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GERIATRIC BEHAVIORAL HEALTH MATTERS

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We are now eight years into the "elder boom". Sadly, the implications of this vast demographic shift are still not taken seriously.

Yes, there is anxiety about sustaining Social Security and Medicare. And yes, there's increasing talk about "healthy aging". But even with these most obvious concerns there is little happening beyond handwringing.

And when it comes to mental health, older adults are barely on the radar screen.

Does it matter? Indeed, it does. Not only can mental and substance use disorders cause significant unnecessary suffering and dysfunction in old age, but mental health is essential to aging well.

It is long past time for our nation to face up to the behavioral health challenges of old age—including mental and substance use disorders, developmental challenges, and the psychological conditions essential for living well in old age.

In what follows we (1) review the demographic projections for the first half of the 21st century, (2) provide an overview of the mental and substance use disorders of old age, (3) note the developmental challenges of old age, and (4) propose a policy agenda to address the critical mental health needs of older adults.

Demographics

- The **number of older adults** (65+) in the U.S. **will more than double** from 48 million to 98 million from 2015 to 2060.

- The **proportion of older adults will increase from about 15% to about 24%** of the total population, **more than the population of children** under 18, while the **proportion of working age adults declines 5%**.

- The proportion of **non-white older adults will increase** from 20% to over 40%.

- The population of older adults will include **more people who are 85+,** of whom about **half will have a disability** and need help with activities of daily living.

- Older adults will be **more likely to live alone and not to have family support** due to the increase of the number of people who never marry or who divorce after 50, the growing number of older adults with no children living nearby, changes in family values regarding care of elder family members, and our failure as a society to adequately address the needs of family caregivers.

- The **health status of the next generation of older adults will change**.

  A portion will be healthier than ever before.

  But a portion of the next generation will be less healthy, in part because there are more people living with serious chronic disorders, and in part because the current generation of working-class men—who will become a significant part of the next generation of older adults—is at high risk for drug addiction, suicidal depression, and alcohol-related disorders.

- It is more than a little worrisome that because of population growth there will be **more older adults with disabilities** and because of shifts in population mix there will be proportionally **fewer working age adults to help them. Immigration policy,** which may become increasingly restrictive, **could make the shortage of helping workers more acute**.

- But, on the positive side, many **more older adults will continue working** or will be **active volunteers. They may become a significant part of the helping workforce of the future**.

More detail regarding the demographics and epidemiology of old age can be found in ***Geriatric Mental Health: Demographic and Epidemiological Data***

Geriatric Behavioral Health Disorders

Unless there are long-promised, but thus far unrealized, breakthroughs in the treatment of mental and substance disorders or there are social catastrophes that make human life much harder, the prevalence of behavioral health disorders—including dementia--will probably remain about the same—roughly 20% of the population.

But, because of population growth, the **number of older adults with mental or substance use disorders illnesses will more than double**.

They will be a **heterogeneous population**, **most of whom live and want to remain in the community**, including:

- **People with serious and persistent mental illnesses** who are aging. (This population may increase if efforts to reduce premature deaths among people with serious mental illness succeed.)
- **People with dementia**, often with co-occurring psychiatric disorders.
- **People with severe anxiety, depressive, and other disorders** resulting in isolation, dysfunction, behavioral obstacles to living in the community, and high rates of suicide.
- **People with less severe, but clinically significant, disorders**, especially anxiety and mood disorders.
- **People who misuse or abuse alcohol, prescription drugs, and/or illegal drugs**. (Marijuana use will certainly increase—for better or for worse.)
- **People with co-occurring physical and mental disorders**.
- **Family caregivers, who are at high risk** of developing mental and/or physical disorders.

Sadly, **most older adults with mental or substance use disorders do not get treatment**. Most who do get treatment get it from primary health care providers who are poorly prepared to identify or treat these disorders.

The low utilization of mental health services reflects problems of:

- **Capacity**: There simply are not enough clinically, culturally, linguistically, and generationally competent providers.

- **Affordability:** There is a particular shortage of geriatric mental health professionals who accept Medicare.

- **Access:** Many treatment programs are in hard-to-reach locations, and there is a tremendous **shortage of services in home and community settings**.

- **Stigma, ageism, and lack of awareness about mental illness** and the effectiveness of treatment result in reluctance to seek or accept behavioral health services.

Fortunately, **there are effective treatments** for many, though not all, geriatric behavioral health disorders. This includes both pharmaceutical and psychosocial interventions.

Unfortunately, there is, as noted above, a vast **shortage of competent providers.** As a result, behavioral health services are often of **poor quality**.

Aging Well: Meeting The Developmental Challenges of Old Age

Behavioral health is not just avoiding or overcoming mental or substance use disorders; that is the negative side of behavioral health**.** There is also "positive" behavioral health**—achieving well-being in old age (aka "aging well", "successful aging", "healthy aging", "active aging",** etc.).

Old age is widely seen as a bleak time in life especially as health is compromised. But in fact, older adults are by and large satisfied with their lives despite objective declines in health and basic abilities. **It is, therefore, critical to distinguish between objective and subjective healthy aging and to focus on achieving satisfaction despite the typical physical and mental declines of old age**. ("Successful aging" in this sense is remarkably similar to the concept of "recovery" that has emerged from the field of psychiatric rehabilitation.)

Well-being in old age depends fundamentally on having satisfying relationships and engaging in pleasurable and meaningful activities. It is also correlated with having certain personality traits, including having a positive attitude, optimism, adaptability, and resilience.

Achieving well-being also depends on meeting the developmental challenges of old age, which include (1) finding alternative sources of

satisfaction and self-esteem after retirement and changes in family roles, (2) coping with losses of family and friends, (3) tolerating diminished physical and mental capacities, (4) living with chronic illnesses, which often result in persistent pain and sometimes in disability, (5) learning to accept increased dependency if necessary, and (6) coming to terms with mortality.

Well-being in old age fundamentally means being at peace with oneself. This includes (1) having a **sense of authenticity, (2)** having **pride in the life one has lived**, despite inevitable regrets, remorse, and disappointment, (3) **finding sources of pleasure**, and—for many older adults—finding opportunities to continue to be **productive, to make a contribution, and to feel meaningful.** For some people, this is achieved through new family roles, such as grandparenting. For others, it is achieved through community or artistic activities. For still others, it is through continuing education and personal improvement. And for many, it is found through spiritual experiences of various kinds.

What most people dread about old age is dementia, the subjective effects of which are largely misunderstood. Most importantly, it is important to understand that **people with dementia can experience satisfaction.** This varies from one stage of dementia to another. In early stages some people continue productive activity and meaningful relationships with people. Some, of course, experience considerable emotional pain, especially sadness and fear. But these are frequently mental conditions that can be effectively treated, resulting in relief from emotional pain and sometimes improvements in functioning. In addition, people with dementia in the middle and end stages frequently get considerable personal satisfaction from **creative arts,** especially visual art and music**.** In general, even though people with dementia may have starkly limited memories, the satisfaction of **being in the moment** can be considerable.

In general, it is possible for society to take actions to promote well-being in old age. Reducing social isolation is particularly important, as are opportunities for paid and volunteer work, safe spaces for exercise, and access to continuing education and creative activities. Efforts now underway to develop "**age-friendly"/"livable communities**" will be key to supporting successful aging in the next generation.

Geriatric Behavioral Health Policy Goals

With the elder boom already well-underway, it is long past time for our nation to respond to the problems of old age and to promote its opportunities. The Geriatric Mental Health Alliance of New York has developed a ten-point agenda to do this:

Community Integration ("Aging In Place"): Provide supports to enable older adults with major behavioral health disorders, including dementia, to remain in or return to the community and avoid institutionalization. Needed supports include:

- **Housing alternatives to institutions**
- **Community and home-based behavioral health services**
- **Improved behavior management skills**
- **Improved health care for people with serious mental illnesses**
- **Rehabilitation designed for older adults**
- **Family caregiver supports**.

2. **Improve Access**: Increase service capacity, affordability, availability in home and community settings, and outreach and engagement services.

3. **Improve Quality**: Of behavioral health, healthcare, and aging services in the community and in institutions. This includes:

   - **Integrating behavioral and physical healthcare and aging services**
   - **Increased "generational" and cultural competence** in both behavioral and physical health care
   - **Increased clinical services, and translational research** to identify evidence-based practices and to promote their use.

4. **Provide Public Education**: **Combat stigma, ageism, and ignorance** about behavioral health, its treatment, and how to find resources.

5. **Promote Positive Aging** via **reduced social isolation** and supporting opportunities for older adults to play **meaningful social roles**.

6. **Workforce Development**: Build a **clinically and culturally competent workforce**, including the use of "peers", particularly older adults.

7. **Improve Finance Models**: Assure that new finance models will:

   - **Support behavioral health services in the home and the community**
   - **Support best practices and innovation**
   - **Promote integrated service delivery**
   - Assure **continuity of care** from pre-to-post age 65
   - **Create incentives to enhance the workforce**.

8. **Address Social/Economic Issues** such as inadequate income, threats to the Social Security Trust Fund, and inadequate housing.

9. **Epidemiological Research:** Develop new data sources for planning and evaluation.

10. **Promote Readiness of the Public and Private Sectors:** including knowledgeable leadership, coordinating structures, and private sector initiatives related to access to treatment, work opportunities, retirement planning, and family support.

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