A HIDDEN POPULATION: 
OLDER ADULTS RESIDING IN INSTITUTIONAL SETTINGS

Nadia H. Cohen. Ph.D.
Senior Research Scholar

September 2011

RAVAZZIN CENTER ON AGING
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Ravazzin Center on Aging

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Graduate School of Social Service
Fordham University

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</tbody>
</table>
Part I - A Hidden Population

A. Research Objectives

Every society encompasses social groups who are hidden - whether voluntarily or involuntarily from the mainstream of everyday life. In some cases such groups fail to be acknowledged in the national/state/city-wide counting records. This exploratory study is an attempt to bring to the surface one of these quasi-hidden groups: Older New York City residents housed in institutional settings.

The “institutionalized” population is formally defined as people under authorized supervised care or custody in institutions at the time of enumeration. Generally they are restricted to the institutional buildings and grounds, have limited interaction with the surrounding community and are generally under the care of trained staff who have responsibility for their safety. (US Census Bureau, 2008).

Commendable efforts have been expended in federal, state and city data collection procedures to enumerate older adults as a distinct population and highlight their presence and socio-economic characteristics. As a complement to the numerical count and demographic projections, the research community on aging has produced numerous studies, investigations and research projects to highlight the life circumstances, felt and real needs as well as distinctive issues affecting older adults. Not much, however, is known about older persons residing in institutional settings (Federal InterAgency Forum on Aging Related Statistics, 2004).1

Forecasts for the nation-wide expansion of the number of adults ages 65 years and over between 2010 and 2030 report a growth from 40.2 million to 72.1 million (US Department of Health and Human Services, Administration on Aging, 2009, Figure 1). In New York City that same population is projected to rise from 931,650 in 2010 to 1,352,375 in 2030 (New York City Department of City Planning, 2006, p.13).

This projected expansion calls for greater attention to be given to potential circumstances that might affect older adults. The strong commitment of New York State towards gradual

1 Because of the complex methodological issues involved with collecting data from people in institutions, the institutionalized population is often excluded from large national household based surveys and only recently paid attention to by the Census Bureau. Persons living in assisted living facilities, group homes, continuing care retirement communities and other types of residential settings as alternatives to long term care in a nursing home have been typically defined by the US Census Bureau as being part of the non-institutionalized population. Refer to: Federal InterAgency Forum on Aging Related Statistics (2004), p. 60.
deinstitutionalization makes this an even more pressing topic for inclusion into the agenda of policy makers as they grapple with problems that impact the life of these facilities and its residents.

The referent point for much of the statistical account of older adults (as is true of the population in general) is based on a methodology of data collection practices adopted by both the census and household surveys which yields information on the socio-economic and residential patterns of older adults. Though extremely useful to the research community, this methodology carries serious limitations because much of the information yielded about older persons is centered on the family and the household as the unit of analysis.

What we attempt to do in this exploratory study is two-fold:

First, to stretch beyond this conventional methodology in order to explore the latest information available on one segment of the non-household population, specifically older adults residing in selected institutional settings. For the purpose of this study the settings selected include: Nursing Homes, Psychiatric Centers, Adult Homes and Correctional Institutions.

Citing the critical need for this data, the Federal InterAgency Forum on Aging-Related Statistics (2004) states: “Recent concerns have been raised regarding the scarcity of awareness/knowledge regarding the life conditions of older adults housed in institutional settings accompanied by a call for the inclusion of the institutionalized population in national surveys” (p. 59), at the same acknowledging the complex methodological issues involved in collecting data from people residing in institutions (refer to footnote 1).

Second, to inquire in what manner the current downturn in the economy nationwide and in New York City has affected the living standards and services to which institutionalized residents are entitled.

B. Statistical Acknowledgement

In September 2007, the US Census Bureau's American Community Survey released new data sets providing “the first social and economic characteristic profiles of the people living in group quarters - such as adult correctional facilities, college dorms and nursing homes - in nearly three decades” (US Census Bureau News, 2007). In the words of the Census Bureau Director Louis Kincannon at the time: “This release marks the first in-depth look at the characteristics of the non household population since the 1980 census” (US Census Bureau News, 2007). At the
time of this writing this is the only official data set available on this topic.\textsuperscript{2} The data collected under the Group Quarters Population includes two categories of persons: the institutionalized and the non institutionalized population.\textsuperscript{3}

In 2009, in preparation for the 2010 census count, the American Community Survey released data of the nationwide characteristics of the Group Quarter Population by Type of Group Quarters, Gender and Age for the years 2006, 2007 and 2008, based on 1-year estimates. Drawing from this data, the information presented in Table 1 centers selectively on residents 65 years and older in two particular institutions during these years: Adult Correctional Facilities and Nursing/Skilled Nursing Facilities.

In percentage terms, the older population in Correctional Facilities represents a miniscule fraction relative to the overall inmate population (0.9, 1.03, 1.07 percent). The opposite is true of Nursing Facilities, where the presence of older persons is overwhelming (averaging 85\%). In absolute numbers, older adults have a significant presence. To illustrate: in 2008, the older inmate population numbered 23,231, almost all men; 1,568,499 were living in Nursing Homes/Skilled Nursing Facilities (72.4\% were women). The 2006 and 2007 data denotes similar trends. Refer to Table 1.

\textsuperscript{2} As part of the Bureau's Re-Engineered 2010 census, data collected by the American Community Survey helps federal officials determine where to distribute more than $300 billion to state and local governments yearly. The estimates are based on an annual nationwide sample of about 250,000 addresses per month. In addition, approximately 20,000 group quarters across the United States were sampled comprising approximately 200,000 residents. Geographic areas for which data are available are based on total populations of 65,000 or more. (US Census Bureau News, 2007).

\textsuperscript{3} The latter include: assisted living, group homes, religious group quarters, college quarters off campus, college dormitories, military quarters, agricultural and other workers dormitories, dormitories for nurses, interns in general and military hospitals, emergency and transitional shelters with sleeping facilities for runaway children, abused women, soup kitchens, crews of maritime vessels, residential facilities providing protective oversight, staff residents for runaway children, abused women, soup kitchens, crews of maritime vessels; residential facilities providing protective oversight; staff residents of institutions, living quarters for victims of natural disasters, other non household living situations (US Census Bureau, 2008).
### Table 1

**Nationwide Group Quarters Population Residing in Adult Correctional Facilities and Nursing/Skilled Nursing Facilities**

<table>
<thead>
<tr>
<th></th>
<th>Adult Correctional Facilities</th>
<th>Nursing Facilities/ Skilled Nursing Facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2008</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Group Quarters Population</td>
<td>2,140,256</td>
<td>1,845,567</td>
</tr>
<tr>
<td>Group Quarters Population Age 65 years and over</td>
<td>23,231</td>
<td>1,568,499</td>
</tr>
<tr>
<td>Male</td>
<td>96.6%</td>
<td>27.6%</td>
</tr>
<tr>
<td>Female</td>
<td>3.4%</td>
<td>72.4%</td>
</tr>
<tr>
<td><strong>2007</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Group Quarters Population</td>
<td>2,099,689</td>
<td>1,788,167</td>
</tr>
<tr>
<td>Group Quarters Population Age 65 years and over</td>
<td>21,648</td>
<td>1,536,790</td>
</tr>
<tr>
<td>Male</td>
<td>94.5%</td>
<td>28.0%</td>
</tr>
<tr>
<td>Female</td>
<td>5.5%</td>
<td>72.0%</td>
</tr>
<tr>
<td><strong>2006</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Group Quarters Population</td>
<td>2,050,206</td>
<td>1,834,880</td>
</tr>
<tr>
<td>Group Quarters Population Age 65 years and over</td>
<td>19,327</td>
<td>1,585,378</td>
</tr>
<tr>
<td>Male</td>
<td>96.7%</td>
<td>27.3%</td>
</tr>
<tr>
<td>Female</td>
<td>3.3%</td>
<td>72.7%</td>
</tr>
</tbody>
</table>

*Source: US Census Bureau (n.d.(a)).*

For the U.S. population as a whole, roughly equal numbers reside in correctional facilities and nursing homes, but for the population age 65+ the nursing home population dwarfs the population in correctional facilities. See Figure 1 and Figure 2.
Figure 1
Total Population in Selected Group Quarters

<table>
<thead>
<tr>
<th>Year</th>
<th>Correctional Facilities</th>
<th>Nursing Homes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>2,050,206</td>
<td>1,834,880</td>
</tr>
<tr>
<td>2007</td>
<td>2,099,689</td>
<td>1,788,167</td>
</tr>
<tr>
<td>2008</td>
<td>2,140,256</td>
<td>1,845,567</td>
</tr>
</tbody>
</table>

Source: US Census Bureau (n.d.(a)).

Figure 2
Population Age 65+ in Selected Group Quarters

<table>
<thead>
<tr>
<th>Year</th>
<th>Correctional Facilities</th>
<th>Nursing Homes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>19,327</td>
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</tr>
<tr>
<td>2008</td>
<td>23,231</td>
<td>1,568,499</td>
</tr>
</tbody>
</table>

Source: US Census Bureau (n.d.(a)).

With respect to gender, the population age 65+ in the correctional facilities is overwhelmingly male, while the population age 65+ in nursing homes is primarily female. See Figure 3 and Figure 4.
Figure 3
Breakdown of Population Age 65+ in Correctional Facilities by Gender

Source: US Census Bureau (n.d.(a)).

Figure 4
Breakdown of Population Age 65+ in Nursing Homes by Gender

Source: US Census Bureau (n.d.(a)).
C. Historical Data Sources for New York

Table 2 presents comparative data for the institutionalized population nationwide, in New York State and in New York City, classified by gender and age.4

Table 2
**Institutionalized Population by Age and Sex,**
*Nationwide, in New York State and New York City - 2000*

<table>
<thead>
<tr>
<th>Institutionalized Population</th>
<th>United States</th>
<th>New York State</th>
<th>New York City</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Men</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 18 Years</td>
<td>122,112</td>
<td>8,240</td>
<td>1,809</td>
</tr>
<tr>
<td>18 to 64 Years</td>
<td>1,968,245</td>
<td>116,074</td>
<td>27,467</td>
</tr>
<tr>
<td>65 Years +</td>
<td>443,707</td>
<td>32,516</td>
<td>11,718</td>
</tr>
<tr>
<td>Total</td>
<td>2,534,064</td>
<td>156,830</td>
<td>40,994</td>
</tr>
<tr>
<td><strong>Women</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 18 Years</td>
<td>36,006</td>
<td>2,757</td>
<td>778</td>
</tr>
<tr>
<td>18 to 64 Years</td>
<td>291,600</td>
<td>17,286</td>
<td>7,413</td>
</tr>
<tr>
<td>65 Years +</td>
<td>1,197,369</td>
<td>85,389</td>
<td>26,685</td>
</tr>
<tr>
<td>Total</td>
<td>1,524,975</td>
<td>105,432</td>
<td>34,876</td>
</tr>
<tr>
<td>Grand Total</td>
<td>4,059,039</td>
<td>262,262</td>
<td>75,870</td>
</tr>
</tbody>
</table>

Population 65 Years + Residing
Residing in Institutional Settings

<table>
<thead>
<tr>
<th></th>
<th>United States</th>
<th>New York State</th>
<th>New York City</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>443,707</td>
<td>32,516</td>
<td>11,718</td>
</tr>
<tr>
<td>Women</td>
<td>1,197,369</td>
<td>85,389</td>
<td>26,685</td>
</tr>
<tr>
<td>Total 65 Years+</td>
<td>1,641,076</td>
<td>117,905</td>
<td>38,403</td>
</tr>
<tr>
<td>% Women</td>
<td>73.0%</td>
<td>72.4%</td>
<td>69.5%</td>
</tr>
</tbody>
</table>

*Source: US Census Bureau (n.d.(a)), US Census Bureau (n.d.(b)), US Census Bureau (n.d.(c)).*

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4 The institutionalized population included those residing in: Correctional Facilities; Hospitals/Wards for the Chronically Ill/Psychiatric Hospitals/Wards and Other Institutional settings.
1. **Nationwide:** The count of the overall population residing in institutional settings numbered over 4 million (4,059,039). Close to two thirds (62.4%) were men totaling 2,534,064 compared to 1,524,975 women. Among men, the overwhelming majority (77.7%) was within the 18 to 64 age group; it was different for women: 78.5% were 65 years and older. Older residents totaled 1,641,076 persons characterized by a substantial gender gap: 73% (1,197,369) were women. (Refer to Table 2.)

2. **New York State** reported 262,262 residents in institutional settings; the gender difference was close to the nationwide trend: 60% (or 156,830) were men and 117,905 were 65 years and older. The share of the older age group (65 years and over) relative to all the State's institutionalized population reached 45%. (Refer to Table 2.)

3. **New York City** reported 75,870 residents (or 28.9%) of the New York state total living in an institutional setting. The proportion male relative to all those institutionalized in the City (54%) was slightly lower than the corresponding fraction in New York State (60%); the gender gap was slightly narrower. The older age group (65 years and over) housed in institutions numbered 38,403, and accounted for 51% of all those institutionalized in the City. Women numbered 26,685, and accounted for 69.5% of all older aged people who were institutionalized at the time - a share slightly lower than the corresponding fraction for New York State, 72.4%. (Refer to Table 2.)

4. **Across the Boroughs** - The geographical distribution of the overall institutionalized population was uneven across the City's boroughs, most likely due to borough-specific variations in the size of the facility. The heaviest concentration of residents was in the Bronx (36.8%), followed by Brooklyn and Queens with Manhattan following closely behind. Staten Island facilities housed the smallest number of residents – 5,034 – or 6.6% of the total number institutionalized in New York City (Table 3).
### Table 3
**Total Institutionalized Population in New York City, By Borough, by Sex and Age – 2000**

<table>
<thead>
<tr>
<th>Borough</th>
<th>New York City</th>
<th>Bronx</th>
<th>Brooklyn</th>
<th>Manhattan</th>
<th>Queens</th>
<th>Staten Island</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Men</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 18 Years</td>
<td>1,809</td>
<td>895</td>
<td>382</td>
<td>29</td>
<td>488</td>
<td>15</td>
</tr>
<tr>
<td>18 to 64 Years</td>
<td>27,467</td>
<td>13,564</td>
<td>4,320</td>
<td>4,912</td>
<td>2,856</td>
<td>1,815</td>
</tr>
<tr>
<td>65 Years +</td>
<td>11,718</td>
<td>3,313</td>
<td>2,662</td>
<td>1,857</td>
<td>3,137</td>
<td>749</td>
</tr>
<tr>
<td>Subtotal</td>
<td>40,994</td>
<td>17,772</td>
<td>7,364</td>
<td>6,798</td>
<td>6,481</td>
<td>2,579</td>
</tr>
<tr>
<td><strong>Women</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 18 Years</td>
<td>778</td>
<td>168</td>
<td>238</td>
<td>101</td>
<td>238</td>
<td>33</td>
</tr>
<tr>
<td>18 to 64 Years</td>
<td>7,413</td>
<td>2,749</td>
<td>1,635</td>
<td>1,440</td>
<td>1,167</td>
<td>422</td>
</tr>
<tr>
<td>65 Years +</td>
<td>26,685</td>
<td>7,215</td>
<td>6,345</td>
<td>4,083</td>
<td>7,042</td>
<td>2,000</td>
</tr>
<tr>
<td>Subtotal</td>
<td>34,876</td>
<td>10,132</td>
<td>8,218</td>
<td>5,624</td>
<td>8,447</td>
<td>2,455</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>75,870</td>
<td>27,904</td>
<td>15,582</td>
<td>12,422</td>
<td>14,928</td>
<td>5,034</td>
</tr>
</tbody>
</table>

**Institutionalized Population Age 65+ New York City**

<table>
<thead>
<tr>
<th></th>
<th>New York City</th>
<th>Bronx</th>
<th>Brooklyn</th>
<th>Manhattan</th>
<th>Queens</th>
<th>Staten Island</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Men</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>65 Years +</td>
<td>11,718</td>
<td>3,313</td>
<td>2,662</td>
<td>1,857</td>
<td>3,137</td>
<td>749</td>
</tr>
<tr>
<td><strong>Women</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>65 Years +</td>
<td>26,685</td>
<td>7,215</td>
<td>6,345</td>
<td>4,083</td>
<td>7,042</td>
<td>2,000</td>
</tr>
<tr>
<td><strong>Total 65 Years+</strong></td>
<td>38,403</td>
<td>10,528</td>
<td>9,007</td>
<td>5,940</td>
<td>10,179</td>
<td>2,749</td>
</tr>
</tbody>
</table>

*Source: US Census Bureau (n.d.(b))*

Residents of Nursing Homes in New York City accounted for an overwhelmingly large number of older people (65 years and over), accounting for 95.3% of all institutionalized women and 91.5% of the men. Over one half (55.2%) of the Nursing Home population were housed in the Bronx and Queens. In addition, 8,322 (or 23.0%) were located in facilities in Brooklyn (Table 4).
### Table 4

**Institutionalized Population 65 Years and Over**

*By Type of Institutional Setting, Age, Sex and Borough: New York City, 2000*

<table>
<thead>
<tr>
<th>Type of Institutional Setting and Sex</th>
<th>Bronx</th>
<th>Brooklyn</th>
<th>Manhattan</th>
<th>Queens</th>
<th>Staten Island</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Institutionalized Men 65+</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Correctional</td>
<td>39</td>
<td>8</td>
<td>16</td>
<td>7</td>
<td>11</td>
<td>81</td>
</tr>
<tr>
<td>Nursing Homes</td>
<td>3,025</td>
<td>2,405</td>
<td>1,540</td>
<td>3,046</td>
<td>703</td>
<td>10,719</td>
</tr>
<tr>
<td>Hospitals/Wards for chronically ill</td>
<td>97</td>
<td>141</td>
<td>271</td>
<td>5</td>
<td>0</td>
<td>514</td>
</tr>
<tr>
<td>Mental Hospitals/Wards</td>
<td>88</td>
<td>71</td>
<td>22</td>
<td>12</td>
<td>13</td>
<td>206</td>
</tr>
<tr>
<td>Other institutions</td>
<td>64</td>
<td>37</td>
<td>8</td>
<td>67</td>
<td>22</td>
<td>198</td>
</tr>
<tr>
<td>Total</td>
<td>3,313</td>
<td>2,662</td>
<td>1,857</td>
<td>3,137</td>
<td>749</td>
<td>11,718</td>
</tr>
<tr>
<td><strong>Institutionalized Women 65+</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Correctional</td>
<td>22</td>
<td>0</td>
<td>8</td>
<td>3</td>
<td>0</td>
<td>33</td>
</tr>
<tr>
<td>Nursing Homes</td>
<td>6,985</td>
<td>5,917</td>
<td>3,681</td>
<td>6,892</td>
<td>1,962</td>
<td>25,437</td>
</tr>
<tr>
<td>Hospitals/Wards for chronically ill</td>
<td>41</td>
<td>291</td>
<td>380</td>
<td>8</td>
<td>0</td>
<td>720</td>
</tr>
<tr>
<td>Mental Hospitals/Wards</td>
<td>114</td>
<td>91</td>
<td>11</td>
<td>28</td>
<td>20</td>
<td>264</td>
</tr>
<tr>
<td>Other institutions</td>
<td>53</td>
<td>46</td>
<td>3</td>
<td>111</td>
<td>18</td>
<td>231</td>
</tr>
<tr>
<td>Total</td>
<td>7,215</td>
<td>6,345</td>
<td>4,083</td>
<td>7,042</td>
<td>2,000</td>
<td>26,685</td>
</tr>
</tbody>
</table>

**Total Institutionalized Ages 65+**

| Total Institutionalized Ages 65+ | 10,528 | 9,007 | 5,940 | 10,179 | 2,749 | 38,403 |

- Male and Female of All Ages Institutionalized in New York City: 75,870
- Male and Female 65+ Institutionalized in New York City: 38,403
- Percent Institutionalized 65+ of all NYC Institutionalized: 50.6%
- Male/Female 65+ in Nursing Homes: 36,156
- Percent Institutionalized Men 65+ in Nursing Homes: 91.5%
- Percent Institutionalized Women 65+ in Nursing Homes: 95.3%
- Percent 65+ in Nursing Homes of all 65+ in Institutions: 94.1%

*Source: US Census Bureau (n.d.(b))*
With this as background, the substance of this study was centered on collecting the most recent quantitative and qualitative information available on older residents in the selected institutional settings. The initial goal was to gain some insight into these institutions and what it means for an older person to reside in these settings. In the course of the research, however, it became clear that a number of obstacles were encountered in the information gathering process. This has meant that not all of what was initially planned and hoped to be achieved was possible.

D. Methodological Constraints

As noted earlier, this is an exploratory study. Its most serious limitation has been the lack of access to meet with the subjects themselves - older persons residing in institutional settings. The findings reported in the following pages are drawn from: (a) the nation-wide literature; studies and statistics provided in reports submitted by New York State agencies and by the particular institutions under review; and (b) information obtained through meetings with resource professionals and experts on the subject of institutional settings who offered tremendous help and guidance in pursuing this topic. To them, we are most grateful.

They include, in alphabetical order: Michael Friedman, Geriatric Mental Health Alliance of New York City; Jessica Harold, Friends and Relatives of the Institutionalized Aged; Clare Horn, Aging in America; Geoff Lieberman, Coalition of Institutionalized Aged and Disabled; Joel Sender, MD, St. Barnabas Nursing Home; William Smith, Aging in America; Amy Torres, Friends and Relatives of the Institutionalized Aged; Debbie Warburton, New York Foundation for Senior Citizens; Kimberly Williams, Geriatric Mental Health Association of New York City. Of equal great assistance in guiding, contributing and finalizing this study were Irene Gutheil and Karen Dybing of the Ravazzin Center to whom I extend my appreciation. The reader will note an unequal balance in the coverage of information between the different institutional settings under review. This can be traced to differences in the availability of comprehensive published information between some institutions as compared to others and to differential opportunities encountered in gaining access to experts knowledgeable of institutional life, particularly as it relates to older adults.
A. Brief Nationwide Profile

Reliable estimates on the 2008 Group Quarter Population placed the nationwide number of Nursing Home residents at 1,845,567 - 72.4% women and 27.6% men (US Census Bureau, n.d.(a). Among these 1,568,499, or 85% of the total number of residents were 65 years and older. (Refer to Table 1). Despite the closing gap in female/male mortality rates, the gender differences in the patient population continue to be high. A contributing factor is that older men tend to remarry in their later years much more frequently than widows, and have wives to take care of them.\footnote{The 2008 data shows 72\% of men 65 years and older to be married versus 42\% of the women; Men were also less likely to be widowed (14\%) or divorced/separated/spouse absent (10\%) (Department of Health and Human Services, Administration on Aging, 2009).}

Yet despite the aging of the population, the actual percentage of older adults residing in nursing homes has declined. For example, about 7.4\% of Americans ages 75 and older were nursing home residents in 2006, compared to 8.1\% in 2000 and 10.2\% in 1990. Fewer than 16\% of the 85 year and older population resided in nursing homes in 2006, as compared to 21\% in 1985 (El Nasser, 2009, p.1A). Many factors have contributed to this shrinkage. Certainly the downturn reflects the improved health of elders in conjunction with the availability of greater choices for the care of older adults. For those in the upper income groups, assisted living facilities and at-home/family care have been fast growing options available for elder care; while other socio economic segments benefit from the expansion of home and community care facilities (El Nasser, 2009).

There are other factors at play as well.

1. Costs. The nursing home industry - evaluated at $122 billion - generates most of its revenue from Medicaid and Medicare (Lagnado, 2008, p. 1). According to the 2006 Met Life Market Survey of Nursing Home and Home Care Costs, the average cost of nursing home care is $67,000 a year and tops $100,000 in some urban areas (MetLife Mature Market Institute, 2006). The average nursing home patient runs out of money within 6 months and must go on Medicaid. That not only bankrupts individuals, but also strains the Medicaid system.

2. Resistance to Enter Nursing Homes. Many elderly individuals shun the thought of entering a nursing home. According to a 2003 AARP Survey, only one percent of Americans
over the age of 50 years with a disability wanted to move to a nursing home (Lagnado, 2008). Evidence of institutional abuse has been plenty. A 2001 study prepared by the minority (Democratic and Independent) staff of the Special Investigations Divisions of the House Government Reform Committee found that 30% of Nursing Homes in the country, numbering 5,283 facilities, were cited for almost 9,000 instances of abuse over a two year period ranging from January 1999 to January 2001 (Minority Staff, Special Investigations Division, 2001).

3. Out-Migration Flows. Older persons, shocked by the high cost of nursing facilities and care offered at assisted living facilities, have in steadily increasing numbers fled abroad, crossing the border to Mexico. There, for $1,300 monthly, a person has access to a studio apartment, three meals a day, laundry and cleaning services, as well as 24 hours of personalized care by staff, which includes a number of English-speaking nurse’s aides. Mexico's proximity (particularly for West and Southwest Coast residents), low labor costs and a warm climate make this alternative attractive, though residents did mention that quality of care provided may vary considering that this a nascent industry (Hawley, 2007).

4. Rating and Ranking Nationwide Nursing Homes. Vast differences in the quality of care provided to patients across the country were revealed in the findings of a complex rating system developed at the federal level in 2008. Applied to 16,000 nursing homes in the country, this system assigned each institution a one to five stars format rating based on how their quality of care, staffing and health inspections were evaluated. The scores reflect thousands of inspection records, complaint investigation and quality measures as to how many nursing staff hours were provided each day to patients; how many patients developed bed sores and how many were placed in restraints.

Analysis of the findings highlighted the following:

- 1,855 nursing homes received top five star ratings;
- Only 27 among them were listed as meriting “honor roll status,” indicating they received perfect five stars on the criteria outlined above.

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6 In 2007, an estimated number of American retirees living in Mexico varied from 40,000 to 80,000; though no reliable data is available on the number residing in nursing homes. As of 2007 at least five nursing homes were available in Lake Chapala. In Ensenada (Baja California), Residence Lourdes opened in 2003 offering care for Alzheimer’s patients and those with senile dementia. Expatriates not quite ready to enter a nursing home were found to be exploring options such as Home-Health Care services, which can be provided by Mexican nurses/nurse’s aides, at a fraction of the cost in the United States (Hawley, 2007).
• “For profit” facilities are more likely to provide lesser care to patients compared to “not for profit” institutions.

• 27 percent of the 10,542 “for profit” facilities vs. 13% of the 4,182 “not for profit” facilities were assigned only one star.

• 19% of the “not for profit” facilities received FIVE stars, compared to only 9% of facilities run “for profit” (Appleby, Steinberg & Gillum, 2009)

B. New York City's Nursing Home Institutions

1. Estimated Number of Patients Institutionalized. There was a lack of consistency in the information obtained on the current number of nursing homes located in New York City. An official source identifies a total of 180 facilities (derived from New York State Department of Health, n.d.(a)), providing 45,277 beds. The 2000 census count of the Group Quarter Population reported 177 facilities, distributed by borough and number of beds as follows (Murphy and Carroll, n.d.):

<table>
<thead>
<tr>
<th>Borough</th>
<th>Number of Facilities</th>
<th>Number of Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bronx</td>
<td>46</td>
<td>11,919</td>
</tr>
<tr>
<td>Brooklyn</td>
<td>45</td>
<td>10,733</td>
</tr>
<tr>
<td>Manhattan</td>
<td>19</td>
<td>7,084</td>
</tr>
<tr>
<td>Queens</td>
<td>56</td>
<td>12,392</td>
</tr>
<tr>
<td>Staten Island</td>
<td>11</td>
<td>3,149</td>
</tr>
<tr>
<td>Total</td>
<td>177</td>
<td>45,277</td>
</tr>
</tbody>
</table>

Information on the current size of the City's nursing home population was also impossible to obtain from either official or non official sources. Their accounting system is apparently not directed at “number of patients” but rather at “number of beds,” and an estimate of their occupancy rate. Moreover, patients are classified by their health status and not by age, which makes it difficult to estimate the proportion of those ages 65 years and over from the total patient population. The lack of information is accounted for by the constant flux of changes in the patient population and changes in ownership of these facilities.

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7 The count varies: Friends of the Institutionalized Aged reported 273 facilities; the Department of Health, 280; The NYS Department of Health 180 (derived from New York State Department of Health, n.d.) and the New York Ombudsman Program for Long Term Care, 177. It is not clear whether the 557 nursing home beds in the City's Veteran Hospitals are included in the count. The same number of beds are cited for the most recent data.
New York State has the reputation of having the highest occupancy of nursing homes in the nation. This lends credibility to information gathered through interviews that cites the occupancy rate in the City's nursing homes to range between 90% and 95%. Applying the estimated lower range of these rates (90%) to the 45,277 beds yields an estimate of around 40,500 nursing home residents of all ages. Drawing upon the data in the 2008 nationwide count, which cites the proportion of the 65 years and older age group as representing 85% of all nursing home residents country-wide (refer to Table 1) yields a tentative estimated number of 34,425 patients age 65 and older currently residing in New York City's nursing home institutions. 

2. Regulatory Agencies and Staffing. Federal and State laws and regulations largely determine the character of a nursing home. To be licensed and receive Medicare or Medicaid reimbursement the institution must meet minimum federal standards and provide certain services. The New York State Department of Health regulates nursing homes based on the Federal Nursing Home Reform Act of 1987 that sets standards of care and outlines protection of resident's rights. Nursing homes fall into three types: “for profit” proprietary nursing homes, which operate as small business enterprises and comprise the majority of facilities in New York City; “voluntary not-for-profit” facilities typically sponsored by religious organizations, fraternal or community groups in which any and all profit made is returned back into the operation of the facility; and “municipal/public” nursing homes which are few in number and owned/operated by a county or municipality.

The City's facilities are moderate in size, ranging between 200 and 300 beds. Nursing home administrators are full time employees licensed by the New York State Department of Health, accountable to the facility's Operator, and responsible for the day to day operation of the facility. To maintain an active license, 74 hours of approved continuing education must be completed every two years. The medical director, licensed by the State of New York, coordinates medical care for all patients.

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8 The 2000 Census count of New York City's Group Quarter Population identified nursing home patients 65 years and older to total 36,156 (refer to Part I).

9 New York State does not allow publicly-traded national nursing home chains or corporations, though a single owner may control many nursing home institutions.

10 Some among the municipal/public facilities - notably the Goldwater Agency - admit people without health insurance and in a number of cases undocumented persons as well.
Reported costs of the City's private nursing homes range between $100,000 and $160,000 yearly per bed. New York being known to be most generous in extending health care, it is estimated that 75% to 95% of patient's payment is through Medicaid reimbursement, though personal assets (whenever available) have to be contributed within the guidelines of the law.

3. Monitoring and Supervision. The Ombudsman Program located in New York City has the responsibility of monitoring all the nursing homes in the five boroughs. Its role and function are to be advocates to protect patients' rights, safety and well being by acting as information brokers, listening to patients’ complaints, mediating and facilitating conflict situations, and solving problems encountered. Nursing home staff have their own perception of the monitoring process at times, as being less than collegial.

The monitoring is done by a group of about 200 trained, staff certified volunteers who are closely supervised by each Borough's supervisor who, in turn, visit each facility once weekly. Volunteers work closely with both staff supervisors and regulatory agencies on site to help patients address and resolve their concerns and improve the quality of their daily life. The Department of Health is assigned the responsibility to conduct surveys of nursing homes every nine to 15 months, and of certified Home Health Care Agencies every three years.

C. Problems Encountered by Patients

1. Quality Care. The findings from two Round Table Discussions highlighted - among other problems - systemic weakness in the current quality of care provided to patients in New York's Nursing Home institutions, most pointedly due to increased shortages and turnover rates of staff, which fail to enable meeting and responding to patients needs (Long Term Care Community Coalition, 2008).

2. Presence of Residents with Mental Illness. It is estimated that 50% to 70% of nursing home residents in New York suffer from co-occurring mental illness, most particularly dementia (commonly thought of as a physical rather than a mental disorder); depression and anxiety disorders (Friedman & Williams, 2008, p.12). 11

11 Current information from the Center for Medicare and Medicaid Services indicate that the prevalence of mental and behavioral disorders in New York State's nursing homes is high and increasing: 46% have dementia, often with emotional/behavioral complications; 35% are clinically depressed; 17% have other psychiatric problems and 23% have behavior problems associated with mental illness (Friedman & Williams. 2008, p.12).
Some nursing facilities offer good individualized care to dementia patients without establishing a special program. Some may promote a dementia unit, but don't always provide the care of a specialized trained staff. How many staff members take advantage of the training and supervision offered by the New York chapter of the Alzheimer’s Association in caring for dementia patients is not known. Few nursing homes have mental health professionals on staff; others contract with outside mental health professionals.

Overall, however, it is believed that most nursing home staff lack knowledge and skill to deal with psychiatric, addictive and behavioral problems.\(^\text{12}\)

3. Abuse and Mistreatment. Reliable information on institutional abuse occurring in the City’s nursing homes was not available, though anecdotal references do appear in the press regularly.\(^\text{13}\) The Administration on Aging (2006) does maintain records on reported nursing home abuse by state. For the year 2006, the percentage breakdown of “Abuse, Gross Neglect, and Exploitation in Nursing Homes” for New York State was:

<table>
<thead>
<tr>
<th>Type of Abuse</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical abuse(^\text{14})</td>
<td>30%</td>
</tr>
<tr>
<td>Verbal/ mental abuse</td>
<td>23%</td>
</tr>
<tr>
<td>Gross neglect</td>
<td>17%</td>
</tr>
<tr>
<td>Resident to resident abuse</td>
<td>16%</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>4%</td>
</tr>
<tr>
<td>Financial exploitation</td>
<td>3%</td>
</tr>
<tr>
<td>Other</td>
<td>6%</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
</tr>
</tbody>
</table>

A different perspective on abuse occurring in nursing home institutions was identified by a medical director of a large New York City nursing facility. Though acknowledging the lack of

\(^\text{12}\) During the heyday of de-institutionalization, a large number of patients with serious and persistent mental illness were discharged to nursing homes, as part of the official state policy. In the 1980's changes in federal law prohibited this practice. This slowed down the process, but did not stop it.

\(^\text{13}\) To exemplify: a Brooklyn nursing home was ordered to pay $19 million dollars in damages to the family of a 76 year old patient, who entered the facility weighing 237 pounds and after 9 months was down to 148 pounds, with bedsores over his whole body. Transferred to another facility he succumbed to an ongoing infection caused by the earlier bedsores. Allegations were made that the first nursing home had doctored the records to cover up the neglect (Ginsburg, 2009).

\(^\text{14}\) Physical abuse in nursing homes may at times be over reported or incorrectly defined. This is particularly true in cases where dementia patients have to be restrained.
recognition of abuse from staff across the board, the most pervasive abuse suffered by older patients was described as perpetrated by family members and female predators by way of financially exploiting elderly, frail patients, who are often suffering from dementia.

4. Ignoring End of Life Decisions. A number of nursing homes, especially those with religious affiliations, have policies that allow them for religious and moral reasons to refuse to follow some end-of-life treatment decisions made by patients. Typically, this is done by refusing to withhold artificial nutrition and hydration, ignoring the wishes of patients who want to end their life. Whether or not these facilities explain their policies about end-of life treatment in advance or help transfer patients to other nursing homes is not known.

D. Handling Complaints

Complaints of abuse and neglect whether voiced by patients, their families, advocacy groups, or the staff itself can be reported and filed with the New York State Department of Health. The Medicaid Fraud Unit of the State's Attorney General's Office also investigates criminal cases of abuse, neglect or mistreatment. Unfortunately many complaints are difficult to evaluate, particularly when they occur without the presence of witnesses.

Of great support in handling patient complaints in nursing homes, are informal organizations such as the Family and Resident Councils and/or Friends and Relatives Councils. Made up of patients’ families, visitors, partners, and even neighbors, their most important mission is to provide a forum for their members to discuss concerns regarding the quality of care provided to patients. Many among them will meet with nursing home administrators to bring up complaints voiced by patients, by their families and friends. When necessary, members will meet with Department of Health officials during the latter's inspection surveys.

The advocacy strategies of the Friends and Relatives of Institutionalized Aged (FRIA) played an important role in the formation and activities of these Councils. Their knowledgeable and well-trained multi-lingual counselors provided assistance to new and existing Councils; helped families and friends solve problems encountered in nursing homes; made them aware of the regulations and responsibilities binding nursing homes, and directed them to the appropriate staff member to approach for a particular issue.
E. Impact of the Financial Crisis

Nationwide, nursing homes are perilously close to cutting services and possibly even closing because of the recession and deep spending cuts. As reported in October 2009, a rate adjustment was announced by the federal Centers for Medicare & Medicaid Services to the effect that these entitlements are expected to be cut by an estimated $16 million in nursing home funding over the next ten years (America’s nursing homes, 2009). This is in addition to state cuts. At the New York State level, Medicaid funding is in a perilous state as well. A 2009 Kaiser Family Foundation Report showed the $50 billion State program might be impacted by other priorities (Smith et al., 2009).15

As of the end of 2009, reports on the impact of the crises on New York City's nursing homes were mixed. However, the Metropolitan Jewish Health System in the City laid off about 200 employees at three nursing homes in Brooklyn because of State-cut Medicaid funding by 10 to 14% (America’s nursing homes, 2009). The Westchester Medical Center close to New York City said it would lose a nursing home and cut 400 jobs to deal with cuts in Medicaid and other funding (America’s nursing homes, 2009).

A large nursing home in the Bronx has also felt the repercussions of the financial crises, being forced to lay off 50 full time employees mostly clerical, managerial and rehabilitation staff. In taking this step, special precautions were taken to ensure that high quality care of patients would not be affected. Additional problems voiced that would affect the City's nursing homes in general, include the following:

- reduction in services provided by the Mayor's Office;
- failure of Managed Care to make co-payments;
- difficulties encountered in fund raising;
- “not for profit” nursing homes forced to sell their facilities to “private for profit” homes;
- Pressuring facilities to close a number of beds to create more single space rooms which, though more expensive, are more marketable;
- downsizing “not for profit” nursing homes by New York State in order to save money.

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15 The argument made is that Albany has hastened the crises through Spitzer-era budget deals by: extending its children health program to cover 19 and 20 year olds; adding coverage for several procedures including anti smoking counseling; allowing state employees to have access to certain Medicaid programs.
The financial difficulties encountered in the public sphere have indirectly affected the workings of nursing homes in other ways. To exemplify: residents' families are dealing with more stress and their impatience directed toward nursing staff. At the root of these difficulties may be financial constraints and frustrations caused by the lack of housing, loss of family jobs and difficult family situations.
Part III - Mental Health Institutions

A. Background

Older persons with mental illness include individuals who have had psychiatric disabilities most of their lives and those who developed a form of mental illness as they aged. In some cases, persons suffering from psychiatric disorder early on in their life tend to develop dementia. There is also a tendency for those who have suffered from a moderate mental illness in their younger years to develop serious psychiatric disorders as they age. (Friedman & Steinhagen, n.d.(b)).

Geriatric mental health problems have been classified as follows: (a) persons with long term psychiatric conditions who are aging; (b) people with developed or exacerbated disorders in late life, including dementia; late onset of psychosis; severe anxiety, depressive and paranoid disorders leading to social isolation; less severe anxiety and depressive disorders; addictive problems especially with alcohol and drug abuse; and (c) emotional problems adjusting to old age. For persons falling in the first category, life expectancy tends to be at least 10 years shorter than the general public population because of poor health, high rates of suicide and accidents (Friedman & Williams, 2006). A recent study put it at 25 years earlier (Torgovnick, 2008).

An older person experiencing any of the above may also experience forms of cognitive and functional impairment: specifically, difficulties in managing basic activities of daily living. In many, though not all, cases older adults with mental illness tend to develop chronic health conditions such as obesity, hypertension, diabetes, heart disease and pulmonary problems. Often if depression sets in with old age it is associated in many cases with severe chronic physical ailments. It is at that stage that older persons may become substance abusers of drugs and/or overuse alcohol and medication (Friedman & Steinhagen, n.d.(b)).

Working age adults have been the primary target for mental health services in the past. It has taken many years for the inaccuracy of this assumption to be acknowledged and for the urgency of responding to the specific mental health needs of persons as they age to be recognized (Friedman & Williams, 2006).

B. Difficulties in Documenting Older Adults with Mental Illness

1. Facilities Available. The New York State Office of Mental Health has estimated the current nationwide size of the mentally ill population ages 65 years and older at 7 million; at
480,000 in New York State (New York State Office of Mental Health, n.d.(a)). Estimates from the Geriatric Mental Health Association in New York place the number of people suffering from mild to severe depression in New York City at 220,000 as of 2009. The City has responded to the magnitude of the problem in terms of the number of psychiatric centers and psychiatric services offered in institutionalized and non-institutionalized settings.

Currently there are 10 State Psychiatric Centers across the boroughs of New York City; among these, seven provide mental health services to adults (New York State Office of Mental Health, n.d.(b)). They are:

- Bronx Psychiatric Center (Bronx);
- Creedmor Psychiatric Center (Queens);
- Kingsboro Psychiatric Center (Brooklyn);
- Kirby Forensic Psychiatric Center (Wards Island);
- Manhattan Psychiatric Center (Wards Island);
- New York Psychiatric Center (Manhattan);
- South Beach Psychiatric Center (Staten Island)

In addition to the above institutional settings, there are a total of 92 hospitals and extension clinics in New York City numbering a total of 3,166 beds that are earmarked to provide psychiatric services across all the City's boroughs for all ages. These are not institutional settings in the strict sense of the word and are mostly used for short term stay. Namely,

- In Manhattan, 27 units with 1,097 beds;
- In Brooklyn, 22 units with 902 beds;
- In Queens, 17 units with 619 beds;
- In the Bronx, 19 units with 424 beds;
- In Staten Island, 7 units with 124 beds.

2. Difficulty in Compiling Information. Despite all these facilities, it was not possible to gain access to a comprehensive data set to identify the size of the older mentally ill population in New York City, least of all to estimate the number of patients residing in institutionalized settings. There are several reasons for this.

a. Lack of interest on the part of the seven Psychiatric Centers to grant interviews or share information limited to the size and age of their in-patient residents. Given that the central
focus of this study is centered around institutional settings, the inability to obtain information from this source created a significant data gap.

b. The hidden numbers of those with mental illness. It is estimated that in the overall population, close to 50% of people with mental illness receive no treatment whatsoever. Fewer than 25% of mentally ill persons actually receive services from mental health professionals; and another quarter prefer to be treated by their primary physician. For many others, their disability goes undetected, undiagnosed or hidden (Friedman & Steinhagen, n.d.(a), p.3).  

   c. The fact that some City residents with serious mental afflictions are receiving care in psychiatric institutions outside of New York City. The Rockland Psychiatric Center in Rockland County and the New York Presbytarian Center in Westchester County are prime examples of those facilities; the latter being reputed as having one of the best geriatric units in psychiatry. At some point in time New Yorkers with psychiatric illnesses were also being sent to facilities in Massachusetts (Levy, 2002 November 17).

   The only tangible and publicly available source of fragmented information on the mentally ill population in New York City is the “Patient Characteristics Survey (PCS)” conducted every two years by the New York State Office of Mental Health. This Survey collects demographic, clinical and service-related information for each person who receives a mental health service during a specified one-week period. All programs licensed or funded (directly or indirectly) by the NYS Office of Mental Health are required to complete the survey. The 2007 PCS (latest available at the time of this writing) collected data from approximately 5,000 mental health programs serving 170,000 people during the specified survey week. Conducted every two years, it provides a comprehensive one week snapshot of the mentally ill population served by the State's mental health system by region. Furthermore, it has the advantage of presenting age-disaggregated data providing visibility to the adult population ages 65 years and older.

   Keeping in mind the limitations of the "snap-shot" data collected, the Patient Characteristic Survey provides interesting information on the type of program17 in which

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16 There is anecdotal evidence that people with serious and persistent mental illness or mental retardation are hidden by family members without access to mental health and retardation services most of their lives. It is only when family members become incapable of continuing care that they ask for help; turning not to mental health systems, but to Senior Centers. (Friedman & Williams, 2006, p.16)

17 The classification of all the programs identified in the Patient Characteristics Survey include: Emergency Programs; Inpatient Programs; Outpatient Programs; Mental Health Residential Programs and Community Support Non-Residential programs.
surveyed patients are involved; specifies institutions rendering services to the patients surveyed, in addition to disaggregating the population served by age and ethnic background. For New York City, borough-specific data pertaining to the location where mental health services are provided are also included.

Given the central focus of this study, the closest “proxy” indicator of patients residing in institutional or semi institutional settings is the information provided in the Survey under “In-Patient Programs.” This includes surveyed patients receiving treatment in: State Psychiatric Centers, Residential Treatment Facilities for Children/Youth; Private Psychiatric Hospitals and Psychiatric Units of a General Hospital.

The information in Table 5 below provides a glimpse of the number of “in patients” covered under the 2007 Patient Characteristic Survey (PCS) in the New York City region according to the particular psychiatric institutions where they received treatment. Specifics related to the presence of older adults in this patient population are noted.

<table>
<thead>
<tr>
<th>Table 5</th>
<th>Clients Served During Week of 2007 PCS in In Patient-Psychiatric Programs by Age and Program Location. New York City Region</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All Ages</td>
</tr>
<tr>
<td>New York City Region</td>
<td>6,286</td>
</tr>
<tr>
<td>Psychiatric Centers</td>
<td>2,376</td>
</tr>
<tr>
<td>Residential Treatment Children/Youth</td>
<td>115</td>
</tr>
<tr>
<td>Private Psychiatric Hospital</td>
<td>331</td>
</tr>
<tr>
<td>Psychiatric Unit/General Hospital</td>
<td>3,490</td>
</tr>
</tbody>
</table>


In New York City's total PCS client population reported to be receiving treatment in in-patient Psychiatric programs, slightly over one-half were treated in Psychiatric Units located in
General Hospitals (3,490). Slightly over one third (38.0%) were receiving care in State Psychiatric Centers. A small number were in Private Psychiatric Hospitals. Six in every ten among the older age group of inpatients received treatment in the Psychiatric Units of General Hospitals and close to 22% were in State Psychiatric Centers. It is interesting to find that close to 30 percent in patients in a private psychiatric hospital were 65 years and older.

The 6,286 clients surveyed in the 2007 PCS Inpatient Programs in New York City were serviced unevenly across the five boroughs: Manhattan, Queens and Brooklyn reported the highest numbers serviced; the Bronx and Staten Island the lowest; 44 percent of the older age group of clients surveyed were receiving treatment in Manhattan.

<table>
<thead>
<tr>
<th>City/Borough</th>
<th>Numbers Receiving In-Patient Services</th>
<th>65+ as a Percent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All Ages</td>
<td>Ages 65+</td>
</tr>
<tr>
<td>New York City</td>
<td>6,286</td>
<td>517</td>
</tr>
<tr>
<td>Bronx County</td>
<td>955</td>
<td>50</td>
</tr>
<tr>
<td>Brooklyn</td>
<td>1,346</td>
<td>80</td>
</tr>
<tr>
<td>New York County</td>
<td>2,107</td>
<td>227</td>
</tr>
<tr>
<td>Queens County</td>
<td>1,389</td>
<td>132</td>
</tr>
<tr>
<td>Staten Island County</td>
<td>509</td>
<td>30</td>
</tr>
</tbody>
</table>


Participation in other programs included in the PCS Survey indicated that older age clients showed highest visibility in Outpatient Programs: among the 7,281 older age patients surveyed, 73% were participants. The same percentage held true with regard to the total patient population surveyed. Below is a breakdown for the two groups.
Table 7

<table>
<thead>
<tr>
<th>Table 7 Clients Receiving Services in Other Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Ages</td>
</tr>
<tr>
<td>-----------</td>
</tr>
<tr>
<td>Total Number/Program Type</td>
</tr>
<tr>
<td>MH Residential Program</td>
</tr>
<tr>
<td>Outpatient Programs</td>
</tr>
<tr>
<td>Community Support non-residential Program</td>
</tr>
</tbody>
</table>


Were it not for the significant number of older persons with mental disorders being absorbed into the nursing home and adult home systems (refer to Parts II and IV), and the number living with their families, there might have been a larger participation of older persons in these programs.

C. Problems in Responding to the Needs of Older Persons

1. Inadequacies in the System. Addressing the inadequacies of the existing system in the quality of services provided for older adults, the following factors have been identified by (Friedman & Steinhagen, n.d.(a), pp.2,7,13-15):
   - overutilization of institutions, such as nursing homes and adult homes;
   - uneven quality of services provided both in institutional and community settings;
   - limited integration of mental health, physical health and aging services;
   - neglect in addressing addictive disorders of older adults;
   - limited capacity to serve cultural minorities;
   - workforce shortages;
• stigma, ageism and ignorance attached to mental illness and its treatment;
• lack of adequate family support;
• serious financial problems.

It is precisely problems such as the above that led to the establishment of the Geriatric Mental Health Alliance of New York in January 2004, with the goal of promoting changes in practice and policy that would enable older adults with mental health problems to receive the help they need.

2. **Barriers to Overcome in Geriatric Mental Health.** Friedman and Steinhagen (n.d.(a)) identify the major barriers that stand in the way of acknowledging and responding to the needs of the older population afflicted with mental illness.

a. Financial barriers. In addition to the lack of adequate funding, the Medicare and Medicaid restrictions in covering mental health service costs deserve mention. Under Medicare, the co-payment of mental health services has to date been a 50% share; compared to the 20% copayment for physical health services. This, in and of itself, has caused problems of affordability. The discrepancy should disappear as parity is phased into the Medicare stipulations in the proposed Health Reform Bill between 2010 and 2014. Also of note is that the Medicare system does not cover case management while transportation costs are covered only in emergencies. The Medicaid system has problems as well. It pays very low rates for home visits and covers very low fees for clinicians in private practice.

b. Shortages of geriatric mental health services in the home-based service system; in community settings; in many neighborhoods (particularly ethnic minority ones); and in clinics dealing with substance abuse problems. There is also a lack of professional attention paid to mentally ill persons in nursing homes, in adult homes and in assisted living facilities.

c. Lack of an adequate work force affecting quality of care. To date, the mental health system relies in large part on primary care providers inadequately trained in dealing with mental illness and on non-geriatric trained mental health professionals. Issues of alcohol and substance abuse among the elderly are overlooked, despite the fact that 17% among the elderly have been found to have substance abuse problems (Friedman & Steinhagen, n.d.(a), p.7).

d. Cultural obstacles. The estimated 50% of mentally ill older adults who do not seek treatment includes many who either consider such services as alien to their culture; identify mental illness as equal to “being crazy”; and/or are suspicious of western medicines. A number
prefer non-traditional forms of help provided by faith healers, herbalists, religious leaders, feeling more comfortable in non clinical settings, with people they trust and who speak their language.

e. The placement of mentally ill adults in inappropriate facilities. New York State has relied on the adult home system (refer to Section IV) to de-institutionalize adults with serious mental illnesses who are neither violent nor dangerous. Estimates place the number of mentally ill residents in adult homes at 12,000 to 15,000 across the State, many among them 55 years and older. Among the 10,600 adult home residents in New York City, just under 40% are deemed to be mentally ill. Though some adult homes have mental health services on site or contract outside professionals, the general impression is that, overall, this institution does not provide quality care for residents who have mental disorders, nor does it provide an atmosphere for their rehabilitation (Friedman & Steinhagen, 2006, p.12).

The judicial system agreed. Following a 2003 lawsuit filed against New York State for keeping mentally disabled people in adult homes, Judge Garaufis of the Federal District Court in Brooklyn ruled that the State was discriminating against its mentally ill population by steering them into institutions where they were warehoused in segregated settings; deprived of receiving proper health care and of opportunities to learn independent living skills that would promote independence and help people make the transition to living in a community setting (Barron, 2009)\(^\text{18}\). On March 1, 2010, the Judge ordered New York State to develop at least 1,500 units of supported housing a year for 3 years. If this ruling is supported it will give nearly all capable residents currently in adult homes the chance to live alone or in small groups while receiving professional services from social workers and mental health counselors (Mc Donald & Abuza, 2010).

The other potentially “inappropriate placement” of mentally ill adults is nursing homes across New York State. Current data from the Centers for Medicare & Medicaid Services in addition to reports from nursing home staff and social workers point to the ever-increasing behavioral problems encountered in New York State nursing homes with the admission of patients with emotional, volatile behavior and personality disorders. These data indicate “that

\(^{18}\) The ruling which applies to the City's mentally ill people not considered dangerous to themselves or others suggested that the State would have to begin finding individual apartments or small homes for adult home residents who wanted one; pointing out that supported housing was less expensive yearly ($40,253) than residence in an adult home ($47,946) (Barron, 2009).
46% have dementia; often with emotional and behavioral complications; 35% are clinically depressed; 17% have other psychiatric diagnosis, and 23% have behavior problems associated with mental illness” (Friedman & Williams, 2008, p.12). The presence of this population stems from practices followed to shorten hospital stays by transferring patients to nursing homes for short term physical rehabilitation. Upon completion, those with mental health problems are not being discharged to a less restrictive due to the scarcity of community-based services and housing.

f. Individual and family attitudes. These are manifested in rejecting services offered by mental health professionals, seeking instead primary care practitioners. Much of this stems from fear of the stigma attached to mental illness and ignorance regarding mental illness; its treatment and the resources available to seek professional help. (Friedman & Steinhagen, n.d. (a), p.4).

D. Steps Taken Towards De-Intitutionalization

Forceful actions are being taken by the Office of Mental Health and advocates of mentally ill adults to shift from an institution-based mental health policy to one that is based on community care. There is a strong commitment to the belief that in addition to the delivery of appropriate psychiatric treatment, providing a change in housing and new rehabilitation care models could make it possible for many more older adults with psychiatric problems to live, survive and even thrive in community settings.

Steps towards de-institutionalizing the mental health care system had been taken earlier, during the 1970's when assistance was provided for mentally ill persons to live in the community - an effort that for the most part could not claim success. Instead of living independently more than two thirds moved from institutions into their parents home; many were trans-institutionalized intentionally into adult homes and nursing facilities; others, ended up in prison and jails. Those who ventured to live independently ended up living with other poor people in squalid and often dangerous neighborhoods, where they often ended up as victims of crime (Friedman & Steinhagen, n.d.(b), p.4).

In its recently developed Community Support Policy the Office of Mental Health learned from past mistakes, namely that individuals with long term psychiatric disabilities cannot live in the community without being offered a range of supports. Overall, the Policy currently formulated has been successful across New York State in providing supportive structures in the
form of rehabilitation programs and outpatient treatments. In addition, general hospitals helped in absorbing much of the inpatient load previously institutionalized in State Psychiatric Centers (Friedman & Williams, 2006, p.8).

As yet, there are still a significant number of people with disabilities who reject mental health services even when provided through community based programs. It is not clear whether a number of those rejections come from the older aged group. Outreach efforts organized through a Program of Assertive Community Treatment have scored some success, but there is need to focus more aggressively in reaching the older adult population.

A top priority for the continuing success of these community efforts is the OMH Supported Housing Program, which aims to maximize access to housing opportunities for individuals whose mental illness has stabilized, who are free from substance abuse and alcohol dependencies, but still have specific needs. The availability of such opportunities is still scarce and in some ways inadequate. According to the latest information available at the time of this writing, the New York State Office of Mental Health Housing Program was serving 36,000 people with serious mental illness in 28,500 units of community based housing - at most 17% of adults with serious and persistent mental illnesses. The beneficiaries included 5,875 older adults 55 years and older; approximately 9 percent of all older adults with serious mental illness. An additional 7,500 more units were committed for completion by 2016 (Friedman & Steinhagen, n.d.(b), p.9; Mental Health Association of New York City, n.d.; New York City Department of Health and Mental Hygiene, 2009).

Reports published in 2006 noted that the provision of housing for people with long term mental illnesses provided by the NYS Office of Mental Health included only a few beneficiaries from older age groups. Only 7% of people in community residences were 65 years and older; but less than one percent in that age group resided in housing designated for older adults (Friedman & Williams, 2006, p.12.)

The NYS Office of Mental Health's Supportive Housing Program provides the three different models listed below:
Community residences which may be congregate living settings or scatter-site apartment intended for transitional living arrangements;\textsuperscript{19}

Single Room Occupancy apartments in buildings that have minimal onsite services. These are both licensed and unlicensed. The former are similar to group homes designed on the assumption that residents will have an extended stay, exclusive of permanent housing.

Permanent Housing subsidized by the Office of Mental Health. In all cases tenants receive case management services, three monthly visits by a case manager and twice by a trained peer specialist (New York City Department of Health and Mental Hygiene, 2009).

Unfortunately, there are critical weaknesses in the Housing Program models. One, mentioned earlier, is the absence of a strong assertive outreach to the older population. The second is that none of the three housing models selected nor the housing funded Rehabilitative Day Program meet the needs and limited mobility of an older population with serious long term psychiatric disabilities. The outcome is that many aging people with disabilities are forced to shift from residential rehabilitative and treatment programs to nursing homes that stress physical care (Friedman & Williams, 2006, p.17). This is just another factor propelling the older mentally ill into nursing homes, rather than community supported facilities.

The current services available to people with long term psychiatric disabilities are designed primarily for working-age adults, not geared to respond to developmental challenges faced by those who are aging. Community residences operate on the assumption/expectation that the resident will live independently or with limited supports. As they now stand, houses offer very limited assistance to undertake basic activities of daily living for older disabled adults, who are at risk to fall (Friedman & Williams, 2006, p.17).

As for the Single Room Occupancy model, virtually none provides home based services such as home health care to meet the needs of older adults. Unfortunately, funding levels are not available for additional staff needed to provide ADL supports, medication management, etc. nor to cover costs for remodeling the current residential settings to meet the needs of older people with disabilities.

\textsuperscript{19} Scatter site studios and one bedroom apartments for a single person and scatter site two bedroom apartments for parents and one child located in Manhattan and the Bronx provide tenants with case management services on a needed basis.
Part IV - Adult Homes:
A Congregate Care Facility Or An Institutional Setting

A. Background

Adult homes are a subcategory of the Adult Care Facility System, formally defined as a residential congregate care setting for individuals who "by reason of physical or other limitations associated with age, physically or other factors are unable or substantially unable to live independently" (New York State Office of Mental Health, 1999, p.1).

Established and operated to provide long term residential care, adult homes provide room/board, three meals and a nutritious snack per day, housekeeping, personal care and supervision. The system provides single or double occupancy bedrooms, with one toilet and lavatory for every 6 residents and one tub/shower for every ten. Their responsibilities include offering services such as case management, recreation, medication management, but not medical care. These homes are not health care facilities and regulations prohibit operators from directly providing health care or employing staff to do so.²⁰

Adult homes were originally established to specifically serve frail older adults who needed a supervised living arrangement, but did not need nursing home care. That objective changed dramatically. When New York State began closing its psychiatric hospitals in the 1960's and deinstitutionalizing some of the mentally ill, it was done with inadequate planning as to how to treat or house them. With the emphasis shifting from institutional to community-based care, the function of adult homes expanded to become the depository of individuals with psychiatric disabilities released or discharged from a psychiatric hospital operated or certified by the Office of Mental Health - thereby transforming itself from a congregate care setting for the frail older adults to a “home” serving individuals of all ages with either physical or mental disabilities. This resulted in a mixed population of residents, given that the system continues to serve the originally targeted clients: older and frail people unaffected by a mental disorder, requiring a supervised living arrangement.

Adult homes are perceived in different ways. Run almost exclusively on a proprietary for profit basis, New York State chooses to continue defining them as “long term community

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²⁰ Refer to license under Section 460 et.seq of Social Services Law and defined in 18 NYCRR 18 -section 485.21. State of New York Office of Mental Health, 1999.
residences,” though in many ways they are run as institutions. Though an individual has the right to refuse placement in an adult home, despite pressures exerted by hospital/mental health discharge planners or other referral sources; in practice, it can be difficult for frail, elderly, or mentally ill people to insist on their right to informed choice.

Applicants may be refused admission into an adult home for a number of reasons: These include applicants who: require intermittent or on-going skilled nursing care that cannot be met by a home care services agency; suffer from serious and persistent mental disabilities; require health or mental health services not available and cannot be provided; repeatedly behave in a manner which directly impairs the well being, care or safety of residents (Murphy & Carroll, n.d., pp.61-61). 21

Because of the State's reliance on adult homes to house former institutionalized adults, many facilities accept a large number of residents with serious and persistent mental illnesses, many among them individuals 55 years and older. In addition, there are many older residents who have not had a lifelong mental illness, but developed significant mental problems as they aged.

Many adult care facility residents pay for room and board through a supplement to the federal SSI program. Rates for SSI recipients are established in State statutes and cover room, board and other required services. Additional support services for SSI eligible residents, such as personal, home care, mental and medical care are reimbursed through Medicaid. In the particular case of adult homes, SSI covers expenses of residents diagnosed as mentally disabled. There is no coverage from Medicare, since this facility does not provide medical care. In cases where an individual adult home only accepts private payments, residents whose funds run out can be evicted (Murphy & Carroll, n.d.). 22

21 Other conditions include persons: with unstable medical conditions which require continual skilled observation; incapable of coping with a prescribed treatment program; are chronically bed or chair fast; require assistance from another person to walk, climb, descend stairs; has chronic unmanageable urinary or bowel incontinence; suffers from a communicable disease; dependent on medical equipment; is not self directing and engages in drug or alcohol which results in aggressive or destructive behavior (Murphy & Carroll, n.d., pp 61-62).

22 Costs covered by private sources are higher compared to SSI payments, ranging from $1,250 to $1,500 monthly; Single room occupancy raises the cost to $1,800. (Murphy & Carroll, n.d.)
B. Profiling the Resident Population

In the absence of updated studies of adult homes since 1999, only estimates and anecdotal evidence are available. As of 2009, New York State was estimated to house 453 licensed adult domes, with an in-house resident population estimated at 28,600 persons. In this group, 11,152 (or 39%) were estimated to have a serious mental disorder; 74% were 65 years and older and 63% were women. The estimated number of adult home facilities in New York City numbered 52 with a resident population ranging from 9,000 to 10,000 persons; among them close to 50% were estimated to be mentally disabled. The overwhelming majority of facilities in the City are located in Queens and Brooklyn (New York State Department of Health, n.d.(b)).

Residents can only be characterized as a “mixed population” comprising a diversity of people previously living in shelters, substance abusers diagnosed with mental illness, poor elderly persons with no family support, etc. A detailed description of the mentally ill residents in New York’s adult homes comes from the 2006 testimony of an Adult Home Project Director affiliated with the Coalition of the Institutionalized Aged and Disabled, a New York-based advocacy group. It reads:

Adult home residents’ ages range from 25 years to the elderly in their 80’s and 90’s. They include the younger de-institutionalized mentally ill and increasingly the geriatric mentally ill who are aging in Adult Homes. Some residents are extremely high functioning and others are in need of greater care. Some residents have developmental disabilities; some need drug and alcohol education and/or treatment. Many suffer from obesity, high blood pressure, diabetes, cardiac conditions and pulmonary diseases, especially those with long term psychiatric disabilities. (New York State Office of Mental Health, 2006(b)).

C. Housing Arrangements

To accommodate the “mix” of the mentally ill and the frail and aged individuals without a mental illness has led to two types of homes: the “impacted” and the “non-impacted” homes. The designation of “impacted” applies to individual facilities in which 25% or more of the residents (or 25 residents in actual number) are psychiatrically disabled individuals, released or discharged from a facility operated or certified by the Office of Mental Health. Indications are that the number of “impacted” homes is on the increase.
In the absence of any updated information regarding the current status of “impacted” vs. “non-impacted” homes the only data source that can be presented comes from State-wide reports published in 1997. At that time, 176 (or 39%) of all the 453 facilities were “impacted homes,” housing 10,294 (or 36%) of the residents; among this number, 32% were 65 years and older. (State of New York Office of Mental Health, 1999).

In 1999, the New York State Office of Mental Health described the characteristics of the State-wide residents of adult homes as follows, demarcating some interesting demographic differences between impacted and non impacted home residents. Whether or not these hold true today is not known:

- In all adult homes: 63% were women; 86% where Caucasian, and 49.7% were 65 years and older.
- In non impacted homes: 76% were women; 98% were Caucasian and 98% were 65 years and older.
- In impacted homes: 40% were women; 64% were Caucasian and 32% were 65 years and older.

Due to statuses and regulations guiding service to persons with mental illness, the Operator of an “impacted” home must have a written agreement with a mental health provider to be available to serve the needs of such individuals. In some cases, mental health services contracted are quite good. Yet there is a widespread impression that in most adult homes, such services are inadequate, living conditions are poor and health care lacks the quality of care desired (Friedman & Williams, 2006, p.34)

Previously the responsibility of the Department of Social Service, adult homes are now licensed, regulated and inspected by the New York State Department of Health and the State Office of Mental Health. The latter licenses and monitors mental health providers attending residents diagnosed with mental illness. The Department of Health's regulations are noted to be more protective than is the case in other States. Its mandate is to conduct yearly inspections of all adult homes and operate a Hot Line, where resident/staff complaints are recorded and investigated. During these inspections the physical plant, case management, medication management and other patient services are checked for compliance. In addition a random set of residents are interviewed to monitor resident treatment (State of New York Office of Mental Health, 1999).
With regard to impacted homes, regulations require the operator/owner to contract mental health providers/teams such as New Horizon, the Catholic Charities, to provide their services to mentally ill residents. Operators/owners are held responsible for assessing the mental health needs of psychiatrically ill residents; supervise their general mental health care and provide for visits from a social worker.

The law requires adult homes to have staff on duty 24 hours a day, seven days a week to supervise and provide all required services. During daytime hours, a full staff is to include: an Administrator and operator (licensed by the Department of Health); a Case Manager or Social Worker; an Activities Director and a Personal Care director. Since adult homes cannot provide medical services, residents can have personal doctors, and receive medical services from visiting nurses, mental health teams and home health care agencies. Residents can keep and take their own medicines if they have a doctor's approval that they are capable of self medication. Otherwise, staff persons are allowed to measure and prepare approved doses of medication for residents. Staff are not authorized to judge on the basis of their observation when to medicate residents outside of the medically approved treatment. This stipulation is particularly important in cases where mentally ill residents may need powerful anti psychotic drugs to enable them to continue residing in that facility (Murphy & Carroll, n.d., pp.54-55). Staff members may not confine residents to their rooms or beds (unless necessary for the treatment of short term illnesses), or place residents in physical restraints (Murphy & Carroll, n.d., p.53).

The supervisory functions required from the operator include, above all, ensuring the safety and security of the facility and its residents. Part of their day-to-day responsibilities includes the following:

- keep track of the whereabouts of each resident;
- monitor residents for sudden behavioral changes;

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23 A mental health provider is licensed/certified by the Office of Mental Health under Article 31 of the NYS Mental Hygiene Law, according to regulations of the Commissioner of the Office of Mental Health Contracts are funded under article 41 of the Mental Hygiene Law (NYS Office of Mental Health, 1999).

24 This is usually done through either the outpatient or after-care department of the nearest State Psychiatric or Development Facility, the local community Mental Health Service or a State-funded Community Support Service Provider.
• monitor and - when necessary - assist residents in their daily activities. i.e. their meal attendance, personal hygiene and grooming; participation in community-based programs, and their basic money management.

D. Support and Advocacy Groups

Adult home residents can rely on a number of outside organizations that function as legal and social resources. An important advocacy organization working on their behalf is the Coalition of Institutionalized Aged and Disabled (CIAD), a non-profit, grass root organization run by and for adult home and nursing home residents and resident councils. Governed by a Board of Directors, the majority of whom are City residents of both these institutions, CIAD's mission is mostly focused on the mentally ill residents of adult homes, with the specific goal of: empowering them; impacting policy on their behalf and developing leadership by way of forming alliances with other organizations to form an Adult Home Constituency as a podium to voice their problems and priorities. This mission came to fruition in 2003 with the formation of the Adult Home Policy Committee composed of residents of all ages. Its purpose: formulating a policy agenda and a cadre of resident leaders able to lobby, speak in front of policy makers, legislators and officials from the Department of Health.

Sensitive to the desire of some residents to move to a less restrictive environment and have greater access to alternative independent housing, CIAD has supported a Mental Health Housing Waiting List that provides the data necessary for the development and deployment of community housing for people with psychiatric disabilities, urging the Office of Mental Health to support such legislation. A major request made is to support setting aside 500 units for adult home residents from the 2000 allocated for mental health housing (NYS Office of Mental Health, 2006(b)).

E. Problem Areas

There are a number of problem areas in the management of adult homes; most are system-related. Given the absence of any formal or systematic evaluation of the New York City-

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25 These include: The Schuyler Center for Advocacy and Analysis (SCAA); the New York Association of Psychiatric Rehabilitation Services (NYAPRS); the Long Term Care Community Coalition, and the MFY Legal Services which works in concert with community organizations to provide free civil legal assistance to those in greatest need.
based facilities, the problems cited below are drawn from discussions with credible social service professionals, advocacy and support leaders intimately involved with the workings of the adult home system. These have been identified as follows:

1. **The practice among some Owners/Operators** managing these facilities, to accept people who though they have the entitlements or private means to pay, do not in actuality need the services offered. Along these lines is the related concern that people with bad track records in this field, are still allowed to continue to own and manage adult homes.

2. **The irregularity of the Department of Health's mandated yearly inspections and enforcement of penalties** stipulated in cases where adult homes may have received poor ratings and/or been cited for violations.

3. **The insufficient staff-to-resident ratio required.** When combined with a weak quality of staff training, it becomes very difficult to respond to resident's needs. This is particularly true in large size facilities.

4. **Medication management is a major issue.** Counter to the State's regulations, some unlicensed staff are allowed to handle medication in ways that would be highly restricted in hospitals and nursing homes. Not all adult homes hire qualified personnel and/or registered nurses to supervise medication management, leaving the task instead to untrained temporary staff.

**F. Medical and Institutional Abuse**

1. **In past years,** the most widely reported medical abuse taking place in one of the largest adult homes in New York City involved 24 to 26 elderly mentally disabled men who unnecessarily underwent prostrate surgery. Further investigation uncovered additional medical abuses in other adult homes as well, with doctors conducting inappropriate and unnecessary cataract surgery on residents (Levy, 2002, April 30).

2. **Verbal abuse incidences** have been cited in the form of Owners/Operators intimidating residents when they would voice complaints; menacing them with threats that they would be sent back to the psychiatric institution or to a hospital (Levy, 2002).
3. **Financial Abuse** has occurred perpetrated by staff members taking away a resident's personal allowance as a form of behavior controls.\(^{26}\)

4. **Applying policies and regimens** that promote dependency and erode personal autonomy; deprive residents of their independence and decision making abilities (Mc Donald & Abuza, 2010, p.1).

5. **Disallowing residents** to have personal contact in their rooms; in some cases denying them access to the internet (New York State Office of Mental Health, 2006(a))

G. **Impact or the Economic Downturn**

As to the question whether adult homes' services to residents is being affected by the City's economic crises, the general impression gained from meetings conducted in 2009, was that adult homes have always suffered from a lack of funding and financial support, and were not suffering at the time any more than in the past.

A major concern expressed that could have affected New York City's Social Service agencies in general, and adult homes, in particular, was former Governor Paterson's earlier proposal to cut SSI entitlements, which would hurt a large number of residents, particularly those with mental disabilities. At the time, approximately 15,000 adult home residents in New York City were receiving Supplemental Security Income, a number which includes most, if not all, residents diagnosed as mentally disabled. By 2009, these entitlements had not been affected; the situation could, however, be potentially precarious, given that adult home residents cannot benefit from other entitlements, such as Medicare.

\(^{26}\) MFY Legal Services has in the past challenged home operators who withhold residents' SSI Income as a form of controlling them, in Cortigiano versus Ocean View Manor Home for Adults. (MFY Legal Services, 2008)
Part V - Older Inmates and the Prison System

A. The Nationwide Profile

One of the most striking changes in the nationwide profile of the prison population over the past 30 years has been the rapidly expanding number of elderly prisoners. As defined by the Department of Corrections, “old age” is set at 55 years and over, but data sets stretch the definition to ages 60 and/or 65 years and older. In either case the prison population houses a considerable number of older adults.27

The percentage of prisoners in federal and state prisons age 55 years and older increased by 33% from 2000 to 2005 (Aging Inmates Clogging Nation's Prisons, 2007) while the overall prison population grew by only 9 percent. Nationwide the number of prisoners over age 50 in State and Federal prisons is rising about 8 percent yearly. (US Dept of Justice, Office of Justice Programs, 2008). Prisons will soon mirror the situation in nursing homes: terminal illness, strokes and dementia, etc.

The forecast calls for the percentage of elderly prisoners relative to the overall prison population to continue rising. With projections indicating that the 65 year plus population will number 72 million people nationwide by 2030, there will be more and more elderly offenders growing old behind bars. Projections for 2020 call for older inmates to represent anywhere from 21% to 33% of the US prison population (Rikard & Rosenberg, 2007). Among those serving life sentences, 16% will be elderly (Aday, 2003).

There are several reasons to give credibility to this forecast. Fear of crime has led the federal government and individual States to institute “tough” policies for punishing offenders: determining sentencing guidelines, mandatory sentences and most recently the institution of the three strikes laws for habitual offenders. The “get tough” movement mirrors an underlying shift occurring in the criminal justice discipline, which emphasizes the replacement of rehabilitative correction goals for goals of retribution and incapacitation (Yates & Gillespie, 2000).28 These policies have diminished the ability of judges and parole boards to take into account mitigating

27 Inmates often have long histories of alcohol /drug abuse, insufficient diet and lack of medical care. The combination of physical and mental declines make aging inmates, on the average, 10 to 15 years older physiologically than their non incarcerated peers (Formby & Abel, 1997).

28 The trend is particularly pronounced in the South which applies the nation's toughest sentencing laws. In 16 Southern States the growth rate of inmates has escalated by an average of 145% since 1997, according to the Southern Legislative Conference documentation (Williams, 2006).
individual circumstances - such as old age - in computing the length of an offender's sentence (Aday, 2003). Many jurisdictions have also restricted good time and/or eliminated parole. Violent crimes supersede all other felonies; as per the proportion of prisoners - 53% - serving time for such actions in the total State prisoner population contrasted with 20% sentenced for drug related charges and 19% for offenses against property (US Department of Justice, Office of Justice Programs, 2008).

States have established different ages for the definition of “older inmates” (50 years, 55 years, 60 years and 65 years) which makes comparative differences between States difficult and can often influence prisoner statistics at the federal level.

In 2009, the nationwide estimated number of sentenced prisoners of all ages under State or Federal jurisdiction numbered 1,548,700 - 1,443,500 were men (or 93%) and 105,200 were women. As part of this population the number of inmates ages 55 years and older was estimated at 79,100; 75,300 men and 3,800 were women. In relation to the overall estimated nationwide prisoner population in that year, these “older inmates” represented a 5 percent fraction (US Department of Justice, Bureau of Justice Statistics, 2008). This same 5% fraction held true for corresponding information reported for 2007 and 2008. (US Department of Justice, Bureau of Justice Statistics, 2009, 2010).

Though a 5 percent fraction may seem small, the importance of the presence of the 55 years and over age group as part of the prison population is best illustrated in absolute numbers. These speak for themselves as seen in Table 8 which presents data for 2007, 2008 and 2009.
Table 8

*Estimated number of sentenced prisoners under State or Federal Jurisdiction*

<table>
<thead>
<tr>
<th></th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Ages</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1,427,300</td>
<td>1,434,800</td>
<td>1,443,500</td>
</tr>
<tr>
<td>Female</td>
<td>105,500</td>
<td>105,300</td>
<td>105,200</td>
</tr>
<tr>
<td>Total</td>
<td>1,532,800</td>
<td>1,540,100</td>
<td>1,548,700</td>
</tr>
<tr>
<td>Male</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ages 55-59</td>
<td>38,600</td>
<td>39,100</td>
<td>39,600</td>
</tr>
<tr>
<td>Ages 60-64</td>
<td>18,900</td>
<td>19,200</td>
<td>19,600</td>
</tr>
<tr>
<td>65 and Older</td>
<td>15,500</td>
<td>15,800</td>
<td>16,100</td>
</tr>
<tr>
<td>Total, Ages 55 and Older</td>
<td>73,000</td>
<td>74,100</td>
<td>75,300</td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ages 55-59</td>
<td>2,100</td>
<td>2,100</td>
<td>2,200</td>
</tr>
<tr>
<td>Ages 60-64</td>
<td>900</td>
<td>1,000</td>
<td>1,000</td>
</tr>
<tr>
<td>65 and Older</td>
<td>600</td>
<td>600</td>
<td>600</td>
</tr>
<tr>
<td>Total, Ages 55 and Older</td>
<td>3,600</td>
<td>3,700</td>
<td>3,800</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ages 55-59</td>
<td>40,700</td>
<td>41,200</td>
<td>41,800</td>
</tr>
<tr>
<td>Ages 60-64</td>
<td>19,800</td>
<td>20,200</td>
<td>20,600</td>
</tr>
<tr>
<td>65 and Older</td>
<td>16,100</td>
<td>16,400</td>
<td>16,700</td>
</tr>
<tr>
<td>Total, Ages 55 and Older</td>
<td>76,600</td>
<td>77,800</td>
<td>79,100</td>
</tr>
</tbody>
</table>

*Source:* U.S. Department of Justice, Bureau of Justice Statistics Reports: Prisoners in 2007 (publication NJC 224280), Prisoners in 2008 (publication NJC 228417); Prisoners in 2009 (publication NJC 231675)

Historical data show that in past decades, older persons mainly committed shoplifting offenses, a pattern that has now declined substantially. “Older prisoners” today are very different from a few decades ago. As a group they are the most likely to have committed violent crimes against persons - murder, child molestation and other sexual offenses, aggravated assault - all of which mandate harsh sentences and result in many offenders growing old or even dying in prison.
(Marquart, Merianos & Doucet, 2000). In many instances their crime marks their first serious offense. Then there is the “old timer,” who in fulfilling a life sentence has simply grown old in prison; or first offenders incarcerated during their middle age years who turned old while in prison. The latter type includes non violent offenders and often typifies white collar criminals, such as the older-age financial agents and senior executives who were convicted and recently sentenced to lengthy years of imprisonment. In most cases, older inmates represent a “special needs population” in terms of their health condition, individual adjustment to institutional life and family relationships; posing special demands on the prison system, in terms of custody issues, safety and health care. (Aday, 2003).

One of the most recognized changes in the prison system is the increasing number of elderly inmates facing life threatening illnesses, mostly due to the high prevalence of communicable diseases, rising number of HIV and hepatitis outbreaks which may be inappropriately treated (Aday, 2003). Few prisons in the country have been designated as special “medical prisons” for elderly inmates or for those with chronic illnesses. The outcome has meant that thousands of frail, sick, elderly inmates are remaining behind bars, awaiting death alone (Elder & End-of-Life Care, n.d.).

The continuing growth of the elder inmate population has brought higher health care costs. The nation spends an estimated $60 billion yearly on the Correctional system. Because of health and other aging-related needs of what is considered a “special needs population,” older prisoners are up to three times more costly to maintain than younger inmates: they use more prescription drugs and spend twice as much time in medical facilities. Estimates place the annual cost of holding an inmate at between $18,000 to $31,000 annually - $33 daily for the average prisoner and $100 for the older inmate (Prisons in the US; Rikard & Rosenberg, 2007).

B. The Prison System in New York State

As is noted in the forthcoming pages a discussion of New York City's prison system and its inmates is incomplete without an understanding of the intrinsic linkage existing between the City's and the State's Correctional systems. First, then, a glance at the State profile.

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New York State is facing the same graying of the prison population as the country as a whole, indexed by the climbing rate of its older age inmate population. As of January 1, 2008, the total number of inmates under custody in New York State prisons totaled 62,599: 59,845 or 95.6% were men and 2,754 (4.4%) were women. Inmates 60 years and older numbered 1,694 representing a 2.7 percent share in the total number under custody. The recent proportion of older inmates ages 60+ has increased since 2000, at which time they only represented a 1.2% fraction of all inmates in New York State (State of New York, Department of Correctional Services, 2008). See Figure 5.

Figure 5
Inmates 65 Years Old or Older


The Hub systems data reported that 58% of New York State's overall inmates had been convicted of violent felony crimes; another 7.8% of other coercive offenses; 21.4% of drug offenses and 11% for property and other crimes. Slightly over 3,000 or 5.3% of the State's total inmate population were veterans, which included a significant number falling within the older age group given their military service background. The majority had served in the Vietnam War
(825); 153 were pre-Vietnam veterans; 139 were mobilized during Afghanistan/Iraq wars.
Information for an additional 127 veterans was incomplete.

Based on a separate 2006-2008 date set, some information is available on women prisoners in New York State, a subject mostly ignored (Correctional Association of New York Women in Prison Project, 2008). To note: 84% of the women were convicted for non violent offenses; among those incarcerated for non-violent offenses, more than 8 in every ten were “first term” felony offenders. Nearly 33% were held for drug offenses. On the health side, just under 90% had alcohol or substance abuse problems; more than 42% were diagnosed with a serious mental illness (compared to 12% of male inmates): specifically depression, psychotic depression, bipolar disorder, schizophrenia or other psychotic disorders. Approximately 12% were found to be HIV positive, double the rate of male prisoners. More than 22% had hepatitis C - a rate nearly double that of male inmates.

C. Older Prisoners in and from New York City

1. The Hub System. In 1992, as part of the effort extended by New York to re-organize its delivery of program services to inmates across the State, correctional facilities were grouped according to geographical proximity into administrative regions referred to as Hubs. These are basically groups of neighboring facilities that share administrative support and program services. Nine such regional Hubs were delineated within the State (refer to Figure 6), namely Oneida, Watertown, Clinton, Sullivan, Green Haven, Great Meadow, Wende, Elmira and the New York City Hub, each of which has its own correctional facilities. Facilities included in the New York City Hub are: Arthur Kill, Bayview, Bayview Work Release, Edgecombe, Fulton, Lincoln, Queensboro General and Sing Sing (the latter is located in nearby Westchester and does not fall strictly within the New York City boundaries).
The value of the Hub system lies in the information it yields in publishing: the demographics of inmates; the distribution of prisoners across the State and the geographical flow of inmates out of their area of residence and jurisdiction to other parts of the State. Moreover, the published data is often disaggregated by age, which enables specific references to be made about older adults.

In 2008, the New York City Hub’s population under custody numbered 3,606 inmates (3,410 men and 196 women). They included 103 inmates 60 years and older; the majority among them held in the Sing Sing and Queensboro facilities at the time (State of New York, Department of Correctional Services, 2008, Table 1). The share of older inmates (60 +) in the total prison population of the New York City Hub was 2.9%. Numerically older inmates were underrepresented in the City’s facilities when compared to the numbers in the other Hubs:
A 2008 snapshot of the New York City Hub inmates by age and gender is illustrated below in Table 9.

<table>
<thead>
<tr>
<th>Table 9</th>
<th>Population of New York City Hub, 2008</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total Male Inmates</td>
</tr>
<tr>
<td></td>
<td>Total Female Inmates</td>
</tr>
<tr>
<td></td>
<td>Total Inmate Population</td>
</tr>
<tr>
<td></td>
<td>All Inmates 60 to 64 yrs</td>
</tr>
<tr>
<td></td>
<td>All Inmates 65+</td>
</tr>
<tr>
<td></td>
<td>All Inmates 60+</td>
</tr>
</tbody>
</table>


2. A Scanty Profile of the Inmates. It is difficult to draw a generalized profile of the prisoner population. Comparative studies to date have shown the findings to be inconsistent (Formby & Abel, 1997). New York City-specific information compiled by the Hub system for 2008 provides some general background data pertaining to its total prisoner population, but unfortunately not for the older age group (State of New York, Department of Correctional Services, 2008).

a. Close to 72% of the City's Hub inmates under custody originated from New York City itself; 14.4% from the suburbs; 5.9% from upstate urban counties in the State and 7.5% from other upstate areas.

b. The prisoner population included 12.3% of foreign born inmates and 4.7% of veterans; of the 196 women inmates, 157 were held in the Bayview facility; the remainder in the Bayview Work Release facility.
c. Close to two thirds of the group, 2,292, had never married; 58.5% had one or more living children. The majority had a long history of substance abuse and drug charges; in addition to serious mental illness. Eight percent of the men and 18% of the women were HIV positive.

d. Sixteen percent of the City's inmates (588) had committed murder; 2.8% attempted murder; 6.1% manslaughter 1st degree; 14.7% robbery; 5.5% assault; 7.0% burglary; 3.0% rape and 1.1% sodomy.

Drawing upon research conducted about older prisoners outside of New York State indicates that their health condition tends to deteriorate rapidly during incarceration mostly due to the high prevalence of communicable diseases such as HIV and hepatitis, which are often undiagnosed and/or inadequately treated. Serious mental and emotional disorders among older prisoners are also reported: depression, anxiety, psychiatric disorders, senile dementia and great fear over the prospect of dying in prison (Aday, 2003; Rikard & Rosenberg, 2007). Few prisoners have structured programs that provide dying patients the opportunity to receive spiritual and community support to abate their fears at the end of life (Elder & End-of-Life Care, n.d.).

The general literature has not addressed the subject of abuse against elderly inmates except for the reporting of anecdotal incidences. The general perception is that older prisoners are not a constant target, though instances of being pushed around, shoved, cursed, robbed and victimized by younger inmates have been reported (Marquart, Merianos & Doucet, 2000). The fact that older inmates represent such a small fraction of the prison population, coupled with their double minority status as elderly and criminal, carries the risk that they are given low priority within the prison structure and may often find themselves disadvantaged (Formby & Abel, 1997).

D. The Transmigration of New York City Inmates

The New York City Hub is a paramount exporter of its inmates not only to other Hubs in New York State, but to other States across the country. This explains in large part the rather
small size of its own prisoner population. The census count complicates the issue of tracking down the original residence of inmates, because incarcerated people are counted/reported as residents of the geographical location of where they are serving time and not according to their place of origin or where they have been convicted (Heyer & Wagner, 2004). The transmigration of prisons and prisoners convicted in New York City to other Hubs follows the predictable pattern of moving inmates out of large urban centers into rural communities.

As of 2008, 52.1% of inmates were committed from the five boroughs of the New York City to other facilities; an additional 11.4% from suburban New York; 36.5% from upstate counties. There were differences across the Hubs in the proportion of inmates from each region.

The listing below provides more detailed information on the proportion of inmates committed from New York City.

<table>
<thead>
<tr>
<th>Table 10</th>
<th>Inmates Committed from New York City to Other Hubs in New York State, January 1, 2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hub</td>
<td>Percent of Population in Hub from New York City</td>
</tr>
<tr>
<td>New York City Hub</td>
<td>72.2%</td>
</tr>
<tr>
<td>Sullivan Hub</td>
<td>71.7%</td>
</tr>
<tr>
<td>Watertown Hub</td>
<td>64.4%</td>
</tr>
<tr>
<td>Green Haven Hub</td>
<td>60.9%</td>
</tr>
<tr>
<td>Oneida Hub</td>
<td>53.0%</td>
</tr>
<tr>
<td>Clinton Hub</td>
<td>49.7%</td>
</tr>
<tr>
<td>Great Meadow Hub</td>
<td>48.8%</td>
</tr>
<tr>
<td>Elmira Hub</td>
<td>46.4%</td>
</tr>
<tr>
<td>Wende Hub</td>
<td>36.2%</td>
</tr>
<tr>
<td>Total – All Facilities</td>
<td>52.1%</td>
</tr>
</tbody>
</table>

E. What Do We Know About Institutional Life in Prisons?

Prisons have been described as

one type of domiciliary institution where inmates live together 24 hours a day every week, within a circumscribed space, under a scheduled routine administered by staff. Compared to other "Group Quarters", the prison is unique in that its functions revolve around the control of inmates who have been convicted and sentenced as criminals” (Formby & Abel, 1997, p .1051).

Unable to locate a body of literature describing qualitative aspects of life in a New York City prison leads us to present overall findings observed and researched in correctional institutions nationwide. A fair amount of that literature has placed emphasis on the experiences encountered by older inmates. The following discussion draws selectively upon those generalized findings in presenting a characterization of what prison life means for an older.
inmate. Though fully cognizant that each State and Federal system operate within its own guidelines and policies, the assumption made here is that the specific issues selected for discussion below are, at least to some extent, applicable to prison conditions encountered by older inmates in New York City's facilities.

Older inmates are typically divided into categories based on their capacity and self sufficiency levels, resulting in a three-fold classification (Formby & Abel, 1997, p. 103):

- those with the mental and physical capacity to live within the general inmate population;
- those not totally dependent, but have limitations in their ability to function independent of support;
- those dependent inmates with chronic health problems that require assistance of prison staff for virtually all daily needs. In those cases, prisons function as a nursing home.

Though the interpretation of “caring” for older inmates is subject to different viewpoints and interpretations, three broad types of care mentioned earlier have been instituted in prisons (Formby & Abel, 1997, 105-106). In some form or another, they are presumed to be part of the care extended to older inmates in New York City as well:

- *humanitarian care* - focused on helping elderly inmates adjust and adapt to the prison environment because of their vulnerability.
- *therapeutic care* - revolving around effecting change in elderly inmates: change of those attitudes, aptitudes and capacities the inmate believed to be part of the explanation for having committed an offense.
- *custodial care* - ensuring that prisoners not escape or harm anyone in prison.

F. Services Provided to New York City Inmates

1. **Inmates in the New York City Hub** are well provided for in terms of the health care services they have access to for their physical and mental health problems. Hospital care is available to them in a number of City boroughs. Seriously ill inmates and those requiring intensive psychiatric observation are held in prison wards that the Department of Correction operates in Elmhurst Hospital (Queens) for female inmates requiring acute psychiatric care, and in Bellevue Hospital (Manhattan) for male inmates requiring psychiatric or medical treatment.
The North Infirmary Command on Rikers Island houses detainees with less serious medical problems and prisoners with AIDS not requiring hospitalization. A portion of the West facility on the Island contains specialized housing units for inmates with tuberculosis and other communicable diseases.

2. **Between 2007 and 2009**, the New York State Prison System established both a Dementia Unit at the Fishkill State Prison and a Residential Mental Health Unit at the Marcy Correctional facility.

   a. The Dementia Unit is considered unique in that it is the first for New York and possibly the nation, though experts say it likely will not be the last, as more people grow old behind bars. The unit counts with 30 beds on the 3rd floor of the prison's medical center. The average age of patients is 62 years; all have been diagnosed with some level of dementia, which in some cases is related to Alzheimer’s or AIDS. The unit has also attended to the needs of patients with Parkinson's and Huntington's disease in addition to other psychiatric and medical disorders (Hill, 2007).

   b. Through the joint collaboration of the Department of Correctional Services and the New York Office of Mental Health, a 100-bed Residential Mental Health Unit was opened at the Marcy Correctional Facility in Oneida County in December 2009. A first of its kind in the nation, this Unit serves male inmates with serious mental illness and disciplinary sanctions, through various treatment interventions and strategies that have demonstrated effectiveness in addressing the unique and difficult issues of this population.

   According to the Commissioner's Office of Mental Health, this latest collaborative effort represents the most comprehensive prison mental health program in the country, and reduces the need of special housing/segregation of inmates with mental illness (New York State Department of Correctional Services, 2009).

   c. New York State has also taken steps to ease the inmate's pain of dying in prison. At Coxsackie, 130 miles north of New York City, a hospice program was started in 1996 in response to the AIDs epidemic, using an outside hospital at the start. By 2001, this arrangement changed to have inmate volunteers as caretakers which guarantees that those terminally ill will have round-the-clock companionship in their final days (Leland, 2009).
Part VI - End Notes

Due to the uncertainty surrounding future legislation and reform actions at the time of this writing, it is difficult to advance any firm prediction as to what future developments hold for persons residing in the institutional settings covered in this study. Because of their high dependency on health care and financial means, the final outcome of certain provisions will bear a stronger impact on the older institutionalized population, more so than on younger age groups.

In what follows certain actions, events and developments are cited which are expected to bear some impact on the institutions covered and on the life of older adults housed in those settings.

A. What May the Future Hold for Nursing Home Patients?

1. Financial Containment. Whereas projections for the increasing growth of the older population clearly suggest the need to expand nursing homes to care for poor, sick and disabled older adults, the future of these institutions in New York is confronting major changes (Long Term Community Coalition, 2009). The primary force at play is the increasing focus placed by the State (as well as throughout the country) on “de-institutionalizing” nursing home patients by targeting more public funds into home and community-based long term care services. This will come at the expense of depleting financial resources/public funds needed for nursing home care and diminishing regulatory and oversight services (Long Term Community Coalition, 2008). Such actions are being justified by preferences expressed by consumers to live in less restrictive and more home-like settings.

There is ample cause for New York State to have concerns regarding the depletion of funding sources allocated to nursing home care. The data below from the Empire Center for New York State Policy (Bragdon, n.d.) highlight the Nursing Home and Medicaid expenditures of New York when compared to the average expenditures in a set of “other states.” The numbers speak for themselves.

- Nursing home services in New York used 35% more than in other states, and at 74% higher costs per year.
- Medicaid expenses per elderly recipient showed to be 142% higher than in other states: $27,000 vs. $11,300;
Medicaid expenses per elderly user was reported at $13,448 in New York; $5,712 in other states;\(^{32}\)

New York State's high medical expenditures - more than double the per capita norm for all other states - can be traced to deeply rooted patterns of expansive health care spending. The question to be raised is whether the regulations and utilizations of these funds produced a higher and better quality of care when compared to other states.

2. **Quality of Care.** Inspections conducted from August 2004 to November 2005 reported that 98% of New York State's nursing homes fall within the range at which a comprehensive federal study showed the quality of care for long stay residents to be suffering. About 70% of New York's nursing homes were found to not meet the standards for Registered Nurses set in Florida. Corresponding percentages not meeting those same standards in other States are: 38% in California; 26% in Vermont and 25% in Ohio (New York State Office of Attorney General, 2006.)

3. **What Does All this Mean for Needy Individuals?** With the ultimate goal of facilitating the transition of institutionalized patients to less restrictive settings that would ensure access to community-based services, New York State has focused on putting more public funds into home and community-based long term care. In pursuing this objective, the State undertook a series of actions to promote and encourage de-institutionalization - a goal that has been pro-actively supported by initiatives taken by the federal system.

- **At the New York State Level.** During 2007, the Governor's Executive Budget called for a series of Medicaid cost containment measures, including a freeze on hospital and nursing reimbursement rates (New York State Division of the Budget, 2007).
- In 2009, the New York State budget approved a provision to downsize nursing home capacity across the State by 6,000 beds over the next five years; these beds will be allocated to the Assisted Living Program in order to increase their capacity to absorb de-institutionalized patients (New York State Department of Health, 2010).
- **At the Federal Level.** The signing in 2005 of the “Deficit Reduction Act” brought into effect a new law that significantly changed the ability of older people to access Medicaid benefits for long term health care. Access to Medicaid to pay for nursing

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\(^{32}\) Bragdon.(n.d.).
home care became considerably more difficult, at the same time that Medicare recipients in nursing facilities continue to tap into their own assets (Crowley, 2006).

In 2007, the enactment of the “Money Follows the Person Federal Rebalancing Demonstration Program” provides enhanced Federal Medical Assistance for a one year period to the following candidates: persons who had resided in a nursing home for at least six months; had been a recipient of Medicare for at least one month prior to transitioning out from the nursing home; and are in the process of transitioning into a qualified residence (New York State Department of Health, 2007).

In 2009, a Medicare rate adjustment was enacted by the Federal Centers for Medicare and Medicaid Services that cuts an estimated $16 billion in Nursing Home funding over the next ten years, in addition to cuts made on the part of the State (America’s nursing homes, 2009).

4. Problems with De-Institutionalization. While the principle of “transitioning” older persons out of a restrictive environment is commendable, there is a series of problems inherent in the politics of de-institutionalization. These stem, for the most part, from systemic problems related to the availability and quality of care provided in community-based alternatives, and from some of the intrinsic complexities of home care.

- Some of the serious systemic problems confronted in “transitioning” out of an institutional setting into a community based alternative are: the financial affordability involved; scarcity of case-management services; in some cases, the unavailability of sufficient nurse’s aides, and the unknown quality of care of services provided by the community based setting (Long Term Care Community Coalition, 2008).
- The allocation of 600 more beds to the Assisted Living Program raises some questions. For example, will discharged patients transitioning from nursing homes to this Program be residing in an environment that encourages a certain quality of autonomy and self reliance which the ultimate goal of deinstitutionalization is intended to uphold. According to the 2009 NYS budget approved in spring, the Assisted Living Program is housing “beds” in Adult Homes “many of which are highly institutional settings” (Long Term Care Community Coalition. 2009. p. 58.)
- Questions have also been raised regarding procedures adopted to certify a patient as sufficiently competent to make the transition out of a nursing home facility to a non-restrictive setting. It would appear that neither the patient nor the nursing home
facility has much of a voice in deciding who and where a resident is to be transitioned to. Establishing the competency to make the transition lies in the hands of Assessment Centers, following criteria set up by Medicaid and the Department of Health.

5. Home Care Can Be Dysfunctional. There are often difficulties encountered when a discharged patient returns home to live with his family, which in some cases can be traced to cultural factors. Prevalent norms may pressure a family to take care of an older relative released from a nursing home or a hospital - a responsibility which some may not want or be truly able to assume, yet do so out of feelings of guilt. Such situations often lead to stress and marital tensions between family members and spouses.

Home care solutions are also difficult for families who are under financial pressure, where family members are working and not sufficiently financially stable to afford or undertake the responsibility of feeding and taking care of another family member. In many such cases, the adult daughter in the household becomes the caretaker; often forced to leave her job, thereby further reducing household income.

Returning to the family is easiest when sufficient disposable income is available in the household to hire a full time caretaker. The least problematic case applies to a discharged patient who can afford to move back to an apartment of his/her own; has sufficient assets to live independently and/or hire competent caretakers to respond to their needs, without placing any imposition on family members.

B. A Growing Commitment to Mentally III Adults

Projections on the aging of the population call for the adoption of important measures to ensure availability of services to an increasing number of older adults suffering from mental illnesses with priority attention given to those with long-term psychiatric disabilities.

According to the New York State Office of Mental Health, in 2011 the first of the post-war “baby boom” generation (those born between 1946 and 1964) will reach the traditionally defined “old” age of 65 years. In New York State this “boom” will result in an over 50% increase in the number of older adults - from 2.4 million to 3.7 million. The number of older adults with mental illness will increase by more than 50%, from 480,000 to 740,000. Keep in mind from current data that only 20-25% of this older group receives services from mental health
professionals, while others prefer to be treated by their primary physician or their illness goes undiagnosed (New York State Office of Mental Health. n.d.(a), p.1). In New York City, older adults dealing with mild to severe depression are expected to increase from 200,000 to 292,500 thousand (Friedman, 2009).

As part of the growing commitment to advance geriatric mental health care and prepare for the impending elder boom, New York State enacted the Geriatric Mental Health Act on August 23, 2005 (New York State Office of Mental Health, n.d.(c). The Law which took effect on April 1, 2006 authorized the establishment of:

- An Interagency Geriatric Mental Health and Chemical Dependence Planning Council;
- A Geriatric Service Demonstration Program; and
- A requirement for an annual report to the Governor and Legislature with a long term plan regarding the Geriatric Health Needs of New York residents.

In 2008 an Annual Report was presented to the Governor and Legislature of New York State. In addition to the Amendments and Highlights included therein two major subgroups from among the geriatric population were highlighted as requiring a special focus for current and long term planning: (a) the aged with new mental health needs; and (b) aging mental health recipients whose medical co-morbidity is associated with worse medical outcomes and higher mortality compared with individuals without mental illness (New York State Office of Mental Health, 2008).

These stipulations will require a full range of home and community-based services including: coordinated/integrated physical and mental health care; outreach and early intervention; caregiver support and long term care. In addition, there will be need to bring forth evidence-based practices in models of support and care that are both cost effective and efficacious across different cultures. With strong support and collaboration, these actions should bring about essential changes that will drive program and policy expansion in the field of geriatric mental health.

C. Potential Changes Affecting Adult Home Residents

The future of the adult home institution could potentially be affected by two negative events. One, to the extent that a number of Assisted Living Program “beds” will be housed in adult homes, as has been provided for in the NYS Budget approved in the spring of 2009, one
could expect an inflow of a number of deinstitutionalized residents into an institutionalized setting. If such an inflow were to occur, one may question, given the nature of the adult home setting, whether such an action falls in line with the goal of minimizing the institutionalization of older adults.

Two, the 2009 judicial decision handed down in the Federal District Court in Brooklyn could seriously diminish the stature of the adult home institution covered in this study. As mentioned in Part IV, this decision followed a lawsuit filed against New York State for placing mentally ill persons in adult homes. In 2009, Judge Garaufis handed down a verdict that decried conditions existing in that institution and ruled that the State had discriminated against New York City's mentally disabled and violated the American's With Disabilities Act by steering over 4,000 mentally ill people into large and poorly run adult homes across the City. Advocates and witnesses testified that adult homes fostered helplessness and dependency and in some respects were more restrictive than the psychiatric institutions they replaced (Balsamini, 2009).

Following this verdict, Judge Garaufis ordered the State of New York to develop at least 1,500 units of supported housing yearly for 3 years, to absorb capable adults currently residing in adult homes. If the number of supported housing units is upheld, it will enable many of those residents to face the outside world and a chance to live alone or in small groups, while receiving services from professional social workers and mental health counselors.

D. What Can Older Inmates Look Forward to?

Two contentious issues bear relevancy to the fate of older prisoners. One is the debate in both gerontological and correctional communities as to whether older prisoners should be held in age-segregated or age-integrated settings. The second, more radical issue, questions whether senior citizen status is sufficient a condition to grant early parole or reduce sentences for inmates who have committed heinous crimes.

1. The Age Segregated Position argues that physical separation is necessary to protect a “special needs population” from victimization, exploitation and harassment by younger, more aggressive prisoners. Separate housing is called for to accommodate older inmates who have limited mobility and to help maintain their mental health by diminishing their depression and feelings of anxiety as well as eventually facilitate their adjustment to community life for those
who would be released. Placing older inmates into separate facilities or wings can also help States consolidate costs (Yates & Gillespie, 2000; Rikard & Rosenberg, 2007).

The counter argument upholds mainstreaming, citing that age segregation may have a negative effect on older inmates by way of heightening their feelings of inadequacy; of being discriminated against; stigmatized for being old, weak and helpless, in need of special care. Furthermore it is argued that segregated living will make inmates lead an idle life and increase their institutional dependency (Formby & Abel, 1997).

2. Alternative Release and Sentencing of Older Inmates. The thrust of this debate surrounds the issue as to whether senior citizen status is sufficient a condition to grant early parole and/or give lighter sentences. Early release has been granted in some states for one of two reasons: terminal illness or record of good behavior. Medical parole also known as “compassionate release” applies to inmates suffering from a terminal disease and whose remaining life expectancy is within a specified threshold. Georgia has been on the forefront of releasing frail and dying inmates. Chronically, but not terminally ill older inmates do not benefit from this release policy (Lanzano, 2009).

Use of age as a mitigating factor in sentencing can be controversial. Early release of prisoners before their completed term of incarceration has been one of the most controversial topics (Rikard & Rosenberg, 2007). Critics argue that age and wisdom presumably make older inmates more culpable than younger ones. Advocates of older defendants argue that equal sentences for older and younger offenders can be unfair in practical effect, because older offenders have fewer years of life remaining and such sentences are disproportionately harsh for older persons (Aday, 2003). Independent of medical and compassionate parole, a number of states have been reported as enacting legislation directed at the release of safe elderly prisoners, and loosening stringent sentencing laws.

The 2007 Second Chance Act implemented a two-year pilot project in 2009 directed at the early release of a number of prisoners 65 years and older convicted of non violent crimes. More recently, the criminal system's resistance to consider old age as a reason for differential treatment has been pressured to soften its opposition, as it confronts the painful truth regarding prison overcrowding.

Advocates believe that age-based sentencing reforms or simply restoring judicial discretion in sentencing older inmates offer the most potential benefit to reducing, or at least
slowing the increase of the elderly prison population (Yates & Gillespie, 2000). Federal sentencing guidelines provide some support for this, pointing out that age may be relevant in extraordinary cases, such as when the offender is elderly and infirm and where punishment may be met more efficiently and less costly by other means than incarceration. Yet, while these provisions technically give federal judges discretion in cases involving older inmates, in practice, “the extraordinary requirement has had a chilling effect on judicial discretion and age has ceased to be a mitigating factor in sentencing, since the guidelines were amended” (Yates & Gillespie, 2000, p.173).

Serious opposition to reducing long term sentences have been voiced by legislators in a number of States who maintain that regardless of their age, criminals should serve their full sentence as a matter of principle and to prevent them from engaging in further crimes. Their argument is that age and wisdom presumably make older inmates more culpable than younger ones, and that exploring alternative sentences and release policies based on age means that the crime itself is considered less serious with little regard for the victims (Yates & Gillespie, 2000).

Some of the most important concerns being raised in the ongoing debate between legislators, criminal justice officials and advocates are of immediate concern to the conditions under which older inmates live and to their future. They include the following (Aday, 2003, p.7):

- Should an older persons with no previous conviction be given special consideration by police and the courts;
- Should sentencing structures change to reflect the probable years remaining in an inmate's life;
- What type of research is needed to help correctional officers be better able to respond to the needs of the aging prisoner;
- What type of end-of-life care should the correctional system provide for inmates who are expected to die in prison;
- How to assist older offenders to make a successful transition into and out of prison.
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