Dementia, Mental Illness, and Substance Use Disorders in Older Adults: One Mind, Many Silos

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Key Takeaways

> The sharp distinctions drawn between Alzheimer's disease (and other dementias), mental illness, and substance use disorders unfortunately result in separate and insular fields of policy and practice.
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> The long-term care system and the fields of mental illness and substance misuse can and should develop expertise in serving people with co-occurring cognitive and behavioral health conditions.
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> It's time for moving toward real integration of both policy and practice.

In the worlds of advocacy and policy-making, there are sharp distinctions drawn between **Alzheimer's (and other dementias) <https://ncoa.org/older-adults/health/physical-health/chronic-disease/alzheimers>**, mental illness, and substance use disorders. This results in separate, distinct, and insular fields of policy and practice, often referred to as "silos".

Frankly, I've never understood the imagery. Are we talking about grain silos in farm country or nuclear silos in secret locations? Whatever the source of the metaphor, what is meant by "silos" is that they are insular fields with inadequate communication, coordination, and collaboration. The result is not good for people with co-occurring disorders.

In my view, it's time for a change, not just by promoting more and more inter-agency councils, but by moving toward real integration of both policy and practice.

Why are cognitive disorders split from mental illness treatment?

There are good historical reasons why a field of cognitive disorders—dementia and cognitive impairment—split off from the field of treating mental illnesses. The population of state hospitals prior to deinstitutionalization was 30% older people, mostly with "organic brain syndrome" as it was often called at the time.[1] Deinstitutionalization could not be the same for them as for people with greater functional capacity. At that time, there was also an erroneous diagnostic distinction between "organic" and "functional" conditions of the mind. "Organic" meant that there were observable problems in the brain on autopsy; "functional" meant that it was psychological rather than physical.

In the mid-20th century, psychoanalytic theory prevailed when it came to psychological matters.[2] This emphasis on intra-psychic conflict was an additional reason for the separation of the fields of mental illness and dementia. It also contributed to the emergence of a separate field for substance abuse, actually to two separate fields—"drug" abuse and alcohol abuse.

In addition, as the populations of state hospitals began to decline, **Medicaid was created <https://sgp.fas.org/crs/misc/IF10222.pdf>** , and it funded nursing homes but not long-term psychiatric hospitals.[3] The **movement of people with organic brain conditions to nursing homes <https://www.kff.org/wp-content/uploads/2013/01/7684.pdf>** made considerable sense both clinically and financially, but the simultaneous transinstitutionalization of people with serious and persistent mental illness to nursing homes became a scandal.[4] It was wisely discouraged, but with unfortunately insufficient housing and other community-based alternatives.

The separation of dementia, mental illness, and substance use disorders carried over to outpatient services, which split between adult medical day care in the long-term care system and various forms of clinics, day treatment, and rehabilitation programs in the mental health and substance abuse fields.

> **Thus, the schisms emerged between treatment for people with so-called "brain disorders" and for those with mental and/or substance use disorders, lately referred to as "behavioral health" disorders.**

The link between mental illness, substance use disorders, and dementia

This is obviously a false trichotomy. Over the years, mental illnesses and substance use disorders have increasingly been understood as brain disorders with powerful psycho-social dimensions.

For example, research studies have made it entirely clear that virtually all people living with dementia will at some point during their progressive cognitive decline also have behavioral disorders—generally referred to as "neuro-psychiatric symptoms"—including anxiety, depression, psychosis, substance misuse, behavior problems, etc. **98% is the number reported in recent research <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6544588/>.**[5]

We also know that mental and substance use disorders are frequent precursors of the development of dementia.[6,7] In fact, they may be the early phases of as yet unnamed conditions of the mind that begin with psychiatric symptoms and end with an admixture of cognitive and behavioral health disorders.

We also know that there is considerable co-occurrence of mental and substance use disorders.[8]

> **So, to put it simply, because cognitive, mental, and substance use disorders commonly co-occur, people are potentially subject to multiple silos even though each has just one mind.**

What difference does this make for policy?

It suggests to me that we ought to re-conceptualize policy and service systems from the standpoint of the unity of the mind rather than a fictitious fracturing. "Person-centered" care, which is frequently called for as the essence of improved care, should not be understood as person-centered dementia care OR mental illness care OR substance use care. It should be understood as care of each person's mind.

Ideally, systems of care should be remade emphasizing early identification and intervention with entry into a compassionate continuum of care rather than into non-communicative and competitive "silos".

The continuum needs to be the commonly noted mix of crisis, inpatient, outpatient, residential, rehabilitation, health, family support, community education, and care management services.

But as currently structured, these elements are not adequately integrated. And they are not adequately responsive to the social problems that people confront —including racial and class disparities and inadequate housing, income, family support, community acceptance, protective services, and more.

> **As a result, people, especially older people, are too often shuttled between, or shifted from, one system to another without regard to the continuity of their lives. Despite decades of talk about integration of care, we still fit people to the system rather than vice versa.**

The pursuit of the ideal, of course, is often elusive. But it really is not far-fetched to believe that at the very least the long-term care system can and should develop expertise in serving people with co-occurring cognitive and behavioral health conditions and that the fields of mental illness and substance misuse could and should develop expertise in serving people who also have, or will develop, cognitive impairments.

How to promote better lives for those with cognitive and behavioral health issues

All of this also suggests that advocates for the various silos ought to make an effort to work together to promote better lives for people with cognitive and/or behavioral health disorders. Yes, that's hard to do when there is such intense competition for limited resources. But for the sake of the people who have problems of the mind, it needs to happen:

- Advocates to meet the needs of people with dementia should acknowledge and confront the fact that these people also often have mental and/or substance use disorders.
- Advocates for people with mental disorders need to confront the fact that as they age this population is increasingly likely to develop dementia.
- Advocates for a humane approach to substance misuse should acknowledge and confront the fact that the population they care about

is at high risk for dementia and/or mental illness.

To say it again, each person has just one mind. Multiple silos reflecting the intricacies of the human mind may have been historically useful. But it is time now to focus far more on its unity.

NCOA hosts the annual **Older Adult Mental Health Awareness Day <https://connect.ncoa.org/oamhad2022>** to highlight critical issues in addressing mental health needs as we age.

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