POLICY ISSUES REGARDING GERIATRIC BEHAVIORAL HEALTH

A Presentation To:
The NYS Interagency
Geriatric Mental Health and Substance Use Disorder Council

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by

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I have been asked to provide a quick—very quick—overview of key geriatric behavioral health policy issues. Here goes: **13 points in 10 minutes**.

1. First the good news. In New York and many states around the country **there has finally been an awakening to the aging of America, and master plans are in the works.** It's a little late since we are already halfway through the elder boom, but better late than never.

   The challenge for those of us concerned about behavioral and cognitive health is **making sure that attention to the older mind does not fall off the planning table**, as it usually does.

2. Effective planning for the future will need to take into account that **the population of older adults is changing, as is the world in which we live**.

   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. If longevity increases as expected, people will work much later in life; retirement age could slip up to 75 or 80. In addition, older people will be more likely to live alone and not to have family support due to changes in family structure and inadequate attention to the needs of family caregivers.

3. 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, if only because age increases the likelihood of having serious chronic disorders such as dementia, diabetes, cardiac conditions, arthritis, and more.

   Behavioral health status may change as well. Hopefully, efforts to **address the mortality gap** between people with serious mental illness and the general population will pay off, and more people with long-term, disabling mental disorders will survive into old age, as are people with developmental disabilities.

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.

4. Very importantly, **environmental circumstances**, the social drivers of behavioral health status, **are likely to change in dramatic ways**. I think not just of the usual so-called "social determinants"—poverty, violence, education, racism, etc.—but also of what I call "adverse world events"—the political divide and consequent social division, climate change, which appears to be driving an increase of environmental disasters, warfare and rising numbers of refugees. For example, climate change may result in more and more weather disasters and could drive significant migrations away from the coasts with consequent challenges of re-location. Are we prepared?

5. Because of the increase in chronic cognitive and physical health conditions with age, **integrated service delivery will be more important than ever**. Some progress has been made with regard to the co-occurrence of mental and substance use disorders and the co-occurrence of behavioral and physical disorders. But the co-occurrence of cognitive impairment, especially dementia, and psychiatric disorders is barely on the radar screen even though nearly 100% of people with dementia have co-occurring psychiatric and/or substance use disorders at some point during their cognitive decline. In fact, it's not just ignored, there continues to be very strong advocacy to maintain the mythical separation of cognitive and mental disorders.

6. <u>**Geriatric behavioral health is not just about addressing diagnosable disorders**</u>. 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**.

   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 or transient but not seriously disabling in the long-term. These two populations call for two quite different kinds of approaches.

   In addition, there are many people who experience non-diagnosable emotional distress, and that calls for still a third approach to addressing issues of the mind.

7. **Aging in Place** is a key goal of behavioral health policy, but the term "aging in place" is misleading. It includes moving people from institutions—state hospitals, nursing homes, adult homes, and prisons—to community settings. 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 that will require creating housing programs that people with long-term mental disorders and **co-occurring dementia and/or chronic physical conditions and disabilities** can remain in. Failure to do so contributes to movement in the wrong direction—from supportive community housing to institutions.

8. **Home and community-based services** that address issues of physical, cognitive, and behavioral health are crucial to enable older adults to live decently in the community. This calls for **structural changes of the service system**, which is too much a system of professionals waiting in offices for people to come to them for help. There is too little outreach, too few in-home services, too few services in community settings, and too few services available at times that work for older adults and their family caregivers.

9. Improved quality **is a critical goal for cognitive and 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.

   Of course, since we are thinking futuristically, we need to raise the question **will there finally be breakthroughs in the prevention and treatment of behavioral and cognitive disorders**. A cure for dementia as promised by 2025? A cure for schizophrenia? Wouldn't it be wonderful if that happened! But I'm not betting on it.

10. A larger and better **workforce** would help, but that's much 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 depends on **intelligent immigration policy**, which sadly is not on the political horizon.

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

11. **Technology**, of course, may also make a very big difference. Telehealth fortunately has arrived. 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. Maybe AI will replace the memories of people with dementia. Much promise, but whether changing technology will be usable by older adults is a critical question.

12. **Funding**, of course, 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. **Keeping pace will depend on preserving entitlement funding**.

    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**. Yes, there are a variety of elaborate, managed integrated systems being developed. Will they promote well-being in old age better than the old fee-for-service structure? I'm skeptical.

13. We need **better data** to inform the planning process.

Much more could be said and hopefully will be by other panelists. **My fundamental point is that we must work to make issues of the human mind a top priority in the new master plans and that the plans must draw from an understanding of the changes taking place in the older population** and in the world in which we live. No easy task!