KEEPING COGNITIVE AND BEHAVIORAL HEALTH ON THE TABLE WHILE PLANNING TO MEET THE CHALLENGES OF AN AGING SOCIETY

A Very Brief Presentation By
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Several states including New York, Maryland (where I now live), California, Massachusetts, Minnesota, and others are developing or have developed state master plans on aging. Sadly, none of these plans pays adequate attention to matters of the mind.

No surprise. Historically, matters of the mind get short shrift in the development of aging policy. At best they get included as a component of broad concerns about health, and even there they seem more like an afterthought. For example, statements about healthy aging often include dementia and depression, with little attention to substance misuse, mental illnesses such as anxiety disorders and psychoses, or reactive emotional distress. Aging people with serious, lifelong mental disorders get barely a whisper.

Of course, master plans have to address a much broader range of issues than health or mental health. For example, AARP's model for becoming an age-friendly community, state, or nation (which NYS and others have drawn from) includes 8 domains of livability.

Note that there is no domain for cognitive and/or behavioral health. They can be included in the eighth domain—community and health services—but they don't have to be. The AARP and the WHO models leave it up to

communities to determine the important elements of the eight required domains.

Very recently Federal legislation has been proposed for strategic planning on aging. It calls for the development of "multi-sector" plans addressing a broad range of service needs and issues.

- KEY SERVICES

    - Disease prevention and health promotion, long-term care, health and human services and supports
    - Services and supports re. retirement, nutrition and food security, economic security, elder rights, housing, education, transportation, social engagement and broadband access
    - Disaster services and supports

- KEY AGING ISSUES

    - Stable and safe housing
    - Access to disease prevention and health promotion **including behavioral health and substance use disorder services**
    - Promoting age friendly communities
    - Access to long-term care
    - Access to services that promote elder justice
    - Promoting economic and retirement security
    - Promoting social connection, reducing social isolation
    - Improving equity
    - Ensuring accessible public spaces
    - Ensuring access to healthy and affordable food

Similarly, The New York State preliminary report on master planning addresses a broad range of issues. But it does not have a domain for cognitive and behavioral health. It has a broad category called "health and wellness" which includes the following:

Health and Wellness

• Promote and sustain physical and mental health, well-being, and quality of life, including primary and secondary prevention and self-management of chronic disease

• Access to Medicare and Medicaid annual wellness and prevention benefits & communication to improve utilization

• Behavioral health and substance use disorders

• Cognitive health, Alzheimer's disease and other dementias

• Nutrition and food insecurity

So, matters of the mind are included and could, by my very rough calculation, be almost 10% of the substance of the plan. Not bad, but not a headline either.

And all the master plans seem to me to leave out several considerations that are very important given that **the aging population is not just growing but is also changing**.

Projected changes include more people 85+ and even 100+, more non-white people, and both more healthy people and more people with chronic illnesses and disabilities. Retirement age is likely to shift from roughly 65 up towards 80 so that more older adults will be working. The availability of family support is likely to diminish as marriage rates decline, family size diminishes, and families disperse geographically.

It's particularly important that the expected increased longevity will probably result in a much **larger population with co-occurring cognitive, behavioral, and physical health disorders and disabilities**.

That means that **integrated treatment** will be increasingly important and that long-term plans for helping old people to have decent lives really should include **structural changes in service delivery**.

Some of this is happening, of course. Certified community behavioral health clinics, which require integrated services for mental and substance use disorders, are growing. Collaborative care is increasingly used in primary health care practices. Several federal departments are working together to develop "no wrong door" approaches. And there are a variety of managed care management structures that presumably will be more effective in reaching and organizing services for people who do not do well with traditional service structures.

But there is **not much to integrate cognitive and behavioral health services** despite the fact that **virtually all people with dementia will have a behavioral disorder at some point while they are living with dementia**. In fact, there continues to be **resistance to acknowledging the co-occurrence of cognitive and behavioral disorders** and disabilities.

In addition, all of the integrative efforts underway are happening fairly quietly. No headlines. They are not priorities. Unfortunate, because what we need are for master plans for aging to cry out loudly that **our nation's systems to address physical, cognitive, and behavioral health need major structural change**.

In addition, **we live in an extremely troubled world**. Everyone I know is very distressed by the vituperative political divide in America, by the risks to human life of climate change, and by the loss of life and homes in wars that have little mercy on civilian populations. I call these "**adverse world events",** a counterpart to the popular concept of "adverse childhood events".

The psychological consequences of this troubled world are not hard to see. Increased emotional distress. More fear, for ourselves but more for our children and grandchildren. More social and family division. More loneliness. More suicide.

Master plans for aging need to address expectable emotional strain, and not just with calls for more mental health services for older people but with innovative ways to provide emotional support.

It also strikes me that master plans need to address the likelihood that climate change will result in more frequent disasters and perhaps, as we edge towards the end of the century, more movement of people away from the coasts. This too will have psychological consequences. Are our systems prepared to help growing populations in crisis and growing populations forced to leave their homes?

I am trying to make the case for more extensive and more prominent inclusion of matters of the mind in master plans on aging. "Matters of the mind", that's a strange way of talking, isn't it? And it is not an expression that is much used. Lately, the term "brain health" appears to have become a more popular way to get beyond the siloed use of separate concepts for cognitive impairment, mental illness, and substance use disorders. And it is a term with certain political advantages; not too many enemies and possibly unifying. So perhaps what we need now is an exercise to spell out the breadth of the concept of brain health, that it includes not just dementia, but also mental and substance use disorders and emotional distress.

I personally am not enamored of "brain health" as the overriding concept. Too organic. Leaves out the intellectual, the creative, the spiritual dimensions of the human mind. So, I am pleased to see the use of the terms "mind" or "mentation" in some state plans.

But this dispute about language is much to be avoided if we want to actually make matters of the mind prominent parts of master plans.

And it's really pretty simple. **Well-being in old age depends to a very large extent on the well-being of the mind**. That's the message we have to deliver over and over again as plans are made for the old people of the future.

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