MEET THE BEHAVIORAL HEALTH CHALLENGES OF THE ELDER BOOM:

A Statement to Maryland State Aging Commission and The Department on Aging

by
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Madam Secretary and Commission Members, thank you for inviting me to speak with you today on behalf of AARP Maryland and its 800,000 members.

Recently, AARP Maryland established an advocacy group focusing on brain and behavioral health. In part we did so because of the clear psychological fallout of the pandemic. But we also did so because of significant unmet behavioral health needs that existed prior to the pandemic and that will exist after. Today I will focus on post-pandemic needs.

The major goal of my comments is to encourage the Commission and the Department to add **a data-driven, multiyear plan to meet the behavioral health challenges of the elder boom** to your impressive current plans.

As the elder boom, which began a decade ago, gathers force the population of older adults will double as will the population of older adults with cognitive and behavioral health conditions.

This should be a matter of major concern. About 25% of people 65 and over have diagnosable cognitive and/or behavioral disorders. Even more experience emotional challenges that have significant negative impact on quality and length of life. Troubling conditions include:

- Dementia,
- Psychiatric disorders such as psychosis, depression, and anxiety disorders
- Substance misuse, particularly overuse of alcohol and of medications
- Co-occurring physical, cognitive, psychiatric and substance use disorders
- Disturbing emotional reactions to catastrophic events, such as the pandemic and economic insecurity and to the revelation of societal fault lines such as systemic racism and health disparities
- Difficult developmental challenges of old age including:
    - Retirement and other role changes
    - Decreasing social connections and increasing social isolation as friends and family die
    - Dealing with grief

- Declining physical health
- Living with chronic illnesses and pain
- The increasing possibility of dependency
- The inevitability of death.

These conditions result in substantial human suffering. In addition, they are major contributors to premature disability and death.

In part this is reflects the high rate of suicide among older adults. In larger part, it reflects the negative consequences of co-occurring disorders.

Many people with dementia, for example, also have diagnosable psychiatric disorders, especially depression or anxiety disorders, that increase the risk that they will be institutionalized. And people with co-occurring chronic physical and mental conditions have increased risks of long and very costly hospitalizations.

The co-occurrence of mental and physical conditions is a major driver of the very high costs of health care in the United States. Addressing co-occurrence is key to improving health outcomes and to controlling health care costs.

So, I will say again, the mental health of older adults should be a matter of major social concern, especially for

- Socially isolated older adults
- Victims of economic hardship
- People of color, who will become a much larger portion of the population in the coming years and currently suffer from health disparities
- Older veterans, who are at high risk for dementia, depression, post-traumatic stress disorder, substance use disorders, and suicide
- Victims of elder abuse
- Family caregivers
- People with long histories of mental and/or substance use disorders.

Sadly, most older people with cognitive and/or behavioral disorders do not get adequate care and treatment.

- There are insufficient home and community-based services
- There are too few clinically, culturally, and geriatrically competent health and behavioral health professionals and paraprofessionals.
- There is over-reliance on primary health care providers without adequate expertise.
- And, even though the vast majority of older adults with cognitive and/or behavioral disorders live in the community, there is still over-reliance on institutional care, largely due to:

(1) inadequate support for family caregivers, who are at high risk for "burn out" (i.e., depression and/or anxiety disorders)

(2) a shortage of supportive housing as an alternative to institutional care.

In addition to addressing shortfalls in meeting the needs of older adults with behavioral health disorders, it is important to note that mental health is a critical component of well-being in old age. As all of you know, it is possible—contrary to the ageist perspective of our society—for people to age well. They not only can achieve considerable personal satisfaction; they can be, and are, contributors to society. Older adults are not, as the ageist perspective has it, only people in need of help; they are people who can give help. Promoting psychological well-being, promoting lives of engagement and meaning, can result in a vastly stronger American society.

To address the behavioral health needs and opportunities of older adults, AARP of Maryland believes there needs to be a master plan--a multi-year, inter-agency plan that draws from sound data regarding demographics, epidemiology, service provision, and financing.

The plan will need to address a broad range of issues including:

- How to help older people with cognitive or mental disorders to live where they prefer in the community
- How to support their family caregivers
- How to provide housing alternatives to institutions
- How to increase the capacity of and access to home and community-based services including telehealth services
- How to improve the quality of both community-based and institutional services
- How to enhance integration of physical, cognitive, and behavioral health services and of health and aging services
- How to build a larger and more clinically, culturally, and geriatrically competent behavioral health and long-term care workforce
- How to provide public education regarding dementia, psychiatric illness, and substance misuse

- How to address social determinants of behavioral disorders including social isolation, economic hardship, food insecurity, dangerous living conditions, and systemic racism

- How to include older adults as part of the effort to meet the needs of their peers

- How to re-organize financing so that funding structures align with service needs.

Addressing these issues is key to achieving goals included in the Department of Aging's current long-term plan. 4 quick examples:

- You have set as a goal to "Avoid costly nursing home institutionalization". 2 major reasons for institutionalization that must be addressed are:

    - Burnout (i.e., depression and anxiety) among family caregivers
    - The co-occurrence of dementia and psychiatric disorders.

- You have also set as a goal reducing long hospitalizations. This requires addressing co-occurring severe physical and behavioral disorders.

- Another of your goals is to "Finance and coordinate high quality services that support individuals with long term needs in a home or community setting". Clearly, this must include a comprehensive array of behavioral health services.

- Your plans also call for the creation "of opportunities for older adults … to lead active and healthy lives". Well-being in old age has an outer and an inner dimension. Adequate income, decent housing, safe streets and the like are critical to achieving well-being, but so are the emotions of connection, affection, engagement, belonging, hope, and meaning. Promoting these positive emotions is a critical challenge for our society.

The behavioral health challenges of the elder boom are vast and difficult, but meeting them is critical to the health and well-being of older adults.

On behalf of AARP of Maryland, I urge this Commission and the Department of Aging to work jointly with other state agencies and advisory groups to develop the multi-year plan that is necessary to make this happen.

Thank you again for the opportunity to speak to you today. Needless to say, we would be glad to help in any way we can.

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