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Seniors in Public Housing

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I. Executive Summary

In recent years, the Boston Housing Authority (BHA) discovered that close to 40 percent of the residents aged 62 and over living in their public housing developments reside in *family* housing developments rather than in senior/disabled housing developments. At present, BHA routinely makes support services available to vulnerable elders living in senior/disabled developments, but does not make similar services available to elders living in family housing. Consequently, BHA was concerned about potential unmet needs in this unexpectedly large population of elders.

To learn more about the population of seniors living in family developments, and with the support of the Boston Foundation, the Gerontology Institute at the University of Massachusetts Boston joined with the Boston Housing Authority in a collaborative research and service planning effort. An advisory board was established to provide input to the research and to help develop recommendations to BHA in response to the research findings. In collaboration with the advisory board, a questionnaire was designed focusing on identifying the characteristics, potential contributions, and needs of this population. Data collection occurred between March and June, 2002. To be included in the sample, an individual had to be age 62 or older, living in one of the selected developments, and able to be interviewed in English or Spanish. Only one resident per household was chosen. The final sample includes 217 completed interviews with an overall response rate of 65%.

Research Findings

Sociodemographic features:

- Compared to the population of individuals aged 62 and over living in Boston as a whole, seniors living in family developments are younger and more likely to be people of color. More than half are under age 70, and 50% are either nonwhite or Latino.
- More than three-quarters are widowed, divorced, or separated; only 14% are currently married. Nearly 60% live by themselves, a percentage much higher than that reported for similarly-aged individuals nationally or in the Boston area.
- Overall, this group is less well educated than the older population living in Boston as a whole. Fifty-seven percent reports not graduating from high school.
- Participation in the Supplemental Security Income (42%) and Food Stamps (14%) programs appears to be quite low.
- Almost half of the older residents have lived in the same development for 30 years or more. As a result, many of those aging in place within these neighborhoods have seen their children grow up and move away as the community around them changed radically.

Social attachments & productive contributions:

- Many of the seniors are actively involved in their communities. Almost 20% report doing volunteer work for organizations such as schools or churches. Many others report that they would be interested in volunteering.

- Almost one-fifth of the seniors have minor children in the household, most of whom are grandchildren. Many more seniors report babysitting or caring for minor children who do not live with them, suggesting an active role in childcare for these seniors.
- Relatively few of the older residents appear to be socially isolated. Most have children living nearby, with almost two-thirds having one or more children living with them, in the neighborhood, or elsewhere in the Boston area.
- Most seniors have frequent contact with family and friends. Well over half report seeing or communicating with family or friends “almost every day.”

Health and needs for assistance:

- Overall, the health profile of the older residents is poor. More than half rate their own health as “poor” or “fair.”
- A significant minority has some problems with depression or anxiety.
- More than half of the older residents report that health limits their activities, and more than 60% report some difficulty in managing stairs. More than 45% report that they have some difficulty remembering things.
- More than 40% report receiving help with common activity of daily living tasks. Only about 5% report that they need help but do not get any assistance.

Service use and service needs:

- Most older residents have seen a physician during the previous 12 months, and only a small share report that they have not but feel that they need to. Significant unmet need is reported for dental care—14% report that they have not seen a dentist but feel that they need to. Fewer than 20% have seen a social worker, psychiatrist, psychologist, or other mental health worker in the previous year.
- Non-medical service use in this population is fairly low overall. Fewer than 20% report that they have a caseworker or participate in senior activities in their development. Ten percent or fewer report using home-delivered meals, going to a senior center located off-site, or using the RIDE.
- High expressed interest is reported in special transportation for seniors for shopping (60%) and in access to a case manager to provide information and to help arrange needed services (60%). About one-third express interest in group meals, and more than 40% have some interest in having a place where they could learn to use computers.
- More than one-fifth of our respondents report that transportation constitutes a problem for them in getting where they want to go.

Security and safety:

- Fewer than one-fifth feel “very safe” going out alone at night.
- Only about one-third of the respondents report having safety equipment such as grab bars in their bathrooms.
- More than a quarter of the residents both live on the upper floor of a multistory building that has no elevator and report that they have trouble handling stairs.

Knowledge about BHA senior/disabled housing:

- We asked respondents if they had ever heard of the elderly-disabled public housing developments coordinated by the BHA that are designed specifically for people over the age of 61 and people who are disabled. Almost half say that they have never heard about these developments.
- Among those who had heard of them, only 10% say they are on the waiting list.
- BHA staff believes that awareness of senior-disabled housing may be greater than reported, reflective of the respondents' anxiety and sense of vulnerability about being moved.

Recommendations

Based on these findings and our discussions with members of the advisory group, we make the following recommendations:

1. Improved service coordination should be made available to the vulnerable elders living in BHA family units. The service coordination approach currently used in BHA elderly/disabled developments should be adapted for these developments, taking into account the generally lower concentration levels of seniors in the family developments. Special transportation options, improved information dissemination, and collaboration with tenant groups are vehicles for improved service delivery.
2. More units should be adapted and made available to elders and others with disabilities. Home modifications that improve bathroom safety should be a high priority.
3. With sensitivity, seniors in family developments should be provided improved information about BHA's senior/disabled developments.
4. Expanded opportunities should be made available for elders in family units to contribute to community-building efforts in their developments.

II. Introduction

A desire to remain independent and living in familiar surroundings is widely shared by older individuals. A recent survey conducted by AARP suggests that more than 90% of individuals 66 years of age and older express a desire to remain in their current residence for as long as possible (Bayer & Harper, 2000). However, as their physical capabilities change, many seniors need environmental adjustments or support services if they are successfully to "age in place."

In recent years, the Boston Housing Authority (BHA) discovered that nearly 40% of the seniors (residents aged 62 and over) living in their public housing developments were living in *family* housing developments rather than in senior/disabled housing developments. Administrators at the BHA were aware that some seniors lived in family developments, but they were committed to learning more systematically about this population and their needs. They turned to the Gerontology Institute at the University at Massachusetts Boston as a partner in this effort. With funding from the Boston Foundation, the collaboration resulted in a research and policy development effort on which this document reports.

This collaborative activity includes both research and service planning. As part of the research plan, we obtained information on the older population living in family developments through a variety of sources, including site visits, informal discussions with residents and on-site managers, and finally through a survey of older residents. To facilitate service planning, we established an advisory committee including representatives of the BHA, residents, health care and aging services providers, and the UMass Gerontology Institute (see Appendix A for a list of participants). This committee met during the initial phase of the project in order to provide guidance regarding the research effort. The committee met again following the completion of the research in order to discuss the results and contribute to the planning process for addressing the needs of elders living in family public housing.

Several goals guided the research. First, we sought to profile the characteristics and special needs of seniors living in family housing, in terms of both their physical and their social needs, and to determine the extent to which family housing is providing an environment conducive to meeting those needs. We sought to examine the ways in which family housing could be made more suitable for successfully aging in place, and to estimate the extent to which elders currently living in family housing are interested in moving to senior housing, where the services are more readily available. Finally, we sought to examine the ways in which existing social networks shape older residents' needs for services and their interest in moving to alternative sites.

III. Background

As individuals get older, their housing needs often change. What was once a suitable home for rearing a family may be too large, too hazardous, or too isolated after children have left home or after health declines. These deficits of the structure are often countered by a desire to stay in familiar surroundings, within the context of a familiar community. "Aging in place" also allows elders to continue participating in often long-standing informal support networks with neighbors, friends, and nearby family members, which may have beneficial consequences both for the older individual and for others in the community. Many elders experience difficulty balancing the social, economic, or other benefits of remaining in familiar surroundings with the potential benefits of moving to alternative settings more in line with physical capabilities and needs for services. Research and field experience suggest that the benefits of aging in place are frequently so substantial that considerable effort to facilitate this goal is appropriate. This effort commonly requires home adaptation and delivery of services to the home, either through informal (e.g., family-based) or formal mechanisms.

The literature on aging in place highlights two dimensions of the housing environment that are critical to sustained well-being and quality of life. The first dimension is the built environment—the physical characteristics of the housing unit and its spatial context, including the characteristics of the building in which it is located, features of the neighborhood such as shopping or recreation possibilities, and services readily obtainable in that location. Just as important as these features, however, is the social environment. Aging in place allows ongoing relationships with others living nearby to continue more easily. Reciprocal helping relationships with neighbors can beneficially continue. Participation in community groups and other formal and informal groupings—essential for the maintenance of social support—can continue when a person

is able to age in place. The ongoing attachment to a space jointly defined in physical and social terms is known to yield benefits for many older individuals, their families, and the communities in which they live.

Aging in Place in Public Housing

How these issues play out in the context of public housing is largely unknown. The policy and social science literature on elders living in public housing has focused largely on those living in senior-disabled housing. The challenges posed by mixed-age populations residing in senior housing have long been recognized by the BHA and housing experts. However, because these challenges are shaped substantially by the fact that the younger residents in senior housing are all disabled, little guidance for the current research is available.

Aging in place in *family* public housing has not been examined in the literature. Indeed, national estimates of the prevalence of seniors in family developments are not readily available. A HUD report on “Housing Our Elders” indicates that nationally, “a sizable percentage” of the 416,000 elderly public housing households in 1997 were living in “general-occupancy public housing” but does not elaborate further (U.S. Department of Housing and Urban Development, 1999). Yet it is likely that concerns regarding the safety and security of vulnerable elders, as well as unmet needs for services, are present in family housing.

The Boston Example

The first public housing development in Boston was built in 1934 (Old Harbor Village, since renamed Mary Ellen McCormack); virtually all of the current family developments were built either pre-WWII (1938-1942) or between 1949 and 1954 (Vale, 2000). The developments have been renovated to varying extents over the years, but the housing was not built with older or frail residents in mind. Consistent with the reasonable accommodations policy of the BHA, the building maintenance staff will make minor modifications, such as installing grab rails in bathrooms, upon request. As well, individuals experiencing difficulty with features of the building or apartment may be moved to a more suitable unit, if an acceptable alternative exists and is available. However, mobility limitations that are routinely anticipated in senior housing may constitute difficult or intractable challenges for those in family housing. For example, although senior/disabled housing is typically structured as high-rise buildings with elevators, most family public units are in three-floor walkups, with no elevators.

Despite the lack of senior-friendly features characteristic of the family developments, many of the older residents have lived in the same development for a very long time. Many came to public housing as young parents in the 1960s, settling in what were then characterized as desirable and affordable developments. Many of those aging in place within these neighborhoods, some for 40 years or more, have seen their children grow up and move away as the community around them changed radically.

Seniors in Boston Family Public Housing

A recent tabulation by the BHA suggests that more than 1600 individuals aged 62 and over live in *family* public housing developments, representing about 39% of all the seniors residing in public housing in Boston. Institutional data from BHA indicate that the vast majority of the older individuals in family developments are age 62-74, but almost one third is age 75 or older. Over two-thirds of the seniors are either household heads or spouses of the household heads, and most live alone. With respect to racial composition, 44% of the seniors living in a family development are non-Hispanic White, and 32% are non-Hispanic Black. About 17% are Hispanic/Latino, and the remaining fall into some other racial category, mostly Asian. Compared to the population of individuals aged 62 and over living in Boston as a whole, the population of seniors living in family developments is younger and more heavily composed of people of color (see Figures 1 and 2).

Seniors who are aging in place in Boston family housing developments pose a challenge for the BHA and for organizations seeking to support elders in the community. The housing needs of these individuals have almost certainly changed over the years, both because their households have become smaller and because their own physical abilities and limitations continue to evolve. The services and facilities presently offered through family public housing, geared primarily to addressing issues faced by younger families, may no longer meet their needs; but there are currently no programs or services specifically targeting elders living in family public housing in Boston. Conversely, a substantial number of elders serve as heads of household and are also functioning as primary caregivers to grown children and/or young grandchildren. These individuals may have a strong desire to remain in family housing, but the current level and type of services provided may inadequately meet their needs.

In the early stages of this study, we had conversations with staff from BHA, on-site managerial staff at the family housing developments, members of the Advisory Group, and non-random samplings of older residents in two of the family developments. These discussions suggested that among BHA staff and management staff on-site in the developments, key concerns included the health and social isolation of the older residents. Discussions with the older residents themselves tended to focus on concerns about maintenance and safety in the buildings and tensions with neighbors. We drew on these discussions as we developed a questionnaire for a more systematic study of the needs and characteristics of older residents.

IV. The Survey

The Center for Survey Research (CSR) at the University of Massachusetts Boston was responsible for the actual data collection. A questionnaire was designed drawing on the themes motivating this study and the additional issues that were raised during our discussions with BHA staff, development management, the Advisory Board, and older residents. The questionnaire primarily makes use of closed-ended questions, with a few open-ended questions included.

According to the BHA institutional roster, 16.5% of the elders living in family developments are Hispanic. To approximate more closely the overall rate of older Hispanics living in Boston family housing developments, it was necessary to oversample

those who were listed as speaking Spanish. Due to cost considerations, interviews in languages other than English or Spanish were not possible.

For purposes of drawing a sample, the BHA provided CSR with a roster of residents aged 62 and over living in family housing developments. It was decided to sample residents from the 10 developments that had the largest number of seniors. This was a practical decision both from the standpoint of sampling and also because interventions would most likely occur at least initially in developments with sizable concentrations of seniors. Two of these developments (Bromley Park and Camden Street) are closely affiliated with other developments. Therefore their affiliated developments (Heath Street and Lenox Street, respectively), though small, were also included. The sampled developments are listed in Table 1.

Table 1: Family Housing Developments Represented in the Sample

Alice Taylor	Bromley Park/Heath
Camden Street/Lenox Street	Cathedral
Charlestown	Commonwealth
Mary E. McCormack	Maverick
Old Colony	West Broadway

The protocol for the survey consisted of sending a prenotification letter of introduction to all sampled respondents. The letter was dual-sided, with English on the front and Spanish on the back. Interviews were conducted by trained interviewers primarily by telephone using a CATI (computer assisted telephone interviewing) system, with a small number of interviews conducted in person. Data collection occurred between March and June, 2002. To be included in the sample, an individual had to be age 62 or older, living in one of the selected developments, and able to be interviewed in English or Spanish. Only one resident per household was chosen. The final sample includes 217 completed interviews.

A number of challenges occurred while attempting to conduct the survey. It was not possible to ascertain eligibility for almost 20% of the sample because CSR staff could not locate them. In many cases, it was determined that individuals on the roster were no longer living in the development; in others, it was not possible to confirm whether or not a potential respondent was living there. If we assume that the true sample excludes those who CSR was unable to track—that is, those who were not located at the address or phone number provided by BHA—then the overall response rate was 65%. Included among the non-respondents are 6% of the selected sample who were too ill to participate. Inasmuch as proxy interviews were not permitted, the sample likely excludes a disproportionate number of older frail residents. A comparison of the age composition of the weighted sample with the population of seniors in the sampled developments confirms that our sample is slightly younger than the population of seniors living in the selected developments (see Figure 3).

V. The Results

Demographic Profile

The demographic features of the sample are reflected in Figures 4 through 9. All data presented in this report are weighted to adjust for differential probabilities of selection associated with the sampling strategy. As a result, our results should be representative of the population of seniors living in the sampled developments. The median age of the sample is 69, with nearly half of the sample age 70 and over (see Figure 4) and more than three-quarters of the sample are women (Figure 5). Like the older population living in family developments (see above), the sample includes large proportions of non-whites and Latinos (Figure 6). More than three-quarters of the sample are either widowed, divorced, or separated; only 14% are currently married (Figure 7).

Overall, this group of individuals is less well educated than the older population living in Boston as a whole. Fifty-seven percent report not graduating from high school (see Figure 8). Despite a generally poor economic profile characterizing the population living in public housing developments overall, participation in the Supplemental Security Income and Food Stamps programs appears to be at inappropriately low levels (see Figure 9). Information about these programs and assistance in applying for them might be a useful intervention for this population.

Duration of Residence in Family Public Housing

Many of the older residents in family public housing developments throughout Boston have lived in the development for a very long time. Figure 10 shows that almost half of the older residents have lived in the same development for 30 years or more and relatively few are “newcomers” of 10 years or less. Although not shown here, we note that duration of residence is substantially lower for Latinos than for others. The median duration of residence for Latinos is 6-10 years, but for non-Latino White and Black residents, the median is more than 30 years.

Social attachments & Productive Contributions

A large share of older residents in family housing might be at risk of isolation, by virtue of the fact that so many live alone. Figure 11 shows that 59% of these seniors live by themselves, a percentage much higher than that reported for similarly-aged individuals nationally or in the Boston area. Living with a spouse or partner is uncommon among this group—only 12% report this arrangement. A sizable minority—29%—live with others, but not a spouse or partner. These individuals most commonly include children and grandchildren, some of whom are minors.

Indeed, one of the factors possibly contributing to the desire to “age in place” is the fact that many seniors are still participating in raising children or grandchildren who live with them, or for whom the older resident provides babysitting from time to time. Figure 12 shows that 18% of the seniors live with minor children in the household. The majority of these individuals are grandchildren, many of whom are in the custody or sole care of the elderly grandparent. Many more seniors report babysitting or caring for minor children who do not live with them, suggesting an active role in childcare for these seniors.

Other indicators suggest that relatively few of the older residents are socially isolated. Most have children living nearby, with almost two-thirds having one or more children living with them, in the neighborhood, or elsewhere in the Boston area (see Figure 13). Moreover, most have frequent contact with family and friends (Figure 14). However, the 13% of seniors who report seeing or speaking with friends or family members once a week or less, and especially the 4% who report *never* seeing or speaking with any friends or family members, may be at risk of social isolation.

Many of the seniors are active in their communities as well as their families. As noted above, a significant share provides childcare or substitute parenting for grandchildren. As well, almost 20% report doing volunteer work for organizations such as schools or churches (see Figure 15). In addition, many of the seniors report that they would be interested in volunteering to help make their development a better place in which to live, or in volunteering to help children in the development with their homework. (About 35% report that they would be “very interested” and an additional 28% report being “somewhat interested.”) Providing and advertising opportunities for seniors to make these kinds of contributions to the developments in which they live would be beneficial for all residents.

Health and Needs for Assistance

Perhaps the biggest challenges faced by the population of seniors living in family housing are those associated with declining health. Overall, the health profile of the older residents is poor (see Figure 16). Twenty percent of the sample rated their own health as “poor” with another 36% rating it as “fair.” Fewer than 5% rated their own health as “excellent.” The self-rated health question is a widely used indicator of health, and is known to correlate well with more objectively rated health assessments such as physician evaluations and even subsequent mortality. In national community-based samples, populations age 60 and over typically have much better health profiles according to this question than is evidenced here.

Our assessment of depression and anxiety also suggests poorer mental health in this population (see Figure 17). Although most respondents scored in a favorable range, a significant minority scored in a range indicative of some mental health problems. For example, 31% reported feeling “so sad that nothing could cheer you up” all, most, or some of the time. Published reports using the same questions suggest that only 14% of individuals in this age range report this level of sadness nationally (Pleis & Coles, 2002). These results suggest that mental health services may be useful to a number of older residents.

Additional questions focused on health limitations, mobility problems, and problems remembering. More than half of the older residents reported that health limited their activities, and more than 60 percent reported some difficulty in managing stairs (see Figure 18). One-quarter reported that they use a mobility aid such as a cane or a walker. More than 45% reported that they had some difficulty remembering things.

Finally, an important and commonly assessed indicator of disability is the extent to which individuals experience difficulty with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). ADLs refer to personal care tasks such as bathing, eating, dressing, or toileting; IADLs refer to tasks such as meal preparation, cleaning, or food shopping. A relatively large share of the sample (41%) reported

receiving help with ADL/IADL tasks (see Figure 19). Only about 5% reported that they needed help but did not get any assistance; and the remaining 54% reported that no help was needed. Although those reporting that they received some help with these tasks may still have some additional needs for assistance, it is encouraging that the vast majority who report needs for assistance also report that they are receiving help.

Service Use and Service Needs

Key to aging in place is the availability of appropriate medical and nonmedical services that promote independent, community living. The integration of service provision and shelter is a central feature of most innovations in housing elders, including assisted living and, for that matter, elderly public housing.

The vast majority of older residents of family public housing developments in Boston reported that they had seen a physician at least once during the previous 12 months, and only a small share reported that they had not but felt that they needed to (see Figure 20). Far greater shares of unmet need were reported for dental care—28% of the respondents reported having seen a dentist in the previous year while another 14% reported that they had not but felt that they needed to. Respondents were also asked if they had seen a social worker, psychiatrist, psychologist, or other mental health worker in the previous year. Fewer than 20% reported that they had, with another 4% reporting that they had not but felt a need to. Given the relatively high levels of depression and distress apparent in this population (see Figure 17), the improved availability of mental health services may be important.

Non-medical service use in this population was fairly low overall (see Figure 21). Fewer than 20% reported that they had a caseworker or participated in senior activities in their development. Ten percent or fewer reported using home-delivered meals, going to a senior center located off-site, or using the RIDE. In contrast, the reliance of this population on public transportation such as buses and the subway is extensive, with 60% noting that they had taken public transportation within the last month. We also asked about interest in services that might be useful to seniors living in family developments (see Figure 22). Interest was particularly high in special transportation for seniors for shopping (57%) and in access to a case manager to provide information and help arrange for needed services (59%). About one-third expressed interest in group meals, and more than 40% had some interest in having a place where they could learn to use computers.

Transportation is frequently a significant issue for seniors living in the community. More than one-fifth of our respondents reported that transportation constituted a problem for them.

Security and Safety

Respondents were asked about several issues involving their feelings of safety in the development and neighborhood (see Figure 23). When asked about feelings of safety when going out alone in the development, about half of the older residents reported feeling “very safe” going out during the day, but only 16% felt “very safe” going out alone at night. Only about one-third of the respondents reported having safety equipment such as grab bars in their bathrooms. More than a quarter of the residents both live on an upper floor of multistory buildings that have no elevators and report that they have

trouble handling stairs. With respect to both of these issues, the safety of older residents could be improved by more aggressively promoting the installation of safety equipment in apartments housing older residents, and by facilitating the relocation of residents with mobility problems to apartments on the first floor of buildings.

Feelings about Senior Housing

Our initial plan in the survey was to ask respondents a number of questions regarding their knowledge and attitudes about elderly housing. Pre-testing of the questionnaire demonstrated that asking specifically about interest in moving to senior housing (or anywhere else) was inadvisable—respondents became very upset with this line of questioning and frequently closed down the discussion in response. Instead, we chose to ask respondents if they had ever heard of the elderly-disabled public housing developments coordinated by the BHA that are designed specifically for people over the age of 61 and people who are disabled. Almost **half said that they had never heard about these developments**. Among those who had heard of them, only **10% said they were on the waiting list**. BHA staff believes that this apparent low level of awareness may be an overestimate, reflective of the respondents' anxiety and sense of vulnerability about being moved.

We also asked respondents about “things that are sometimes important to people about where they live,” asking about features that may condition their enthusiasm for moving to another neighborhood or another development. The importance of public transportation and attachment to community and place emerged once again as very important in these responses (see Figure 24). Almost 90% reported that living near public transportation was important to them, with more than 70% identifying living near family and friends, living near restaurants and stores, and living in the same neighborhood as they do now as important. Lesser amounts of enthusiasm were found for living in a place with a mix of younger and older residents, and in a place that provides house cleaning services, although more than 50% of respondents indicated that these, too, were important.

Description and Feelings about Current Housing Situation

We asked the older residents to tell us the one thing they liked best about living in their development, as well as the one thing they liked least. A wide range of responses was provided to both questions; however, the responses can be grouped into several categories. Positive features most frequently mentioned referred to aspects of the neighborhood or the area, especially the convenience of shopping, medical services, and other community amenities. Some residents are also strongly attached to the development simply because they have been there for so long. For example, one respondent liked the development because “...stores, hospitals are close by and I like this neighborhood because I have been here so long” and another reported “I enjoy living here...to me it's my home.”

When asked about what they liked least about their development, the majority indicated that there was nothing about which they were particularly unhappy. Among those who did mention a source of dissatisfaction, most frequently noted were problems with other residents, or dissatisfaction with maintenance of the buildings. For example,

one respondent reported “it’s not the place, it’s the people...the people outside make the yard dirty, dropping garbage...” and another disliked “the loud noise from kids’ radios in the summer.”

VI. Recommendations

Service Coordination

Improved service coordination should be made available to the vulnerable elders living in BHA family units. The survey provides evidence not only that a substantial proportion of elders in family units is in poor health and has limited capacity for self care; significant numbers of these elders are not taking full advantage of the public programs available to assist low-income elders. Nationally, the strategy of deploying service coordinators in housing programs for low-income and frail seniors is widely embraced. BHA currently stations service coordinators in its senior/disabled housing units to help residents obtain needed services.

A well designed plan is needed for the introduction of service coordinators to serve the frail elders who live in family units. The plan should take into account the fact that elders in family units are widely dispersed and the numbers of frail elders in small developments is modest. Even part-time coordinators may need to serve elders in multiple developments.

The plan must also take into account the BHA’s severe financial constraints. Further, the service coordinator role should be defined in a way that encourages thorough documentation of the coordinator’s contributions. The efficacy of service coordination is also often questioned. Evidence that service coordination is effective and efficient will be helpful in justifying continuing public funding for service coordinators.

The service coordination approach currently in use in the BHA’s elderly/disabled developments should be adapted for use in family developments. A somewhat different approach will be needed in family developments because of the fundamental differences between the two types of developments; nevertheless, the similarities in needs of vulnerable elders in the two types of settings are sufficient so that many of the elements of successful service coordination in elderly/disabled developments can be adapted successfully in family developments.

In developing their roles, service coordinators should map the proximity of each development to key services for elders. In instances in which services are remote and public transportation access is weak, service coordinators should seek to develop special transportation options. Service coordinators should also work closely with outreach personnel of major service providers to assure that elders are well informed about service resources. Service coordinators should explore possibilities for collaboration with tenant groups in strengthening efforts to disseminate information to residents about service options.

Two or more approaches might be explored:

- Training of selected residents to serve as paraprofessional service coordinators
- Contracting with one or more of the three Aging Services Access Points (ASAPs) in Boston for an extension of their case management services to

include frail elders in public housing who do not qualify for the state-funded home care program for the elderly.

Access for Residents with Mobility Limitations

More units should be made habitable for elders and others with disabilities, and these units should be made available to elders and others with disabilities. Home modifications that improve bathroom safety should be a high priority.

More widespread use of even inexpensive, low-technology strategies to make residences more habitable for vulnerable elders should be encouraged. Two thirds of the older residents reported a lack of safety equipment in their bathrooms. These findings suggest more widespread difficulties experienced by residents with disabilities with their residential environments

Elders with mobility limitations should be given improved opportunities to move into first floor units. One-fourth of seniors report both difficulty with stairs and living on the second or third floor of buildings that lack elevators.

Improved shopping assistance should be provided to those with mobility limitations. Nearly two-thirds expressed interest in services that would help them with shopping.

Senior/Disabled Housing as an Option

With sensitivity, provide seniors in family units with improved information about BHA's senior/disabled developments. Some seniors living in family units would benefit from the supportive services and barrier-free environments that are available in senior housing. Half of the seniors reported that they did not even know of senior/disabled housing developments. Better information about senior/disabled housing options might lead some current residents to apply for senior/disabled housing. Caution is needed, however, because many residents are strongly attached to their developments and their neighborhoods. Further, because many residents lack trust in the Housing Authority, the provision of information about senior housing options could be misinterpreted as an effort to force elders to leave their units.

Civic Engagement of Elders

Expand opportunities for elders in family units to contribute to community-building efforts in their development. Many of the elders living in public housing are healthy, and a fifth are active as volunteers. A majority of seniors is receptive to being more extensively involved as volunteers to improve their development. A community organizing project that seeks to improve the development and draws upon elders as volunteers could be beneficial both directly and indirectly. Improvement in relationships between elders who are long-time residents and young families that are newer to the development would be a welcome indirect benefit. A key to this initiative is skillful

community organization to identify needed projects, development of attractive and viable volunteer roles, and careful recruitment, training, and placement of volunteers.

VII. Implementation

The Boston Housing Authority initially chose to undertake the needs assessment of seniors living in its family public housing units to assess whether there were some steps the BHA could take to serve better this population of residents. At the time that discussions began around this topic, the funding picture was very different than it is today. Unfortunately, programs through the US Department of Housing and Urban Development that fund resident service coordinators for assistance to seniors are only available to seniors living in elderly/disabled developments at this time. Therefore, the BHA plans to explore other sources of private funding to meet this need. In the meantime, the BHA also plans to do/explore the following in response to the report:

- BHA's Community Services Department has begun to train a cadre of public housing residents who have expressed an interest in becoming Resident Health Advocates (RHAs). Upon the successful completion of their training, these RHAs are hired to work in their communities to conduct outreach to residents and provide them with needed health and wellness services. While the first group of trainees received minimal training specifically targeted to those concerns expressed by seniors, during their first three months of work they have had significant contact with seniors and have expressed a willingness to focus more attention on this group's needs. Additionally, BHA has engaged in discussion and planning for additional training for these RHAs to become more aware of resources available to older residents. Our partners at the Boston University School of Public Health and the Boston Public Health Commission through the Partners in Public Housing Prevention and Research Center are investigating the possibility of piloting an intergenerational program to take into account the social service and health needs of our seniors in family public housing. It is our hope that these smaller pilot projects will lead to positive results and the ability to apply successfully for funding to expand these services to more of the family developments.
- BHA will establish a small working group made up of members of the Advisory Committee who will continue to share information and coordinate ways that the service coordinators that exist for the residents of Elderly/Disabled housing can be replicated for the family developments, once additional financial and personnel resources become available.
- The CSD Director will maintain close ties with the three Aging Services Access Points (ASAPs) to encourage their outreaching to seniors in the family developments. The Aging Services Access Points are home care agencies that individuals can contact to get assistance in finding home makers, case managers, and access to all state-funded elderly services. In Boston, our ASAPs are: Ethos, Central Boston Elder Services, and Senior Home Care.

- With respect to the recommendation for access for residents with mobility limitations, BHA will continue to respond to all requests by residents to have modifications to units such as grab bars. RHAs will also be made aware of this and will be encouraged to be pro-active in making this “reasonable accommodation” policy known and utilized. Seniors who qualify for an emergency reasonable accommodation transfer will receive priority on the waiting list to move into an elderly/disabled development of their choice or a first floor apartment, depending on what is needed. In addition, at this time, BHA is undertaking a major initiative in both its elderly and family public housing to make 5% of its units accessible as well as improve methods of communication with all residents.
- With respect to the recommendation to inform residents better about senior/disabled housing as an option, it is hoped that through closer communication among the Community Services Department, the Service Coordinators Working Group, and the Resident Health Advocates, more residents will become aware of the Senior Housing in the areas closest to where the residents are currently living. Some shared activities among the two groups of seniors might also foster a greater level of comfort. Additional work in this area will need to be pursued. At present, the CSD is working with Elderly/Disabled staff to streamline the Resident Participation policies, which dictate the relations between the BHA and resident organizations in both family and elderly/disabled developments. Perhaps this will present an additional opportunity for joint understanding and a safer environment for pursuing new housing options.
- BHA Community Services Department will promote the Frank J. Manning Gerontology Program as an opportunity to build capacity among the seniors living in family developments at no additional cost to BHA. This program is a part of the College of Public and Community Service at UMass Boston and includes direct services, including four courses over two semesters. Seniors who enroll in the Manning Certificate Program receive full remission of tuition and fees, making this a cost-effective way successfully to involve key residents in shaping the type of service delivery they feel would be most advantageous.
- BHA Community Services Department will explore transportation and meal services that are available to seniors in the City of Boston. Through the Resident Health Advocates and activities listed above, the CSD will distribute this information to ensure that seniors are aware of services available to them.

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Figures 1 through 24

Figure 1: Age distribution for population 62 and over, family developments compared to city of Boston

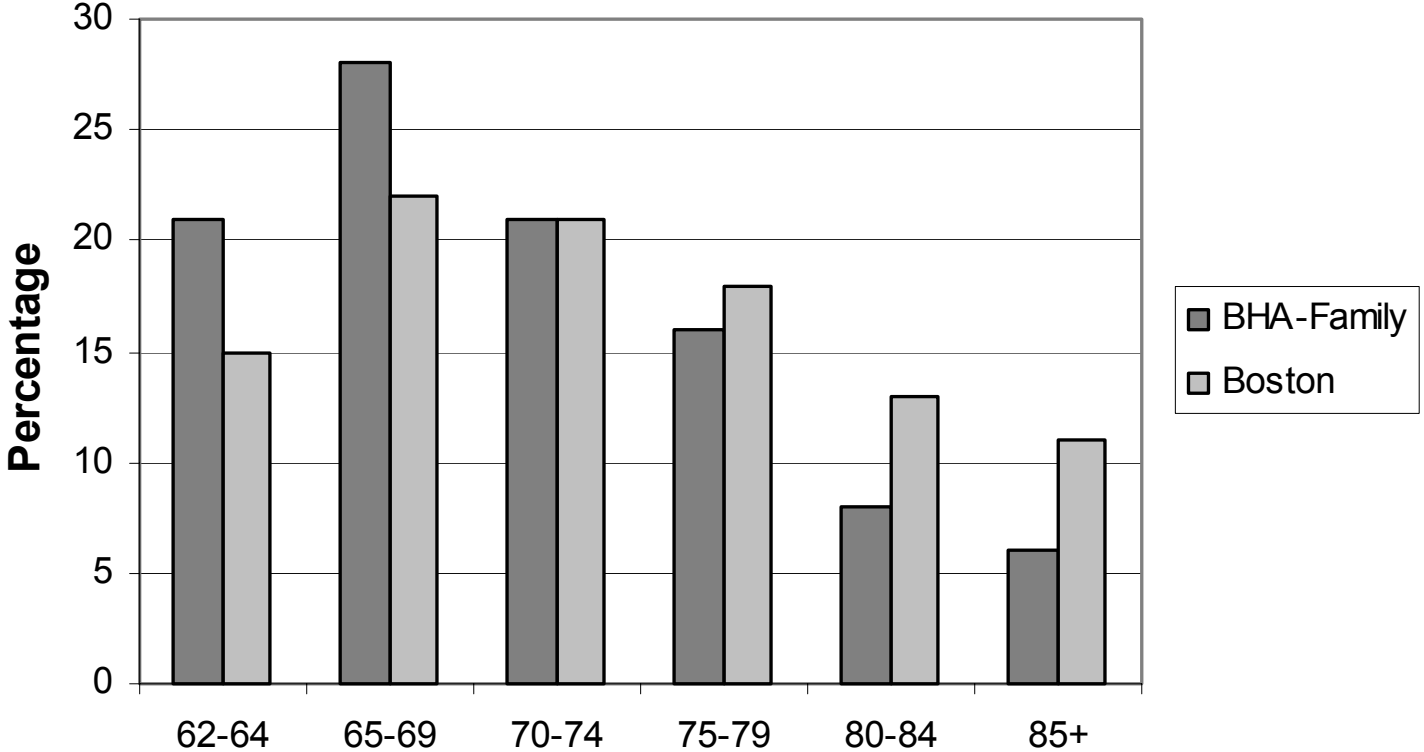


Figure 2: Race composition of population aged 62 and over, family developments compared to city of Boston

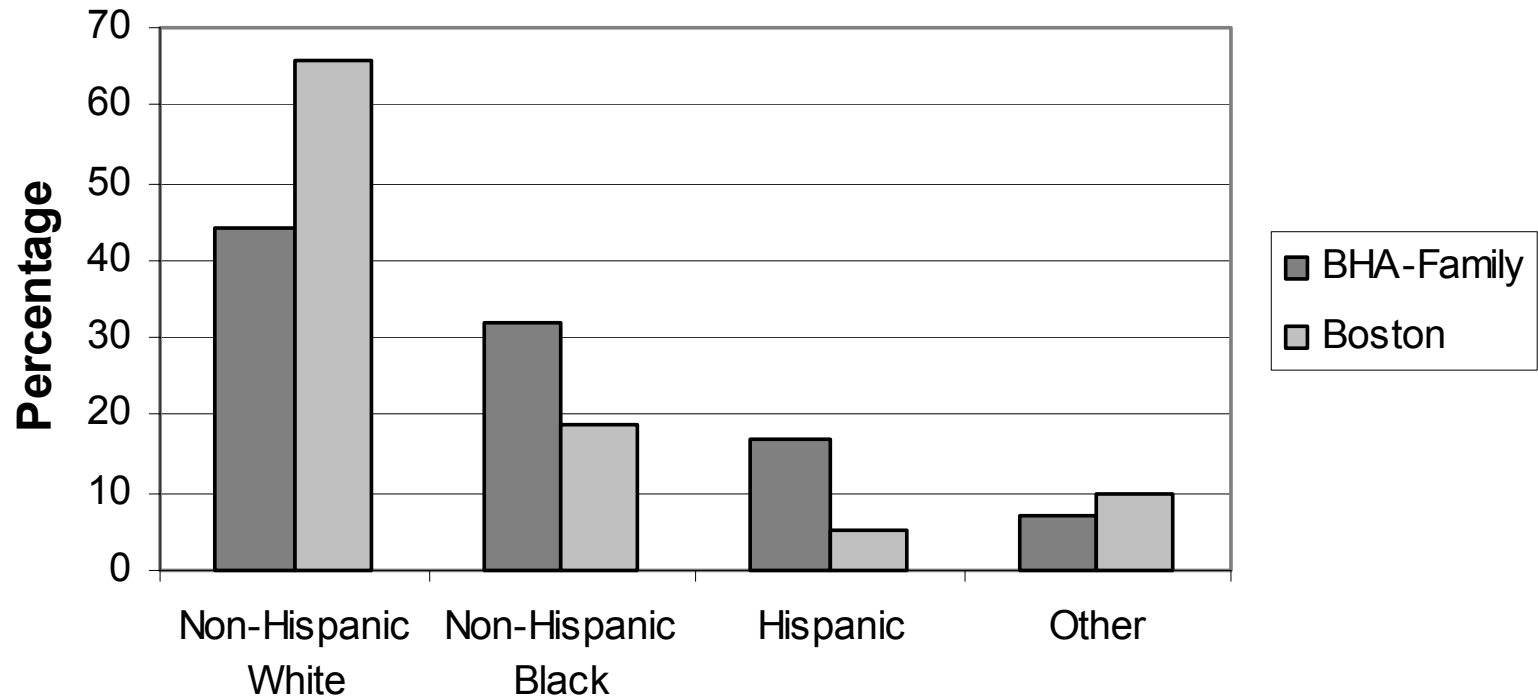


Figure 3: Age distribution of residents aged 62 and over in family developments

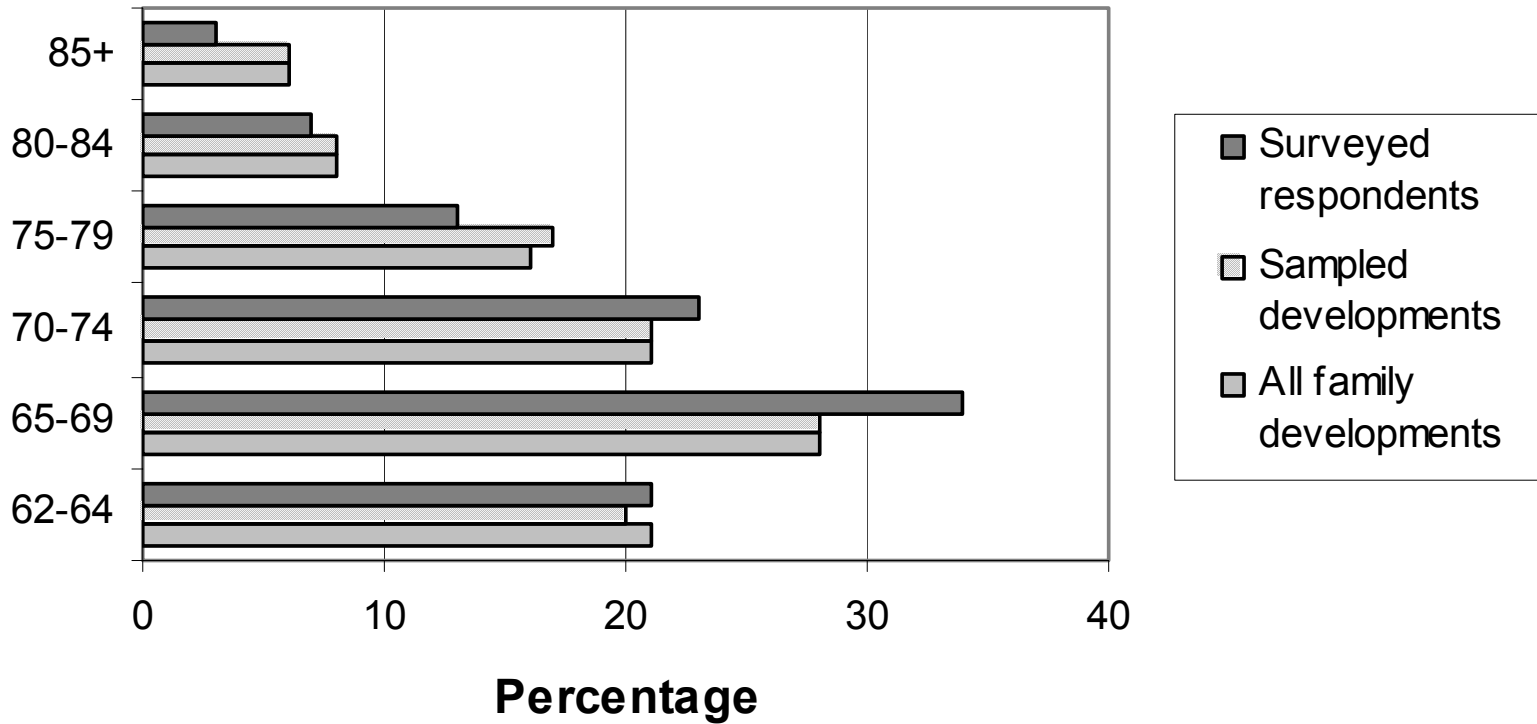


Figure 4: Age Distribution of Sample

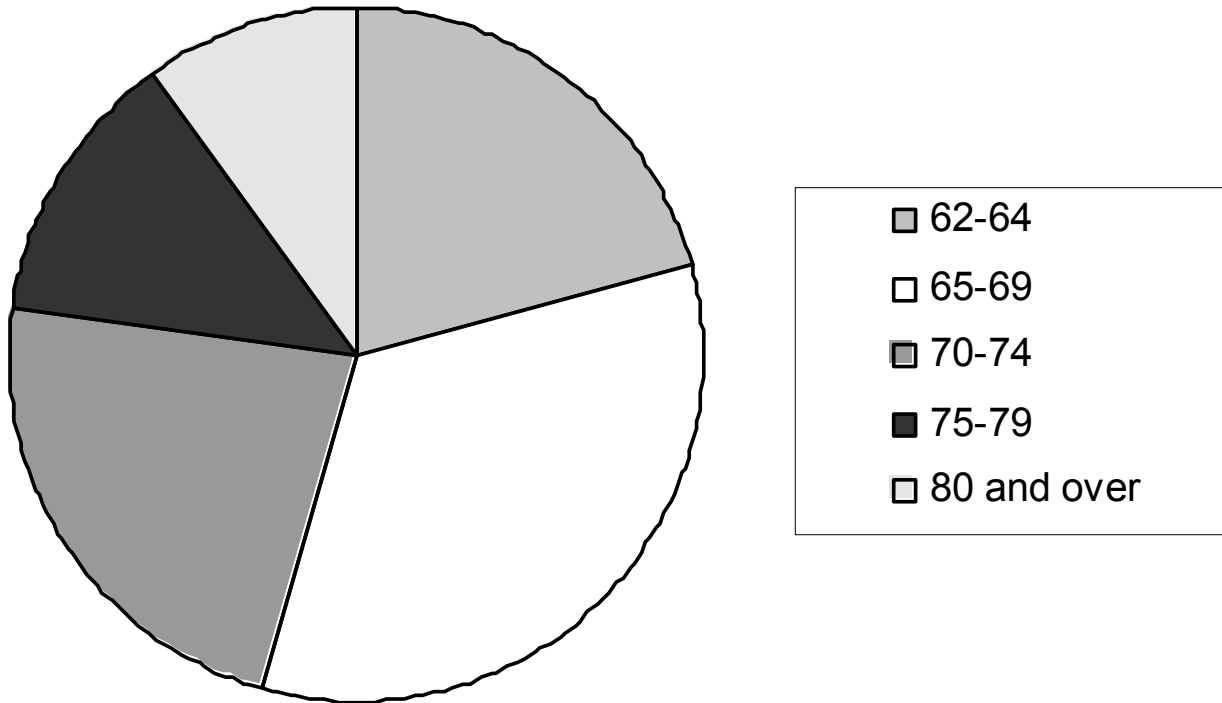


Figure 5: Gender composition of sample

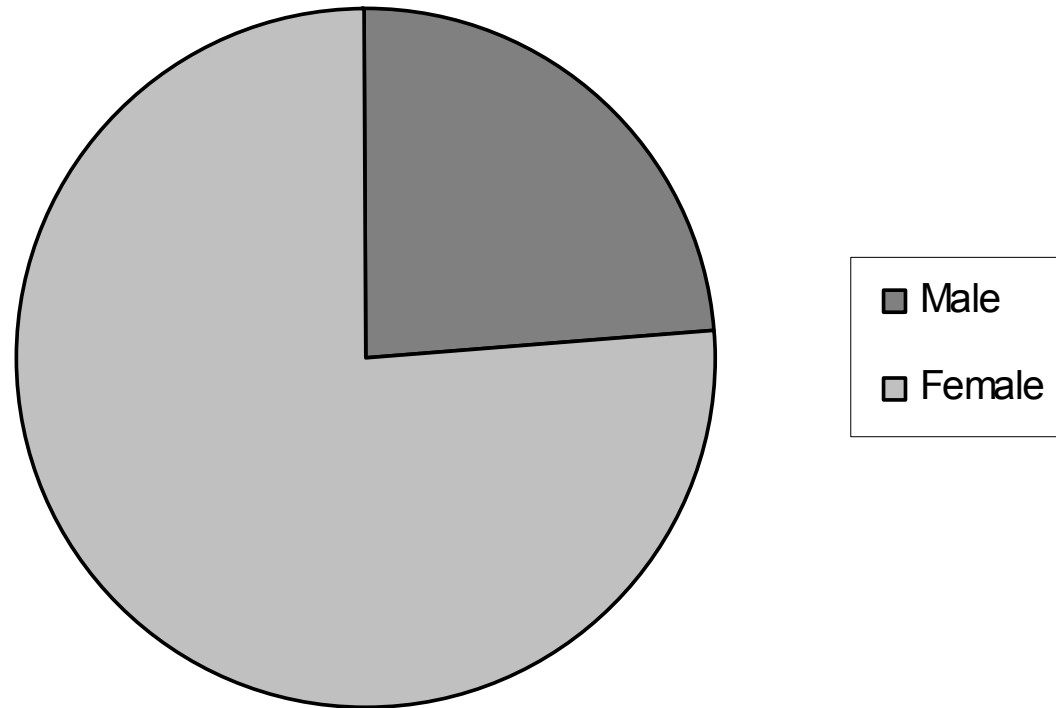


Figure 6: Race and ethnic composition of sample

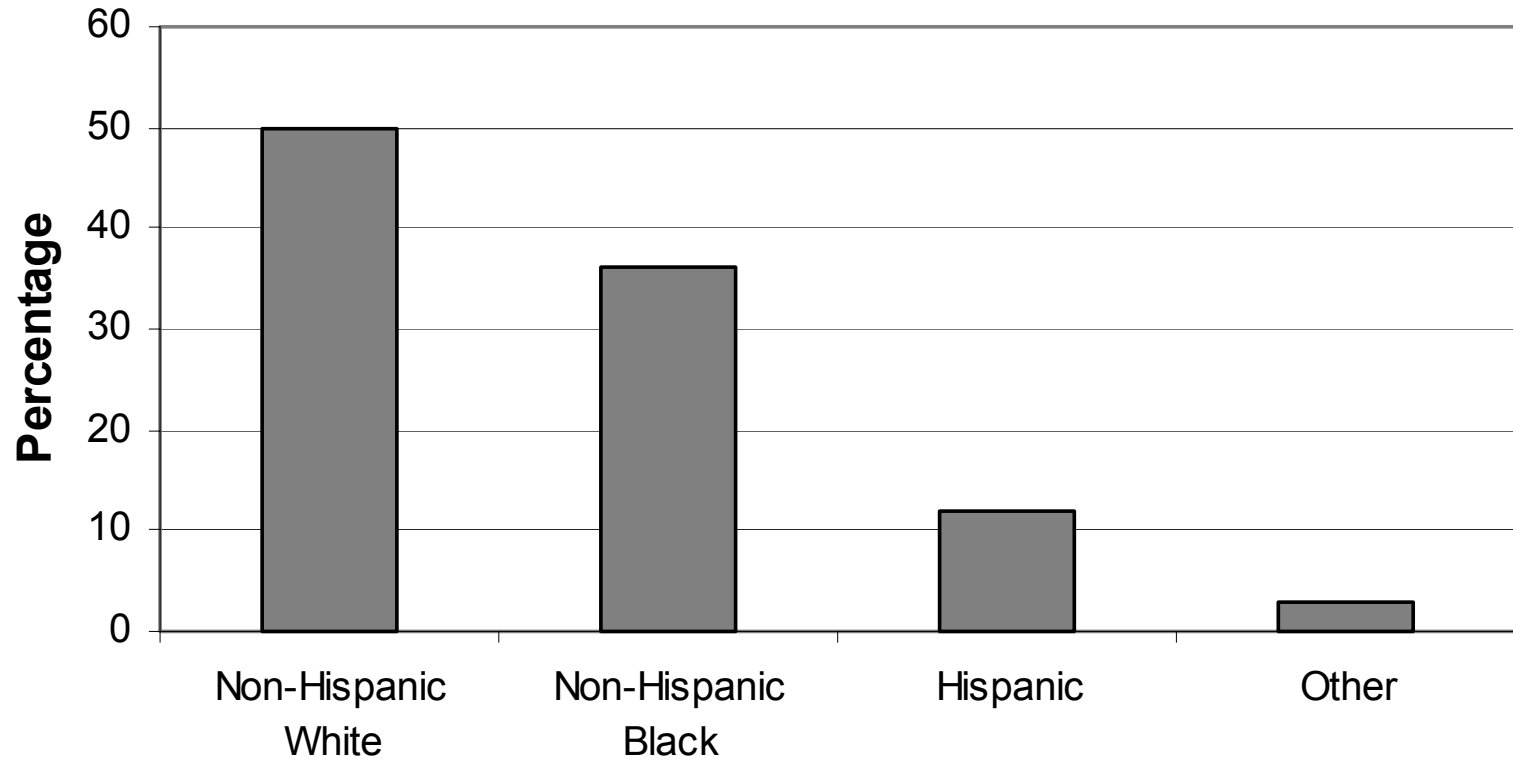


Figure 7: Marital Status of Sample

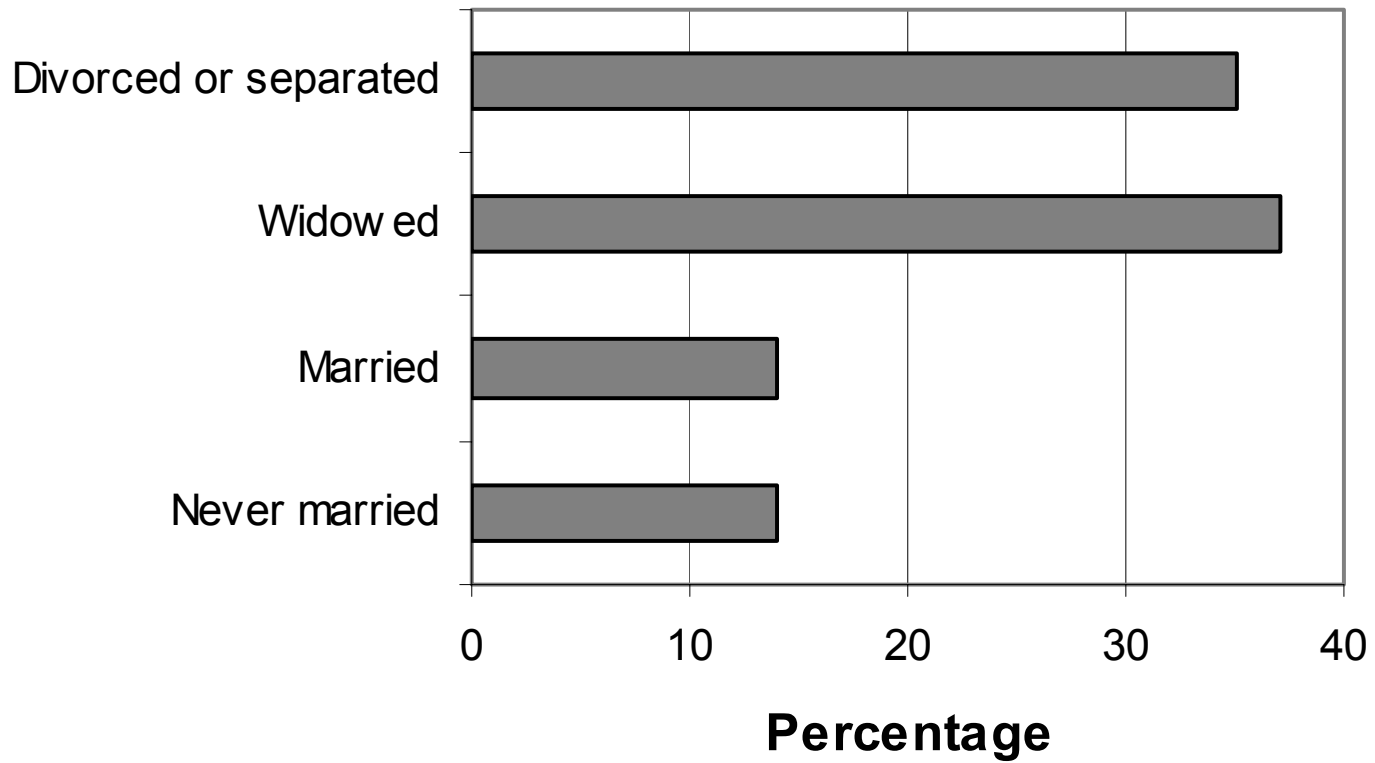


Figure 8: Educational attainment of sample

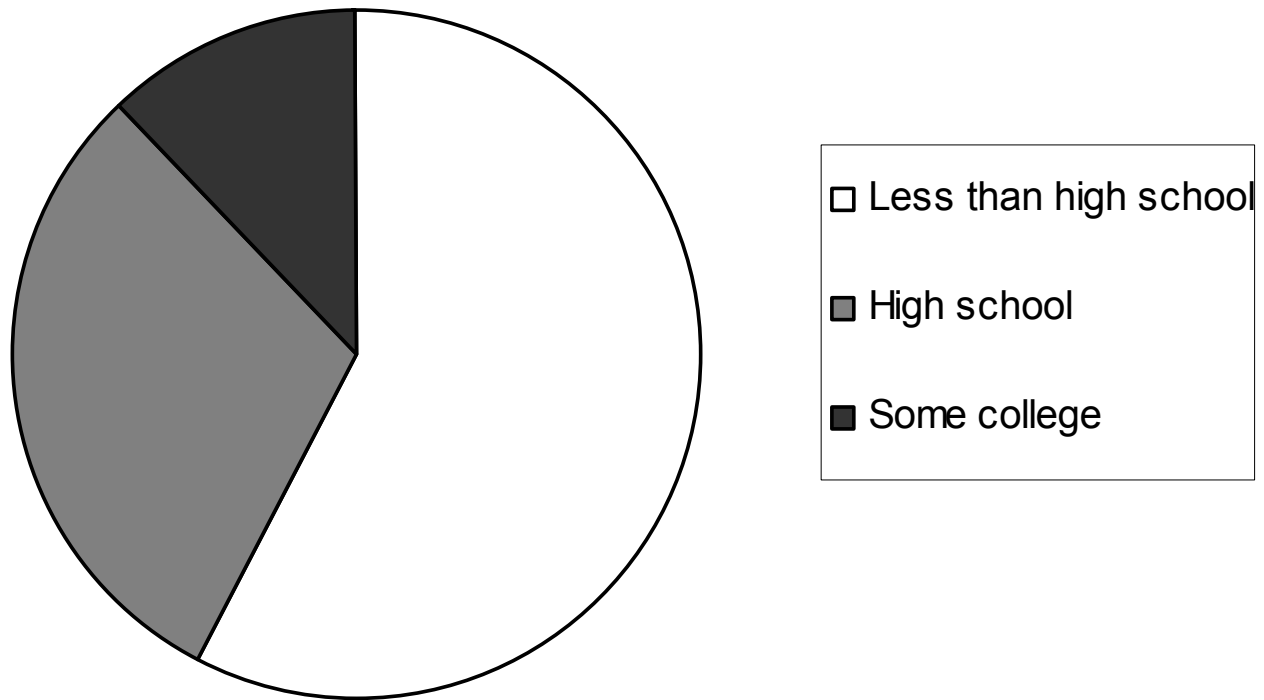


Figure 9: Public assistance received by households including seniors

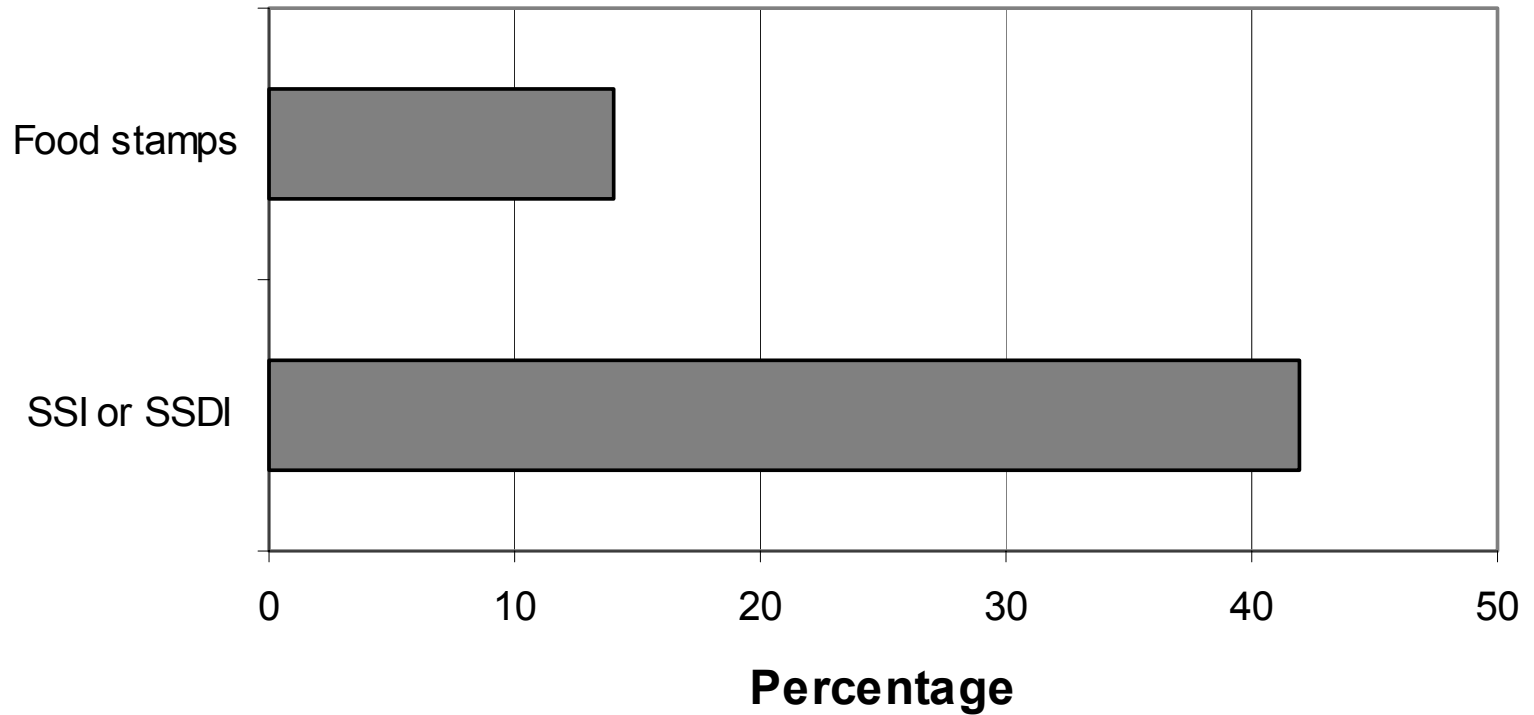


Figure 10: Number of years older residents have lived in their development

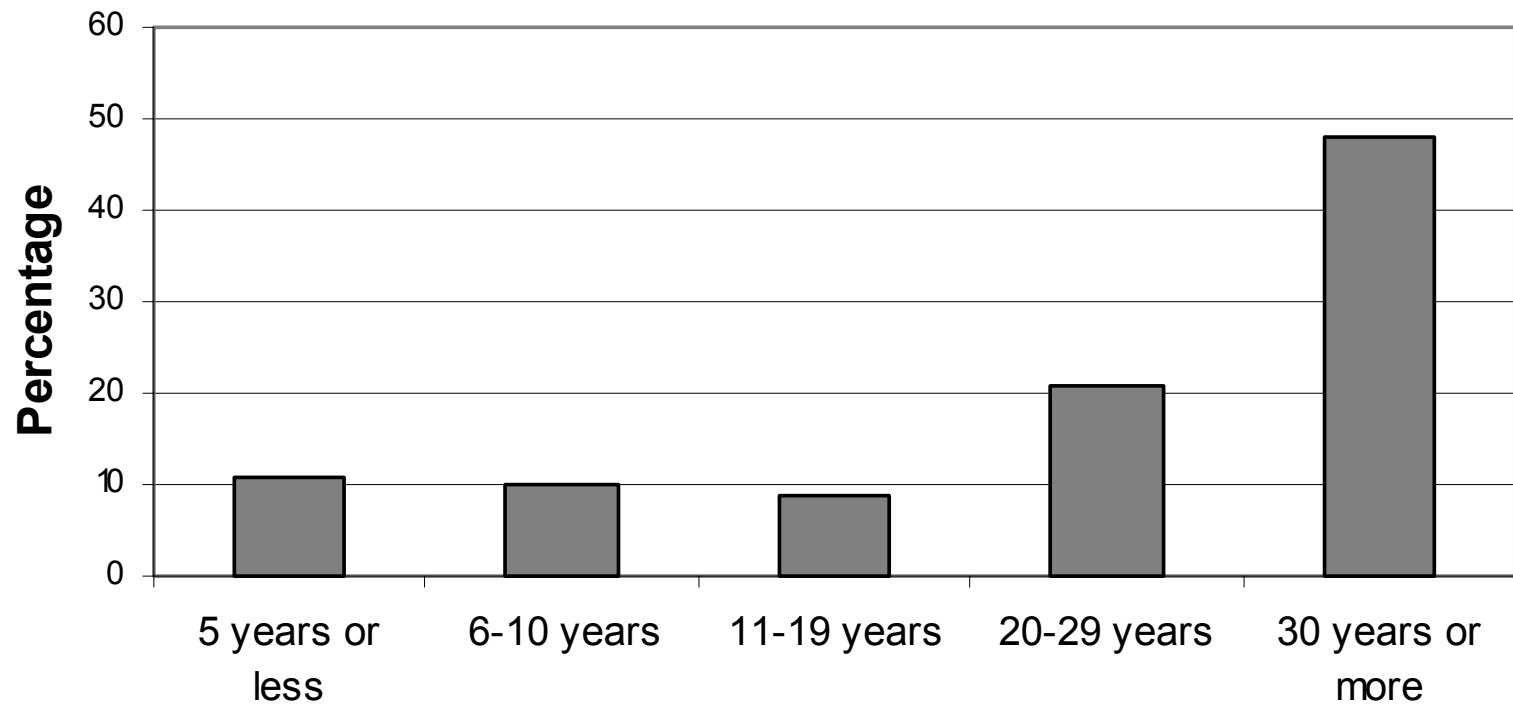


Figure 11: Living arrangements of residents aged 62 and over

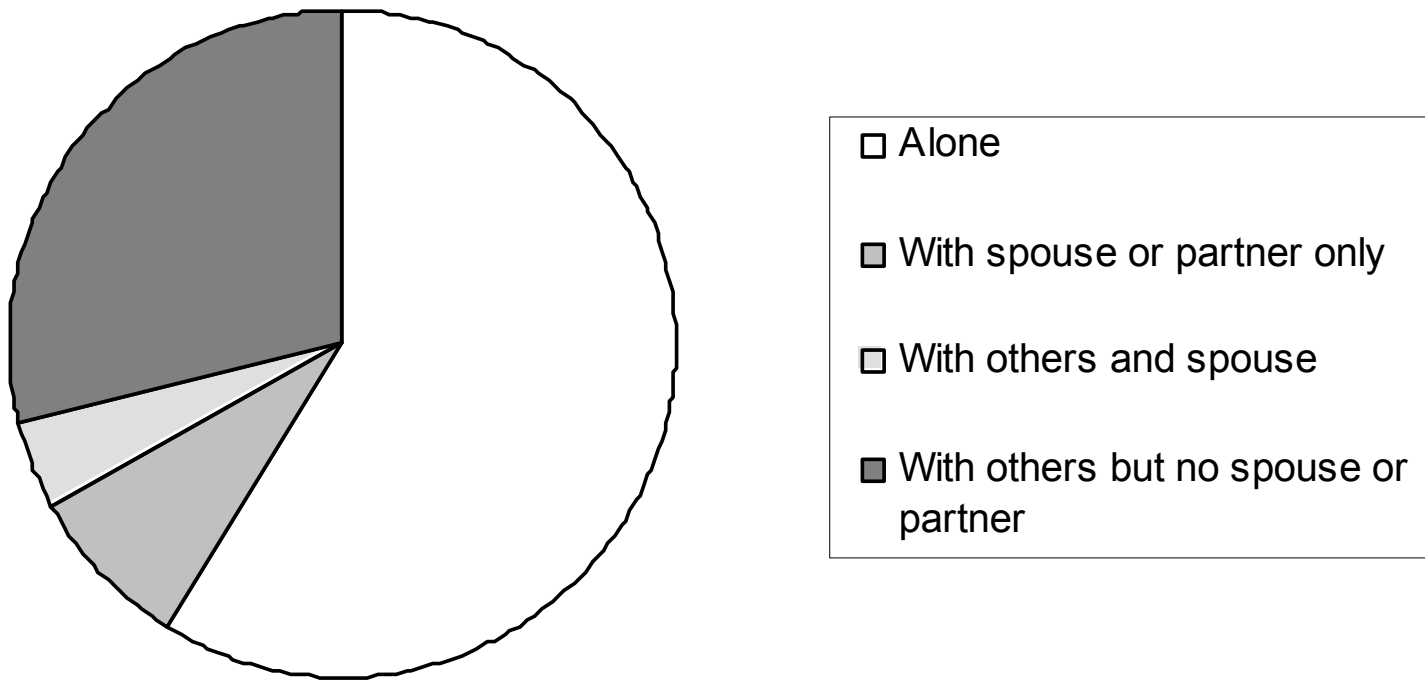


Figure 12: Care of minor children

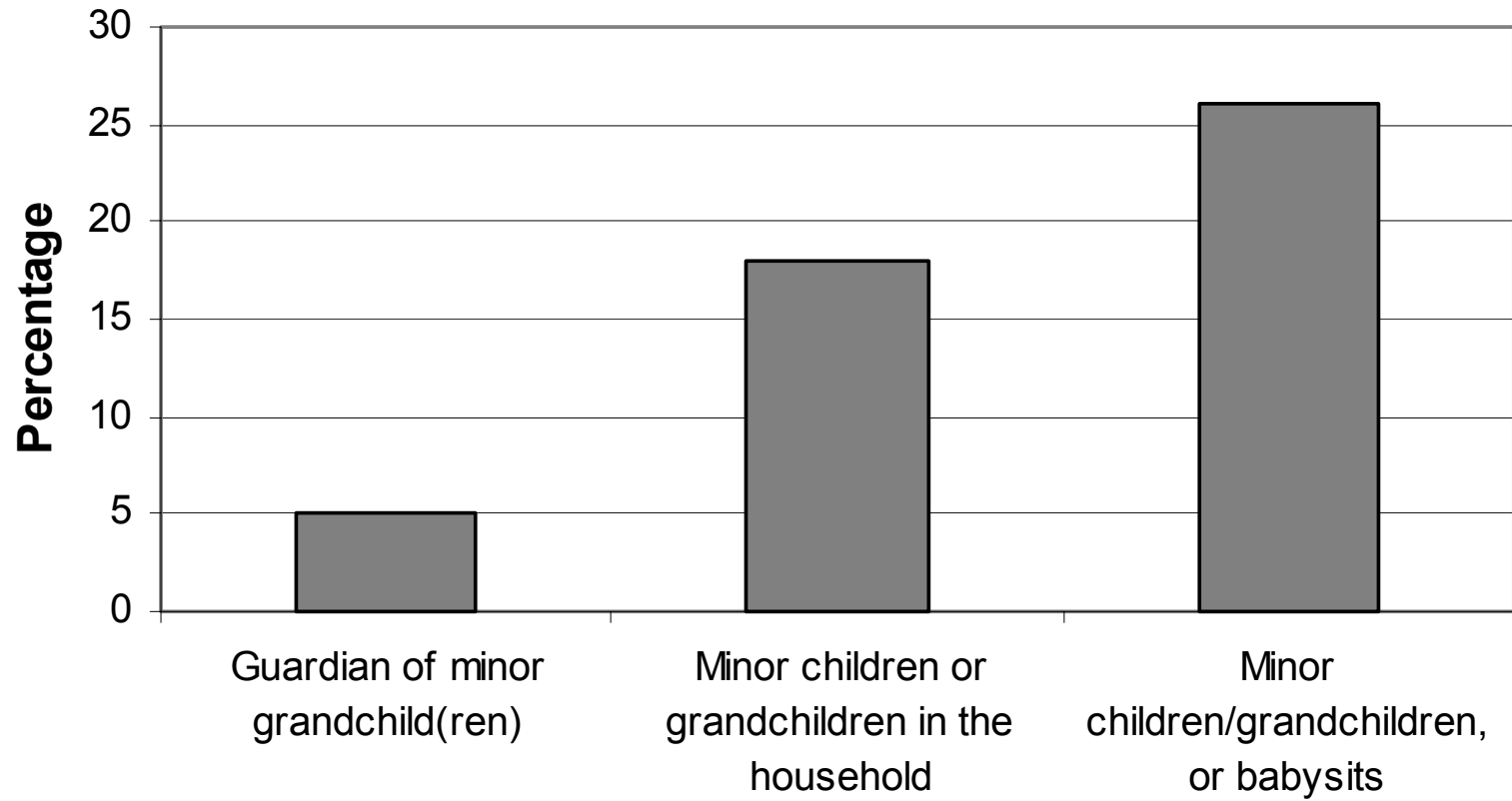


Figure 13: Offspring in closest proximity

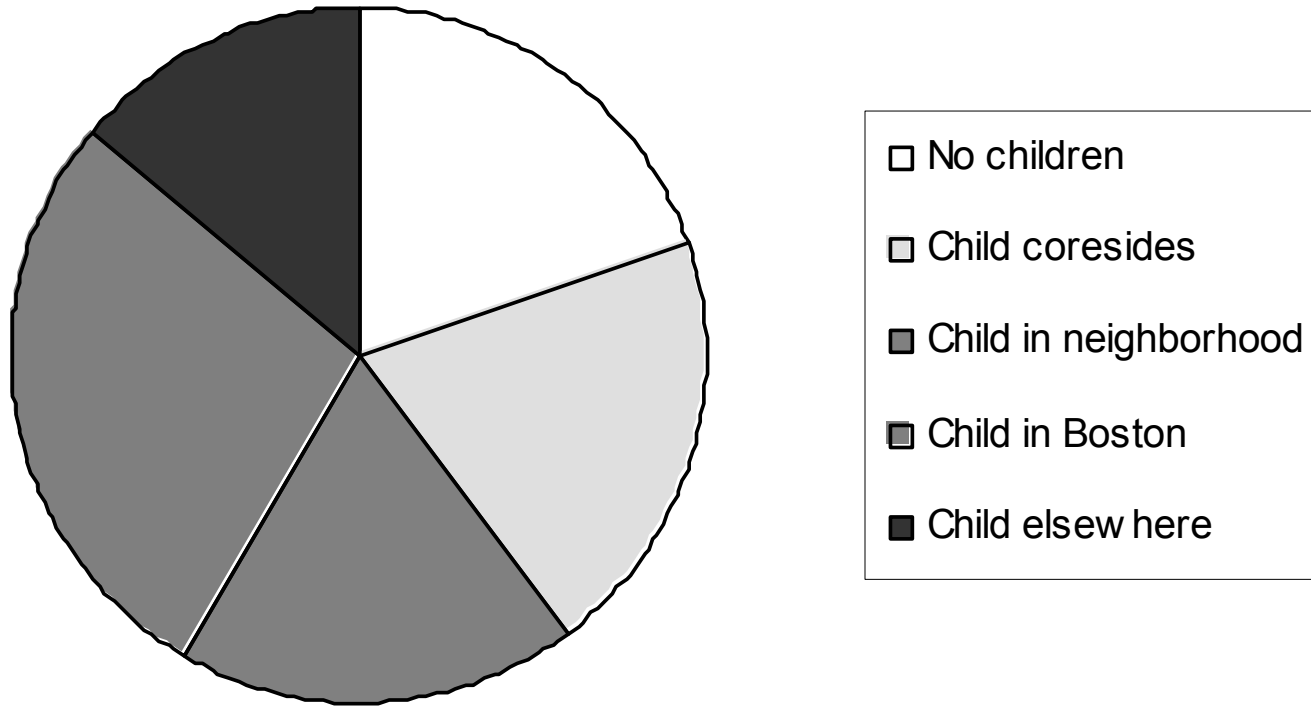


Figure 14: Frequency of personal or phone contact with friends or family in the past month

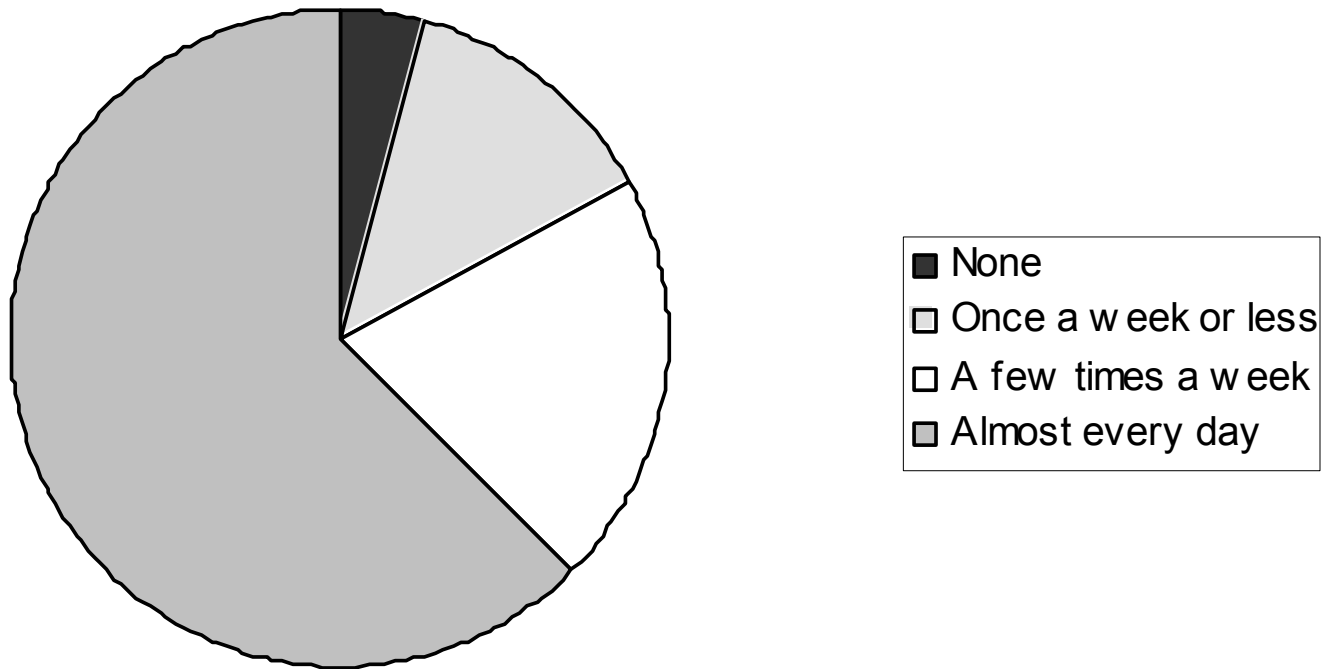


Figure 15: Participation and interest in volunteering

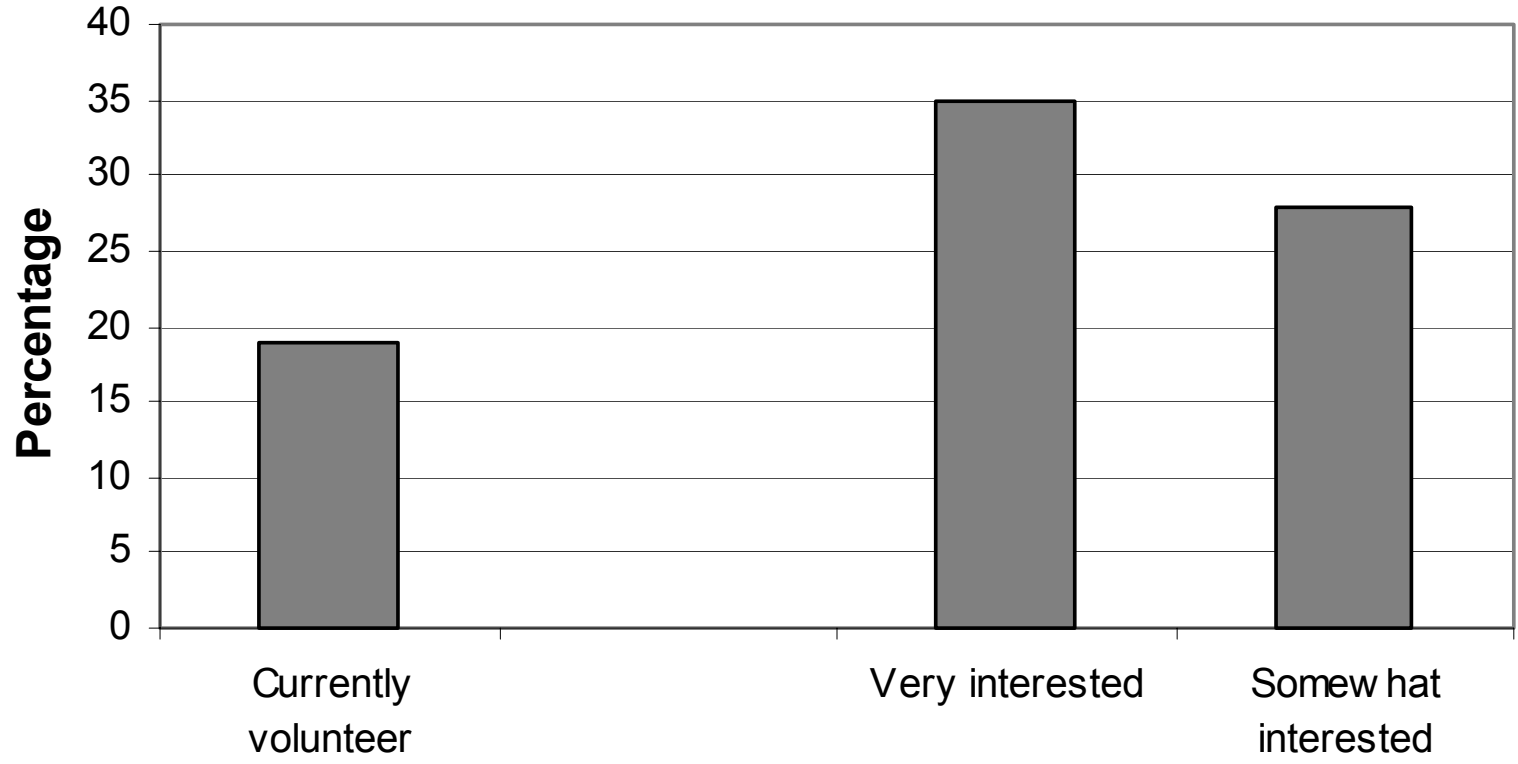


Figure 16: Self-reported health status

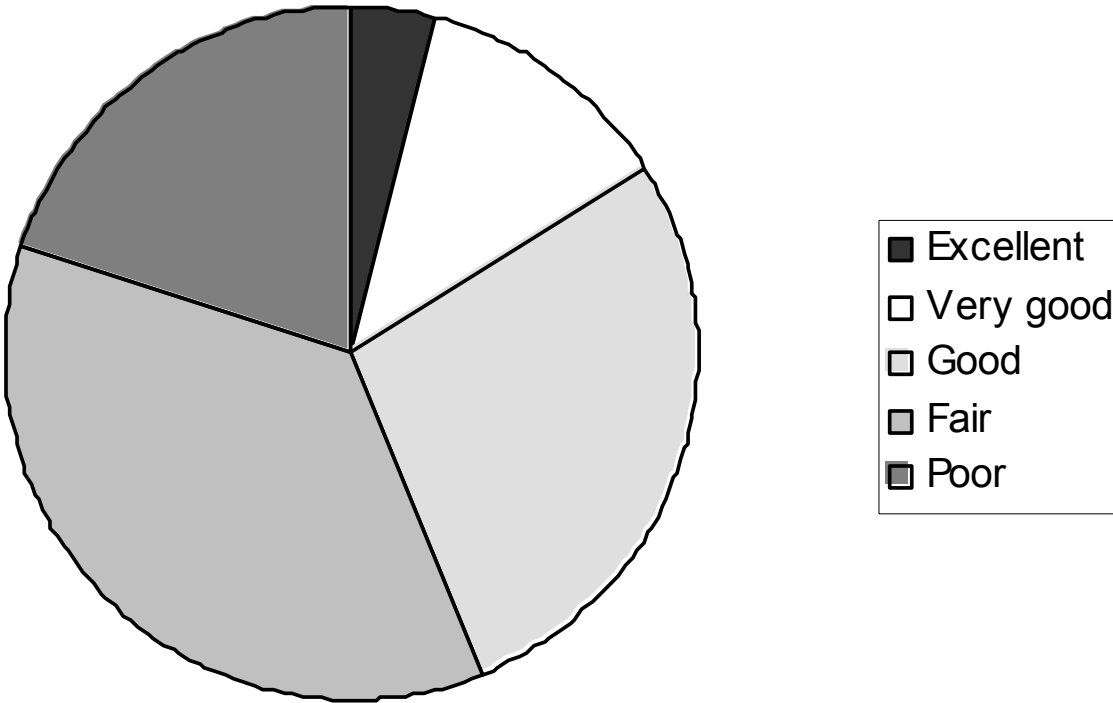


Figure 17: Mental Health

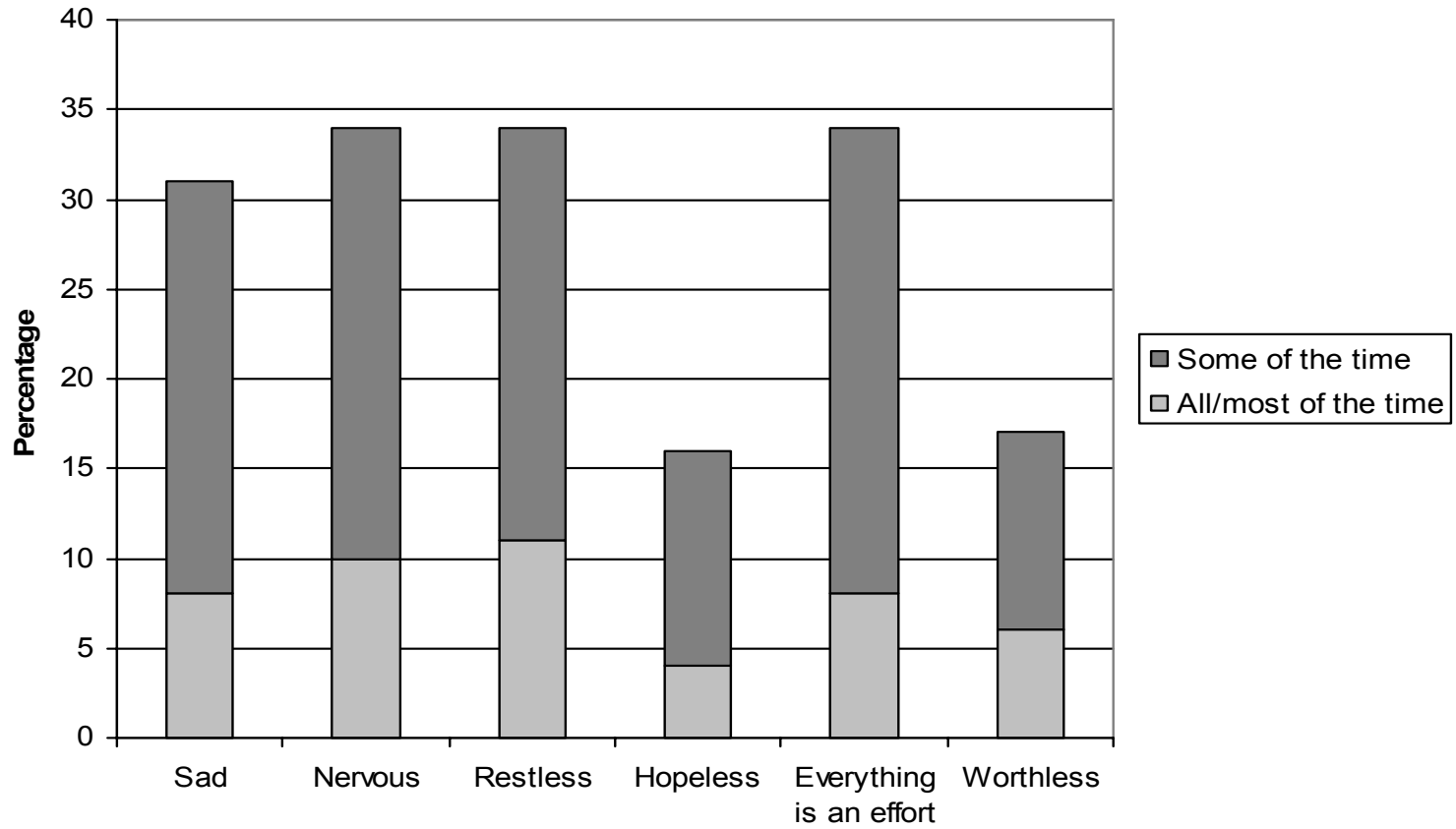


Figure 18: Health-related problems

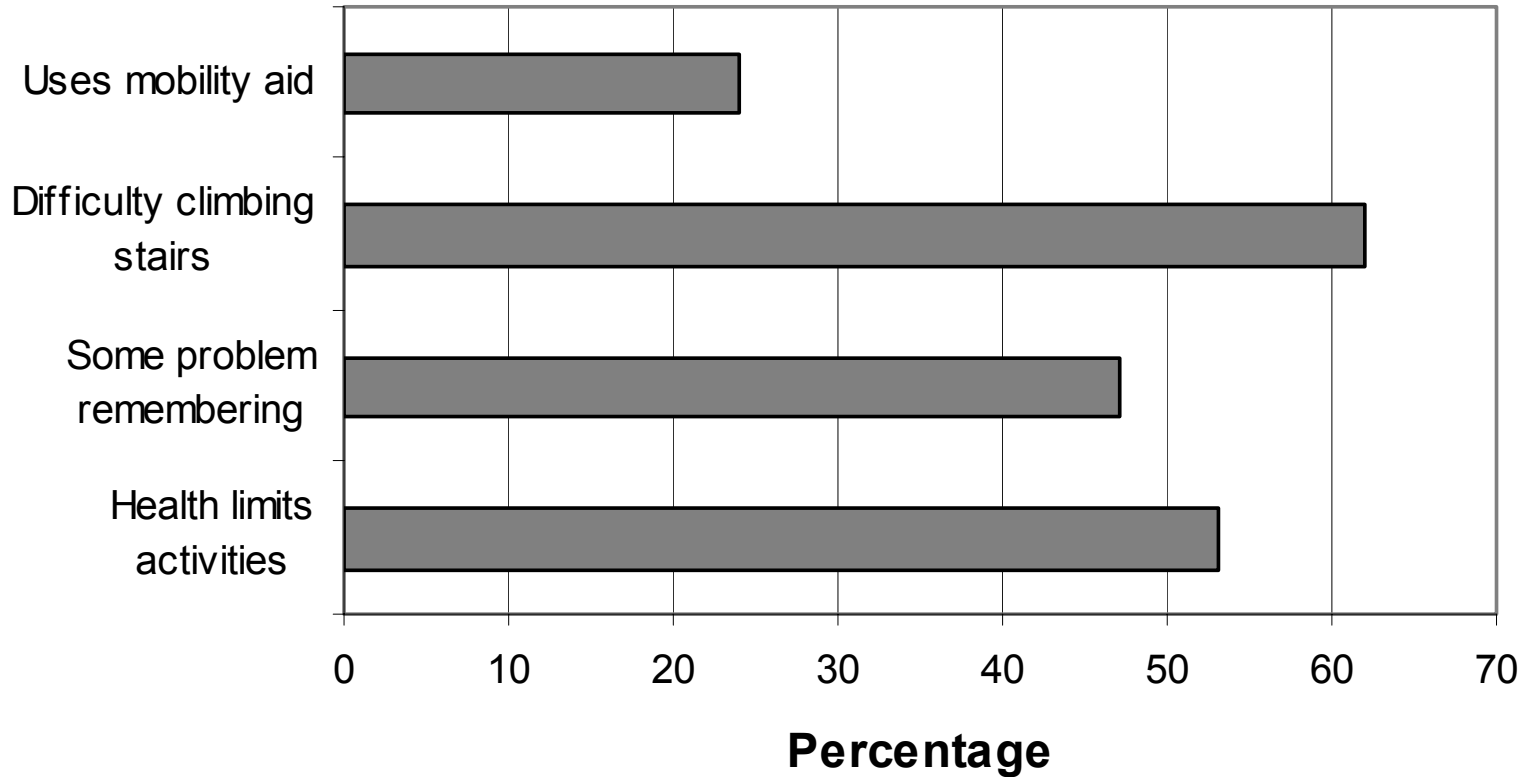


Figure 19: Help with ADLs or IADLs

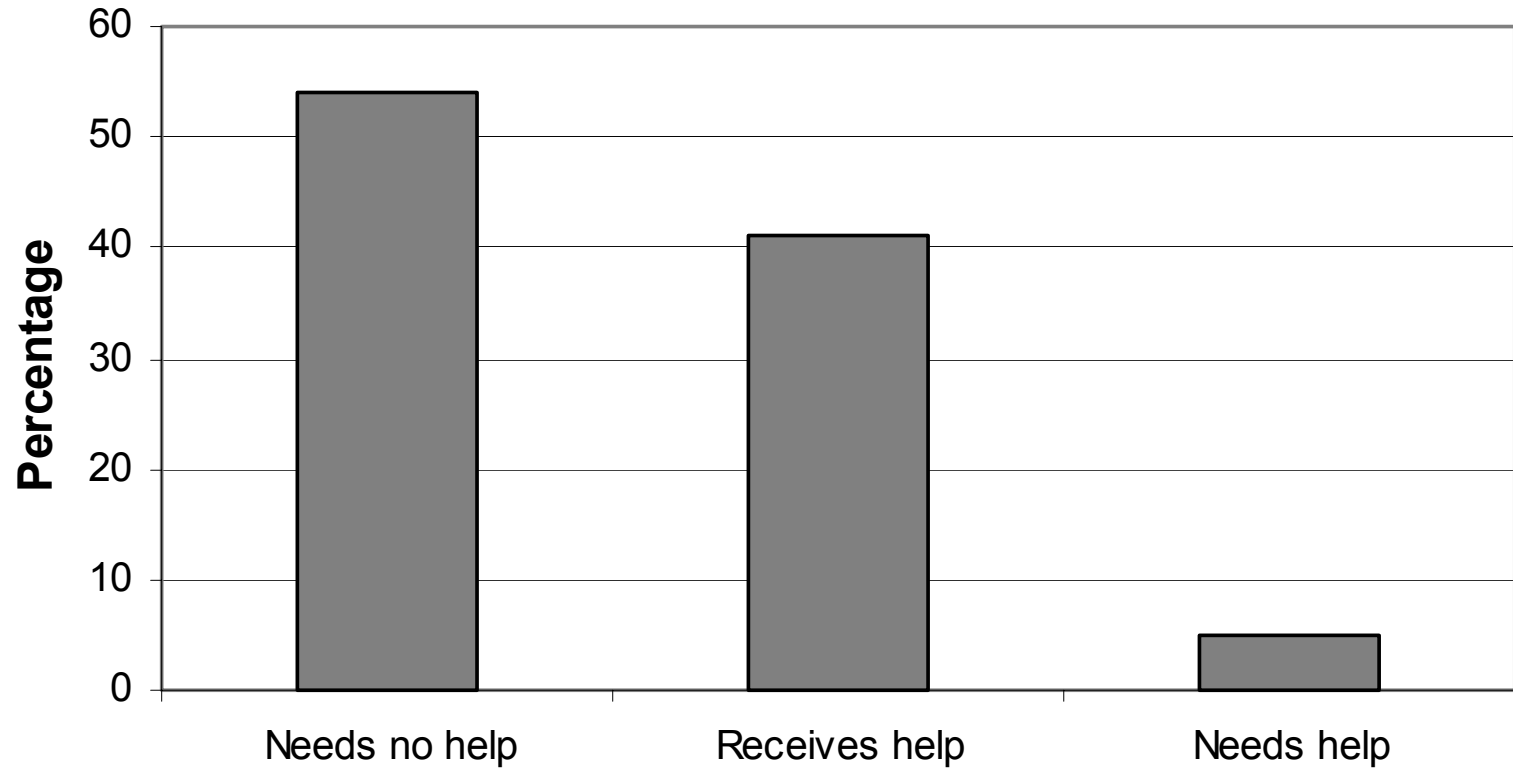


Figure 20: Use and unmet need, medical services

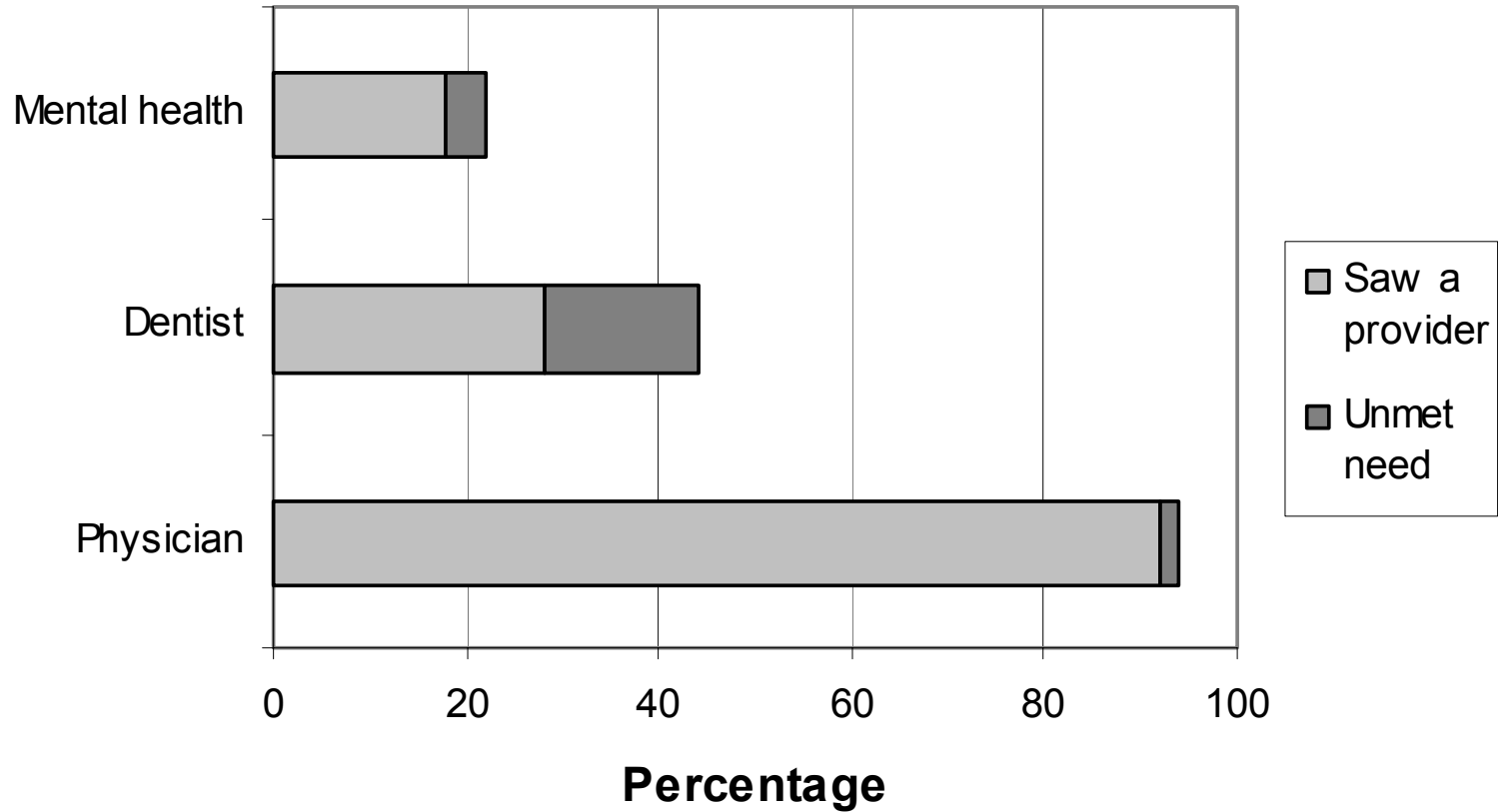


Figure 21: Use of services in the past month

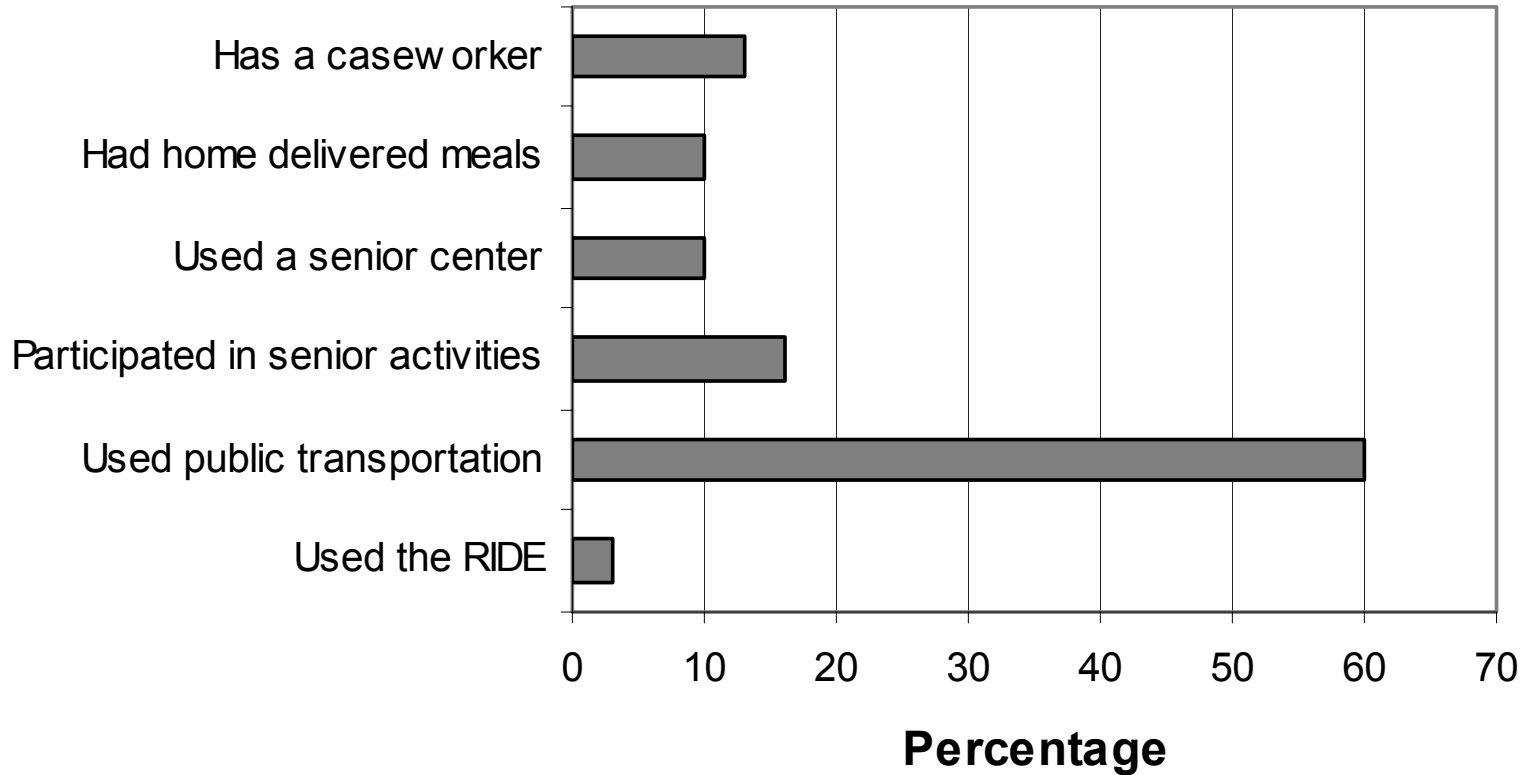


Figure 22: Self-assessed likelihood of using potential services

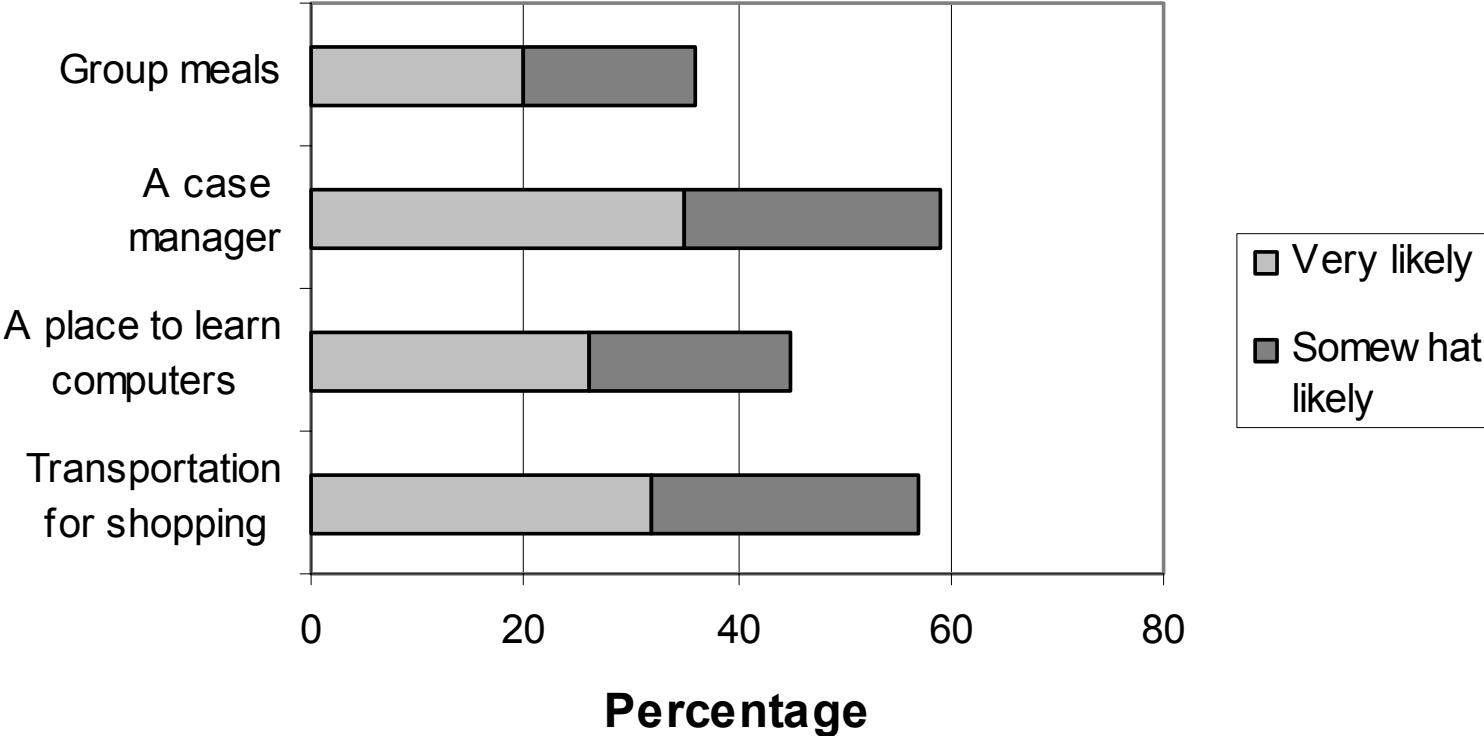


Figure 23: Safety and Security

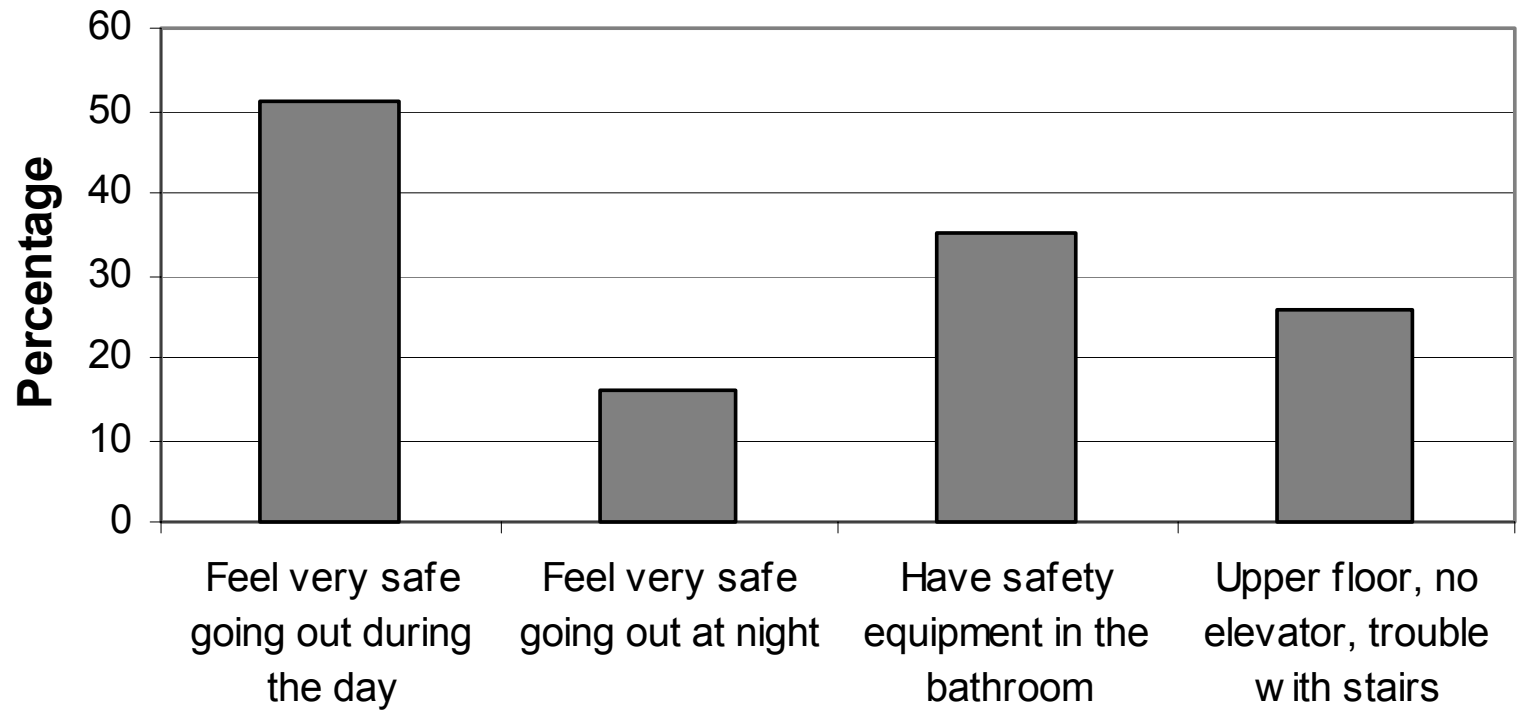
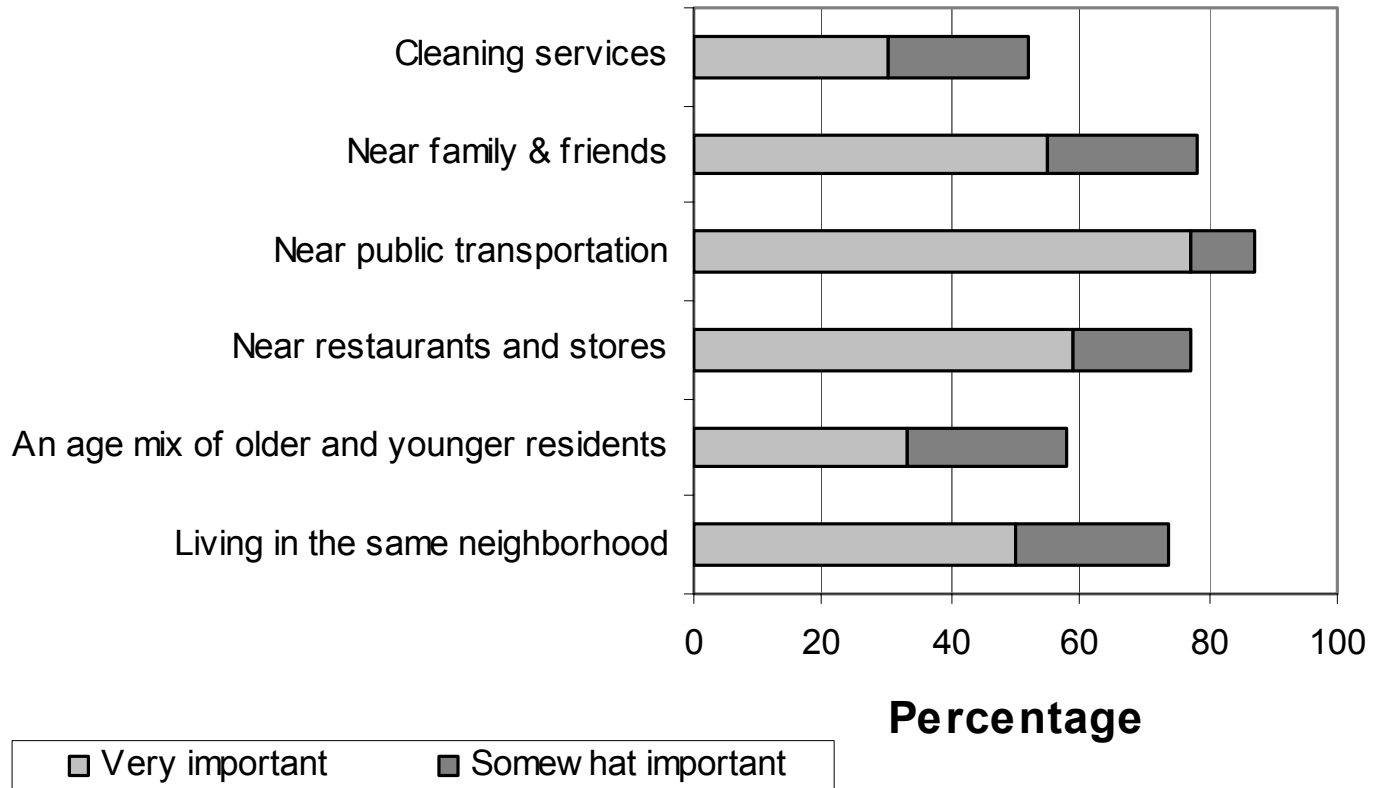


Figure 24: Important features of housing



Appendix A
Senior Advisory Group Members

Rachel Goodman	Director, Community Services Department, BHA
Kate Bennett	Director, Planning Department, BHA
Gwen Friend	Director of Property Management, BHA
Carol McCaffrey	Assistant Director of Property Management, BHA
Regina Dennis	Assistant Director of Property Management, Elderly/Disabled, BHA
Alfred Davis	Program Director Elder/Disabled Resident Services
Francina Brown	Manager II, Bunker Hill Development
Ruth Barkley	Chairperson, Cathedral Tenants United
Gloribell Mota	Executive Director, Mary Ellen McCormack Tenants Task Force
Dale Mitchell	Executive Director, ETHOS
Guillermo Gonzalez	Deputy Commissioner, Boston Elder Commission
Francis G. Caro	Director, Gerontology Institute, U-MASS Boston
Jan Mutchler	Gerontology Institute, U-MASS Boston
Ronald Marlow	Vice President/Director of Operations, MA CDC
Gail Douglas	Assistant Dean of Academic Services, Boston University School of Public Health

THE GERONTOLOGY INSTITUTE

University of Massachusetts Boston

The Gerontology Institute at the University of Massachusetts Boston addresses social and economic issues associated with population aging. The Institute conducts applied research, analyzes policy issues, and engages in public education. It also encourages the participation of older people in aging services and policy development. In its work with local, state, national, and international organizations, the Institute has four priorities: 1) productive aging, that is, opportunities for older people to play useful social roles; 2) health care for the elderly; 3) long-term care for the elderly; and 4) economic security for older people. The Institute attempts to pay particular attention to the special needs of low-income minority elderly.

Established in 1984 by the Massachusetts Legislature, the Gerontology Institute is a part of the University of Massachusetts Boston. The Institute furthers the University's educational programs in Gerontology. One of these is a multidisciplinary Ph.D. program in Gerontology. Through the Institute, doctoral students have the opportunity to gain experience in research and policy analysis. Institute personnel also teach in the Ph.D. program.

The Institute also supports undergraduate programs in Gerontology. Foremost among these is the Frank J. Manning Certificate Program in Gerontology, which prepares students for roles in aging services. Most students are over 60 years of age. Each year the Institute assists this program in conducting an applied research project in which students administer a large telephone survey. The Institute also supports an Advanced Certificate program; its in-depth courses focus on specific policy issues.

The Institute also publishes the *Journal of Aging & Social Policy*, a scholarly, peer-reviewed quarterly journal with an international perspective.

You can obtain information about recent Institute activities by visiting the Gerontology Institute's web pages: www.geront.umb.edu or email: gerontology@umb.edu.