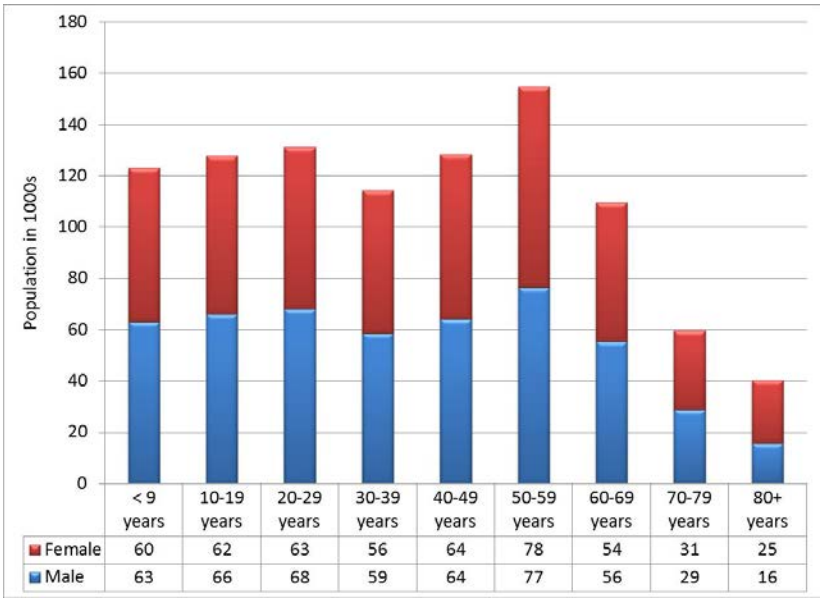
Montana

June, 2012

POLICY ACADEMY STATE PROFILE

Montana's Population

MONTANA'S POPULATION (IN 1000S) BY AGE GROUP



Source: U.S. Census Bureau, 2010

Montana is home to nearly 1.0 million people. Of these, approximately 364,000 (37 percent) are over 50; 210,000 (21%) are over 60; 100,000 (10%) are over 70; and 40,000 (4%) are over 80. The proportion of females rises with each age group – 61% of the 80+ are female. The racial/ethnic composition of older Montanans is as follows:

Race/Ethnicity of Montanans

Age	White	Black	Am Indian AK Native	Other	White not Hispanic
<55	87.8%	0.6%	7.4%	4.3%	85.7%
55+	95.2%	0.1%	3.0%	1.6%	94.4%

Source: U.S. Census Bureau, 2009 Projections

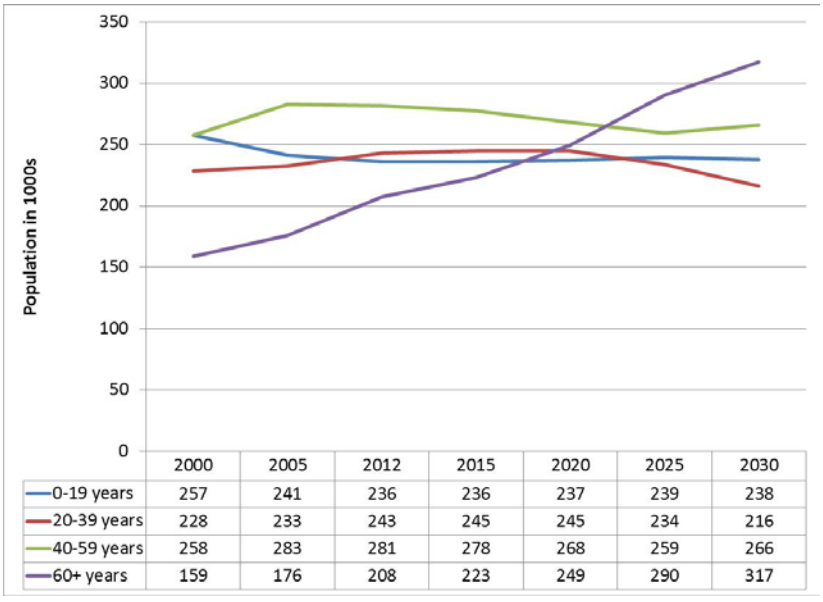
THE NUMBER OF OLDER MONTANANS IS GROWING (POPULATION IN 1000S)

The proportion of Montana's population that is over 60 is growing while the proportion that is under 60 is shrinking. The U.S. Census Bureau estimates that more than 30 percent of Montana's population will be over age 60 by the year 2030, an increase of 43% percent from 2012.

Projected Montana Population

Age Group	2012	2020	2030
0 to 19	24.4%	23.7%	22.9%
20 to 39	25.1%	24.5%	20.9%
40 to 59	29.1%	26.8%	25.6%
60+	21.4%	25.0%	30.6%

Source: U.S. Census Bureau, 2009 Projections



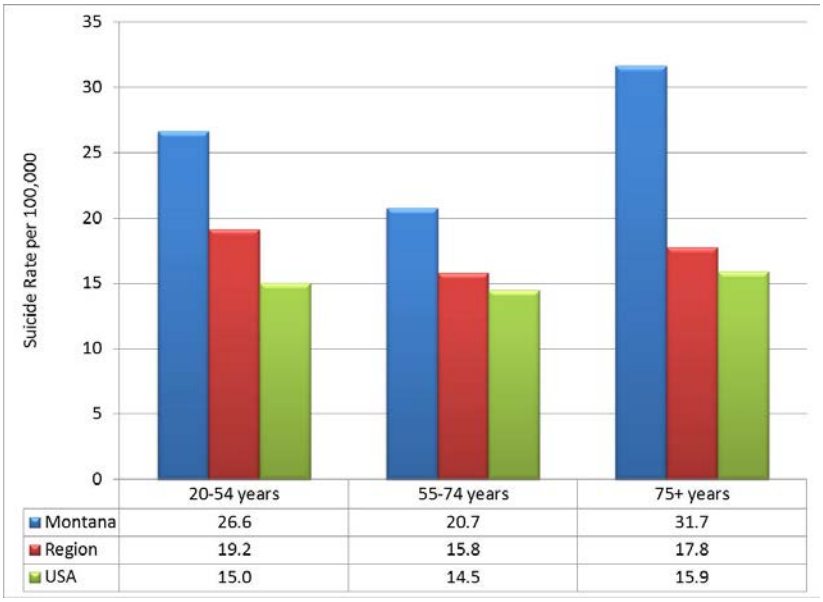
Source: U.S. Census Bureau, 2009 Projections

Suicide Among Older Montanans

2008 Suicide Rate per 100,000 Population - Montana Compared to Region and Nation

The suicide rate among older Montanans (over age 55) is lower than the rate among younger age groups. In 2008, the latest year in which comparable national data were available, an estimated 57 Montanans over age 55 committed suicide. As this graph illustrates, the suicide rate among older Montanans was higher than the U.S. and higher than the surrounding Region including Colorado, Iowa, Kansas, Missouri, Nebraska, North Dakota, South Dakota, Utah and Wyoming.

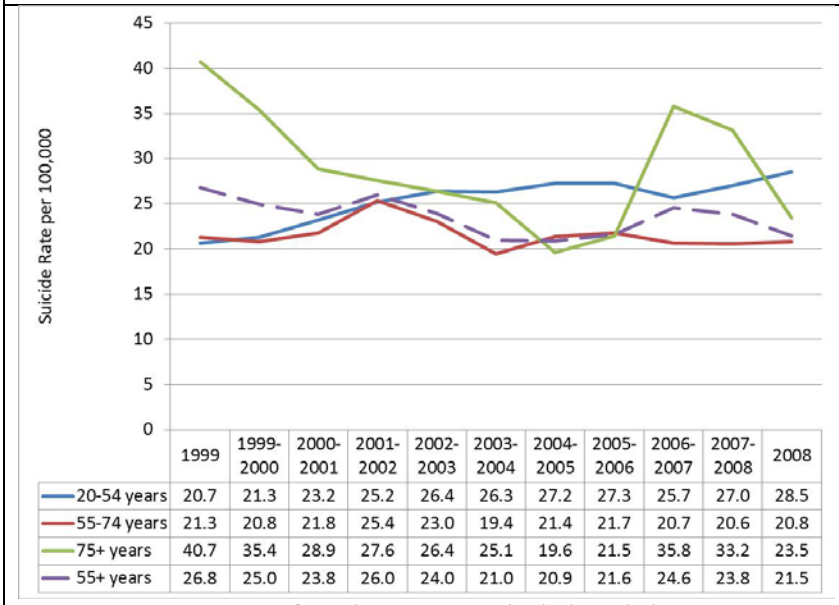
Please Note: States vary in their reporting practices surrounding suicide deaths. The apparent rate of suicide is influenced by these reporting practices.



	20-54 years	55-74 years	75+ years
Montana	26.6	20.7	31.7
Region	19.2	15.8	17.8
USA	15.0	14.5	15.9

Source: Centers for Disease Control Vital Statistics 2008

Trend in Suicide Rate Montana's Population



	1999	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005	2005-2006	2006-2007	2007-2008	2008
20-54 years	20.7	21.3	23.2	25.2	26.4	26.3	27.2	27.3	25.7	27.0	28.5
55-74 years	21.3	20.8	21.8	25.4	23.0	19.4	21.4	21.7	20.7	20.6	20.8
75+ years	40.7	35.4	28.9	27.6	26.4	25.1	19.6	21.5	35.8	33.2	23.5
55+ years	26.8	25.0	23.8	26.0	24.0	21.0	20.9	21.6	24.6	23.8	21.5

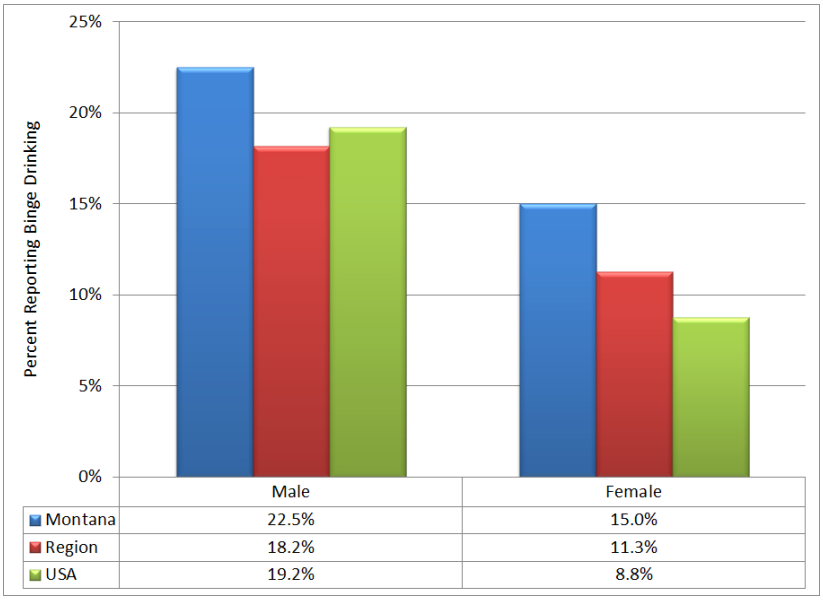
Source: Centers for Disease Control Vital Statistics, 2009

The rate of suicide among older Montanans age 55+ (shown with the dashed line) fluctuated from a high of 26.8 per 100,000 in 1999 to a low of 20.9% per 100,000 in 2004-2005.

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

Older Montanans' Substance Use / Abuse

30-Day Binge Drinking among older Montanans by GENDER



Source: Behavioral Risk Factor Surveillance System 2011

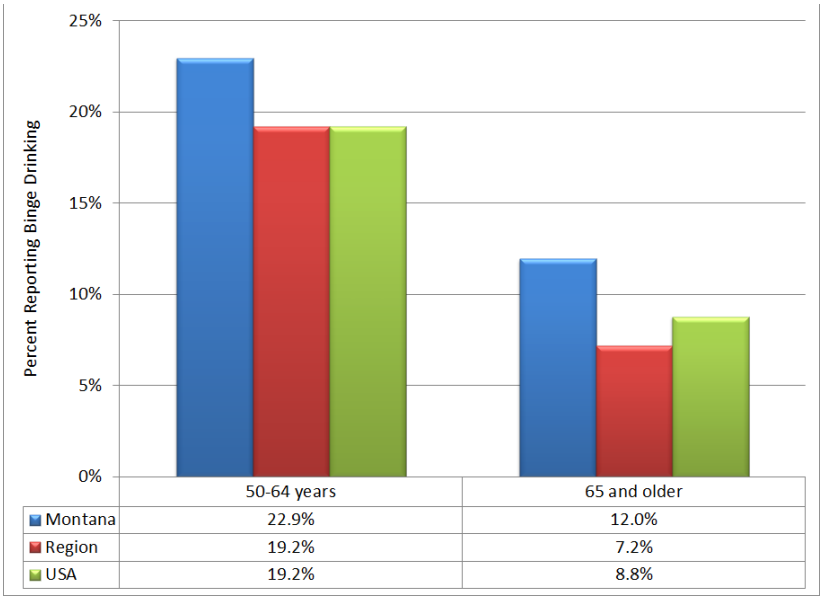
Duke Medicine News (August 17, 2009) notes that binge drinking can cause: "serious problems, such as stroke, cardiovascular disease, liver disease, neurological damage and poor diabetes control." Binge drinkers are more likely to take risks like driving while intoxicated, and to experience falls and other accidents. Older people have less tolerance for alcohol. Therefore, this table defines a "binge" as 3 or more drinks in one event for women and 4 or more for men. Binge drinking is higher among men. 22.5 percent of Montana males age 50 and over reported binge drinking while nearly 12 percent of females reported similar behavior. The confidence intervals around the regional / national and Montana estimates are less than ± 0.2 and ± 1.1 percent respectively.

30-Day Binge Drinking Among Older Montanans by AGE GROUP

Binge drinking decreases with age. 22.9 percent of Montanans age 50-64 reported binge drinking, while 12.0 percent in the 65+ age group reported similar behavior. The confidence interval around the regional / national and Montana estimates are less than ± 0.2 and ± 1.5 percent respectively. Binge drinking remains highest among males regardless of age group. The following table illustrates:

Binge Drinking among Older Montana Males and Females by Age Group

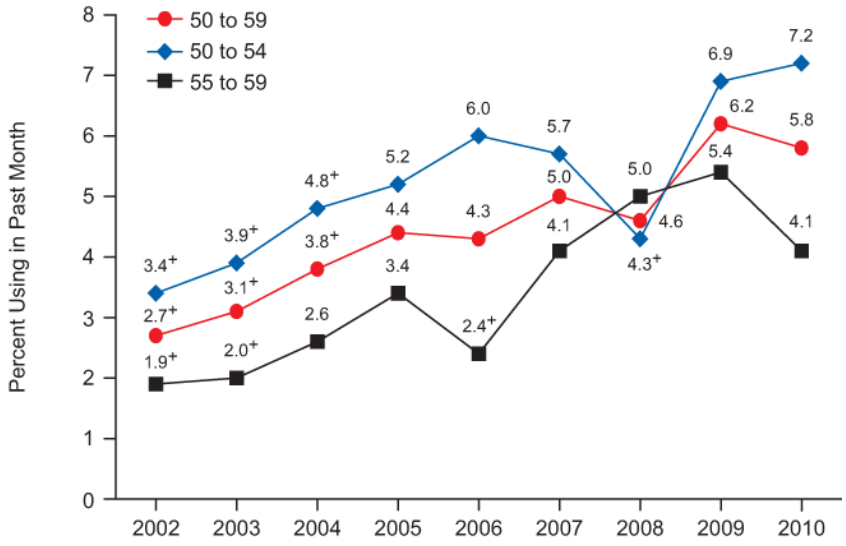
	Male	Female
50-64 years	28.8%	18.5%
65 and older	14.2%	10.1%



Source: Behavioral Risk Factor Surveillance System, 2011

Illicit Drug Use Among Older Americans

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



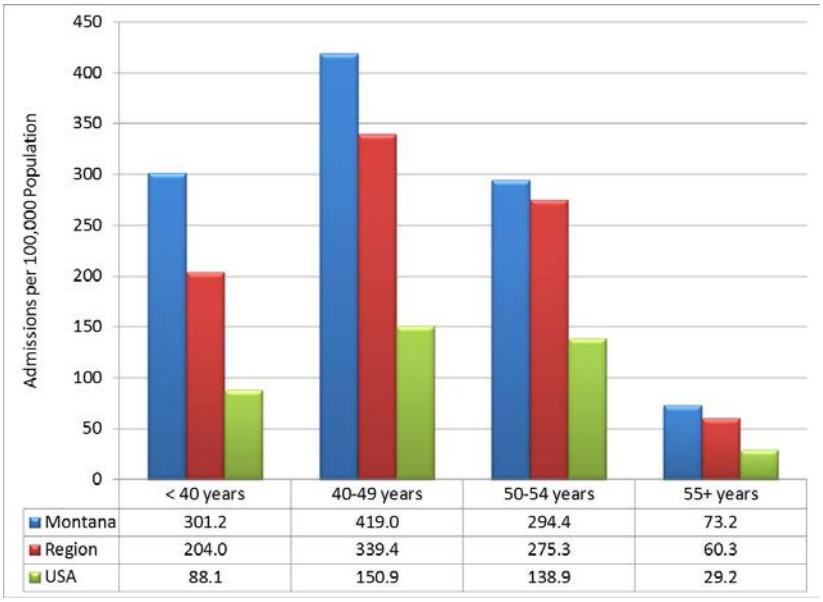
Source: National Survey on Drug Use and Health, 2010
Volume 1. Summary of National Findings

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

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

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

Older Montanans in Substance Abuse Treatment



	< 40 years	40-49 years	50-54 years	55+ years
Montana	301.2	419.0	294.4	73.2
Region	204.0	339.4	275.3	60.3
USA	88.1	150.9	138.9	29.2

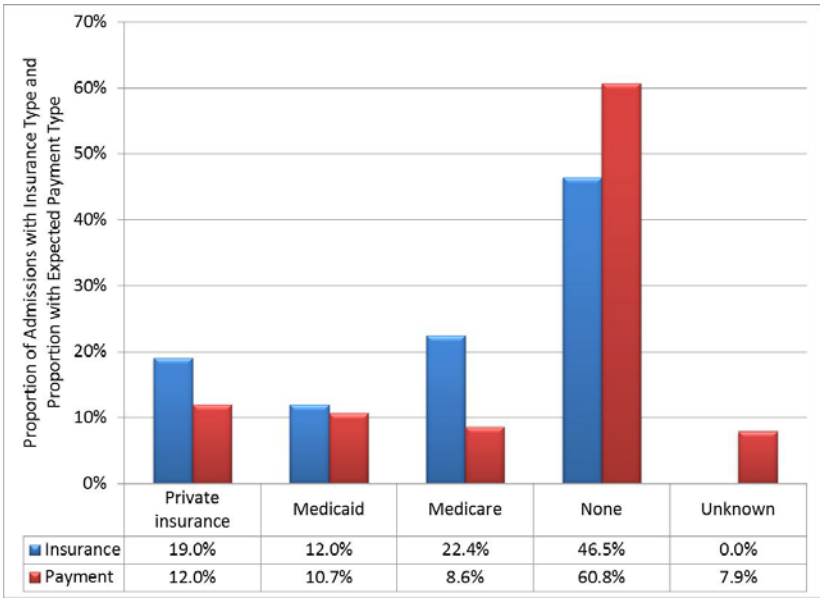
Source: Treatement Episode Data Set, 2009
Includes only those clients reported to SAMHSA

More than 200 older Montanans (age 50+) were admitted to substance abuse treatment in publicly funded facilities in 2009, a rate of 121.0 per 100,000. This rate was higher than the regional and national averages. Characteristics of this population include:

- 65% (287 individuals) were males, similar to national and regional rates.
- 70% percent (310 individuals with known race) were White.
- 22% (95 individuals) were Native American / Alaska Native
- 4% (17 individuals with known ethnicity) identified themselves as being of Hispanic descent.
- 40% (178 individuals) were referred to treatment by the criminal justice system.
- 30% (134 individuals) entered treatment through self or other individual-referral.

Treatment Admissions among Age 55+ by Insurance Type

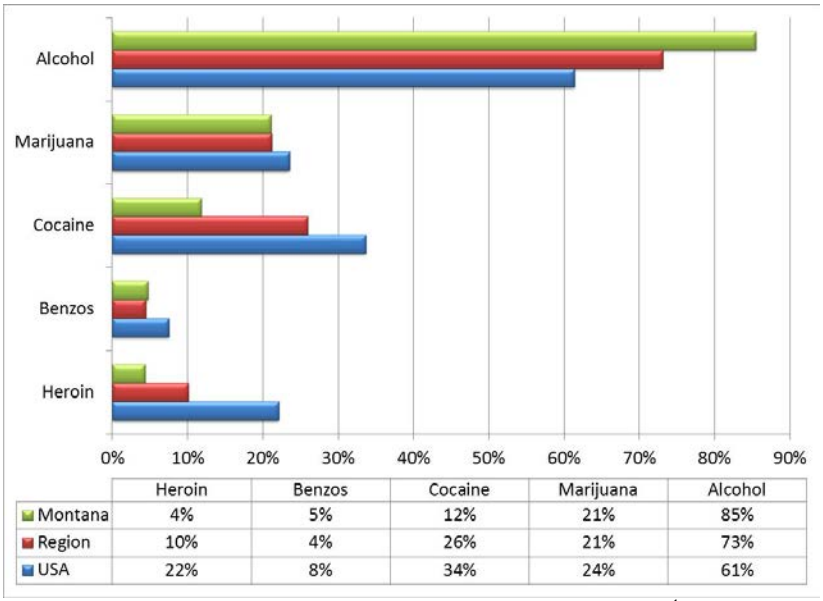
Nearly 20 percent of older Montanans who were admitted to substance abuse treatment reported they had private insurance, yet this was the expected source of payment in only 12 percent of the admissions. Nearly 35 percent reported they were insured by Medicare or Medicaid; yet, this was the expected source of payment in just about 20 percent of cases. In the vast majority of cases (nearly 70 percent in total) the source of payment was "None" or "Unknown." In these instances, the bills were likely directed toward the State's SAPT Block Grant / State-funded treatment programs.



	Private insurance	Medicaid	Medicare	None	Unknown
Insurance	19.0%	12.0%	22.4%	46.5%	0.0%
Payment	12.0%	10.7%	8.6%	60.8%	7.9%

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

AGE 55+ TREATMENT ADMISSIONS - SUBSTANCES USED



	Heroin	Benzos	Cocaine	Marijuana	Alcohol
Montana	4%	5%	12%	21%	85%
Region	10%	4%	26%	21%	73%
USA	22%	8%	34%	24%	61%

Source; Treatment Episode Data Set, 2009[1]
Includes only those clients reported to SAMHSA

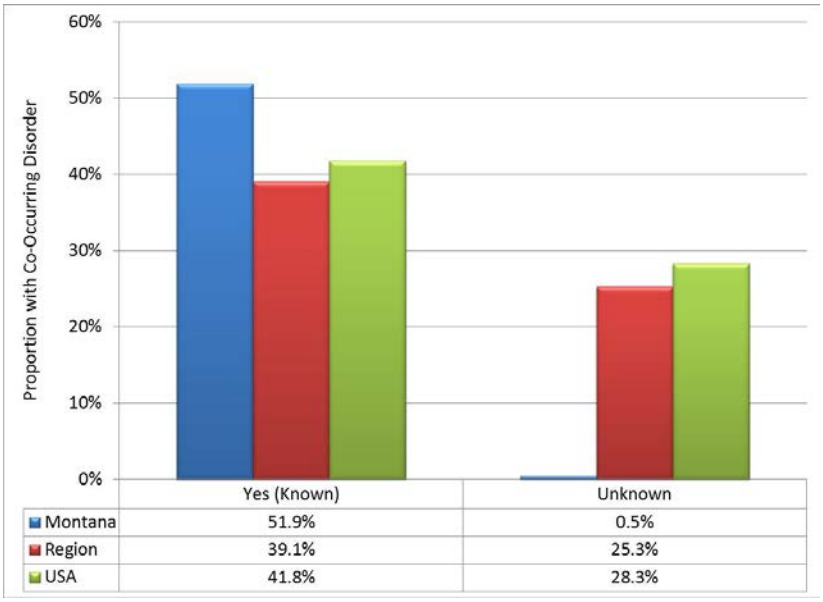
Alcohol was - by far - the most frequent drug of use among older Montanans in publicly financed substance abuse treatment. Alcohol was mentioned as the primary, secondary or tertiary substance of abuse in 85 percent of admissions among those age 50 plus. This was higher than both the national and regional rates.

Other substances of primary, secondary or tertiary use were: Marijuana at 21 percent; cocaine at 12 percent; benzodiazepines / tranquilizers at 5 percent; and heroin at 4 percent.

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

Substance Abuse and Mental Health

Co-Occurring Mental Health Disorder



	Yes (Known)	Unknown
Montana	51.9%	0.5%
Region	39.1%	25.3%
USA	41.8%	28.3%

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

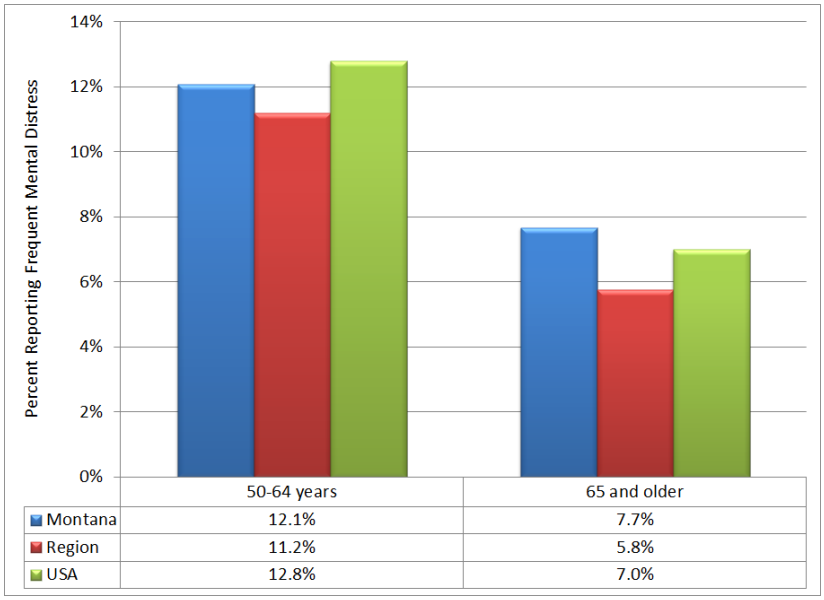
Research shows a strong relationship between substance use and mental health disorders. Studies show 30-80 % of people with substance abuse or mental health disorders also have a co-occurring substance abuse/mental health disorder. The graph to the right shows the proportion of older Montanans (50+) who were admitted to substance abuse treatment and also had a mental health diagnosis. While this rate appears higher than the rates in the nation or region, reporting practices should are a factor in these results.

Admissions to State Mental Health Facilities

Nearly 8 percent of the people served by the Colorado mental health system were age 65 or older (3.3 percent were age 65 to 74 and 4.5 percent were age 75 or older). This represents a total of approximately 2,300 people. Data available at: http://www.samhsa.gov/dataoutcomes/urs/2010/Montana.pdf

Mental Health

Older Montanans Reporting Frequent Mental Distress by Age Group



Source: Behavioral Risk Factor Surveillance System, 2011

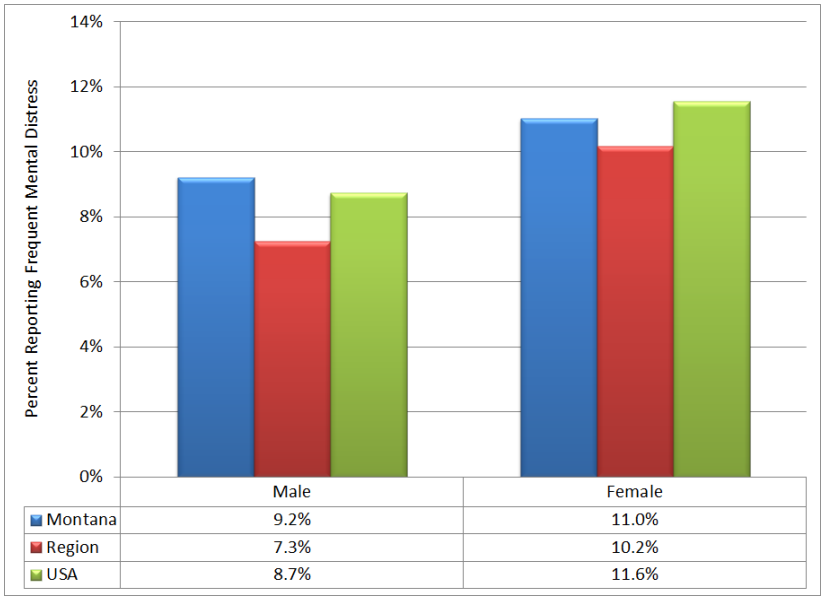
The Behavioral Risk Factor Surveillance System (BRFSS), a household sruvey conducted in all 50 states and several territories, asks the following question: "Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?" The Centers for Disease Control defines those individuals reporting 14 or more "Yes" days in response to this question as experiencing frequent mental distress (FMD). More than 10 percent of older Montanans report that they experience FMD: 12.1 percent in the 50-64 and 7.7 percent in the 65 and older age group. Confidence intervals around national / regional and Montana estimates are less than ±0.2 and ± 1.5 percent respectively/

Older Montanans Reporting Frequent Mental Distress by Gender

While older males are more likely to binge drink, older females are more likely to report FMD. 11 percent of older Montana females reported FMD whil 9.2 percent of males made such reports.The confidence interval around regional / national and Montana estimates were less thaan ± 0.2 and ± 1.5 percent respectively.

The following table shows reports of FMD by age group and ge4nder.

Older Montanas Reporting FMD by Age Group and Gender



Source: Behavioral Risk Factor Surveillance System, 2011

OTHER MEASRUES OF MENTAL HEALTH

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

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

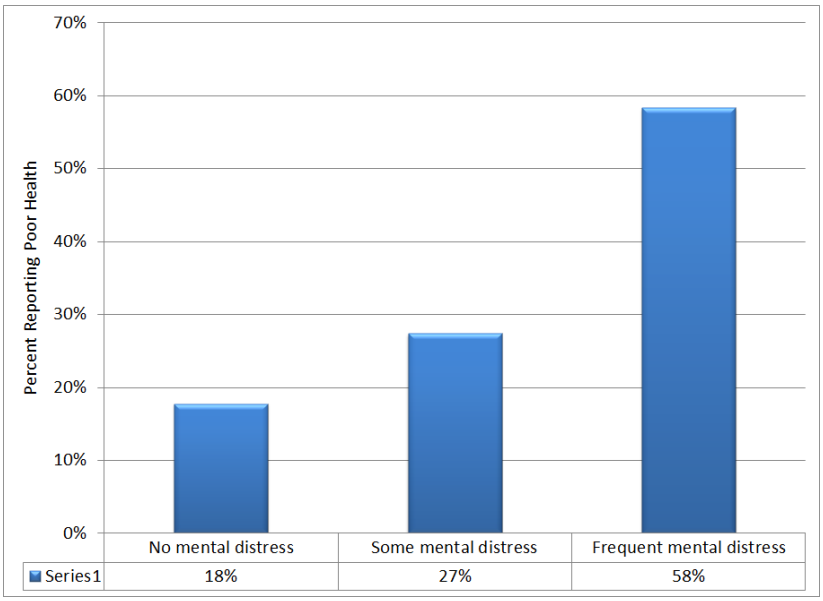
The results of these surveys among older Montanans are shown below:

BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM, 2010

Age Group						
	Age 50+		Age 50–64		Age 65+	
Indicator	Data %	Confidence Interval	Data %	Confidence Interval	Data %	Confidence Interval
Core BRFSS Indicators (2010)						
Rarely or never get social or emotional support (revised)	9.7	(8.7-10..7)	7.6	(6.4-8.7)	12.9	(11.2-14.7)
Very dissatisfied or dissatisfied with life (revised)	4.9	(4.1-5.6)	5.6	(4.6-6.6)	3.7	(2.7-4.7)
Anxiety and Depression Optional Module Indicators (2006)[2]						
Current Depression	5.7	(4.8–6.7)	6.8	(5.6–8.3)	3.9	(2.8–5.4)
Lifetime Diagnosis of Depression	16.9	(15.5–18.5)	20.9	(18.9–23.1)	11.0	(9.3–13.0)
Lifetime Diagnosis of Anxiety Disorder	9.3	(8.2–10.5)	11.2	(9.6–12.9)	6.4	(5.2–8.0)

[2] Data available at http://apps.nccd.cdc.gov/MAHA/StateDetails.aspx?State=MT

People with Frequent Mental Distress Report Poor Physical Health



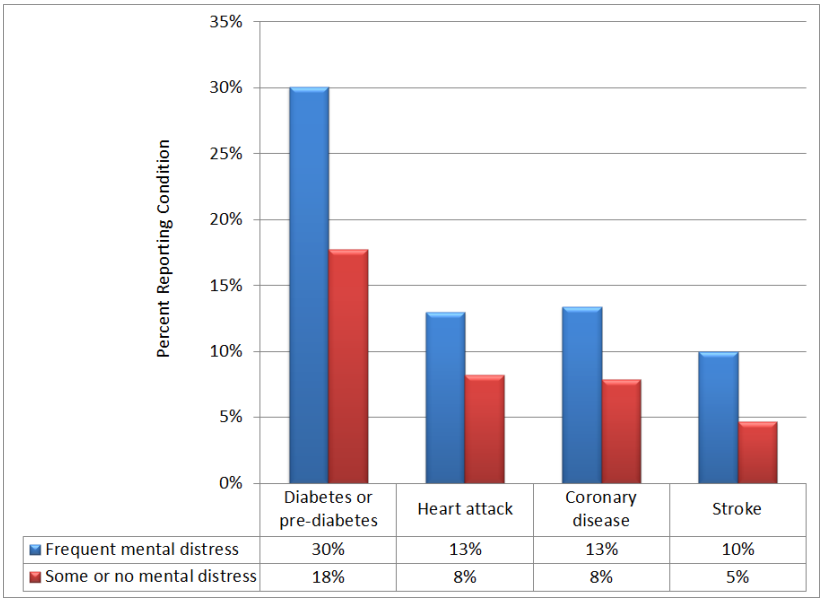
Source: Behavioral Risk Factor Surveillance System, 2011

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

These differences are statistically significant.

Relationship between Mental Distress and Serious Health Problems

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



Source: Behavioral Risk Factor Surveillance System, 2011

DATA SOURCES

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

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

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

NATIONAL SURVEY ON DRUG USE AND HEALTH (NSDUH) (https://nsduhweb.rti.org/). United States Department of Health and Human Services. Substance Abuse and Mental Health Services Administration. Center for Behavioral Health Statistics and Quality. National Survey on Drug Use and Health, 2010. ICPSR32722-v1. Ann Arbor, MI: Inter-university Consortium for Political and Social Research [distributor], 2011-12-05. doi:10.3886/ICPSR32722.v1 The NSDUH, managed by SAMHSA, is " an annual nationwide survey involving interviews with approximately 70,000 randomly selected individuals aged 12 and older." NSDUH data are most frequently used by State planners to assess the need for substance abuse treatment. NSDUH data also include information about mental health needs.

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

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

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