HUNTER | Brookdale Center for Healthy Aging

**TESTIMONY OF MARK BRENNAN-ING**
**OF THE BROOKDALE CENTER FOR HEALTHY AGING, HUNTER COLLEGE**
**BEFORE THE NEW YORK CITY COUNCIL COMMITTEES ON AGING**
**AND WOMEN & GENDER EQUITY**

**OVERSIGHT HEARING**
**"CHALLENGES FACING LGBTQ+ OLDER ADULTS"**

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My name is Dr. Mark Brennan-Ing and I am the director of research and evaluation at the Brookdale Center for Healthy Aging. We are CUNY's aging research and policy center and a part of Hunter College.

Thank you, Chairpersons Hudson and Cabán and members of the committees for holding this oversight hearing, and for the opportunity to provide testimony on this important issue.

My scholarship focuses on the socioemotional challenges facing LGBTQ older adults and on the critical role of behavioral health on efforts to combat the HIV/AIDS epidemic. As a sexual minority person who came of age during the HIV epidemic who has known many who have faced the challenge of HIV infection, and many who have died from this disease, this is also a very personal issue to me.

For older New Yorkers, a lack of sexual health education is a barrier to getting tested for HIV. There is a pervasive belief in society at large that older people do not have sex and are therefore at low risk for contracting and transmitting HIV. Medical providers often do not address sexual health issues with older patients, and do not have conversations with them about HIV and other STI risks. As a result, older people are more likely to be infected with HIV years before getting tested and are more likely to receive a dual diagnosis of HIV and AIDS. In 2018, the latest year for which we have data, 17 percent of new HIV diagnoses were among people age 50 and older. At the same time, due to successful treatment, fully 50 percent of people living with HIV today are age 50 and older, and according to the CDC, 60% of these people are gay, bisexual, and other men who have sex with men. Thus, there are two separate reasons why the HIV epidemic is now a majority 50+ phenomenon: new cases due to ignored unprotected sexual activity and increased survival of people who got HIV at younger ages.

HIV infection does not inevitably lead to AIDS and is no longer the death sentence it was at the start of the epidemic. Increasingly sophisticated antiretroviral therapy, or ART, has lowered the share of HIV positive people whose infection progresses to AIDS by keeping viral loads undetectable. Staying healthy through viral load suppression depends on regular testing to catch infection early, engaging in care, and importantly, adhering to ART. This depends on having uninterrupted access to high quality, culturally appropriate medical care. But if you are an older person, a lower income person on Medicaid, a person of color, a person with unstable housing, or a person with behavioral health challenges you are less likely to get the quality care that you need to stay healthy after an HIV diagnosis.

Our research finds that Black people living with HIV are particularly overrepresented among those whose viral loads are consistently unsuppressed. Diagnoses of depression, bipolar disorder, schizophrenia, and PTSD, drug and alcohol use are all associated with consistently unsuppressed viral load status.

Why is this of concern? Depression is one of the strongest predictors of non-adherence to ART and other medical treatments. Alcohol and substance use not only interfere with ART adherence, but also reduce the effectiveness of ART in controlling HIV. Our research on older people with HIV finds that over 60 percent suffer from clinically significant depressive symptoms, and rate of current use of tobacco, alcohol and other substances is quite high.

Overcoming the behavioral health barriers to HIV treatment adherence is especially difficult for lower income people because they have very little access to mental health services. In one clinical study I was involved with, we worked with a large AIDS Services provider in the City and were referring their clients who screened positive for depression to the provider's mental health clinic. Within two weeks we had overwhelmed them with new referrals for care. This experience highlighted for me both the extreme lack of capacity in the mental health services system and the disconnect between the HIV treatment system and the mental health system.

While the city of New York has been a national leader in driving public awareness around the need to get tested and treated for HIV, the system also has a critical blind spot. That is, the city has not placed an equal effort on screening people with HIV for behavioral health issues that interfere with their treatment plans. Thus, the best efforts to end the HIV/AIDS epidemic founder on the issue of unmanaged behavioral health problems. If New York City wants to be a global leader in helping end the HIV/AIDS epidemic, it must add robust behavioral health screening to the test-and-treat regimen for HIV-positive people.

Furthermore, the city must affirmatively tackle HIV stigma and social isolation, which negatively affect behavioral health, by supporting community-led spaces that are open and welcoming to people of all ages who are living with HIV. In service needs assessments of older adults with HIV, opportunities for socialization inevitably top the list of unmet needs. My research on this population has found that community connections help in coping with the challenges of aging and also promote healthy behaviors like being physically active. In focus groups I've conducted, older people with HIV want a safe space in their communities to hang out and relax, not necessarily a place to go to access more programming. Some would prefer keeping these spaces limited to others with HIV, but others would like more integrated spaces, perhaps building from existing community centers such as settlement houses or public libraries.

Thank you again for the opportunity to testify. We remain, as always, available to you as you think about how New York City can become an even better place for those aging with HIV and all New Yorkers.