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ONE MIND, TOO MANY SILOS:
Towards The Integration of Cognitive and Behavioral Health

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Let me be blunt. The field of geriatric mental health is a community, really a non-community, divided against itself. Ideological divisions, clinical disagreements, and competition for resources find the Alzheimer's community seeking resources to deal with cognitive impairment, while denying that it is a mental illness. A brain disease, they say. Never mind that 98% of people with dementia will have a behavioral health condition as well. And the mental health community seeks resources for mental health services as if mental illnesses were not precursors of dementia and as if older people with mental illnesses don't also develop dementia and then get dumped into long-term care, such as it is. And neither the Alzheimer's community nor the mental health community pays nearly enough attention to substance misuse, which affects both people with mental disorders and, yes, sweet old people with dementia.

Everyone complains about the fragmentation of our service systems, but we organize our advocacy in ways that perpetuate it.

I am here today to take a step toward changing that. I will talk about the health of the minds of older adults. We used to be able to do this by talking about "mental" health. Unfortunately, "mental" is no longer the adjectival form of the noun "mind". We've divided the mind into several fictitious fragments. One fragment can become disordered with anxiety, depression, psychosis, and the like. That's the one we label "mental". Another fragment can lose cognitive capacity. That usually gets called the "brain", as if mental and substance use disorders were not also matters of the brain. And the third fragment is the one that is subject to addiction. That's now referred to as SUD in order to avoid the stigma of the term "substance abuse".

WHAT? Does this make any sense? Obviously, there aren't different fragments of the mind—one for mental illness, one for substance use disorder, and one for cognitive impairment. But in advocacy, policymaking, and service delivery, sharp distinctions are drawn among Alzheimer's (and other dementias), mental illnesses, and substance use disorders.

This is done with little regard for the common co-occurrence of these—please may I call them—"mental" problems.

Many older people suffer from cognitive impairment, mental illness, AND substance use disorders. Neglect of this fact has resulted from and contributed to the development of separate and distinct fields of policy and practice, often referred to as "silos".

Frankly, I've never understood the imagery. Are we talking about silos filled with grain or other nutrients or about nuclear silos in secret locations waiting for the order to destroy the world?

Whatever the source of the metaphor, what is meant by "silos" is that they are insular fields with inadequate communication, coordination, and collaboration. And the result is not good for people with co-occurring disorders.

For their sake, it is time for a change. It is time to break down the silos.

There are, of course, good historical reasons why these silos emerged, why, for example, the field of cognitive disorders—dementia and cognitive impairment—split off from the field of treating mental illnesses.

One reason for the separation is that the population of state hospitals prior to deinstitutionalization was 30% older people, mostly with "organic brain syndrome" as dementia was often called at the time.[1] Deinstitutionalization could not be the same for them as for people with greater cognitive capacity.

And, as the population of state hospitals began to decline, Medicaid was created. It funded nursing homes but not long-term psychiatric hospitals.[2] So, the movement of people with organic brain conditions to nursing homes made considerable sense both clinically and financially.

(It is worth noting, parenthetically, that the simultaneous transinstitutionalization of people with serious and persistent mental illness to nursing homes became a scandal.[3] It was wisely discouraged, but unfortunately with insufficient housing and other community-based alternatives. A topic for another time.)

During this period, 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 the condition was psychological rather than physical. And, at that time in history, psychoanalytic theory prevailed when it came to matters of mental illness.[4] Because its emphasis on unconscious intra-psychic conflict simply made no sense for people with dementia, a distinction emerged between brain disorders and mental illnesses—a major reason for the separation of the fields of dementia and mental illness.

The dominance of psychoanalytic thinking also contributed to the emergence of a separate field for substance abuse, actually to two separate fields—"drug" abuse and alcohol abuse. The people who emerged as leaders in these fields had no patience for the view that addictions would disappear after their roots were uncovered through the psychoanalytic process. They had no patience for insight without behavioral change. They believed that people could and should control their behavior—one day at a time with the help of a higher power. This was not the stuff of professional psychiatry or psychology, and the leaders of efforts to address drug and alcohol abuse generally were not mental health professionals. They were people who were in recovery from addiction. In a sense, they rebelled and formed their own field free from professional rule.

The conceptual and administrative separation of dementia, mental illness, and substance use disorders resulted in a chaotic array of residential and outpatient services, including nursing homes, adult homes, social and medical daycare, and home care in the long-term care system; detox, residential and outpatient rehabilitation, and clinics in the substance abuse system; and various forms of inpatient care, residences, clinics, day treatment, and rehabilitation programs in the mental health system.

They functioned under various governmental authorities each with its own regulations regarding location, structure, and the nature of services, which made it almost impossible to provide integrated treatment.

As I noted, the silos rest on the outdated belief that dementia is a "brain disorder" and that mental and/or substance use disorders are not. This is obviously a false dichotomy. Over the years, mental illnesses and substance use disorders have increasingly been understood as brain disorders with powerful psycho-social dimensions.

Let me digress here to note that there has been some movement towards linking mental and substance use disorders via the concept of "behavioral health". This term is a policy lingo shortcut that refers to a field of both mental and substance use disorders. It arose historically from workplace mental health companies, which used it to signal to potential customers that

they could handle people who had depression and other mental illnesses and those who had alcohol, cocaine, or other drug problems. The term "behavioral" also was meant to signal a break with the tradition of multi-year psycho-analytic psychotherapy that might produce improved personal insight but often did not produce a change in clinical condition or behavior. The companies that paid for health insurance wanted clinical improvement that resulted in behavioral changes that improved functioning at work, preferably quickly. Short-term functionally focused therapies promised that and may have been effective to some extent.

Sadly, however, the conceptual combination of mental and substance use disorders as behavioral health resulted in little actual integration of treatment for those with co-occurring disorders.

And there is vast co-occurrence of cognitive, mental, and substance use disorders. 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.[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 say it again, cognitive, mental, and substance use disorders commonly co-occur. One person with one mind has multiple disorders, but they usually get only partial care or, at best, divided care.

To get integrated care we need to break down the silos.

We need a thoroughgoing change in policy. How?

First, we need 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 holistic care of each person's mind and, for that matter, body.

Second, systems of care should be remade emphasizing early identification and intervention with entry into a **compassionate continuum of care** rather than in multiple referrals to separate non-communicative "silos".

Third, although the continuum needs to be the commonly noted mix of crisis, inpatient, outpatient, residential, rehabilitation, health, family support, community education, and care management services, it should not be just a continuum of mental health services or substance use services or dementia services. It ought to be **a continuum that cuts across the silos**.

Fourth, all service systems should have a **"No wrong door"** policy. That is, no one who comes to, for example, a mental health clinic should be turned away with a referral to, say, a substance use clinic or a neurologist. Easier said than done, of course.

Sadly people, especially older people, are too often shuttled between, or shifted from, one system to another without regard to the **continuity of their lives**.

I find it particularly troubling that older people with serious mental illness are frequently dumped from the mental health system when they develop some of the common physical ills of old age or a bit of dementia. They are transferred from the places that have become their homes to other so-called "homes" in the long-term care system, leaving many years of relationships behind.

Despite decades of talk about integration of care, **we still fit people to the system rather than vice versa**.

And those systems tend to be narrowly focused and thus abandon the people they serve to struggle with social problems such as racial and class disparities, inadequate housing and income, the need for family support, stigma and lack of community acceptance, inadequate protective services, and more. We need the systems that care for our minds to also care about the worlds in which we live.

The pursuit of the ideal, of course, is often elusive.

But is it really far-fetched to believe that, at the very least, the long-term care system should develop expertise in serving people with cognitive and behavioral health conditions and that the fields of mental illness and substance misuse should develop expertise in serving people who also have, or will develop, cognitive impairments?

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, when there are vast differences about who should provide care, and when ideological differences and differences in clinical philosophy are vituperative. 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. And advocates for people with mental disorders need to confront the fact that as they age this population is increasingly likely to develop dementia. And 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.

Pie in the sky? Maybe. And I'm going to ask for your help in identifying some concrete steps that can be taken.

But first I want to say I'm a bit encouraged. Just last week, for example, the new Secretary for Aging in Maryland posted a job for a "cognitive and behavioral health specialist". Cognitive AND behavioral health linked in a single role. That's the idea. Here are some other suggestions:

- Convene a group of advocates regarding dementia, mental illness, and substance use disorders (1) to get insight into the most recent scientific findings regarding co-occurring disorders and the relationships between cognitive and behavioral impairments and (2) to develop a shared policy agenda for future years. This could be done in Maryland and other states and at the national level.

- Create ongoing workgroups at national and state levels with representatives from the silos to identify barriers to integration and possible ways to advance integration.

- At the national level:

    - Urge NIH, SAMHSA, HRSA, CDC, etc. to develop research plans re. integration of cognitive and behavioral health policy, management, and services.

    - Establish a national demonstration grants program.

    - Expand the mission of the National Advisory Council on Alzheimer's.

- Expand the role of Deputy Secretary for Behavioral Health to the Deputy Secretary for Cognitive and Behavioral Health

- Establish a planning group in NIH to move towards the integration of NIMH, NIDA, and NIAAA.

- At the state level

  - Restructure state departments.

  - Redefine and restructure various state advisory groups.

  - Create licenses and funding streams that support a no-wrong-door approach.

  - And more

Let me give you a couple of examples of actions that could have been taken during last year's legislative session in Maryland.

- The Alzheimer's Association pushed a bill to create "dementia navigators" in local aging agencies. I suggested making them "dementia and behavioral health navigators". The Alzheimer's Association hated the idea as apparently did the bill sponsor, even though there was considerable support among the local area agencies on aging.

Here's another example:

- There was a bill to address the workforce shortage for behavioral health. I suggested making a bill to address the workforce shortage for cognitive and behavioral health. No dice.

I'm just scratching the surface here. Hmm. Maybe I'm grasping for straws.

When I was still working, I used to keep a sign over my desk that said, "Collaboration is an unnatural act committed by non-consenting adults." I'd say the evidence is strong for that.

But these silos are bad for people, and everyone says they want to end fragmentation.

Do you think I have taken leave of my senses to want to do something about it? If not, do you have thoughts about how to break down the silos?

Speak to me.

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