# TEN POLICY ISSUES REGARDING GERIATRIC BEHAVIORAL HEALTH

For

The Coalition Conference: The Future of Geriatric Behavioral Health

September 13, 2018

Presented by

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- I have been asked to provide a quick—very quick—overview of key policy issues regarding geriatric behavioral health. I will try to make **10 points in 10 minutes**.

- My over-riding point is this: **OLDER ADULTS ARE NOT A PRIORITY FOR PUBLIC BEHAVIORAL HEALTH POLICY. WE NEED TO PRESS LOCAL, STATE, AND FEDERAL AGENCIES TO MAKE IT A PRIORITY**.

1. Effective planning for the future will need to take into account that the population of older adults is changing. The next generation of older adults will be a larger portion of the population—larger even than children. It will be older, with more people 85 or older. It will be increasingly non-white. It will be more likely to live alone and not to have family support due to more people who never marry, more who divorce after 50, more who have no children, more with children living at a substantial distance, growing changes in family values regarding care of elder family members and, very importantly, due to our failure as a society to adequately address the needs of family caregivers.

   In addition, health status will change. A portion of the next generation of older adults will be healthier than ever before. But a portion of the next generation will probably be less healthy. This includes the population recently identified in sociological literature on "deaths of despair", working-age men at high risk for drug addiction, suicide, and alcohol-related disorders. The next generation will also include more and more people living with serious chronic disorders.

   In addition, efforts to address the mortality gap between people with serious mental illness and the general population hopefully will pay off, and more people with long-term, disabling serious mental illness will survive into old age.

   It is also likely that in the future more older adults will use currently illegal drugs, especially marijuana. What the negative, or positive, impact will be is unclear.

I also suspect that the next generation of older adults will be somewhat less affected by stigma and more willing to accept mental health services, creating an increase in demand.

2. Geriatric behavioral health is not just about addressing diagnosable disorders. There are two dimensions of behavioral health—the negative, which addresses behavioral disorders, and the positive, which addresses the potential for well-being in old age, sometimes called "healthy" aging, sometimes "successful" aging, sometimes "active" aging, etc.

   Behavioral health policy needs to address both dimensions, including actively **promoting the well-being of older adults living with serious mental illness and/or dementia**. The concept of "recovery" is applicable, but rarely applied, to older adults.

   In addition, behavioral disorders are of two distinct varieties—those that are seriously disabling over long periods of time and those that are troubling but not seriously disabling in the long-term. These two populations call for two quite different kinds of services.

   **For people with serious, long-term disorders, housing and rehabilitation are absolutely key.**

3. Aging in Place is a key goal of behavioral health policy, but the term "aging in place" is a bit misleading. It includes moving people from institutions—state hospitals, nursing homes, adult homes, and prisons—to community settings with adequate supports. And it includes helping people seeking a good life in old age to move from their homes to other places—Florida, retirement communities, etc.—if that is what they prefer.

   For older people with long-term disabling conditions who are currently in one form or another of supportive housing, "aging in place" is absolutely the right idea, but it will depend on **providing settings in which they can live with the chronic physical conditions and disabilities** that are part and parcel of old age. Failure to do so contributes to movement in the wrong direction—from supportive community housing to institutions.

4. Home and community-based services that address issues of physical health, behavioral health, isolation, and inactivity are crucial to enable older adults to live decently in the community. This calls not just for expansion and improved access but also for **structural changes in the behavioral health system**. It is too much a system in which professionals wait in offices for people to come to them for help. There is too little outreach, too few in-home services, and too few services

available outside office hours that are convenient for providers but not for older people and their family caregivers.

5. Improved quality is a critical goal for behavioral health services. Too many people get inadequate treatment from primary care physicians. And, of those who get treatment from behavioral health professionals at best half get even minimally adequate services. As a system, we are not doing a good enough job, even though we know how.

6. Integrated care is currently seen as one major solution to the problem of uneven quality. This includes integration of mental health and substance abuse services, integration of behavioral and physical health services, and integration of health and aging services. All good ideas, but far easier said than done.

   There are a variety of elaborate integrated systems being developed via Medicaid and Medicare— "medical homes", "health homes", "accountable care organizations", HARPs, FIDAs, and so forth. Will they make life better for older adults with behavioral health problems? Will they promote well-being in old age? I'm skeptical, but I'm a dinosaur. You will have to wait to see. I doubt that I'll live long enough to find out.

7. A larger and better **workforce** is another major hope for a better behavioral health system. This is also easier said than done.

   Old people are not a popular population for young people becoming doctors, nurses, social workers, mental health counselors, etc.

   And building a better workforce of home health aides and other paraprofessionals will run into **financial barriers** and the possibility of **devastating changes in immigration policy**.

   **More use of peers**, especially retired people hoping to remain meaningful, could help.

8. Technology, of course, may also make a very big difference. Telehealth is on everyone's agenda, as it should be. There are also apps to counter social isolation and loneliness, to promote healthy behavior, etc. Self-driving cars will increase mobility. Robots with artificial intelligence could become companions and, for better or worse, even psychotherapists. The Jetsons old, here we come.

9. Funding is key to improving the system. No matter what cost savings are promised, **it will cost more**. Dorothea Dix promised that asylums would cost less than poorhouses. Didn't happen. The shift from asylums to

community mental health centers was supposed to save money. Didn't happen. ACOs are supposed to reduce Medicare costs. So far, it's almost nothing. And, in any event, per person savings mean little in the context of rapid population growth. And, let's be frank, **there is sadly little sympathy anywhere in the political world for spending more on any kind of health care, let alone behavioral health care.**

In addition, the forms of funding we use don't fit service needs. Fee-for-service has become the villain and value-based payment is the hero in the current script. Melodrama, I'm afraid, that is far **more focused on cost containment than on aligning funding and service needs**.

10. Finally, <u>better data</u> and more meaningful outcome measures are critical to developing appropriate plans for systems change and development. Currently **planning goals are too often determined by available data rather than vice versa**. We need a major push in epidemiological research during an era in which biomedical research dominates funding, leaving clinical, services, and epidemiological research sadly behind.

Obviously, there are other key policy concerns regarding geriatric behavioral health. Hopefully they will emerge as the panel unfolds. But as I said at the beginning, the key point is:

**WE NEED MORE ADVOCACY FOR GERIATRIC BEHAVIORAL HEALTH!!!**