Supportive Services in Housing for the Elderly: Emerging Needs and Problems*

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Looking forward, despite the great increase in the numbers of the very old, constraints on government funding of all services, and especially of health care, make it unlikely many additional nursing home or mental hospital beds will be funded. It is probable that government funds for home care, including personal care will increase. Expenditures for home care have increased sharply during the Reagan Administration. The financial resources of the elderly and their families have been increasing. In a combination of government, philanthropic and personal resources, additional funds will be available to provide appropriate and effective home care services for residents of "housing for the elderly" developments. The independence of even the most impaired homebound persons is best preserved in their own home.

A major need in services for the elderly is the provision of housing at affordable rents and with appropriate supportive services. The Jewish Association for Services for the Aged, a multiservice agency, has made the development of such housing a central objective since the agency's inception in 1968. Given the large concentration of Jewish elderly in New York City, the sponsorship of five apartment residencies (with a total of 1814 apartments) and provision of management and supportive social services for six does not nearly meet the need. Two additional residencies with 304 apartments are being completed.

The majority of residents pay rents which do not exceed thirty percent of monthly income. The remaining others pay a subsidized low rental. Federal, state and municipal subsidies make this possible. They average $500 per month per apartment.

Direct payments by tenants will average $165 per month. The lowest monthly rent for tenants whose sole income is supplementary social security of $392 per month, is $102, or 26 percent of their income.

The housing facilities were designed in a partnership between the architects and the agency housing management and social work staff. Advances in the "state of the art" in housing for the elderly were incorporated into the blueprints for the apartments and community facilities. The housing facilities are entirely accessible to the handicapped with ramps, elevators, no door sills, and larger door frames. Safety features in bathrooms, kitchens and throughout are incorporated into the plan. There are emergency intercommunication systems in each building, from the apartments to the housing management office and building superintendant's residence.

A major design emphasis made possible the incorporation of extensive community facilities in each building. These facilities included a large social hall-dining room, institutional kitchen, library-conference room, arts and crafts shop, a lounge, club rooms, staff offices and public toilets. Philanthropic contributions paid for the cost of additional community facility space above the very modest four percent of the gross square

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footage allowed by the government funding services.

Facilities like these made it possible to operate comprehensive senior citizen centers, to facilitate tenant association activity, and to provide social work counseling and care.

At one residence, which has four buildings, there is a primary care medical office staffed by a nearby hospital, and at another residence, a medical office operated by a medical group affiliated with a public hospital. Its dental office is staffed by a university dental school. *However, none of the facilities was designed to provide institutional care, with such services as three meals a day, medically supervised physical therapy or nursing care.*

Supportive Services

The apartment houses were completed between 1967 and 1982. They include well designed *community* facilities. Advocacy and planning for funding of senior citizen centers and services for these buildings, all located in neighborhoods with a very large population of older people, were initiated five years prior to completion of each project. Increased federal, municipal, and philanthropic funding of services for the aged through Title XX of the Social Security Act and the Older American's Act, during this period, made it possible for JASA to secure substantial funding for establishment of senior centers and services in the housing facilities.

Center Activities and Hot Lunches

Four Senior Citizen Centers serve more than 1000 elderly people a day in Center activities and provide a hot lunch, five days a week. Another house is immediately adjacent to a YM-YWHA which operates a Senior Citizen Center funded by the city.

Casework Enablement

Caseworkers assigned to these Center facilities provide individual services to the elderly and their families. The caseworkers assist the frail, impaired or homebound residents to secure Medicare and Medicaid benefits. The City of New York, having secured a waiver of Medicaid regulations, grants provision of home attendant personal care for physically and mentally disabled persons who are eligible for Medicaid or who are even somewhat above Medicaid income level but are otherwise eligible. Home care may be secured for the "near-poor" elderly above the Medicaid poverty level through Older American's Act-funded home-care services. For some home bound, a hot meal, delivered five days a week, may be secured. For the impaired elderly with some financial resources, and for a family which is willing and able to contribute, assistance is rendered to purchase such home care.

Residents may be referred to an agency socialworker for assistance at the request of the housing management. Such referrals are made, usually at a point of crisis to help the physically or mentally impaired to secure home care or resolve other problems.

The Severely Mentally Impaired

For the most severely mentally impaired tenant, who is unable or refuses to accept psychiatric treatment or hospitalization, and whose family is equally unresponsive, a referral is made to the Protective Services Unit of the New York City Department of Social Services (DSS). If, after persistent efforts by the Protective Services Unit, assistance or treatment is still required, then D.S.S. may secure an appropriate court order to require temporary hospitalization. Alternatively, the psychiatric crisis units

operated by the State Department of Mental Hygiene, or voluntary agencies may be called in.

Tenants Associations

Within each housing complex, the agency has assisted residents to organize tenants associations. They have their elected officers and board. Assisted by a social worker, the Tenants Associations are actively engaged in conducting evening and weekend social, recreational and educational programs, in representing tenants grievances and interests, and resolving tenant problems.

Function of Floor Captains

Of great importance to the well-being of elderly residents is the "floor captain" program. "Floor Captains" are designated for each floor to be responsible for a friendly, daily check on the well-being of each neighbor. They are available to assist a neighbor during a spell of illness or an emergency.

General Availability of Services

The Senior Citizen Center programs, the social case work programs, the Protective Service Unit of the city Department of Social Services, and the Psychiatric Crisis Intervention Units of the New York State Department of Mental Hygiene, were *not* established for the exclusive or even primary use by apartment house residents. These are services available to *all of the elderly* or *all of the mentally impaired* in the community. There is no priority formally accorded tenants of JASA's housing facilities for service. The residents are not entitled to such priority by virtue of residence alone.

No doubt the location of the senior centers and social service office in the housing facility has accorded a de facto priority to residents. Propinquity and familiarity with service increase access and actual usage. The close working relationship of housing management and social service staff facilitate referral and accords a de facto priority to residents as well.

However, the ultimate responsibility of the sponsor of the housing facility and providers of community based social services for the well-being of the residents of the Apartment houses is inescapable. The troubled and troubling resident affects neighbors, provokes tenant association protests, and creates great difficulties for housing management.

Major Problems of Residents

The housing management and social service staff have identified the major problems of aging housing facility residents: *chronic illness, physical impairment* and *mental disability.* Social work staff have been reasonably successful in assisting the chronically ill, homebound and physically impaired elderly residents to secure medical, home health and home attendant personal care, particularly when the tenant is poor enough to be eligible for Medicaid benefits. With greater difficulty, social workers have been able to persuade tenants with some savings to "spend down" the assets for personal care. When impairment has become so severe as to require nursing supervision, nursing home placement has occurred after hospitalization for some medical crisis, rather than directly from their home.

Given the availability of home attendant personal care, relatively few residents have been placed in nursing homes. The universal preference has been to remain at home with a personal care attendant. This is the strong preference of sons and daughters as well.

Assisting the mentally impaired el-

derly has become far more difficult. Bizarre and self destructive behavior characterizes many of the mentally disabled aged. Self denial of food and water often leads to malnutrition, dehydration and other illnesses. Stoves lit or faucets turned on and unattended are very hazardous and destructive. The "Collyer brothers syndrome" results in filthy, insect-infested apartments. Frequently, indeed typically, the mentally impaired elderly tenants are neglected by relatives, or rejected. Many do not have known relatives. The mentally impaired aged persons frequently refuse assistance, medical care and hospitalization; relocation of a mentally impaired aged person with the most carefully designed, sensitively planned placement is very difficult to achieve. The mentally impaired person may and does refuse relocation.

The management presumably has a remedy at law in court in securing enforcement of leases or to force appropriate relocation by eviction.

Standard tenant leases provide for termination for non-payment of rent or "other good cause". "Good cause", or "material non-compliance with this agreement", includes "one or more substantial violations" or "repeated minor violations which disrupt the livability of the project, adversely affect the health or safety of any person or the right of any tenant to the quiet enjoyment of the leased premises and related project facilities, interfere with the management of the project, or have an adverse financial effect on the project".[1]

However, for a tenant in New York City, enjoying the protection of housing law and housing courts which weigh heavily in favor of the individual tenants against the rights of co-tenants or landlords (however charitable or benign), eviction for cause can be long delayed—and is. Legal aid attorneys will generally defend the right of the mentally impaired tenants to remain in possession of their apartment, regardless of the danger to the mentally impaired person or to their fellow tenants.

The Protective Service Unit of the city Department of Social Services has the legal authority to secure a court order to obtain mandatory hospitalization for a mentally impaired person where life is endangered and such care is required. But if such danger does not exist, the remaining solution is to seek the appointment of a Committee of Person and Property (a guardian) for a mentally disabled tenant. A guardian would then be legally responsible to the court to secure the most appropriate care and placement of the impaired person. This procedure is complex, tedious, and difficult. It may be, for some, the only remedy to securing the care needed by the mentally impaired tenant and to effect appropriate relocation.

Major Findings of the Survey of Residents

Confronted by increasing incidence of the problems of an aging elderly population of residents, the staff** undertook a preliminary social and demographic survey of the residents to gain a better understanding of their status and the probable incidence of incapaciting chronic illness, physical disability, mental illness, and accidents. Data were sought that would provide a foundation for evaluation of current policies and procedures of housing

[1] Lease (for use under Section 202 Program of Housing for the Elderly or Handicapped in Conjunction with the Section 8 Housing Assistance Payments Program). Para. 8(b)1, and Para. 8(d).

** Directed by Morris Stutman and Norman Rumelt, Management Staff.

management and provisions of social service and needed revisions in the five-year period ahead.

The survey of March 1, 1985 confirmed our impression of the increasing longevity of residents and particularly the startling increase in the number of those over 75 and over 85 years of age. The number of occupants in each apartment has sadly diminished and now averages 1.17.

- Of 2089 tenants, 1544, or 74 percent were women, and 545, or 26 percent were men.
- The average age of all tenants was 77.926. At the oldest building, completed in 1967, the average age was 80.70; at the "youngest" building, the average age was 71.10. At the former, 28.5% were over 80, and of them, 10% were over 90.
- The average length of occupancy ranged from 2.24 years at the most recently constructed building to an average of 9.89 years at the "oldest" buildings.

Highlights: Age Distribution

- The average age of residents is 77.926; the number over age 75, is 1407, or 67.4 percent. In 1980, the U.S. Census reported the total number of aged in the United States over 75 years to be 9,965,000, or 39 percent of the aged over 65. In New York City, the aged over 75 numbered 381,213, or 40 percent of the aged over 65.
- The number of residents over 85 years of age was 423, or 20 percent of the residents. The 1980 U.S. Census reports a total of 2,240,000 aged over 85, or 9 percent of the aged over 65. In 1980 in New York City there were 77,332 persons over 85, or 8 percent of those over 65.

A most extraordinary increase in longevity is anticipated. In the next 30 years, the number of persons over 85 in the general population is expected to increase by 150 percent![2]

Highlights: Personal Status

- Some eleven percent of the residents were reported as single and never married, a total of 224 persons. This is high compared to the Census reports that in 1982, 4 percent of elderly men and 6 percent of elderly women had never been married.[3] This may reflect some greater tendency of single unmarried persons to seek a congregate living arrangement in retirement since they do not have a supportive net of children.
- Sixty percent of the population, or 1261 persons were widows or widowers. Added to the single persons, 71 percent of the residents were in one-person households, 604 persons, 29 percent of population, were married couples.
- A surprising 21 percent, 380 households, had had no children, but this too may reflect the natural selective process at work making housing of this type more attractive to those without children.
- Of the elderly with children, 1403 households, 79 percent, 1220 households had children in the metropolitan area.
- Eleven percent of the households had children who were out-of-town, which together with the 21 percent of the resident households that had no children made 32 percent, about one third of the households, which had no adult children in the immediate area from whom to secure

[2] U.S. Bureau of Census, *Current Population Reports*, Series P-23, No. 128. *America in Transition: An Aging Society*, U.S. Government Printing Office, Washington, DC 1983.

[3] *Ibid.*, No. 28, p. 21.

immediate help or support in the event of a personal crisis.

Physical and Mental Disability

An effort was made to secure data about the physical condition of residents, their major physical disabilities and employment of home attendants, and about their mental disabilities. Most of this information was not available at the housing management offices, nor was it expected to be. Managers refer residents with problems of disability, benefits eligibility or other personal management situations to the social workers. However, housing managers in the smaller housing facilities were more directly aware of the physical status of their residents:

- Managers reported that from 8% to 31 percent of the residents had major obvious physical disabilities.
- Housing management staff are conscious of the mental disability of individual tenants. Their behavior and impact upon their neighbors brought their problem to the immediate and continuous attention of housing management. Their estimates of mentally disabled average 7 percent of the resident population.

Summary of Findings and Future Prospects

The National Center for Health Statistics of the United States Public Health Service reported the nation's death rate was down to a record low and American longevity greater than ever. Life expectancy at birth had increased to 74.6 years in 1982, up from 74.2 years in 1981, and 73.7 years in 1980. The life expectancy for males gained slightly; females could still expect 78.2 years and males, 70.9 years.[4]

Of far greater significance is the continuous and rapid increase in the longevity of older Americans. In 1982, people at age 65 could expect to live an additional 16.8 years, 18.8 years for women and 14.4 years for men.[5]

At age 78, the average age of JASA's housing facility residents, life expectancy is no less than an additional 9 years.[6]

Physical and Mental Disability

Accurate data on the incidence of major physical disability need to be secured. Partial, informal data in JASA's survey reflect an incidence of physical disability of 8 to 31 percent, an average of 21 percent of 867 tenants. This finding is consonant with the findings of the National Health Interview Survey (NHIS) of 1979, reported by the National Center for Health Statistics, in 1983[7] which reported on the number of adults who need help in basic physical activities because of a chronic health problem or major disability. In persons 65–74 years, the rate was 5.26 percent, rising to 15.7 percent for persons 75 and over. At age 85 the rate rose to 34.84 percent.

The need for provision of home health care, personal care, housekeeper and chore services will continue to rise probably to levels of 30 percent of the population.

With mental disability reported at an

[4] New York Times, February 12, 1985, p. A17.

[5] *Profile of Older Americans, 1984,* American Association of Retired Persons, and the Administration on Aging, vs. Department of Health and Human Services, p. 1.

[6] *Vital Statistics of the United States, 1978,* Volume 11—Section 5 *Life Tables,* U.S. Department of Health and Human Services, Public Health Service, pp. 5–23.

[7] NCHS Advance Data, Vital and Health Statistics of the National Center for Health Statistics, Public Health Service, U.S. Department of Health and Human Services, No. 92, September 14, 1983.

average of 7 percent of the residents, with a high of 12 percent at one of the oldest buildings, and with the increasing age of the population, an overall increase in mental impairment to reach 12 percent is to be anticipated.

Longevity in residences such as those described is a significant measure of the consequence of a benign, secure environment in which a range of supportive services is available at the choice of the residents. This longevity is consonant with national trends in aging and the probable selection of a healthier group at original tenancy. Increasing longevity will be accompanied by a significant increase in physical and mental disability.

It is noteworthy that 21 percent of the studied resident households had *no* living children, and 11 percent of the households had no children in the metropolitan area. Thus, 32 percent of the residential households had no son or daughter to call on for immediate personal assistance in a crisis.

Inescapably, the supporting social agency must develop effective modes of service to meet the needs of a disabled population and also protect the interests of the normal functioning aged residents. Ways and means must be found to provide a greater measure of support to residents, yet permit their retention of independence and choice. Do these needs inevitably lead to creating or recreating an institutional nursing home?

The survey and its evaluation point to a need to develop and strengthen the following resources:

1. Management and social service information systems must be able to provide comprehensive current data about the physical, mental and social status of residents.

2. An active health, education, and lifestyle assessment conference should be offered to each resident prior to age 75. This will ensure knowledge of available health care and home care resources by the residents if required in the future.

3. The agency should make available a "package" of supportive services, individually determined and at the option of the residents, with costs charged on a sliding scale. Such services as homecare, case management, conservatorships and financial management, and referral to comprehensive health maintenance, may be included.

4. In the instance of a comprehensive service like JASA, the provisions of home attendant care to residents of housing facilities through the agency's own subsidiaries should be explored with government funding agencies. Some economies of management and allocation of home attendant time may be achieved with a single home care provider in residential buildings for the elderly.

5. An agency with housing services must consider taking the initiative in providing protective services for the mentally impaired on a regular ongoing basis rather than as a response to crisis. A case management evaluation should be completed for every mentally impaired resident, and an appropriate plan of service determined and carried out.

6. Severe disability and mental impairment of some elderly residents may require their relocation to appropriate nursing home and mental hygiene facilities. Such relocation is a necessity to sustain the life of the tenant, and to ensure the well-being of fellow tenants. (In New York City, the rights of tenants established in law and judicial practice has often made it difficult to relocate tenants if they are unwilling, even if the relocation is appropriate or benign).

Looking forward, despite the great increase in the numbers of the very old, constraints on government funding of all services, and especially of health care, make it unlikely many additional nurs-

ing home or mental hospital beds will be funded. It is probable that government funds for home care, including personal care will increase. Expenditures for home care have increased sharply during the Reagan Administration. The financial resources of the elderly and their families have been increasing. In a combination of government, philanthropic and personal resources, additional funds will be available to provide appropriate and effective home care services for residents of "housing for the elderly" developments. The independence of even the most impaired homebound persons is best preserved in their own home.

Sponsors of housing for the elderly facilities face the inescapable responsibility of planning now for the provision of supportive services for the care of an elderly population far older, within this decade, than ever anticipated. The last several decades of development of community-based home care and other health and social services have demonstrated their effectiveness. But inescapably, "housing for the aged" will be converted into "homes for the aged" for some very old people. Somehow, the ambiance of housing for the well elderly must be maintained, however impaired the "aging in" population.