at some time. These individuals tend to be homeless for many years. Many began using substances in early adolescence and left home as young teens.

■ **Percent of Emergency Shelter Users Who Have a Substance Abuse Disorder, by Shelter Type<sup>ii</sup> — Portland: 1996**



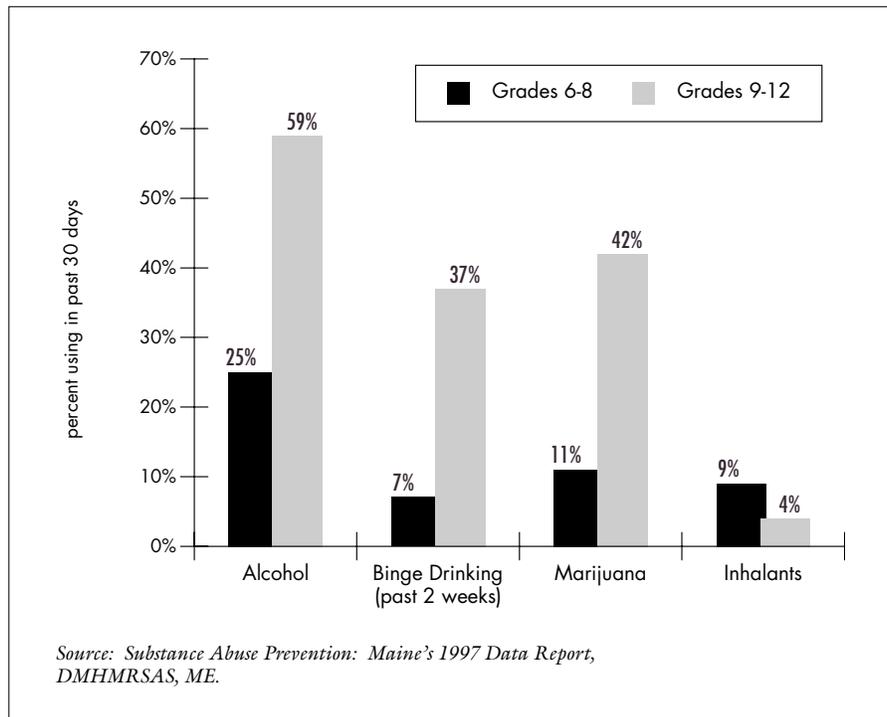
• The vast majority of the adult emergency shelter population has a substance abuse disorder. About one in three occupants of adolescent shelters, and one in five occupants of family shelters also have substance abuse disorders.

*Source: Portland, ESAC.*

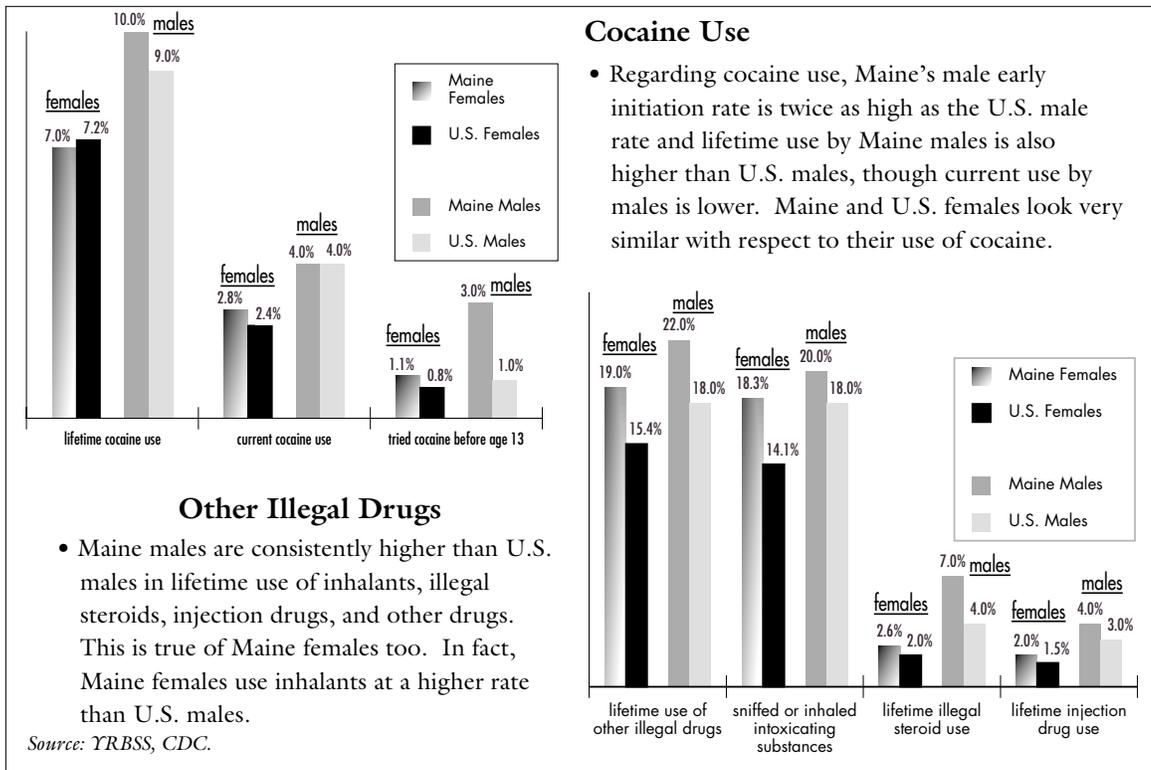
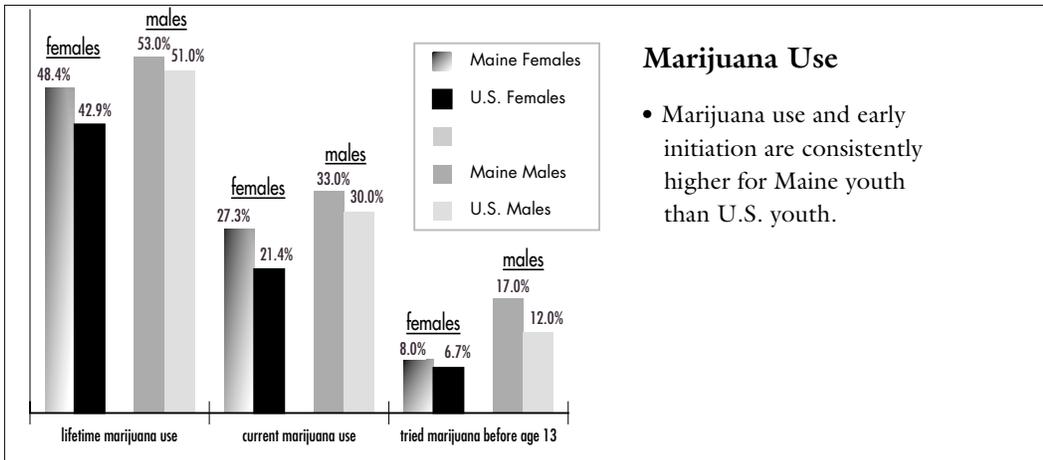
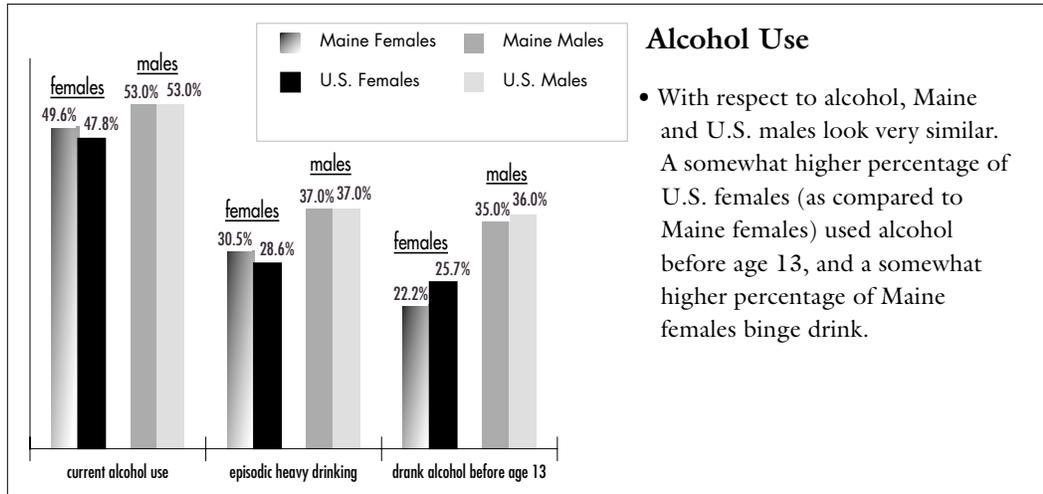
## Youth Prevalence and Outcomes

### ■ Middle and High School Student Substance Abuse Prevalence — Cumberland County: 1996

- Abuse of alcohol and marijuana more than doubled between middle school and high school for Cumberland County youth in 1996.
- Twice as many middle school students, compared to high school students, used inhalants.

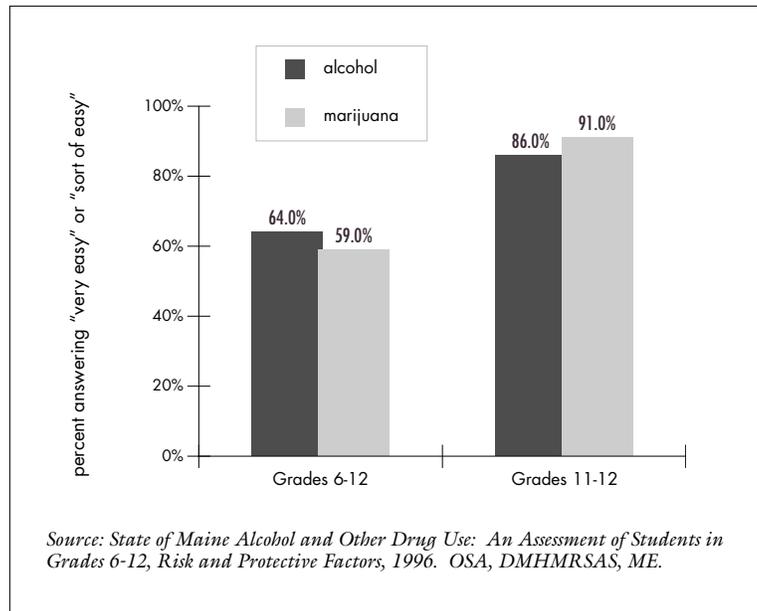


■ **Percentage of High School Students Who Used Alcohol and Other Drugs, by Sex — Maine and the U.S.: 1997**

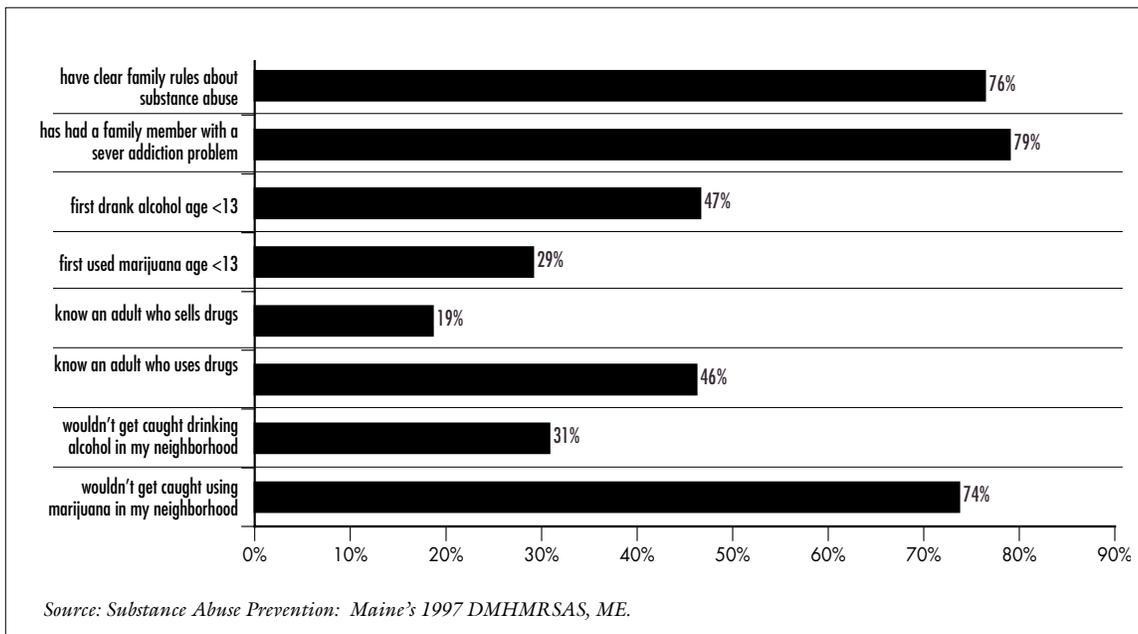


■ **Percentage of Students Who Felt They Could “Easily” Procure Substances — OSA Region 1: 1996<sup>iii</sup>**

- Well over half of middle school students, and about 90% of high school students felt that they could “easily” procure alcohol and/or marijuana, in a 1996 survey of OSA Region I.



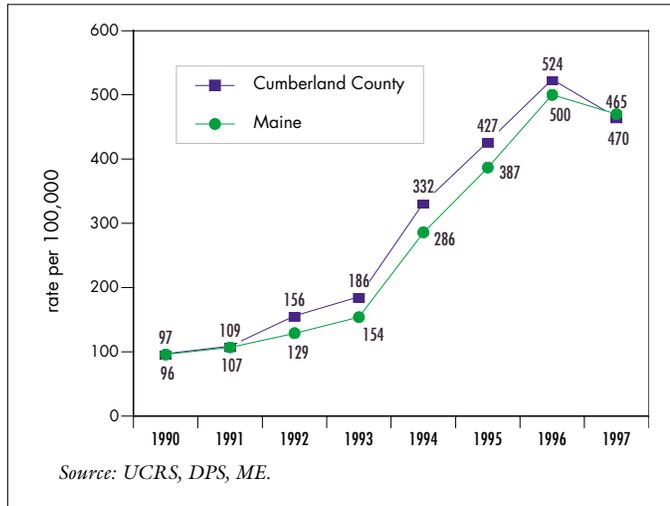
■ **Family and Community Factors Affecting Substance Abuse, 6th - 12th Graders — Cumberland County: 1995-1996 combined**



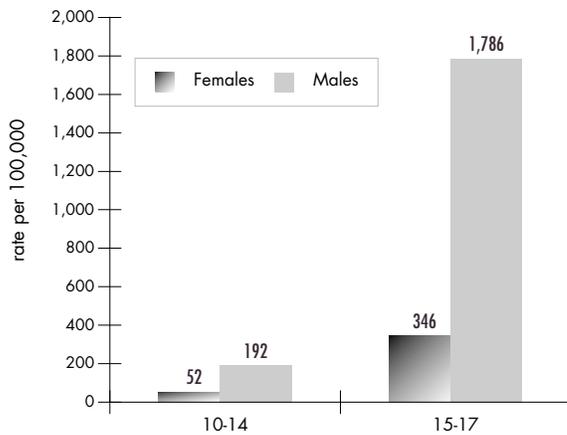
- While three out of four Cumberland County youth report having clear family rules about substance abuse, close to one in three have had a family member with a severe addiction problem with drugs and/or alcohol.
- Nearly half of Cumberland County youth drank alcohol at age 13 or less; and, almost one in five first smoked marijuana at age 13 or less.
- Almost half of Cumberland County youth know an adult who uses drugs (alcohol not included); and, close to one in three know an adult who sells illegal drugs. More than three out of four youth feel that they can drink alcohol or smoke marijuana in their neighborhood without getting caught.

**■ Rate of Arrests for Drug Law Violations, Persons 10-17 —  
Cumberland County and Maine: 1990-1997**

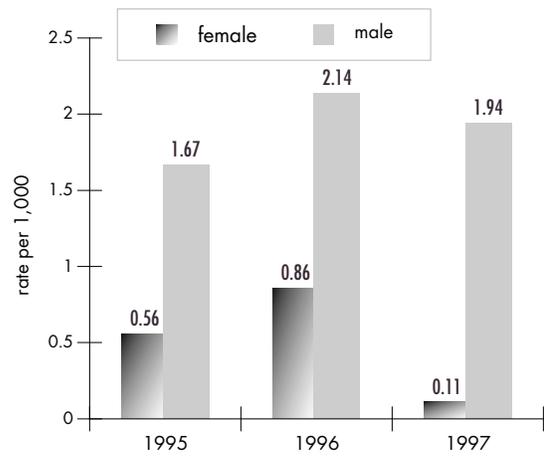
- Juvenile arrests for drug law violations increased steadily from 1990 to 1996 in both Cumberland County and Maine.



**■ Rate of Arrests for Drug Law Violations, Ages 10-14 and 15-17, by Sex —  
Cumberland County: 1995-1997 combined**



**■ Rate of Arrests for Drug Law Violations, Ages 10-14, by Sex —  
Cumberland County: 1995-1997**

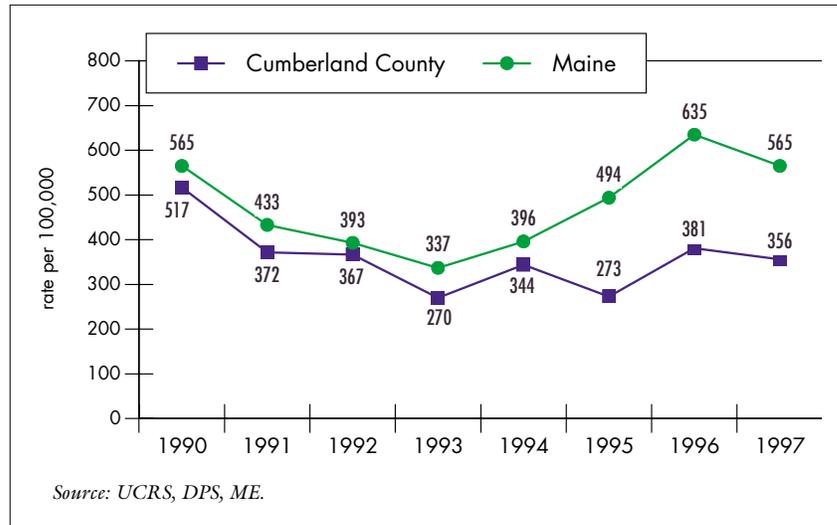


- In the late 1990s, among juveniles, males between 15 and 17 years old were most likely to be arrested for drug law violations in Cumberland County (and in Maine). Drug law violation arrests for young females decreased during this period.

Source: UCRS, DPS, ME.

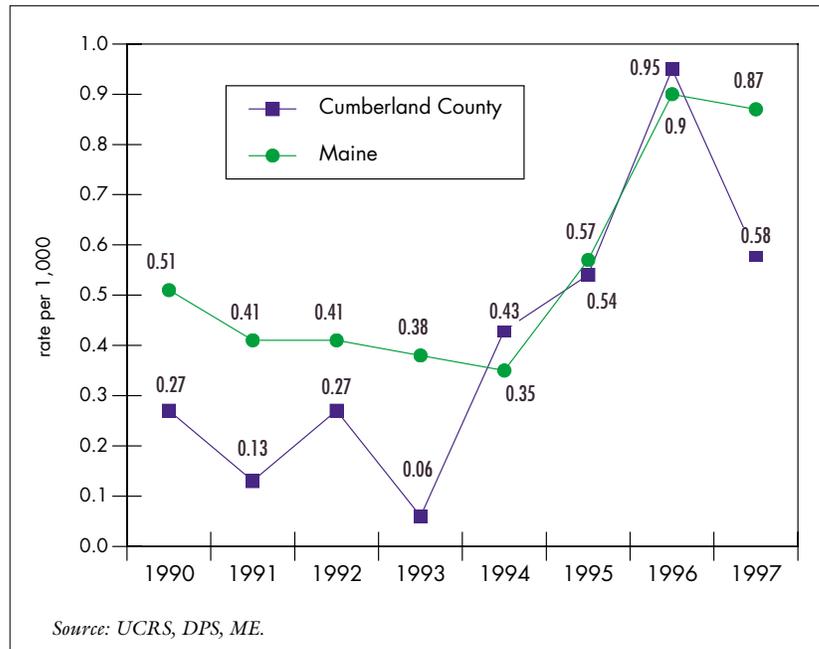
■ **Rate of Arrests for Alcohol-Related Violations, Ages 10-17 years —**  
 Cumberland County and Maine: 1990-1997

• Juvenile arrest rates for alcohol-related crimes somewhat decreased in Cumberland County, though not in Maine, during the end of the 1990s.

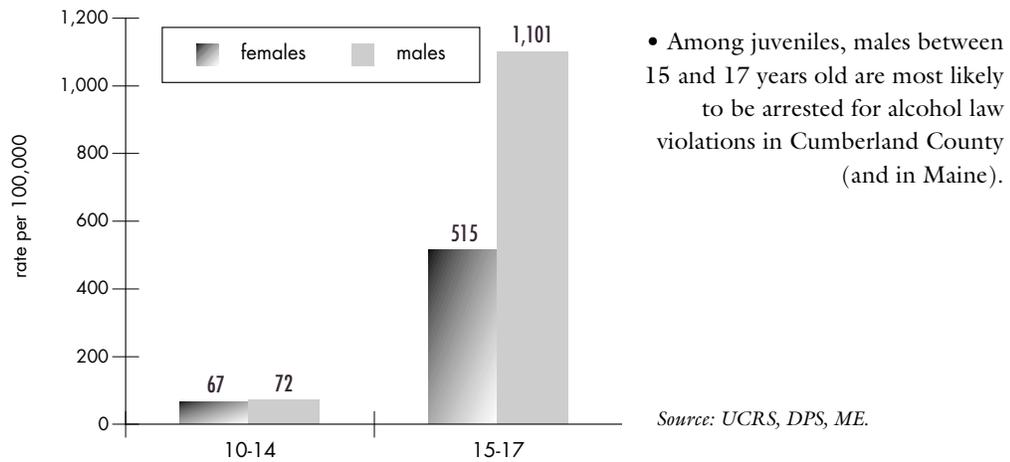


■ **Rate of Arrests for Alcohol-Related Violations, Ages 10-14 years —**  
 Cumberland County and Maine: 1990-1997

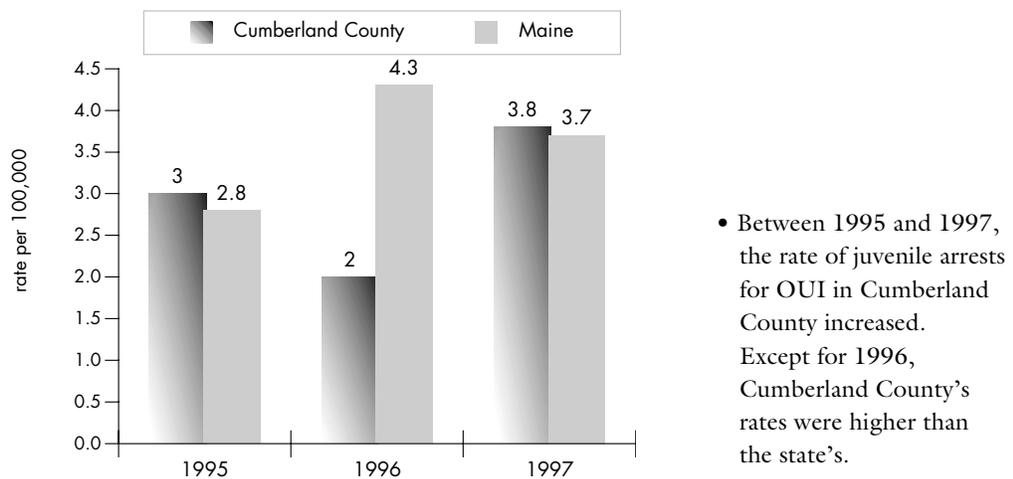
• Among children, ages 10 to 14 years old, arrest rates for alcohol-related crimes increased in Cumberland County and Maine during the 1990s.



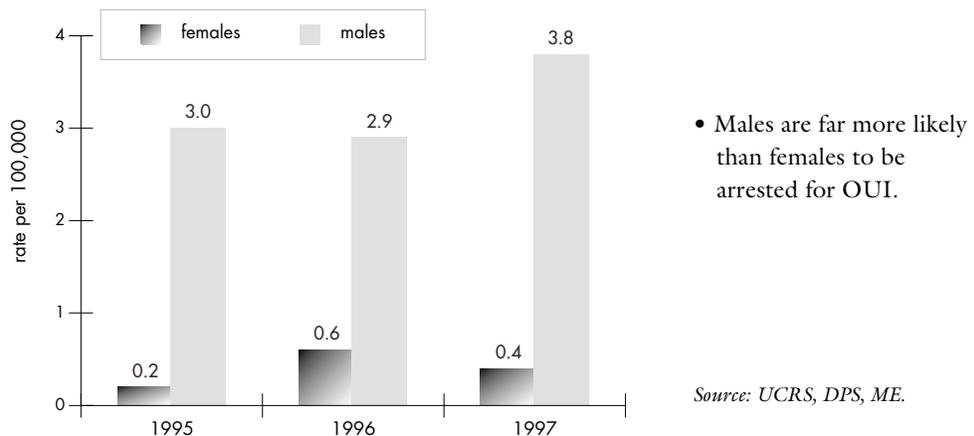
■ **Rate of Arrests for Alcohol Law Violations, Ages 10-14 and 15-17, by Sex —  
Cumberland County: 1995 - 1997 combined**



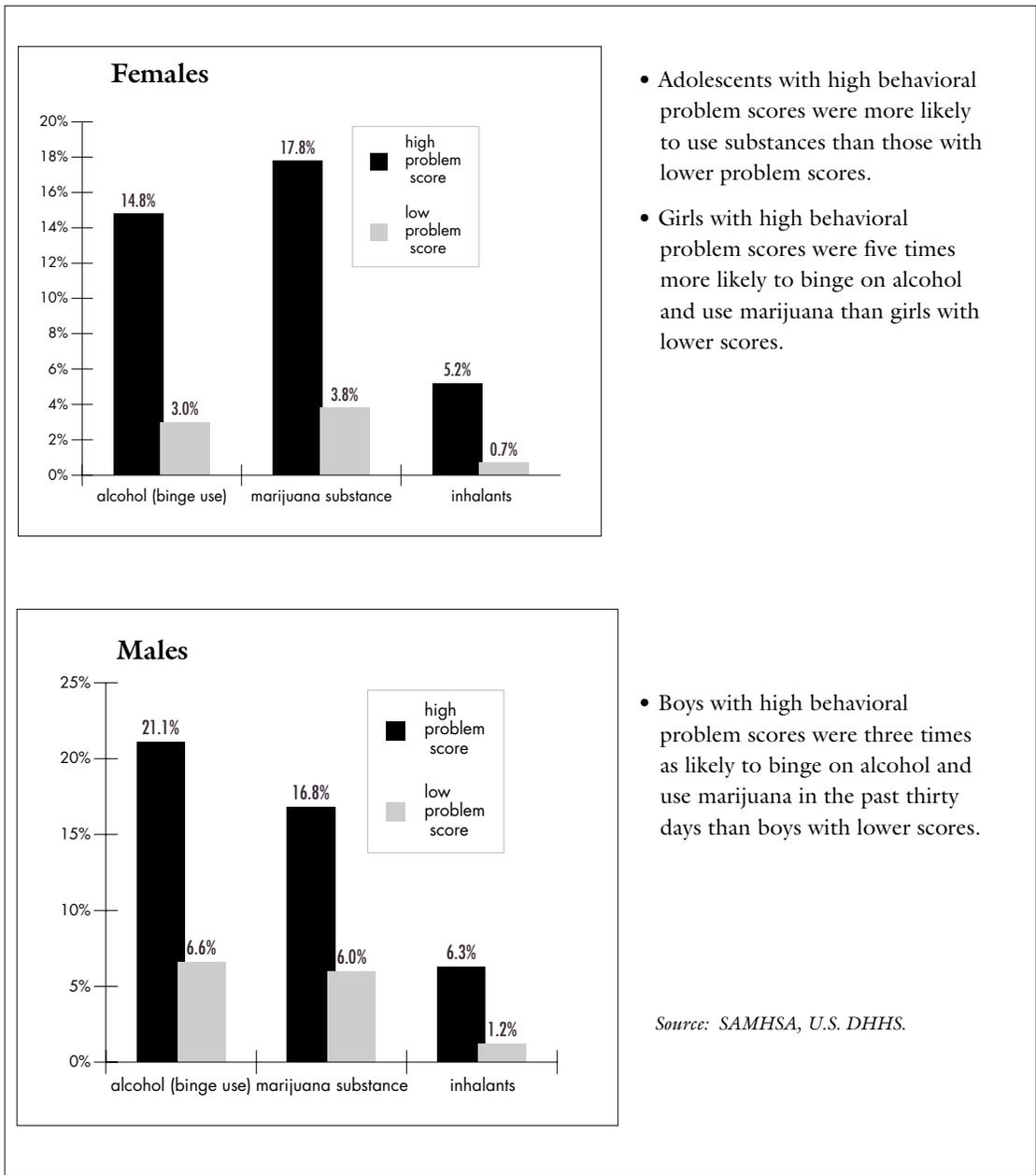
■ **Rate of Arrests for OUI, Juveniles —  
Cumberland County and Maine: 1995 - 1997**



■ **Rate of Arrests for OUI, Juveniles, by Sex — Cumberland County: 1995 - 1997**



■ Past Month Substance Use Among Youth Ages 12-17, by Behavior Problem Score<sup>iv</sup> — U.S.: 1996



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## Endnotes

- <sup>i</sup> Pronouncement of a national estimate of the percent of the homeless population with an addictive disorder is fraught with complication. However, research reveals that regardless of the subpopulation examined, the prevalence of addictive disorders within the homeless population is greater than the rate of the disease among the general population.
- <sup>ii</sup> Evidence from recent research undertakings demonstrate that treatment is an effective antidote to homelessness for those with addictive disorders and that services customized to the unique needs and life circumstances of those without homes can resolve both their addictive disorder and their homeless condition. In 1997, the percentage of clients reporting homelessness in the past 12 months dropped over 40%, among those served by the Center for Substance Abuse Treatment (CSTAT) programs, according to the National Treatment Improvement Evaluation Study (NTIES). (*Impact of Substance Abuse Treatment on Homelessness*).
- <sup>iii</sup> OSA Region I (1995-1996): Cumberland, Knox, Lincoln, Sagadahoc, Waldo, and York counties.
- <sup>iv</sup> “Behavior problem score” in this study was a measure of delinquency.



## Source Book Error Log

### ERRATA

*The Greater Portland Community Health Assessment and Source Book 2000* brings together secondary data from a host of Federal, State, and Private agencies about the health status of the Portland area population. Updates and corrections to the information presented in the Source Book are continuously becoming available and we present them to our readers in this table of errata. The table below gives the error location in the printed document and the correction. We update this table the first week of each month.

**If you believe you have found an error please email: [healthassess@portlandmaine.gov](mailto:healthassess@portlandmaine.gov).** Or contact the Department of Health and Human Services, City of Portland, Portland, ME 04101, (207) 775-7915 x267.

ERROR		CORRECTION	DATE
location	text	text	
page: xiv ¶: 1 line: 3	25	27	1/30/01
page: xvii list: towns line: 10	Standish is not  an Inner Town	Standish is  an Outer Town	1/30/01
page: xxi section: A (excellent) line: 1	Children's Oral Health	Children's Oral Health  (City of Portland only)	1/30/01
page: xxii section: F (poor) lines: 9, 10	arrest	known offense	3/15/01
page: xxiii ¶: 5 (Oral Health) line: 1	Oral Health	Children's Oral Health	1/30/01
page: 73 section: 1 (Dom. Violence) line: 1	arrest	known offense	3/15/01

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page: 73 section: 2 (Youth Violence) line: 1	arrest	known offense	3/15/01
page: 73 section: 3 (Violent Crime) lines: 1, 3,6	arrest	known offense	3/15/01
page: 81 graphs: 3, 4 titles	arrest	known offense	3/15/01
page: 81 ¶: 3 line: 1	arrest	known offense	3/15/01
page: 87 ¶: 3 line: 2	19.9%	19.1%	4/10/01
page: 88 ¶: 2 line: 5	arrest	known offense	3/15/01
page: 89 graphs: 1, 2 titles	arrest	known offense	3/15/01
page: 90 graph: 1 title	arrest	known offense	3/15/01
page: 90 ¶: 1 line: 1	arrest	known offense	3/15/01
page: 153			

### Source Book Error Log

¶: 2	71%	65%	4/13/01
line: 2			
page: 173			
section: 3	life time: 1,986 7,316 35,574	life time: 7,517 27,687 134,624	01/26/01
(any affective disorder)	per year: 1,207 4,447 21,624	per year: 4,401 16,211 78,821	
lines: 1, 2			